Received: 26 September 2020 | Accepted: 21 February 2021

DOI: 10.1111/jmft.12505

ORIGINAL ARTICLE

JMFT Journal of Marital and Family Therapy

"You helped me out of that darkness" Children as dialogical partners in the collaborative post-family therapy research interview

Mira Helimäki[1] | **Aarno Laitila**[1] | **Kirsti Kumpulainen**[2]

[1]Department of Psychology, University of Jyväskylä, Jyväskylä, Finland

[2]Child Psychiatry, University of Eastern Finland, Kuopio, Finland

Correspondence
Mira Helimäki, Department of Psychology, University of Jyväskylä, Jyväskylä, Finland.
Email: mhelimaki@gmail.com; aarno.a.laitila@jyu.fi

Abstract

Applying *Dialogical Methods for Investigations of Happening of Change* (DIHC), this study investigated how children who had been diagnosed with an oppositional defiant or conduct disorder participated in a collaborative post-therapy research interview and talked about their experiences of family therapy. The results showed that the children participated as dialogical partners talking in genuine, emotional, and reflective ways. Encountered as full-membership partners, the children also co-constructed meanings for their sensitive experiences. However, their verbal initiatives and responses appeared in very brief moments and could easily have been missed. The collaborative post-therapy interview offered a safe forum for co-reflection by participants on what they had found useful or difficult in the family therapy process. In this interview setting, the family first listens to reflection by the therapists on the therapy process and their thoughts on some of the family's related sensitive issues. The results indicate that when therapists present themselves as not-knowing, receptive and accountable, therapists may facilitate reflection for all family members, including children.

KEYWORDS

children, collaborative, family therapy, post-therapy research interview

INTRODUCTION

When a family seeking help enters therapy, it is often the case that the family members are unable to precisely describe their most sensitive experiences or their primary concerns. Family therapy can be seen as an interactive and co-constructive process in which the family members and therapists together find language for experiences in the family members' lives that have not yet been expressed in words (Seikkula et al., 2012). In this study, we were interested in exploring, through qualitative analysis, how children who have been diagnosed with a conduct or oppositional defiant disorder participated in joint conversations and talked about their experiences of family therapy in a collaboratively conducted post-therapy research interview.

The authors applied a dialogical method (*Dialogical Methods for Investigations of Happening of Change*, DIHC) where dialogical refers to reciprocal conversations in which the participants jointly examine, question, speculate, and reflect on the issues at hand. Through these two-way exchanges, participants seek to understand each other and the uniqueness of each other's language from each other's perspectives and not solely their own (Anderson, 2012, p. 11). However, if finding language, meanings, and understandings and generating a new narrative for the past (Anderson, 2001, 2012; Anderson & Goolishian, 1988, 1992) in the family therapeutic context is difficult for many adults (Bowen, 1978; Stierlin, 1977), it is clearly more challenging for children with smaller vocabulary, poorer cognitive (Henderson & Thompson, 2011) and linguistic skills (Lobatto, 2002) and a less individualized self (Piaget, 1959).

Family therapy as an institutional setting is typically and predominantly adult-led, with children having little input in conversations about their healthcare (Stivers, 2002). In settings where both parents and child are present, there may a tendency for clinicians to place more weight on the parents' than child's views, thereby putting the child at risk of being positioned as a passive listener to their parents' talk about them (Hutchby & O'Reilly, 2010; Lobatto, 2002; Parker & O'Reilly, 2012). To avoid this, therapists working with children and their families need to find ways to create space for children's voices (Gehart, 2007).

The collaborative post-family research interview

In this study, collaborative post-family research interviews were conducted by a researcher who is also a clinical practitioner. The collaborative post-therapy interview model applied here was developed in Norway by Andersen (1995, 1997). The idea is that clients and therapists meet 6 to 24 months post-therapy and reflect with a consultant on how they experienced the therapy. The model aims to generate a genuine dialogue in which all participants reflect on the understanding they have gained. While collaborative post-therapy research interviews are not primarily intended to be therapeutic, they have sometimes been reported to have a greater therapeutic impact than the therapy itself (see Gale, 1992).

The process starts with a consultant or a "visiting colleague" (Andersen, 1997) (in this study an interviewer) asking the therapists to start the session by talking reflectively with each other while the family members listen. This offers the family a role model not only for the reflection process but also for a willingness both to be vulnerable and to take responsibility. After hearing, the therapists reflecting and before inviting the family to reflect, the interviewer asks the family members to comment on what they have heard. Shifts between speaking and listening are fundamental in the process (Andersen, 1995), "to have a different experience of each other and what is being said and heard" (Anderson, 2012, p. 17). If one discovers that one is heard, it may become possible to begin to hear and to become curious about other's experience and opinions (Seikkula & Trimble, 2005).

The primary aim of the post-reflection dialogue is to increase the participants' mutual understanding of the therapeutic process and deepen the family's understanding of their difficulties while potentially also allowing the participants to reflect internally.

Core ideas informing the collaborative approach

Collaborative therapies and approaches have long been a focus of interest in couple and family therapy (e.g., Andersen, 1991, 1995, 1997; Anderson & Gehart, 2007; Anderson & Goolishian, 1992; Hoffman & Cecchin, 2003; Madsen, 2007; Rautiainen & Seikkula, 2009). Collaborative approaches are guided by the idea of "we-ness" and "withness" (Anderson, 2012). The therapist's role is to facilitate therapy as a "joint-action" (Shotter, 1984) from a non-hierarchical, not-knowing position. Focusing on a non-hierarchical "in-there-together" process, the therapist aims at generating "newness" in meanings, understandings, and narratives (Anderson, 2012; Anderson & Goolishian, 1992; Madsen, 2007). By inviting multiple perspectives into conversations, the therapist promotes shared inquiry into clients' dilemmas. The goal is to create space for a rich dialogue that enables every family member's voice to enter the conversation. At its best, this process increases the participants' self-reflection and self-understanding (Rogers, 1942), an outcome which can be viewed as therapeutic *per se*.

Mutual inquiry by the participants directs the process of inquiry and shapes story telling, re-telling, and new telling. Therapists' questions should stem from genuine curiosity and a desire to understand each family member's worldview and perspective. The therapist should always aim to appreciate and value all clients, including children, equally as experts on their own story (Anderson, 2012; Anderson & Goolishian, 1992). By adopting a position of positive curiosity (Cecchin, 1987), we can learn about the unique perspectives of clients, including children. However, to access a child's world and learn how the child makes sense of his or her life experiences within the family, therapists may need to be more than usually curious (Gehart, 2007). According to Anderson (2012), the therapist's curiosity is contagious: what begins as one-way curiosity can shift to two-way curiosity, and hence to a back-and-forth process of mutual learning. The joint search for new ways of conceptualizing the client's story through dialogue about the latter's "problems," that is, events, behavior, symptoms, and feelings, is both cathartic, transforming, and therapeutic (Anderson, 2012; Anderson & Goolishian, 1992; Madsen, 2007; Rogers, 1942; Seikkula & Trimble, 2005; Tomm, 1987).

Children as dialogical partners

Working with children and seeing the world through the eyes of a child is challenging (O'Reilly, 2006, 2008) but important. Dialogue with children (often) differs from dialogue with adults. Dialogue with children is often characterized by overlapping, shifting and, at first glance, unrelated themes (McDonough & Koch, 2007). Moreover, children, unlike adults, also communicate their meanings through play, movement, art, and other activities (Gehart, 2007; Gil, 2009), relying less heavily on words and verbal language (Shotter, 1993). Thus, children generate meanings, even if they often construct them differently from adults. Consequently, adults working with children need to attend to nonverbal aspects of communication, such as tone, emotion, and facial expressions, rather than focusing exclusively on the literal content of spoken messages (Gehart, 2007; Gil, 2009). Despite such differences, dialogue with children nevertheless involves a cocreation of meaning that is key to the therapeutic process (Anderson & Levin, 1997; McDonough & Koch, 2007).

Children are also in the process of developing "common sense" and gaining familiarity with dominant cultural discourses (Gehart, 2007). Among adults, however, adult-child differences in meaning-making processes may cause stress and frustration both within the family and in the therapy meetings. It has been noticed that children are frequently interrupted in family therapy (O'Reilly, 2008) and treated in negative ways (O'Reilly, 2006; Parker & O'Reilly, 2012). At worst, children's initiatives are ridiculed or simply disregarded. Children, however, seem to want to be involved in family therapy in a meaningful way (Stith et al., 1996).

Listening carefully to what children have to say entails slowing down and is thus more time-consuming. Gehart (2007) points out that, unlike adults, who often rush in and put words in their children's mouths, children require more time to express themselves. Parents also often tend to talk about topics that are important for their children's lives *around* rather than *with* their children (Galinsky, 2000). In doing this, we can easily fail to understand children's meanings or overlook their significance.

Listening intently and creating space for children's voices reveals how children fit seemingly unrelated fragments together to form a whole. Expressing positive curiosity about children's definitions of problems and their possible solutions can facilitate children's sense of being appreciated and valued (Anderson & Levin, 1997; McDonough & Koch, 2007). However, showing curiosity is never innocent (Tomm, 1987). Curiosity implemented through questions is neither objective nor neutral (Anderson, 1997, 2001, 2012). Instead, questions are always informed from within and related to what has previously been said (e.g., Bakhtin, 1984). Therefore, adopting the collaborative stance of *not-knowing* (Anderson, 2001, 2012; Anderson & Goolishian, 1992; Madsen, 2007) is especially important when working with children. This stance implies that the interviewer or therapist, as Gehart (2007) puts it, "avoids certainties" about the child's experience and does not try to understand too quickly but instead allows ideas to emerge through the ongoing dialogue. Not-knowing requires tolerance of uncertainty in the face of a mystery. Offering too quickly an interpretation or rational explanation may lead a child to defend him- or herself, which only inhibits the process of understanding (Seikkula & Trimble, 2005). It is not unusual for adults to assume they know more about children and children's perspectives than they actually do (Gehart, 2007).

Taking a not-knowing approach requires a belief and trust in human beings' drive to realize their innate potential. As Rogers states: "all individuals have within themselves the ability (…) to find their inner wisdom (…) and make increasingly healthier and more constructive choices" (Kirschenbaum & Henderson, 1989, xiv). According to Rogers, the client's change is a natural side-effect of a warm and collaborative climate, and as such supports the client's competence and growth in self-understanding (Anderson, 2001, 2012; Rogers, 1942). The development of heightened client reflection in psychotherapy has received increased attention recently (Santos et al., 2009).

Focus on children with behavioral problems

Family therapy research has not previously analyzed collaborative post-therapy interviews that include children. Three collaborative interviews with children present were conducted in Sweden by Buvik and Wächter (2006) but none were post-family therapy interviews. In this study, collaborative post-therapy research interviews were used with families who had a child diagnosed with a conduct disorder. Such a diagnosis refers to persistent patterns of behavior in which the rights of others and age-appropriate social norms are violated (American Psychiatric Association, 2013). Children with behavioral problems often exhibit distortions and deficiencies in cognitive processes and mentalizing skills that generate interpersonal problems.

In addition, deficiencies in strategies for making and keeping friends, unawareness of the possible consequences of one's action, and not perceiving how others feel are among the difficulties that

generate stress and strains in social situations and impede the achievement of socially satisfying goals (Hill & Maughan, 2001; Kazdin, 2005; Shirk, 1988; Spivack & Shure, 1982). A recent study by Wells et al., (2020) showed that the ability to identify others' emotions and intentions is impaired in children with behavioral problems. These social cognitive processes were found to be related and inversely associated with the severity of behavioral problems.

From a systemic perspective, the families of children who struggle with behavioral problems typically experience dysfunctional family relations, unhappy marital relations, interpersonal conflict and aggression, less participation in activities as a family, and defensive communication patterns, including less warmth, affection, and emotional support, among family members (Hill & Maughan, 2001; Kazdin, 1997, 2005).

AIMS OF THE STUDY

This study applied a qualitative method to investigate how children diagnosed with a conduct- or oppositional defiant disorder participated and talked about their experiences of family therapy in the collaborative post-therapy research interview. We were particularly interested in exploring these children's verbal communication, as they are used to expressing themselves through acting rather than talking.

DATA

The research data consisted of nine video-taped post-family therapy research interviews held at [University Hospital Blinded]. The interviews were conducted within the framework of the previously described collaborative model. The research material forms part of a follow-up family therapy research project comprising altogether 14 families with a 10- to 15-year-old child diagnosed with oppositional defiant or conduct disorder. The therapeutic approach in the research project was systemic and collaborative with elements of structured games and interactive tasks.

All participants gave their informed consent to take part in the study and to publication of the results. The research plan was approved by the ethical committee of [Ethical Committee Blinded].

In this report all participants' names are pseudonyms.

METHODS AND PROCEEDINGS

Interviews (9/14; 5 dropouts) were held at approximately 18 months post-therapy and were analyzed afterwards with the multi-actor *Dialogical Methods for Investigations of Happening of Change* (DIHC) (Seikkula et al., 2012). Before the analysis, the first author watched all nine videotaped interviews, chose three for closer analysis and transcribed the family interview parts in full. The criteria for choosing cases followed the "revelatory" case study principles proposed by Yin (2014). The selected cases represent the extremes in the variety and richness, in either content or amount, of the children's verbal initiatives.

Three excerpts, one from each interview, illustrate the main categories in which the children positioned themselves (see below) in the dialogical topical episodes. All three children were boys (aged 10–15 years). One of the boys represents the youngest and the other two the oldest group of the child participants. The interviews varied in duration from 71 to 87 minutes. The part of the interview with the family therapist(s) (2 cases also included a child psychiatrist) varied from 27 to 38 minutes and that with the family from 40

to 50 minutes. The transcription criteria were planned to meet the needs of DIHC, that is, verbal rather than prosodic content. To capture all the nuances in talk, the data were analyzed in Finnish, the participants' native language. The English translation was checked by a native English speaker familiar with Finnish. The meanings of the translations were, however, negotiated together with the first author. The excerpts in the *Analysis and Results* section are presented in English. The analysis was performed by the first author, with the second and third authors acting as supervisors and auditors.

After careful reading, all episodes considered topical were explored. A change of topic was considered a new episode. The responses to each utterance were noted to gain a picture of how each interlocutor participated in the construction of the joint conversation. Thereafter, the episodes containing the children's verbal initiatives or responses were first selected and then analyzed and organized into categories. Four positioning categories were found in which the children participated as dialogical partners: "I- Thou," "reflective," "vulnerable self," "meaning co-construction."

The concepts used to analyze the response categories were *semantic dominance*, referring to who introduces new themes or new words at a certain moment in the conversation, and *interactional dominance*, referring to the dominant influence of one participant over the communicative interaction. Utterances were coded following the narrative process coding system (Angus et al., 1999; Laitila, 2016; Laitila et al., 2001), using the concepts *external process mode*, referring to descriptions of things that have happened (either in a physical or imagined reality), *internal process mode*, referring to participants' descriptions of their own experiences of the events they describe, and *reflexive process mode*, referring to participants' efforts to understand the connection between the events in question and their personal experiences. In this step, the focus shifted to the interlocutors' *Voices, Addressees, and Positioning*. *Voices* refer to the speaking consciousness (Bakhtin, 1984) that becomes visible in exchanges between interlocutors in the context of the ongoing storytelling. *Positioning* in turn refers to the question "from what position is the person speaking?" (e.g., Seikkula et al., 2012, p. 670). Positioning gives the person a perspective, including both its possibilities and limitations, on what they see, hear, and experience. While positioning can be an active and voluntary act, it often happens unreflectively, in the process of continuous responses to what is uttered. *Addressees* are the persons to whom an utterance is addressed. In analyzing multi-actor dialogues, addressees are not always easy to identify. Speech can also be addressed to someone in the inner dialogue (Seikkula et al., 2012). The analysis and results were discussed and reflected on together by the authors and relevant literature was consulted, including research on family therapy.

The results of each case are presented in a narrative form with a contextualizing description of the treatment process including brief excerpts of the interviews.

ANALYSIS AND RESULTS

"You helped me out of that darkness" ("I—Thou" and "meaning co-construction")

Jack, aged 15.

Before the home-based family therapy (5 meetings plus network meetings) Jack had exhibited severe behavioral and mood problems and his relations with his family had deteriorated. At school, Jack had lied about having encountered domestic violence at home. This had led to contact with the child-care agency and the placing of Jack in urgent custody for a few days. In the post-therapy interview, Jack and his mother reported that having family therapy had helped the family members to find their lost connection with each other. Jack's relations with both his father, who lived abroad, and his stepfather had become closer and more open.

The following excerpt presents a short dialogical conversation, in which Jack constructs the meaning of his perceived difficulties together with his mother and the interviewer (Table 1).

TABLE 1 (Excerpt 1) Topical episode 25/26 of family discussion: *"I -Thou" -relation; "position of meaning co-construction"*

I	J	L	Response category	Addressee, Positioning, Voices
		I guess, it can't be that bad that I had to look for help and admit to myself that I couldn't help my child	Semantic dominance Dialogical Reflective mode	Addresses I + J + T1 Positions self as vulnerable and hesitant. Voices of ambivalence. On the one hand, the voice of vulnerability and on the other hand, the voice of one who was able to admit the facts, i.e., seek and receive help.
	Well, but you helped me out of that darkness		Symbolic meaning Dialogical Response to L Interactional and semantic dominance Reflexive and internal mode	Positions himself as one who expresses empathy, recognition, and loyalty. Position of one who gives the name of his perceived difficultness in a symbolic/metaphorical way. I-Thou mode. Voices of consolation and encouragement.
		Well, yes but I got help to do it	Dialogical Response to J Reflexive mode	Addresses all present. Positions self as one who becomes a little surprised and touched and shows slight discomfort at receiving recognition/empathy from her son. Positions self as one who hesitates about whether she merits her son's recognition. Voices of embarrassment and gratitude
	Mmm			Positions self as hesitating/evaluating what his mother said.
		It wasn't…	Mixture of outer and inner dialogue Reflexive mode	Positions self as one who wants to find more words to describe her experience. Voice of self-reflection.
	But I could never sink that deep anymore…		Symbolic meaning Dialogical Response to L Interactional and semantic dominance Reflexive and internal mode	Adopts a position of self-reflection: gives words to his difficult experience in a metaphorical/ symbolic way. Voices of loyalty, affection, and self-confidence.

(Continues)

TABLE 1 (Continued)

I	J	L	Response category	Addressee, Positioning, Voices
		Well that…		Positions self as one who is touched and surprised. Voice of embarrassment.
Do you think Jack that this experience or these discussions have somehow created more permanent protection for your future?			Interactional and semantic dominance Dialogical Response to Jack's words relating to "not sinking that deep anymore"	Addresses J ositions self as one who offers reformulation of Jack's metaphorical expression "not sinking that deep", in order to offer the more concrete word "protection" for his experience.
	Yes		Response to I	Positions self as one who accepts the suggested reformulation.

Interviewer (I), Jack (J), Jack's mother Laura (L), Therapist (T1) as listener.

In the above dialogical dialogue, Jack and his mother talk about their perceived difficulties reflectively, openly, emotionally, and personally. The mother had earlier said how "surprised" she had been when she noticed that "talking aid" had helped Jack so quickly. She had found Jack's improvement a relief. However, in her inner dialogue, it had simultaneously aroused self-critical thoughts about herself as a good enough mother. This had prompted the interviewer to ask her to elaborate, thereby helping the mother find more words to describe her experience. After listening carefully to his mother's reflection, Jack adopted an empathic position and expressed his experience and his mother's contribution to it symbolically in the words: "You helped me out of that darkness." Jack's words addressed to his mother can be heard and interpreted as I-Thou talk.

Jack gives his difficulties a name and presents himself as a boy who will "never sink that deep anymore," prompting the question whether his words are also addressed to his mother as a promise, consolation, and sign of loyalty. Hearing Jack's response, the interviewer offers him a more concrete word, a reformulation of his symbolic utterance, which Jack accepts: his perceived difficulties and the past and present "in-here-together" conversations during therapy and the research interview serve as "protection" for himself in the future.

Jack went on to state that "the large amount of help and positive feedback" he had received had been the primus motor that had brought about the change in his relations with his family and peers. Discussing this change, Jack said that he had been the first in his family to change. Jack's words indicated that the aid he had received had functioned as a navigation tool that had informed his personal goals, leading to changes in his behavior, relations, and self-narrative.

"I'm not doing it on purpose" ("meaning co-construction," "vulnerable self").

Sean, aged 10.

Sean's family had been referred to the child psychiatric clinic owing to Sean's persistent oppositional behavior. Sean had been in the first grade at school at the start of the family therapy. The collaborative post-therapy research interview took place 18 months after the last meeting (15 meetings). The family therapy appointments at the clinic had been frustrating and stressful for both Sean and his parents. Sean had protested the meetings and acted in defensive ways. Positive change in the family's negative interactional patterns and Sean's externalizing behavior had taken a long time to become visible. Sean was continuing to have individual psychotherapy, and home-based treatment had also been needed after the family therapy ended. The collaborative post-therapy interview offered the participants a possibility to talk about their perceived challenges in the therapy process in a safe climate and co-create joint understanding of things that had been both helpful and harmful.

Prior to the following excerpt, there had been talk about the mother's emotionally loaded feelings and thoughts relating to the earlier therapy process. After listening to the mother, the interviewer had expressed interest in Sean's experience of being heard in relation to his own issues. Sean's mother had described how difficult it had been for Sean to leave the waiting room and enter the therapy room. Sean had commented on his mother's description, but his response had been inaudible. The interviewer had noticed this, apologized for not hearing what Sean had said and asked him to repeat his words. At first, Sean had not been cooperative, but he had then taken his mother's request seriously, that is, that the adults really wanted to hear what he had to say.

In the following excerpt, Sean puts into words something that he had not previously been able to say in relation to his behavior (Table 2).

It had become obvious in the interview that Sean found talking about sensitive issues difficult. Here, Sean reveals his vulnerability and positions himself as an observer in relation to his being difficult and says in the I-mode that it is not his conscious intention to act in a negative way, even if that is how it might appear. His personal and emotionally loaded words offer his mother a possibility to show her son understanding and empathy, rendering visible a positive change in their interaction.

TABLE 2 (Excerpt 2) Topical episode 16/21 of family discussion: *"position of meaning co-construction", "position of vulnerable self"*

I	S	P	Response category	Addressee, Positioning and Voices
	I'm not doing it on purpose		Semantic dominance Dialogical Reflexive mode	Addresses all present. Positions self as one who speaks honestly and genuinely. Gives meaning to his being difficult, thereby revealing his vulnerability. Voice of the vulnerable self.
		Of course, you don't	Dialogical Response to Sean	Addresses all present. Positions self as empathic
Yes. Did we discuss it in the way that we would think you do it somehow maliciously, deliberately or on purpose?			Interactional dominance Dialogical Reflexive mode	Addresses SeanPositions self as one who negotiates meaning and encourages Sean to say something not-yet said. Voicing emphatic.
	Maybe		Dialogical	Addresses all. Positions self as one who hesitates about what to say. Voice of one who hesitates about what is worth saying.
es. Were you able to say then what you just said that you don't do it on purpose?			Semantic dominance Dialogical	Addresses Sean Positions self as one who is interested in hearing more about Sean's experience.
	No			Positions self as one who speaks honestly.
Yes. Then it was left unsaid but now it's possible to say… yes..			Dialogical Reflexive mode	Addresses all. Positions self as one who makes the change visible and concrete and confirms Sean's experience.

Interviewer (I), Sean (S), Sean's mother Paula (P), T1 & T2 as listeners.

The interviewer helps Sean to strengthen and create a new understanding and self-narrative of his behavioral problem, thereby rendering the change visible.

"I don't know where I'd be right now if…" ("reflective"; "vulnerable self").

William aged 14.

William was 11 years old when, owing to severe behavioral and mood problems, he was referred to the child psychiatric hospital ward for a week of treatment. William's parents were divorced, following several years of marital problems. William's father had a substance abuse problem and William had seen and experienced his father acting violently. The family had been offered home-based therapy, and the therapists had considered his hospital stay, which had initially frightened his mother, as useful for William. In the interview, both William and his mother found the home-based therapy useful and safe. In the following excerpt, William describes the meaning of therapy for the problems in his life. Prior to the excerpt, there had been talk about how William's aggressiveness had been manifested in the family's everyday life, and the interviewer had wondered whether talking together would have been possible at that time (Table 3).

In the above excerpt, William, helped by the interviewer, finds words for his experience, and co-creates the meaning of the help he has received and the change that has happened in his life. William is then encouraged, in a cautious tone, to look back and reflect on what might have happened to him if he had not received help. The issue was particularly sensitive owing to William's father's continuing problems.

DISCUSSION

This study focused on exploring how children who had been diagnosed with an oppositional defiant or conduct disorder participated and talked about their experiences of family therapy in the collaborative post-family therapy research interview. Aside from externalizing symptoms, these children had also experienced severe mood problems. These might have impaired their cognitive processes and emotional and mentalizing skills, and challenged their ability to position themselves as an observer both of their own and of others' actions (Shirk, 1988; Spivack & Shure, 1982; Wells et al., 2020). However, we found that the children participated in these post-therapy research interviews as dialogical partners, talking in a reflective, open, and emotional way. They talked about their painful experiences, verbally co-constructed meanings for their difficulties and the help they had perceived, and thus cautiously revealed their vulnerability in front of the adult participants.

The children's dialogical initiatives nevertheless appeared in very brief moments during the interviews. It is noteworthy that they were also uttered in a somewhat symbolic and taciturn manner, as fleeting blurts, and could easily have been missed. The children were encountered as full-membership partners. Their initiatives as well as responses were recognized seriously despite their taciturnity or their fleeting nature. It can also be argued that the interviewer's collaborative approach, that is, his not-knowing stance, positive curiosity, and respectful orientation, might have functioned as a pre-requisite for a dialogical conversation.

The findings support the previous results of, for example, Gehart (2007); Gil (2009); McDonough and Koch (2007); Rober (1998) and Shotter (1993), indicating that children's dialogues and meaning-making processes often differ from those of adults in both, for example, form and content and are therefore at risk of being overlooked. In this study, acknowledging these differences seemed to help the children to make meaningful and reciprocal verbal initiatives, such as expressing themselves from a genuine and vulnerable I-Thou position (Buber, 2002, 2004) voicing something hitherto unsaid.

However, it remains speculative as to whether the collaboratively conducted post-therapy research interview, which began with an open reflection by the family therapists, who seemed to appear themselves as not-knowing, receptive and accountable, promoted the children's sense of security and made it easier for them to reveal their vulnerable selves. The authors agree with Anderson (2012) that when

TABLE 3 (Excerpt 3) Topical episode 3/29 of family discussion: *"Reflective positioning"; "position of vulnerable self"*

I	W	Response category	Addressee, Positioning, Voices
	I don't know where I'd be right now if I hadn't ended up in hospital.	Responds to I Dialogical Semantic dominance Reflexive mode	Addresses all present. Positions self as one who reflects honestly on the meaning of having been helped. Voice of hesitation over other possible scenarios in his mind, possibly also including his father's situation.
Yes, what do you mean "I don't know where I'd be now…?		Dialogical Reflexive mode	Addresses W Positions self as empathizing with W's experience by repeating his words in a search for more exact words. Voice of curiosity.
	Well..	Responds to I Dialogical	Positions self as one who is trying to find more words. Voice of hesitation.
What are the alternatives in your mind?		Dialogical Responds to W's inner voice concerning other scenarios Reflexive mode	Addresses W. Positions self as one who encourages W to talk about sensitive issues. Voice of one who wants to listen and understand.
	That I would go carousing around town and…	Dialogical Semantic dominance Reflexive mode	Addresses all present. Positions self as one who reflects on "the old him" as honest and vulnerable. Voice of hesitation. Did W have his father's problems in mind?
Yes, do you mean that the situation could have got out of hand?		Dialogical Semantic dominance Reflexive mode	ddresses W. Positions self as one who is not afraid of talking about difficult issues, while simultaneously encouraging W to talk about anything at all. Voice of empathy.
	Yes		

Interviewer (I), William (W), William's mother Ann (A), Therapist (T) as listener.

a speaker has room to fully express him- or herself without interruption and the others have equal room for listening, the seeds of newness can emerge.

Given that the objective of family therapy is to understand and treat whole families (Goldenberg & Goldenberg, 2017) and improve their members' ability to relate and meet one another in a deeper,

more open and personal sense (e.g., Kazdin, 1997, 2005; Sprenkle et al., 2009; Tseliou et al., 2020), it is important that each family member's voice and experience is equally heard. However, only limited evidence has been gathered thus far on how children experience therapy (e.g., Moore & Seu, 2011; Strickland-Clark et al., 2000). The present small-scale study contributes to addressing this gap in the literature.

Every setting and approach also has its limitations. In this research interview context, the children reacted in different ways to the presence and position of the interviewer as a new professional adult in the family interview which took place at the same clinic where the therapy had taken place. For some children, the presence of a new adult might have made their participation and talking about their sensitive experiences more genuine, and hence more exciting and challenging. For others, the interviewer's presence might have increased their existing tendency to compliance. However, none of the children studied here showed a strong reluctance to participate in the joint conversations.

PRACTITIONER'S POINTS

While acknowledging that engaging children in family therapeutic work in a meaningful way is challenging, all efforts to promote children's participation are important and necessary. If for adults a safe atmosphere is an important starting point, for children a safe and child-friendly space is crucial. From that perspective, the principles of a collaborative approach that emphasizes the non-hierarchical nature of the therapeutic conversation and the expertise of all participants can be valuable. Seeing children as dialogical full-membership partners and co-reflectors who merit being listened to carefully offers possibilities to enrich the multi-voicedness of conversations. These can potentially provide surprises, valuable information, and creative perspectives inconceivable to adults' minds.

The authors warmly recommend the use of the collaborative interview to those working especially with high-risk families in, for example, the context of supervision or consultation, especially when the treatment has got stuck. In a setting where children can first listen to the therapists while they reflect, encourages the children, including their parents, to do the same. Seeing and hearing the therapists talking openly, authentically, and thus even as vulnerable can construct for participants a safe and joint forum where also painful emotional experiences can be shared.

At its best, the collaborative interview can serve both as a learning and therapeutic process for all the participants. Reflecting together on the ongoing or terminated therapy in order to ascertain what worked or was useful, what needs to be said or what could have been done differently is important to facilitate or strengthen positive change in the client. These sharing "in-there-together" experiences of therapy in which all the participants co-create new words for something hitherto unsaid can also increase participants' agency. An interviewer can function as an equal who can exhibit his/her not-knowing curiosity to facilitate or maintain a generative process. More important than any methodological rule is, however, to be fully present in the moment.

Actively remembering that to access a child's world challenges the therapist's tolerance of uncertainty can be helpful. Working with children sometimes needs more time, dialogical space along with positive curiosity. Tolerating a situation, not to understand too quickly or offer ready-made responses, can enable children to make better use of their own resources and find their own words. In this process, the adoption of a position of not-knowing can be rewarding.

As Rober (1998) states, "nobody can be as silent as a child"; however, in a safe, collaborative, and non-hierarchical climate where there is empathetic recognition and respect for the stories that children tell, not-yet told stories can also be heard.

Ethics

All participants have given their informed consent to take part in the study and the research plan was approved by ethical committee of Kuopio University Hospital.

Language check

In addition, proper use of English was checked and corrected by Papercheck, which is a professional essay editing service.

ORCID

Mira Helimäki https://orcid.org/0000-0001-6107-0043

REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th edn). American Psychiatric Publishing.

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. Norton.

Andersen, T. (1995) Reflecting processes: Acts of informing and forming. You can borrow my eyes, but you must not take them away from me. In S. Friedman (Ed.), *Reflecting team in action: Collaborative practice in family therapy* (pp. 11–37). Guilford Press.

Andersen, T. (1997). Researching client-therapist relationships: A collaborative study for informing therapy. *Journal of Systemic Therapies*, *19*, 125–133. https://doi.org/10.1521/jsyt.1997.16.2.125.

Anderson, H. (1997). *Conversation, language, and possibilities: a postmodern approach to therapy*. Basic Books.

Anderson, H. (2001). Postmodern collaborative and person-centred therapies: what would Carl Rogers say? *Journal of Family Therapy*, *23*, 339–360. https://doi.org/10.1111/1467-6427.00189.

Anderson, H. (2012). Collaborative relationships and dialogic conversations: Ideas for a relationally responsive practice. *Family Process*, *51*(1), 8–24. https://doi.org/10.1111/j.1545-5300.2012.01385.x.

Anderson, H., & D. Gehart (Eds.) (2007). *Collaborative therapy. Relationships and conversations that make a difference*. Routledge.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: evolving ideas about the implications for theory and practice. *Family Process*, *27*, 371–393. https://doi.org/10.1111/j.1545-5300.1988.00371.x.

Anderson, H., & Goolishian, H. (1992). The Client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). Sage.

Anderson, H., & Levin, S. (1997). Collaborative conversations with children: Country clothes and city clothes. In C. Smith & D. Nylund (Eds.), *Narrative therapies with children and adolescents* (pp. 255–281). Guilford.

Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative process coding system: research applications and implications for psychotherapy practice. *Journal of Clinical Psychology*, *55*(10), 1255–1270. https://doi.org/10.1002/(SICI)1097-4679(199910)55:10<1255:AID-JCLP7>3.0.CO;2-F.

Bakhtin, M. (1984). *Problems of Dostoevsky's poetics*. University of Minnesota Press.

Bowen, M. (1978). *Family therapy in clinical practice*. Jason Aronson.

Buber, M. (2002). *Between Man and Man*. Translated by R. Gregor-Smith with an introduction by M. Friedman. Routledge Classics.

Buber, M. (2004) *I and Thou*. 1. Ed. published 1937. Translated by R. G. Smith. Continuum.

Buvik, C., & Wächter, A. (2006). En Utmaning för alla. In A. Wächter (Ed.), *Samforskning. -Att lära av klienten* (pp. 9–91). Bokförlaget Mareld. www.mareld.se.

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. *Family Process*, *26*, 405–413. https://doi.org/10.1111/j.1545-5300.1987.00405.x.

Gale, J. (1992). When research interviews are more therapeutic than therapy interviews. *The Qualitative Report*, *1*(4), 1–4.

Galinsky, E. (2000). *Ask the children: the breakthrough study that reveals how to succeed at work and parenting*. Quill.

Gehart, D. (2007). Creating space for children's voices: A collaborative and playful approach to working with children and families. In H. Anderson & D. Gehart (Eds.), *Collaborative therapy. Relationships and conversations that make a difference* (pp. 183–196). Routledge.

Gil, E. (2009) Helping Abused and Traumatized Children – Integrating Directive and Nondirective Approaches (transl. by K. Kankaansivu). UNIPress.

Goldenberg, I., & Goldenberg, H. (2017). *Family therapy: An overview* (9th edn). Cengage Learning.

Henderson, D., & Thompson, C. (2011). *Counselling Children* (8th edn). Brooks/Cole Cengage Learning.

Hill, J., & Maughan, B. (2001). *Conduct disorders in childhood and adolescence*. Cambridge University Press.

Hoffman, L., & Cecchin, G. (2003). *Exchanging voices: a collaborative approach to family therapy*. Karnac Books.

Hutchby, I., & O'Reilly, M. (2010). Children's participation and the familial moral order in family therapy. *Discourse Studies*, *12*(1), 49–64. https://doi.org/10.1177/1461445609357406.

Kazdin, A. E. (1997). Practitioner's review: Psychosocial treatments for conduct disorder in children. *Journal of Child Psychology and Psychiatry*, *38*(2), 161–178. https://doi.org/10.1111/j.1469-7610.1997.tb01851.x.

Kazdin, A. E. (2005). *Parent management training treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.

Kirschenbaum, H., & Henderson, V. L. (1989). *Carl rogers: dialogues*. Houghton Mifflin.

Laitila, A. (2016). Introducing novelties into therapeutic dialogue: The importance of minor shifts of the therapist. In M. Borcsa & P. Rober (Eds.), *Research perspectives in couple therapy* (pp. 31–46). Springer International Publishing.

Laitila, A., Aaltonen, J., Wahlström, J., & Angus, L. (2001). Narrative process coding system in marital and family therapy: An intensive case analysis of the formation of a therapeutic system. *Contemporary Family Therapy*, *23*(3), 309–322. https://doi.org/10.1023/A:1011183016456

Lobatto, W. (2002). Talking to children about family therapy: A qualitative research study. *Journal of Family Therapy*, *24*, 330–343. https://doi.org/10.1111/1467-6427.00221.

Madsen, W. C. (2007). *Collaborative therapy with multi-stressed families*. Guilford Press.

McDonough, M., & Koch, P. (2007). Collaborating with parents and children in private practice: shifting and overlapping conversations. In H. Anderson & D. Gehart (Eds.), *Collaborative Therapy. Relationships and Conversations that make a Difference* (pp. 167–181). Routledge.

Moore, L., & Seu, I. B. (2011). Given children a voice: Children's positioning in family therapy. *Journal of Family Therapy*, *33*, 279–301. https://doi.org/10.1111/j.1467-6427.2011.00556.x.

O'Reilly, M. (2006). Should children be seen and not heard? An examination of How children's interruptions of parents and children are treated in family therapy. *Discourse Studies*, *8*, 549–566.

O'Reilly, M. (2008). ´What value is there in children's talk?' Investigating family therapist's interruptions of parents and children during the therapeutic process. *Journal of Pragmatics*, *40*(3), 507–524. https://doi.org/10.1016/j.pragma.2007.12.005.

Parker, N., & O'Reilly, M. (2012). ´Gossiping' as a social action in family therapy: The pseudo-absence and pseudo-presence of children. *Discourse Studies*, *14*(4), 457–475.

Piaget, J. (1959). *The language and thought of the child*. Routledge & Kegan Paul Ltd.

Rautiainen, E.-L., & Seikkula, J. (2009). Clients as co-researchers: How do couples evaluate couple therapy for depression? *Journal of Systemic Therapies*, *28*(4), 41–60. https://doi.org/10.1521/jsyt.2009.28.4.41.

Rober, P. (1998). Reflection on ways to create a safe therapeutic culture for children in family therapy. *Family Process*, *37*, 201–213. https://doi.org/10.1111/j.1545-5300.1998.00201.x.

Rogers, C. (1942). *Counseling and Psychotherapy*. Houghton Mifflin.

Santos, A., Goncalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways. A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *82*(4), 449–466. https://doi.org/10.1348/147608309X462442.

Seikkula, J., Laitila, A., & Rober, P. (2012). Making sense of multi-actor dialogues in family therapy and network meetings. *Journal of Marital and Family Therapy*, *38*(4), 667–687. https://doi.org/10.1111/j.1752-0606.2011.00238.x

Seikkula, J., & Trimble, D. (2005). Healing elements of therapeutic conversations: Dialogue as an embodiment of love. *Family Process*, *44*(4), 461–475. https://doi.org/10.1111/j.1545-5300.2005.00072.x.

Shirk, S. R. (Ed.) (1988). *Cognitive development and child psychotherapy*. Plenum.

Shotter, J. (1984). *Social accountability and selfhood*. Blackwell.

Shotter, J. (1993). *Conversational realities: Constructing life through language*. Sage.

Spivack, G., & Shure, M. B. (1982) The cognition of social adjustment. Interpersonal cognitive problem solving thinking. In B. B. Lahey, & A. E. Kazdin (Eds.), *Advances in clinical child psychology*, Vol. *5* (pp. 323–372). Plenum.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy. The Overlooked Foundation for Effective Practice*. The Guilford Press.

Stierlin, H. (1977). *Das Erste Familiengespräch: theorie, praxis, beispiele*. Klett-Cotta.

Stith, S., Rosen, K., McCollum, E., Coleman, J., & Herman, S. (1996). The voices of children: Preadolescent children's experiences in family therapy. *Journal of Marital and Family Therapy*, *22*, 69–86.

Stivers, T. (2002). Presenting the problem in pediatric encounters. "Symptoms only" versus "candidate diagnosis" presentations. *Health Communication*, *14*, 299–338.

Strickland-Clark, L., Campbell, D., & Dallos, R. (2000). Children's and adolescents' views on family therapy. *Journal of Family Therapy*, *22*, 324–341. https://doi.org/10.1111/1467-6427.00155.

Tomm, K. (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, *26*, 167–183. https://doi.org/10.1111/j.1545-5300.1987.00167.x.

Tseliou, E., Burck, C., Forbat, L., Strong, T., & O'Reilly, M. (2020). How is systemic and constructionist therapy change process narrated in retrospective accounts of therapy? A Systematic Meta-synthesis Review. *Family Process*, 1–20. https://doi.org/10.1111/famp.12562

Wells, A., Hunnikin, L., Ash, P., & Van Goozen, S. (2020). Children with behavioural problems misinterpret the emotions and intentions of others. *Journal of Abnormal Child Psychology*, *48*, 213–221.

Yin, R. K. (2014). *Case study research: design and methods*. Sage.

How to cite this article: Helimäki M, Laitila A, Kumpulainen K. "You helped me out of that darkness" Children as dialogical partners in the collaborative post-family therapy research interview. *J Marital Fam Ther*. 2021;00:1–16. https://doi.org/10.1111/jmft.12505