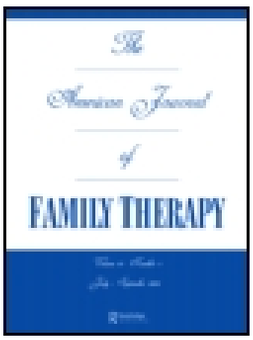

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Why Am I the Only One You're Talking to, Talk to Them, They Haven't Said a Word?

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

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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.

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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

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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.

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