JYU DISSERTATIONS 428

Mira Helimäki

Children's Participation in Family Therapy

Towards a Dialogical Partnership

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF EDUCATION AND PSYCHOLOGY

JYU DISSERTATIONS 428

Mira Helimäki

Children's Participation in Family Therapy

Towards a Dialogical Partnership

Esitetään Jyväskylän yliopiston kasvatustieteiden ja psykologian tiedekunnan suostumuksella
julkisesti tarkastettavaksi syyskuun 25. päivänä 2021 kello 12.

Academic dissertation to be publicly discussed, by permission of
the Faculty of Education and Psychology of the University of Jyväskylä,
on September 25, 2021 at 12 o'clock noon.

JYVÄSKYLÄN YLIOPISTO
UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2021

Editors
Noona Kiuru
Department of Psychology, University of Jyväskylä
Ville Korkiakangas
Open Science Centre, University of Jyväskylä

Cover picture by Sade Helimäki.

ISBN 978-951-39-8826-5 (PDF)
URN:ISBN:978-951-39-8826-5
ISSN 2489-9003

Permanent link to this publication: http://urn.fi/URN:ISBN:978-951-39-8826-5

ABSTRACT

Helimäki, Mira
Children's participation in family therapy: Towards a dialogical partnership
Jyväskylä: University of Jyväskylä, 2021, 76 p.
(JYU Dissertations
ISSN 2489-9003; 428)
ISBN 978-951-39-8826-5 (PDF)

Children, or more specifically their symptoms, often bring their families to therapy. Children can be seen as "doors" through which to enter the family as a multigenerational and multifaceted chain of relations and its systemic conscious or unconscious core beliefs, rules and habits. Given that a child's symptoms reflect some uneasiness in family relations that might have increased over the years, or even generations, frees the child from being positioned as the problem or as a scapegoat. Seeing one family member's symptoms as an issue or difficulty shared by the whole family enables family therapists to treat the whole family and view its problems as well as possibilities and resources from relational perspectives in accordance with systemic principles. Children's participation in family therapy has not, however, always been self-evident, despite the original idea of family. Children's engagement in a meaningful way in family therapy practice has commonly been noted as presenting both therapists and families with a challenge. The number of studies in which the voices of children as family therapy participants are heard continues to be limited. This doctoral research contributes to filling this gap by presenting three case studies on children's perspectives. The first investigated how a child diagnosed with an oppositional defiant disorder participated in family therapeutic discussions when the family's difficulties were discussed. The second studied how sensitive and multigenerational family secrets were dealt with when children were present. The third examined how children participated in collaborative post-therapy research interviews and talked about their perceived difficulties and experiences. The three studies applied qualitative methods. The research data were drawn from data gathered for a larger family therapy research project titled "Family-centred Treatment and Systemic Feedback in the Prevention of the Social Exclusion of Children Diagnosed with Oppositional Defiant or Conduct Disorder and their Families". The research project is a collaborative effort by the University of Jyväskylä, Kuopio University Hospital, and the University of Eastern Finland. The data consist of video-taped family therapy sessions with 14 families of children aged 6-12. The results presented in this dissertation are primarily intended for those who are working with families and promoting children's participation and agency in family therapy. The most central result of this thesis underlines the importance of seeing children in family therapy as subjects, i.e., as active and meaningful dialogical partners whose presence and contributions need to be supported and approached in a respectful way. The challenging responsibility of the family therapist is to construct a positive and balanced alliance with each family member. By focusing on a family's strengths, family therapy can mobilise the family's hidden resources and thus activate an intrinsic healing process within the family.

Keywords: children, family therapy, dialogical approach, qualitative research

TIIVISTELMÄ (ABSTRACT IN FINNISH)

Helimäki, Mira
Perheterapiaan osallistuva lapsi – kohti dialogista vuorovaikutuskumppanuutta
Jyväskylä: University of Jyväskylä, 2021, 76 s.
(JYU Dissertations
ISSN 2489-9003; 428)
ISBN 978-951-39-8826-5 (PDF)

Huoli lapsen oireista tuo perheen tavallisesti terapiaan. Lapset edustavat perheen systeemisesti ja ylisukupolvisesti rakentuneiden suhderakenteiden ”eteisovia” perheessä vallitseviin tiedostettuihin tai tiedostamattomiin ydinuskomuksiin, sääntöihin ja tapoihin. Lapsen oirehdinta voi olla reagointia perheessä vallitseviin ongelmiin, jopa ylisukupolvisesti siirtyneisiin ja kumuloituneisiin haasteisiin. Oirehdinnan tarkasteleminen koko perheen yhteisenä vuorovaikutus- tai suhteessa olemisen kysymyksenä voi vapauttaa lapsen ’ongelman’ tai syntipukin roolista. Tällainen lähestymistapa asettaa perheterapialle erityisen tehtävän hoitaa perhettä kokonaisuutena ja tarkastella perheen sisäisiä haasteita systeemisesti eli suhdekäsittein. Lasten läsnäolo, tai heidän aktiivinen osallistamisensa perheterapiaan ei kuitenkaan ole ollut itsestäänselvyys perheterapian perustamisesta lähtien, mikä on lähtökohtaisesti ristiriidassa perheterapian perustamisen ydinajatuksen kanssa. Lasten kokemusta ja ääntä esiin nostava perheterapiatutkimus on määrällisesti vielä vähäistä. Tämän väitöskirjan tutkimusartikkelit on toteutettu laadullisia tutkimusmenetelmiä käyttäen. Tutkimusaineisto kuuluu osana laajempaa perheterapiatutkimushanketta “Perhekeskeinen hoito ja järjestelmällinen potilaspalaute uhmakkuus- ja käytöshäiriödiagnoosin saaneiden lasten syrjäytymisen ehkäisynä”. Tutkimusprojektissa yhteistyökumppaneita ovat Jyväskylän yliopisto, Kuopion yliopistollinen sairaala ja Itä-Suomen yliopisto. Tutkimusaineisto sisältää 14 perheen perheterapiatapaamiset yhden vuoden ajalta ja 9 perheen osalta toteutuneet seurantahaastattelut, jotka toteutettiin n. 18 kuukautta terapian päättymisen jälkeen. Väitöskirjatutkimus sisältää kolme kansainvälistä julkaisua aihepiireistä 1) miten uhmakkuushäiriö diagnoosin saanut lapsi osallistutettiin perheterapiatapaamisiin perheen vaikeuksista puhuttaessa, 2) miten perhesalaisuuksista puhuttiin perheen lasten kanssa ja miten lapset osallistuivat avoimuutta välttelevään vuorovaikutussysteemiin, 3) kuinka uhmakkuus- tai käytöshäiriödiagnoosin saaneet lapset osallistuivat yhteisen tutkimisen seurantatutkimushaastatteluihin ja puhuivat kokemuksistaan. Tutkimuksen keskeisin tulos tukee käsitystä lapsista aktiivisina vuorovaikutustoimijoina, joiden tuottama vuorovaikutus kaikissa sen eri vivahteissa on tärkeä nähdä merkityksellisenä. Terapeutin aitous, lämminhenkinen ja tasapuolisesti jakautuva myönteinen kiinnostus kaikkia perheenjäseniä ja heidän vuorovaikutustaan kohtaan tukee lapsen myönteistä minäkuvaa tasa-arvoisena toimijana, mikä voi tarjota perheelle mahdollisuuksia nähdä kaikissa perheenjäsenissä vahvuuksia, jotka parhaimmillaan voivat rikastaa perheen sisäisiä voimavaroja ja suhteessa olemisen tapoja.

Avainsanat: lapset, perheterapia, dialogisuus, laadullinen tutkimus

Author

Mira Helimäki
Department of Psychology
University of Jyväskylä
mhelimaki@gmail.com
ORCID 0000-0001-6107-0043

Supervisors

Senior Lecturer Aarno Laitila
Department of Psychology
University of Jyväskylä

Professor Emerita Kirsti Kumpulainen
University of Eastern Finland

Professor Juha Holma
Department of Psychology
University of Jyväskylä

Reviewers

Associate Professor Eleftheria Tseliou
Department of Early Childhood Education
University of Thessaly

Associate Professor Riikka Korja
Department of Psychology
University of Turku

Opponent

Associate Professor Eleftheria Tseliou
Department of Early Childhood Education
University of Thessaly

ACKNOWLEDGEMENTS

I wish to express my deepest gratitude to my supervisor, Dr Aarno Laitila, for his guidance, dedication, and commitment, and especially for his dialogical partnership. I cannot imagine a more suitable supervisor for my 'blood type'. His professional and attentive support was present throughout this journey whenever it was really needed. Aarno, the way you have broadened my horizon on what dialogue is and can be, has been truly inspiring. Thank you.

It has been a great honour to have MD Kirsti Kumpulainen, Professor Emerita of Child psychiatry, as my co-supervisor. It has meant a lot to me that you wished to be involved in this research project. The co-operation between the Psychology Department of the University of Jyväskylä and the Child Psychiatry Department at Kuopio University Hospital, which you established together with Aarno, was fundamental in enabling this research. Without the child psychiatry data produced in Kuopio this research would not have seen the light of day. Special thanks also go to my co-supervisor, head of the department of psychology in Jyväskylä, Professor Juha Holma, for his sharp remarks, justifiable and constructive criticisms.

This research project would definitely not have proceeded as smoothly as it has without the friendly and helpful aid of the personnel of the department of psychology at Jyväskylä university. Especially, I want to show my gratitude to Tiina Volanen, who was always ready to help in practical issues. In some critical moments your help was just crucial. Michael Freeman, thank you for checking my English, which sometimes might have and will raise positive curiosity!

I want also to express my gratitude to my pre-examiners Associate Professors Eleftheria Tseliou and Riikka Korja for reviewing this thesis. Your suggestions helped me to see more clearly.

This doctorate has not been done completely in isolation from clinical work. All my clients, no matter of age, gender or background, in Espoo family counselling, Ludus and Shortum have truly been my teachers in this path. From them I learn every day what is "healing", useful and not necessary so important. I want to express my thanks to Family Counselling Centres of the city of Espoo for granting me leave of absence to dedicate more time to completing this study.

Working on my doctorate in psychology has brought back memories of my doctoral studies in theology at the University of Helsinki. The years that I spent learning ancient theology, philosophy, semantics and Greek philology form a firm foundation for my thinking and understanding today. I was privileged to study for several years under the guidance of "Mystic" Dr Pauli Annala. From you, Pauli, I learned secrets and wisdom that transcend cognition and words. Thank you.

I have been blessed with friends whose presence, love and support remind me what life is all about. Sharing life with you is a gift for which I thank the Lord every day. "If I speak in tongues of men and angels, but have not love, I am only a resounding gong or a clanging cymbal" (1 Cor. 13:1). Matti, my dear husband, thank you for loving me all these 20 years, seeing the best in me, encouraging me

to be loyal to my calling. You have never presented obstacles to my endeavours to reach my goals and dreams – quite the opposite. You are amazing and crazy, never doubting your trust in me. Sade, you fulfilled my deepest dream to be a mother. I love you so much. You bring me pure joy and happiness every single day. I feel so privileged to share this life with you. Thank you. And Taavi, I am so proud of you. You are a lovely young man!

To mum and dad, thanks for all your love, support and care. I want to dedicate this doctorate to you. It is never too late to find new ways of being together – during this busy year of 2021, you have supplied me with a luxurious taxi service, unfailing and always on time!

Helsinki, 5.8.2021

Mira Helimäki

LIST OF ORIGINAL PUBLICATIONS

I Helimäki, M., Laitila, A., & Kumpulainen, K. (2021) "Why am I the only one you're talking to, talk to them, they haven't said a word?" Pitfalls and challenges of having the child in the focus of family therapy. *The American Journal of Family Therapy.* 1-18. https://doi.org/10.1080/01926187.2020.1870582

II Helimäki, M., Laitila, A., & Kumpulainen, K. (2020) "Can I tell?" Children's participation and positioning in a secretive atmosphere in family therapy. *Journal of Family Therapy,* 0 (1-2), 1-28. https://doi.org/10.1111/1467-6427.12296

III Helimäki, M., Laitila, A., & Kumpulainen, K. (2021) "You helped me out of that darkness" Children as dialogical partners in the collaborative post-therapy research interviews. *Journal of Marital and Couple Therapy,* 00, 0-16. DOI: 10.1111/jmft

Taking into account the comments given by supervisors, co-authors and reviewers, the author of this thesis wrote the original research plan, transcribed and analysed the data, designed the research questions, made decisions on what methods were used and wrote the original publications.

FOREWORD

To deepen my understanding of children's participation in family therapy practice has been my driving force and motivation throughout this doctoral research project. The dialogical approach, encountered on this journey, taught me a great deal and changed my thinking. In the real world, it is actualities that (often) set limits to our good intentions, like the wind at sea. Similarly, this research project started out of curiosity to learn and understand more. I was and still am curious to learn how can therapists work better with families, empower parents to be 'good enough' parents for their children, and free children to become who they are and actualize their potentialities? This curiosity translated into 'a living dialogue' with the data, literature, and questions asked by my supervisors that in turn directed and determined the objectives of this research, the literature to be read, the methods to be used, what points to leave in the shadows, and what eventually was found.

In this context, the expression 'a living dialogue' aims to describe the vitality and mutuality of the process. The data comprise 'stories' of living persons, whose stories 'spoke' to this researcher and aroused ideas, questions and emotions. In other words, the aim was to approach the data as living and not as an immutable object. This means that the aims in the three case studies were not pre-planned. Instead, they were reconstructed in and through the 'dialogical' process, forming three separate, yet interrelated, studies that also can stand on their own. The frame of reference and intention, however, remain the same: to approach children from a dialogical and systemic perspective as participants in the family therapy setting.

My interest in studying children as dialogical participants in the institutional setting of family therapy was aroused and constructed in dynamic and systemic ways. This interest, which sprang from both professional and personal motives, has only been enriched and deepened in this journey. Children's ability to see things in the world that we adults have 'forgotten' reminds me of the Little Prince's wisdom that "it is only with the heart one can see rightly". When working with families and children we need to follow our heart as much as our head. Around 20 years ago, I heard a senior child psychologist saying: "If we want to help children, we need to love them. We need to see the good in them, that can start to grow, otherwise "the game is lost". This advice works with adults too. Children live mostly in an adult-led world, both in real life and in the family therapy context. When working with children, it would be well to remember the Little Prince's words: "grown-ups never understand things by themselves." Therefore, children find it tiresome that adults "always need explanations" (De Saint-Exupéry, 2000, p. 2).

While doing research is sometimes tiring or difficult, it is always challenging. Explaining to others results which to you, the researcher, seem so 'obvious', needs hard work. However, the Little Prince's view that it is the time we waste on a rose that makes a rose *finally* so important to us is true (De Saint-Exupéry, 2000). The dialogical approach focuses more on the process and exploration than

the outcome. Doing dialogical research, one engages oneself in an unfinalised process, a choice that demands tolerance of uncertainty, acceptance that there is no 'truth' to be found. The question is not how far you walk but rather with whom you walk. Active co-operation, exchange of ideas and the reflections of other researchers, colleagues and conversational partners enrich the learning process and invite new explorations. They can also give hope and keep the process on track at those moments one has lost sight of it. Most new questions, approaches, insights and explorations are the product of living dialogical conversations.

In a living dialogue, someone shows curiosity towards another's thinking, listens carefully, asks questions, and reflects on what he or she has heard. There are insights that are born *in* and *through* visible social contexts, but there are also those that result from one's inner conversations. Inspired by Bakhtin's idea of the dialogical self as a polyphony of inner voices (Bakhtin, 1981, 1984) one maintains an inner dialogue with oneself, which fuels new ideas and questions. Peter Rober's (2005) *Explorations in dialogical family therapy: The concept of the therapist's inner conversation* addresses the idea and meaning of inner conversation at great length. In this research journey, outer and inner dialogues together constructed its design, form and content.

Some words need to be said about the content of introduction. Writing that was somewhat difficult owing to the limited number of family therapy studies with a focus on children's participation. The introductory chapter presents some of the reasons why helping children should always include multimodal and family-focused approaches. However, it only briefly addresses the general topic of children as clients of health care services and does not seek to present an all-encompassing overview. The focus is on presenting findings on how children have participated, been seen and heard, and contributed especially to family therapy. The findings are the results of family therapy research past and present, of ideas presented and explored in the family therapy literature and in family therapy practice. Following Bakhtin's dialogical and polyphonic self (1981, 1984), the purpose is not to present children as a homogeneous group who participate in the multi-actor settings of family therapy with only *one voice* but rather to acknowledge that every child participates with both his or her inner and outer voices that can simultaneously, and paradoxically, include independent, interrelated, inextricable, contradictory and inconsistent speaking conscious.

The descriptions of how children have been presented therefore give only some ideas about how the researchers through their personal-, history,- and profession-informed lenses have seen and heard children speaking and acting with the important others involved in the institutional settings of family therapy at particular historical moments. In line with Bakhtin's (1981) thinking, this means that ultimately none of the results, any more than voices, represents an objective truth or the participants' pure intrapsychic reality or construct; on the contrary, consciousness is socially constructed.

Discussion is a part of the research journey where findings and explorations are re-lived. As Bakhtin (1986) says a "word" creates something new that was not

there before. Being in a dialogical relation to your study, means that it is impossible to repeat your study. Engaging oneself in the data and literature again and again, one always finds something new that was not there before.

In the first steps of this research journey, Dr Aarno Laitila, my supervisor, asked me: *who you are writing for*? This dialogical opening was important in finding my way to make this journey. This study has been written for family therapists, people who work with families and children, and those who are enthusiastic about learning through case studies and facilitate family members to find new, perhaps more constructing ways to meet one another. This summary does not offer ready-made answers or working models or recipes but rather fuel and reflection for the development of ones' own thinking and way of working. In this study, my interest in philosophical thinking hopefully offers an 'appropriately unusual' perspective that at its best can enrich the therapist's inner and outer conversation. Like Tom Andersen (1991, 1995) I too believe that in order to generate new thinking or change, we should provide something unusual to an appropriate extent. Providing only ideas that are too unusual presents a risk for shutting down rather than inspiring interest.

CONTENTS

1 INTRODUCTION

1.1 Helping children with their families

In children, we can see our future. This means that children's wellbeing should be a global priority. According to The Lancet (2011) mental health problems affect 10-20 % of children and adolescents worldwide. However, not all children who need help appear in such statistics. Child distress, despite geographical differences, is ubiquitous. Estimates of the proportion of children who suffer from serious emotional disorders range from 12 to 20 %, and less than a third of them receive help. In other words, more than two-thirds of children who would qualify for help for mental disorders are unlikely to receive treatment. Whether these children's mental distress is a response to adults' problems, marital or family distress or whether marital distress is a response to the child's behaviour remains unclear to researchers. However, the impact of circular and reciprocal patterns of stress can be burdensome for families (Miller & McLeod, 2001). It is also known that aggression in childhood and early conduct problems are the most frequent reasons for referrals for clinical and school-based treatment (Hill & Maughan, 2001; Kaslow, Broth, Smith, & Collins, 2012; Kazdin, 1993, 1997, 2005). Young children who exhibit high levels of aggression in diverse settings are known to be at elevated risk for developing serious behavioural, academic and social-emotional problems in adolescence and beyond (Kellam, Ling, Merisca, Brown, & Ialongo, 1998; Puustjärvi & Repokari, 2017).

In helping children, it is generally conceded that multimodal and family-focused approaches, which can be regarded as evidence-based treatments, are needed to address the complex, cumulative, multidetermined nature of early-onset conduct disorders (Kazdin, 1993, 1997, 2005; Miller & Prinz, 2003; Theodor, 2017). Family-based interventions, including family therapy, have been also considered effective for a range of disorders in children and adolescents (Kaslow, Broth, Smith, & Collins, 2012). Family therapy with a systemic (Carr, 2016) emphasis on promoting interactional relationships within the family (Kazdin, 1997, 2005; Sprenkle et al., 2009, Sprenkle, 2012) has achieved good results in

families where a child has been diagnosed with an oppositional defiant or conduct disorder (von Sydow, Retzlaff, Beher, Haun, & Schweizer, 2013).

Helping children with their families presents challenges. First, seeking out professional mental health support for their children requires persistence on the part of parents. The process often takes time and the family needs to navigate the complexities of the service system. Second, parents often have their own theory about what is needed to 'fix' their child's problems and do not necessarily agree with professionals on the treatment plan (Shanley, Reid, & Evans, 2008). Rather than seeing difficulties in the family system and seeking familial reasons, parents often present the child as the family member who has a doctorable problem that needs a diagnosis and medication (O'Reilly & Kiyimba, 2021, 3). Moreover, to cite O'Reilly & Kiyimba (2021, 16), "In developing a dispositional account that individualised the child's difficulties, parents worked to move away from potentially blaming aspects of family system explanation to bio-psychological explanations" (O'Reilly & Kiyimba, 2021, 16.), simultaneously constructing accounts of themselves as good parents. In such cases, parents often shake their heads in family therapy, indicating their confusion about their child and ask, "What in the world is wrong with this kid?" In contrast, a systemic question might be "What in the world is affecting my child so profoundly that she/he is acting this way?" From a systemic perspective, children often react to their environment and manifest the family's symptoms of stress or dysfunction.

The Milan model of a systemic approach (e.g., Palazzoli, Boscolo, Cecchin, Prata, 1980) suggests that therapists must strive for relational definitions of problems and thus incorporate a systemic epistemology into their understanding of family members' accounts of their troubles. This requires therapists to maintain a non-judgemental, neutral stance. This is difficult to achieve given the nature of language itself, which is not, of course, neutral (Gergen, 1999). Patrika and Tseliou (2016) argue that despite therapists' good intentions to introduce relational perspectives into family members' reports of their problems, doing so may sometimes produce unwanted results, such as further blaming the person identified as the patient. This is not to say that systemic approaches do not work; instead, it reminds that when working with families and issues of parenthood we are necessarily dealing with feelings of guilt, shame and responsibility. Despite different challenges, when the family is treated holistically, a degree of success can be expected (Andolfi, 2016; Goldenberg & Goldenberg, 2017; Miller & McLeod, 2001).

1.2 Children as the clients of health care services

Mental health problems in children have become increasingly recognized, and as a result, services for children have increased. Greater emphasis is also placed nowadays on child-centred care, as manifested in the encouragement children are given to be more actively involved in their healthcare and decision making (Stafford, Hutchby, Karim, & O'Reilly, 2016). However, children are seldom the

main initiators of the search for help or among those who help make treatment decisions (Ackerman, 1970; Hutchby, 2002; Wolpert & Fredman, 1994). The latter has been seen as one of the reasons why children are reluctant to seek help (Stafford et al., 2016). The asymmetry of the positions of the participants in family therapy, including children, have also received attention. The asymmetry that exists between the therapist and family members and between children and their parents needs to be properly addressed. This asymmetry in power and status is typically manifested and negotiated in family therapy through language (Cederborg, 1997). Hence, the role and meaning of the language in which the differential status of the participants' status is manifested has also become a focus of interest in family therapy studies.

Asymmetric positioning is often at its most visible at the beginning of treatment and manifests as demotivation, over-compliance, and a passive and negative disposition towards participation. In their study on child psychotherapy, Núñez, Midgley, Capella, Alamo, Mortimer, & Krause (2021, 6) show that a positive therapeutic relationship is not a starting point; instead it evolves gradually as the children and their parents come to notice that therapists are "friendly and nice [people] who treated them well".

The importance of children's perspectives on family functioning is acknowledged in public health services. Several interventions for the children of mentally ill parents have been developed in recent years that aim at preventing mental disorders and promoting mental health and resilience for this group of children, who are known to be at elevated risk for psychiatric disorders (WHO, 2004). Beardslee's family intervention (BFI) (Beardslee, Gladstone, Wright, & Cooper, 2003), in the US Family Talk Intervention project, is a clinician-based, cognitive psycho-educational structured method developed to encourage communication within families about parental affective disorder. The theoretical foundation of the method is eclectic, and it includes narrative, cognitive, psychoeducational and dialogical elements. The intervention is not designed to be a therapeutic intervention for any of the family members per se. Its focus is on preventing depressive symptoms and promoting resilience in the children of affectively ill parents by opening up communication about a parent's illness within the family and helping parents to recognise and support factors that protect their children (Pihkala, Sandlund, & Cederström, 2011). It has been shown to have positive long-term effects in both children and parents, including improved parental child-related behaviours and attitudes, child-reported understanding of parental illness, and children's internalising symptoms (Beardslee, Gladstone, Wright, & Forbes, 2007; Solantaus, Paavonen, Toikka, & Punamäki, 2010).

Mental illness is known to be surrounded by silence and stigma that make talking about it difficult (Pihkala & Johansson, 2008). Pihkala, Sandlund, & Cederström (2011) showed that it is primarily due to feelings of guilt that parents find it difficult to start talking about their illnesses to their children. Children, according to their parents, seemed to contribute to this silence by adapting their behaviour: they did not demand any explanation; they became 'nice' and quiet.

They played by themselves, did not disturb the parent, tried to comfort the parent, and mirrored the parent's mood. Depressed parents are, nevertheless, worried about their children, and long for dialogue with them. However, they feel uncertain about whether it is right to involve them and, if so, how to do this (Pihkala & Johansson, 2008). Parents experienced BFI as positive, owing to its solid, logical and predictable structure that provides parents with a sense of security and control. Parents said that it was easy to talk with professionals, who were just ordinary people, 'fellow human beings', who treated them in a fair, noncontrolling way. Professionals were perceived as supportive, emphatic, and caring and the atmosphere in the sessions was informal. Many parents pointed out how pleased, relieved or astonished they had been that their children had talked openly with the professionals (p. 260). The parents emphasised the role of professionals as mediators who can help them start dialogue with their children (Pihkala & Johansson, 2008).

Pihkala, Dimova-Bränström, & Sandlund (2017) explored family members' experiences of BFI in cases of a parent with a diagnosed substance use disorder. The results showed that increased openness in the family about the substance use disorder was a recurrent theme throughout the material and a central issue reported by children. While the children themselves had a high level of psychological symptoms, the majority of them felt that BFI had made a positive difference in both their families and themselves. Almost all the children said that it felt good to have spoken out in the family, to be able to speak to their parents frankly, especially about their feelings regarding the parent's abuse, which no one had talked about before (p. 398) Parents also reported improved wellbeing in their children. Relationships in the family were felt to be closer after BFI in most of the participating families.

Children's wellbeing and the family's functionality are put at risk not only by a parent's mental illness but also by a parent's somatic illness. In his doctoral dissertation (2012), Mika Niemelä showed that parental cancer is a serious risk factor for psychosocial problems in children. Effective support for the diverse needs of a family and a child requires flexible inter-team collaboration and networking with local children's services. Clinicians' long-term experiences of the use of structured child-centred interventions in every-day clinical practice highlighted the importance of taking children's needs into account. A significant improvement in the parent's psychosocial wellbeing was also observed four months after completion of the structured intervention. In another doctoral dissertation, Florence Schmitt (2008) showed that a child-centred family intervention offered space for elaborating on cancer in the family and that this was useful in validating the children's sense of coherence and feelings, and in promoting open communication.

In sum, in recent years a large body of research has been conducted with children from a rights perspective, especially on their right to be heard, informed, and participate in discussions on topics that affect them. Seeing children as too vulnerable or lacking agency in dealing with their own issues violates children's

human rights and does not protect them even that has been the intention from an adult-centric perspective (Garcia-Quiroga & Agoglia, 2020).

1.3 Where are the children in family therapy?

Studying the participation of children in family therapy practice is challenging as it remains limited in practice (e.g., Miller & McLeod, 2001). This is surprising given the original idea of family therapy and its commitment to systemic principles. Fifty years ago, the child psychiatrist Nathan Ackerman (1970) stated, "without engaging the children in a meaningful interchange across the generations, there can be no family therapy" (p. 403). Ackerman considered children's involvement important and treated the family as the basic patient unit for diagnosis and treatment. According to Andolfi (2016), "Ackerman was the one that introduced the metaphor of the child as the family scapegoat in the field" (p. 144).

Ackerman's work emphasised two pairs of concepts: the intrapsychic and interpersonal, and the unconscious and conscious. His model was seen in the field as outspoken and provocative (Andolfi, 2016). He did not hesitate to be confrontational and, if needed, he challenged defence mechanisms. His familiarity with complex interplay, family problems and the dances of selves within family systems (Kaslow, 2010) strengthened his resolve to confront the field: "Where are the children"? Around 30 years later, Salvador Minuchin (1998), in turn, implicitly voiced his concern over the absence of children in a paper titled *Where is the family in narrative family therapy*? Although Minuchin does not explicitly refer to children, his concern over conducting family therapy without seeing *the family* can be understood to include children.

A study by Korner and Brown (1990) echoes the same concern expressed by the founders of systems theory. In the U.S., 40 % of family therapists never included children in their therapies and 31 % invited children into the session without really engaging them in the therapy process. In light of the fact that a large number of publications in the field of family therapy argue for the importance of children in the family therapeutic process Korner & Brown (1990), Lowe (2004), Miller & McLeod (2001) and Rober (1998) have outlined the challenges presented by actively engaging or wholly excluding children. These vary from personal and educational history to relational factors. Whatever the reasons for excluding children, it is widely considered that family therapy should provide children with a forum through which their voices and perspectives can be equally heard (Strickland-Clark, Campbell, & Dallos, 2000). If children are not admitted to family therapy sessions, not only are their voices and experiences entirely mediated by their parent's perceptions, but they are also unable to benefit as individuals from multi-voiced discussions. Parents may also lose an opportunity to hear their children talking about what bothers them in different or new ways (Lowe, 2004).

Despite differences in family systems approaches and ways of doing family therapy, the relationship perspective is predominantly inclusive. The aim to

understand a family's communication and its patterns of interaction has been seen as the best way to intervene and help individuals change their behaviour (Andolfi, 2016; Miller & McLeod, 2001; Sprenkle, Davis & Lebow, 2009). Critical voices have, however, been raised against this idea. Josephson (2015) questioned the idea of approaching the family as a system and how in that approach change in an individual is thought to occur. Josephson does not deny the importance of noticing family factors; on the contrary, he considers the family as the core component of resilience and sees the family's role as regulating the child's affect and behaviour and shaping his/her mind. However, Josephson reminds us that when treating a child, given that the child never develops in vitro but in vivo, the whole spectrum of factors related to the child's family needs to be taken into consideration. Therefore, he argues for the importance of a thorough family assessment when planning a family intervention and also sees that in some cases individual treatment may be more effective. According to Josephson (2015, 465) "change in family interaction is often resisted due to the inner world of parents, which has to be altered if family interactions are to be changed." Changes in the child's inner world and its working models also require individual psychotherapy (Josephson, 2015).

The focus of the question 'Where is the family?' pondered by Minuchin (1998) was not aimed at arousing discussion on family therapists' personal preferences but rather at challenging the postmodernist turn, and more particularly the ideas of social constructionism, currently prevalent in the field of family therapy. Minuchin's concern was that family therapy has been narrowed down to a forum of individuals who, instead of co-constructing meanings together with other family members, privilege the discourse of individual members. For Minuchin, the family is a natural interpersonal context in which people, both children and adults, learn and develop their views about themselves and others in the world and tell stories that colour their lives. Combs and Freedman (1998) replied to this by challenging Minuchin's concept of the family, which they saw as oversimplifying. In their view, children learn about the self and others in many contexts and not only in the family. The exchange of views on telling and retelling between Minuchin and Combs and Freedman offers an excellent example of similarities and dissimilarities, in which even unshared assumptions and contradictory voices can be seen as generating 'newness' by introducing new strands that make the story richer and thus more interesting and useful. This is precisely the reason why the stories to be shared are richer and more multi-layered the greater the number of family members present in the family therapy setting. Seeing each family member's unique perspective as a resource, one can say, as Lowe (2004) says, "the more the merrier".

Children, unlike adults, are less hampered by societal constraints, have better access to the unconscious and as such may bring such an honesty and zest to therapy sessions that without their presence may be lacking (Korner & Brown, 1990). Although every individual reflects on and carries both cultural impacts and "the family" in his or her inner and outer voices, these reflections cannot replace the contributions of the living voices of living participants as present. In

treating family conflicts with the whole family present, new ways of relating and deeper emotional honesty between family members become possible (Ackerman, 1970). Seeing the whole family, family members can learn from each other how multi-voiced human experience is and how each member's concerns do not relate to objectively existing conditions but are representations that are continually negotiated through joint conversations (Lowe, 2004).

Going through the definitions of social constructionism cited by both its supporters and critics, Minuchin concludes that there is nothing in social constructionist theory as such that would dictate the absence of the family: quite the opposite. Focusing on Gergen's (1994) and Bruner's (1996) view of the self as a social construct, Minuchin (1998) argues that no family therapist could put it better. The idea that the self develops through give and take, from the outside in as well as from the inside out, is in line with systems theory. On the supposition that in theory social constructionism recognises diversity and favours interventions that are oriented towards increasing diversity in the internalised voices of clients, why is it that, in practice, where only selected family members are present, does this notion seem to be at risk of disappearing? By including the entire family in therapy, therapists genuinely become witnesses of the family's dynamics rather than being indirectly exposed to it by hearing just some family members talking about family conflicts. Taking the views of all family members into account ensures a more balanced understanding (Miller & McLeod, 2001). Excluding children from family therapy risks seeing the family as an island cut off from its multigenerational dimension. Children are the natural relational bridges in intergenerational dialogue (Andolfi, 2016). Given that the objective of family therapy is to treat whole families (Goldenberg & Goldenberg, 2017), the exclusion of children is surprising.

Roger Lowe (2004) shows how the ideas of family therapy and constructive therapies can be bridged to serve the family and its relationships. Both therapies emphasise relationships and contexts, meanings and processes in their understanding of human difficulties.

1.4 The half-membership status of children

Children's engagement in a meaningful way in family therapy practice has been observed to present a constant challenge to therapists. O'Reilly's and Parker 's (2013) article "*You Can Take a Horse to Water But You Can't Make it Drink": Exploring Children's Engagement and Resistance in Family Therapy*" shows that children can competently remove themselves from therapy through passive resistance and active disengagement. The authors' message is clear: this is the way children express their autonomy. Family therapy as an institutional setting is typically and predominantly adult-led, ignoring the differences between adults and children in their cognitive and linguistic skills. In settings where both the child and the child's parents are present, clinicians may tend to place more weight on the views of the parents than those of the child, thereby putting the child at risk of being

positioned as a passive listener to talk about them by their parents (Hutchby & O´Reilly, 2010; Lobatto, 2002; Parker & O'Reilly, 2012).

Therapists who base their decisions on input from parents alone risk overlooking issues, and even problems, that matter to the child, and thus may alienate or fail to engage the child (Hawley & Weisz, 2003). In engaging children for joint discussions, therapists should pay more attention to the differences between children and adults in their cognitive (Henderson & Thompson, 2011) and linguistic skills (Lobatto, 2002). To engage children in joint discussions, therapists need to create more space for children to express themselves.

Therefore, slowing down, and using short, clear and concrete sentences is important. 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 (Carnevale, 2020; Gehart, 2007; Gil, 2009). Children's narratives, if listened to only through a *thin* reading of their explicit utterances (Spyrou, 2016), can be interpreted as illogical, unintelligible, and couched in non-expressions that are difficult to understand. According to Carnevale (2020), these misconceptions have led professionals and researchers to draw caricaturistic and outdated models of child development that characterise children's perspectives as immature, incompetent and not substantially meaningful (Hogan, 2005). Hearing children's narratives through a *thick* lens requires a hermeneutical orientation with an empathic attunement. This means not only showing a genuine interest in trying to sense the emotional perspective of the "other" but also a striving to grasp that person's understanding of the matter at hand to the greatest extent possible (Gadamer, 1975/2004; Carnevale, 2020).

Some studies have demonstrated that children have little input into their healthcare conversations (Stivers, 2002) when incidentally present. Many studies conducted with children in alternative care and adopted children have found that they are not considered active subjects and are rarely invited to participate (Garcia-Quiroqa, & Agoglia, 2020). According to Atwool (2016) there is strong evidence to show that decisions made by adults for children in care are not always the best decisions and may have lifelong consequences. The role of children in decision-making processes pertaining to their welfare and protection has been understudied, despite the direct effect of such decisions on their lives (Garcia-Quiroqa, & Agoglia, 2020).

In the child psychotherapy literature one can read that children are unable to 'collaborate' with the therapist or "agree on goals and tasks" or that children are invalid informants about their own therapy experiences (see, e.g., Núñez et al., 2021). Such claims are based on the belief that children are unable to comment legitimately on their experiences (Gibson & Cartwright, 2014) or that their views are too superficial (Midgley, Target, & Smith, 2006). Fortunately, these assumptions have been criticised by social researchers (for more details, see, e.g., Núñez et al., 2021).

It has also been noticed that the presence of parents can inhibit children's conversational contributions (Strickland et al., 2000). Rober (1998) states that

nobody can be as silent as a child, although it is often said that children are spontaneous and open beings who enjoy revealing what they think, feel and want. Rober considers that children have good reasons for behaving as they do. Staying silent or covert may be the wisest and safest way for a child to act in an adult-led culture. From another perspective, children may also be unaccustomed to being treated as equal conversational partners whose views are valuable. As Galinsky put it, adults often talk about topics that are important for their children's lives *around* rather than *with* their children (Galinsky, 2000). In any case, children need to feel that they are respected and safe in the family therapy session, and not afraid of being ridiculed, punished or blamed for the things they say or do. Moreover, children not only speak less than their parents, but they are also more frequently interrupted (O'Reilly, 2008), treated in negative ways (O'Reilly, 2006) and talked about as a third party (Parker & O'Reilly, 2012) than adults.

1.5 Giving children a voice in family therapy

Since the 1970s, many studies have addressed users' views of family therapy. However, despite the trend towards respecting the rights of children and the post-modern focus on texts as objects of study, which have motivated interest in hearing the voices of child and adolescent users of therapy, very few qualitative studies have focused exclusively on children's views of family therapy. The legitimisation of qualitative methodology in psychology has provided researchers with a tool to discover and report on children's views of their therapy in ways that are user-friendly (Moore & Seu, 2011). Contemporary social researchers have also criticised adult-centred approaches and proposed new methods to foreground children's perspectives and experiences (e.g., Luttrell, 2010). In psychotherapy, it has been noticed that researching children's views in therapeutic encounters requires the development and use of innovative research methods that enable children to express themselves in a safe and age-appropriate way (Midgley, 2004; Núñez et al., 2021).

A synthesis of the results of qualitative interview studies on children's and adolescents' experience of family therapy suggest that children approach family therapy through practical lenses (Moore & Seu, 2011). According to Fidell (2000), Lobatto (2002), Marshall and Reimals (2002), Stith, Rosen, McCollum, Coleman, & Herman (1996) and Strickland-Clark et al., (2000), children understand that there is a problem in the family and that family therapy is a place to improve the situation in the family, by increasing understanding and finding solutions. In reflecting on their experiences, children reported that, owing to its potential to arouse difficult feelings or memories which one would prefer to avoid, therapy can be painful. For all children, the role of the therapist has a fundamental effect on how they perceive the quality of therapy. A child's age also affects how big a role the therapist's personality plays in the therapeutic encounter. Moreover, the younger the child, the greater the importance to the child of having an opportunity to participate in the therapy.

A central theme in interviews with children was being heard. Children reported that even though it felt good to be listened to, they did not want to become the focus of therapy (Moore & Seu, 2011). Unsurprisingly, children reported feeling good becoming visible through their strengths rather than weaknesses. Children felt uncomfortable if they asked too many questions, were not understood, or were asked to behave rationally by therapists. Children wanted to be involved in therapy by being physically present and taking part in therapeutic activities. Children also wanted to be involved in discussions focusing on finding solutions to the problems they perceived in the family. They talked about feeling relieved, speaking honestly, and feeling worried if they were excluded. Children expressed their concern that a family member would react negatively if they spoke freely. Speaking in front of their parents was not perceived as easy, despite their awareness of their parents' motivation for discussing and sharing sensitive topics or experiences related to their lives. Children also valued the opportunity of seeing therapists without their parents. In sum, children saw family therapy as useful in bringing about both solutions and changes and causing their parents to see them differently.

Stith et al., (1996) interviewed 16 children between the ages of 5 to 13 who had participated in at least four family therapy sessions. Eleven of the twelve families participating in the study presented for therapy owing to a child-related problem. The remaining family identified marital problems as the area of most concern. Eight of the problematic children were having difficulties expressing or managing anger, and two were identified as having problems with self-esteem. The children were asked to describe their perspectives and experiences on family therapy. By exploring the hitherto missing voices of children in this debate, the findings make an important contribution to the long-held concern about the need to engage children more effectively in family therapy. Stith et al. were interested in finding out how children perceived the importance of being involved in the family therapy process. They wanted to let children speak for themselves.

Stith et al., (1996) found that all the children they interviewed, regardless of age, indicated a desire to be actively included in the family therapy. Moreover, they wanted to be included in therapy *with* their family. Many of the children even said that inclusion was important to them. They wanted to be included in conversations that concerned their family life. They wanted their family to get help and find solutions to perceived problems, and they wanted to be included in a meaningful way. Some children said that getting help in answering questions is important. Those at the age of latency (5-9 years) saw play as an important part of therapy. They enjoyed activities initiated by the therapist. An hour of 'adult-talk' might be too much for a young child. The pre- and early adolescents (10-13) were more likely than the younger children to understand the relationship between supervisor and therapist and the purpose of call-ins. They wanted to hear the purpose and goals of the therapy. The children let the researchers know that the more they know about what is going on, and what is expected from them, the more comfortable they are with therapy. The researchers found that children's perceptions of the reasons for therapy sometimes differed from the

reasons their parents had given them. There were also children to whom it was not clear why their family was in therapy. It became clear that one conversation with children on the purpose and motives of therapy may not be sufficient; instead repeated conversations are needed. Some children made it clear that inclusion in the therapy did not necessarily mean that they wanted to be the focus of attention. Rather, inclusion meant ways that helped them to feel welcome as participants. Like their parents, children emphasised the personal attributes of the therapist as a meaningful ingredient in the therapy process.

In their qualitative research, Moore and Seu (2011) freely discussed with families, including their children, how they experienced their first session of family therapy. The data consisted of 20 family interviews. Thirteen children, ranging in age from 8-15 were included in 9 interviews. The reasons for referrals varied from trauma (1), challenging behaviour (3), school refusals (2), sexual abuse (1), difficulties in concentration (1) and depression (1). The interviews followed a protocol in which the interviewer asked questions concerning the background to the referral for therapy, inviting participants to talk about and evaluate their experience, particularly in comparison to their (possible) prior expectations of therapy. The data were analysed by applying discourse analysis following the ideas of Foucault (1969). Four prominent discourses were identified: Reliable witness, Child, Patient and Scholar. According to the authors the positions the children took in a relation to therapy rendered the interviews a site in which the relative power of the adults, whether parents or therapists or both, could be met with compliance or resistance. Moore and Seu (2011) found that children may independently complement positions assumed by adult speakers. In other words, they concluded that it cannot be assumed that parental satisfaction with therapy will always mean a satisfied child. They further concluded that the positions adopted by the children seemed much more closely bound to the dynamics of the interview than the positionings of the adults. The children used the interviews as sites to express compliance, resistance and vulnerability to adult power, thereby pointing to own lower power status relative to that of the adults.

While Moore and Seu (2011) found no obvious gender differences in the subject positions adopted by the children, some age differences emerged. The younger children more easily accepted the position they were invited to occupy whereas the older children showed more independence, constructing for themselves a position ('scholar'), which often differed from that constructed for them by their parents. The younger children more often tended to position themselves as the playful child. Accordingly, they expressed a need for play and stimulation and showed some resistance to being questioned. Overall, Moore and Seu (2011) showed that children are active participants who construct for themselves different and multiple positions towards the therapy from its very outset. Their study suggests that therapists who are aware of the multiple positions that their child clients adopt may be able to create a fruitful therapeutic relationship. The study also suggests that if the positions that children adopt can be identified, this might offer participants topics that can be jointly discussed.

In conclusion, it appears that children want to be treated respectfully and that it is important for them that their positive sides are recognised (Rober, 1998) and that they are seen and heard in the same way as adults. However, Rober notes that children want to be welcomed as children and not as miniature adults. This sets specific criteria for the furnishing of the therapy room, which should include toys, crayons and paper for use by children.

1.6 Children as consultants and co-therapists

Helping children and their families is the ultimate goal and driving force in developing family therapy-related research, methodology and work. Andolfi (1994) in his article *The Child as Consultant* describes how he and his team developed to help families with their difficulties. Andolfi's aim is to show that how a child's participation in family therapy is seen by the therapist makes a difference to the whole family. For Andolfi, the child is the doorway to the family (Andolfi, 2016). His key message for family therapists is that the child is never "the problem". The child's symptoms are an alarm signalling a deep uneasiness that has accumulated over the years in each member of the family. Learning from his own mistakes, Andolfi (1994) says that *the problem hunt* did not benefit the family, and sometimes it even made the situation worse. To help the family, the first and most important task of family therapists is to form a balanced alliance with each family member. Therapists need to understand and take into equal consideration the reality presented by the individual family members. The greatest challenge of all is how to free the problematic child from that label (Andolfi, 2016).

The best and quickest way to de-label the child is to transform him or her into a subject of competence from the very first family therapy meeting (Andolfi, 2016). Andolfi (1994) describes how the perspective or situation might change if it is assumed that the child brings the family into therapy rather than the child is brought into therapy. Instead of approaching symptoms as behaviours that need to be fixed, they can be seen as gifts that, via the child, offer the whole family the potential for vitality. For Andolfi, it is important to accept the child's symptoms and approach them playfully. This approach made families feel safe, which in turn made room for increased curiosity (Andolfi, 1994).

Andolfi's team started approaching the 'problem' child as a consultant partner. They proposed forming a consultative alliance with a child by requesting the child's assistance in working with the therapsist(s) to help his or her parents. Complimenting and employing the competence of the child indirectly compliments the parents, who have raised a competent child. In this idea, one can also hear echoes of Winnicott (1965/2018), who discusses how a child is seen altogether, both through relational lenses and the lens of parental care. For Winnicott, there is really no such a thing as an infant without a nursing environment. Through the child, as Andolfi (1994, 77) argues, it is possible to access the memories and lives of other generations, and thus transgenerational patterns can become jointly shared, discussed and re-evaluated. Seeing the

child's symptoms from the perspective of competence leads to the idea that the children are active in *choosing* the symptoms they have.

Andolfi assumes that children choose their symptoms according to what they profoundly want to become in touch with. In this sense, aggressiveness in a child may be the key to a transgenerational aggression problem that has not been faced. If the child's aggression is seen and handled as something that is transmitted intergenerationally, and which happens to be intensified through and in this child rather than the child's personal speciality, it may relax and free the child from guilt and anxiety. Seen in this way, the child represents the recent evolution of the multigenerational family. Children are to be immersed in the family system even before they become aware of it. Being able to use their systemic competence is a therapeutic resource for the whole therapeutic system. Andolfi's team introduced the concept of the grandparental child to indicate that the child as consultant becomes the pathway to historical and unconscious meanings that transcend his or her knowledge (Andolfi, 2016.).

Adolescents are often less willing than younger children to adopt the role of consultant. However, Andolfi suggests that if a therapist is able to engage with them and work on their ambivalence, adolescents can also be potentially resourceful consultants. A creative-minded and playful approach is the key in persuading adolescents to co-operate and give up their resistance.

1.7 The mentalising skills of children with conduct problems

Some words need to be said about the mentalising skills of children who struggle with conduct problems, as the present research data is drawn from therapeutic encounters with families whose children have been diagnosed with an oppositional defiant disorder or a conduct disorder. Antisocial behaviour (ASB) in children is an umbrella term for a broad range of behaviours, including psychiatric diagnoses of oppositional defiant disorder (ODD), conduct disorder (CD), and disruptive behaviour disorder (DBD) that can operationalised and studied in different ways. Common to diagnoses of ODD, CD and DBD are displays of chronic and repetitive aggressive behaviour, a disregard for the rights of others, and the violation of social norms (American Psychiatric Association, 2013). Child aggression and conduct problems constitute the biggest proportion of referrals for clinical treatment (e.g., Theodor, 2017). Early aggression problems also present an elevated risk both for academic and socio-emotional problems in adolescence and beyond (Kellam et al., 1998), and for personal and family tragedies (Kazdin, 2005), and hence effective treatment is needed.

Children with behavioural problems have been shown to have more difficulty with mentalising skills than peers without such problems. Distortions and deficiencies in cognitive processes generate interpersonal problems. Poor self-regulating skills and anger-management generate difficulties in social situations. Deficiencies in strategies for making 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 in achieving socially satisfying goals (Shirk, 1988; Spivach & Shure, 1982).

Mentalising skills develop in and through interpersonal relations with others, through one's perception of oneself in another person's mind as a thinking and feeling individual. One learns to mentalise only as a result of being mentalised, and therefore mentalising skills can be seen to develop from outside in (Allen, 2003; Allen, Fonagy, Bateman, 2008; Fonagy, Gergely, Jurist, & Target, 2004). However, mentalising requires a differentiated self (Bowen, 1978), which enables one to see others as separate persons. In Bowen's (1978) thinking, differentiation also refers to the distinction between the cognitive and emotional systems. The greater the autonomy of each system, the greater the differentiation between them, as manifested in individual decisions and thinking, and in less reactive behaviour (Willis, Miller, Yorgason, & Dyer, 2021).

According to Allen (2003), mentalising occurs explicitly and implicitly. Mentalising explicitly is a relatively conscious and verbal process of reflection. Mentalising implicitly occurs when we empathise intuitively and nonverbally, "mirroring" others' mental states. In psychotherapy, a therapist mentalises implicitly when responding to what a patient has said with a look of interest or emotionally engaging in interaction (Allen, 2003).

Winnicott (1971) argues for the role of maternal mirroring in the development of a mentalised sense of self. An important question for Winnicott is what a child sees in the mother's face. If the infant is able to see him- or herself in the mother's face, then the mirroring function is in play. Failure of the mirroring function can affect an infant's creativity, as it makes it difficult for the infant to situate him or herself in the maternal environment and later on in other relationships.

Misinterpretation of other's emotions and intentions is a risk factor for antisocial behaviour. A recent study by Wells, Hunnikin, Ash, & Van Grooten (2020) showed that children with behavioural problems are impaired in their ability to identify others' emotions and intentions. These social cognitive processes were related and inversely associated with the severity of behavioural problems. The authors found that a deficit in emotion recognition in children with behavioural problems extends to the recognition and interpretation others' intentions. Therefore, emotion recognition skills are essential for initiating and maintaining social relationships. Hubble, Bowen, Moore, & Van Goozen (2015) showed that fear, anger and sad recognition improved in youth offenders following emotion recognition training and that the improvement was associated with a significant reduction in the severity of crimes committed six months later.

2 THE AIMS OF THE STUDY

The main aim of this study was to deepen understanding of children as participants in family therapy. The three appended articles offer insights on 1) how a child diagnosed with an oppositional defiant disorder became engaged in his family's therapeutic discussions when the family's difficulties were discussed, 2) how sensitive and multigenerational family secrets were dealt with in the presence of children and the children's role in these discussions, and 3) how children participated in collaborative post-therapy research interviews and talked about their difficulties and experiences.

3 DATA

The research data form part of a larger family therapy research project "Family-centred Treatment and Systemic Feedback in the Prevention of Social Exclusion for Children Diagnosed with Oppositional Defiant or Conduct Disorder and their Families". The project is a collaborative effort involving the University of Jyväskylä, the University Hospital of Kuopio, and the University of Eastern Finland. The data consist of video-taped family therapy sessions on 14 families with children aged 6-12 years. Therapy sessions are held at Kuopio University Hospital Child Psychiatry Clinic. The research material also includes collaborative post-therapy research interviews (9/14; 5 dropouts) that took place around 18 months post-therapy.

All participants gave their informed consent to take part in the study and the research plan was approved by the ethical committee of the Northern-Savo Health Care District.

4 METHODS

This research applied qualitative methods. Study I was conducted by applying thematic analysis with a blend of inductive and deductive approaches (Braun & Clarke, 2005). Studies II and III applied the Dialogical Methods for Investigations of Happenings of Change (DIHC) approach (Seikkula, Laitila, & Rober, 2012), which is a relatively new method and not yet widely used and tested in family context where children are present. The DIHC method is described in detail in Seikkula, Laitila & Rober (2012) and will not therefore be elaborated on here. Instead, in the following sections I reflect on some of the core ideas and premises of DIHC and show how it has been designed to meet specific criteria in multi-actor settings, especially the setting of family therapy.

4.1 The choice of method

This section discusses the choice of a method, explains implicitly why the method was changed to DIHC and outlines the basic concepts that can be viewed as fundamental to family therapy. This is done because the method should be chosen in accordance with the essence of a phenomenon one is studying. In other words, if one is interested to study how the phenomenon of 'dialogical' takes place in a natural family therapeutic setting it appears logical to choose a method which is designed for that purpose. The concepts presented here also inform the theoretical frames of the DIHC method.

Doing research calls for passion, but even more for commitment and discipline. Without a sound method, there is no such a thing as 'doing research'. The word method (*meta hodos, Gr.)* refers to *following a path*. In much the same way as a traveller uses a map to stay on track, it guides others in taking the same steps (Gadamer, 1975/2004) making research more transparent, the principle of *sine qua non*. The method itself is however blind without a traveller with a curious mind. The researcher's questions are the traveller's eyes that inform what she sees on the road. Questions are never innocent or objective. The researcher

always observes the data through hermeneutical lenses that have been shaped by both the scientific community and by the researcher's personal experiences.

What motivates research is the researcher's interest in better understanding a phenomenon. According to Gadamer (1975/2004), understanding only begins when something starts to speak to you. Understanding however never ceases. It co-constructs and develops in unpredictable and dialogical ways. Understanding is manifested through language; it is sought through the exchange of ideas and words and from within a complex web of diverse voices, which challenges understanding as "the truth". Words are paradoxically simultaneously infinite and 'living individual consciousness' that want to become heard (Bakhtin, 1981, 1984). Listening carefully to the data, understanding comes to 'fruition' in in the results of the study and our answers to the research questions, which in turn create new questions and new narratives to become '*re*-searched' and *re*-understood.

4.2 The concept of family therapy

As mentioned above, in choosing her method, the researcher needs to acknowledge the 'essence' of the phenomenon she wants to look closer at. In this research, the phenomenon of interest has been children's participation, dialogical happenings, interaction, and communication in family therapy. To understand this, one needs to have some idea of the nature and logic of the family therapy context. Rober (2005) conceptualises family therapy as a dialogue of living persons in that it offers a perspective that makes it possible to capture something of the mutuality and shared activity of the therapeutic encounter in practice (p. 385). From that perspective, family therapy is not primarily for data collection and problem analysis; instead, it is a meeting with living persons who together are searching for new and trusting ways to relate to each other, navigate through differences and negotiate power imbalances (Tseliou, Burck, Forbat, Strong, & O'Reilly, 2021).

Conceptualising family therapy as a dialogue of living persons puts the therapist, whose heart also beats and who shares the life's realities, on an equality with the family member clients (Rober, 2005). The therapist's position as the one who 'knows' is thus challenged, and the therapist is now seen as the one who finds ways to create and maintain dialogical conversations. Family members, including children, are seen as the masters of their lives. By taking each family member's story seriously, the therapist joins with the family in a mutual exploration of each family member's understanding and experience (Anderson & Goolishian, 1992; Seikkula & Trimble, 2005). Showing interest in each family member's utterances, the therapist is not interested in facts, something that can be evaluated along the axis of true and false, but rather, reflecting Bakhtin's ideas of dialogism (Bakhtin, 1981, 1984), social constructionism and the postmodern epistemology, family members' subjective and relational-based experiences.

4.3 The dialogical approach

Approaching family therapy as a dialogical, meaning-generating practice emphasises the role of language (Anderson & Goolishian, 1988, 1992; Rober, 2005). Through exchanging their ideas 'in there together' the family members jointly with the therapists search for new words and expressions for something not yet said, in the past and present. In this process, the therapists listen respectfully to the family members' stories and strive to create more space that could facilitate their finding expressions for lived experiences. It is, however, commonly the case that when entering therapy and seeking help, family members are unable to describe their most sensitive experiences or their primary concerns. For children with poorer vocabulary and cognitive skills (Henderson & Thompson, 2011), this is even more difficult. Engaging children respectfully in joint discussions in family therapy can at its best offer them a learning forum where they can internalise the multi-voiced speech that forms the foundation for their inner speech, which in turn serves as an instrument for the regulation of emotional states and behaviour (Bruner, 1985). Listening carefully not only to family members' utterances, but also their hesitations, silences and unspoken themes, therapists can co-create and co-construct new understanding and meaning for family members' life experiences that have not yet been given words (Seikkula et al., 2012).

The words a person uses are also living (Bakhtin, 1981). This means that "no living word relates to its object in a singular way" (Bakhtin, 1981, p.276). With the term *heteroglossia* (in Greek *heteros* + *glossa* = *other language*), Bakhtin says that words are not limited to any single specific and intrinsic meaning but rather carry traces and fragments from a diverse linguistic heritage. This explains Vygotsky's (1971) idea that it is never enough to understand a word outside of its psychological context (motivation and meaning). Bakhtin expresses the same idea: "To study the word as such, ignoring the impulse that reaches out beyond it, is just as senseless as to study psychological experience outside the context of that real life toward which it was directed and by which it is determined" (Bakhtin, 1981, p. 292).

In *Peri* Hermeneias, Aristotle states that words only interpret one's thoughts, never capture them *an sich*. In Plato's dialogue *Cratylos*, Socrates reflects with Hermogenes and Cratylos on whether language is a conventional or natural system. Socrates ultimately rejects the idea that words have an intrinsic relation to the things they signify. In accordance with these ancient ideas and those of Dostoevsky, Bakhtin (1981, 1984) states that words are always born and shaped in dialogue and as such they are socially constructed. In this sense there is no such a thing as 'neutral' words - words that belong to no one. According to Bakhtin (1981), words are always inhabited by the individual consciousness. This idea underlines the role of listening in Bakhtin's dialogism. Although inhabited by the individual consciousness, a word is also simultaneously half someone else's. Thus, words are *polyphonic* (Bakhtin, 1984). With this paradox in mind, family therapeutic conversations can be seen as multidimensional and

polyphonic, that is, they take place simultaneously on both the vertical and horizontal levels – as inner and outer dialogues. Bakhtin says that the word "becomes 'one's own' only when the speaker populates it with his own intention" (p. 293). When we listen to each other, it is good to notice, that no one is speaking *in* but rather *through* language (p. 299). In order to understand what the other says we need to become curious about it. Borrowing from Dostoevsky, Bakhtin (1984) says that a human being is a speaking subject, meaning that there is no other way than 'turn to' each other and let the other speak for her/himself.

In Buber's idea of a personal growth the I – Thou relation, which occurs in the dialogical relations between I and Thou, is central. In this sense, a dialogue is not primarily a matter of communication, an exchange and exploration of ideas, but a rather meeting with another at a particular moment in his or her uniqueness.

Let us probe further into what a dialogue is through the lens of Buber's I – Thou relation. When we meet others as persons, living human beings, who have their own thoughts, fears and dreams, we enter into a relationship with them. In this way, we can find ourselves as persons. I – Thou relationships are not, however, produced by a person's own action or will. Nor are they stable positions that continue unchanged forever; instead, they are something that happens and is created in and through these I - Thou meetings. To be truly dialogical, the meeting needs to be mutual: "for it is really mutual when the other comes to meet me as I him" (Buber, 2002, p. xiii).

For Buber, the I-Thou -relationship is the ontological and existential reality in which the self comes into being and through which it fulfils and authenticates itself. Moreover, Buber sees love as the fullness of dialogue, which recognises the other's freedom to exist in the world in their own uniqueness, thereby necessarily also recognising the other person's otherness per se. In I – Thou relationships 'otherness' is acknowledged as a richness and uniqueness. Seeing oneself and another as a differentiated self (Bowen, 1978) makes room for genuine dialogical meetings. Differentiation means that one can have different opinions or values than others, but still stay emotionally connected to them. This is precisely what dialogical family therapy represents for me personally: the promotion of more honest and warm family relations which makes room for otherness in its uniqueness and richness.

4.4 Family therapy as a multi-actor setting

The ideas of dialogue presented in this chapter are rooted in Bakhtin's dialogical principles (Bakhtin, 1981, 1984, 1986). Searching for new narratives and shared and increased understanding is often challenging and demands of the therapist the hermeneutic principles of *bona fide* and *tolerance of uncertainty* (Seikkula & Olson, 2003). Navigating through differences means welcoming and allowing different perspectives to emerge without taking sides. Clients have reported it to be helpful and beneficial when therapists notice differences or point out different ways of viewing issues. However, "differences" in views between family

members can also be stressful for therapists, inducing in them feelings of helplessness and being stuck. Therapists have a critical role in balancing tensions that might arise from clients' different views on who is accountable for reported difficulties (Tseliou et al., 2021.). Maintaining neutrality and taking care that each family member feels safe and is heard is challenging in the multi-actor, *polyphonic* family therapy settings.

Bakhtin's (1984) concept of *polyphony* refers to the idea that each participant's outer and inner dialogues take place simultaneously. The 'problem' of polyphony is its endlessness and non-finite nature, which paradoxically opens limitless possibilities and the idea that there are no 'wrongs' or 'rights'. In the family therapy and open dialogue context, polyphony is understood to mean that everyone present is invited and encouraged to enter the conversation in his/her own way (Seikkula & Olson, 2003). However, a therapist who emphasises positives, normalises problems, seeing them as understandable and realistic, might promote a sense of safety, encouraging participants to express themselves more freely, a situation which can facilitate change and offer family members hope and a new and more constructive way of communicating (Tseliou et al., 2021). In multi-actor settings, the participants are aware that all the other participants can hear what they say (Seikkula et al., 2012), which naturally also establishes societally normative requirements and limitations on can be said or what it is useful to say.

The concept of *selective disclosure* (Rober, Walgravens, Versteynen, 2012) is useful in the context of multi-actor settings. It offers a perspective on the complexity and dialectic tension of dialogues as such. The concept refers to the continuous selection made by participants about what to say and not to say in the presence of others. This phenomenon is not, strictly speaking, limited to secrets or especially sensitive issues. The concept takes seriously the idea that people have good reasons for telling the stories they tell or why they choose to remain taciturn or silent at particular moments. Sometimes, only stories that one can live with are told (Rober & Rosenblatt, 2013).

The idea that people continuously select what to say or not to say can also be found in Bakhtin's thinking. In *The Dialogical Imagination* (1981), Bakhtin describes how people accommodate their words to situations in their casual and every-day dialogues. Accommodation takes place in both what is said and what one is expected to say. Acts of accommodation are not, however, limited to our outer dialogues; they also reach into our inner dialogues. Bakhtin in *The Problems of Dostoyevsky's Poetics* (1984) describes how the characthers of Dostoyevsky's novels are presented polyphonically. Their inner conversations include conflicts, contradictions and inconsistencies. Marcus Aurelius' *Meditations* and Augustine's *Confessions* are the first examples of inner dialogues in literature. In the Bible, Paul, in his Letters to parishioners, powerfully describes the dialogic tensions of the voices of the 'world' and 'God' in a human's inner speech. The richness of the family therapeutic conversation becomes more evident if we focus on the voices which are not "heard" but which are present in each person's inner dialogues (Seikkula et al., 2012, 669.)

The idea is that one selects 'disclosures' from the complex web of inner voices, defines the words to be said in one's outer dialogue and makes the words intentional. Bakhtin (1981, 1986) says that words are born and shaped in dialogue and are always *directed* toward an answer. This means that we carefully accommodate our words to those (the addressees) we are speaking to. Thus, every utterance has an author and an addressee. However, the addressee of an utterance is not always present. This makes sometimes analysis of the addressee challenging. Bakhtin (1986) uses the concept of the *super-addressee* to refer to ideology-related addressees. It has been noticed that in multi-actor settings, while speaking to one person, we may simultaneously need to accommodate how we express ourselves to the other persons present (Seikkula et al., 2012). Addressees who are present, whether visible or invisible, in any case affect the utterances one uses or the reasons why one remains taciturn or silent. In multi-actor settings where small children are present, both parents and therapists are typically sensitive in choosing their words in order to protect the child.

What is said, in direct or indirect ways, influences how the dialogue continues. Utterances can be seen as active participants in a social dialogue (Bakhtin, 1981, 1984, 1986) that create an atmosphere. In dialogue, words are born collaboratively "as a continuation of dialogue and rejoinder to it" (Bakhtin, 1981, 276). This means that "utterances" are constructed to answer previous utterances, which in turn await an answer from the utterances that follow (Seikkula, 2002, 268). In other words, everything said or done is a response to what has been earlier said or done. If someone understands what a person says, that person's understanding comes "to fruition" (Bakhtin, 1981, 282) in their answering words. In dialogue, the intention of words is to be heard and responded to. In family therapy, understanding is shown in the family members' responses (Seikkula et al., 2012). The importance of responses is taken into consideration in the DIHC method, which assigns them a distinct *response category*. When analysing participants' responses, their relational aspects need to be taken into account. This means that responses do not purely represent the participants' intrapsychic reality or construct but also represent the socially constructed consciousness that come into being at that particular historical moment (Bakhtin, 1981).

4.5 The core concepts of DIHC

In DIHC, the concept of *positioning* in relation to the act of understanding is central. Whereas the concept of "voice" refers to the question "who is speaking"? positioning refers to the question "from where is one speaking?" Each point of view offers a perspective and a hermeneutical horizon that explains what one sees, hears, and experiences. Positioning also explains why some things can be seen while other things remain out of focus and out of sight. In multi-actor settings, positioning is not usually a voluntary act; rather, it more often happens unreflectively, in the dynamic exchange of utterances said (Seikkula et al., 2012).

When listening actively to clients' stories and noticing how they position themselves and others, the therapist might observe instances when some questions or answers may be too difficult to voice. In these cases, therapists need to proceed very slowly and be alert to even the smallest signs indicating what someone finds too hard to talk about and/or hear (Andersen, 1997). Therapists can ask participants to slow down and challenge them to find more precise words or ask them to find more local meanings or speak for themselves. Using the Socratic method, therapists can work as midwives to help the family members find new words and extend the limits of understanding.

In DIHC category of *addressee* is important reminder to show that every utterance has the person or persons to whom it is addressed. The utterance may sometimes be addressed to someone who is not physically present in the meeting but still relevant to be noticed.

Through the application of DIHC, the researcher can gather information on such issues as who dominates in different conversational topics, that is, who takes *interactional dominance* (makes initiatives), who offers new themes to be discussed (*semantic dominance*), who speaks a lot (*quantitative dominance*), and who withdraws (Seikkula et al., 2012). Such questions can aid therapists' understanding of the family's dynamics and serve as an opening for a joint discussion. The method puts the spotlight not only what is said but rather on how things are told and to whom they are addressed.

5 SUMMARIES OF THE ORIGINAL STUDIES

5.1 Study I

Children with conduct disorders are at risk of being positioned in family therapy as 'the problem'. This study, applying a qualitative framework and thematic analysis, explored how the difficulties of a family with a (male) child diagnosed with a conduct disorder were discussed and how the child coped in situations where he was talked about. Three family therapy processes were studied over a one-year period. One process differed from the other two in the amount of problem talk and the high level of negativity in the family, which is a known risk factor for children's conduct disorders. This case was selected for closer study owing to its challenging nature.

The main finding was that the parents produced direct and indirect symptom-oriented talk when describing the family's difficulties. Their indirect symptom-oriented talk showed characteristics of 'gossip'. Despite being present, the child was 'objectified' and described in a derogatory way as an outsider. The parents' symptom-oriented talk was characterised by negativity, which compromised the safety of the therapy atmosphere, and contributed to a stagnated and unproductive interactive cycle. The results support the findings of previous family therapeutic studies indicating that children are typically positioned as not being full participants in the therapeutic encounter in adult-led family therapy practice.

The child's reaction to the unsafe climate was to protest against the therapy in direct and indirect ways. The child's coping strategy was *re*active and in line with his symptomatic behaviour. The child's indirect protest strategies were to disengage from the discussion and to produce nonsense talk. His direct coping strategies, in turn, were blaming and confrontation, which he deployed in situations when his emotional regulation skills failed and the adults present did not come to his aid. From both the systemic and negative interactional cycle perspectives, the child's behaviour was an understandable and meaningful way of being seen and heard in an emotionally intolerable situation.

The practical implications of the findings for family therapy practice were that therapists should actively seek to stop blaming and to take responsibility for the safety of the therapeutic climate. Moreover, therapists should take advantage of the possibilities for good outcomes of certain factors specific to couple and family therapy. This means 1) approaching the family's situation using relational concepts and conceptualising difficulties in relational terms, 2) disrupting dysfunctional relational patterns, 3) expanding the direct treatment system, and 4) expanding the therapeutic alliance so that the diagnosed child can be seen as a child with functional abilities.

This case study enriches understanding of the therapeutic challenge high-risk families, such as the families of children with diagnosed conduct disorder, present right from the beginning of the treatment. The results of this case study can be generalised to the therapeutic models used to treat children's challenging behaviour in the family therapeutic setting.

5.2 Study II

As a multifaceted phenomenon, family secrets affect interaction in the therapeutic system. This qualitative study, applying the multi-actor *Dialogical Methods for Investigations of Happening of Change* (DIHC), explored how children participated and positioned themselves in family therapy in a climate of family secrets. One of the therapeutic process was selected from the research data of the larger family therapy project for a further study owing to its distinctive feature of family secrets concerning multigenerational traumatic losses. This family therapy process comprised 15 sessions, varying in duration from 55 min-1 h 47 min, conducted over a one-year period. For closer study, three distinct types of family therapy session were selected: 1) a genogram workshop implemented at home (4th session) lasting 1 h 37 min; 2) a network meeting at the Child Psychiatry Clinic (11th session) lasting 1 h 43 min.; and 3) a session implemented at home (13th session) lasting 60 min.

The results showed that the children were active co-participants in the complex dynamics of a secretive atmosphere, involving themselves in the paradoxical processes of reconstructing and deconstructing the family's secretive and unsafe climate. In family therapy, a child's symptomatic behaviour can function as a visible "cover story" for invisible constructions of secrets, thereby preventing sensitive topics from becoming the focus of therapy. Family secrets therefore continue to present a challenge in family therapy practice and research.

Suggested practical implications of the findings were that family secrets should be asked about in the pre-therapy assessment and diagnostic interviews where all the family members are present. The use of genograms enables the exploration of multigenerational family patterns and functions that might be influenced by family secrets. By normalizing the phenomenon of family secrets, therapists can make room for joint discussions on these and encourage family members to talk about their good reasons for not talking.

5.3 Study III

This study applied *Dialogical Methods for Investigations of Happening of Change* (DIHC) to investigate 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 authors were particularly interested in exploring these children's verbal communication, as they are used to expressing themselves through acting rather than talking.

The research data consisted of nine video-taped post-family therapy research interviews held at Kuopio University Hospital Child Psychiatry Clinic. Interviews (9/14; 5 dropouts) approximately 18 months post therapy. The research material forms part of a follow-up family therapy research project with a total of 14 families with a 10- to 15-year-old child diagnosed with oppositional defiant or conduct disorder. The collaborative post-therapy research interviews were conducted by a researcher who is also a clinical practitioner. The co-research interview model applied here was developed by Tom Andersen and his colleagues.

For this study, three interviews were chosen and analysed. The three children in these interviews were all boys (aged 10-15 years). One of the boys represents the youngest and the other two the oldest group of the child participants. The selection criteria for the cases to be analysed followed the 'revelatory' case study principles proposed by Yin (2014). The selected cases and the excerpts from the interview represent the extremes in the variety and richness, in either content or amount, of the children's verbal initiatives. This study focused on three excerpts, one from each interview, that illustrate the four main categories in which the children positioned themselves (see below) in the dialogical topical episodes. The positioning categories were: "I- Thou", "reflective", "vulnerable self", and "meaning co-construction".

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 to their thoughts on some of the family's sensitive issues. The results indicate that when therapists present themselves as not-knowing, receptive and accountable, they may facilitate reflection for all family members, including children.

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. The findings of this study should thus encourage use

of the collaborative interview, especially by therapists working with high-risk families, in, for example, the context of supervision or consultation, particularly when the treatment has got stuck. Applying 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 full-membership partners in the dialogue and as 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.

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, and positive curiosity. Tolerating a situation and not rushing to understand 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.

6 DISCUSSION

6.1 Tripartite structure

Borrowing Aristotle's classic and somewhat simple idea that to be a story every story needs a beginning, middle and end, this discussion consists of three stories of explorations, reflections, and missteps related to the three study articles. The stories present only some glimpses of this tripartite research journey from its beginning to its end. Every doctoral student who has taken all the steps needed to accomplish their doctoral thesis, knows that it is much more than just the process of writing articles. However, to keep this story within bounds, I decided to follow this principle. Aristotle, of course, in his *Poetics* (1995) focuses on plays, especially tragedies.

This story is not a tragedy, even if it can also be considered to contain some elements of a tragedy. The data comprise the stories of living persons, of families, whose lives contain tragic ingredients: stress and strains, despair, shame, and suffering. I must admit that there were moments when remaining 'objective' was difficult. The stories contained in the data touched and reminded me of the realities and challenges of family therapy practice. This story is clearly not a comedy either, even if it also had its comical moments. It is, however, important to tell this story and leave readers to form their own judgment.

Writing the story of this research project reminded me of Aristotle's reasoning on the notion of *mimesis*. Aristotle had learned the concept of *mimesis* as a student in Plato's Academy. *Mimesis* refers to the idea of imitation, which in this context, means something like *re*-writing. For example, an artist who makes sculptures has ideas about his subjects in his mind that he then tries to realise concretely. Applying the same notion in the context of this dissertation, written words can only imitate the ideas and events in the mind and memories of the author. It is also important to notice the difference between written and spoken words. In his treatise *On Interpretation*, Aristotle says that spoken words are symbols for affections of the soul, just as written words stand in for spoken words (this supreme formulation has formed the basis of theories of signification in the

Western world for 2000 years). In Plato's dialogue of *Phaedrus* (275c-d), Socrates says that written words are only instruments in the service of remembrance. In other words, written words in comparison to living and spoken words, are dead, meaning that these cannot offend against themselves. However, my aim here is to *re*-write my story, which can only be an interpretation of the real events of which it is composed.

6.2 The Beginning

This research journey started in spring 2018. In the orientation phase, two articles were important: *The Client is the Expert: A Not-Knowing Approach to Therapy* (1992) by Harlene Anderson and Harry Goolishian and *Postmodern collaborative and person-centred therapies: What would Carl Rogers say*? (2001) by Harlene Anderson. The ideas contained in these articles fascinated me then and continue to do so.

6.2.1 The position of not-knowing

Reading and re-reading the above-mentioned two articles, the similarities (and dissimilarities) with ideas from my earlier academic studies of theology, philosophy, and semiotics became clear to me. In preparing my doctoral thesis on the Christian neo-Platonic philosopher Pseudo-Dionysius the Areopagite (2005-2011) and immersing myself in his writings and ideas on "the dialogical relationship between the God and man", the Platonistic and neo-Platonistic tradition and the ideas related to apophatic theology and discourse had become familiar. The concept of not-knowing resonates in my thinking about apophatic discourse in man-man relations. The not-knowing stance is the position of genuine curiosity in the service of understanding: "Please speak – I will listen – is this what you mean…?" For Anderson, the concept of not-knowing refers to expertise, power and certainty (Anderson, 1997, Anderson & Goolishian, 1988, 1992). According to Anderson (2001, 350) "Not-knowing refers to a therapist's *intent:* how they position themselves with what they know or think they know and to a willingness to their therapist knowing open to question and change." A therapist's *not-knowing* position in the collaborative, give and take relationship between the client and therapist reminds me of man's relation to God.

In working with clients, especially children, a not-knowing stance is important. With children, therapists should "avoid certainties" about the child's experience, as Gehart (2007) puts it, and not try to understand too quickly, but instead allow ideas to emerge through ongoing dialogue. It is not unusual for adults to assume that they know more about children and children's perspectives than they actually do (Gehart, 2007). Tolerating uncertainty, slowing down, letting children lead and committing oneself to following their initiatives, rhythms and timing, and showing a positive curiosity, about even the smallest detail, can be rewarding. Offering a rational explanation too quickly may stop or hinder continuation of the dialogue and lead a child to defend him- or herself,

thereby hampering the process of understanding (Anderson & Levin, 1997; Gil, 2009; McDonough & Koch, 2007; Núñez et al., 2021; Seikkula & Trimble, 2005).

Not-knowing refers to a philosophical stance rather than a theory or model (Anderson, 2001). Following Anderson, philosophy is not a matter of finding scientific truths but a way being in the world with a curious mind-set and openness to self-critique. Applying not-knowing in doing research means 'letting the data speak for itself', giving up predetermined ideas about the research questions and having the curiosity to enter unknown terrain and embark upon a path which may lead to the investigation of topics and issues that arise from the data and that speak to the researcher. Ideas do not spring forth in a vacuum, but always develop within a context and become influenced and informed by the lived and current history of one's conversational partners. The theme of the first article was not pre-planned or consciously intended but was born, constructed and re-constructed in a dialogical enterprise aimed at responding to the child's question, "Why am I the only one you are talking to?" This gave rise to a number of questions: what did the child really say? What did he mean by saying this? From what position did he say these words? Who was he addressing with his words? This process of understanding is known in hermeneutical language as moving from a *thin* to a *thick* reading (e.g., Carnevale, 2020; Gadamer, 1975/2004). The child's words prompted a desire to learn more. The lesson that Study I taught me was that *without a context, without a family history and without all the relationships, there is no child*. Here, one can detect Winnicott's influence.

To study children's participation in family therapy, we need to study children *with* their parents, *with* the therapists *in* a particular historical context. Words, behaviour, and feelings are always intentional, relational, addressed to somebody, and a response to something. Even symptoms might have relational meanings if we become curious about them. Study I is informed by systemic thinking and the view that "the child is not an island" (Andolfi, 2016). Recognising and conceptualising the family's problems and difficulties in relational terms (Sprenkle et al., 2009; Sprenkle, 2012; Tseliou et al., 2020) can, I suggest, free the child from the position of being the problem and help all the family members, including the child, to discover their resources and capabilities with and alongside their weaknesses or vulnerabilities.

6.2.2 Towards systemic thinking and the question of diagnosis

In my efforts to better understand how 'systemicity' could possibly be investigated and practised in the family therapy setting, the concept of *circular questioning* offered a useful and practical tool. The Milan Associates introduced the circular interview to enable systemic investigation of the differences and changes in family relationships which recursively support dysfunctional interactions or symptoms in the family. In addition to its value in gathering information, circular questioning provides the family and therapists with an opportunity to view the family systemically (Fleuridas, Nelson, & Rosenthal, 1986). The words in the title of Study I, "Why am I the only one you are talking to?", are those of a seven-year-old child, who addressed his question to the adults in the therapeutic system. The

child's question can be interpreted as calling for the importance of a systemic approach and a more balanced investigation, in which circular questioning might have offered a suitable working tool and led to a possible solution.

The child's question can also be understood as provocative and defiant, in line with his symptomatic and aggressive behaviour, and hence diagnosis (conduct- or oppositional defiant disorder), which brought his whole family into family therapy. The child's visible behaviour during the meetings rendered visible the family's *invisible* interaction patterns. In this study, the role of diagnosis is challenged from a systemic perspective, scrutinised with a critical eye and questioned as to whether it may set a trap, affecting how the "problem" is constructed in therapy. Andolfi (2016) says that all too often children's symptoms are assessed as if they belong only to the child and hence treated in individual therapy, leading children to believe that they are the problem. This was not the case in this instance. However, the question of who is identified as the patient, can challenge the neutrality of a balanced investigation and also permit parents to see the child as the problem. A closer look at the etymology of the word 'diagnosis' shows that it refers to *shared knowledge* (Gr.), which sounds reasonable. Explicitly adopting that meaning as a navigating tool, I suggest that diagnosis as shared knowledge instead of a label can function as a useful starting point for joint and cathartic discussions in the family therapy setting. It may offer eye-opening topics and point to beliefs and concerns that merit discussion. Each family member can be asked the same questions about who does what and when in relation to the problem while the others listen. In what way is the diagnosis, the visible symptoms, a problem for each family member? How is it seen? What functions might the diagnosis serve? Why does a systemic member of a family identified as a patient react to the problem(s) in a particular way? In what service the symptoms can possibly be? Who might be most and who the least affected by the ending of the symptoms? Who suffers most from the symptoms? Using circular questions with an emphasis on relationality may deliver information on the cyclical sequences of interaction which interconnect the family's beliefs and patterns of relating (Tomm, 1987, 1988).

Acknowledging, that a diagnosis is not 'black' does not mean that it is 'white'. On the level of language, the same issue applies as discussed above. However, the important question here is *how it is used*. A diagnosis can serve the 'good' of the family by facilitating the creation and reconstruction of a new and better functioning story rather than determining who is guilty or inviting a process of 'naming' and 'labelling'. White (1995) argues that the discourses of mental health have had a consistently negative impact in shaping people's experiences and legitimating practices that have had fatal consequences for people's self-conceptions through the dispensing of diagnoses and the stigmatisation that often ensues. However, the use of a diagnosis as *shared knowledge* offers a relational mind-set to perceived difficulties and shifts the focus away from individual characteristics and traits. At its best, this can free the 'diagnosed' from the role of scapegoat or the position of being the 'problem'. A diagnosis as shared knowledge facilitates its interpretation as something fundamentally socially and

interpersonally constructed. This is a good example of the powerful role of language in constructing the way we perceive the world (Berger & Luckman, 1973). We all both create and participate in our social world and hence also have our responsibilities in relation to how we do this.

With the above discussion in mind, I support Dallos and Urry (1999) and Lowe (2004) who argue that the ideas of systemic thinking and narrative approaches representative of social constructionism can be integrated and seen as interrelated and complementary, rather than mutually exclusive. Discussions related to diagnoses and the thoughts they induce in family members can be considered as propositional 'as ifs', that not only construct and make visible cultural beliefs and discourses, but also exhibit diversity in how they are uniquely transformed in the day-to-day flow of family life (Dallos & Urry, 1999).

6.3 The Middle

6.3.1 Towards the phenomenon of family secrets

From its starting point to publication, Study II, titled "*Can I tell all*?" *Children's participation and positioning in the secretive atmosphere of family therapy*, took one year and 3 months. The process opened a perspective on the complex, multifaceted and even paradoxical phenomenon of family secrets. Evan Imber-Black is probably the best-known author on family secrecy in the family therapy field. Her classic publications (e.g., Imber-Black, 1993, 1998) offer the reader a systemic perspective on family secrets. Unlike my other two studies in this doctoral research, 'the family' as a link in a multigenerational chain of relations was more concrete.

A natural way to research family history and main events with children is to draw a map of the family's world, a genogram or, alternatively, a family timeline. It is also a practical way to join oneself with the whole family (Lowe, 2004; McGoldrick, Gerson, Petry, 2008) Children tend to be curious and active in making genograms. Children often tell with whom they are attached or detached, and who they often meet or have no contact with (Andolfi, 2016). The usefulness and effectiveness of genograms in the exploration of multigenerational relations, especially with children, became evident in this study. Drawing genograms offered children an easy way to approach family relations, important and sensitive events and topics, losses, and chronic illnesses. In other words, it facilitated the process of becoming more familiar with one's family history, and also perhaps, hearing not-yet-told stories. Working with genograms can help family members to explore in-there-together the key persons in their lives and notice the generational patterns and scripts that affect their lives (McGoldrick et al., 2008) as well as sharing family legends and myths (Byng-Hall, 1988). Genograms can also be used to orientate family members to exploring their resources rather than emphasising problems and pathology. A resource-oriented genogram offers therapists a possibility to ask family members to talk about the

resources of other family members (Lowe, 2004). As suggested by Rober (1998), when a child is the focus of therapy it is important to engage both the child and the parents in a positive story about the child. From my point of view, the genogram as a tool for family therapists is a successful embodiment of the alliance of theory and practice.

The idea of researching family secrets was not pre-planned. Looking back, it was not really a surprise, if one assumes that every family has its secrets (Imber-Black, 2010; Knauth, 2003, Vangelisti & Caughlin, 1997). A family secrets is defined as the intentional concealment of information by one or more family members who are affected by it (Berger & Paul, 2008). Sometimes secrets may even, explicitly or implicitly, be the driving force for entering therapy (Tracy, 2015). Despite their universality in families, little qualitative research has been done on how family secrets are experienced (Tracy, 2015) and their long-lasting effects on people's lives and well-being. The universal prevalence of family secrets presents therapists with important and compelling challenges in their work with families. Deslypere and Rober (2018) found that family therapists seem to deploy certain basic strategies in dealing with the challenges posed by secrets and stress the importance of further study. The perspective of children especially warrants more attention. It would be interesting to ask children what they think family secrets are and what good and bad consequences secrets have.

In discussing secrets, we simultaneously and inevitably come up against issues of privacy and family rules (Imber-Black, 1998), that is, the rules governing internal and external boundaries (Petronio, 2002), including boundaries between generations and between members of the same generation (Minuchin & Fishman, 1981), the levels of closeness and disengagement of the family system (Minuchin et al. 1967), the levels of the undifferentiated egos of family members (Bowen, 1988), legacies and delegations (Stierlin, 1977), and both visible and invisible loyalty structures (Boszormenyi-Nagy & Sparks, 1973).

From a family dynamics perspective, secrets are a multi-layered and complicated phenomenon that is always somehow related to communication. When encouraging family members to explore the above-mentioned aspects and dimensions with positive curiosity and perhaps thereby expand their horizon on family relationships, a therapist needs to be sensitive and avoid being intrusive.

6.3.2 Communication as a gift

During my theology studies (2001-2011), I was impressed by Risto Saarinen's (2005) exploration of the origin and meaning of the word communication in Latin. According to his findings, the origin and etymology of *communicare* refers to the word *munus,* a gift. Considering communication from the perspective of *giving and receiving a gift* opens a new perspective on thinking about family secrets and a family's communication system. Families differ in their communicational styles, rules, integrity, closeness and problem-solving skills. Families also differ in their how they share gifts. In the family therapy field, it has been common to think that the more open the family's communication system, the better the functioning or 'healthier' the family is (Kaslow, 2010).

Applying the idea of communication as sharing a gift, one might simply assume that in families gifts are normally given and received, along with mutual acceptance, warmth and empathy. But is it as simple as that? The sociologist and ethnologist Marcel Mauss (1967) noted that gifts are complex in their nature and not inevitably good and welcomed in all contexts. In the context of family secrets, the idea of delivering information as gift can be problematic, especially in cases where the secrets are 'toxic' (Imber-Black, 1998). Secrets are regarded as toxic if they hurt those from whom they are concealed. In this sense, toxic secrets are like the sweets given to children in the fairy tale of Hansel and Gretel. Everything that looks good is not necessarily good. In pondering the question of whether or not to tell, we have to come to terms with the ethical issue of how we should live to have a good life. In *Nicomachean Ethics* (2009), Aristotle gives the reader practical means to decide what is good and virtuous. Without going deeper into this question here, it can be said that Aristotle's way of thinking from the perspective of consequences (teleological ethics) might be useful. The basic principle is that the rightness of an act is determined by its end: a knife is good if it cuts well, pain caused is good if it heals or saves one's life, etc.

6.3.3 Secrets, a privacy and systemic perspective

In families, secrets are often kept with the best of intentions, generally out of a desire to protect ourselves or others. The distinction between private and secret is sometimes obscure. Imber-Black (1998) makes the distinction by arguing that it is a matter of the damage caused: what is truly private does not harm anyone, or have any impact on another's physical, mental health and development. If the withholding of information influences another person's decision-making and life choices, then it is a secret that we are talking about. There are, however, cultural differences. Imber-Black (1998, 20) reminds us that "the definitions of what is secret and what is private change across time, cultures, socio-political circumstances, depending on what a given culture, or a particular family stigmatizes and values".

Who knows and who does not know a secret in a family is a central question that may reveal something fundamental about the family's dynamics and its systemic effects. Sometimes, the strategies family members use to maintain a secret can eventually lead to family dysfunction, manifested in distorted communication and reduced trust (Berger & Paul, 2008). Topics that are usually veiled in secrecy vary in nature (alcoholism, extramarital affairs, adoption, suicides, mental health problems, financial troubles) (Imber-Black, 1993). In short, stories that are not told or are difficult to tell are those that are embedded in intense fear, shame and guilt. Understandably, the aim of protecting sensitive issues from the knowledge of others is to save ones' own face. However, the price to be paid can be high, causing ethical dilemmas as well as stress-related physical symptoms, anxiety, loneliness, self-doubt and tension, all of which create barriers and coalitions between family members (Berger & Paul, 2008). As has been shown, secrets may not only distance some family members but may also draw others closer to each other, like magnets, while repelling others and thereby

distorting relationships. In this regard, family secrets set boundaries between insiders and outsiders, forming dyads, triangles, splits and hidden alliances (Imber-Black, 1998, 2010).

The family as a breeding ground for both good and bad influences teaches children what is 'normal', causing them to build a mental representation of what is and can be expected from family life. The family as an intrinsically emotional system differs from other systems. Imber-Black (1998, 52) state that "although we encounter secrets in every area of life, they are perhaps the most destructive when kept in the home. In the present study, in a case in which family secrets played a crucial role, Bowen's family systems theory was useful in drawing attention to the role of family relationship patterns that are often repeated through the generations, affecting both the health and behaviour of family members (Bowen, 1978, Kerr & Bowen, 1988). Bowen had specialised in the treatment of schizophrenia in the 1940s during his years at Menninger Clinic and become intrigued by mother-child symbiosis. His work on distorted attachment patterns led to his theory of the differentiation of the self. The concept of the differentiation of the self has two dimensions: an intrapsychic and an interpersonal dimension. Intrapsychic differentiation enables us to tell our thoughts, emotions and wishes to others. Interpersonal differentiation, in turn, helps family members to distinguish their own experiences from the experiences of the other family members they are connected to. Both dimensions are important (Butler & Randall, 2013) and merit consideration in the context of family secrecy.

6.3.4 The dialectics of telling and not-telling

Family members' mutual emotional relationships, bonds, visible and invisible loyalty structures, conscious and unconscious transmitted legacies and delegations understandably explain why information about a certain person in the family that is considered to be of critical importance to that individual is also typically withheld from them. The concept of selective disclosure (Rober, Walgravens, & Versteynen, 2012) offers a dialogical tool for use in the world of family secrets. In addition, it aids understanding of the complexity of family communication around sensitive issues, especially in cases of losses and grief. In line with its name, the concept refers on the one hand to the idea that people have good reasons for selecting what, when and to whom they tell or do not tell and on the other that there is an intrinsic tension in the word of 'disclosure', reminiscent of Derrida's concept of deconstruction. Deconstruction aims to avoid dichotomies and refers to the idea that words can contain paradoxical dimensions. The word 'disclosure' refers simultaneously to revealing and concealing. When we say something, some meaning-horizons inevitably remain in shadow while some others become visible. There is a continuous dialectic tension between the said and not said. People are continuously making selections, sometimes small and sometimes big, in their every-day meetings with those sharing their lives. The understanding that disclosure is not inevitably 'a once in a life-time event' but rather an ongoing dialogical process, characterised by family members' tensions

and hesitations about openness and silence, is valuable (Deslypere & Rober, 2018). According to Bakhtin (1981, 1984, 1986), the dialogical dimension of language is manifested in speech where the words spoken determine the words that follow and hence the direction of the conversation. To certain people, certain things are told in a different way or remained unsaid. The stories that are told are always the results of dialogical happenings.

Sometimes we only tell stories that we can live with or we consider the people we love can live with (Rober et al., 2012; Rober & Rosenblatt, 2017). This is a deeply humane and merciful idea. Stories that deviate from realistic events can be heard as the stories of vulnerable and 'imperfect' people in an imperfect world. The stories of people who struggle to deal with sorrow, insecurity, insufficiency and pain. Selective disclosure opens a dialogical horizon that makes room for an appreciation of the caution with which people deal with sensitive issues. Rather than more information, it focuses on inviting more dialogical space into the conversation. This could mean creating an atmosphere in which all kinds of questions could be asked and all kinds of answers would be accepted. In such an atmosphere, the family members would be invited to reflect on and attribute reasons for their silences, hesitations, and choice of words.

Family therapists and those who work with families are no doubt well aware of the typical topic-avoidance mechanisms of clients at moments when they experience talking about an issue as uncomfortable. Some withdraw from the discussion, change the subject, look away, become hesitant or silent and so on. Might it be useful to discuss these behaviours with families? I suggest it might be good to draw attention to the different ways in which family members show that they would rather not talk about something. If our hesitations were respectfully noticed, seen and heard, might this encourage people to ask each other to give their reasons for this? Rober and Rosenblatt (2017) wisely remind us that when confronted with family secrecy in clinical practice, it is important to carefully consider the potential destructive versus life-giving aspects of silence. Rober (2002) argues that a client's silences and hesitations should be a therapist's main focus in the systemic therapy. He observed that hesitations and silences are unevenly distributed among family members and, further, that the dialectical tension between family members who want to say something and those who hesitate and sense the potential dangers of speaking out may boost the therapeutic process.

The stories told might change over time. Some stories wait for the 'right' moment to be told. In the context of family counselling, every now and then some parents want help in telling their children age-appropriate stories. Some parents find it useful to consult first with a therapist (psychologist) about how and what to tell their children about perceived sensitive experiences and issues of relevance to their children's lives. The creation of a dialogical space to talk about sensitive issues is no easy matter. Some family therapists have reported their need to balance between parents' and their children's best interests when seeking to create more space to talk. If a parent considers that withholding information from children can be dangerous or harmful, the risk for resorting to lies can be

tempting. Hearing secrets that cannot be shared together might endanger the position of a family therapist and evoke strong feelings of uncertainty and powerlessness. To avoid being stuck by family secrecy, some family therapists refuse to meet family members separately. For many family therapists, it is crucial to preserve their position as trustworthy for each family member (Deslypere & Rober, 2018.).

Andolfi (2016) argues for being direct with children. For him being direct means being authentic. Regarding children, Andolfi's answer is clear: "The worst truth is better than the best lie!" (p.162) Being direct is, according to Andolfi, an important therapeutic skill that gives family members permission to speak on painful issues. His view is not, however, as strictly held as it first looks. Andolfi (2016) knows that forcing family members to disclose secrets or reveal lies when they are not ready to do so can be damaging. Therefore, therapists must learn about the right timing and the therapeutic relationship must be safe.

6.3.5 Some personal reflections

Studying family secrecy was an eye-opening process. First, it reminded me of just how difficult and traumatic some of the experiences are that families face, struggle with, and ultimately deal with. Second, it showed the power of secrets and the systemic effects of secrecy on the family therapy system. Third, it prompted the idea that sometimes the stories that families tell after entering therapy may, in the family therapist's mind, turn out to be 'cover' stories, not-yet told stories, or not shared-together stories. These untold stories may be more primary, more relevant stories that could induce family therapists to 'take action' in the direction of disclosure. However, as Deslypere and Rober (2018) have shown, the aim of creating more space to talk about secrets among family members can be a hazardous project.

To avoid the risk of clients breaking off therapy or recanting their story, it is crucial that therapists attune to the pace of the participating family members. It is good to remember that sometimes what might be useful is different from what is possible. Following Harlene Anderson (2001), I can only wonder "What would Carl Rogers say?" In his client-centred way he would probably say that all we can do as therapists is to strengthen the clients' self-understanding and their inner wisdom and confidence to help them make healthier and more constructive choices in the future. Rogers believed that "if a person is fully accepted, they cannot but change" (Kirschenbaum & Henderson, 1989, 61).

Fourth, the idea of creating space for reflection and dialogue also seems to apply to the phenomenon of secrecy. In the present cases, the children dealt with secrets in complicated and paradoxical ways. They were not 'innocent' participants; on the contrary, they were active in constructing as much as deconstructing a secretive atmosphere. One child's cryptic comment "I don't need any health" raised questions and confusion in the editorial office during the publishing process: "Did the child really say this?", "What does the child mean?" These questions are good and revealing examples of the outcomes of a secretive atmosphere and talk related to it. The meaning of the expression remained open.

Perhaps, the story of "I don't need any health" will be told to somebody, someday, in another context.

Children are sensitive to forbidden topics in their families. In his autoethnographic study related to family secrecy, Rober (2017) describes how, as a young boy, he had often thought about his grandfather's history as a German prisoner during the World War II. Rober recalled that nobody ever talked about it. However, he was unable to stop thinking about it. He said that he had 'sensed' that talking about it was a 'forbidden' topic: "Although I never mentioned my fascination with my grandfather's war experience to anyone, I thought a lot about it and developed my ideas" (p. 251). Like Rober, children tend to create myths, twisted beliefs and wild fantasies about what actually happened (Imber-Black, 1993, Rober et al., 2012). The children in my study were interested in hearing about issues that were relevant both to their own and their loved ones' lives. This observation demonstrates both the importance of relationships and children's capacity to position themselves as 'other-oriented'. By asking questions, children construct their thinking and understanding. Children also need to hear answers that facilitate this process. Children also need words to help them find their way out of emotionally difficult places. If they don't receive answers, children will fill 'broken' stories, gaps and silences with their own imaginings, at its worst increasing their insecurity and anxiety.

As family therapists seem to be familiar with the systemic and their 'toxic' effects of family secrets, they deserve an explanation of why it makes sense to assist a family towards disclosure (Deslypere & Rober, 2018). Further research is, however, called for, among other things, to increase understanding of children's symptomatic behaviour, visible or invisible, in relation to family secrets. Owing to the delicacy of information relating to family secrets, autoethnographic research and art in its different forms offer a suitable approach to dealing with this topic. Following Rober and Rosenblatt (2017), I cite Ellis (2008) "…we may never fully reconcile with our parents, but eventually, as part of growing up and moving on, we have to figure out how to accept our parent as they were and the secrets they lived…we hope our children will do the same for us."

6.4 Towards the end

6.4.1 Children's experiences in family therapy

The focus of Study I was on events at the beginning of the family therapy process. The aim was to investigate how a child with behavioural problems engaged in the therapeutic process, his role and participation in the construction of 'the problem' and his ways of coping in that situation. Study II focussed on the participation and positioning of children in ongoing therapy in a case that involved transgenerational family secrets. Study III focussed on participants' retrospective reflection on the changes that had occurred during the therapy process. Given that the objective of family therapy is to understand and treat whole families

(Goldenberg & Goldenberg, 2017), the intention of this final study was to deepen understanding of all the family members', especially the children's, experiences of their therapy process, to learn what had been helpful and what could have been done differently.

Learning how the children participated in the collaborative post-therapy research interviews and what they found important and meaningful was interesting and touching. The children's thoughts, responses and the meanings they constructed for their painful experiences and memories resembled the power obtained from sharing or overcoming battles together. "You helped me out of that darkness" was spoken in the research interview by a son to his mother. The child's words metaphorically crystallise the goal of family therapy, which is to help family members find their own ways to meet, relate, help and communicate with one another (e.g., Tseliou et al., 2020). The child's words addressed to his mother words were expressed in the dialogical I – Thou mode, indicating openness, directness, mutuality and presence (Buber, 2002, 2004). The child's utterance also beautifully captures the family therapists' success in making the client a hero (Duncan & Miller, 2000). These words, used in the title of the third article were, owing to their metaphorical nature, also used in an earlier version of this summary. Family members often bring metaphorical images to therapy sessions. The joint construction of such images has been seen as strengthening the therapeutic alliance and offering possibilities to create new relational meanings for the family's difficulties (Andolfi, 2016).

For me personally, the child's words symbolise something common to families' seeking help through therapy. There is often "darkness", something not yet formulated or even identified, grief and pain without a name, reason or understanding for which the exact words have not yet been found. I believe that at its best family therapy can offer a family a forum where thoughts and feelings can be uttered, shared and better understood. The present boy's words testify to the success of the family therapists in helping a mother to help her son and find a more open and deeper connection and mutual trust. As Andolfi (2016) says, "the family is the best medicine" for the child (p.146). The therapist's task is to make direct contact with each family member, free the problem child from the label of being a patient, avoid adopting the role of an expert, and to work towards empowering parents (Andolfi, 2016).

Empowerment can be seen as interrelated with the core ideas of dialogism. The subtitle of the third article, *Children as dialogical partners in family therapy*, draws on the Bakhtinian tradition in that children are considered as full-membership participants who, as human beings, have the same need and right as adults to be listened to and understood. It underlines the importance of dialogue, which can be seen as a precondition for positive change and growth in any form of therapy (Seikkula & Trimble, 2005). From this perspective, the duty and responsibility of family therapists is to act as dialogical partners who create, support and facilitate elements of dialogical conversations that can generate mutual understanding among family members. Such understanding requires that participants engage in an active process of listening and talking. The idea of

shifting between listening and talking has many important purposes. One is to create space for reflection leading to the creation of new self-understanding (Andersen, 1995). If one can detect from another's responses that one's words are entirely accepted and important, one can start to reflect on their meaning (Seikkula & Trimble, 2005).

Shifting between careful listening and talking also enable emotional exchange among the participants, including the therapists, who together construct a caring and safe atmosphere, which paves the way to saying something not-yet-said. As Seikkula and Trimble (2005, 472) put it, "If one discovers that one is heard, it may become possible to begin to hear and to become curious about others' experience and opinions." In a Bakhtinian (1981, 1984) approach to dialogue, the speaker and listener have an equally important role in the creation of meanings. The meanings to be created 'happen' in the interpersonal space between a speaker and listener *in* and *through* language. In practice, this means that while one person speaks, the others listen. This shifting between listening and speaking also makes room for participants to adopt a reflective position in inner dialogues. It also helps the interlocutors to have a different experience of each other (Anderson, 2012).

In the moments that one feels that one is fully understood, something happens that Seikkula and Trimble (2005) call healing power. According to Seikkula and Trimble (2005, 468), "the heavier the experiences and emotions lived through together in the meeting, the more favourable the outcome seems to be." Sharing painful emotions stimulates participants' feelings of sharing and belonging together, the sense of solidarity. Moreover, realising that talking about painful issues is not dangerous can be healing as such (Seikkula & Trimble, 2005). In the collaborative post-therapy research interviews, the families' commonly reported that the therapists had helped them. The clients, including children, felt that they had been heard and seen. After getting help, the families had learned to talk with their children, which in turn had resulted in better communication and warmer family relations.

In the multi-actor family therapy setting, amid competing and contradictory multiple voices being heard and understood is more complicated and challenging than in one-to-one meetings (Seikkula et al., 2012). However, the more voices that are incorporated into a polyphonic (Bakhtin, 1984) dialogue, the richer the possibilities for emergent meanings and understanding. In this sense, the inner and outer voices of all participants, including children and therapists, are similarly important. It can be argued that excluding children's voices and experiences of family therapy is to risk failing to understand their perspectives on how to improve the way family members 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). As Andolfi (2016) puts it: "if we are ready to listen to them and to respect their opinions, children will offer information, hope, sensitivity, and fervent desire to help the parents to be more harmonious" (p. 155).

During my research process, the importance of more effectively engaging children to participate and commit themselves in family therapy sessions became clearer. I am therefore grateful to have access to data that included collaborative post-family therapy research interviews that demonstrated children's participation as full-membership and dialogical partners in an adult-led institutional setting. The children's honesty and the open way they participated is, in my view, the result of the respect with which they were encountered. This result is evidence of the significant role children can play in family therapy and gives hope for future successful therapeutic outcomes.

The recent results of Núñez et al., (2021) show that a positive therapeutic relationship with children and their parents is a co-constructed process that evolves gradually, but in which an inviting, interested and committed stance and playful approach by the therapist plays a significant role. This supports the results of previous studies by, e.g., Stith et al., (1996) and Kazdin, Whitley, & Marciano (2006) showing that children are a central part of the therapeutic relationship and hence of the therapeutic process and change. The therapist's genuineness, use of the real self and sincere behaviour encourage children to reveal their real self, participate in therapy process in a deeper and more emotional way, and express themselves more freely (Blanco, Muro, & Stickley, 2014; Núñez et al., 2021). In sum, the therapists' role, attitude and approach cannot be overlooked in relation to the positive participation of children in family therapy.

6.4.2 Children and the collaborative approach

The third study differed considerably from two earlier studies in its setting, as the post-therapy research interviews were conducted by a researcher who was, for the children and their parents, a new professional adult. For some children and their families, the presence of a new adult might have made talking about sensitive and personal topics even more challenging. However, the children and their parents talked about and shared something not previously said. The research interviews applied the collaborative model developed by Tom Andersen (1995, 1997). The model emphasizes a non-hierarchical structure and shifting between listening and hearing, features which might have helped construct an atmosphere safe enough for the family members to connect their emotions to the 'not-yet-spoken'.

The collaborative setting is based on the idea of creating a space for dialogical conversations. The participants involved in the process are seen as co-learners who create new narratives and ideas 'in there together'. Transformation in the process is seen as inherent and the role of knowledge and language as relational, local, and generative. No importance is attached to the content or direction of change; instead, a fundamental assumption is that the client is an expert on his or her own life (Anderson, 2001). While collaborative approaches may differ in emphasis (*reflective* Andersen, 1991; *collaborative* Anderson, 2001; *constructive* Lowe, 2004; *dialogical* Seikkula & Trimble, 2005; *narrative* White, 1995), they all subscribe to the importance of the therapeutic relationship as mutual and

egalitarian, to the view that reality is socially constructed, and to the notion that the client is an expert on his/her experience.

Collaborative therapies and approaches with roots in social constructionism (Gergen, 2006) 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; Lowe, 2004; Madsen, 2007; Rautiainen & Seikkula, 2009; Rautiainen, 2010). However, family therapy research has not previously analysed collaborative post-therapy research interviews that include children. Three collaborative interviews with children present were conducted in Sweden by Buvik and Wächter (2006); however, none of them were post-family therapy interviews. In light of the outcomes of Study III, we recommend use of the collaborative interview model in, for example, the context of supervision or consultation to those working with families – especially families at high risk– and, above all, in situations where the treatment has got stuck.

The reason for this is that a setting where children can first listen to therapists while they openly reflect, encourages children, as well as their parents, to do the same. Seeing and hearing therapists talking 'authentically and transparently as whole persons' (Seikkula & Trimble, 2005), and even as vulnerable human beings, can contribute to safety in the sense that it may generate new ways of relating (Tseliou et al., 2020) including for children. I assume that many family therapists have, like Rober's (1998), observed the silence of children in an adult-led atmosphere where their presence has been ignored. What does this perception say about us adults? Study III showed that children differed from adults as dialogical partners in both content and form. To adults' ears, their verbal initiatives often appeared as fleeting blurts, which could so easily have passed unnoticed or overlooked as unimportant. In general, initiatives made by children with behaviour problems are easily interpreted in line with their symptom-orientated behaviour or learned negative behaviour/interactional patterns, and thus not worth considering or approaching with positive curiosity.

Rober (2005) conceptualises family therapy practice as a dialogue of living persons. Drawing on this notion, I suggest family therapists and researchers would benefit from studying children's participation with an open and curious beginner's mind. Seeing children as dynamic interactive partners who can actively contribute to family therapy discussions as living human beings with their own motives, thoughts, fears and dreams, can be valuable. Children are the subjects and masters of their own lives and experiences, not 'objects' to be positioned in specific ways. Children actively position themselves and accommodate or assimilate to the other systemic participants. Here, I am following Winnicott's (1965/2018) idea of no child without its parents. Arguing that children should participate as dialogical full-membership participants means that both the 'setting' and the participants involved in the meeting encounter children respectfully and equally as dialogical full-membership partners. In this study, the children present in the therapeutic system were asked questions about their life and family equally with the adults. The children's

answers were attentively listened to, and sometimes further elaborated in order to create a shared understanding of what they had said.

7 CONCLUSIONS

The results of this thesis confirms the importance of recognising children as subjects, i.e. active and competent (e.g. Andolfi, 2016) agents who both have interests and capacity to show their autonomy, (Moore & Seu, 2011; O'Reilly & Parker, 2013) willingness and capability to talk frankly about their own family-related issues, even difficult and painful ones (e.g. Carnevale, 2020; Galinsky, 2000; Pihkala et al., 2017; Stith et al., 1996). Seeing children too vulnerable to participate in joint discussions on the topics that matters their life and families can be seen, on the one hand, violating their rights (Garcia-Quiroga & Agoglia, 2020) and on the other hand, in the worst scenario, sustaining a harmful transgenerational chain of family secrets, silence, shame and stigma, which does not help their resilience to deal with difficulties in the reality. Like Rober have stated, children tend to create myths, twisted beliefs and wild fantasies in any case (Rober et al., 2012) and sometimes hearing the truth is better than imagination and lies (Andolfi, 2016), even told with best intentions.

The results of this dissertation support the use of contemporary social research frameworks that encourage people working with families to pay more attention to approaches and methodologies that enable children to express themselves in safe and age-appropriate ways, and to veer away from adult-centred approaches (e.g. Gehart, 2007; Midgley et al., 2006; Núñez et al., 2021). Advances in childhood studies (Spyrou, 2016) have also been useful in shedding more light on the importance of listening respectfully to children's voices. The legitimisation of qualitative methodology in psychology has also provided researchers with a tool to discover and report on children's views in user-friendly ways (Moore & Seu, 2011). Fortunately, these positive developments have all been acknowledged in public health care services as bona fide and have led to the development of several family interventions (e.g., Beardslee et al., 2003) aimed at promoting the wellbeing of the whole family, including children.

Overlooking the children's rights, capacities and needs especially and typically in the adult-led contexts there is a risk that children remain in their half-membership positions (e.g. Hawley & Weisz, 2003; Hutchby & O´Reilly, 2010; Lobatto, 2002; Parker & O'Reilly, 2012) which might sustain their more or less

active or passive resistance towards a treatment process. It is easy to agree with Carnevale (2020) who argues that serious attempts need still to be done that children's views, utterances and initiatives will not be heard and interpreted only through a thin hermeneutical horizon, that is, as explicitly literally rather than relational, contextual and rich in the webs of significance. Actively remembering that, although as dialogical partners children may differ from adults (e.g. Gehart, 2007; Gil, 2009), children's initiatives, disclosures, gestures, silences, even in difficult-to-understand moments or contexts, are always important, intentional and meaningful. It cannot be overemphasised that it is equally important to hear and notice what children say, what leave unsaid, to whom they address their voices, and who they invite to talk, as it is with adults.

Concluding, the main finding elaborates the importance of children's participation in family therapy, with special focus on how we "see" children, approach their symptoms, construct understanding with the whole family (Sprenkle et al., 2009; Tseliou et al., 2020) and invite children to participate and engage as equal participants whose voices are equally important. For therapists, this means often adopting a playful, informal and relational stance (e.g. Anderson, 2012) towards children in their clinical practice as well as theoretical and conceptual assumptions. In other words, how we think about children influences how we act with them. To see children as systemic and dialogical partners means that we can invite them to participate in joint conversations genuinely as unique 'persons' and family members who all have unique interests, strengths and weakness as we all do. Approaching children and their parents in the early phase of treatment resource-oriented (e.g. Lowe, 2004; Rober, 1998), especially high-risk families, is also important. Focusing on strengths orientates family members to tell rather positive than negative stories about others, which increases safety which is a minimum criterium for paving the way for moments, in which talking also about painful issues becomes possible.

A family therapist who shows actively positive and warm curiosity (Cecchin, 1987), adopts a not-knowing position (e.g. Anderson, 2001; 2004), and demonstrates an active intention to build a balanced alliance with each family member can facilitate a safe *polyphonic* experience for the whole family. To tell, listen to and reflect on each family member's experiences without interruption creates possibilities to expand one's understanding and to take both I- and other-oriented positions (e.g. Seikkula & Olson, 2003; Seikkula & Trimble, 2005). The presence, emphatic attunement (Carnevale, 2020), and courage of the therapist as a living and genuine person in the discussions can and should increase the sense of safety and promote a collaborative atmosphere, where new ways of relating (e.g. Tseliou et al., 2020) and experience may become possible.

7.1 Critical eye

The decision to take a dialogical approach in this research project has its advantages and challenges. The dialogical method appeared useful as a way of

orienting my thinking toward a dialogical horizon and giving due consideration to the multi-actor setting of family therapy practice. Retrospectively, it was challenging to conceive the overall picture and concisely present the differing theoretical frameworks of the three studies and their results.

The choice of qualitative methods means that the findings cannot be generalised. While acknowledging the merits of quantitative research, I share with Sprenkle (2012) the view that the paradigms of qualitative and quantitative are complementary. The importance of qualitative research in therapy is to add richness and depth when reporting on the subjective experiences of clients. In this research project, the total dataset was relatively small. The small number of families and children limits the conclusions that can be drawn on children's participation in family therapy. However, irrespective of the number of participants, every family is unhappy in its own way, as Tolstoy puts it in Anna Karenina. Accordingly, each child is unique in his or her own way. Bakhtin (1981) says that seeing "a human in a human" means that we make contact with man's infinity in the sense that no word or definition can capture or objectify what man is. Similarly, to see also the child *as human* remains an undefined mystery. To answer the question "what are children like as participants in family therapy?" we need to ask children themselves.

On the issue of the reliability of the results, presented as they are in the form of a living language, I refer to Harlene Anderson's (2004) ideas about words and their complex and multi-layered meanings in her conversation with Tapio Malinen. Words and concepts contain a universe of possibilities and variations in meaning, and as such carry the risk of being misunderstood. This is especially the case with written words, as they cannot defend themselves, as Plato puts it. I can only hope that the ideas presented in this dissertation offer "food for thought and dialogue" (Anderson, 2004).

The critical and curious notions of supervisors and peer reviewers are essential in the research process. They are needed to develop, expand and enrich the researcher's thinking. Better thinking produces better solutions and clearer meanings, more precise utterances and more exact words. The idea of the evolving nature of understanding and learning as 'unfinished business' means in practice that the heuristic ideas of today will be history tomorrow. Yesterday's findings are, however, important in the search for new ones. This research journey has been no exception in that respect, as manifested, for example, in the change of method after the first study. One may later ask, was this a mistake? From the viewpoint of the overall coherence of this research project the use of the same method throughout would perhaps have been a benefit. However, considered from the perspective of learning, it takes on a different aspect. The researcher's development from novice to a more experienced and skilled 'expert' is in some ways comparable to the development of a child.

7.2 Future research

Family therapy research in the future should be done in collaboration with health care services and bodies offering family therapeutic services. Data on the interaction between family therapists and families and on the participation and role of children in family therapy are needed. Research that offers food for thought and practice and increases therapists' and clients' willingness to work for the whole family is both valuable as well as motivating.

This research offered promising results of usable of DIHC-method, however more research is needed to apply relatively newly introduced method in the contexts where children are present.

Future research remains possible while a researcher holds on to her data and attains familiarity with it. Possible questions are always determined by the data available. In the present case the researcher's interests and background are conducive to further family therapy research. The views of children diagnosed with conduct disorders on how the diagnosis has changed their life, and on what they perceive as having been positive or useful or as negative and harmful in relation to their self-knowledge and self-understanding would be an interesting potential research topic. It would also be interesting and useful to ask children about family secrets, about how they see the role and meanings, pros and cons, of secrets.

In the end, children's participation and engagement in a meaningful way in adult-led multi-actor settings has for several decades presented professionals with a constant and serious challenge. Is this challenge an issue of training and supervision or does it speak about lack of research remains still an open question.

SUMMARY IN FINNISH

Perheterapiaan osallistuva lapsi – kohti dialogista vuorovaikutuskumppanuutta

Lasten oirehdinta tuo tavallisesti perheen terapiaan tai saa perheen hakeutumaan ulkopuolisen avun piiriin. Lapset voidaan nähdä perheeseen johtavina ”eteisovina”, jotka avaavat näkymiä perheiden systeemisesti ja ylisukupolvisesti rakentuneisiin suhderakenteisiin ja niissä vallitseviin tiedostettuihin tai tiedostamattomiin ydinuskomuksiin. Nämä ydinuskomukset pitävät usein sisällään käsityksiä esimerkiksi suhteessa olemisen tavoista, liittymisestä, kiintymyksen ja läheisyyden sekä osoittamisesta että vastaanottamisesta. Edellisten lisäksi myös lukuisista ääneen sanotuista ja sanomattomista perheissä vallitsevista säännöistä, rajoista ja tehtäväksi annoista (jälkisäädöksistä). Perheterapian lähtökohtana voidaan pitää olettamusta, ettei lapsi sen enempää kuin kukaan muukaan yksittäinen perheenjäsen ole ongelma, vaan lapsen tai perheenjäsenen oirehdinta heijastaa aina perhesuhteissa, suhteessa olemisen tavoissa tai vuorovaikutuksessa vallitsevaa epätasapainoa/hankaluutta/ongelmallisuutta. Perheessä oireilevan lapsen käytös voidaan nähdä myös reagointina ongelmiin, jotka voivat olla seurausta pitkäänkin jatkuneista, jopa ylisukupolvisesti siirtyneistä, vuosien varrella kehittyneistä ja kumuloituneista haasteista tai elämän traagisuudesta. Lapsen oirehdinnan tarkasteleminen koko perheen yhteisenä vuorovaikutus- tai suhteessa olemisen kysymyksenä voi vapauttaa lapsen ”ongelman” tai syntipukin roolista. Tällainen lähestymistapa asettaa myös perheterapialle erityisen tehtävän hoitaa perhettä kokonaisuutena ja tarkastella perheen sisäisiä haasteita suhdekäsittein systeemisestä näkökulmasta.

Lasten läsnäolo, tai heidän aktiivinen osallistamisensa perheterapiaan ei kuitenkaan ole ollut itsestäänselvyys perheterapian perustamisesta tai sen alkuajoista lähtien, mitä voidaan pitää lähtökohtaisesti ristiriitaisena perheterapian perustamisen ydinajatuksen kanssa toimia perhesuhteiden hoitamisen foorumina, jossa kaikkien perheenjäsenten, myös lasten, kokemukset ja äänet voisivat tulla tasa-arvoisesti kuulluiksi perheen yhteisistä asioista keskusteltaessa. Suhtautuminen vakavasti käsitykseen, että perheterapeuttiset keskustelut voivat parhaimmillaan vapauttaa perheenjäsenissä vaiettuja, tukahdutettuja, ohitettuja tai kiellettyjä - ääneen lausumattomia tai ääneen sanottuja - ääniä tai kertomuksia, ei oikeuta lasten jättämistä perheterapian ulkopuolelle. Näin ollen jo edesmenneen strukturaalisen perheterapian edustajana tunnetun Salvador Minuchinin provokatiivista kysymystä kentälle ”missä ovat lapset perheterapiassa?” voidaan pitää relevanttina ja oikeutettuna yhä tänä päivänä kaikille perheiden hyvinvoinnin eteen työskenteleville ammattilaisille.

Lasten kokemusta ja ääntä esiin nostava perheterapiatutkimus on määrällisesti vielä suhteellisen vähäistä. Tämä väitöskirjatutkimus, joka sisältää kolme kansainvälistä julkaisua tarjoaa perheterapeuttiseen tutkimukseen ja perheiden kanssa työskenteleville ammattilaisille näkökulmia yhteiseen keskusteluun seuraavista aihepiireistä 1) miten uhmakkuushäiriö diagnoosin saanut lapsi

osallistutettiin perheterapiatapaamisiin perheen vaikeuksista puhuttaessa, 2) miten arkaluonteisia ja ylisukupolvisia perhesalaisuuksien lähestyttiin perheterapeuttisissa keskusteluissa ja miten lapset osallistuivat salamyhkäiseen ja avoimuutta välttelevään vuorovaikutussysteemiin, 3) kuinka uhmakkuus- tai käytöshäiriödiagnoosin saaneet lapset osallistuivat yhteisen tutkimisen seurantatutkimushaastatteluihin ja puhuivat kokemuksistaan suhteessa koettuihin vaikeuksiin ja saamaansa hoitoon. Kaikissa osatutkimuksissa yhteisenä tavoitteena on ollut syventää ymmärrystä lasten osallisuudesta perheterapiassa. Orientaatio tutkimukseen on ollut lähestyä lapsia aktiivisina vuorovaikutustoimijoina, joiden ajatukset, tunteet ja toiminta ovat mielekkäitä, intentionaalisia ja informatiivisia.

Lasten osallistaminen ja sitouttaminen perheterapiakäytänteisiin hoidon tavoitteiden kannalta mielekkäällä tavalla on osoittautunut tutkimuskirjallisuuden ja perheterapeuttien itsensä tuottaman kokemuksen mukaan haasteelliseksi. Perheterapiatutkimuksessa lapsen asemoitumisesta perheterapiatapaamisissa on käytetty ilmaisua puolijäsenyys, jolla viitataan lapsen epätasa-arvoiseen asemaan suhteessa aikuisiin osallistujiin ja tapaan, miten lapsiin tyypillisesti suhtaudutaan aikuisvetoisissa asetelmissa. Syinä lapsen epätasa-arvoiseen asemaan ja kohteluun on pidetty lapsen kehitykseen läheisesti liittyviä eroavaisuuksia, muun muassa kognitioon, kielenkehitykseen ja merkitysten antoon liittyen. Lasten tiedetään osallistuvan heidän asioitaan, terveyttään ja hoitoaan koskevaan keskusteluun ja päätöksentekoon vähäisesti. Lasten puheenvuoroja myös keskeytetään useammin kuin aikuisten. Lapsista ja heidän asioistaan puhutaan heidän läsnä ollessa ikään kuin he eivät itse olisi paikalla. Pahimmillaan heihin kohdistuu leimaavaa ja objektivoivaa puhetta, mikä on lapsen ihmisarvoa mitätöivää ja ohittavaa. Jotta lasten osallistamista perheterapiaan ja erinäisiin perheinterventioihin voitaisiin edistää, tehostaa ja kehittää tavalla, mikä huomioi heidän ikänsä, tutkimusta lasten kokemuksista ja äänestä tarvitaan lisää. Tähän asti valtaosa psykoterapiatutkimuksessa esitetyistä lasten kokemuksista perustuu lähtökohtaisesti terapeuttien tai vanhempien tuottamiin näkemyksiin, mikä osaltaan voidaan nähdä heijastavan oletusta lapsista epävalideina informantteina.

Kysymyksen ohittaminen, miten perheterapia palvelu- ja hoitomuotona vastaisi omalta osaltaan lapsen perustarpeisiin tulla nähdyksi, kuulluksi, informoiduksi omissa asioissaan, tuntea itsensä turvalliseksi ja arvostetuksi, sisältää riskin, että lapset tekevät omat ratkaisunsa terapiaan osallistumisen hyödyllisyydestä ja sen mielekkyydestä. Lapset tutkimustiedon valossa haluavat olla osallisia heidän perhettään koskevien asioiden käsittelyssä ja päätöksenteossa. Tarve kokea itsensä nähdyksi ja kuulluksi on merkittävää myös lapsille. Lapset kokevat mielekkäänä jakaa osallisuuden kokemuksensa muiden perheenjäsenten rinnalla ja kanssa, tulla kohdatuksi heidän vahvuuksiensa kautta vaikeuksien ja huomion kohteena olemisen sijasta. Kokiessaan hoidon heidän kannaltaan epämielekkäänä, lapset myös osoittavat haluttomuuttaan ja motivoitumattomuuttaan sekä epäsuorin että suorin keinoin. Tutkimustiedon mukaan lapset pitävät terapeuttista suhdetta ja siinä esiintyviä ulottuvuuksia hoidon ja itsensä kannalta tärkeänä. Suhteen rakentumisessa luottamukselliseksi ja muutoksia mahdollistavaksi terapeuttien

aloitteellinen rooli suhteen alussa ja sen määrittelyssä on nähty merkityksellisenä. Lapset kokevat terapeutit helposti lähestyttäväksi, jotka aktiivisesti kutsuvat heitä vuorovaikutukseen, osoittavat kiinnostusta, inhimillistä lämpöä ja ystävällisyyttä unohtamatta leikinomaista lähestymistapaa.

Tämän väitöskirjan tutkimusartikkelit on toteutettu laadullisia tutkimusmenetelmiä käyttäen. Ensimmäisessä tutkimusartikkelissa metodina käytettiin temaattista analyysiä, toisessa ja kolmannessa dialogista monitoimija tilanteisiin kehitettyä suhteellisen uutta ja lapsiperhekontekstissa vielä vähäisesti tutkittua vuorovaikutusmetodia, *Dialogical methods for Investigations of Happenings of Change* (DIHC). Tutkimusaineisto kuuluu osana laajempaa perheterapiatutkimushanketta "Perhekeskeinen hoito ja järjestelmällinen potilaspalaute uhmakkuus- ja käytöshäiriödiagnoosin saaneiden lasten syrjäytymisen ehkäisynä". Tutkimusprojektissa yhteistyökumppaneita ovat Jyväskylän yliopisto, Kuopion yliopistollinen sairaala ja Itä-Suomen yliopisto. Tutkimusaineisto pitää sisällään yhteensä 14 perheen perheterapiaistuntojen videotallenteita yhden vuoden ajalta sekä 9 perheen seurantahaastattelut n. 18 kk terapian päättymisen jälkeen. Hoitoon ohjaamisen syynä on ollut lapsella diagnosoitu uhmakkuus- tai käytöshäiriödiagnoosi. Tutkimuksiin osallistuneiden perheiden lapset olivat perheterapian alkamisen yhteydessä 6-12 vuoden ikäisiä. Perheterapiaistunnot ovat toteutettu Kuopion yliopistollisen sairaalan Lasten psykiatrian osastolla. Perheiden hoitoon osallistuneet terapeutit ovat koulutukseltaan perheterapeutteja. Tutkimushankkeelle on myönnetty Pohjois-Savon eettisen toimikunnan hyväksyntä ja kaikki tutkimukseen osallistuneet ovat antaneet suostumuksensa tutkimukseen osallistumisesta.

Ensimmäisessä tutkimusartikkelissa todettiin uhmakkuus- ja käytöshäiriödiagnoosin saaneen lapsen asemoituneen oirekuvastolle ja diagnoosille tyypillisesti 'ongelmaksi', mikä haastoi lapsen käyttäytymisen tutkimisen yhteisissä perhetapaamisissa systeemisten periaatteiden mukaisesti. Lapsen uhmakas ja aggressiivinen käyttäytyminen teki perheen sisäisen kielteiseksi ja haitalliseksi rakentuneen vuorovaikutuskuvion näkyväksi, mikä osaltaan tarjosi terapiassa ilmiön puheeksi ottamista, mutta samalla ylläpiti negatiivisen vuorovaikutuksen jatkumista vaikeuttaen muutoksen mahdollisuutta perheen sisäisissä suhteissa. Lapsi protestoi epätasapainoista tutkimusasetelmaa ja turvautui puolustamaan itseään uhmakkuushäiriöisen lapsen oirekuvalle tyypillisellä tavalla, mikä vaikeutti lapsen mahdollista kokemusta kohdatuksi tulemisesta myös muutosta mahdollistavalla tavalla. Artikkelin pohdintaosuudessa kysytään, mikä yksilöllisesti annetun diagnoosin merkitys ja rooli on perhehoitojen yhteydessä? Voiko diagnoosi implisiittisesti ohjata, kapeuttaa tai peräti vinouttaa ajattelua ja orientoitumista siihen, kuka on 'potilas'?

Terapeuttinen työskentely riskiryhmään kuuluvien perheiden kanssa kuin myös perheenjäsenten sitouttaminen muutokseen johtavaan työskentelyyn tiedetään olevan haasteellista. Käytöshäiriödiagnoosin saaneiden lasten vanhemmat ovat ymmärrettävästi alttiita kokemaan häpeää, mikä voi näkyä ulospäin myös omaa vastuuta välttelevänä käytöksenä ja syyn hakemisena itsen tai perheen ulkopuolisista tekijöistä. Perhe- ja pariterapialle yhteisten tekijöiden

aktiivinen mielessä pitäminen ja suhdetermein työskentely on kuitenkin tuloksellisen hoidon kannalta tärkeää. Jokaisen perheenjäsenen turvallisuuden tunteesta perheterapiatapaamisessa on tärkeä kantaa ammatillista vastuuta. Erityisesti kuitenkin lasten suojeleminen vahingolliselta vuorovaikutukselta tulee olla ensisijaista. Luottamuksellisen ja turvallisen ilmapiirin rakentumista voidaan pitää terapeuttisen muutoksen vähimmäisedellytyksenä, jotta perheenjäsenille mahdollistuu itsensä ilmaiseminen ilman pelkoa kritisoiduksi tulemisesta. Tämä muutoksen mahdollisuutta edellyttävä vähimmäisvaatimus voi tehdä mahdolliseksi myös perheenjäsenten uusien, tyydyttävämpien, keskinäisiä suhteessa olon ja toisiinsa liittymisen tapojen tutkimisen ja myös kokemisen. Terapeuteilta edellytetään rohkeutta puuttua perheen haitallisiin vuorovaikutuskuvioihin perhettä kunnioittaen. Tässä haastavassa tehtävässä systeeminen lähestymistapa ja esimerkiksi sirkulaaristen ja reflektiivisten kysymysten käyttäminen voivat olla hyödyllisiä työkaluja. Nämä voivat auttaa tasapainoittamaan yhteistä tutkimista, liittymään tasa-arvoisesti jokaiseen perheenjäseneen erikseen sekä edesauttamaan perheenjäsenten itsehavainnointi- ja mentalisaatio kyvyn kehittymistä.

Toisessa tutkimusartikkelissa tarkasteltiin, miten perhesalaisuudet vaikuttivat terapeuttisen työskentelyn ilmapiiriin ja miten perheen lapset osallistuivat teemojen ympärillä käytyyn keskusteluun. Tapaustutkimuksen tulokset osoittavat, että lapset osallistuivat arkaluonteisten ja traumaattisten teemojen käsittelyyn aktiivisina vuorovaikutustoimijoina, kuitenkin paradoksaalisesti, toisaalta pyrkien purkamaan salailevaa ilmapiiriä, mutta samanaikaisesti myös sitä rakentamalla. Lapset osoittivat uteliaisuutta perheen arkaluonteisia ja vaiettuja teemoja kohtaan, mutta he myös itse tuottivat puhetta, mikä oli salamyhkäistä ilmapiiriä korostavaa. Tutkimuksessa pohditaan lapsen oirekäyttäytymisen mahdollisuutta toimia perhehoitoon hakeutumisen yhteydessä eräänlaisena peitetarinana, joka voi kätkeä sisäänsä perherakenteissa ehkä näkymättömiäkin perhesalaisuuksia, joiden yhteinen tutkiminen voisi avata uusia mahdollisuuksia lapsen oirekäyttäytymisen vaihtoehtoiseksi tutkimiseksi.

Perheterapeuttien on hyvä tiedostaa, että perhesalaisuudet voivat toimia perheen tiedostettuna tai tiedostamattomana terapiaan hakeutumisen motiivina. Tästä syystä mahdollisten perhesalaisuuksien puheeksi ottaminen välittömästi hoidon alussa kaikkien perheenjäsenten ollessa paikalla voi olla hyödyksi. Sukupuutyöskentely voi tarjota lapsiperheille oivallisen tavan tutustua perheen ja suvun sisäisten suhteiden ja voimavarojen lisäksi myös arkaluonteisempien perhetapahtumien ja vaiettujen teemojen yhteiseen tarkasteluun. Normalisoimalla perhesalaisuusilmiötä terapeutit luovat parhaimmillaan perheenjäsenille mahdollisuuden ottaa puheeksi asioita, joista voi olla vaikea puhua. Perhesalaisuuksien kohdalla erityisesti kallisarvoista on käydä yhteistä keskustelua myös niistä hyvistä syistä, miksi joidenkin asioiden puheeksi ottamisesta ihminen haluaa pidättäytyä. Tutkimuksessa esitetyt tulokset vahvistavat käsitystä lapsista tärkeinä heidän elämäänsä liittyvistä ja heille tärkeänä näyttäytyvien asioiden informantteina myös sellaisten asioiden suhteen, joilta aikuiset ovat usein hyvistä syistä ja tyypillisesti suojelutarpeista johtuen säästäneet. Lapset ovat kuitenkin erityisen herkkiä tunnistamaan ja sisäistämään perheensisäisissä vuorovaikutussuhteissa,

mitkä aiheet ovat perheessä niin sanotusti vaarallisia tai ”myrkyllisiä” ja reagoivat näihin jännitteisiin eri tavoin, sisään- ja ulospäin, etsien ulospääsyä, helpotusta ja tapaa tasapainotella vaikeina pitämiensä asioiden kanssa. Perheterapeuttien tulisikin osoittaa myönteistä uteliaisuutta tasapuolisesti kaikkien perheenjäsenten vuorovaikutusta kohtaan. Erityisesti lasten kohdalla kaikkiin aivan pienimpiinkin vuorovaikutuseleisiin tai aloitteisiin myönteisen huomion kiinnittämiseen tulee kiinnittää erityistä huomiota, myös niihin ei niin sanotusti ensisijaisesti tarkasteltuna kaikkein luokseen kutsuviin tanssiin pyyntöihin. Nämä päältäpäin katsottuna varsin oudotkin ulostulot voivat pitää sisältää tärkeitä teemoja ja avauksia johonkin sellaiseen, mitä perheessä ei ole vielä pystytty ääneen sanomaan.

Kolmannessa tutkimusartikkelissa tarkasteltiin, miten uhmakkuus- tai käytöshäiriödiagnoosin saaneet lapset osallistuivat ja puhuivat kokemuksistaan yhteisen tutkimisen seurantatutkimushaastatteluissa. Vaikka tutkimushaastatteluiden tavoite ei ensisijaisesti ole toimia terapeuttisena näyttämönä, tehty tutkimus osoittaa niiden voivan pitää sisällään myös terapeuttisia elementtejä. Tutkimuksen tulokset osoittavat, että lapset puhuivat kokemuksistaan aidosti, tunteellisesti ja reflektiivisesti. Lapset tuottivat puhetta ja merkityksiä suhteessa omaan häiriökäyttäytymiseensä myös havaitsijapositiosta käsin paljastaen itsestään myös haavoittuvaisempaa puolta. Haastatteluista kävi ilmi perhesuhteissa tapahtunutta lähentymistä, mikä näkyi myös perheenjäsenten keskinäisessä vuorovaikutuksessa ja siinä tapahtuneissa muutoksissa.

Tuloksia voidaan pitää sekä toivoa antavina että osoituksina lasten dialogisista kyvyistä. Uhmakkuus- tai käytöshäiriödiagnoosin saaneet lapset tuottivat ääneen asioita ja merkityksiä, joita eivät olleet aikaisemmin ääneen muotoilleet. Lasten tuottamat ja tai keskustelussa yhdessä rakennetut vuorovaikutusteot ja merkityksenannot esiintyivät kuitenkin sangen ohikiitävissä hetkissä, vähäsanaisesti, ikään kuin sivulauseissa sanottuina tokaisuina. Tavoin mikä olisi helposti mahdollistanut niiden huomioitta jättämisen merkityksettöminä tai lähempää tarkastelua kutsumattomina. Kokoavana ajatuksena totean, että lasten vuorovaikutuksellisia tekoja, on suositeltavaa lähestyä lahjoina, jotka saattavat olla paketoituina siten, ettei lahjansaaja tunnista sitä ensisilmäykseltä lahjaksi. Ne saattavat olla puutarhan vaatimattomimpia kukintoja, rannan vaatimattomimpia kiviä, joiden kauneus ja merkitys avautuu vasta niiden ääreen pysähtyvälle ja sen avautumista kärsivällisenä ja uteliaana esiin kutsuvalle. Yhtä lailla ne voivat olla myös niitä piikikkäitä ohdakkeita, joista tekee mieli riuhtaista itsensä nopeasti irti, ohittaa ja unohtaa.

REFERENCES

Ackerman, N. (1970) Child Participation in Family Therapy. *Family Process,* 9, 403-410.

Allen, J. G. (2003) Mentalizing. *Bulleting of the Menninger Clinic,* 67(2), 91-112.

Allen, J.G., Fonagy, P., & Bateman, A.W. (2008) *Mentalizing in Clinical Practice.* Washington, DC: America Psychiatric Pub.

American Psychiatric Association, (2013). Diagnostic and Statistical Manual of Mental Disorders (5 th edition). Arlington, VA: American Psychiatric Publishing.

Andersen, T. (1991) *The reflecting team: Dialogues and dialogues about the dialogues.* New York: 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* (p. 11-37). New York: Guilford Press.

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

Anderson, H. (1997) *Conversation, Language, and Possibilities: A Postmodern Approach to Therapy.* New York: Basic Books.

Anderson, H. (2001) Postmodern collaborative and person-centred therapies: what would Carl Rogers say? *Journal of Family Therapy,* 23, 339-360.

Anderson, H. (2004) The Wisdom of Not-Knowing – A Conversation with Harlene Anderson. *Journal of Systemic Therapies,* 23(2).

Anderson, H. (2012) Collaborative Relationships and Dialogic Conversations: Ideas for a Relationally Responsive Practice. *Family Process,* 51(1), 8-24. DOI:10.1111/j.1545-5300.2012.01385.x

Anderson, H. & Gehart, D. (ed.) (2007) *Collaborative Therapy. Relationships and Conversations that make a Difference.* New York: 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.

Anderson, H. & Goolishian, H. (1992) The Client is the Expert: A Not-Knowing Approach to Therapy. In McNamee, S. & Gergen, K. J. (eds.), *Therapy as Social Construction* (p.25-39). London: 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* (p. 255-281). New York: Guilford.

Andolfi, M. (1994) The Child as Consultant in M. Andolfi, & R. Haber (eds.) *Please help me with this family – Using Consultants as Resources of Family* (p. 73-89). New York: Brunner/Mazel.

Andolfi, M. (2016) How to Give Voice to Children in Family Therapy in M. Borcsa, & P. Stratton (eds.) (2016) *Origins and Originality in Family Therapy and Systemic Practice* (p. 143-168). Switzerland: Springer.

Aristotle (1975) *Categories and De Interpretatione.* Transl. with notes and glossary by J. L. Ackrill. Oxford: Clarendon Press.
Aristotle (1995) *The Poetics.* Edited and translated by Stephen Halliwell. Cambridge, Mass: Harvard University Press.
Aristotle (2009) *Nicomachean Ethics.* Translated by D. Ross; revised with introduction and notes by L. Brown. New York: Oxford University Press.
Atwool, N. (2006). Participation in decision-making: The experience of New Zealand children in care. Child Care in Practice, 12(3), 259–267. https://doi.org/10.1080/13575270600761727
Bakhtin, M. (1981) *The Dialogic imagination.* Austin: University of Texas Press.
Bakhtin, M. (1984) *Problems of Dostoevsky's poetics.* Minneapolis: University of Minnesota Press.
Bakhtin, M. (1986) *Speech genres and other late essays.* Austin: University of Texas Press.
Beardslee, W. R., Gladstone, T. R., Wright, E.J., & Cooper, A.B. (2003) 'A Family-based Approach to the Prevention and the Depressive Symptoms in Children at Risk: Evidence of Parental and Child Change.' *Pediatrics,* 119-131.
Beardslee, W.R., Gladstone, T.R., Wright, E.J., Forbes, P. (2007) 'Long-Term Effects From a Randomized Trial of Two Public Health Preventive Interventions for Parental Depression.' *Journal of Family Psychology,* 21, 703-713.
Berger, P. L. & Luckman, T. (1973) *The Social Construction of Reality.* Harmondsworth, Middx: Penguin Books.
Berger, R., & Paul, M. (2008) Family secrets and family functioning. The case of donor assistance. *Family Process,* 47(4), 553-566. 10.1111/j.1545-5300.2008.00271.x
Blanco, P., Muro, J., & Stickley, V. (2014). Understanding the concept of genuineness in play therapy: Implications for the supervision and teaching of beginning play therapists. *International Journal of Play Therapy*, 23(1), 44–54. https://doi.org/10.1037/a0035478
Boszormenyi-Nagy, I., & Sparks, G. (1973) *Invisible loyalties: Reciprocity in intergenerational family therapy.* New York: Harper & Row.
Bowen, M. (1978) *Family therapy in clinical practice.* Northvale, NY: Jason Aronson.
Buber, M. (2002) *Between Man and Man.* Translated by R. Gregor-Smith with an introduction by M. Friedman. London & New York: Routledge Classics.
Buber, M. (2004) *I and Thou.* 1. Ed. published 1937. Translated by R. G. Smith. London: Continuum.
Buvik, C. & Wächter, A. (2006) En Utmaning för alla. In A. Wächter (ed.) *Samforskning. -Att lära av klienten* (p. 9-91). Bokförlaget Mareld: www.mareld.se
Butler, E. A., & Randall, A. K. (2013) Emotional coregulation in close relationships. *Emotion Review,* 5(2), 202-210.

Braun, V. & Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology,* 3, 77-101.
Bruner, J. (1985) Vygotsky: A historical and conceptual perspective. In J. Wertsch (ed.), *Culture, communication and cognition: A Vygotskian perspective* (p. 21-34). Cambridge, MA: Harvard University Press.
Bruner, J. (1996) *The Culture of Education.* Cambridge: Harvard University Press.
Byng-Hall, J. (1988) Scripts and Legends in Families and Family Therapy. *Family Process,* 27, 167-179.
Carnevale, F. A. (2020) A "Thick" Conception of Children's Voices: A Hermeneutical Framework for Childhood Research. *International Journal of Qualitative Methods,* 19, 1-9. DOI: 10.1177/1609406920933767
Carr, A. (2016) How and Why Do Family and Systemic Therapies Work? *Australian and New Zealand Journal of Family Therapy,* 37, 37-55. https://doi.org/10.1002/anzf.1135
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
Cederborg, A-C. (1997) Young Children's Participation in Family Therapy Talk. *The American Journal of Family Therapy,* 25(1), 28-38.
Combs, G. & Freedman, J. (1998) Tellings and Retellings. *Journal of Marital and Family Therapy,* 24(4), 405-408.
Dallos, R. & Urry, A. (1999) Abandoning our parents and grandparents: does social construction mean the end of systemic family therapy? *Journal of Family Therapy,* 21, 161-186.
Dallos, R. & Draper, R. (2005) *An Introduction to family therapy: systemic theory and practice*. Maidenhead, Berkshire, England: Open University Press.
De Saint-Exupéry, A. (2000) *The Little Prince.* English translation by R. Howard. Orlando, Florida: Harcourt Inc.
Deslypere, E., & Rober, P. (2018) Family Secrecy in Family Therapy Practice: An Exploratory Focus Group Study. *Family Process, x: 1-14.* DOI:10.1111/famp.12409
Duncan, B. L, & Miller, S. D. (2000) The Client's Theory of Change: Consulting the Client in the Integrative Process. *Journal of Psychotherapy Integration,* 10(2), 169-187.
Ellis, C. (2008) Do we need to know? *Qualitative Inquiry,* 14, 1314-1320.
Fleuridas, C., Nelson, T. S., & Rosenthal, D. M (1986) The Evolution of circular questions: training family therapists. *Journal of Marital and Family Therapy,* 12(2), 113-127.
Fonagy, P., Gergely, G., Jurist, E.L., Target, M. (2004) *Affect Regulation, Mentalization and the Development of the Self.* New York: Other Press.
Gadamer, H. G. (1975/2004). *Truth and method.* Translated by J. Weinsheimer & D. G. Marshall. London/New York: Continuum.
Gale, J. (1992) When Research Interviews are More Therapeutic than Therapy Interviews. *The Qualitative Report,* 1(4), 1-4. https://nsuworks.nova.edu/tqr/vol1/iss4/3

Galinsky, E. (2000) *Ask the children: the breakthrough study that reveals how to succeed at work and parenting*. New York: Quill.
Garcia-Quiroga, M., & Agoglia, I. R. (2020) Too Vulnerable to Participate? Challenges for Meaningful Participation in Research with Children in Alternative Care and Adoption. *International Journal of Qualitative Methods,* 19, 1-11. https://doi.org/10.1177%2F1609406920958965
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* (p. 183-196). New York: Routledge.
Gergen, K. J. (1994). *Realities and relationships: Soundings in social construction*. Cambridge: Harvard University Press.
Gergen, K. (1999) An Invitation to Social Construction. London: SAGE.
Gergen, K.J. (2006) *Therapeutic realities: Collaboration, oppression and relational flow.* Cleveland: Taos Institute Publications.
Gibson, K., & Cartwright, C. (2014). Young clients' narratives of the purpose and outcome of counselling. *British Journal of Guidance & Counselling*, 42(5), 511–524. https://doi.org/10.1080/03069885.2014.925084
Gil, E. (2009) *Helping Abused and Traumatized Children – Integrating Directive and Nondirective Approaches* (transl. by K. Kankaansivu). UNIPress: Suomi.
Hawley, K. & Weisz, J. (2003) Child, parent, and therapist (dis)agreement on target problems in outpatient therapy: the therapist's dilemma and its implications. *Journal of Consulting and Clinical Psychology,* 71(1), 62-70. https://doi.org/10.1037/0022-006X.71.1.62
Hill, J. & Maughan, B. (2001) *Conduct disorders in childhood and adolescence.* Cambridge, U.K.: Cambridge University Press.
Hoffman, L., & Cecchin, G. (2003) *Exchanging voices: a collaborative approach to family therapy:* London: Karnac Books.
Hogan, D. (2005). Researching 'the child' in developmental psychology. In S. Greene & D. Hogan (eds.), Researching children's experience: Approaches and methods (p. 22–41). Sage Publications
Hubble, K., Bowen, K. L., Moore, S. C., & Van Goozen, S. H. M. (2015) Improving negative emotion recognition in young offenders reduces subsequent crime. *PLoS One,* 10(6), 1-13. https://doi.org/10.1371/journal.pone.0132035.
Hutchby, I. (2002) Resisting the incitement to talk in child counselling: aspects of the utterance 'I don't know'. *Discourse Studies*, 4(2), 147-168. https://doi.org/10.1177/1461445602004002020l
Imber-Black, E. (1993). Secrets in families and family therapy: An overview. In E. Imber-Black (ed.), *Secrets in families and family therapy* (p. 3-28). New York, NY, US: W. W. Norton & Company.
Imber-Black, E. (1998) *The secret life of families.* New York. Bantam Books.
Imber-Black, E. (2010) Family Secrets. *Good Housekeeping,* 250(2), 125-129.

Josephson, A.M. (2015) From Family Therapy to Family Intervention. *Child Adolesc Psychiatric Clin N Am* (24), 457-470. Http://dx.doi.org/10.1016/j.chc.2015.02.002

Kazdin, A. E. (1993). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology*, 5, 277-310. 10.1017/S095457940000439

Kazdin, A. E. (1997) Practitioner's Review: Psychosocial Treatments for Conduct Disorder in Children. *J. Child Psychol. Psychiat.,* 38(2), 161-178. 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.* New York: Oxford University Press.

Kazdin, A. E., Whitley, M., & Marciano, P. L. (2006). Child-therapist and parent-therapist alliance and therapeutic change in a treatment referred for oppositional, aggressive, and antisocial behaviour. *Journal of Child Psychology and Psychiatry*, 47(5), 436–445. https://doi.org/10.1111/j.1469-7610.2005.01475.x

Kaslow, F. W. (2004) Family therapy. In W. E. Craighead & C. B. Nemeroff (eds.), The concise Corsini encyclopedia of psychology and behavioral science (p. 362—364). New York: Wiley.

Kaslow, F. W. (2010) A Family Therapy Narrative. *The American Journal of Family Therapy,* 38(1), 50-62. DOI: 10.1080/01926180903430030

Kaslow, F. W., Broth, M. R., Smith, C. O, & Collins, M. H. (2012) Family-based Interventions for Child and Adolescent Disorders. *Journal of Marital and Family Therapy,* 38(1), 82-100. Doi: 10.1111/j.1752-0606.2011.00257.x

Kellam, S. G., Ling, X., Merisca, R., Brown, C.H., & Ialongo, N. (1998). The effect of the level of aggression in the first-grade classroom on the course and malleability of aggressive behaviour into middle school. *Development and Psychopathology, 10,* 165-185. 10.1017/S0954579498001564

Kerr, M. E., & Bowen, M. (1988). *Family evaluation*. An Approach based on Bowen therapy. New York, NY: Norton

Kieling, C., Baker-Henningham, H., Belfer, M. et al., (2011) Child and adolescent mental health worldwide: evidence for action. *Lancet,* 378, 1515-1525.

Kirschenbaum, H. & Henderson, V. L. (1989) *Carl Rogers: Dialogues.* Boston, MA: Houghton Mifflin.

Knauth, D. G. (2003). Family secrets: An illustrative clinical case study guided by Bowen family systems theory. *Journal of Family Nursing,* 9(3), 331-344.

Korner, S. & Brown, G. (1990) Exclusion of Children from Family Psychotherapy. Family Therapists' Beliefs and Practices. *Journal of Family Psychology.* 3(4), 420-430.

Lobatto, W. (2002) Talking to children about family therapy: A qualitative research study. *Journal of Family Therapy, 24,* 330-343.

Lowe, Roger (2004) *Family Therapy: A Constructive Framework.* London: Sage Publications.

Luttrell, W. (2010). 'A camera is a big responsibility': A lens for analysing children's visual voices. Visual Studies, 25(3), 224–237. https://doi.org/10.1080/1472586X.2010.523274

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

Marshall, R. and Reimers, S. (2002) In the centre of the looking glass: what do children think of reflecting teams? Context, 64, 14–17.

Mauss, M. (1967) *The gift. Forms and functions of exchange in archaic societies.* New York: Norton.

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* (p. 167-181). New York: Routledge.

McGoldrick, M., Gerson, R., & Petry, S. (2008). *Genograms: Assessment and intervention* (3rd ed.). New York, NY: Norton.

Midgley, N. (2004). Sailing between Scylla and Charybdis: Incorporating qualitative approaches into child psychotherapy research. Journal of Child Psychotherapy, 30(1), 89–111. https://doi.org/10.1080/007541704200020581

Midgley, N., Target, M., & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. Psychology and Psychotherapy: Theory, Research and Practice, 79(2), 257-269. https://doi.org/10.1348/147608305X52694

Miller, L. D. & McLeod, E. (2001) Children as Participants of Family Therapy: Practice, Research, and Theoretical Concerns. *The Family Journal: Counseling and Therapy for Couples and Family,* 9(4), 375-383.

Miller, G. E. & Prinz, R. J. (2003) Engagement of Families in Treatment for Childhood Conduct Problems. *Behavior Therapy,* 34, 517-534. 10.1016/S0005-7894(03)80033-3

Minuchin, S. (1998) Where is the family in narrative family therapy? *Journal of Family and Marital Therapy* 24(4), 397-403. DOI:10.1111/j.1752-0606.1998.tb01094.x

Minuchin, S., Montalvo, B., Guerney, B. G., Rosman, B. L., & Shumer, F. (1967) *Families in Slums.* New York: Basic Books.

Minuchin, S., & Fishman, H. C. (1981) *Family therapy techniques.* Cambridge, MA: Harvard University Press.

Moore, L. & Seu, I. B. (2011) Given children a voice: children's positioning in family therapy. *Journal of Family Therapy,* 33, 279-301.

Niemelä, M. (2012) *Structured Child-Centred Interventions to Support Families with a Parent suffering from cancer. From practiced-based evidence towards evidence-based practice.* University of Oulu. Acta Universitatis Ouluensis D1166.

Núñez, L., Midgley, N., Capella, C., Alamo, N., Mortimer, R., & Krause, M. (2021) The therapeutic relationship in child psychotherapy: integrating the perspectives of children, parents and therapists. *Psychotherapy Research,* 1-13. https://doi.org/10.1080/10503307.2021.1876946

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. 10.1016/j.pragma.2007.12.005

O'Reilly, M. & Kiyimba, N. (2021) Responsibility inoculation: Constructing 'good parent' accounts when accessing child mental health services. *Human Systems: Therapy, Culture and Attachments,* Vol 0 (0), 1-18. DOI: 10.1177/2634404121999961

Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. (1980) Hypothesizing-circularity-neutrality: three guidelines for the conductor of the session. *Family Process*, 19, 3–12.

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. https://doi.org/10.1177/1461445612452976

Patrika, P. & Tseliou, E. (2016) Blame, responsibility and systemic neutrality: a discourse analysis methodology to the study of family therapy problem talk. *Journal of Family Therapy,* 38, 467-490. Doi: 10.1111/1467-6427.12076

Petronio, S. (2002) *Boundaries of privacy: Dialectics of disclosure.* Albany: State University of New York Press.

Pihkala, H., & Johansson, E. E. (2008) 'Longing and Fearing for Dialogue with Children: Depressed parents' Way into Beardslee's Preventive Family Intervention.' *Nordic Journal of Psychiatry,* 62, 399-404.

Pihkala, H., Sandlund, M., & Cederström, A. (2011) Initiating communication about parental mental illness in families: An issue of confidence and security. *International Journal of Social Psychiatry,* 58(3), 258-265.

Pihkala, H., Dimova-Bränström, N., & Sandlund, M. (2017) Talking about parental substance abuse with children: eight families' experiences of Beardslee's family intervention. *Nordic Journal of Psychiatry,* 71(5), 395-401. DOI: 10.1080.08039488.2017.1308009

Plato (1989) Plato 1. *Euthyphro, Apology, Crito, Phaedo, Phaedrus.* Translated by H. N. Fowler. Loeb Classical Library: Harvard University Press.

Puustjärvi, A. & Repokari, L. (2017) Lasten käytöshäiriöihin tulee puuttua ajoissa. *Lääkärilehti,* 21, 1364-1367. Summary in English. http://www.potilaanlaakarilehti.fi/site/assets/files/0/14/80/338/sll212017-1364.pdf

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. 10.1521/jsyt.2009.28.4.41

Rautiainen, E-J. (2010) *Co-construction and Collaboration in Couple Therapy for Depression.* Academic dissertation. Jyväskylä Studies in Education, Psychology and Social Research 396. Jyväskylä: University of Jyväskylä.

Rober, P. (1998) The Reflections on Ways to Create a Safe Therapeutic Culture for Children in Family Therapy. *Family Process* 37, 201-213.
Rober, P. (2002) Some hypotheses about hesitations and their nonverbal expression in family therapy practice. *Journal of Family Therapy,* 24(2), 187-204. 10.1111/1467-6427.00211
Rober, P. (2005) *Explorations in dialogical family therapy. The concept the therapist's inner voice.* Universiteit Gent: Faculteit Psychologie en Pedagogische Wetenschappen.
Rober, P., Walgravens, G., Versteynen, L. (2012). "In search of tale they can live with": About loss, family secrets and selective disclosure. *Journal of Marital and Family Therapy*, 38(3), 529-541. 10.1111/j.1752-0606.2011.00237.x
Rober, P., & Rosenblatt, P. C. (2013) Selective Disclosure in a First Conversation about a Family Death in James Agee's Novel "A Death in the Family". *Death Studies,* 37(2), 172-194. 10.1080/07481187.2011.628555
Rober, P., & Rosenblatt, P.C. (2017) Silence and Memories of War: An Autoethnographic Exploration of Family Secrecy. *Family Process,* 56(1), 250-261.
Saarinen, Risto (2005) *God and the Gift: an ecumenical theology of giving.* Collegeville, MN: Liturgical Press.
Schmitt, F. (2008) *Families in the shadow of cancer*. Department of Child Psychiatry, Turku University, Turku University Hospital, Finland. Annales Universitatis Turkuensis, Medica – Odontologica Series D. Turku: Painosalama Oy.
Shanley, D.C., Reid, G. J., & Evans, B. (2008) How Parents Seek Help for Children with Mental Health. *Administration and Policy in Mental Health Services Help,* 35(3). 135-146. DOI 10.1007/s10488-006-0107-6
Shirk, S. R. (1988) (ed.) *Cognitive development and child psychotherapy.* New York: Plenum.
Seikkula, J., & Olson, M. E. (2003) The Open Dialogue Approach to Acute Psychosis. Its Poetics and Micropolitics. *Family Process,* 42(3), 413-418.
Seikkula, J., & Trimble, D. (2005). Healing elements of therapeutic conversations: Dialogue as an embodiment of love. *Family Process*, 44(4), 461–475. 10.1111/j.1545-5300.2005.00072.x
Solantaus, T., Paavonen, EJ, Toikka, S., Punamäki, R-L. (2010) Preventive Interventions in Families with Parental Depression: Children's Psychosocial Symptoms and Prosocial Behaviour. *Eur Child Adolesc Psychiatry,* 19(12), 883-892. Doi: 10.1007/s00787-010-0135-3
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, 5* (p. 323-372). New York: Plenum.
Sprenkle, D. H. (2012) Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue. *Journal of Marital and Family Therapy* 38(1), 3-29. doi: 10.1111/j.1752-0606.2011.00271.x

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009) *Common Factors in Couple and Family Therapy. The Overlooked Foundation for Effective Practice.* New York: The Guilford Press.

Spyrou, S. (2016). Troubling children's voices in research. In F. Esser, M. S. Baader, T. Betz, & B. Hungerland (eds.), Reconceptualising agency and childhood: New perspectives in childhood studies (p. 105–118). Routledge.

Stafford, V., Hutchby, I., Karim, K., & O'Reilly, M. (2016) "Why are you here?" Seeking children's accounts for their presentation to Child and Adolescent Mental Health Services (CAMHS). *Child Psychology and Psychiatry,* 21(1), 3-18.

Stierlin, H. (1977) *Das Erste Familiengespräch: theorie, praxis, beispiele.* Stuttgart: 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. https://doi.org/10.1111/j.1752-0606.1996.tb00188.x

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. 10.1111/1467-6427.00155

Theodor, L. A. (2017) (ed.) *Handbook of evidence-based interventions for children and adolescents.* New York: Springer Publishing Company.

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

Tomm, K. (1988) Interventive Interviewing: Part III. Intending to ask Lineal, Circular, Strategic, or Reflexive Questions? *Family Process,* 27(1), 1-15. https://doi.org/10.1111/j.1545-5300.1988.00001.x

Tracy, O. (2015) *Mapping the Hidden. An Interpretative Phenomenological Analysis of Multigenerational Family Secrets.* Department of Family Therapy Thesis and Dissertations. NSU Florida: Nova Southeastern University.

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,* Vol x(x), 1-20. https://doi: 10.1111/famp.12562

Vangelisti, A. L., & Caughlin, J. P. (1997). Revealing family secrets: The influence of topic, function, and relationships. *Journal of Social and Personal Relationships*, 14(5), 679-705. 10.1177/0265407597145006

Von Sydow, K., Retzlaff, R., Beher, S., Haun, M.W & Schweizer, J. (2013) The efficacy of systemic therapy for childhood and adolescence externalizing disorders: A systemic review of 47 RCT. *Family Process,* 52(4), 576-618. https://doi.org/10.1111/famp.12047

Vygotsky, L. S. (1971) *Thought and Language* (6th ed.). Cambridge, MA: MIT Press.
White, M. (1995) *Re-authoring Lives: Interviews and Essays.* Dulwich, Adelaide, Australia: Dulwich Centre Publications.
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.
Willis, K., Miller, R.B., Yorgason, J., & Dyer, J. (2021) Was Bowen Correct? The Relationship Between Differentiation and Triangulation. *Contemporary Family Therapy,* 43, 1-11. https://doi.org/10.1007/s10591-020-09557-3
Winnicott, D. W. (1965/2018) *The Maturational Processes and Facilitating Environment: Studies in the Theory of Emotional Development.* New York: Routledge.
Winnicott, D.W. (1971) *Playing and Reality.* London: Routledge.
Wolpert, M., & Fredman, G. (1994) Modelling the referral pathway to mental health services for children. *Association for Child Psychology and Psychiatry: Newletter, 16,* 283-288.
World Health Organization (2004) *Prevention of Mental Disorders. Effective interventions and Policy Options. Summary Report.* Geneva: World Health Organization.

ORIGINAL PAPERS

I

"WHY AM I THE ONLY ONE YOU'RE TALKING TO, TALK TO THEM, THEY HAVEN'T SAID A WORD?" PITFALLS AND CHALLENGES OF HAVING THE CHILD IN THE FOCUS OF FAMILY THERAPY.

by

Mira Helimäki, Aarno Laitila, & Kirsti Kumpulainen 2021

Journal of *The American Journal of Family Therapy*. 1-18.

https://doi.org/10.1080/01926187.2020.1870582

THE AMERICAN JOURNAL OF FAMILY THERAPY
https://doi.org/10.1080/01926187.2020.1870582

Why Am I the Only One You're Talking to, Talk to Them, They Haven't Said a Word?

Pitfalls and Challenges of Having the Child in the Focus of Family Therapy

Mira Helimäki[a], Aarno Laitila[a] and Kirsti Kumpulainen[b]

[a]Department of Psychology, University of Jyväskylä, Jyväskylä, Finland; [b]Department of Child Psychiatry, University of Eastern Finland, Kuopio, Finland

ABSTRACT

Children with conduct disorders are at risk of being positioned in the family therapy as 'the problem'. This study describes how the difficulties were talked about and how the child coped in this situation. The results showed: the parents produced symptom-oriented problem talk about the child's behavior, rendering systemic reformulation of the problem challenging. The negative interaction made the climate unsafe and impaired consideration of the child's behavior as a meaningful way for the child to become seen and heard. This study enriches understanding of the therapeutic challenge therapists face with high-risk families from the very beginning of the treatment.

ARTICLE HISTORY
Received 21 December 2020
Accepted 23 December 2020

KEYWORDS
Family therapy; conduct disorder; interaction; problem-talk

Introduction

Childhood aggression and early conduct problems constitute the most frequent referrals for clinical and school-based treatment (Hill & Maughan, 2001; Theodor, 2017). Children exhibiting high levels of aggression in diverse settings are at elevated risk for developing serious behavioral, academic and social-emotional problems in adolescence and beyond (Kellam et al., 1998; Puustjärvi & Repokari, 2017). Effective treatment is needed, as antisocial behavior that regularly violates social norms causes stress to both children and their families. In interpersonal relations, children with conduct disorders are in danger of being perceived as difficult personalities. This hinders their being seen and heard in a meaningful way. Conduct disorder is a tragedy not only for the children themselves but also for their families (Kazdin, 1997, 2005). This study investigated how a family's difficulties were talked about in the early sessions of family therapy and how the parents' symptom-oriented problem talk, by keeping the focus on the child's dysfunctional behavior, contributed partially to

CONTACT Mira Helimäki mhelimaki@gmail.com; aarno.a.laitila@jyu.fi Department of Psychology, University of Jyväskylä, Kärki, Mattilanniemi 6, PL 35, Jyväskylä, FI-40014 Finland

the continuance of the child's symptomatic behavior and challenged balanced investigation and exploration of the family's situation.

Many factors contribute to child conduct disorders. Children who meet the criteria for conduct disorders are also likely to meet the criteria for other disorders, including neuropsychiatric disorders, traumatic experiences, and depression, i.e., comorbidity (Hill & Maughan, 2001; Kazdin, 1997, 2005; Theodor, 2017). Negative interaction within the family and careless or inconsistent upbringing are additional psychosocial risk factors. Dysfunctional relations are reflected in less acceptance, warmth, affection, and emotional support. It has also been shown that more defensive communication among family members, less participation in activities as a family, and the marked dominance of one family member are associated with conduct disorder (Hill & Maughan, 2001; Kazdin, 1997, 2005).

It is generally conceded that multimodal and family-focused approaches, which can be regarded as evidence-based treatments, are needed to address the complex, cumulative, multidetermined nature of early-onset conduct disorders (Kazdin, 1993, 1997, 2005; Miller & Prinz, 2003; Theodor, 2017). Family therapy with a systemic (Carr, 2016) emphasis on promoting interactional relationships within the family (Kazdin, 2005; Sprenkle et al., 2009) has achieved good results in families where a child has been diagnosed with an oppositional defiant or conduct disorder (von Sydow et al., 2013).

On the premise that the child-parent and family context includes multiple and reciprocal influences that affect each participant and the systems in which they operate, a diagnosis of conduct disorder is problematic if it is understood solely as the child's dysfunction (Bowen, 1988; Kazdin, 1993, 1997, 2005; Kerr & Bowen, 1988; Theodor, 2017). For treatment to be effective, the whole system must be addressed. On the assumption that problems on the interactional level manifest as individual "symptoms," which in turn challenge interaction, then such problems should also be discussed in relational terms, that is, in terms of interactional cycles (Sprenkle et al., 2009). In child-parent sequences of interaction, the influences are always bi-directional (Hill & Maughan, 2001). The use of relational terms, however, is challenging, as the tendency to attribute children's behavior to internal dispositions or environmental factors outside their parents' control is known to be high in families with children referred for conduct problems (Miller & Prinz, 2003). Additionally, families with children referred for conduct problems show high rates of defensiveness in their communication, including blaming and negative attributions (Kazdin, 1997; 2005). In written family therapy history, this has been shown to present a persistent phenomenon. Different family therapeutic schools (e.g., Boszormenyi-Nagy & Framo, 1965; Cecchin, 1987; Stierlin, 1977; Tomm, 1987, 1988) have sought to develop family members'

awareness of their reciprocal interrelatedness with the aim of reducing the mechanism of "scapegoating" and supporting parental agency.

The beginning of family therapy is a critical time both for joining with a family and identifying unconstructive interactional patterns as well as hidden or lost resources, achieving a systemic framing of the problem and for finding the motivation for change (Nelson et al., 1986; Stierlin, 1977; Tomm, 1987). Achieving a shared understanding of the problem also lays the foundation for the therapeutic alliance and therapeutic goals (Bordin, 1979; Tryon & Winograd, 2011). Fostering a working alliance in couple and family therapy with multiple members with different motivations and perceptions of the problem is, however, challenging (Sprenkle et al., 2009), as the development of multiple interacting working alliances is heavily influenced by preexisting family dynamics (Friedlander et al., 2011).

Therapists who base their decisions on input from parents alone risk overlooking issues, and even problems that matter to the child, and thus may alienate or fail to engage the child (Hawley & Weisz, 2003). The way therapists ask questions also matters. A long series of questions may be experienced as an inquisition or a punishment (Tomm, 1988). Sprenkle and Blow (2004) suggest that a balanced alliance might be even more important to the outcome than the strength of the alliance. Children should be noticed and recognized seriously by therapists as full-membership-partners, despite their possible resistance, taciturnity or – from an adult's perspective – irrelevant or illogical talk (e.g., Gehart, 2007).

The reason families seek therapy is that they are facing problems that they cannot solve on their own. This in turn means that the help-seekers' sense of agency may be diminished or lost (Adler, 2012). Advancing clients' agency is regarded as a central task of therapists (Avdi et al., 2015). It is especially important in cases where the family perceives entry to therapy as "forced" upon them. In such families the sense of agency can be extremely fragile. The initiator of the therapeutic process is also of relevance. Children seldom occupy that role (Ackerman, 1970; Hutchby, 2002; Wolpert & Fredman, 1994). Parents' sense of poor agency explains why the narratives of the first few sessions are often problem-saturated (Gonçalves et al., 2010) and include blaming (Buttny, 1996).

Talking about problems carries the risk of attributions of guilt (Buttny, 1996; Parker & O'Reilly, 2012) and thus the risk of loss of face for a participant. Offering "an account" of one's actions is one way of managing such problematic events. An account is an explanation offered to an accuser that attempts to change the demeaning meanings attributed to one's actions. In presenting clients' problems, the therapist actively engages in how problems are narrated and stops clients from continually blaming others. Reformulation of the problem is often a necessary therapeutic intervention (Buttny, 1996.).

While family therapy research findings support the importance of including the child in interventions for child aggression and behavior problems (Miller & Prinz, 2003), concerns have been raised about the inclusion of children due to the potential harm this may cause them (Miller & McLeod, 2001). Parker and O'Reilly (2012) found that children in family therapy are at risk of being positioned as passive listeners to their parents' negative talk about them. Being talked and "gossiped about" – downgrades the child's position and has a negative influence on the child's self-esteem (Fine, 1986), and sense of agency. Bruner (1977) has argued that from childhood onwards children internalize conversations held with others and heard between others, especially those between significant others. Outer dialogues become internal dialogues which in turn affect children's perceptions of who they are. Stierlin (1977) sees the presence of children in family therapy sessions as crucial to recognize systemic perspectives. Children see and hear more than we adults are aware of, and discussing problems jointly will not cause them further harm. However, research on children as participants in family therapy is scarce (Avdi, 2015), as also is research on children with conduct disorders (Miller & Prinz, 2003).

Study aims

This study explored 1) *how the family's difficulties were constructed or formulated in family therapeutic interaction* and 2) *how the child himself coped when he was talked about in the session*. The overall aim was to extend the results of previous studies on children diagnosed with conduct and oppositional defiant disorder and their participation in family therapy.

Data

The research data comprised video-taped family therapy sessions implemented at Kuopio University Hospital Child Psychiatry Clinic. The research material forms part of a larger family therapy research project on families with children aged 6–12 years diagnosed with oppositional defiant or conduct disorder. Three family therapy processes were studied over a one-year period. One process differed from the other two in the amount of problem talk and the high level of negativity in the family, a known risk factor in children's conduct disorders (Kazdin, 1997; Puustjärvi & Repokari, 2017). This case was selected for closer study because of its challenging nature. Yin's (2003) "representative" and "typical" principle in case study research was followed.

The excerpts chosen for closer analysis are drawn from sessions 1 and 4 and are representative of the main findings and categories of the analyzed data.

The family members (pseudonyms) were Marika (mother), Jaakko (father), 7-year-old Seppo, and his younger brother Petri, who was not

present during the first four sessions. In the excerpts, Marika, Jaakko, and Seppo are referred to by the abbreviations M, J and S. The family therapists who took part in the process are referred to as T1 and T2.

Methods and procedure

This study applied a qualitative framework using thematic analysis. The analytical tool was a blend of deductive and inductive approaches (Braun & Clarke, 2006). First, the videotaped sessions were transcribed and analyzed with special attention to the interactional sequences in which the reason for seeking help was discussed. The problem-talk sequences were analyzed and organized thematically into categories. Two main problem-talk categories, related to the child's diagnosis of oppositional defiant and conduct disorder, were identified: direct talk and indirect talk. The two main categories were further divided into the subcategories presented below in the analysis and results section. The analyzed themes/categories followed the list of diagnostic criteria for oppositional defiant and conduct disorders (ICD-10/DSM-5), and thus applied a deductive approach. Themes that arose from the data (induction), were discussed from the standpoint of family therapy. The analysis and results were discussed and reflected on jointly with the other authors. The research results are presented in narrative analytic form (Braun & Clarke, 2006).

Analysis and results

Case history

Seppo (7) and his family had been referred to the child psychiatric clinic owing to Seppo's persistent external behavior at home and at school. Following a clinical diagnostic evaluation, Seppo had been diagnosed with oppositional defiant disorder. Seppo was cognitively competent and had, for example, learned to read a couple of years before reaching school age. The family was recommended for family therapy owing to Seppo's aggression problem. According to the parents, the family had been "brought" to therapy. The mother said that she knew nothing about family therapy and the father that they had been told that family therapy was the only "alternative" left. The family therapists were both female with a long history of working with families. T1 met the family for the first time in the first session. T2 had met the whole family once before the first meeting. The therapy process lasted several years. At the end of the first year of therapy, the circle of negation characterizing the interaction between Seppo and his mother remained pervasive.

Symptom-orientated talk and a negative atmosphere

The main finding of this study was that, in presenting the family's difficulties, the parents produced direct and indirect symptom-oriented talk. The first therapy session (60 min) was characterized by direct problem talk: the parents made approximately 60 negative comments or problem-saturated utterances about Seppo. The parents' indirect symptom-oriented talk displayed the features of *gossip*, meaning that the child was present during derogatory talk about him by adults. The indirect negative problem talk was subcategorized into 1) *negative descriptions of features of the child's personality* and 2) *negative evaluations and interpretations of his behavior*. The direct symptom-oriented talk was subcategorized into 1) *commands by parent* ("Speak up!," "Don't touch!"), 2) *invalidation of the child's response* ("Are you serious?" "That's not true!"), 3) *blaming by imitating the child's own words* ("This is mine!"), and 4) *accusations and reference to violent behavior.*

The communicational device used to reconstruct the picture of the child as a problem was generalization using temporal and quantity qualifiers, such as "always," "very often" and "every."

The child's coping in the situations in which he was talked about as the problem was categorized as 1) direct protest (subcategories: *confrontation* and *blaming*) and 2) indirect aggressive protest (*disengagement* and *nonsense talk*).

The following excerpt is from the very beginning of the first session. It is known that the beginning of a therapy process contains condensed, vital information of relevance to the entire therapy process. Some therapists and researchers have claimed that the nuclear contents for therapeutic work are present already at the very beginning and in the client's first utterances (Laitila, 2016). Excerpt 1 illustrates the negative interaction pattern between mother and son.

Excerpt 1. Indirect: negative interpretation of behavior (lines 4–9), 11–35 s

T1: so, you weren't that interested in coming along, were you Seppo?

M: nope, it just didn't interest him

T2: what kind of talk did you have about today's meeting?

M: well, I tried a little a bit to explain what's going on here, about the research… but… not interested

T1: okay, and it's pretty difficult to figure out what's actually the point.

The discussion had already started in the corridor, which might have slightly confused the therapists and probably affected the start of the session. We do not know for certain what led T1 to interpret Seppo's

behavior in a negative way: was it her own interpretation of the situation or acquiescence in his mother's negative interpretation of him? The excerpt exemplifies several therapeutic challenges. First, the active negative interactional pattern between Seppo and his parents exemplified in that moment reduced the therapists' possibility for a neutral start. Second, constructing a balanced alliance with each family member became challenging in a situation where one of the family members was already negatively positioned. Third, Seppo's half-membership status was visibly manifested in his not being given opportunity to speak for himself. If it is assumed that the first utterances are meaningful for the entire therapeutic process, then what is foregrounded in this extract is the family's dysfunctional interactional pattern. T2 offers a topic for open discussion and invites the parents to describe how they introduced Seppo to the idea of family therapy. The mother is the first to answer the question, after which she shifts the focus back onto Seppo, repeating her comment on his oppositional attitude. T1 reacts to the mother's comment, which downgraded Seppo, by validating his experience and correcting her unfortunate interactional start. This short extract shows how symptom-orientated, blaming talk, indicating the family's dysfunctional interactional pattern, was implicitly present at the very beginning of the session.

The following excerpt was chosen to show more closely how T1 tries to shift the problem-talk into the relational domain. T1's question to the parents implicitly indicates that the child's behavioral problems are in fact the parent's business and that they are under an obligation to help their children. The mother's response to this shows how sensitive she is to the theme of parental responsibility. The excerpt additionally shows how Seppo copes when positioned in the role of scapegoat.

Excerpt 2 direct: accusation and reference to violent behavior (614–627), 42.38–43.20

T1: have you at home how much have you gone through situations about what Seppo could do when his little brother starts to get on his nerves?

M: well, there's been quite a lot of talk about it what should you do if you're getting annoyed?

S: well, come and tell

M: what shouldn't you do?

S: should stop then

M: yes, but you shouldn't ever hit, kick, bite or no other way hurt Petri. But that's what you do every time.

S: minibottejaaaa! (nonsense-talk)

T2: how often do you have situations like that?

M: all the time

T2: every day?

J: almost

M: yes

T1's question to the parents implies that Seppo's difficulties are not solely of his own making. Instead, parents are responsible for helping their children to find workable means of dealing with relational issues. The mother's response "there's been quite a lot of talk about it" could be interpreted as somewhat defensive. While admitting that there has been talk about it, she soon turns to Seppo, whom she sees as responsible for the problem, for an answer to the question. Seppo's answer does not satisfy his mother, who then presses him to confess his guilt while positioning herself as a boundary-setting parent. Seppo tries to save face, does not confess, but repeats how he should act. The mother's despair become visible when she details Seppo's violence and its frequency. She makes it clear how fraught their situation is at home. T2 hears the mother's despair and asks emphatically how often such events occur. Positioned as guilty, Seppo disengages from the joint interaction. T2 focuses on the mother's generalizing expression by offering the mother the milder expression "every day?" T2's intervention succeeds, as the father moderates the mother's expression with "almost." The attempt to reconstruct the problem talk in relational terms and stop the negative process fails. Seppo copes by protesting indirectly: he talks nonsense and disengages from the situation.

The next extract is drawn from a session containing a lot of problem talk about Seppo's behavior. It shows how the therapists and Seppo try to cope in an unsafe therapeutic climate. It also demonstrates the persistence of diagnostic talk and shows why reformulating the problem is a difficult task.

Excerpt 3 indirect: subcategory 2 "gossiping" (662–674), 45.58–47.05

T1: well, are we talking about pretty tough things?

T2: well, it might be a bit hard to talk about them. At least not so nice to talk about for example Legos or some other nice stuff.

S: dabadabadapadapa….(*nonsense*)

J: that's how one's own problems and figuring them out always tends to be.

M: totally it is – he doesn't want to talk about or discuss them.

T1: so, it's difficult to get in touch with that…have you any idea what's he's feeling at the moment when you start talking about them?

M: were you allowed to take them?

S: yes!

M: no!

T1: so, he gets upset when we try to talk about them, doesn't he?

M: he *doesn't want to and then he gets angry and he starts to scream and behave sort of and then often he behaves violently among others*

T1 recognizes that problem talk is getting hard for Seppo to listen to and offers words to make Seppo's experience understandable and visible to his parents. T2 makes space for the issue in general, observing that talking about sensitive themes can be difficult. An effort to empathize and normalize the phenomenon can be detected here. Seppo reacts to the problem-saturated talk indirectly, by talking nonsense, demonstrating that he hasn't been listening. The father's response indicates that talking about problems hasn't been easy for him either. This offers an opportunity for talking about the problem in relational terms; however, the mother's response once again attributes the problem to Seppo and the chance is missed. T1 responds to the mother's response by inviting the parents to mentalize Seppo's feelings, but Seppo has simultaneously been excluded from the discussion concerning him and reacts to this by behaving unconstructively, in turn irritating his mother. T1 interprets Seppo's reaction while the adults discuss his problematic behavior. The mother validates T1's interpretation.

Seppo's responses to his positioning regarding the problem

The negative and locked interactional pattern established in the first session was repeated in the fourth session, where Seppo protested his being positioned as THE problem. He expressed his aggression and defiance both verbally and physically. The following extract exemplifies Seppo's direct verbal aggression toward the therapists. The context is the therapists' school visit. The therapists had told the family about their meeting with Seppo's teacher. Seppo had, from the beginning, protested the school visit and was upset to hear that the therapists had talked privately with his teacher. His parents reported that Seppo's behavior had become increasingly aggressive during the previous weeks. His mother's interpretation of this was "because you have to talk it over, because things don't go away."

While we don't know how disappointed Seppo was with the therapists that the situation at home had not become easier and the family had not yet received help, Seppo produces a striking metaphor for his 'experience' in this challenging therapeutic encounter.

Excerpt 5 Direct: blaming (lines 80–86), 08.03–08.30

S: I want to throw darts at you.

T1: Oh boy! We're not dartboards

S: Yes you are! Or then you're stupid!

T2: Well, if I can choose, then we must be stupid.

S: You are stupid, so stupid, so stupid!

M: Remember Seppo, he who calls someone is stupid, is stupid himself.

S: No, I'm not, they choose to be it themselves.

Here, Seppo expresses his feelings about the therapists directly, but metaphorically. Seppo calls the therapists "stupid." In another situation, the therapists were also "deaf." T1 chooses to respond lightheartedly Seppo's aggressive outburst. However, while the use of humor injects some playfulness into the handling of this escalating situation, it also prevents the therapists from facing head-on the emotion contained in Seppo's metaphoric utterance. His mother reminds Seppo of the consequences of bad behavior with a Finnish saying which can also be interpreted from a humorous point of view. Seppo's coping strategy is to counterattack. Being positioned unilaterally as the problem leads him to develop this symbolic way of expressing his feelings.

The following extract shows how Seppo confronted the therapist directly. His mother had told the therapists that Seppo has "greater problems at school" than at home. The therapists were interested and started to look for possible explanations. The therapists' curiosity annoyed Seppo and he refused to answer. The therapists and his mother did not, however, give up questioning him, which annoyed him even more. Seppo finally mentioned some of the things that angered him at school, adding that there was something more, "but it doesn't relate to anything else." T1 took Seppo's words seriously and sought to motivate him to tell more, saying "we want to understand what you're trying to tell us." Seppo responded to this by saying "but you won't understand." The conversation continued and Seppo described what kind of arrangements he would like to see in the classroom. His mother reminded him that it was not up to him to decide how things should or should not be. This angered Seppo again, after which the conversation proceeded as shown below:

Excerpt 6 Direct: confrontation (221–229) 17.43–18.09

T2: but I hope you would realize that it's better for you

S: *why am I the only you're talking to, talk to them, they haven't said a word.*

T2: I think we're discussing things together here

S: sure, sure, sure (*making a face and producing loud nonsense syllables*)

T1: and mum and dad aren't at school, you're the one who can tell us what the school and what you yourself *(Seppo interrupts T1's sentence)*

S: sure sure (*making a face and loud nonsense syllables*)

M: Seppo! Don't interrupt!

S: sure (*making a face and loud nonsense syllables*)

Seppo's confrontational question "Why am I the only one you're talking to?" was meaningful in a context where his problems had been discussed at length. T2 attempts to neutralize Seppo's confrontational approach by offering an alternative interpretation. However, T2's words "I think we're discussing things together here" do not convince Seppo. His response "sure, sure, sure" renders the dissimilarity of his experience visible.

Discussion

This study explored how the difficulties of a family with a child diagnosed with a conduct disorder were discussed and how the child coped in situations where he was talked about. This qualitative case study applied the method of thematic analysis. The main finding was that the parents produced direct and indirect symptom-oriented talk when describing the family's difficulties. Their indirect symptom-oriented talk showed characteristics of "gossip," supporting the findings by Parker and O'Reilly (2012). Despite being present, the child was "objectified" and described in a derogatory way as an outsider. The first four sessions with the family were problem-saturated, as early sessions often tend to be (Buttny, 1996; Gonçalves et al., 2010; Robbins et al., 2003).

The parents' symptom-oriented talk was characterized by negativity, which compromised the safety of the therapy atmosphere, and contributed to a stagnated and unproductive interactive cycle. Seppo reacted to the unsafe climate by protesting the therapy in direct and indirect ways. His coping strategy was *re*active and in line with his symptomatic behavior. His indirect protest strategies were to disengage from the discussion and to produce nonsense talk. His direct coping strategies, which he deployed in situations when his emotional regulation skills failed and the adults

did not come to his aid, were blaming and confrontation. From both the systemic and negative interactional cycle perspectives, Seppo's behavior was an understandable and meaningful way of being seen and heard in an emotionally intolerable situation (Bowen, 1988; Kazdin, 1997; Kerr & Bowen, 1988). In general, young children often seem to be assigned the participant status of a nonperson (e.g., Cederborg, 1997) or half-membership (e.g., Hutchby & O'Reilly, 2010), even in family therapy sessions where no negative interactional load is present in the atmosphere.

In this case, the child's aggressiveness had brought the family into therapy and made the family's *invisible* interaction patterns visible in the "here and now" of the session, offering these for joint discussion and reflection. This analysis does not, however, explain the ways how they were dealt with during the therapy. One possible explanation is that parents are typically the therapists' main conversational partners (e.g., Hutchby & O'Reilly, 2010). This may lead some therapists to feel that if they challenge parental authority by not listening to the parents' view of the family's problems, they could lose the opportunity to help the children (Cederborg, 1997). Another explanation might be the therapeutic impasse resulting from the excessive amount of blaming between family members and the consequent anger, helplessness and frustration felt by the therapists (Tseliou et al., 2020a).

The child's unconstructive behavior offered an "acting in relation" perspective (Cecchin, 1987) for joint discussion while at the same time maintaining the therapeutic focus on the child, thereby demonstrating the validity of his parents' descriptions. Thus, the family's dysfunctional interaction pattern was allowed to continue, hampering any movement away from the stuck and unhelpful dialogue. What functionality did the participants' aggressiveness play in the family's dynamics? (Bowen, 1988; Kerr & Bowen, 1988) In this case, a polyphonic orientation and shifting away from a non-pathologizing therapeutic dialogue toward positive curiosity (Cecchin, 1987) and an empowering and resourceful dialogue (Tseliou et al., 2020b) remained for future sessions. Assuming the goal of systemic treatment is to alter interaction and communication patterns in a way that fosters more adaptive functioning (Kazdin, 1997) and new ways of relating, and thereby increasing family cohesion (see Tseliou et al., 2020a), the results of the study prompt questions about the role of diagnosis, and diagnostic, problem-oriented talk. An emphasis purely on diagnostic talk directs discussion toward a monophonic and linear mode without recognizing other empowering perspectives of family life (e.g., Cecchin, 1987).

This study supported the view that the very beginning of the therapy process, including the client's first utterances, can yield information vital to the entire therapy process (Laitila, 2016). The negative interactional pattern found in the present family system was visible from the outset. It is tempting to speculate why this pattern remained neither spoken nor

jointly reflected on (Anderson, 2012). What prevented the family members from speaking "with" instead "to" one another (Anderson & Goolishian, 1988, 1992; Anderson, 2012)? Parker and O'Reilly (2012) note that parents often have a strong stake in the process and outcomes of therapy which leads them to dominate the session and resist or question a systemic interpretation. By positioning the child as the focal point of the problem, parents, anxious to "save" face as decent parents, avoid facing up to the themes of shame and guilt (Goffman, 1999; O'Reilly, 2005). In this way they also indicate who needs to be fixed (Parker & O'Reilly, 2012).

Offering help to families with a child with a conduct and oppositional defiant disorder is not easy (Kazdin, 1997; Robbins et al., 2003). For example, family members might have stories about aggressiveness and violence that arouse guilt, shame, and pain. These stories are naturally also stories that are both difficult to tell and hear. For therapists, whose duty is to validate each family member's views while simultaneously navigating the differences between these, maintain neutrality (Tseliou et al., 2020a, 2020b) and adopt adult communication suitable for young children, helping families can be a challenging task (e.g., Cederborg, 1997; Gehart, 2007). A context judged to be unsafe leaves little room for not-yet-told stories (Rober, 2002; Rogers et al., 1999) and revealing vulnerability. Family members' acts of sabotage, resistance and confrontation can sometimes be interpreted as indicators of an unsafe atmosphere, impairing their genuine participation (Rober, 1998, 2002).

Children, like people in general, need to be heard and seen in a meaningful way (Stith et al., 1996). However, children, especially those with conduct disorders, are in danger of being interpreted through the "diagnostic lens." The presence of externalizing symptoms can obstruct the conversation being opened up to meet the child's personal concerns and needs from the child's own perspective, thereby putting at risk optimistic predictions about the child's future (Kazdin, 1997; Puustjärvi & Repokari, 2017). Children, when constructed as the central problem, are likely to take "possession" of it and align themselves with this account (Lobatto, 2002).

Despite the challenges encountered in the present case, the family did not add to the drop-out rate of families of children with external symptomology (Robbins et al., 2003). In fact, their therapy lasted several years, and the family showed commitment to the therapeutic process and achieving a good outcome. From a competence viewpoint (Hutchby & O'Reilly, 2010), the child in this case defended himself in an emotionally unbearable situation by deploying a confrontational strategy. In accusing the therapists of being "curious," "deaf," and "stupid," the child questioned the adults' ability to "understand." What the therapists failed to hear from the child's perspective remains a mystery (Cecchin, 1987; Tomm, 1987, 1988).

The present excerpts exhibit some of the challenges and pitfalls in seeking to form a balanced alliance and investigation in a case where a child with externalizing symptoms is the identified patient in family therapy. In such a situation, the adults present are tempted to keep the focus on the child, in turn hindering a dialogical approach to achieving change (Tseliou et al., 2020a, 2020b).

Implications for family therapy practice

Therapists have a responsibility for the safety of the therapeutic climate. In practice, this means that therapists should actively seek to stop blaming (Buttny, 1996) and recognize the possibilities of the common factors specific to couple and family therapies (Sprenkle et al., 2009). This can be done through 1) approaching the family's situation using relational concepts and conceptualizing difficulties in relational terms, 2) disrupting dysfunctional relational patterns, 3) expanding the direct treatment system, and 4) expanding the therapeutic alliance so that the diagnosed child can be seen as a child with functional abilities. It is noteworthy that an expanded therapeutic alliance includes not only the emotional bond or connection between therapist and client but also the shared understanding of goals and tasks (Sprenkle et al., 2009; Tryon & Winograd, 2011). This calls for the inclusion of children in discussions on the family's therapeutic goals and activities.

When helping families to discard dysfunctional or otherwise harmful interactional patterns, therapists should simultaneously encourage and assist self-observation by family members (Leiman, 2012), thereby enabling them to compare different contexts of problematic behavior and adopt non-pathologizing constructions of problems that emphasize positives and strengths (e.g., Tseliou et al., 2020a, 2020b). Safety and trust in the therapeutic relationship, enabling clients to express themselves without fear of criticism and explore new ways of thinking and being is a precondition for therapeutic change (Tseliou et al., 2020a, 2020b). Therefore, in the therapy room, therapists have a professional responsibility to set the rules for appropriate conduct. On the other hand, clients are known to consider that the therapist's role of challenging and even confronting them, when needed, is important (Tseliou et al., 2020a). It is recommended that the boundaries to be set in the therapy context are discussed with clients early on, since this helps in defining the responsibilities of each party in the process. With children, especially, discussion should be done firmly but gently. Protecting children from exposure to harmful narratives must be a priority (Rober, 2002). Circular questioning (Palazzoli Selvini et al., 1980; Tseliou et al., 2020b) or reflexive questions (Tomm, 1988, Tseliou et al., 2020a, 2020b) could also contribute to balancing the investigation and offering each participant an opportunity for being noticed.

Direction for future research

This case study enriches understanding of the immediate therapeutic challenge therapists face with high-risk families, such as families with conduct disorder-diagnosed children, right from the beginning of the treatment. The results of this case study can be generalized to the therapeutic models used to treat children's challenging behavior in the family therapeutic setting. Further research could investigate the therapeutic processes of families with children diagnosed with conduct disorders and change in their personal and joint narratives. To better identify the factors promoting successes in family therapy, this should be done in cases with good and poor treatment outcomes.

Ethics

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

ORCID

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

References

Ackerman, N. (1970). Child participation in family therapy. *Family Process*, *9*, 403–410.

Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of Personality and Social Psychology*, *102*(2), 367–389. https://doi.org/10.1037/a0025289

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., & Goolishian, H. (1988). Human systems as linguistic systems: preliminary and evolving ideas about the implications for clinical theory. *Family Process*, *27*(4), 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.

Avdi, E. (2015). Discourses of development in the consulting room: Analysing family therapy with children. *Feminism & Psychology*, *25*(3), 363–380. https://doi-org.ezproxy.jyu.fi/10.1177/0959353514564196

Avdi, E., Lerou, V., & Seikkula, J. (2015). Dialogical features, therapist responsiveness, and agency in a therapy for psychosis. *Journal of Constructivist Psychology*, *28*(4), 329–341. https://doi-org.ezproxy.jyu.fi/10.1080/10720537.2014.994692https://doi.org/10.1080/10720537.2014.994692

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy*, *16*(3), 252–260. http://dx.doi.org.ezproxy.jyu.fi/10.1037/h0085885https://doi.org/10.1037/h0085885

Boszormenyi-Nagy, I., & Framo J. L. (Eds.), (1965). *Intensive Family Therapy*. New York: Harper & Row.

Bowen, M. (1988). *Family therapy in clinical practice*. Jason Aronson.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bruner, J. S. (1977). Early social interaction and language acquisition. In H. R. Schaffer (Ed.), *Studies in mother-infant interaction* (pp. 271–290). Academic Press.

Buttny, R. (1996). Clients' and therapists' joint construction of the clients' problems. *Research on Language & Social Interaction*, *29*(2), 125–153. https://doi.org/10.1207/s15327973rlsi2902_2[Mismatch] https://doi-org.ezproxy.jyu.fi/10.1207/s15327973rlsi2902_2

Carr, A. (2016). How and why do family and systemic therapies work?*Australian and New Zealand Journal of Family Therapy*, *37*(1), 37–55. https://doi.org/10.1002/anzf.1135

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. *Family Process*, *26*(4), 405–413. https://doi.org/10.1111/j.1545-5300.1987.00405.x

Cederborg, A.-C. (1997). Young children's participation in family therapy. *The American Journal of Family Therapy*, *25*(1), 28–38. https://DOI:10.1080/01926189708251052

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.

Goffman, E. (1999). On face-work: An analysis of ritual elements in social interaction. In A. Jarowski & N. Coupland (Eds.), *The discourse reader* (pp. 306–320). Routledge.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L. E., & Greenberg, L. S. (2010). Innovative moments and change in emotion-focused therapy: The case of Lisa. *Journal of Constructivist Psychology*, *23*(4), 267–294. https://doi.org/10.1080/10720537.2010.489758

Fine, G. (1986). The social organization of adolescent gossip. The rhetoric of moral evaluation. In J. Cook-Gumperz, W. Corsaro, & J. Streeck (Eds.), *Children's worlds and children's language* (pp. 405–423). Mouton de Gruyter.

Friedlander, M. L., Escudero, V., Heatherington, L., & Diamond, G. M. (2011). Alliance in couple and family therapy. *Psychotherapy*, *48*(1), 25–33. https://doi.org/10.1037/a0022060

Hawley, K., & Weisz, J. (2003). Child, parent, and therapist (dis)agreement on target problems in outpatient therapy: The therapist's dilemma and its implications. *Journal of Consulting and Clinical Psychology*, *71*(1), 62–70. https://doi.org/10.1037/0022-006X.71.1.62

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

Hutchby, I. (2002). Resisting the incitement to talk in child counselling: Aspects of the utterance 'I don't know'. *Discourse Studies*, *4*(2), 147–168. https://doi.org/10.1177/1461445602004002020l

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. (1993). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology*, *5*(1-2), 277–310. https://doi.org/10.1017/S0954579400004399

Kazdin, A. E. (1997). Practitioner review: Psychosocial treatments for conduct disorder in children. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *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.

Kellam, S. G., Ling, X., Merisca, R., Brown, C. H., & Ialongo, N. (1998). The effect of the level of aggression in the first grade classroom on the course and malleability of aggressive behavior into middle school. *Development and Psychopathology*, *10*(2), 165–185. https://doi.org/10.1017/s0954579498001564

Kerr, M. E., & Bowen, M. (1988). *Family evaluation*. Norton.

Laitila, A. (2016). Introducing novelties into therapeutic dialogue: The importance of minor shifts of the therapists. In M. Borcsa, P. Rober (Eds.), *Research perspectives in couple therapy* (pp. 31–46). Springer International Publishing. https://doi.org/10.1007/978-3-319-23306-2

Leiman, M. (2012). Dialogical sequence analysis in studying psychotherapeutic discourse. *International Journal for Dialogical Science*, *6*(1), 123–147.

Lobatto, W. (2002). Talking to children about family therapy: A qualitative research study. *Journal of Family Therapy*, *24*(3), 330–343. https://doi.org/10.1111/1467-6427.00221

Miller, G. E., & Prinz, R. J. (2003). Engagement of families in treatment for childhood conduct problems. *Behavior Therapy*, *34*(4), 517–534. https://doi.org/10.1016/S0005-7894(03)80033-3

Miller, L. D., & McLeod, E. (2001). Children as participants in family therapy: Practice, research, and theoretical concerns. *The Family Journal*, *9*(4), 375–383. https://doi.org/10.1177/1066480701094004

Nelson, T. S., Fleuridas, C., & Rosenthal, D. M. (1986). The evolution of circular questions: Training family therapists. *Journal of Marital and Family Therapy*, *12*(2), 113–127. https://doi.org/10.1111/j.1752-0606.1986.tb01629.x

O'Reilly, M. (2005). 'What seems to be the problem?' A myriad of terms for mental health and behavioural concerns. *Disability Studies Quartely*, *25*(4). https://doi.org/10.18061/dsq.v25i4.608 10.1177/1461445606064835

Palazzoli Selvini, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing – circularity – neutrality: Three guidelines for the conductor of the session. *Family Process*, *19*(1), 3–12. https://doi.org/10.1111/j.1545-5300.1980.00003.x

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. https://doi.org/10.1177/1461445612452976

Puustjärvi, A., Repokari, L. (2017). Lasten käytöshäiriöihin tulee puuttua ajoissa. *Lääkärilehti*, *21*, 1364–1367. Summary in English. http://www.potilaanlaakarilehti.fi/site/assets/files/0/14/80/338/sll212017-1364.pdf

Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: individual and systemic effects. *Journal of Family Psychology 17*(4), 534–544. https://doi.org/10.1037/0893-3200.17.4.534

Rober, P. (1998). Reflections on ways to create a safe therapeutic culture for children in family therapy. *Family Process*, *37*(2), 201–213. https://doi.org/10.1111/j.1545-5300.1998.00201.x

Rober, P. (2002). Some hypotheses about hesitations and their nonverbal expression in family therapy practice. *Journal of Family Therapy*, *24*(2), 187–204. https://doi.org/10.1111/1467-6427.00211

Rogers, A. G., Casey, M. E., Ekert, J., Holland, J., Nakkula, V., & Sheinberg, N. (1999). An interpretive poetics of languages of the unsayable. In R. Josselson & A. Lieblich (Eds.), *Making meaning of narrative* (pp. 77–106). Sage.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, *30*(2), 113–130. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

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*(1), 69–86. https://doi.org/10.1111/j.1752-0606.1996.tb00188.x

Theodor, L. A. (Ed.) (2017). *Handbook of evidence-based interventions for children and adolescents*. Springer Publishing Company.

Tomm, K. (1987). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, *26*(2), 167–183. https://doi.org/10.1111/j.1545-5300.1987.00167.x

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions? *Family Process*, *27*(1), 1–15. https://doi.org/10.1111/j.1545-5300.1988.00001.x

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. *Psychotherapy*, *48*(1), 50–57. https://doi.org/10.1037/a0022061

Tseliou, E., Burck, C., Forbat, L., Strong, T., & O'Reilly, M. (2020a). 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:10.1111/famp.12562

Tseliou, E., Burck, C., Forbat, L., Strong, T., & O'Reilly, M. (2020b). The Discursive performance of change process in systemic and constructionist therapies: A systematic meta-synthesis review of in-session therapy discourse. *Family Process*, 1–22. https://doi.org/10.1111/famp.

von Sydow, K., Retzlaff, R., Beher, S., Haun, M. W., & Schweitzer, J. (2013). The efficacy of systemic therapy for childhood and adolescent externalizing disorders: A systematic review of 47 RCT. *Family Process*, *52*(4), 576–618. https://doi.org/10.1111/famp.12047

Wolpert, M., & Fredman, G. (1994). Modelling the referral pathway to mental health services for children. *Association of Child Psychology and Psychiatry: Newsletter*, *16*, 283–288.

Yin, R. (2003). *Case study research. Design and methods*. Sage.

II

"CAN I TELL?" CHILDREN'S PARTICIPATION AND POSITIONING IN A SECRETIVE ATMOSPHERE IN FAMILY THERAPY.

by

Mira Helimäki, Aarno Laitila, & Kirsti Kumpulainen 2021

Journal of *Journal of Family Therapy*, 0 (1-2), 1-28.

https://doi.org/10.1111/1467-6427.12296

journal of
family therapy

Journal of Family Therapy (2020) **0**: 1–2
doi: 10.1111/1467-6427.12296

'Can I tell?' Children's participation and positioning in a secretive atmosphere in family therapy

Mira Helimäki [a], Aarno Laitila[b] and Kirsti Kumpulainen[c]

As a multifaceted phenomenon, family secrets affect interaction in the therapeutic system. This qualitative study, applying the multi-actor *Dialogical Methods for Investigations of Happening of Change*, explored how children participated and positioned themselves in family therapy in a climate of family secrets. The results showed that the children were active co-participants in the complex dynamics of a secretive atmosphere, involving themselves in the paradoxical processes of reconstructing and deconstructing the secretive and unsafe climate. In family therapy, a child's symptomatic behaviour can function as a visible 'cover story' for invisible constructions of secrets, preventing sensitive topics from becoming the focus of therapy. Family secrets therefore continue to present a challenge in family therapy practice and research.

Practitioner points

- Family secrets should be asked about in pre-therapy assessment and diagnostic interviews where all family members are present
- The genogram enables the exploration of multigenerational family patterns and functions that might be influenced by family secrets
- By normalising the phenomenon of family secrets, therapists could make room for joint discussions on these and encourage family members to talk about their good reasons for keeping secrets

Keywords: children's positioning; family secret; family therapy; systemic interaction

Introduction

All families have their secrets (Knauth, 2003; Tracy, 2015). As a normative phenomenon, secrets do not automatically refer to something pathological. Keeping a secret might be indicative of a collective denial

[a] Doctoral student, Department of Psychology, University of Jyväskylä, Jyväskylä, Finland
Email: mhelimaki@gmail.com.
[b] University Lecturer, Department of Psychology, University of Jyväskylä
[c] Emerita Professor of Child Psychiatry, University of Eastern, Finland

that manifests itself in the family as functional. In the family therapy tradition, family secrets refer to topics charged with intense fear, shame and guilt. If the secret becomes taboo, inhibiting dialogue and distorting the adaptability and development of the family system, it becomes problematic (Simon *et al.*, 1985), affecting the dynamics of the family unit as an emotional and relationship system (Bowen, 1978; Vangelisti and Caughlin, 1997) and challenging the task of family therapists (Deslypere and Rober, 2018). In family secrets, the information that is withheld is considered to be critical to the ones from whom the information is concealed, because it has an effect on his or her life (Berger and Paul, 2008; Vangelisti and Caughlin, 1997). Qualitative research is needed to increase an understanding of the complexity of the phenomenon of a family secret and its systemic and multi-directional effects on family members. In this study, our interest was in how children position themselves in relation to the topics kept secret and how they cope in these demanding situations.

Secrets define boundaries telling us who is in and who is out (Imber-Black, 1993). From a systemic perspective, secrets affect all the participants involved in the therapy process. Secrets lead to collusion, psychological distancing, reduced trust, compromised communication and dissatisfaction and to unbalanced family loyalties (Dreman, 1977; Imber-Black, 1998; Vangelisti and Caughlin, 1997). The family as an emotional and relationship unit functions in ways that reflect each family member's thoughts, feelings and behaviour. As all parts of the system are interconnected, no individual functions in a vacuum; instead, each individual responds to the other individuals and contributes to the integrity of the system (Bowen, 1978; Kerr and Bowen, 1988). Secrets in families can become multigenerational phenomena, transferred as rules of communication, delegations or legacies, which can carry and mediate complicated loyalty bond structures. Some stories can, for example, run in families as forbidden topics, or a family member can be determined to fulfil some predetermined duty or task (Stierlin, 1977a, b).

On the individual level, secret-holders experience tension, loneliness and stress-related physical health problems (Kelly, 2002). Maintaining secrecy binds psychic energy, causing holders confusion and anxiety, and affects communication within the family, leading eventually to family dysfunction (Imber-Black, 1998; Karpel, 1980; Vangelisti and Caughlin, 1997). Family secrets may hinder the natural growth of a child's individuation process. Even secrets kept with the best intentions (protection) can negatively affect a family's interactional patterns (Bowen, 1978; Imber-Black, 1998; Stierlin, 1977b). Those kept unaware of a secret

try to deal with distorted communication practices, and may develop self-doubt, suspicion, fear and anxiety, eating disorders, and negative psychological functioning later in life (Imber-Black, 1998). The typical mechanism used to maintain secrets is topic avoidance. Berger and Paul (2008) showed that there is an inverse relationship between topic avoidance and family functioning. They found that, especially among mothers, general topic avoidance was the strongest predictor of family functioning, whereas parental joint disclosure predicted the highest level of functioning. Three distinct motivation categories relating to topic avoidance have been identified: *relationship-based*, *individual-based* and *information-based* (Afifi and Guerrero, 2000; Berger and Paul, 2008; Golish and Caughlin, 2002). The first refers to the need to maintain a close relationship and protect it from, for example, conflict and anger; the second focuses on self-protection; and the third is motivated by the desire to convey information in a clear and relevant way.

Family secrets include a wide range of topics in family life. Negative past experiences, adoption and infertility (Berger and Paul, 2008), alcoholism, extramarital affairs, and traumas such as suicide, physical and mental illness and death are typically veiled in secrecy (Imber-Black, 1993). Protecting children from sensitive and 'toxic' secrets (Imber-Black, 1998), for example in cases of violence taking place inside the family, is understandable. However, it is known that children, as the barometers of the family climate, are especially vulnerable when faced with an aura of secrecy as their self-regulation skills are still evolving. Children also differ in their reactions. Internalising behaviour may manifest as depressive symptoms and externalising behaviour as problem behaviour (Bowen, 1978). Dreman (1977) and Baird (1974) found that a child may become the scapegoat and symptom bearer of a secretive family communication system in which the secretive communication is intertwined with an aggression problem resulting from an inability to deal effectively with anger.

The concept of family secret focuses 'one-sidedly' on its negative effects and thus fails to capture the complex nature of secrecy. The concept of *selective disclosure* offers an alternative approach to this complexity, pointing to the dialectic tension between what is said and not said, between keeping the secret and sharing information (Rober *et al.*, 2012). On the assumption that dialogue is a precondition for positive change in any form of therapy (Seikkula and Trimble, 2005), *selective disclosure* as a dialogical concept has earned its place in family therapy practice. The aim of a dialogical approach is not to induce or pressure open disclosure but rather to invite reflection on the meanings family members attribute to their hesitation and silences (Rober, 2002). From

focusing only on the promotion of 'openness', this approach has shifted the focus towards highlighting the complexity of the dialectical tension between openness and closedness (Baxter, 2011). In the therapeutic conversation, clients are constantly selecting what to tell and what to keep silent about. Rather than focusing on the content of the unspoken story, the therapist should invite family members to talk about the *good reasons* behind their decision.

Some stories that might be relevant in the therapeutic dialogue are too difficult to tell (Rober, 2002). The decision to tell a sensitive story needs to be weighed against the emotional impact it may have on vulnerable family members (Rober and Rosenblatt, 2013.) Some stories remain untold because the context of the conversation is judged to be unsafe (Rober, 2002). The client's silences and hesitations are important information to a therapist and become a therapist's main tools to work within systemic therapy. It is also important to keep in mind that secrets in families are not necessarily toxic; sometimes they serve to create a story that family members can live with (Rober and Rosenblatt, 2013).

The therapist's task is to listen to the client's stories and help to open up a space for the not-yet-said (Anderson and Goolishian, 1988). In the case of family secrets, the task is demanding, given that secrets evoke powerlessness, uncertainty, and even anger. Moving too fast often results in clients closing up and recanting their story or breaking off the therapy (Deslypere and Rober, 2018). A genuinely respectful dialogical approach creates a context in which clients feel that it is safe to tell their sensitive stories (Rober, 2002). This calls for therapists to tolerate uncertainty in a way that can help provide the safety that enables family members also to tolerate uncertainty (Seikkula and Olson, 2003). Tolerating situations in which no ready-made responses exist and taking a not-knowing stance challenges the therapist's role as an expert (Anderson, 1997). In a state of not-knowing, therapists stay in touch with the complexity, uncertainty and unfinalisability of the situation and thus expose themselves to a multiplicity of voices in their inner conversations (Rober, 2002).

Language (spoken and unspoken communication) acquires its meanings through careful attention to *how* it is uttered. Aristotle in *Peri Hermeneias* (De Interpretatione and Categories, 1975) formulated his idea that outer and inner words are not identical, stating that every sentence is only an interpretation of one's thought. In practice, to understand 'you', it is not enough to understand 'your' words. It is also crucial to grasp meaning, thought and motivation (Vygotsky, 1971, p. 151). The only way to do this is to listen to what the other has to say. Harlene Anderson

(1988, 2001, 2012) described family therapy as a meaning-generating system where people participate in an 'in-there-together process'. Meanings are generated in an inter-relational context, through the fluid process of give and take, which by its nature is dialogic. In dialogue, meanings and understandings are jointly constructed. The listener's active presence is what distinguishes dialogue from monologue (Bakhtin, 1986). In dialogue, every utterance needs to be answered. Answering does not mean giving an explanation or interpretation, but rather demonstrating in one's response that one has taken note of what has been said. Hearing is always demonstrated in our answering words (Seikkula *et al.*, 2012). According to Bakhtin, 'For the word there is nothing more terrible than a lack of response' (Bakhtin, 1975, p. 127). Although a key principle in family therapy is that children's perspectives are heard (Strickland-Clark *et al.*, 2000), it is obvious that sessions are typically constructed by adult-led talk and conversation. To hear children's voices means engaging them as full members of the therapeutic dialogue, as participants who have important things to say. The process of engaging children has been found to be challenging. Willis, Walters and Crane (2014) showed that typically children were passive participants and excluded from much of the therapy dialogue. Hutcby and O'Reilly (2010) and Parker and O'Reilly (2012) found that children tend to occupy an unequal position, described as 'half-membership status', in adult interactions. Half-membership status refers, for instance, to the position of the child as the talked-about other (Parker and O'Reilly, 2012) and as being interrupted (O'Reilly, 2008). Positioning refers to the question 'from where is the person speaking?' (Hermans, 2006; Seikkula *et al.*, 2012).

The aims of the study

The objective was to study how children participate and position themselves in episodes concerning secretive topics in family therapy sessions and how they cope in these situations. We also investigated how therapists and parents responded to children's initiatives in talking about sensitive or forbidden topics. Qualitative research on family secrets in family therapy is scarce. This small-scale study contributes to answering this need.

Data

The research data consisted of video-taped family therapy sessions held at Kuopio University Hospital Child Psychiatry Clinic. The research

material forms part of a larger family therapy research project on the fourteen families of children aged 6 to 12 years diagnosed with oppositional defiant or conduct disorder. All participants gave their informed consent to take part in the study and the research plan was approved by ethical committee of Northern-Savo Health Care District. One of the therapeutic processes was selected for further study owing to its distinctive feature of family secrets concerning multigenerational traumatic losses. This family therapy process comprised fifteen sessions, each varying in duration from 55 minutes to 1 hour 47 minutes, conducted over a one-year period. For a closer study, the first author selected three distinct types of family therapy session: (1) an at-home implemented genogram workshop (4th), duration 1 hr 37 mins; (2) a network meeting at the child psychiatry clinic (11th), duration 1 hr 43 mins; and (3) an at-home implemented session (13th), duration 60 mins.

The family consisted of (pseudonyms) Jane (mother), Brian (father) and 9-year-old Mark and his younger sister, 8-year-old Clara. They are identified in the excerpts by the abbreviations J, B, M, C. The sessions were conducted by two family therapists, T1 and T2. The therapeutic approach was systemic with elements of structured games and interactive tasks.

Methods and procedure

This study applied the multi-actor *Dialogical Methods for Investigations of Happening of Change* (DIHC) (Seikkula *et al.*, 2012). Before the analysis, three videotaped sessions dealing with the theme of secrecy in the family were transcribed in full by the first author. Non-verbal information was also taken into account. The accuracy of transcription was planned to meet the needs of DIHC with an emphasis on the verbal content, without prosody. The analysis was made in Finnish, the participants' native language, in order to capture all the nuances of speech. The translation process into English was done by the native English speaker, who has lived in Finland for a long time. The meanings of translations were, however, negotiated together with the first author. The analysis was carried out by the first author and the second and third authors acted as supervisors, and as the auditors of the analysis. After the authors' careful reading, the research proceeded in the following steps. (1) Episodes defined as topical were explored. A change of topic was considered a new episode. The episodes concerning family secrets were chosen for microanalysis. (2) The responses to each utterance were noted to gain a picture of how each interlocutor participated in the

construction of the joint conversation. In this study, the concepts used to analyse 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. (3) In this step, the narrative process coding system was followed (Angus *et al.*, 1999; Laitila, 2016; Laitila *et al.*, 2001). The analytical tools used were concepts such as *external process mode*, referring to descriptions of things that have happened, *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. (4) After analysis of the *response categories*, the focus shifted to the interlocutors' *voices, addressees and positioning*. *Voices* refers to the speaking consciousness (Bakhtin, 1984) that becomes visible in exchanges between interlocutors in the context of the storytelling currently taking place. *Positioning* links a voice with a participant's point of view. *Addressees* are the persons to whom an utterance is addressed. In analysing multi-actor dialogues, addressees are not always easy to identify. Speech can be also 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 are presented partly in narrative form, following the chronology of therapy sessions (Braun and Clarke, 2006).

Analysis and results

The results of the analysis presented in this paper focus on two topical episodes concerning the family's secrets, one relating to the past and the other to the present. The results concerning the secret of an uncle's suicide (past) is presented first, but only in analytic narrative form. The second analysis concerns the mother's health (present) and is presented in detail and in full in Table 1. The transcriptions in the tables are presented according to the following principle: first the original Finnish data is presented, then follows the English translation in italics and in parentheses.

Case history

Mark's family had been referred to the child psychiatric clinic due to Mark's aggressive behaviour and he had been diagnosed with a conduct disorder.

TABLE 1 *Sequence 1: Jane mother (J), Clara (C), Mark (M) and therapists 1 (T1) and 2 (T2), session 13, topical episode 2 (Lines 25–75 Minutes 2.13–4.40)*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
	Kuunnellaan nyt äitiä (*Let's listen to the mother*)				Interactional dominance	Addresses C in the first instance but also the others. Position of making room for mother's speech
Joo. Vaikea viikko niinku suhteessa mihin asiaan? (*Yes. Difficult week…in what sense?)*					Dialogical dialogue. Responds to T2 and the theme of 'difficult week', a topic previously mentioned by the mother	Addresses J. Positions self as listening and curious to hear more. Makes room for her talk.
		Perheeseen, terveyteen, työhön (*In relation to the family, health, job*)			Dialogical, semantic dominance. Responds T1	Addresses T1 + T2. Dual position of revealing and concealing. Voice of secretiveness and suggestive- ness
				Mä en tarvii terveyttä (*I don't need any health*)	A blend of dialogical and monological modes. Dialogical in that the utterance responds to the theme of health, monological in that it does not invite other interlocutors to contribute	Addresses his mother and her multigenerational relatives. Positions self to shift attention to himself and rescue his mother from having to talk about a sensitive topic. His self-positioning also challenges his mother and given delegation. The voice of defiance is suggestive, concealing more than it reveals
		Mitä? (*What?*)			Responds to M Dialogical	Positions self as 'astonished', a bit irritated, position of a mother used to obedient behaviour on the part of her son

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
Äitin vuoro kertoo perheen kuulumiset.. perhe, työ, terveys					Interactional dominance by making room for mother's talk and silencing M's positioning of self as defiant	Addresses M. Pedagogical voice. Positions self as restricting others
(*It is mother's turn to tell us what's up…family, job and health*)					Dialogical response to mother's topic of a 'difficult week'	Addresses M. Positions self as one who returns to the topic of the mother's storytelling. Voice of neutralising a tense climate
		Hmmm			Responds to T1 + M	
Minkälaisia asioita siitä nousee sulla mieleen? (*What kind of things do they make you think of?*)					Dialogic. Responds to J, encouraging her to say more on the theme	Addresses J. Positions self as one who is interested in listening more
		Lasten kuullen en viitsi enempää (*In the presence of the kids I don't want (to say) more*)			Responds to T1 + T2 + M?	Positions self as one who selects what to say. Voices of secrecy, hesitation and protectiveness The addressees of the mother's inner voice are her multigenerational relatives/generalised other
Joo, okei (*I see, ok*)					Responds to mother with acceptance	Positions self as understanding J's point of view
		Niille tulee enemmän.. (*Otherwise, they will have/get more…*)			Responds to T1 + T2	Positions self as mother who protects her kids from unpleasant things. Voice of suggestiveness and secretiveness. Addressees of her inner voice are her multigenerational relatives/generalised other

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
			Minä tiiän mikä äitillä on (*I know what's wrong with my mum*)		New initiative. Address to all participants, especially T1 Dialogical Semantic dominance	Positions self as active, protesting against being positioned as excluded. Voice of one who knows what her mother is trying to keep unsaid
No sulla on joku aavistus no… sä voit äitiltä kysyä sit ja äiti sit varmaan sanoa nii et kysy vaan (*Well, you might take a guess, well, you can ask your mother about it and she can probably tell you, so please ask*)					Dialogical, Semantical and interactional dominance, responds to C's initiative and encourages C to continue dialogue on the theme with her mother	Positions self as one who encourages daughter and mother to discuss theme. Voice of taking seriously what C said but moderates C's certainty about knowing what her mother's problem is
		Saat sä nyt sanoo jotain, mut.. (*You can say something, but..*)			Responds to C	Voices of balancing between openness and closeness, uncertainty and hesitation. Positions self as hesitant about whether it is safe to talk. The addressees of her inner voice are her multigenerational relatives
			Saaks' sanoo kaikki? (*Can I tell everything?*)		Responds to theme of asking and telling. Dialogical	Addresses all present including herself and her mother's multigenerational relatives. Adopts position of ambivalence (loyalty vs. openness) and positions herself as not really knowing what she was asking for when requesting licence to talk. Ambivalent voices of courage, insecurity and hesitation, trying to ensure whether is it safe to talk, assessing mother's emotional reaction

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
		Mmm			Responds to C and T1 + T2	Position of hesitation. The addressees of her inner voice are her multigenerational relatives
			Jee…äitiä on pyörryttänyt (*Jeee… Mum has been dizzy*)		Semantic dominance. Monological. External process mode	Addresses all present including herself plus the mother's multigenerational relatives not at present. Positions self as ambivalent. On the one hand relieved to talk and on the other afraid of what to say. Ambivalence about revealing sensitive information conveyed with artificial, upbeat voice
	Maha on ollu kippee? (*The stomach's been aching..?*)				Dialogical, even it is T2's own interpretation of situation. It however invites J to particularise what C is referring to	
			Ja se on hyppiny sohvalla kun sitä on pyörrytti (*And she has been jumping on the sofa, while being dizzy*)		Semantic dominance. Monological. External process mode	Address to T1 + T2+M Positions self as active informant. Voices her licence to talk
		Nii että toisin sanoen on kouristanut pahasti (*Well, in other words there have been ugly spasms*)			Responds to T1 + T2. Internal process mode	Positions self as ambivalent, revealing and concealing. Voice of suggestiveness and secretiveness

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
Joo (*Yes*)	Joo (*Yes*)				Responds to J + C	Position themselves as showing that they hear but need more information. Voices of hesitation
			Äiti joutu sairaalaan ja sit siltä lähti ajokortti niin se ei nyt äiti voi ajaa autolla (*Mom was sent to hospital and she lost her driving licence and now she can't drive the car*)		Semantic dominance. Monological External process mode	Positions self as active informant. What C tells and how she tells it are inconsistent: internal mode is lacking
Hmm	Hmmm				Responds to the all participants	Positions self as confused and evaluative
				Miksi sä sitten meijät ajoit risteykseen? (*Why did you anyway drive us to the crossroads?*)	New initiative Dialogical. Responds to C's utterance about J's driving licence	Addresses J. Positions self as challenging his mother's choice of action. Voice of challenge
		Jotkut asiat on pakko tehä muuten ei (*There are things that need to be done, otherwise..*)			Responds to M. External process mode	Positions self as defensive. Voice of one who carries responsibility for everyday tasks in family. Addresses all participants

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
			Isi ei oo kotona (*Daddy is not at home*)		Semantic dominance New theme of father's absence	Positions self as her mother's protector. Voice of sensitiveness to her mother's talk
		Meni työt ynnä muut tässä kaikki nii (*I lost my job plus all as well*)			Dialogical. Responds to the theme, why it has been difficult week. External process mode	Positions self as having lost agency. Voices of secretiveness and suggestiveness. Balances between openness and closedness
Joo (*Yes*)					Responds to J	Positions self as understanding
	Niin ootko sä nyt kotona? (*So, are you now at home?*)				Responds to J Dialogical	Positions self as seeking to make things more concrete and visible. Voice of normalization
		Mmm (raising her hands)				Addresses T1 + T2. Positions self as uncertain and embarrassed
			Se on työtön (*She's unemployed*)		Responds to T1 Monological	Positions self as knowledgeable
		En tiedä (*I don't know*).			Responds to T1	
Joo (*Yes*)					Responds to J	Positions self as understanding the bizarre situation
	Ainakin nyt tänä päivänä (*At least today*)				Responds to J's uncertainty drawing attention to what can be known at that moment Dialogical.	Positions self as neutralizing/stabilizing and paying attention to the facts at hand

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
		Mmm				Voice of accepting the response
			Ja jos äitille niinku huutaa ja kiljuu niin äitiltä saattaa katketa verisuoni.. olikse sillee.. oliko? (*And if we yell and shout at mum, she might break a blood vessel, am I right? Am I?*)		New initiative. Semantic dominance. External process mode Dialogical	Positions self as active informant who wants to talk about the sensitive theme of her mother's health. Voice of insecurity. Addresses
Jos äiti suuttuu sille.. (*If your mother gets angry, she…*)					Responds to C	Addresses to C Positions self as curious
			Oliks se sillee? (*Am I right?*)			Address to her mother. Position of the one who needs the answer to be relaxed
		Äiti ei sais oikein hermostua mistään (*Mother* (refers to herself) *is not allowed to get upset*)			Responds to C Semantic dominance bringing the new theme of getting upset	Positions self as needing to be protected from getting upset. Voices of warning, meaning please, be kind to mother' and of suggestiveness and secretiveness. The addressees of her inner voice are her multigenerational relatives

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
Okei, joo…pystyiskö sitä tota mmm vähän silleen niinku avaan sen verran että mitä niinku silleen ja mehän voitais… mitä sää aattelit sovittaisko me joku semmonen aika sulle tonne vaikka niinku…erillinen aika et voitais (*Ok, well.. is there any way… possibly to open the theme a bit… sort of that much… what do you think about it.., we could for instance arrange a separate meeting for you so that we could…*)					Starts in dialogical mode encouraging J to open up the theme, but after hesitation switches to mode that suggests excluding the children from the joint discussion T1 responds to the secretive and emotionally difficult atmosphere with a solution-based alternative Interactional dominance	Shifts towards a new topical episode of arranging a new appointment. Positions self as balancing the importance of talking about what is really going on and taking seriously the mother's wish not to talk about the topic, when the children are present Voices of confusion, uncertainty and negotiation
		Mä en voi tulla sinne. mulla ei ole kyytiä (*I can't come… I don't have transport*)			Responds to T1 Monological	Positions self as irritated and frustrated. Voice of 'can't you hear, what I was just telling you?'

The therapists asked J, whether B could bring her to the appointment at the clinic. J rejected the proposal, appealing to the difficulty of making practical arrangements regarding Brian's shifts at work.

TABLE 1 *Continued*

T1	T2	J	C	M	Response category	Voices, addressees, positioning
	No entäs se seuraava kotikäynti vaihetaanko se sillee et lapset olisivat koulussa? (*Well, what about the next meeting at home, shall we change to a time when the kids would be at school*)				Dialogical, responds to T1's suggestion of making a new appointment and takes mother's response into account. Suggests new practical alternative that would simultaneously exclude the children	Address to the mother and T1 Positions self as wanting to create space for the mother's private story.
			EI! (*NO!*)		Responds to T1 + T2+J	Positions self as protesting against exclusion from conversation. Addresses all

He had spoken of having thoughts of suicide and this also occurred in the process of therapy. Mark's younger sister Clara suffered from internalising symptoms, was problematically dependent on her mother and had fears and sleeping problems. In recent years, the family had experienced multigenerational traumatic losses (the suicides of the children's uncle and grandmother) that had remained unspoken due to their sensitive nature.

The secret of the uncle's suicide

In the fourth session, the therapists suggested to the family that they attend a genogram workshop in order to study the family histories of both the parents over the period of three generations. This proved effective in getting the children to examine their complex family patterns, relational resources, significant events, and losses. The genogram offered them the possibility to approach hidden, unspoken themes. Both children positioned themselves as active on the topic of their uncle's death. Clara took the initiative by informing the therapists that her mother's brother had died. Mark, who posed several questions, wanted to know how it had happened. The therapists' role was to balance the needs of the children and those of their mother. Using non-verbal body language (gestures), the mother indicated the difficulty she had in talking about the topic and answering Mark's questions. T2 assumed the role of negotiator. She tried to encourage the mother to disclose something, however small. The mother's reply was ambiguous, simultaneously opening and closing the topic. It was *open* in that she stated that the theme was a difficult one but *closing* in that she stated that answering 'would have serious consequences'. The mother's good reason for remaining secretive can be viewed understandably as protective; however, from a dialogical perspective it tied the hands of the therapists, categorised the topic as dangerous, as taboo, and thus reconstructed the secretive atmosphere around it.

The secretive atmosphere surrounding the mother's wellbeing

The thirteenth session started in the family's kitchen in an aura of secrecy. Mark and Clara were lying at the fireside. As a result of therapists routinely asking family members to complete in-session feedback forms at the beginning of the session, with the aim of tracking and focusing the intervention, T1 had noticed that the mother's self- evaluated wellbeing scores were exceptionally low. As is usual in therapeutic conversational contexts where multi-actors are present, several themes were competing for selection and attention. These included Clara's question to T1 and T2 about when the family could visit the child psychiatric clinic again,

Mark's defiance about attending school that day and the alarming observation concerning the deterioration in the mother's wellbeing. The therapists decided to focus on the last of these. T1's 'let's listen to mother' was the starting point for the microanalysis of the topical episode.

Mark's and Clara's self-positioning

Mark and Clara reacted differently to the secretive atmosphere. Mark positioned himself in accordance with his diagnosis, as the following excerpt illustrates. The mother had just said that 'it has been a difficult week and troubled times' and the therapists were interested to learn more about those things.

Lines 27–28 Minutes 2.13–2.15
The mother (J), Mark (M)

T1	T2	J	C	M	Response category	Addressee, positioning, voices
		Perheeseen, terveyteen, työhön (*In relation to family, health, job*)			Dialogical, semantic dominance. Response to T1	Addresses T1 + T2. Dual position of one who reveals and conceals. Secretive and suggestive use of voice
				En minä tarvii terveyttä (*I don't need any health)*	A blend of dialogical and monological modes. Dialogical in that it responds to the theme of health, monological in that the utterance does not invite other interlocutors to contribute	Addresses his mother and her multigenerational relatives. Positions self so as to shift attention to himself and rescue his mother from having to talk about a sensitive topic. His self-positioning also challenges his mother and given delegation. The voice of defiance is suggestive, concealing more than it reveal

Mark's 'I don't need any health' is significant in the conversational context in which the therapist's 'difficult week, in what sense?' had just invited Mark's mother to explain her response. Mark's intervention can be interpreted as a rescue operation. Mark shifts attention, even negatively, to himself and away from the sensitive issue of his mother's health. To protect his mother from having to talk about a sensitive issue, he assumes the role of a defiant child, one that he and his family are used to. By acting in this way, Mark reconstructs both the secretive atmosphere and his role as a defiant child. His utterance can also be understood from the perspective

of his inner voice as challenging the multigenerational delegation. Were the real addressees his mother's no longer present multigenerational relatives? What Mark was really saying was not taken up.

The mother had had a sudden seizure at home just a few days ago. Clara assumed an active and initiating role as a key informant concerning her mother's seizure. Clara had witnessed this frightening situation and at her mother's request had obtained help from her father. Clara's positioning in the conversation was ambivalent. She asked her mother for permission to tell what she knew. In telling her story, Clara observed her mother's reactions and sought to balance between her need to tell and her loyalty to her mother's reluctance to embark on the topic. The voices in Clara's storytelling can be interpreted as contradictory in both *what* she said (content) and *how* she said it (form), as in the following excerpt:

Lines 41–43
Clara (C), the mother (J)

T1	T2	J	C	M	Response category	Addressee, positioning, voices
			Saaks sanoo kaikki? (*Can I tell everything?*)		Responds to theme of asking and telling. Dialogical	Addresses all present including herself and her mother's multigenerational relatives. Adopts position of ambivalence (loyalty vs. openness) and positions herself as not really knowing what she was asking for when requesting licence to talk. Ambivalent voices of courage, insecurity and hesitation, trying to ensure whether it is safe to talk, assessing mother's emotional reaction
		Mmm			Responds to C and T1 + T2	Voice of hesitation. The addressees of her inner voice are her multigenerational relatives
			Jeee.. äitiä on pyörryttänyt (*Jeee..(cheerfully)… Mum has been dizzy*)		Semantic dominanc Monological. External process mode	Addresses all present including herself plus her mother's non-present multigenerational relatives. Positions self as ambivalent. On the one hand relieved to talk and on the other afraid of what to say. Ambivalence about revealing sensitive information conveyed with artificial, upbeat voice

Clara's initiative can be interpreted as multidimensional. She shows courage in broaching a sensitive theme but simultaneously fear of rupturing the multigenerational legacy of loyalty structures. While it remains unclear how permitted it has been *in general* in this family's history for its members to talk about difficult themes and negative emotions, it is evident that for Clara it has been difficult.

The mother

The mother's seizure had occurred a few days before the session took place. In discussing the theme, the mother positioned herself as unsure what to say in the presence of the children. When positioned by the therapists to give an account of what she meant by a 'difficult week' her response 'family, work, health' seemed to offer *big* themes for discussion. However, the words both opened and closed off any potential discussion. The distancing words, addressed to the therapists, indicated her reluctance to talk about it anymore. Simultaneously, echoes of loyalty to her multigenerational relatives (*speaking about difficult topics around the kids is forbidden*) can be heard in her inner voices. The therapists nevertheless tried to make more room for the mother's suggestive and secretive topics and encouraged her to talk, as illustrated below:

Lines 34–35
Therapist 1 (T1) and mother (J)

T1	T2	J	C	M	Response category	Addressee, positioning, voices
Minkälaisia asioita siitä nousee sulla mieleen? (*What kind of things do they make you think of ?)*					Dialogic. Responding to the mother, encouraging her to say more on the them	Position of not knowing, voices interest in hearing more
		Lasten kuullen en viitsi enempää (*In the presence of the kids I don't want (to say) any more*)			Responds to T1 + T2	Positions self as one who selects what to say. Voices of secrecy, hesitation and protectiveness The addressees of the mother's inner voice are her multigenerational relatives/ generalised other

The mother's good reason for being taciturn was *protecting her children* as representative of the family past and present. Her hesitant and allusive response 'otherwise they will have more…' refers to her fear and difficulty 'to tell the truth' which she had talked about earlier in her private discussion with T1 at the clinic. In that discussion she made clear that she was not yet ready to tell the facts of her relatives' deaths to the children because the suicides had provoked such a strong outburst of rage and guilt in her. T1 had encouraged the mother to talk about the deaths with the children in an age-appropriate manner, suggesting that unspoken themes can cause invisible anxiety. The mother admitted that this had been the case in her family. The mother's health was also a sensitive issue, as the mother had also told T1 that Clara had spoken of being afraid of losing her mother and asking every now and then in the mornings 'are you going to die today?' Despite the mother's good intentions here, her suggestive words made room for further imaginary fears and interpretations, and thus reconstructed an unsafe climate.

T1 and T2

The secretive atmosphere, with its ambivalent and contradictory voices, was inimical to the therapists' task of opening up a space for the not-yet spoken. The therapists positioned themselves as listening and not knowing. They encouraged the mother to generate local meanings (Anderson and Goolishian, 1992) in order to construct an understanding of her response of 'family, work, health'. They created a space for dialogue between the mother and Clara and tried to stabilise the unclear and emotionally demanding situation. However, the secretive atmosphere also aroused voices of ambivalence in the therapists, voices of confusion and hesitation in the competing dialectics of whether to talk or not to talk. The mother's suggestive words were effective: at the point where the mother later appealed implicitly to the children to leave her in charge of her own health with the words 'mother is not allowed to get upset', T1 shifted the focus of the conversation to the arrangement of a next meeting, where the children would not be present.

Discussion

This study focused on how family secrets as a systemic phenomenon affect children's positioning in the family therapy and how they cope in these challenging situations. In the present case we noticed, first, that both children were active co-participants in the complex dynamics

of the secretive atmosphere in the family. Second, they involved themselves in the paradoxical processes of *reconstructing* and *deconstructing* this secretive atmosphere. The children participated actively in the topics concerning the family's secrets. Although children's self-positioning in family therapy is typically passive (Willis *et al.,* 2014), the present results show that children may also engage actively in discussions dealing with sensitive and concealed issues. Both children took initiating roles in their approaches to a sensitive topic. They asked relevant questions and acted as informants.

Paradoxically, and simultaneously, in their ways of deconstructing the secretive atmosphere they also positioned themselves as reconstructing the secretive atmosphere. Mark's symptomatic behaviour, manifested in his speech about committing suicide, offered the opportunity for forbidden themes to be discussed. At the same time, however, he paradoxically kept the attention on himself, thereby implicitly protecting the sensitive topics from becoming a therapeutically relevant topic of discussion. Mark's threats to kill himself kept the suicide secret present, while simultaneously his provocative behaviour, his infantile protest, kept the focus on him instead of on the secret. In this context, *deconstruction* refers to Derrida's idea that every utterance simultaneously contains contradictory aspects and escapes absolute determination; in other words the 'meaning' of a 'thing' comes into existence through and in relation to what the 'thing' is not (Derrida *et al.,* 2003).

Mark's and Clara's coping mechanisms in the family's emotional and relationship system showed differences. Whereas Mark's way of coping was to react externally, Clara, who was problematically attached to her mother, assumed the role of an emotional regulator after she had risked putting her mother in touch with her own vulnerability. Clara had witnessed and even assisted her mother in the chaotic situation surrounding the latter's seizure, which positioned her as having semantic dominance in that conversation topic. However, she found herself in an ambivalent position: on the one hand she wanted to talk, to tell what she knew, while on the other hand she sought to protect her mother from this difficult theme. Clara's insecurity was masked by her cheerful appearance, which was inconsistent with her story, indicating the presence of at least two distinct voices. In the analysis of storytelling, it is important to note if 'there is congruence between the story told and story lived' (Rober *et al.,* 2010, p. 36).

The present findings support previous reports on the negative impact of secrets on family communication, as discussed in the introduction. First, we noticed that a secretive communicative style produced a

tense and psychologically distancing climate, producing voices of ambivalence, hesitation, and confusion. The concept of *selective disclosure* (Rober *et al.,* 2012) enabled a deeper understanding of the mother's good reasons for her reluctance to talk. Her reasons were intended to protect not only her children and her deceased multigenerational relatives (*relationship-based*) but also herself (*individual-based*). Taking the mother's own words seriously, her personal grieving process over her mother's and brother's suicides had been blocked by feelings of anger that had kept her a prisoner of aggression for several years. The mother possibly saw Mark's suicidal speeches as potentially dangerous and as a self-fulfilling prophecy that triggered intense fear in her. In line with the findings of Baird (1974) and Dreman (1977), the mother's mishandled and uncompleted grieving process and anger might have led to secretiveness. The mother's suggestive utterance 'if the topic is discussed, the consequences will be harmful' indicates that joint discussion of the secret would be *dangerous*. According to Imber-Black (1998), dangerous secrets poison relationships, creating barriers and reducing trust. Utterances intended as protection paradoxically have the opposite effect, increasing the emotional demands of the situation and the insecurity of the dialogical climate. A suggestive communication style tends to make room for imaginaries and children's fantasies are often worse than reality (Fine, 1973). In the present instance, suggestive communication succeeded in influencing the emotional climate of the therapeutic system, leading to dysfunction, manifested by the exclusion of the children from the therapeutic discussion on the sensitive topic.

Secrecy had an impact on the therapists' decisions. First, the mother's decisions ultimately determined what could be talked about in the presence of the children. Second, the therapists, who were to become shareholders in the secrets, found their hands tied. They used their mandate in attempting to persuade the mother to say at least something to the children. It can be asked, what more could they have done without losing the mother's confidence? Their task of balancing the needs of the children to talk about sensitive topics and taking the mother's words seriously was challenging. In this case, the therapists saw Mark's visible aggression problem as in some way connected to the invisible constructions of family secrets.

Utilising the genogram, they promoted discussion around past losses. In their attempts at negotiating they vainly endeavoured to motivate the mother to talk about painful issues that would have promoted the shared grieving process. The mother's therapeutic goal was to get help for Mark's aggression problem rather than to talk about past losses.

There is no royal road to knowing for certain whether Mark's suicidal talk and aggressive behaviour was connected to the hidden themes of his relatives' suicidal deaths. However, it has been noticed that a blocked grieving process (Bowen, 1978), secretive communication and mishandled anger (Baird, 1974; Dreman, 1977; Fine, 1973) may unwittingly scapegoat the child.

In this family the mother found that the family secrets concerning the relatives' suicides were topics that were too threatening to be jointly discussed and shared. However, her decision to refuse to talk about the relatives' suicides with children was her conscious, and articulated choice. The family members effectively kept the attention on their visible symptoms, preventing invisible and sensitive topics being effectively and explicitly brought into therapeutic focus. Knowing that keeping secret binds psychic energy, causing stress, loneliness and tension, it was not surprising that the mother's seizure appeared to have been related to stress-related symptoms, symptoms indicative of a keeper of secrets (Kelly, 2002).

Mark's defiant behaviour can be interpreted as a 'cover story' concerning his vulnerability. One can only guess at the role Mark's defiance plays in his family's multigenerational pattern of facing difficult feelings, such as anger. Mark had told the therapists about his need to receive more attention from his parents and had manifested implicit irritation with his mother. Mark's utterances 'Mum doesn't know me' and 'I don't need any health' can also be interpreted as voicing isolation and loneliness. However, provocative utterances by an individual positioned as defiant typically make *hearing* a demanding task. Mark's utterances were interpreted by the adults in accordance with his symptomatic behaviour. An interesting question remains: what role did the father's absence play in the sessions where the family's secrets were offered for joint discussion?

Conclusions

The findings have clinical implications. Granting that family patterns tend to repeat themselves (Bowen, 1978; Kerr and Bowen, 1988), we suggest that the topic of family secrets should be taken seriously in the family therapeutic context. It is recommended that family secrets are asked about in the pre-therapy assessment and diagnostic interviews where all the family members are present. At its best, the genogram as a therapeutic tool can enrich therapeutic processes, enabling open

exploration of multigenerational family patterns and functions that might be influenced by family secrets (McGoldrick *et al.,* 2008). By normalising the phenomenon of family secrets, therapists could make room for joint discussions on these and encourage family members to talk about their good reasons not to talk (Rober, 2002). According to Tracy (2015), 'family secrets can be a driving force, whether explicitly or implicitly, for many seeking therapy'.

A limitation of this case study concerns the generalisability of its results. Because they remained hidden from the children, the effects of the family's secrets on its functioning remain obscure. While conceding that the conclusions drawn in this study are tentative, as they tend to be in studies of this kind, we believe that the study enriches understanding of the multifaceted and systemic nature of family secrets and the self-positioning of children in them. Furthermore, this study offers new insight on the utilisation of the multi-actor *DIHC* method when children are present. Children's conduct disorders in the context of family secrets merit further research. In child psychiatric care there might be many 'cover stories' behind such diagnoses. The meanings embedded in these stories cannot be approached and worked through without safe disclosure. Family therapy can be a forum to investigate them seriously and with respectful curiosity.

References

Afifi, W. A. and Guerrero, L. K. (2000) Motivations underlying topic avoidance in close relationships. In: S. Petronio (ed.) *Balancing the secret in private disclosures* (pp. 165–180). Mahwah, NJ: Lawrence Erlbaum Associates.

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

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

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

Anderson, H. and Goolishian, H. (1988) Human systems as linguistic systems: preliminary and evolving ideas about the implications for clinical theory. *Family Process*, **27**(4): 371–393. https://doi.org/10.1111/j.1545-5300.1988.00371.x

Anderson, H. and Goolishian, H. (1992) The client is the expert: a not-knowing approach to therapy. In: S. McNamee and K. J. Gergen (eds.) *Therapy as social construction* (pp. 25–39). London: Sage.

Angus, L., Levitt, H. and Hardtke, K. (1999) The Narrative Process Coding System: research applications and implications for psychotherapy practise. *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

Aristotle. (1975) *Categories and De Interpretatione*. Transl. with notes and glossary by J. L. Ackrill. Oxford: Clarendon Press.
Baird, M. (1974) Characteristic interaction patterns in families of encopretic children. *Bulletin of the Menninger Clinic*, **38**(2): 144–153.
Bakhtin, M. (1975) *Speech genres and other late essays*. Austin: University of Texas Press.
Bakhtin, M. (1984) *Problems of Dostoevsky's poetics*. Minneapolis: University of Minnesota Press.
Bakhtin, M. (1986) *Speech genres and other late essays*. Austin: University of Texas Press.
Baxter, L. A. (2011) *Voicing relationships. A dialogical perspective*. Los Angeles, CA: Sage.
Berger, R. and Paul, M. (2008) Family secrets and family functioning. The case of donor assistance. *Family Process*, **47**(4): 553–566. https://doi.org/10.1111/j.1545-5300.2008.00271.x
Bowen, M. (1978) *Family therapy in clinical practice*. New York, NY: Jason Aronson.
Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3**(2): 77–101. https://doi.org/10.1191/1478088706qp063oa
Derrida, J., Ikonen, T. and Porttikivi, J. (eds.) (2003) *Platonin apteekki ja muita kirjoituksia*. Gaudeamus: Helsinki.
Deslypere, E. and Rober, P. (2018) Family secrecy in family therapy practice: an explorative focus group study. *Family Process*, **20**: 1–14. https://doi.org/10.1111/famp.12409
Dreman, S. B. (1977) Secrecy, silk gloves and sanctions: a family approach to treating an encopretic child. *Family Therapy*, **4**(2): 171–177.
Fine, S. (1973) Saboteurs, scapegoats and secrets: diagnosis in family therapy. *Canadian Family Physician*, **19**(11): 89–96.
Golish, T. D. and Caughlin, J. P. (2002) 'I'd rather not talk about it': adolescents' and young adults' use of topic avoidance in stepfamilies. *Journal of Applied Communication Research*, **30**(1): 78–106. https://doi.org/10.1080/00909880216574
Hermans, H. J. M. (2006) The self as a theatre of voices: disorganization and reorganization of a position repertoire. *Journal of Constructivist Psychology*, **19**(2): 147–169. https://doi.org/10.1080/10720530500508779
Hutchby, I. and 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
Imber-Black, E. (1993) Secrets in families and family therapy: an overview. In: E. Imber-Black, (ed.) *Secrets in families and family therapy* (pp. 3–28). New York, NY: W. W. Norton & Company.
Imber-Black, E. (1998) The power of secrets. *Psychology Today*, **31**(4): 50-62.
Karpel, M. A. (1980) Family secrets. *Family Process*, **19**(3): 295–306. https://doi.org/10.1111/j.1545-5300.1980.00295.x
Kelly, A. E. (2002) *The psychology of secrets*. New York: Kluwer Academic/Plenum.
Kerr, M. E. and Bowen, M. (1988) *Family evaluation. An approach based on Bowen therapy*. New York, NY: Norton.
Knauth, D. G. (2003) Family secrets: an illustrative clinical case study guided by Bowen family systems theory. *Journal of Family Nursing*, **9**(3): 331–344. https://doi.org/10.1177/1074840703255451

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

Laitila, A., Aaltonen, J., Wahlström, J. and Agnus, 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

McGoldrick, M., Gerson, R. and Petry, S. (2008) *Genograms: assessment and intervention* (3rd ed.). New York, NY: Norton.

O'Reilly, M. (2008) ´What value is there in children's talk?' Investigating family therapists' 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. and 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. https://doi.org/10.1177/1461445612452976

Rober, P. (2002) Some hypotheses about hesitations and their nonverbal expression in family therapy practice. *Journal of Family Therapy*, **24**(2): 187–204. https://doi.org/10.1111/1467-6427.00211

Rober, P. and Rosenblatt, P. C. (2013) Selective disclosure in a first conversation about a family death in James Agee's novel 'A Death in the Family'. *Death Studies*, **37**(2): 172–194. https://doi.org/10.1080/07481187.2011.628555

Rober, P., Seikkula, J. and Laitila, A. (2010) Dialogical analysis of storytelling in the family therapeutic encounter. *Human Systems. The Journal of Therapy, Consultation & Training*, **21**(1): 27–49.

Rober, P., Walgravens, G. and Versteynen, L. (2012) 'In search of tale they can live with': about loss, family secrets and selective disclosure. *Journal of Marital and Family Therapy*, **38**(3): 529–541. https://doi.org/10.1111/j.1752-0606.2011.00237.x

Seikkula, J., Laitila, A. and 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. and Olson, M. E. (2003) The Open Dialogue approach to acute psychosis. *Its poetics and micropolitics. Family Process*, **42**(3): 403–418. https://doi.org/10.1111/j.1545-5300.2003.00403.x

Seikkula, J. and 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

Simon, F. B., Stierlin, H. and Wynne, L. C. (1985) *The language of family therapy. A systemic vocabulary and sourcebook*. New York: Family Process Press.

Stierlin, H. (1977a) *Psychoanalysis and family therapy. Selected papers*. New York: Aronson.

Stierlin, H. (1977b) *Das erste Familiengespräch: Theorie, Praxis, Beispiele*. Stuttgart: Klett-Cotta.

Strickland-Clark, L., Campbell, D. and 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

Tracy, O. (2015) *Mapping the hidden: an interpretative phenomenological analysis of multigenerational family secrets*. Florida: Department of Family Therapy theses and dissertations: NSU, Nova Southeastern University.

Vangelisti, A. L. and Caughlin, J. P. (1997) Revealing family secrets: the influence of topic, function, and relationships. *Journal of Social and Personal Relationships*, **14**(5): 679–705. https://doi.org/10.1177/0265407597145006

Vygotsky, L. S. (1971) *Thought and language* (6th ed.). Cambridge, MA: MIT Press.

Willis, A. B., Walters, L. H. and Crane, D. R. (2014) Assessing play-based activities, child talk, and single session outcome in family therapy with young children. *Journal of Marital and Family Therapy*, **40**(3): 287–301. https://doi.org/10.1111/jmft.12048

III

”YOU HELPED ME OUT OF THAT DARKNESS” CHILDREN AS DIALOGICAL PARTNERS IN THE COLLABORATIVE POST-THERAPY RESEARCH INTERVIEWS

by

Mira Helimäki, Aarno Laitila, & Kirsti Kumpulainen 2021

Journal of *Journal of Marital and Couple Therapy*, 00, 0-16.

https://doi.org/10.1111/jmft.12505

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