Ethics in praxis: Negotiating the presence and functions of a video camera in family therapy

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1. Abstract

The use of video for research purposes is something that has attracted ethical attention and debate. While the usefulness of video as a mechanism to collect data is widely agreed, the ethical sensitivity and impact of recording equipment is more contentious. In some clinical settings the presence of a camera has a dual role, as a portal to a reflecting team and as a recording device to obtain research data. By recording family therapy sessions and subjecting these naturally occurring data to discourse approach we show how recording equipment can have a positive clinical role and demonstrate the benefits of video for participants. Our findings show that the camera is treated as an unproblematic member and is positively oriented to by families. Analysis reveals that members of the therapy interaction do have some appreciation of the value of recordings. We conclude that there are layers of beneficiaries from recordings and there is some clinical benefit and this has wider implication for the ways in which Research Ethics Committees assess and judge protocols involving the need for video.

2. Introduction

Qualitative research uses and relies heavily on direct observations to explore the human experience in the course of everyday life in numerous settings and contexts. For many of these observations to be effective, informative and detailed we need to go beyond merely observing and taking occasional notes (Bottorff, 1994). There is an assumption made that the research setting is 'directly knowable' through observation and as such recordings have the potential to elucidate data in a way that field notes fail to achieve and as such the complexity of social life is captured (Plowman and Stephen, 2008).

The availability of recording devices and further availability of resources has led to an increase in analysis of naturally occurring interactions in the field of medicine and health care, as well as many other settings (Heath, 2004).The advancement of technology has led to the creation of clips, still frames and text (Miles, 2006). These snapshots of interaction enable the analyst to identify the sequential organisation of talk and behaviour as videotaping allows for analysis and reanalysis (Bottorf, 1994).

Recording clinical practice

There is a rising pressure in health care to produce scientific evidence (Lee, 2007). Historically quantitative paradigms dominated evidence based practice but more recently qualitative research has become increasingly recognised as having a significant place in health services research as it provides a different dimension to healthcare and enriches the NHS (Jones, 1995). Health services research is utilised to explore the effect of healthcare delivery on populations and evaluate services (Cassell and Young, 2002). This has evolved to require the collaboration of service users in the research process and qualitative research provides a useful framework for ensuring this. It strengthens capacity in research and provides a comprehensive approach; bridging the gap between the science of discovery and the science of implementation (Jones, 1995). One way in which this has been facilitated in contemporary qualitative research is through the use of video (Lee, 2007) which has also

been a useful clinical tool for clinicians to make sense of their therapeutic interactions (Grimandi, 2007). For example it is common for systemic family therapists to use video recordings as part of their practice (Lee, 2007).

Systemic family therapists consider individual problems as the symptoms of family problems and in accordance set out to 'treat' the whole family; family therapy aims to improve the interrelating pairs of family members (Birtchnell, 2001). The systemic approach to family therapy is language-based and directs clients to concentrate on a relational processes rather than step-by-step operations (Larner, 2004). The aim of systemic family therapy, therefore, is to modify the aspects of the family system that are judged by the therapist to require change (Masson and O'Byrne, 1984). By recording this practice as it unfolds, the use of video as a clinical tool allows for feedback through observation and the reflection allows the family members an opportunity to see patterns and explore the family dynamics thus facilitating change. Furthermore the video is integral for training and research (Lee, 2007).

Justifying intrusions

The use of video has given rise to debate regarding the potential influence of the camera and the its ability to misrepresent human behaviour. Numerous researchers have raised concerns over the potential undue influence of the camera on behaviour (Speer and Hutchby, 2003). For example when speakers are being observed there is a tendency for them to speak in more formal ways and consequentially the presence of recording equipment may alter the styles and content of the language used (Stubbs, 1983). Others suggest, however, that after the first few minutes of being on camera, self consciousness wears off as participants became acclimatised to the presence of the camera (Bottorf, 1994).

Problematically these concerns about recording technology are treated as something going on inside the heads of participants rather than as something topicalized and negotiated in and through interaction; as such there is an assumption that participant concerns are hidden from the researchers who thus have little way of knowing the extent to which the recording has affected the interaction (Speer and Hutchby, 2003). However, Speer and Hutchby (2003) show through analysis that the presence of a recording device from a participant's perspective is not necessarily a determinate or negative force. The participants' displays of awareness of the presence of recording devices are not automatically a hindrance to interaction but are bound up in facilitating a range of activities made relevant by participants.

A new look at 'intrusion': the clinical context of family therapy

These practical debates have provided a useful knowledge base and benchmark for practical research process decisions and in the health context it is necessary to pay attention to the evolution of qualitative research and surrounding arguments. Taking the position Speer and Hutchby advocate, it is clear that more empirically grounded evidence is required to look at how service users and clinicians manage and deal with these issues in clinical and research practice.

In this paper we note that the presence of the camera is negotiated practically in clinical terms, through interaction. Analysis will address how the camera is treated as part of the family therapy reflecting team; as a mediating presence in the conversation. Previously recording equipment has been viewed as an intrusion to interaction; as something to be treated as unobtrusive, and at best ignored. This study, however, indicates that this negative construction of recording devices may underestimate the positive value that the camera has, particularly in clinical settings where participants not only orient to its presence but treat it as a 'member'.

Aims of the paper

1. Recording equipment can have a positive clinical role regardless of research. In other words, the camera is not necessarily treated as an intruder in the interaction but a welcome member, assigned roles within the therapy.
2. The study will show that there is not just a tolerance of recording equipment but an appreciation of the value of the recording; a noting that the video has benefits.
3. Due to the integration of clinical aims and research objectives in the quest for developing an evidence base for practice, there are potential issues relating to the more positive role of the recording device that need to be addressed as we think about who benefits from the recording

3. Methods

Sandelowski (2004) argues that because of the growth of qualitative research and the increasing acceptance of its findings, there have been greater calls to include qualitative work in evidence-based practice. She notes that while there are disagreements on how, scholars generally argue that there is a need to make qualitative research findings more useful and to move them to be more central in the evidence-based practice process. As such this paper utilises a qualitative, discursive design to explore the important and relevant issue of recording devices and their therapeutic value.

The therapeutic setting

Therapy is a social practice between the client and therapist (Leahy, 2004) and in the analysis we show how this social practice is co-constructed by multiple members. The data for this paper comes from a data corpus provided by a UK based family therapy centre specialising in child mental health. The family therapists from this centre practice systemic family therapy. For the context of this article we are not concerned with family therapy debates in terms of the effectiveness of therapy or the competence of different approaches. Rather, like Labov and Fanshel (1979) we do not take any issue with the theoretical frameworks influencing practice but instead focus on the actual therapeutic conversations that take place to explore what actually happens in family therapy.

In this research we draw on a video data corpus of family therapy from two therapists who provided consent and four families with pseudonyms of the Clamp family, the Bremner family, the Niles family and the Webber family (see table one). This totals approximately 22 hours of family therapy.

The approach

This research utilises the discursive approach as typified in the work of Edwards (1997) and Potter (1996). This draws on conversation analysis techniques as pioneered in the work of Sacks (1984), looking at how versions of the world are produced through discourse. By drawing upon conversation analysis those practicing discursive psychology can attend to the sequential organisation of the talk but also address the types of psychological business that informs the sequentially organised conduct (Wooffitt, 2005). The focus for the discursive approach is to understand how discourse accomplishes and is part of social practice rather than to uncover the technical linguistic structure of talk and text (Edwards and Potter, 1992). The discursive approach has led to the formation of new ideas in the context of therapy (Hutchby, 2007; Peräkylä, 1995; Silverman, 1997) and the value of analysing therapy in a discursive way is that it offers an understanding of the therapeutic process based on language

as opposed to trying to interpret what is hidden in the heads of clients (Madill and Barkham, 1997). Using discursive psychology enables a systematic, empirically and analytically grounded observation of the ways in which families interact with the therapist and negotiate the value and use of recording equipment.

The literature notes that the transcription process should reflect the theoretical positions of the researchers (Lapadat and Lindsey, 1999). As expected with this approach transcripts of the video data were produced using the Jefferson transcription system (Atkinson and Heritage, 1999). This reflects a need to capture not only what is said but the way it is sounded to provide a detailed version of the complexity of interaction (Wooffitt, 2005).

Although conversation and discursive analyses have been criticised for being interpretative as different conclusions may be reached from analysis, the evidence shows that just because different interpretations are possible does not make the method subjective (Buttny, 1993). Buttny makes the case that the analyst does not actually interpret the case per se but grounds the claims in the data and that making the data available for scholarly inspection, makes transparent the claims. We find that this is further enhanced by sharing ideas and transcripts during the initial stages of analysis to improve inter-coder reliability (Boyatzis, 1998). To facilitate intercoder reliability we shared our initial thoughts and transcripts with an established in house research group, LIRA (the Language and Interaction Research Assembly).

Ethics

The British Psychological Society's (BPS) guidelines were utilised and followed for this research. All participants were treated with respect and data were treated sensitively. Confidentiality and anonymity were assured and informed consent was obtained at all levels; management, therapist and parents. Informed consent was not sought from children in order to avoid potentially compromising parental authority. Data was video-recorded naturally for clinical purposes and consent provided to use for research. As such data was carefully used and protected.

4. Analysis

Analysis of data revealed that the camera may be a more positive aspect of clinical work than academic debate has previously considered; not necessarily being treated as problematic by participants. Our analysis reveals that there are three key ways in which members orient to and consider the recording in clinical practice; 1) they treat the camera as an unproblematic member, 2) children use non-verbal communication as a means for treating the camera as unproblematic and 3) an appreciation of the value of the recording is offered.

Camera treated as a unproblematic member

Our analysis reveals that the camera as a recording device is a positive member of the therapy; with reference to the team behind the camera as having a role in the therapy. The role of the camera, therefore, is part of the current unfolding interaction; as a portal to a clinically relevant and therapeutically important reflecting team in the first instance. While the camera creates a recording and can be used for training and research, the interlocutors can and do treat the device as a positive aid to the clinical context.

Extract 1: Clamp family

1 FT: we know we have this kind of routine of where I

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2                often (.) shortly before we finish I go and hear
3                what Hannah and Dawn have been thinkin' about (.)
4                I may do that a few times (.) today (.) and next
5                time so that I can stay more in touch with (.)
6                with their ideas as ↓well
7   Dad:         ↑Yeah
8   FT:          >So there's< more of a pool of people to help out
9                if that's okay
10  Dad:         Yeah
```

The therapist's narrative here implicitly constructs the camera as an active presence within the therapy session as a whole, as it acts to enable the reflecting team behind it ('Hannah and Dawn') to play their part in 'thinkin' about' what is being said in the consulting room. The camera's presence is rendered unproblematic through a discourse of ordinariness. Positioning the existence of a reflecting team behind the camera as *'routine'* (line 1) functions to make the event ordinary and as such normalise their input, at the same time demonstrating to the family that they have access to the interactions in the therapy room. As part of this management of their role, the therapist directly refers to the reflecting team by their first names (pseudonyms) *'Hannah and Dawn'* (line 2). This functions to personalise and familiarise the family with their presence and move beyond the camera itself to the people behind it. Thus, while implicitly acknowledging the presence and role of the camera, the therapist simultaneously elides it: the camera itself is not 'named', unlike the team behind it. This reinforces the clinical role of the camera. It is treated as a conduit which both mediates, and renders complete, the therapy 'pool'.

The therapist, however, is not the only member to treat the camera as an active presence. Our analysis demonstrates that family members will also interact with the camera, as a way of accessing the people behind it.

Extract 2: Webber family

```
1   FT:          I'm aware ↓that (0.4) >we are limited by time
2                today< (.)  and I .hh I actually .hh       have
3                no idea what time ↓it ↓is
4   Mum:         N(h)o
5   FT:          Cuz that clock's wrong an' I 'aven't got a ↑watch
6   Mum:         >I 'aven't got one either<
7   Dad:         Neither of us 'ave got ↓watches
8   FT:          I'm sure,
9   Dad:         You couldn't >bring us the time?< ((to the
10               camera)) heh heh
```

Here the therapist identifies that there is a problem related to the request from the family to finish the session earlier than usual. He acknowledges the problem *'we are limited by time today'* (line 1) and then moves to demonstrate why that poses difficulty for him *I actually have no idea what time it is'* (lines 1-2). The absence of time keeping devices by all parties having been established, a possible solution is constructed by the father orienting unproblematically to the camera as a helpful mediator. His turn in line 8 is directed towards the camera lens, thus appearing to treat it it as an interactional member. However, while fixing his gaze on the device, his request is actually directed to the reflecting team in a separate room: *'you couldn't bring us the time?'*.

What these two extracts demonstrate is that the therapist and the family both orient to the camera as a helpful device in the interaction and both recognise the team or presence of persons behind it. In this way the camera is constructed not only as unproblematic to the interaction, but actually integral to the therapy. Notably, children also interact with the

camera and treat it as an unproblematic member of the interaction; mostly through non-verbal communication.

An unproblematic member – interaction through the non verbal

Sparrman (2005) argues that it is important to understand how and when children interact with the video camera. She noted in her analysis that verbal comments on the camera were rare but there were many more non verbal acknowledgements. In our data corpus, we note that children will use verbal mechanisms for making relevant the video camera and non-verbal mechanisms for interacting with it.

Extract 3: Niles family

```
1   FT:     if you had an <attention deficit> (1.4) then >you
2           wouldn't< (.) I think (.) <it would stand to reason>
3           that you wouldn't be able to attend to things and
4           ta[ke in information
5   Dad:      [↑Yeah bu[t it's like
6   Lee:              [I'm   on   the   camera
7   FT:     °you are° ((waves at the camera then points to it))
8   Dad:    Why >why is it< (.) if 'e's concentrating on somet
9           (0.2) he's really like (.) ↑this tryin' t'
10          concentrate and then >if 'e can't do somethin'< 'e
11          gets 'is [hair off doesn't he?=
12  FT:             [((lifts Lee's hand to wave at the camera))
13  Mum:    Hu::m
14  Dad:    He ↑throws things and (.)
15  Lee:    ((waves at the camera))
```

Extract 4 : Clamp family

```
1   FT:     And there's lots of worries about [Jordan's
2           behaviour=
3   Ron:                                      [Loo::k ↑look up
4           there (.) look ((Ron then sticks out his tongue in
5           the direction of the camera))
6   Dad:    =and Phillip's b[ehaviour as well (.) Ronald isn't
7           s::o bad
8   Joe:                    [It's no good pullin' >your tongue
9           out< jus' in case they're watchin' ya
```

In both of these extracts the same kind of sequence can be observed. In extracts 3 and 4 it is notable that an adult party is speaking about therapeutically relevant and rather sensitive information. This is attending to the 'business' of therapy. During this conversation an interruption occurs as one of the children verbally orients to the presence of the video camera. When children interrupt adult conversations, particularly sensitive ones of this nature, the interruption is treated negatively (O'Reilly, 2008). It is unusual, therefore, that in both of these cases the child's interruption is positively attended to by an adult. After the child has drawn attention to the camera *'I'm on the camera'* (lines 5-6 – extract 3) and *'look, look up there'* (line 2, extract 4) in both instances non-verbal behaviour follows which is displayed in a manner that interacts with the camera. In extract 3, Lee waves at the camera and in extract 4, Ron sticks his tongue out. These gestures are not hostile in their display but work to interact with the camera, or with the absent members of the reflecting team. In normal face-to-face interactions gestures of this kind may be mirrored or responded to in some way by the recipient; however in this instance any response of the team behind the camera cannot be available to the child. Notably, though, the child's gesture takes for granted the possibility of

such normative responses, again both treating the camera's presence as unproblematic (as conduit) and eliding it (as mediator). This is validated by the adult party in both sequences of talk. In extract 3, the therapist actively takes Lee's wrist and initiates the first wave and in extract 4, the uncle Joe makes reference to who is being attended to by the reflecting team behind the camera. Joe states *it's no good pullin' your tongue out jus' in case they're watchin' ya'* (lines 5 -6). This makes relevant the notion of who is being watched by whom and what is being attended from behind the camera.

This analysis demonstrates that one function of the camera is as a portal to the reflecting team behind it. This makes relevant the overheard nature of the current interaction; in the here and now. The camera, therefore, is treated by the interlocutors as a member of the therapy. This additional 'member' of the therapy is oriented to by the interlocutors as a positive resource and valuable part of the process. Furthermore the camera is not only a portal to the reflecting team but also a recording device that creates a record of the therapy. The evidence base has raised concerns over the ethics of recording therapy and the intrusive nature of the video. This, however, has potential to obscure the positive value of recording and its benefits for research.

Appreciating the value of the recording

Our data reveals that members of the therapy view the presence of the camera in positive terms. The camera has potential clinical and research benefits and it is notable that the members of the interaction construct the presence of the camera as having value for the therapy.

Extract 5: Clamp family

1	Jordan:	I can see ↑that camera ((points up to the corner
2		of the room))
3	FT:	↑Yes (.) it's still the::re
4	Dad:	We went (.) <in the::re> (.) <to watch Phillip in
5		'ere>
6	FT:	↑Oh right (.) °right°
7	Dad:	°To watch Phillip (.) >you know<°
8	FT:	People find it intriguing (.) I think

Again in this extract it is the child whom draws attention to the camera, both with a verbal and non-verbal acknowledgement. Following receipt from the therapist (line 2) the father makes reference to the value of the presence of the camera by noting the availability of the camera for family use. He references an event in which the parents utilised the camera as a portal to access their children's behaviour, specifically Phillip's. What this manages is the importance of the child in front of the camera and as accessible and viewable by those positioned behind it.

Extract 6 Niles family

1	FT:	I'll sit down 'ere
2	Lee:	'e's just tipped his ↑drink over 'im
3	Nic:	Or you could <move the camera> so it faces ↑there
4	FT:	Well I could (.) ↓yes
5	Mum:	↑Yeah >that's a good idea<
6	FT:	Yes I could do [that
7	Steve:	[Then I'll move then

In this extract the position of the child being in full view of the cameras is also negotiated as valuable. At the start of the session the placement of members in terms of their position in the

room is negotiated and managed. Lee provides an account for why Steve needs to move from the chair located in view of the camera to an alternative seat (line 2). This is treated as creating difficulty by the members as the move means that Steve will no longer be fully visible to the camera. As such Nicola suggests that the physical direction of the camera could be changed to accommodate the new seating arrangement. This indicates that the family view the presence of the camera as important but also negotiate a hierarchy of who should be visible to it. They position Steve as necessarily viewable by the reflecting team through the camera (although Steve, in line 7, appears to indicate that if the camera *is* moved to fcus on him, he will move seats, thereby attempting resistance to this family heirarchy). What this demonstrates is that the camera is a valuable part of the therapy for the family (in a positive sense, but also a sense that can be resisted), and notably the therapist can also make relevant the use of the camera in therapy as a valuable clinical tool.

Extract 7: Clamp family

```
1   FT:         Er::m (.) we do ↑often like t' >video< the
2               sessions >and again< there's (.) there's certain
3               re::asons >for that< (0.2) ↑one is jus' that I
4               can look >at the video< before we meet again >so
5               I can< actually remind [myself of=
6   Dad:                               [↓Yeah
7   FT:         =what we've been sayin' an' I can take some
8               notes from it >'cuz my memory's appalling< heh
9               heh .hh so >it helps if I can< watch a video
10              >bu[t we wouldn't video if you=
11  Dad:           [↓Yeah
12  FT:         =didn't want to be<
13  Dad:        ↑No that's [okay
14  FT:                    [That's ↓okay
15  Dad:        Not a problem
16  FT:         ↑Great
17              (1.2)
18  FT:         I should say (.) <that sometimes> (.) we're
19              asked >t' do training as well< and (.) people
20              ask t' see videos for ↑training
21              (1.4)
22  FT:         we wouldn't do that unless you're happy (.) with
23              that=
24  Dad:        =No that's okay as ↓well
25  FT:         Right okay
```

Through his narrative the therapist here orients to the *recording*, which is different from the previous extracts where the camera was the focus of discussion. Here, in his account for *'videoing'* the sessions the therapist constructs the clinical value of the recording through a two part account. He demonstrates that by allowing the recording he is then able to help the family, clinically, in two ways. First, the recording creates a reference point which he can consult prior to each therapeutic session, thus aiding his memory (line 6); second, the recording creates a reference point to facilitate training to improve services and help families (line 16). At line 15 there is a transition relevance place (Sacks et al, 1974) for a topic shift as the therapist has acquired consent for him to view the video materials. The therapist, however, continues to consider the value of the recording to produce the second part of his account.

The consent form accompanying the negotiation of consent requires three levels of signature, clinical, training and research. As such in the process of obtaining consent the therapist makes reference to the wider access needed. The first part of the account focuses on clinical requirements and relates to the process of therapy. The wider access is managed

through a professional discourse of training (line 15). This is particularly marked through the modal verb used in the phrase *'I should say'* (line 15) which gives a sense of obligation. The response provided by the father works to acknowledge the additional request and wider audiences of the recording. In both requests, the need for recording the therapy is treated as unproblematic by the family and acknowledged to be valuable to the therapist. This is particularly noteworthy, given the fears and debates regarding the problematic presence of recording devices for research and other contexts referred to earlier.

Extract 8 : Niles

1	Dad:	>I mean< I don't mean t' (.) >I ↑know we're
2		bein' video'd now < (0.2) I don't mean t' 'ave <a
3		go> (.) but (.) I want it = t' get it so:rted =
4	FT:	= frustrated er::m
5	Dad:	↑yeah (.) because (.) >I mean< 'e's not >he's
6		not< ↑my real son (.) but 'e gets treated the
7		↓same
8		(2.0)
9	FT:	↓Yeah

What is apparent in this extract is the insertion of reference to the video in between the central point being made by the father. The reference here is bound up with the father's management of face (Goffman, 1955) in the context of presenting a version of how he relates to his step-son. The father has at stake (Potter, 1996) his identity of 'good parent' by not discriminating amongst the siblings and works to dispel any possible negative interpretations made by the therapist (Hutchby and O'Reilly, 2010). He manages this through an acknowledgment of the possible interpretation that he is 'having a go' (line 2). The discalimer '*I don't mean t-...I don't mean t' 'ave a go*' is modified by the inserted phrase '*I know we're being video'd now*' (line 1). This insertion does the work of acknowledging, not only the presence of the video camera, bu the father's awareness that what he is now saying is 'on record'. In a similar way to the examples discussed by Speer and Hutchby (2003), therefore, this displays that a manifest awareness that a recording device is currently recording does not necessarily mean that participants refrain from stating things that they feel need to be stated. Although it is sometimes the case that participants do request the device to be turned off (Speer and Hutchby, 2003) or are given the option to turn it off, extracts such as this demonstrate that 'going on record' can actually be used as a positive resource at certain stages in a consultation.

5. Discussion

Our analysis has demonstrated that the presence of a camera in clinical settings can have positive value. There are layers of beneficiaries from the recordings in terms of clinical benefit, the development of training programmes and the production of analysable data for research. All of these function to contribute to academic debate and improve clinical practice.

The analysis revealed that contrary to fear and concern over the presence of video in clinical settings and for research, the recording equipment can have a positive clinical role. We have noted that family members and therapists do not treat the camera as an intruder on the therapy, rather as a welcome presence with a role to play. We have shown that members do not simply tolerate the presence of the camera but interact both with and through it. The members of the therapy session acknowledge the usefulness of the camera as a portal to the

reflecting team behind it and express appreciation of the recording itself. This demonstrates that the video is viewed as being beneficial to themselves and others. It is notable that the beneficiaries are noted more in the immediate context rather than the wider benefit of training and research. While families consent for the recording to be utilised for training and research purposes, most of their interactions and noticing of the video relates to their own personal circumstances.

What is particularly notable from this study is the setting in which the research is undertaken. The unique and distinctive clinical use of the recording is primary to the secondary aim of research and something that would be considered unusual in many other contexts. In some health settings, the use of video for clinical use is becoming more normative and as such this has implications for the debates around video for research in the discipline of health. Research in health is especially important, particularly in light of the drive for evidence-based practice. While quantitative evidence, drawn mostly from clinical trials is essential for our knowledge and understanding of health, this mainly focuses on outcomes and gives little information regarding process. Qualitative work is increasing in this field as a way of addressing our knowledge gap and paying more attention to the service user and as such there has been a rise in the use of video materials for research. This has thus raised concerns regarding the potential for the camera to intrude on the health setting or in some way become problematic for treatment outcomes.

What we have provided in this study is empirical evidence for the ways in which actual families undergoing therapy deal with the presence of the video camera. This has important implications for the way in which Research Ethics Committees (RECs) deal with protocols utilising qualitative design with the need for video. Currently debate regarding the potentially intrusive nature of video has been based on assumptions regarding psychological reactions taking place within the individual being filmed. Our analysis demonstrates that in clinical settings such as family therapy, the camera and the subsequent recording are at least unproblematic, and at best clinically valuable, to those participating. This perhaps reflects the fact that the use of video is becoming more normative in a contemporary society and is no longer treated as problematically as debate once suggested. Qualitative research can have considerable value for improving services, taking the service user viewpoint seriously and making recommendations for practice and as such should not be underestimated in its contribution. For quality research to have outcomes and impact some methods rely heavily on the use of video for analysis and our evidence suggests that this is not a primary concern of those captured on tape.

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Table 1:

The four families were given the pseudonyms of, **Clamp**, **Niles, Bremner** and **Webber**. **The Clamp family** consisted of two parents, **Daniel** and **Joanne**, one male uncle, **Joe** and three children, **Phillip** ('special needs'*****), **Jordan** ('handicapped) and **Ronald** (Learning difficulties). **The Niles family** consisted of two parents, **Alex** and **Sally** and four children (one with a pending diagnosis), **Steve** (Undiagnosed … suspected ADHD), **Nicola**, **Lee** and **Kevin**. **The Bremner family** consisted of the **mother,** the **grandmother** and two children; **Bob** (Autistic Spectrum Disorder) and **Jeff** ('Mentally handicapped')**.** **The Webber family** consisted on two parents, **Patrick** and **Mandy** and four children (one with a diagnosed disability), **Adam**, **Daniel** ('Special needs'), **Patrick** and **Stuart**. * Terminology is written as described in the therapy by the parents and/or therapist rather than official politically correct terms and diagnoses.

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