

Research highlights

- The study utilised a conversation analysis approach to closely examine family therapy talk, as this has the benefit of illuminating the discursive strategies used by all parties.
- Parents used a range of strategies to display their good parenting, including illustrating how they act in their child's best interests.
- This can present challenges for therapists as they work to reframe the difficulties systemically, without engaging in blame.

Abstract

Systemic family therapy promotes a systemic reframing of individual problems to an understanding of the familial processes influencing family functioning. Parents often attend therapy identifying their child as the key problem which raises issues of accountability and blame. In this paper, we explored the discursive practices used by parents for constructing themselves as 'good parents'. Using the basic principles of conversation analysis and discursive psychology, we analysed actual therapeutic sessions and found that parents used a range of strategies to display their good parenting and manage blame. This included directly stating it, illustrating how they act in their child's best interests, showing that they parent in appropriate ways and by making appeals to scientific rhetoric. It was concluded that in family therapy, the therapists have a challenging task in managing competing versions of events and dealing with blame. We discuss the implications for practice.

Key words: Systemic, family therapy, children, blame, accountability, conversation analysis

Suggested running head: Blame and good parenting in family therapy

Practitioner points:

- 1) Family therapists have the challenging task of managing potentially competing versions of what constitutes the problem from different members of a family.
- 2) Parents tend to blame their children for the problems experienced and this blaming tends to be done in front of the children during the therapy.
- 3) By being overtly aware of the discursive strategies parents employ in therapy, therapists can reflect on how to manage these challenging conversational practices.
- 4) Conversation analysis may serve as a tool to support reflection, as therapists examine their own interactions during the therapy.

Introduction

It is well known that the core aim of family therapy is to facilitate the resolution of the difficulties experienced by families by focusing on the relationship between the individual positioned as having the problem and significant members of the family (Carr, 2012). Family members along with the therapist engage in the institutional task of therapy, including finding solutions to the problems presented (Hutchby and O'Reilly, 2010). In this paper, our interest was in the practice of therapy with parents and children, and our sample reflects the systemic approach to therapy. This was because this approach was used by the therapists who participated in our research, rather than for any particular preference for one approach over another. Systemic family therapy, particularly, aims to facilitate change in the functioning of the family system and requires the cooperation and effort of all family members (Barker and Chang, 2013).

This ethos and process of referral to family therapy may leave parents feeling inadvertently criticised and inherently blamed for their problems. The process of being referred moves the onus away from the child and places the spotlight on all family members. For some this process can call into question their parenting position, raising questions about their abilities and their belief that they are doing what is best for their child. This is further compounded by the process of family therapy whereby the therapist guides the family toward a more flexible understanding of their difficulties with a negotiation of responsibility (Bowen et al., 2002), while also balancing the views and perspectives of all parties that may be in conflict (Sheridan et al., 2010). In this context, it is fairly common for parents to position the child as the main problem (Berg and Steiner, 2003; O'Reilly, 2014), as they are positioned as responding to the behaviours of the child (Sheridan et al., 2010). Yet for therapy to be successful, families must reach a mutual agreement regarding the problems they are to

address (Hawley and Weisz, 2003; O'Reilly, 2013). A challenge for therapists, therefore, is to work with parents in a way that helps move their position from blaming the child, to one whereby they involve the whole family.

This agenda for change is complicated by a blaming culture that can easily be fostered by shifting blame from the child to the parents. Blame is rife in cultural discourses of mothering and women typically carry the societal, and in some cases professional burden because they fail to fit the idealised view of motherhood (Jackson and Mannix, 2004). Accordingly, they are frequently subject to unwarranted judgments when they access services for their children. This blaming discourse has tended to hold mothers responsible and research suggested that they resisted such external pressures by seizing authority with services, but still often felt criticism from society (Blum, 2007). This is worsened further as parents' battle against the inevitable changes to their working life, family life, and social life that having a child with a disability brings (Sen and Yurtsever, 2007). Although many try to hold onto an optimistic outlook and maintain some routine (Heiman, 2002), issues of stigma can affect mothers, and indeed other family members, as they struggle with any negative attitudes from others (Corrigan and Miller, 2004).

More recently, there has been somewhat of a genetic revolution, wherein the genetic influences on particular human characteristics have been given a new cultural focus (Phelan, 2002). Some groups have argued for more education around the biological roots of mental health difficulties in the hopes of reducing the rhetoric of blame (Corrigan and Watson, 2004). This is a particularly pertinent argument in relation to blame because if the genetic claims are accepted as true, then associated symptoms or behaviours cannot be attributed to bad parenting or weak character. Thus, in theory, the potential impact of genetic attributions in reducing the burden of blame is significant. However, genetic attributions may also serve

to strengthen links to undesirable characteristics, with a label being difficult to move past and the possibility of recovery reduced (Phelan, 2002). Clearly, issues of blame are inherently ambiguous and may be difficult to navigate, particularly in the context of a family therapeutic interaction, where there is not always a concrete mental health label attributable to the child.

Issues of blame and responsibility are central to therapy and the therapist may have to manage incommensurable versions of events. The family therapy environment is one whereby family members may perceive the introduction of a systemic perspective as an allocation of blame (Patrika and Tseliou, 2015). Thus, in moving away from an individualised discourse, the therapist runs the risk of being heard to side with a particular member's version of an event (Stancombe and White, 2005). Blaming is an undesirable action and may feel accusatory within a therapeutic environment (Stratton, 2003). Within family therapy particularly, there is an implicit proposition that parents are motivated to present themselves as responsible parents, and typically they seek to recruit the therapist to affiliate with their versions of events (Stancombe and White, 2005). In so doing, parents may structure their accounts as to deny any potential allocation of responsibility in ways to exonerate family members from blame, while simultaneously managing the complexity of the accountability (Patrika and Tseliou, 2015).

As McLeod (2001) noted, therapeutic interactions rely heavily on language and a focus on language can provide insights into therapeutic organisation. The organisation of interactions within institutions has been a particular concern for those with an interest in language and interaction. Specifically conversation analysts and discourse analysts have revealed important insights into clinical areas, such as child counselling (Hutchby, 2007), paediatrics (Stivers, 2002), child psychiatry (O'Reilly et al, 2014), and psychotherapy (Georgaca and Avdi, 2009).

The use of these approaches has the potential to reveal important practices within the family therapeutic environment (Tseliou, 2013). By examining actual family therapeutic interactions and focusing on language, we aim to demonstrate some of the ways in which parents display their ‘good parenting’ within a systemic therapy environment and explore how blame is managed.

Methods

For this study, we employed a qualitative approach to explore the discursive techniques used by parents to construct a ‘good parent’ identity within a systemic environment.

Setting and context

Data were provided in video-recorded format by a family therapy centre based in the UK. The team of therapists providing the data were systemic practitioners who worked within a CAMHS team. A purposive sampling framework was used to guide data collection as is popular in qualitative research (Onwuegbuzie and Leech, 2007). The inclusion criteria required the family to be attending with their children and have no capacity issues for parental consent. Families with capacity issues or who required an interpreter were excluded. Data were provided by two systemic family therapists who provided consent, and four families with pseudonyms of Clamp, Bremner, Niles, and Webber family, two of which were blended families (see Table 1).

INSERT TABLE ONE HERE

All of the families represented were White British, from the Midlands of England, and were from lower socio-economic indices. These therapeutic interactions totalled approximately 22 hours of therapy. The first four families to provide consent were included and several sessions from each family obtained, which always included their first session. This provided continuity and sufficient data for the project. In keeping with the epistemological framework of conversation analysis, issues of saturation were not intrinsic to the approach (see O'Reilly and Parker, 2013). Data were transcribed using Jefferson guidelines in accordance with the analytic method, with the common symbols provided in table 2.

INSERT TABLE TWO HERE

The analytic approach

We utilised the basic principles of conversation analysis (CA) and of discursive psychology (DP), an approach which draws on CA, to illuminate the core discursive mechanisms used by parents in therapy. CA was pioneered by Harvey Sacks who argued that it was preferable to focus on naturally occurring interactions (Hutchby and Woffitt, 2008). For our research we drew upon naturally occurring family therapy interactions. Naturally occurring interactions are those events which occur in real life and are not created for the sole purpose of research (Potter, 2004). The benefit of CA is that it allows the analyst to explore how social realities are constituted through talk-in-interaction (Sacks et al., 1974). For the analysis of therapeutic interaction, therefore, conversation analysis “*makes intuitive sense. Therapy is intrinsically a conversation...*” (McLeod, 2001: 91). By applying the basic principles of CA and combining them with the broader concerns of stake and interest of DP, we were able to explore the sequential processes involved in therapeutic talk to some extent, particularly in terms of how

family members navigated and managed the systemic environment to resist blame and construct themselves as 'good' parents. By using the principles of CA, the researcher, and the therapist, can pay close attention to the ways in which the talk is ordered and how family members make use of sophisticated, linguistic strategies in their attempts to persuade (Stancombe and White, 2005).

Ethics

The research complies with the BPS code of ethics for conducting research with human participants. Although family therapy sessions were routinely collected as part of reflecting practice and training, additional consent were taken for the research. All data were protected and anonymity was ensured through transcription.

Analysis

There were several ways in which parents worked to build a case for being a good parent that covertly managed some resistance of possible blame for the family's difficulties. First, they directly stated that they were good parents. Second, they reported that they acted in their child's best interests, which is consistent with something a good parent would do. Third, they demonstrated that they coped with their child's inappropriate behaviour in appropriate ways. Fourth, they accounted for their child's inappropriate behaviours through appeals to science, which functioned as a mechanism for deflecting any direct responsibility. Notably these strategies tended to be employed in front of the children and with all members of the family present (with the exception of extracts 2 and 4 where the children were not in the room

during that part of the conversation); and all or most of these strategies were used by all four of the families in the data.

Context-setting

Although the systemic framing of certain models of family therapy are well-understood in practice, the familial problem construct is one that is made relevant within the interactional process of therapy. It is this contextual in situ process that is being monitored and oriented to by the interlocutors, and is heard and responded to by family members. Indeed the systemic reframing of the problem is one that therapists overtly evidence through the process of therapy, and can be understood as the context for the discursive work undertaken by families in their accounting practices. Evidently the therapist plays an important role in the co-construction of accountability. While it is not our intention to provide a full analysis of the examples of the systemic context setting, we do offer three, short extracts of data to illustrate the overt systemic environment within which the parents participated.

Example A: Niles family

FT: I I think in o:rderr for Steve t' change in ways that he
 says he wants to change and everybody else wants 'im t'
 change (.) maybe everybody ne::eds t' change a ↓bit (.)

Example B: Clamp family

FT: >And that's what we want t' break< what we want t' do is
break the cycle of (.) of people startin' t' worry that
they're being pushed ↑out and then (0.8) reacting to that

Example C: Webber family

FT: do we jus' need t' just think about ↑how (0.4) ea:rlier
experienceses have affected the way the two of you react to
Daniel

Evidently parents interact within a systemic therapeutic environment which seeks to reframe individualised versions of difficulties to a more familial change ethos, as evidenced in the therapists' talk above. The therapists play an important role in directing the agenda for change and contribute to the interaction in a meaningful way. In doing this systemic reframing, therapists oriented to the need for parents to actively engage in the therapeutic process and change their behaviour, as well as their child's. This orientation was evidenced with statements such as, '*maybe everybody needs to change*', '*break the cycle*' and '*the way the two of you react*'. It is against this backdrop that parents presented particular versions of their child as dispositionally problematic resisting potential parental blaming through a range of combined discursive strategies that took place within and across therapeutic sessions.

Strategy one: Directly stating being a good parent

In society there is an expectation that families will undertake particular duties to appropriately socialise their children (Dallos and Draper, 2010). In so doing, parents take responsibility for the moral behaviour of the family unit and therefore seek to present an

external version of themselves as good parents. In the data set, it was evident that throughout the course of therapy parents engaged in talk designed to persuade therapists of their parenting ability and this occurred in all four families, we present two examples of this below.

Extract one: Niles family

Dad: ↑Oh well >I mean< we try t' be good parents don't we >I
 mean< (1.2) I know he's not genetically mine but 'e gets
 (.) >I mean< I treat 'im like me own (.) >you know what I
 mean< he doesn't go without
FT: You've been around for a long time Alex

Extract two: Clamp family

FT: actually Dan if I were t' ask Joanne where she rates
 herself as a parent (.) where do you think she would put
 herself
(2.0)
Dad: She's good as a parent

In extracts one and two, the social action performed by both sets of parents is one of accounting, i.e., presenting a positive parental identity within the boundaries of family therapy. Within these extracts, both fathers reported directly the case that parenting skills are satisfactory despite the context in which the account is being offered, with both using the word '*good*' to describe their practices. This therapeutic environment was one where the parents were describing stressful situations and reporting negative attributions and behaviours of their children, which directly implicated their abilities as parents.

This was made particularly evident by the father in extract one during a discussion of his role as a step-parent in which he made clear that the lack of biological linkage to the ‘problem child’ has not impinged on his efforts as a father, as he stated: *‘I treat ‘im like me own’*. Notably, the therapist validated the claim in his acknowledgement of the father’s longevity within the family system and therefore to some extent ostensibly seems to be accepting the construction offered by the father. Thus the uptake from the therapist functioned in some sense to affiliate with the version of the parents as being *‘good parents’*. The second extract is slightly different, as the father’s ascription of his wife as a ‘good parent’ failed to address the actual question asked by the therapist. The two second pause signalled trouble with the question and rather than ascribing an answer that illustrated how the mother may rate herself, the father rated her ability as a parent, with *‘she’s good as a parent’*. The CA literature shows us that in normative conversations when a question is asked, a response is the preferred and typical response (Sacks, 1992). However, when a respondent has difficulty in responding to a question (or an invitation, request and so on), they usually show this difficulty by pausing, and using prefaces such as ‘well’ or ‘um’ (Sacks et al., 1974). In both extracts therefore, the same social action was presented; one whereby the parents offered displays of good parenting, which had the potential to reduce their accountability for therapeutic need and for the behaviours of their children.

Strategy two: Acting in the child’s best interests

Displays of good parenting involved more than simply stating that it existed. Parents also illustrated ways of behaving that are commonly associated with positive parenting. One of the strategies used by parents was to demonstrate to the therapist that they acted in ways that

were in the best interests of their child, which typically involved some level of parental sacrifice and all four families considered how they self-sacrificed for their children (again we present two examples to illustrate).

Extract four: Webber family

Mum: And of course I reported him ((*biological father - for sexual abuse of son*)) (0.4) myself and then (0.4) and within two hours I'd got social services on me ↑door the police on me door

(1.2)

FT: Y[eah

Mum: [and that was the end of me ↓marriage

A good mother is one who protects her son from harm, even when that harm is internal to the family unit. In this extract, the mother demonstrated to the therapist that she took such action to protect her son from harm and in so doing, sacrificed her marriage, stating '*that was the end of me marriage*'. This is rhetorically persuasive as it is bound up within a particular version of motherhood, one wherein a woman put the needs of her son above her own and believed her son's report of inappropriate sexual behaviour from his biological father. Thus, through her actions of reporting her former husband, she demonstrated that she was the type of mother who considered her son's needs and continues to do so. Positive parenting was therefore constructed, illustrating that the mother behaved in ways that were consistent with those of a good mother.

Extract five: Clamp family

- Dad: And I said (.) if you want t' ta::ke if you don't
think >I've always said this< a::ll the way along
(.) that we love our children
- FT: Hum
- Dad: If they think that <they can look after our
children> any better then they can try (.) >I mean<
I'm willin' t' let them try "you know"

A similar social action was undertaken in extract five by Mr Clamp. In his reporting of a previous event outside of the therapy room, he illustrated to the therapist that through their actions they behaved in ways consistent with good parenting. In fact, they were willing to act in the child's best interest even if it meant the children being taken away. The insertion sequence¹ is important here as it allowed him to provide a caveat for the therapist, which functioned to allay any misreading of the event. In other words, Mr Clamp began his turn through his own reported speech (Holt, 1996), stating '*if you want t' take*'. This reported speech opened the possible action of social services taking the children away. The insertion sequence, '*we love our children*', provided important contextual information for the therapist, allowing the possibility of social services taking away the children being done within the boundaries of 'love'. Thus Mr Clamp illustrated that his willingness to allow social services to '*look after our children any better*' was a self-sacrificing action that was potentially in the best interests of the children. Through this display, 'good parenting' was implied.

Strategy three: Coping with the child's behaviour in appropriate ways

¹ An insertion sequence is a turn within a conversation that is an aside from the main turn and is inserted between the main turns.

Constructing displays of good parenting also involved making explicit the ways in which the parents were parenting their children in culturally acceptable ways. Quite often, they reinforced what a good parent was by contrasting this with what a bad parent would do in their situation and three of the four families talked in this way, with two families illustrated here.

Extract six: Niles family

- Dad: but it's the only way I fou- I find (0.6) that (0.2) I I
(.) it makes me fee::l better ignoring him
- FT: ↑Yeah
- Dad: 'cause if I (.) if I was to let him get t' me I'd end up
grabbin' him and punchin' 'is head in
- FT: an' you don't want t' do that
- Dad: and I don't want to punch his head in 'cause he's a nice
lad at times

A good father is constructed as one who takes up particular parenting strategies. In extract six, the father demonstrated to the therapist that he knew which actions were effective and appropriate when dealing with his child's misbehaviour. Rather, than '*punchin' 'is head in*', he offered a presumably more appropriate response with, '*ignoring him*.' The therapist validated the father's parenting approach, explicitly noting that '*punchin*' was something to avoid. In other words, the therapist's response here was an important one as it offered a moral reading of the father's turn in a way that suggests that the alternative, more violent response, was inappropriate '*and you don't want to do that*'. In this way, the father produced a contrast structure wherein the first part of the father's statement offered a socially acceptable

approach to parenting and the second part expressed the deviation from the norm. Smith (1978) noted that contrast structures are frequently used to produce context for seeing a specific behaviour as inconsistent or deviating from the general rule. In this case, the contrast structure functioned to locate the father's action as 'appropriate', particularly in comparison to the alternative offered.

Extract seven: Clamp family

Dad: but we finished the course >what we did< on
parenting but that was good (.) because we did
lea:rn a lot on that it didn't help to smack
children and ↑whatever ↓yeah

FT: Yeah

Dad: And we didn't we 'aven't smacked 'em for a long
long time now >not unless< they've been really
rea::lly bad

FT: Hu::m

Within extract seven, Mr. Clamp also offered a contrast between a good and bad parent. In this case, however, the father pointed to a parenting course as being the source of learning how to be a good parent, which resulted in recognizing that '*it didn't help to smack*'.

Mentioning a parenting course functioned to rhetorically position the parents as doing their part to learn what it meant to parent appropriately. Further, the father noted that 'we '*aven't smacked 'em for a long long time*', with the foregrounding of time evidencing Mr. Clamp's commitment to appropriate parenting. Similar to extract six, within this extract, the father distanced himself from being open to critiques of 'poor parenting', as evidentiary statements were offered and functioned to counter potential accusations of inappropriate parenting.

Extract eight: Clamp family

Dad: = It's very hard >I mean< (0.6) 'cause a few years ago I
probably would 'ave (.) killed him by ↓now
FT: ↓Right
Dad: T' be honest
FT: What literally?
Dad: ↑Yeah I would ['ave done (.) I literally would =
Mum: [Yeah
Dad: = 'ave done a few years ago (.) I walk out now

Extract eight took a slightly different approach to offering evidence of good parenting, whilst still employing a contrast structure. Rather than first offering a socially acceptable approach to parenting and then contrasting this with a statement that deviated from the social norm, in this extract, Mr. Clamp began by setting up a contrast between his previous parenting and his present day (good) parenting. The phrase, '*a few years ago*', served to locate Mr. Clamp's previous parenting actions in stark contrast to his current. In this case, a somewhat extreme contrast is set up between '*would 'ave killed him*' and '*I walk out now*', with the father's claims verified by the mother's affirmation that he would have '*literally*' killed the child. Such a response is notably an uptake of the questioning nature of the possibility offered by the therapist, who through his question and intonation '*what literally?*' positioned the response of the father as potentially colloquial, as opposed to reality. Through this, the child's behaviour was implicitly described as problematic in an extreme sense, with the father's current parenting action being aligned with notions of appropriate parenting. Here, then, it is inevitably difficult for the therapist, or anyone for that matter, to cast blame on the parent. Nonetheless, notably the '*walk out now*' is cast as a positive parenting behaviour via the

contrast with the more extreme alternative ‘*would ‘ave killed him*’ and yet this runs the risk of being contradicted by the therapist as not being an appropriate parenting style. Importantly, however, it is the first issue of extreme violence that was picked up on and pursued by the therapist (not shown here).

Strategy four: Appeals to science

Many of the parents also appealed to science as a discursive mechanism for bolstering the case that they were good parents. By pointing to something outside of their parenting abilities, the burden of blame was shifted and the parents’ responsibility was minimized. Additionally, in offering a scientific explanation for their child’s behaviour, the parents distanced themselves and their child from being to blame for that behaviour. A parent and child presumably have no means to control what biology causes; thus, responsibility for the behaviour can be fairly and logically located outside of the family when scientific explanations were offered. Notably, these explanations were offered by three of the four families and examples are offered below, and were often in response to a query pursued by the therapist.

Extract nine: Webber family

FT: >I wuz gonna ask< (.) >you know< what kind of explanations you
'ave, fo::r (.) >you know< why it is that 'e's (.) he's
↑started doin' these (.) <the:se things>
Mum: <I don't know> (.) I ↑say it t' scho:ol (.) and >you
know< there's this theory is it in the g::enes
(1.6)

Mum: >you know< 'cause >you know< (.) ↑I don't know

Within extract nine, the mother initially placed the blame '*in the genes*', thereby constructing the cause of the child's behaviour as being outside her parenting abilities. Importantly this was in response to a question directly from the therapist about providing an explanation for the child's behaviour. An appeal to genetics is significant as it is a powerful way by which to shift all blame toward an entity that no person has control over and therefore was not responsible for causing. Responsibility for a particular behaviour, then, was also shifted away from the parent. Yet, in this case, the claim of a genetic cause was made with some degree of uncertainty. First, it was described as a '*theory*' rather, than the mother stating, 'my child's behaviour is genetically based or caused'. Further, the long pause following her claim pointed to trouble in the interaction, which is further evidenced in her final statement, '*I don't know*'. This perhaps highlights the dilemma inherent in evoking a genetic reason for a child's behavioural problems, as the child's identity may be irrevocably linked to a deficit. Contextually interesting here is the earlier discussion that the father is a step-father rather than the biological one; for, as the session unfolds, there was an orientation to the biological father as being at fault.

Extract ten: Clamp family

FT: What do they mean by that >what do they mean by mental-
what do you two mean d- do you agree with that one<
Joanne?

Mum: Yes

Dad: It's a medical problem in't it you know it's a medical

FT: So is it something to do <wi::th er:::m> (1.0) 'cause
Jordan goes to a special ↑school

Dad: Yeah it is yeah

In extract ten, the therapist asked a clarifying question regarding the parents' description of their child's behavioural problem. The father responded by describing the child's problem as 'medical' rather than inherently linked to anything that they were doing as parents. By offering such an account, the parents distanced themselves from being cast as the cause for the child's issues. Rather, in this case, the medicalisation of the child's problem served to locate the problems as being outside of any particular parenting abilities, and therefore something which the parents could not be blamed for causing. In this way, the parents maintained their positive parenting, with their child's problem being explained through the lens of medicine.

Extract eleven: Niles family

Mum: I was. readin' that thing >and it's< (.) I've told ↑you
it's someth[in' t' do with a chemical >in the< brain =

Steve: [°'ere we go°

Dad: And 'e don't wanna we:ar (.) <I told 'im> 'e's got to
<wear a suit and tie> for the weddin' (.) but 'e won't
'ave it

Similar to extract nine and ten, in extract eleven, the mother appealed to science, offering specific details regarding the ‘cause’ of her son’s behaviour, stating ‘*someth[in] t’ do with a chemical >in the< brain*’. Interestingly, in this example, the child responds with ‘*ere we go*’, perhaps making evident that this idea was not new to him. Furthermore, by positioning the

cause of Steve's behaviour with his 'brain', there is some potential blameworthiness that the difficulty is dispositional with Steve. Thus while ameliorating some responsibility for the behaviour from Steve as being beyond his control, to some extent it does maintain the blameworthy individual as being at fault, which is potentially picked up by Steve through his turn. Notably, the mother did not position her claim as a hunch or even as something gathered from layman's knowledge. Rather, her appeal to science was linked to something she '*was readin*', which served to align her claim with outside knowledge and thereby bolster its validity. Importantly, blaming the mother for her son's behaviour would be ostensibly difficult as her parenting abilities were not to blame but the '*chemical >in the< brain*'.

Discussion

There are many arguments and debates within the broad field of family therapy and a range of different models of family therapy which guide practice. These models operate from different theoretical foundations and are operationalised according to various principles (Dallos and Draper, 2010). In this paper, we have not taken issue with the theoretical frameworks adopted by therapists nor advocated any particular model of therapy as superior. Rather, we have focused on systemic family therapy, as this was the practice of those therapists whom consented to participate, with the focus for the research on the actual conversations that took place during the therapy. It was not our intention to offer any level of judgement on these practices; rather, we have attempted to illustrate the nature of the conversations that actually took place during those sessions and have highlighted the discursive strategies that parents typically used to display their efforts of good parenting. This in itself can raise complex challenges for family therapists, particularly when parents take up

a defensive position on parenting and work rhetorically to manage perceived blaming discourses within the systemic environment.

The analysis has shown that systemic family therapists utilised particular mechanisms in their talk to reconceptualise the problem in a more systemic way, shifting the focus from the individual identified child, to the family unit more broadly. Clearly the parents, as co-present members of the interaction, were sensitive to these cues and had to actively engage with the agenda of familial change for the therapy to be successful. Notably, however, throughout the process of therapy, parents displayed some resistance to sharing accountability for the problem and worked hard to display good parenting roles within their own social and familial sphere. We found that generally parents made direct reference to their ability as good parents, reported that they acted frequently in the best interest of the child, and responded to the extreme and inappropriate behaviours of their children in ways consistent with being a good parent. Furthermore, parents often made appeals to the rhetoric of science to bolster their position as good parents and manage any accountability that might subtly be implied by the systemic goals.

The resistance of blame is an area which has been important to the field of family therapy, and systemic family therapy particularly fosters a culture whereby blame and responsibility are shared among the family members and an agenda for change is promoted. Family therapeutic practice is a challenging one as the therapist must consider and account for all members' contributions, and these can sometimes be conflicting. Parents come to therapy generally seeking support and help for their problem child (Berg and Steiner, 2003; O'Reilly, 2014) and may feel the need to be defensive when this is deconstructed by the therapist. Within the therapy, therapists have the difficult and challenging task of carefully managing

competing versions of events, ensuring that each member is heard, while avoiding joining in with the blaming of other members (Stancombe and White, 2005); thus, the therapist is charged with the task of guiding the conversation in a way that achieves a systemic reframing, without fostering or implying a culture of parent blaming. There are therefore implications for practicing therapists illuminated by our analysis in relation to being overtly aware of the discursive strategies that are often employed by parents to present the good parent identity and this awareness may help them to reflect on how to manage such challenging conversational practice. It is important that therapists remain neutral and that they listen to all family members, and by paying attention to the strategies utilised by parents, they will be better equipped to manage a blaming discourse.

Evidently, therefore, research in the field of family therapy is essential and process research studies are particularly important as they aim to reveal more about the nature of the therapeutic process (Dallos and Draper, 2010). CA specifically is able to offer a reading of family therapy, which has the potential to illuminate practices, encourage reflection, and aid training. CA stays close to the naturally-occurring data and explores the processes that occur within the interactions and is thus a useful reflective instrument for therapists to explore how turn-taking unfolds and the processes that take place. Thus, the video-recording of actual practices offered a rich opportunity to explore how outcomes may be shaped by therapeutic dialogue (Strong et al., 2008).

Conversation in therapy is part of the therapeutic process and these processes (i.e. conversations) ultimately affect therapeutic outcomes (i.e. evidence), with the interactions and outcomes being intertwined and inseparable (Strong et al., 2008). By using CA, therapists are able to detect and potentially overcome some of the issues they encounter when

working with parents and their children (McLeod, 2001). Thus, CA evidence is tangible, empirical, and a justifiable form of outcomes evidence that is useful for the examination of therapeutic process and change (Strong et al., 2008). Ultimately, therefore, CA research has a lot to offer the field of family therapy, when conducted well (Tseliou, 2013) and approaches that focus on language can facilitate therapists' reflexivity about their contributions to therapeutic dialogue (Patrika and Tseliou, 2015).

Notably, CA is a qualitative methodological approach and in line with the quality indicators for this it is necessary to be reflexive in the process of the research to promote transparency and rigor. Thus we recognised the thoughts and feelings that emerged as the analysis unfolded and the two authors discussed to some extent the potential impact that may have. Author 1 for example has partnerships with clinical personnel and works with a local child mental health service and therefore has had conversations with practicing family therapists about the issues raised in this paper. Their thoughts and ideas ultimately shaped the organisation of the analysis and impacted positively on the thinking during analysis. Additionally, the social constructionist position adopted by the authors encouraged us to question some of the taken-for-granted psychological concepts and theories used, such as the theory of genetics, and made us question why parents so readily adopt a neuroscientific explanation.

In conclusion, we have pointed to the ways in which parents go about doing 'good parenting' at the level of talk. Through this, we have highlighted the varied ways in which parents deflect blame and position themselves as capable parents, while also noting the value of a CA approach to understanding family therapy. This has been achieved, recognising that we only drew upon the basic principles of the CA methodology rather than developing a full

sequential analysis associated with the approach. Nonetheless, this basic application of CA allowed for the illumination of some key strategies utilised by parents within the therapy. Future research could benefit from exploring these issues with greater analytic focus in line with the full conversational attention to interactional detail.

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