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2

1 'You can take a horse to water but you can't make it drink': Exploring children's engagement

2   and resistance in family therapy

3

4**Abstract**

5Children's engagement and disengagement, adherence and non-adherence, compliance and

6non-compliance in healthcare have important implications for services. In family therapy

7mere attendance to the appointments is no guarantee of engaging in the treatment process and

8as children are not the main initiators of attendance engaging them through the process can be

9a complex activity for professionals. Through a conversation analysis of naturally occurring

10family therapy sessions we explore the main discursive strategies that children employ in this

11context to passively and actively disengage from the therapeutic process and investigate how

12the therapists manage and attend to this. We note that children competently remove

13themselves from therapy through passive resistance, active disengagement, and by expressing

14their autonomy. Analysis reveals that siblings of the constructed 'problem' child are given

15greater liberty in involvement. We conclude by demonstrating how therapists manage the

16delicate endeavour of including all family members in the process and how engagement and

17re-engagement are essential for meeting goals and discuss broader implications for healthcare

18and other settings where children may disengage.

19

Introduction

21

Children and adolescents' disengagement from clinical services is a significant problem with

cancelled appointments, failure to attend and drop-out all being costly for health services

(Kazdin, Holland and Crawley, 1997; Wang, Sandberg, Zavada, et al, 2006), and frustrating

for therapists (Werner-Wilson & Winter, 2010). Typically children are not the main initiators

of help-seeking and neither are they the main determinants of attendance (Wolpert &

Fredman, 1994), as it is usually the parents who take responsibility to bring the child to

therapy (Hutchby, 2002) and make treatment decisions (Tan, Passerini and Stewart, 2007). In

essence, there is an institutional expectation in therapy to speak about one's problems and

this incitement to speak depends on the client's willingness to comply (Silverman, 1997).

Although the parent can physically bring the child to therapy, whether that child will engage

with the therapeutic process and work towards goals and resolution is not so straightforward.

33

Non-compliance of children in medical and therapeutic contexts is prevalent (Richman,

Harrison and Summers, 1995), with non-completion rates being quite high, for example in

child psychotherapy (Pina, Silverman, Weems, Kurtines, et al, 2003). The accomplishments

of therapeutic aims, therefore, are dependent upon the child's cooperation in the production

of talk about therapeutically relevant issues (Hutchby, 2002). Child engagement requires a

commitment from both the parent and the child (Day, Carey, and Surgenor, 2006). This is

because although research illustrates that the greater the involvement of the child the greater

the therapeutic change (Chu & Kendall, 2004), parents need to be actively involved to sustain

any change (Boggs, Eyberg, Edwards, et al, 2004).

43

44Mental health treatments for young people are usually delivered within the context of

45families (Tan et al, 2007), with family therapy being one arena for families to work through

46their problems. Concerns have been raised however about the increase in the number of

47families dropping out of family therapy and failing to receive the services they need (Topham

48& Wampler, 2008). Ostensibly a key focus for family therapy is to provide a forum through

49which the child's perspective can be aired (Strickland-Clark, Campbel and Dallos, 2000) but

50problematically children and adults have different levels of cognitive and linguistic

51competence and this creates a challenge for mutual exchange (Lobatto, 2002). Lobatto argues

52that it is difficult therefore for the therapist to create an atmosphere which is inclusive of all

53parties as therapy tends to be predominantly adult led, and has potential to contribute to

54attrition rates.

55

56Research illustrates that children want to be included in therapy in a meaningful way (Stith,

57Rosen, McCollum, et al, 1996) but the presence of their parents can inhibit their

58conversational contributions (Beitin, 2008; Strickland-Clark et al, 2000). For example,

59children in family therapy speak less than their parents (Mas, Alexander and Barton, 1985),

60are interrupted more frequently (O'Reilly, 2008), and yet when interrupting are treated in

61negative ways (O'Reilly, 2006). Research indicates that young people are particularly

62difficult to engage in therapy and creating an alliance with them is especially challenging

63(Thompson, Bender, Lantry et al, 2007). In family therapy the parents and the therapist may

64seek to engage in the institutional tasks of therapy such as identifying and finding solutions to

65the problems presented, but notably children may not understand or wish to go along with

66this, and may actively seek to avoid participation (Hutchby & O'Reilly, 2010). Alliance

67between clients and therapists is, therefore, considered essential to the therapeutic process

68(Aspland, Llewelyn, Hardy et al, 2008), and has been an area of interest in relation to

69establishing reliable methods of measurement (Pinsof, Hovarth and Greenberg, 1994).

70Understanding therapeutic alliance is considered particularly important for understanding

71treatment outcomes (Thomas, Werner-Wilson and Murphy, 2005). Unlike didactic therapy

72situations, family therapy invokes additional challenges as the therapist considers how to

73foster alliances with multiple members with different motivations and problem definitions

74(Escudero, Friedlander, Varela and Abascal, 2008). If therapists base their decisions on input

75from the parents alone, however, they risk missing problems that matter to the child and may

76alienate or fail to engage the child (Hawley & Weisz, 2003).

77

78This disengagement or resistance to therapy is potentially averted by increasing therapeutic

79alliance (Frankel & Levitt, 2009), but if alliance is not maintained then rupture in the

80relationship may occur. Ruptures in the therapeutic alliance are defined as the deterioration in

81the relationship between the therapist and the client which may lead to dropout and treatment

82failure (Safran & Muran, 1996). It is important to understand dropout in order to reduce an

83inefficient use of resources in mental health (Masi, Miller and Olson, 2003), and the ruptures

84that frequently precede attrition. Ruptures can be recognised predominantly in changes of

85behaviour such as withdrawal and confrontation (Safran, Muran, Samstag et al, 2001) and

86may arise from unvoiced disagreements about the tasks and goals of therapy (Aspland et al,

872008). Therefore, if the therapy is to progress, the therapist needs to attend to both the

88parental and child perspectives, because if one party perceives the therapist to not understand

89them and their problems they may disengage (Hawley & Weisz, 2003).

90

91Although family therapists have developed strategies for engaging children in the therapeutic

92process we have a limited evidence base for how children experience therapy or how they

93engage with it (Strickland-Clark et al, 2000) or disengage from it. Analysis of the behaviour

94of children and families in therapy can be useful for predicting therapeutic outcomes (Kazdin,

95Marciano and Whitely, 2005). The aims of this paper, therefore, are to explore how children's

96behaviour is an indicator of engagement and disengagement patterns thus enabling

97recognition of when and how these patterns occur in practice. Additionally we investigate

98how therapists manage any potential ruptures in alliance with children and consider how they

99reinstate engagement. Exploring the disengagement strategies of children in family therapy

100has potential to facilitate the recognition of early indicators of potential ruptures in alliance

101and both prevent and manage their occurrence.

102
103**Methods**
104

105For this research we utilise a qualitative framework to explore the different ways children

106attempt to disengage from family therapy.

107
108*Recruitment and participants*

109Our data for this project was provided by a team of systemic family therapists based in the

110United Kingdom. Actual family therapy sessions were video-recorded, totalling

111approximately 22 hours of therapy with four different families. These families have been

112assigned the pseudonyms of Clamp, Niles, Bremner and Webber. Two therapists took part in

113the research and were assigned the pseudonyms of Joe and Kim. The four families included

114in the data corpus were White British, from the Midlands and typically from lower socio-

115economic groups.

116

117A convenience sampling method was employed with the first four families with capacity and

118providing consent being recruited to the study. The only exclusion criterion was parents with

119mental health problems that were judged to impair capacity to consent. Sampling occurred

120within the allocated 9 months for data collection. Sampling was appropriate to the

121methodological framework and issues of saturation are not intrinsic to the approach with its

122deductive discursive epistemology (O'Reilly & Parker, 2012 a). As a deductive mode of

123enquiry the premise of CA is that the micro-mechanisms of talk in the smallest sample can

124shed light on general principles of all aspects of language. This means that the notion of

125saturation is not inherent in this methodology.

126

127The Clamp family constituted, the father (Daniel/Dan), the mother (Joanne), the uncle

128(paternal sibling Joe), and three children; Phillip (aged 13) the referred child, Jordan (aged 9)

129having both physical and mental health difficulties and Ronald/Ron (aged 6) having a

130learning disability. Member of the Bremner family were, the mother (Julie), the maternal

131grandmother (Rose), and two children; Bob (aged approximately 8 years) the referred child

132with Asperger's syndrome and Jeff (approximately 6 years) who had developmental delay.

133The Niles family consisted of the mother (Sally), Alex (father to two, step-father to two

134children) and four children; Steve (14 years) the referred child, suspected ADHD, Nicola (12

135years), Lee (8 years) and Kevin (3 years). Members of the Webber family were, Patrick

136(Step father to two, father to two children), the mother (Mandy), and four children; Daniel

137(15 years) the referred child with special educational needs, Adam (19 years), Patrick (10

138years) and Stuart (8 years).

139
140
141Each of these four families remained in family therapy and with mental health services more

142generally after the data collection period was completed. The actual outcomes of treatment,

143therefore, were not actively pursued as relevant to the research question. The data were

144transcribed in accordance with the analytic method and Jefferson guidelines were followed

145(Jefferson, 2004). See table 1 for detail.

146

147INSERT TABLE ONE HERE

148

149*Conversation analysis*

150A distinct feature of conversation analytic (CA) work is its focus on the action orientation of

151talk (Hutchby & Wooffitt, 2008). Through analysis, the sequential organisation of talk is

152explored to explicate the social actions being performed (Sacks, 1992). For example the

153semantic sentence 'what are you doing this evening?' could perform a variety of social

154actions depending on the context. It may be a simple question or it could be performing the

155social action of a pre-enquiry to an invitation or request. Social processes are revealed

156through close attention to sequential analysis of conversational turns which illuminates the

157way in which the participants in the interaction respond to prior turns. The reliability of this

158method is not constituted in the analysts' interpretations of the participant's talk, but in line

159with ethnomethdological principles, is grounded in the participants own responses.

160

161This method has great potential for illuminating insights into healthcare interactions as it

162enables the identification of patterns of behaviour (Drew et al, 2001). As CA has grown in

163popularity it has illustrated some of the fundamental organisational features and interactional

164processes in medical settings (Pilnick, Hindmarsh, and Gill, 2010) and is used to examine the

165ways in which clinical processes are interactionally constituted in therapy (Georgaca & Avdi,

1662009). For this paper the two authors initially independently scrutinised the data corpus for

167the identification of social actions pertinent to the research question. During the second phase

168these social actions were jointly explored through a more detailed sequential analysis to

169secure inter-rater reliability. This process allowed the authors to explicate the emergent

170patterns of social process requiring further analytic attention, as is consistent with the CA

171methodology.

172

173*Ethics*

174During this project we employed the Principlist approach to ethics, incorporating the four

175core principles of autonomy, beneficence, non-maleficence and justice (Beauchamp &

176Childress, 2008). What this meant in practice was that informed consent was collected from

177all necessary parties, anonymity was maintained, confidentiality assured and data were stored

178securely.

179

180
181**Analysis**
182
183By using conversation analysis to investigate the performative actions in institutional talk,

184our analysis revealed four social processes at work within the dynamics of the family unit

185during the practice of family therapy. First children display passive and active disengagement

186from the therapeutic agenda. Second, children attempt to express autonomy and evade adult

187impositions. Third, siblings are afforded greater liberty in their attempted disengagement.

188Finally, therapists use validation as a technique to reinstate engagement in the therapy

189process.

190
191*Social process one: passive and active disengagement from the therapeutic agenda*
192
193In this section we provide a series of extracts which present a continuum of social actions

194displayed by the children as a way of disengaging from therapy. These range from a

195behavioural passivity through to direct active verbal resistance. We illustrate that children

196passively disengage (through inattention), passively resist (when they do not attend to a direct

197question, or attempt at engagement), and actively resist (when they directly refuse to answer,

198or fail to comply with a request).

199
200Extract one: Clamp family

201
```
202 Dad:      I don't think Jordan understands what you're on about
203           either (.) to be honest
204 FT:       Yeah
205 Dad:      I think Phil[lip(        )
206 Ron:                 [Heh h[eh heh heh ((Ron is jumping))
207 Jordan:             [heh heh heh heh ((Jordan is jumping))
208 Dad:      ↑Will you stop jumpin'
209 (2.0)
210 Dad:      come on
211 (1.0)
212 Ron:      There's no chairs
213 FT:       What happens when they do this at home? (1.0) If the
214           three of them were kind of jumping around at home what
215           would happen
216 Dad:      I'd tell 'em to stop
217
```

218 Disengagement from therapy can be simply inattention to the process. By removing

219 themselves from the therapeutic conversation, children display passive resistance to the social

220 process. The children's laughter and jumping on chairs (lines 5&6) occasion the father to

221 suspend therapy to attend to Ron and Jordan. Sequentially this rupture affords an opportunity

222 for the therapist to initiate a topic shift (Jefferson, 1984) and to make the behaviour of the

223 children therapy-relevant (line 12).

224
225 Extract two: Bremner family
226
```
227 Gran:     so it doesn't make any difference t' 'im at a:ll (.) and I ask
228           'im why 'e's horrible to ↑mummy and basically 'e does it
229           because 'e knows, hh it gets to 'er
230 FT:       Is that what he said?
231 Gran:     ↑Yeah
232 Bob:      Get off ↑that
233 Jeff:     E::y I want t' ↑play with that
234 FT:       So how was it [at Christmas?
235 Bob:                    [Well get me one
236 Jeff:     I want to play with the (black b[locks)
237 FT:                                       [↑Bob (.) how [was it at
238           Christmas?
239 Bob:                                                     [I got it first
240 Gran:     Hey
241 Mum:      Who had them first?
242 Bob:      ↑ME
243
```

244 This extract illustrates that children display more active strategies for inattention than simply

245 passively disengaging themselves from the conversation. Here Bob's attention actively

246 moves from the therapy process to an alternative activity, playing with children's building

247 blocks. By actively attending to the building blocks and the on-going dispute with his brother,

248Bob passively resists attending to the question posed by the therapist *'Bob, how was it at*

249*Christmas?'* (line 8, 11). Notably the therapeutic conversation involved negative descriptions

250of Bob's behaviour toward his mother (lines 1-3) from which Bob disengaged by actively

251verbally diverting the adults' attention to the play. This, like in extract 1, results in a topic

252shift as they discuss possession of the toy blocks.

253
254Extract three: Clamp family
255

```
256FT:        Will you come and >play with someone< out 'ere?
257           (0.6)
258FT:        you can bring your ↓crisps
259Ron:       Na::h
260Mum:       Na::h?
261FT:        0No?0
262Ron:       ((shakes head))
263FT:        Alright then
264Mum:       ↓Na::h
265FT:        Let's see if we can find someone((therapist stands and leads
266           the child to the door))
267
```

268Extracts one and two illustrated that the continuation of therapy is displayed as the primary

269objective of the adult parties, and disruptions to this process are treated as interference. Here

270the continuation of therapy requires the child to leave the therapeutic space due to the delicate

271nature of the topic (paedophilia[i]). Research illustrates that delicate inappropriate topics

272require careful management in the therapeutic conversation (O'Reilly & Parker, 2012, b) and

273here the therapist works to remove the child from the overhearing position he is currently in.

274Interestingly when the child answers the question with the dispreferred response (Pomerantz,

2751984) *'nah'* (line) both the mother and the therapist question this. They repeat the response

276*'nah?', 'no?'* but the questioning intonation implies that the response ought to be revised.

277This occasions a downgraded, less emphatic version of the refusal as Ron shakes his head.

278Although acknowledged by both the therapist *'alright then'* and the mother *'nah',* the

279therapist enforces his original request from line 1, by actively and physically taking the child

280out of the room (line 10).

281

282Extract four: Bremner family
283

```
284FT:        S::o Bob would you like [t' tell me why mummy's in a ↓mood
285Bob:                              [No ↑I'm not in the mood ta tell
286           (0.4) you (.) mummy can (.) she's the one in the mo:od .hh she
287           can tell ya
288Mum:        ᵒMummy can'tᵒ say anythin' ((Mother is crying softly))
289Bob:        You can
290Jeff:       'e's be:en naughty
291
```

292There are occasions in therapy where a therapist will use active engagement strategies to

293involve the children in the process and here the therapist uses first person selection *'Bob'*

294(line 1) to directly address the child. Ostensibly saying *'would you like'* offers Bob a choice

295to provide an explanation for the mother's visually obvious negative affective state. Notably,

296because the therapist is looking at Bob, addressing him by name, and emphasising *'you',* it is

297problematic for Bob to display passive inattention, and therefore necessitates a more active

298response. In this case, Bob interrupts the therapist during her question and actively refuses to

299comply with the request *'no'* (line 2) offering a justification *'I'm not in the mood'* (line 2) and

300a candidate alternative respondent *'mummy can'* (line 3). Although Bob references the

301mother as the next speaker, her distressed state occasions a minimal refusal *'mummy can't*

302*say anything'* (line 5) which is audibly quieter, and in turn precipitates a self-selected answer

303to the question from Bob's sibling, Jeff.

304
305*Social process two: Expressing autonomy and evading adult impositions*
306
307There are two ways in which children express their wish for autonomy to disengage from the

308therapy. First they attend to the present interaction, making requests to cease participation,

309and second, they orient to future sessions by expressing desire not to continue attending.

310Building upon the previous analysis we demonstrate examples of children displaying active

311resistance to the process of therapy by initiating requests to disengage.

312
313
314*Extract five: Niles Family*
315

```
316Steve:      I'm bored (0.4)↑Can I 'ave me 'phone on?
```

```
317Mum:        No (.) you are[not allowed t'
318Dad:                      [You are not allowed t' turn y'r 'phone on >in
319            the< 'ospital
320Mum:        >'cause they< interfere wiv the computers
321Dad:        You could kill someone if <you interfere> with the machine
322Steve:      Can't I jus'
323Mum:        <↑Get your feet off that table>
324Steve:      Can't we jus' (.) >can we go 'ome<
325            (1.4)
326Mum:        ↑No
327
```

328In this extract Steve's request to turn on his mobile telephone is an attempt to actively

329disengage from the therapy. This potential alternative activity is rebuffed by the parents who

330collaboratively account for the refusal by orienting to institutional rules imposed by hospitals.

331By illustrating to Steve that there are potentially severe consequences of his action *'you could*

332*kill someone'* (line 6), they not only provide good reason not to allow the phone to be turned

333on, but also mitigate parental responsibility for the denying the request. Notably this account

334does not attend to the potential social action being performed by Steve, of active

335disengagement. This intersubjective misalignment occasions a second attempt to disengage

336from Steve, *'can't I just'* (line 7) and *'can we go home'* (line 9). At this point this is simply

337declined without any explanation *'no'* (line 11). Parental imposition is not always without

338explanation and in extract six the parents position the child himself as the reason why

339disengagement is not possible.

340
341*Extract six: Niles family*
342
```
343Steve:      Can't we jus' go?
344Dad:        Pardon?
345Steve:      I want to ↓go
346Dad:        No (.) we're 'ere to get you sorted out kid (0.2) I reckon
347            bo:ot (.) >boot camp< will sort you out
348
```
349In this extract the child actively expresses autonomy to disengage from the therapy by

350requesting that the family leave *'can't we just go?'* (line 1). The father's signal for not

351hearing the request, affords the opportunity for the child to reiterate it. However the request is

352upgraded by the footing shift (Goffman, 1981) from 'we' to 'I', and the removal of the

353minimiser 'just'. The direct way in which the child's expressed choice is reformulated *'I*

354*want to go'* (line 3) not only occasions a refusal, but also an account from the father. This

355account positions Steve as the problem which necessitates Steve's attendance.

356
357*Extract seven: Bremner family*
358
```
359FT:      ↑So (.) will you >come back again< (.) and see me again in
360         fo:ur weeks?
361Bob:     No
362FT:      ↑Oh I think ↑so
363Bob:     I will not
364FT:      ↑Can you bring me >a nice picture< of ↑Darth (0.2) of e::rm (.)
365         Star wars (.) the characters .hh
366Bob:     I don't know how to draw them
367
368
```
369The literature on preference organisation in adult-to-adult interactions illustrates that when

370questions such as the one offered by the family therapist are asked, they are designed to elicit

371a 'yes response' (Pomerantz, 1984). Pomerantz notes that when adults offer a dispreferred

372response, it is notably marked by pauses, prefaces and accounts. Although Bob's response is

373semantically congruent with the therapist's turn in the sense that he applies the same modal

374verb, *'will you come'* (line 1) *'I will not'* (line 5), his response lacks any normative social

375conventions of a dispreferred response. While the therapist's question has the illusion of

376offering choice *'will you come back again'* (line 1) her next turn *'oh I think so'* (line 4)

377dispels this possibility as she orients to the expectation of his return. This illustrates the

378adult's imposition of expected attendance overriding the child's autonomy to choose

379disengagement from further sessions. The restriction of autonomy to choose to attend future

380sessions is expressed more explicitly in the following extract.

381
382*Extract eight: Niles family*
383
```
384Dad:     We'll see you in four weeks >sometime I know you< want
385         yo(h)ur t(h)ea
386FT:      ↓No it's not that >I mean I<
387Steve:   ↑I don't want to come anymore
388FT:      I would re::ally like you to come ↑Steve >because I
389         think<
390Mum:     You don't 'ave much ↑choice Steve 'cuz I'm bringin' ya
391         'til [we <get t' the bottom> of this hhh
```

```
392FT:              [Well (.) >and I'm goin' wiv what with what your mom
393          and Alex are sayin'< (.) cuz they're the ↑adults and
394          they've made that decision
395          (1.2)
396
```

397In this extract not only does Steve express a preference to disengage from the current therapy

398session, but he also expresses a clear desire not to attend any future sessions *'I don't want to*

399*come anymore'* (line 4). This attempt at autonomy is met with two different types of

400responses from the adults in the room. Initially the therapist affirms his desire for Steve to

401attend *'I would really like you to come'* (line 5), which indicates a personal preference. In

402contrast, the mother's response imposes a restriction of his liberty *'you don't 'ave much*

403*choice'* (line 7) and enforces her parental authority *'I'm bringing ya'* (line 7). Notably, the

404mother does provide a caveat to the imposition by demonstrating a time limit on attendance

405*'til we get to the bottom of this'* (line 8). Despite this account, Steve's option for choice

406becomes further limited by the therapist aligning with the parents. Therapeutically,

407alignments between therapists and all parties, including children, are important for

408therapeutic processes (Parker & O'Reilly, 2012), but here the therapist has actively disaligned

409from the child which is strengthened with the category use of 'adults'.

410
411*Social process three: The negotiable liberty of the sibling*
412
413Illustrated previously, despite active and passive attempts at disengagement, parental

414imposition has dictated that the child identified as requiring help continues to attend therapy.

415However the necessity for siblings to attend appears to be something open to negotiation with

416the therapist. This demonstrates that it is not simply the category of 'child' in contrast to

417'adult', or 'therapist' in relation to 'client' that defines the direction of autonomy and

418authority. The other children within the family are afforded a different degree of choice

419regarding engagement than the 'problem child'.

420
421*Extract nine: Niles family*
422

```
 423
424FT:          We'll see ↑you in fo:ur weeks ↓then
425Dad:         She said she <don't want to> come again (.) didn't ya?
426Lee:         I don't wanna come again
427Steve:       Oh shu[t up moanin'
428Kevin:           [I *don'[t *want to *come ag(h)ain
429FT:                     [I find it helpful <what you say> hhh it's
430             be:en re::ally helpful today (.)I know it's (.) this
431             isn't what anyone would cho:ose to do >I mean< I
432             understand that
433             (0.8)
434FT:          but (.) it'd be nice if you'd ↑come
435Dad:         ↑Come on then
436Nic:         ↑Oh
437FT:          and I hope you a:ll 'ave a re::ally nice Easter
438Mum:         ₀and you ₀
439
```

440At the end of this therapy session the therapist offers a candidate closing comment *'we'll see*

441*you in four weeks then'* (line 1). The assumptive element of this closing statement

442problematises the pronoun 'you' by raising the possibility of Nicola's non-attendance *'she*

443*said she don't want to come again'* (line 2). The father here legitimises the possibility of

444Nicola's non-attendance by voicing her preference, and notably the other siblings, Kevin and

445Lee, use the opportunity to attempt to express their autonomy. By interrupting the children,

446the therapist focuses attention on responding to the older sibling (Nicola), directly. He

447acknowledges her choice *'it isn't what anyone would choose'* (line 8) and validates the value

448of her contribution *'I find it helpful what you say'* (line 6). By saying *'it'd be nice if you'd*

449*come'* (line 10), the therapist maintains the scope for autonomy but clearly defines a

450preference for attendance. This contrasts significantly with previous extracts where the

451'problem child' is clearly given no choice in the matter of attendance.

452
453
454Extract ten: Webber family
455
```
456Dad:         So <I don't re:ally want> to bring Adam wiv us (.) with
457             what actually 'appened to 'im (.) >you know what I mean<
458             (.) 'e won't <never ever speak about that> ↓again[ii]
459FT:          ↑Oh >you mean< about bringin' 'im 'ere?
460Dad:         ↑Yeah
461FT:          Yeah >I mean< I understand
462Dad:         He won't ever ever talk about it
463Mum:         ↓No
```

464FT: >I mean< this <u>isn't</u> <u>compul</u>sory for <u>anyb</u>ody (.)
465

466As in extract nine, the father here raises the issue that one sibling in the family has a

467preference not to attend the therapy. The father's account hinges on the discrepancy between

468being physically present and actual engagement in the therapeutic process. What he

469highlights is that even if they brought Adam to therapy, he would not actively engage by

470communicating with the therapist about events relevant to the 'problem child', Daniel '*he*

471*won't never ever speak about that'* (line 3). Interestingly this account for possible non-

472attendance is not utilised for the situations where the 'problem child's' attendance is

473questioned or raised. Although in this extract the therapist states that therapy is not

474*'compulsory for anybody',* the lack of choice for some children is clearly marked with

475parental imposition, as highlighted earlier.

476

477*Social process four: Validation as a technique to create or reinstate engagement*
478
479Problematically, where parents impose attendance on their children and those children resist

480or disengage from therapy, it can create difficulty for meeting therapeutic goals. There is an

481onus therefore on the therapist to take responsibility for recognising the probability that

482children may not be willing participants, and to utilise strategies to create or facilitate their

483engagement. One of the ways in which this can be achieved is the circumspect use of

484validation as a clinical intervention. By acknowledging and validating the potential

485challenges for the child such as boredom, the unpleasantness of listening to certain

486descriptions and events particularly when related to them and their behaviour, and the

487uncertainty of what might happen, the therapist creates a space for the child which enables

488them to feel accepted.

489
490
491*Extract eleven: Niles family*
492

```
493FT:          but it might be helpful,
494Steve:       I'm ↓bored
495FT:          for us t' at le:ast 'ave some ↑guesses about what's goin'
496             on with Steve hhh so my kind of ↑first question is >what
497             is it< [like (.)for you ↑Steve (0.2) sittin' 'ere =
498Steve:              [I ↑wanna go 'ome
499FT:          = hearin' us all talkin' about (0.2) the things that <you
500             do> that are ↑naughty
501
```

502This extract demonstrates the complexity of using validation as an engagement technique.

503Paradoxically the therapist here does not initially attend to the overtly expressed feeling

504conveyed by Steve *'I'm bored'* (line 2), but does attend to the implicit implication that Steve

505is finding therapy uncomfortable by directing his question specifically to Steve. Notably the

506child's two attempts to disengage from the therapy, *'I'm bored'* (line 2), and interruptively, *'I*

507*wanna go home'* (line 6) are not attended to by the therapist as he pursues his line of enquiry.

508While children's interruptions are typically ignored (O'Reilly 2006), the validating social

509action of the therapist's turn in this instance is designed to address the potential difficulty for

510the child in hearing the negative descriptions of his behaviour. This redress of a potential

511social breach (Parker & O'Reilly, 2012), of repairing the imminent rupture created by talking

512about Steve in a negative way, takes precedence over attendance to the process of the child's

513interruption. Validation of the child's difficulties in engaging in the process of therapy can be

514in itself a way of engaging the child.

```
515
516Extract twelve: Clamp family
517
518FT:          I wuz also thinkin' >one of the things< we were
519             thinkin' for you Phillip was (.) we did ↑a lot of
520             talkin' abo::ut
521(1.2)
522FT:          some of the things that YOU ↑do (.) that yer ↑mum
523             an' ↑dad aren't too happy about >an' I guess< I
524             jus' wanted t' say that ↑I ↑know that it's re::ally
525             difficult t' sit there and ↑listen an' yer dad
526             mentioned it as well that (.) you kind of sit and
527             listen in
528(1.4)
529FT:          and one thing I didn't ask about is the things that
530             you're really GOOD at
531
```

532In this therapy session where multiple family members are present including the parents,

533three children and the uncle Joe, the use of recipient selection *'you Phillip'* (line 1) may be

534significant in securing the child's attention. This may function to prohibit other members

535from contributing and selects Phillip as the intended audience. The therapist uses a series of

536conversational processes, beginning with acknowledgement of the family's discussions about

537Phillip, validation of the difficulty for Phillip in listening to those discussions and

538culminating in attempts to reengage him in the therapy. The therapist begins with a

539reformulation of the series of negative ascriptions of Phillip and his behaviour that have

540characterised the preceding conversation. The therapist acknowledges his contributions to

541this talk by stating *'we did a lot of talkin' about some of the things that YOU do'* (lines 3-5)

542which is an inclusive footing position. However, there is a footing shift (Goffman, 1981)

543immediately following this as the therapist positions the judgement of Phillip's behaviour

544with his parents *'yer mum and dad aren't too happy about'* (line 6). This sequential shift in

545alignment from talking with the parents moves from 'we' (the three adults), to 'they' (the

546parents), to an alignment with Phillip as he moves to engage Phillip more directly by

547acknowledging how he might feel about those discussions *'It's really difficult t' sit there and*

548*listen'* (lines 6-7).

549
550*Extract thirteen: Webber family*
551
```
552FT:        ↑what we're hopin' t' achieve and >I know that< you're
553           lookin' uneasy already Da(h)niel
554Mum:       Heh he[h heh
555FT:              [I know that this isn't easy stuff for you to talk
556           about >is it<
557           (0.6)
558FT:        especially with your parents (0.2) present. but but we
559           kindda had an <idea that>
560           (0.6)
561FT;        actually it's re::ally important <for us all> to be able
562           to talk about as well
563           (1.2)
```
564

565The same three processes of acknowledgement, validation and engagement, are also visible in

566this extract. The therapist displays an interpretation of Daniel's non-verbal behaviour as

567indicative of his affective state *'you're looking uneasy already Daniel'* (line 2). This is

568followed up with the use of validation as the therapist comments on the difficult nature of the

569conversation and the difficulty Daniel may experience in contributing *'this isn't easy stuff for*

570*you to talk about'* (line 4). The encouragement to engage Daniel is presented inclusively with

571a statement that it is *'important for us all to be able to talk'* (line 10).

572

573**Discussion**
574
575The aims of this paper were to illuminate through empirical analysis some of the ways in

576which children attempt to resist and disengage from family therapy, and also which

577interventions from therapists are helpful in seeking to manage these processes. Our analysis

578revealed four social processes that relate to children's disengagement. Social process one

579considered how children's disengagement from therapy can be active or passive: passive

580disengagement was characterised by inattention to the therapeutic process; passive resistance

581was characterised by active attention to alternative activities; and active disengagement was

582displayed by verbally refusing to answer questions directed specifically to them. Social

583process two considered how children expressed their autonomy and evaded adult impositions.

584These were expressed verbally, conveying a desire to cease therapy either in the present

585moment or in the future, and were set up as contrary to adult expectations and wishes. Social

586process three considered the role of other family members in therapy, specifically exploring

587the more flexible obligations of attendance of siblings. Social process four explored how

588therapists attempt to create engagement or re-engage a child to repair any rupture that may

589have occurred.

590

591Adult and children's adherence to treatments is considered to be an important aspect of

592healthcare (Osterberg & Blaschke, 2005). Research has focused heavily on children's

593adherence to pharmaceutical treatment programmes with non-compliance having serious

594consequences for children's health (Butler, Roderick, Mullee et al, 2004; Osterberg &

595Blashke, 2005). Compliance with medical treatments has clear physical benefits to the child

596which become visible during the course of interventions and has potential to encourage future

597engagement with medical services. Importantly non-compliance in the talking therapies is

598less visible as the child is ostensibly present in the therapy which indicates immediate

599adherence. Problematically, the mere presence of the child does not guarantee their

600participation and this potentially renders the therapy ineffective. For example, using a

601medical metaphor, if a child hides medication under the tongue and later spits it out the

602treatment will not be effective; in therapy, without active engagement in the process of

603therapy, the intervention will not achieve its outcomes. Furthermore, not only will the

604therapeutic process be rendered ineffective, but it may also have an iatrogenic effect. As the

605children are listening to negative descriptions of them, which is common in family therapy

606(Parker & O'Reilly, 2012), without recourse to contribute their own perspective, this may

607have a potentially damaging impact.

608

609The literature indicates that we have a limited evidence base regarding how children engage

610with therapy (Strickland-Clark et al, 2000) and one way to explore this important issue is to

611investigate how children resist and disengage in practice. It is evident that analysis of the

612behaviour of children and families in therapy can be an important aspect of predicting

613outcomes (Kazdin et al, 2005). Our analysis illuminates the range of behavioural and verbal

614indicators of how children withdraw from the therapeutic process and how this is managed by

615the adults. Research with adult participants indicates that they withdraw or disengage from

616therapy when they sense something threatening developing, and use disengagement as a way

617of stalling discussion which may result in criticism from the therapist (Frankel and Levitt,

6182009). Parental criticism of children in therapy through the positioning of the child as the

619problem can lead to them being talked about in a derogatory way (O'Reilly & Parker, 2012,

620b). Sociological research illustrates that children possess social competencies of greater

621sophistication than is typically assumed (Hutchby, 2002; Hutchby & O'Reilly, 2010) and

622therefore disengagement from therapy could be understood as a mechanism for managing

623criticisms.

624

625An understanding of children's contributions to family therapy through qualitative analysis

626facilitates an understanding of the process through which children disengage from services.

627This understanding of disengagement is useful in informing the broader context of attrition as

628cumulatively these disengaged moments can contribute to the failure of the therapy as a

629whole. This has important implications given that families are offered therapy to assist them

630when they experience violence, breakdown or juvenile delinquency (Hutchby & O'Reilly,

6312010) and thus failure in therapy has potential wider social consequences. To avoid dropout

632from family therapy it is important to consider the role the child plays. It is necessary to

633achieve more than just the physical presence of the children, but to prevent, recognise and

634manage disengagement while maintaining alliance with both the parents and children.

635Quantitative scales, such as the CTAS-R (Pinsof, Hovarth and Greenberg, 1994), have been

636designed to measure the possible discrepancies in strength of alliance between individuals in

637couples therapy (Knobloch-Fedders et al, 2004). The advantage of using conversation

638analysis to investigate alliances in family therapy is that it relies on observable data as

639opposed to self-reports and allows the analyst to examine alliance processes as they occurs in

640practice. Our analysis illustrates that validation as a way of recognising the difficulty for the

641child has potential to circumvent disengagement or facilitate re-engagement. The therapist

642therefore has some responsibility for attending to the passive and active disengagement

643strategies of the child in terms of recognising their occurrence and attending to the non-verbal

644indicators. This can be a complex task when the parents are especially active and it is easy to

645overlook the passive disengagement of quieter children.

646

647By applying a micro-analytic approach to the social processes inherent within naturally

648occurring family therapy sessions, we are able to explicate the nuances of the interaction.

649This has allowed us to interrogate the sequential nature of therapeutic interactions in a way

650that highlights the process of children's resistance and disengagements. This has important

651implications for exemplifying wider social processes in order to broaden our understanding of

652approaches that may facilitate engagement. Families are an important social institution and

653our findings suggest that the mere presence of the child within the family unit does not

654necessarily equate to active involvement in family processes.

655

656There are some limitations with the conversation analytic approach to data analysis, for

657example, while suggestions are made, the power to implement these recommendations lies

658with those who commission and practice (Antaki, 2011). It can be difficult, however, for

659family therapists as consumers of research evidence to engage with and implement strategies

660due to barriers such as time and resources (Kosutic, Sanderson and Anderson, 2012).

661Nonetheless research evidence is necessary for informing change and improving services and

662our analysis provides a benchmark for understanding the process of adult-child alliances in a

663family therapy setting. These principles also translate to other domestic situations, for

664example in family disputes, in terms of how children may competently resist alliance with or

665disengage from the family unit. Our findings also have broader implications for

666understanding children's compliance and engagement in other institutional settings such as

667education. In the classroom it may be helpful to consider similar patterns of how children's

668physical presence does not necessarily equate to their active engagement with pedagogy.

669Arguably therefore the strategies children use for resisting and disengaging from education

670may not be that different from therapy and thus this could be a useful area for exploration in

671future research.

672

673The task for the therapist is to actively encourage engagement with the child and to

674circumvent disengagement and dropout regardless of the therapeutic model they adhere to.

675This can be a delicate endeavor as it is necessary to maintain alliances with both parents and

676the children, who may hold contradictory positions. It is clear that to yield the benefits of

677therapy, there is a requirement for children to do more than simply attend appointments, but

678to also be actively involved in the process.

679

680

References

683 Antaki, C. (2011). Six kinds of applied conversation analysis. In C. Antaki, (Ed), *Applied*

684 *Conversation Analysis: Intervention and Change in Institutional Talk (pp: 1-14).*

685 Hampshire: Palgrave MacMillan.

686

687 Aspland, H., Llewelyn, S., Hardy, G., Barkham, M., & Stiles, W. (2008). Alliance ruptures

688 and rupture resolution in cognitive-behaviour therapy: A preliminary task analysis.

689 *Psychotherapy Research, 18 (6),* 699-710.

690

691 Beauchamp, T., & Childress, J. (2008). *Principles of Biomedical Ethics (Sixth Edition).*

692 Oxford: Oxford University Press.

693

694 Beitin, B. (2008). Qualitative research in marriage and family therapy: Who is in the

695 interview? *Contemporary Family Therapy, 30,* 48-58.

696

697 Boggs, S. R., Eyberg, S.M., Edwards, D.L., Rayfield, A., Jacobs, J., Bagner, D., & Hood,

698 K.K. (2004). Outcomes of parent-child interaction therapy: A comparison of

699 treatment completers and study dropouts one to three years later. *Child and Family*

700 *Behavior Therapy, 26 (4),* 11-22.

701

702 Butler, J., Roderick, P., Mullee, M., Mason, J., & Peveler, R. (2004). Frequency and impact

703 of nonadherence to immunosuppressants after renal transplantation: a systematic

704 review. *Transplantation, 77 (5),* 796-776.

705

706 Chu, B. & Kendall, P. (2004). Positive associations of child involvement and treatment

707   outcome within a manual-based cognitive behavioral treatment with anxiety. *Journal*

708   *of Consulting and Clinical Psychology, 72,* 821-829.

709

710 Day, C., Carey, M., & Surgenor, T. (2006). Children's key concerns: Piloting a qualitative

711   approach to understanding their experience of mental health care. *Clinical Child*

712   *Psychology and Psychiatry, 11 (1),* 139-155.

713

714 Drew, P., Chatwin,, J. & Collins, S. (2001). Conversation analysis: A method for research

715   into interactions between patients and health-care professionals. *Health Expectations,*

716   *4 (1),* 58-70

717

718 Escudero, V., Friedlander, M., Varela, N. & Abascal, A. (2008). Observing the therapeutic

719   alliance in family therapy: associations with participants' perceptions and therapeutic

720   outcomes. *Journal of Family Therapy, 30,* 194-214.

721

722 Frankel, Z., & Levitt, H. (2009). Clients' experiences of disengaged moments in

723   psychotherapy: A grounded theory analysis. *Journal of Contemporary*

724   *Psychotherapy, 39,* 171-186.

725

726 Georgaca, E., & Avdi, E. (2009). Evaluating the talking cure: The contribution of narrative,

727   discourse, and conversation analysis to psychotherapy assessment. *Qualitative*

728   *Research in Psychology, 6,* 233-247.

729

730 Goffman, E. (1981). *Forms of talk.* Oxford: Basil Blackwell.

731

732 Hawley, K. & Weisz, J. (2003). Child, parent, and therapist (dis)agreement on target

733   problems in outpatient therapy: the therapist's dilemma and its implications. *Journal*

734   *of Consulting and Clinical Psychology, 71 (1),* 62-70.

735

736 Hutchby, I. (2002). Resisting the incitement to talk in child counselling: aspects of the

737   utterance 'I don't know'. *Discourse Studies, 4 (2),* 147-168.

738

739 Hutchby, I., & O'Reilly, M. (2010). Children's participation and the familial moral order in

740   family therapy. *Discourse Studies, 12 (1),* 49-64.

741

742 Hutchby, I., & Wooffitt, R. (2008). *Conversation Analysis (Second Edition).* Oxford:

743   Blackwell Publishers.

744

745 Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner

746   (Ed), *Conversation Analysis: Studies from the First Generation* (pp: 13-31).

747   Amsterdam: John Benjamins.

748

749 Jefferson, G, (1984), 'On stepwise transition from talk about a trouble to inappropriately

750   next-positioned matters' J.M. Atkinson & J. Heritage, (Eds), in *Structures of Social*

751   *Action,* (pp 191-222). Cambridge University Press, Cambridge.

752

753 Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment

754   and premature termination from child therapy. *Journal of Consulting and Clinical*

755   *Psychology, 65 (3),* 453-463.

756

757 Kazdin, A., Marciano, P., & Whitley, M. (2005). The therapeutic alliance in cognitive-

758   behavioural treatment of children referred for oppositional, aggressive, and antisocial

759   behavior. *Journal of Consulting and Clinical Psychology, 73 (4),* 726-730.

760

761 Knobloch-Fedders, L., Pinsof, W., & Mann, B. (2004). The formation of the therapeutic

762   alliance in couple therapy. *Family Process, 43 (4),* 425-442.

763

764 Kosutic, I., Sanderson, J., & Anderson, S. (2012). Who reads outcome research? Outcome

765   research consumption patterns among family therapists. *Contemporary Family*

766   *Therapy, 34,* 346-361.

767

768 Lobatto, W. (2002). Talking to children about family therapy: A qualitative research study.

769   *Journal of Family Therapy, 24,* 330-343.

770

771 Mas, C.H., Alexander, J. F., & Barton, C., (1985). Modes of expression in family therapy: A

772   process study of roles and gender. *Journal of Marital and Family Therapy, 11,* 411-

773   415.

774

775 Masi, M., Miller, R., & Olson, M. (2003). Differences in drop out rates among individual,

776   couple, and family therapy clients. *Contemporary Family Therapy, 25 (1),* 63-75.

777

778 O'Reilly, M. (2008). 'What value is there in children's talk?' Investigating family therapist's

779   interruptions of parents and children during the therapeutic process. *Journal of*

780   *Pragmatics, 40,* 507-524.

781

782 O'Reilly, M. (2006). Should children be seen and not heard? An examination of how

783   children's interruptions are treated in family therapy. *Discourse Studies, 8 (4)*, 549-

784   566.

785

786 O'Reilly, M & Parker, N. (2012, a). Unsatisfactory Saturation': A critical exploration of the

787   notion of saturated sample sizes in qualitative research. *Qualitative Research* DOI:

788   10.1177/1468794112446106

789

790 O'Reilly, M. & Parker, N. (2012, b) "She needs a smack in the gob": negotiating what is

791   appropriate talk in front of children in family therapy. *Journal of Family Therapy*

792   DOI: 10.1111/j.1467-6427.2012.00595.x

793

794 Osterberg, L., & Blaschke, T. (2005). Adherence to medication. *New England Journal of*

795   *Medicine, 353*, 487-497.

796

797 Parker, N. & O'Reilly, M. (2012). Gossiping' as a social action in family therapy: The

798   pseudo-absence and pseudo-presence of children. *Discourse Studies, 14 (4) XX*

799

800 Pilnick, A., Hindmarsh, J. & Gill, V. T. (2010). Beyond 'doctor and patient': developments in

801   the study of healthcare interactions. In A. Pilnick, J. Hindmarsh & V. T. Gill (Eds),

802   *Communication in Healthcare Settings: Policy, Participation and New Technologies.*

803   (pp: 1-16). West Sussex: John Wiley and Sons.

804

805 Pina, A., Silverman, W., Weems, C., Kurtines, W., & Goldman, M. (2003). A comparison of

806   completers and noncompleters of exposure-based cognitive and behavioural treatment

807   for phobic and anxiety disorders in youth. *Journal of Consulting and Clinical*

808   *Psychology, 71 (4),* 701-705.

809

810 Pinsof, W., Hovarth, A., & Greenberg, L. (1994). An integrative systems perspective on

811   therapeutic alliance: Theoretical, clinical, and research implications. In A. Hovarth, &

812   L. Greenberg, (Eds), *The Working Alliance: Theory, Research, and Practice, (pp:*

813   *173-195).* New York: John Wiley and Sons.

814

815 Pomerantz, A. (1984). Agreeing and disagreeing with assessments: some features of

816   preferred/dispreferred turn shapes. In J. M. Atkinson, & J. Heritage (Eds), *Structures*

817   *of social action: studies in conversation analysis* (pp: 57 – 101). Cambridge:

818   Cambridge University Press.

819

820 Richman, G., Harrison, K., & Summers, J. (1995). Assessing and modifying parent responses

821   to their children's non-compliance. *Education and Treatment of Children, 18 (2),* 105-

822   116.

823

824 Sacks, H. (1992). *Lectures on Conversation* (Vols. I & II, edited by G. Jefferson). Oxford:

825   Basil Blackwell.

826

827 Safran, J., & Muran, J. (1996). The resolution of ruptures in the therapeutic alliance. *Journal*

828   *of Consulting and Clinical Psychology, 64 (3),* 447-458

829

830 Safran, J., Muran, C., Samstag, L., & Stevens, C. (2001). Repairing alliance ruptures.

831   *Psychotherapy, 38 (4)*, 406-412.

832

833 Silverman, D. (1997). *Discourses of Counselling: HIV Counselling as Social Interaction*:

834   London: SAGE Publications.

835

836 Stith, S., Rosen, K., McCollum, E., Coleman, J., & Herman, S. (1996). The voices of

837   children: preadolescent children's experiences in family therapy. *Journal of Marital*

838   *and Family Therapy, 22, 69-86*

839

840 Strickland-Clark, L., Campbell, D., & Dallos, R. (2000). Children's and adolescents' views

841   on family therapy. *Journal of Family therapy, 22,* 324-341.

842

843 Tan, J., Passerini, G., & Stewart, A. (2007). Special section: Consent and Confidentiality in

844   clinical work with young people. *Clinical Child Psychology and Psychiatry, 12 (2):*

845   191-210.

846

847 Thomas, S., Werner-Wilson, R., & Murphy, M. (2005). Influences of therapist and client

848   behaviors on therapy alliance. *Contemporary Family Therapy, 27 (1)*, 19-35.

849

850 Thompson, S., Bender, K., Lantry, J., & Flynn, P. (2007). Treatment engagement: Building

851   therapeutic alliance in home-based treatment with adolescents and their families.

852   *Contemporary Family Therapy, 29,* 39-55.

853

854 Topham, G. & Wampler, K. (2008). Predicting dropout in filial therapy program for parents

855   and young children. *The American Journal of Family Therapy, 36,* 60-78

856

857 Wang, M., Sandberg, J., Zavada, A., Mittal, M., Gosling, A., Rosenberg, T., Jeffrey, A., &

858   McPheters, J. (2006). "Almost there"... why clients fail to engage in family therapy:

859   An exploratory study. *Contemporary Family Therapy, 28,* 211-224.

860

861 Werner-Wilson, R., & Winter, A. (2010). What factors influence therapy drop out?

862   *Contemporary Family Therapy, 32,* 375-382.

863

864 Wolpert, M., & Fredman, G. (1994). Modelling the referral pathway to mental health services

865   for children. *Association of Child Psychology and Psychiatry: Newsletter, 16,* 283-

866   288.

867

63[i] Note that prior to the sequence displayed here the parents were reporting a story about the children's uncle Joe being
64arrested for child sex offences some years ago and that social services have recently raised this as an issue
65
66[ii] Here they are referring to the fact that Adam was victim of sexual abuse from his biological father and the father was
67arrested, charged and sentenced for child abuse. Adam then went on to be an abuser of Daniel, who is now engaging in
68inappropriate sexual behaviour with his younger sibling Stuart. This suggests a cycle of behaviour and thus Adam's
69attendance and engagement could be potentially beneficial.
70
71