

**Negotiation of Responsibility in a Family Therapy Intervention for  
Adolescents who Self-harm: a Discourse Analysis**

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## **ABSTRACT**

Systemic interventions, including family therapy (FT), have been found to have positive outcomes for individuals who engage in self-harm behaviour (SHB) (Brent et al., 2013; Carr, 2016; Cottrell et al., 2018b). A number of factors related to family functioning have been associated with SHB (Fortune, Cottrell, & Fife, 2016).

Research has shown that narratives of responsibility are an important part of the FT process, however, none investigate how responsibility for self-harm is negotiated in a FT setting. This study uses the discursive action model (DAM, Edwards & Potter, 1993) to explore how responsibility is negotiated within FT for adolescents who have self-harmed. Video data of FT sessions were made available under the access provisions of the Self-Harm Intervention-Family Therapy (SHIFT) Trial (Wright-Hughes et al., 2015; Cottrell et al., 2018b).

The findings show that negotiations of responsibility are central to the talk in the initial FT sessions and that family members and therapists managed their interests (stakes) through a variety of actions within the talk. The analysis revealed that family members, in particular the parents, tend to enter therapy with interests which compete with the therapist's goal of achieving a narrative of shared responsibility. For example, parents entered therapy with actions that managed the risk that they are seen as 'bad parents' and responsible for their child's SHB.

It is, therefore, important for therapists to consider how they might negotiate powerful discourses of responsibility, whilst considering the interests of family members and maintaining a therapeutic relationship. I have evidenced the applicability of the DAM in deconstructing the discourse in a FT setting. I suggest its use as a clinical tool in FT practice. Principles from the DAM could be used in identifying the actions and stakes of family members in order to be mindful of these within the FT process.

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS .....</b>	<b>3</b>
<b>ABSTRACT .....</b>	<b>4</b>
<b>TABLE OF CONTENTS .....</b>	<b>5</b>
<b>ABBREVIATIONS.....</b>	<b>9</b>
<b>CHAPTER ONE: INTRODUCTION.....</b>	<b>10</b>
Literature Review.....	11
Self-Harm: What is it? .....	11
A Social Constructionist Critique of Pathology .....	13
Social Construction of Self-Harm.....	14
Language/ Terminology .....	16
Adolescents Who Self-Harm.....	16
The Importance of Involving Families in the Treatment of Self-Harm .....	17
Family Therapy .....	19
Discourse Analysis for the Study of Family Therapy .....	21
Discourses of Responsibility in Family Therapy .....	22
Attribution Theory .....	25
Implications of Assigning Responsibility .....	27
Rationale for this Research .....	28
Aims and Research Questions .....	30
Aims .....	30
Research Questions .....	30
<b>CHAPTER TWO: METHOD .....</b>	<b>31</b>
Choice of Method .....	31
Theoretical Rationale for the Chosen Method .....	31
Historical and Theoretical Underpinnings of Discourse Analysis .....	32
Discursive Action Model .....	33
The Use of Clinical Discourse from Therapy Videos .....	35
Sample .....	36
The Self-Harm Intervention: Family Therapy Trial.....	36
SHIFT inclusion criteria.....	37

Access to the Video Data .....	38
Sample Size and Selection of Sessions .....	38
Inclusion of the Reflecting Team Conversation.....	39
Ethical Considerations .....	40
Clearance.....	40
Consent.....	41
Maintaining Confidentiality .....	41
Managing Risk .....	42
Procedure .....	42
Transcription of Video Data.....	42
Transcription conventions.....	43
Analysis.....	44
Interpretative repertoires.....	50
Identities.....	50
Quality Control .....	51
Reflexivity in systemic research.....	51
My position as a researcher.....	52
Use of a reflective journal.....	53
Validity.....	54
<b>CHAPTER THREE: ANALYSIS .....</b>	<b>55</b>
Family 1: Mina and Nita .....	56
Mina and Nita: A Pen Portrait.....	56
Overview .....	56
Requiring Maturity.....	57
Validating Attunement in order to Undermine the Request for Maturity .....	61
Summary .....	63
Family 2: Kelly and Stacey.....	64
Kelly and Stacey: A Pen Portrait .....	64
Overview .....	64
Undermining Rationality.....	65
Restricting Knowability vs. Increasing Knowability .....	67
Diminishing Difference.....	70

Summary .....	72
Family 3: Kirsty and Nicole.....	73
Kirsty and Nicole: A Pen Portrait .....	73
Overview .....	73
Sharing Responsibility vs. Resisting Accountability .....	74
Assuming Shared Responsibility and Deconstructing Blame .....	76
Summary .....	80
Family 4: Lou and Hannah .....	81
Lou and Hannah: A Pen Portrait .....	81
Overview .....	81
Doubting a Reasonable Explanation .....	82
Implying Independence/ Giving Approval.....	84
Refusing to Tell the ‘Story’ .....	88
Summary .....	90
Family 5: Cal, Anne and Fred.....	91
Cal, Anne and Fred: A Pen Portrait .....	91
Overview .....	91
Claiming Unawareness.....	93
Forcing Visibility .....	95
Rescuing.....	97
Summary .....	99
Summary of Findings Across the Data Sample .....	100
Parents.....	100
Young People.....	104
Therapists and Reflecting Team Members.....	106
Summary in Relation to the Primary Research Question.....	109
Reflections on the Analytical Process.....	110
<b>CHAPTER FOUR: DISCUSSION.....</b>	<b>111</b>
Summary of the Findings.....	111
Parents: Mitigating Responsibility.....	112
The Therapist’s Challenge .....	115
Adolescence and Responsibility .....	117

Agency, Responsibility and Attribution Theory .....	120
Strengths and Limitations .....	121
Strengths.....	121
Limitations .....	124
Clinical Implications .....	126
Reflections .....	128
Avenues for Future Research.....	130
Conclusion .....	131
<b>REFERENCES .....</b>	<b>133</b>
<b>APPENDICES.....</b>	<b>146</b>
Appendix A: SHIFT Screening and Eligibility Checklist.....	146
A.1 Screening Form .....	146
A.2 Eligibility Checklist.....	147
Appendix B: Ethical Approval Letter .....	148
Appendix C: SHIFT Consent Form .....	149
Appendix D: Transcriber Confidentiality Agreement .....	150
Appendix E: Example of Annotated Transcript.....	151
Appendix F: Extracts from my Reflective Journal .....	152



## **ABBREVIATIONS**

CAMHS: Child and Adolescent Mental Health Service

CTRU: Clinical Trials Research Unit

DA: Discourse Analysis

DAM: Discursive Action Model

DSM: The Diagnostic and Statistical Manual of Mental Disorders Volume 5

FT: Family Therapy

GT: Grounded Theory

IPA: Interpretative Phenomenological Analysis

IR: Interpretative Repertoire

IPAS: Interpersonal Psychotherapy Alliance Scale

LFTRC: Leeds Family Therapy and Research Centre

NHS: National Health Service

NSSI: Non-Suicidal Self-Injury

SHB: Self-Harm Behaviour

SHIFT: Self-Harm Intervention- Family Therapy

TAU: Treatment as Usual

## **CHAPTER ONE: INTRODUCTION**

I begin this chapter by describing the dominant discourses that are present when referring to self-harm behaviour (SHB). Whilst outlining these, I critique a pathological stance and provide a social constructionist perspective on SHB and mental illness as a whole. This social constructionist perspective paves the way for many systemic interventions. I go on to provide an overview of the rationale for intervening systemically with adolescents who have engaged in SHB, and the evidence base behind this. I then outline how a social constructionist epistemology provides the foundations for family therapy (FT) specifically, and describe the principles behind FT and the mechanisms through which it is said to work.

This paper will focus on FT for adolescents who engage in SHB. Within this, I have chosen to pay attention to the ways in which responsibility for SHB is negotiated between the adolescent, their family, and the therapist. I situate the rationale for this focus within the existing literature looking at discourses of responsibility which are present in FT for more general populations, and the early literature on attribution theory.

I have chosen to use discourse analysis (DA) as a method and I explain, during this chapter, how this fits with social constructionism and the study of FT.

## Literature Review

### **Self-Harm: What is it?**

The prevalence of SHB in young people in the United Kingdom appears to be increasing (Morey, Mellon, Dailami, Verne, & Tapp, 2016). Morey et al. (2016) completed a self-report survey of 2000 13-18 year olds across England. They recruited by sending out invitations to take part, giving details of the study and reference to the fact that they would be asking questions about SHB. The response rate to the invitation was 37.3%. They used the Child and Adolescent Self-Harm in Europe (CASE) definition of SHB (Madge et al. 2008). This classifies SHB as:

An act with a non-fatal outcome in which an individual deliberately did one or more of the following: 1) Initiated behaviour (for example, self-cutting, jumping from a height), which they intended to cause self-harm. 2) Ingested a substance in excess of the prescribed or generally recognised therapeutic dose. 3) Ingested a recreational or illicit drug that was an act that the person regarded as self-harm. 4) Ingested a non-ingestible substance or object. (Morey et al., 2016, p. 59-59).

They found that, within females aged 13-18, there was an incidence of 54.9% of SHB within the year prior to interview. This strikingly high incidence of SHB might be criticised on the basis of the opt-in nature of the study. It is possible that the study attracted individuals who had engaged in SHB and, as a result, were more interested in contributing to research on the subject. If this were the case, the incidence reported here may be inflated. However, while the reasons for the non-responses are left unknown, it is important to acknowledge that individuals who are experiencing a high level of emotional distress, which is associated with SHB, may have been less likely to or able to respond and participate in the study. Therefore, the incidence of SHB generated by Morey et al.'s survey may not reflect this population of individuals and the actual incidence of SHB amongst young people may be even higher.

The cause for concern about this high incidence of SHB is clear, however, the literature does not appear to reach a consensus on how to conceptualise such a phenomenon. Over the years, a range of terminology has been used by both researchers and professionals to label such complex behaviour: “self-mutilation” (e.g. Walsh & Rosen, 1988); “parasuicidal behaviour” (e.g. Linehan, Heard, & Armstrong, 1993); “suicide gesture” (e.g. Nock & Kessler, 2006); “deliberate self-harm” (e.g. Plener, Schumacher, Munz, & Groschwitz, 2015). The most striking contrast in recent perspectives appears to be between those who view SHB as a diagnosis in itself and those who have studied SHB as something that serves a variety of different functions.

In 2013, *The Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.; *DSM-5*; American Psychiatric Association) introduced non-suicidal self-injury (NSSI) disorder, as a diagnostic category. The category comprises a range of self-injurious behaviours, including cutting and self-battery, which are intended to deliberately and immediately cause damage to the individual’s body (Swannell, Martin, Page, Hasking, & St. John, 2014). There are two major issues with the concept of NSSI as a diagnosis. Firstly, we cannot reasonably separate SHB from suicidal intent. To do so is to ignore that there is significant overlap between NSSI and suicide attempts (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Wester, Ivers, Villalba, Trepal, & Henson, 2016). Studies have shown that SHB, even where non-suicidal, is a predictor of attempted and completed suicide (Asarnow et al., 2011; Conner, Langley, Tomaszewski, & Conwell, 2003; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011).

Secondly, although literature focusing on the association between SHBs and psychopathology has found associations with depression, anxiety and also low self-esteem (Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002), to medicalise SHB as a diagnosis in itself is to ignore the literature that points to the array of functions that the behaviour serves. There are a variety of proposed motivations behind SHBs. Those proposed include the expression or reduction of, distraction or relief from, or the need to detach from intolerable or overwhelming affect (Gratz, Chapman, Dixon-Gordon, & Tull,

2016; Laye-Gindhu & Schonert- Reichl, 2005). These can include feelings of anger/ tension, emptiness, loneliness or depression (Laye-Gindhu & Schonert- Reichl, 2005). SHB may also serve the function of punishing oneself or regaining control when the individual feels this has been lost (Briere & Gil, 1998; Klonsky, 2007; Laye-Gindhu & Schonert- Reichl, 2005).

Having said this, much of the current research on the prevalence, risk-factors and presentation of SHB uses the DSM-5 definition of NSSI (e.g. Cipriano, De Maio, Cella, & Cotrufo, 2017; Swannell et al., 2014).

### **A Social Constructionist Critique of Pathology**

The DSM-5 (2013) and a medical view of mental health hold a stance in which the researcher, clinician or therapist, is the scientist and expert. It assumes that the ‘experts’ are able to identify ‘abnormal behaviour’ or ‘inadequate functioning’ and diagnose accordingly (Spitzer, 1991), and it was this belief that allowed for the creation of the diagnostic categories within the DSM-5. These diagnoses often inform the type of treatment that the individual then receives. However, the DSM-5 can be criticised for its basis on *a priori* assumptions. It provides a reductionist set of categories that ignore an individual’s unique social and environmental experiences, and are founded from the particular experiences of a particular set of ‘experts’ (Spitzer, 1991). To base treatment on a diagnostic label alone disregards the important influence that an individual’s system and unique experiences have in shaping their behaviour and experience of mental illness.

One school of thought in the academic world has begun to move away from this traditional idea of scientific knowledge in mental health. Social constructionists believe that an individual’s experience “is mediated historically, culturally and linguistically” (Willig, 2008, p. 7). This experience includes our perception; how we perceive our realities. Therefore, we cannot assume that ‘reality’ is an objective entity and that there are ‘experts’ and objective diagnoses within it.

It can be argued that there is not one ‘knowledge’ but ‘knowledges’ (Willig, 2008). These are created in accordance with an individual’s perception of their environment; we cannot assume that each and every one of us perceives and reacts to a particular set of circumstances in exactly the same way. What we experience and perceive is a product of the socio-political and historical context in which we have gained ‘knowledge’, including our language. It is through this language that we actively construct the world around us.

Pathology and diagnoses remove the complex explanations of the socio-political influences on individual experience and meaning making, which lead some people to experience their mental health differently to others. By seeking to understand an individual’s social, cultural and political environment, we might also understand these behaviours that are all so often reduced to a pathology or biological cause.

Our understandings of an individual’s behaviour and mental health, are inextricable from society’s values, culture and their social relationships (Kleinman, 1988). These influences mediate how we perceive, interpret and respond to complaints in our environment including the shaping and expression of our distress; here, specifically, SHB. In the same way, the same cultural influences shape how we view and understand the behaviour of others, e.g. how we conceptualise and give meaning to a person’s distress.

### **Social Construction of Self-Harm**

Social constructionists would assert that SHB has meaning beyond the individual; at a social, cultural, historical and political level (e.g. Payne, Swami, & Stanistreet, 2008). It has often been found that the prevalence of SHB in adolescent females is significantly higher than in adolescent males (Laye-Gindhu & Schonert- Reichl, 2005; Morey et al., 2016; Morgan et al., 2017; Ross & Heath, 2002). In a bid to understand this phenomenon, social constructionist literature has begun to explore how the social construction of gender has impacted on female expression of distress, and in particular SHB.

Shaw (2002) describes, from a feminist perspective, how changing historical discourses can shed light on SHB in females. Shaw proposes that SHB “reflects girls’ and women’s

experiences of relational and cultural violations, silencing and objectification” (p. 192). She also argues that the history of the literature examining SHB among females sometimes unintentionally replicates these processes, by either ignoring or distorting their accounts of their experience of SHB. The discourses within the literature that Shaw reviews a shift between an understanding that SHB is meaningful and an expression of a female’s cultural, internal and interpersonal experiences, and viewing SHB as ‘manipulative’ and pathological. What was highlighted in this paper was that, when the former discourse was taken and SHB was understood as related to the individual’s experience of the world, the women engaged in treatment. When the discourse was one of pathology and unreasonable pain and behaviour, the subsequent portrayal of the women in the literature was that they were ‘unresponsive to treatment’.

Having spoken about how the social construction of gender is said to impact on the expression of distress in females, I feel that it is also important to comment on SHB in individuals who are not cisgendered (in that their self-identity does not correspond with their biological sex). For this group of individuals (including but not limited to transsexual, non-binary, genderqueer, dual-gendered and non-gender conforming individuals), rate of reported SHB is rising (Reisner et al., 2015). When compared with the cisgendered population, a much greater proportion of non-cisgendered individuals engage in SHB (Conolly, Zervos, Barone, Johnson, & Joseph, 2016; Jackman et al., 2016). This may be influenced by the victimisation that they encounter due to the fact that they challenge the socially constructed norms of sexuality and binary gender.

Acknowledging the importance of socio-political, cultural and historical influences on the occurrence of SHB provides a strong rationale for considering such influences in the treatment of SHB. It is on these principles that systemic interventions are founded. They are interventions that seek to involve an individual’s wider system in their formulation and subsequently in their intervention.

### **Language/ Terminology**

I have explained that there is a variety of meanings and labels given to self-harm, each being shaped by the context and prior experience that the ‘meaning-making’ individual is coming from. I do, therefore, feel it is appropriate to provide a reason for why I have labelled self-harm behaviour as I have.

Literature exists that points to self-harm as functioning as a coping mechanism for a variety of experiences; whether it be a strategy for regulating affect or a means of communication (e.g. Laye-Gindhu & Schonert- Reichl, 2005). In line with this view, I have decided to use the term “self-harm behaviour”. This is based on the dictionary definition of behaviour: “the way in which an animal or person behaves in response to a particular situation or stimulus” (Oxford Dictionaries, 2017), whether this stimulus or stimuli are internal or external. This highlights the importance of social/ environmental factors on an individual who has self-harmed.

I endeavour not to pathologise self-harm behaviour, and I oppose the idea that it is a diagnosis in itself. However, the choice of the word ‘harm’ could be critiqued alone. The negative connotations that the word ‘harm’ brings, serves to ignore potential positive consequences for the individual. We as professionals/ researchers have observed this behaviour as causing ‘harm’, even though we now acknowledge the many functions that it serves, and it may be that the individual engaging in ‘self-harm’ would not use this choice of words at all. This being said, in order to be harmonious with existing literature on this phenomenon, I have chosen to reflect on this critique and retain the term “self-harm behaviour” (SHB).

### **Adolescents Who Self-Harm**

I focus specifically on adolescents due to the literature that suggests that they are the most ‘at-risk’ population (Nock, 2010). In their recent study, Morgan et al. (2017) examined electronic health records from 647 general practices within the United Kingdom to determine the incidence of SHB in 10-19 year olds over the period of 2001 to 2014. They



found that, for girls aged 13-16 years, there was a sharp increase of 68% in the incidence of SHB between 2011 and 2014 (from 45.9 per 10 000 participants in 2011 to 77.0 per 10 000 participants in 2014). The incidence of SHB reported in Morgan et al.'s (2017) study is considerably lower than that reported in Morey et al.'s (2016) study (who found an incidence of 54.9% in girls aged 13-18). This is most likely due to the fact that not all (and arguably very few) young people who engage in SHB will present to their general practice as a consequence. Morgan et al. (2017) do, however, illustrate the rising incidences of SHB among adolescent girls in the United Kingdom.

The reason for the increasing prevalence in young people remains unknown, and it is debatable whether the frequency at which SHB occurs has increased or whether it is now more likely that an individual will report it. Literature has pointed to the increased availability of information about SHB and suicidal behaviour, which has been highlighted as both an opportunity for education and prevention and a public health concern (Boyce, 2010).

### **The Importance of Involving Families in the Treatment of Self-Harm**

Systemic therapies are based upon the idea that it is not the symptom or behaviour itself that needs to be the focus of the intervention, but the wider system that is impacting on the individual and eliciting such a response. Although not speaking about mental health or SHB specifically, Campbell, Coldicott, and Kinsella (1994) when thinking systemically about organisations, explain that “the problem is not a problem itself, but is part of a larger process involving many “other” people, “other” behaviours, and “other” meanings” (p. 12). To view mental health ‘problems’ in this way and SHB not as an objective pathology, has allowed for systemic treatments to develop.

Systemic therapies have been found to be successful for around 66% of cases, with specific models being particularly useful for specific common mental health problems (Carr, 2016). With regards to SHB specifically, Carr (2014) explains that due to social factors that impact on SHBs, family-based treatments can work to facilitate better attachments and develop

family support skills. Fortune, Cottrell, and Fife (2016) provide a narrative review of family factors that are associated with SHB in adolescents. They defined SHB as any non-fatal self-injury or poisoning regardless of intent (including suicidal ideation). They found a number of family factors found to be associated with SHB. 'Parent-child interaction' was one of their over-arching themes which took into account factors such as: child maltreatment; attachment; parental awareness of suicidality; perceived parental support; and patterns of expressing emotions. Other parental factors were parental conflict and parental mental health. Based on their findings, they made the recommendations that any family-based treatments with individuals who engage in SHB should have a focus on promoting adaptability, attachment, cohesion and support within the family. As part of this, some of the focus should be on promoting parental warmth, reducing any maltreatment and deconstructing any scapegoating which may be present within the system.

Although there is a clear rationale for why family based treatments seem appropriate for adolescents who engage in SHB, the evidence base is still being developed. Brent et al. (2013) provide a review of interventions for the treatment of both NSSI and suicidal ideation and attempts; such treatments included home-based family treatment, integrated cognitive behaviour therapy and multisystemic therapy. In doing so, they highlight that much of the literature had weaknesses in evidencing a treatment's efficacy in reducing symptoms. However, they were able to conclude that those interventions showing promise were those that focused on family interactions or other non-familial sources of support.

The "Self-Harm Intervention- Family Therapy (SHIFT)" trial aimed to evaluate both the clinical and cost effectiveness of FT for adolescents who have engaged in SHB (Cottrell et al., 2018b; Wright-Hughes et al., 2015). During their trial, they administered either treatment as usual (TAU) or FT to 11-17 year olds presenting with either a second or subsequent episode of SHB and collected a series of outcome measures as secondary outcome data. Their primary outcome was whether the young person attended hospital due to repetition of self-harm within the 18 months following assignment to either the FT or TAU arm of the trial. Although they found no significant difference between the FT and

TAU groups in hospital admission, they did find that scores of 'general emotional and behavioural difficulties', as reported by the young person and caregiver, were significantly better within the FT group. This suggests that, even though a reduced repetition of SHB was not observed, overall there was a positive effect on mental health. Furthermore, lower scores of 'self-reported suicide ideation' were seen in the FT group. This difference was only seen at 12 months after assignment, not at 18 months after. However, this arguably indicates that FT may be effective in reducing suicidal ideation sooner than TAU. I go on to explain this trial in more depth during my method, as the SHIFT trial was my data source.

It appears that family interventions should be effective in treating adolescents who engage in SHB, and some research has been undertaken to evidence the effects, although the mechanisms through which such complex interventions prove effective require further examination.

### **Family Therapy**

Although there are many interventions founded in social constructionist and systemic thinking (Dallos & Draper, 2010; Dallos & Vetere, 2009; Hedges, 2005), this paper focuses on FT. Early models of FT were located in the scientific view that families could be classified according to a variety of variables (Dallos & Draper, 2010). It was assumed that these variables could be objectively measured and classified based on observational and experimental data; a notion that fit with the scientist/ expert stance of the DSM. As the literature developed, the idea that these objective descriptions of families existed came in to question. It was often that different therapists viewing the same family would perceive them in a completely different way, and it was also true that their perceptions could vary dramatically from the family's own (Dallos & Draper, 2010, p. 11). Each individual brought with them their own unique experiences and socio-political/ cultural background and these, in turn, informed their judgements; their meaning making.

Currently, FT models are founded in social constructionist principles. They highlight that the individuals in the therapy room (family members and therapists) will hold versions of

'reality' that are unique but are also constructed from the social context and culture that the individuals may share. Family Therapists view language as a window into these meanings, both shared and unique. Social constructionists would posit the idea that the choices that families make are limited by these shared cultural discourses, and maintained by inequalities in power. The process of FT aims to use language to understand and deconstruct powerful discourses, with the aim to reach a shared narrative in which all individuals have the ability to problem solve (Dallos & Draper, 2010).

In their book *Therapy and Social Construction*, McNamee & Gergen (1992, p.2) explain that Family Therapists would not view the individual as the centre of their own or the family's "malfunction". Instead they aim to explore how "individual pathology" has become a manifestation, in that individual, of the problems within both their immediate and extended family system. It is on these principles that Family Therapists then base their formulation which informs their intervention.

There is a vast amount of literature on the principles behind FT and how it is proposed to work. There is, however, little research evidencing these mechanisms. Burck, Frosh, Strickland-Clark, & Morgan (1998) explored how the therapist's interventions contribute to the evolution of 'new meaning' within the family system. They used DA to analyse the course of FT for one family, paying particular focus to how the therapist's contributions shaped 'alternative meanings' in the family. They found the therapist's actions of 'engagement and establishing multi-positionality', 'declaring her views' and 'confirming the family's repositioning' contributed to this meaning making. As they only focus on the FT process for a single family, their findings may be particular to the context of this particular family's therapy. However, they do highlight the applicability of using discursive techniques to analyse therapists' practices to begin to look at *how* FT works; unpicking important processes within sessions and thinking about therapeutic competence.

Although Burck et al. (2008) illustrate some of the actions used by a Family Therapist to influence the therapy process, they do not look at the outcome of this therapy process in

order to suggest whether these actions were linked to a good therapy outcome. In her article entitled *Change Process Research*, Greenberg (1986) explains the importance of measuring three types of outcome during therapy research. The three types of outcome that she highlights are: the “immediate outcomes” (those changes which are evident in session), the “intermediate outcomes” (which are measured each session, and look at changes in concepts such as attitudes and beliefs) and “final outcomes”, which are taken at the end of the therapy process and at follow up (Greenberg, 1986, p. 4).

She explains that in order to study the process of change in therapy, the researcher needs to determine two things: how they are going to measure the immediate outcome (change during session) and how they will measure the process which led to any change. However, although exploring the link between these two concepts might evidence which therapist-actions are linked to in session changes, it would not address the question of whether these actions and in session changes are linked to positive therapy outcomes. It is, therefore, important to link these “immediate outcomes” to the “intermediate” and “final” types of outcome which Greenberg (1986, p. 4) speaks about. In doing so, the researcher is then able to make claims about therapist actions which are linked to good outcomes in therapy.

### **Discourse Analysis for the Study of Family Therapy**

The use of DA has been widely used to investigate the talk-in-interaction occurring within a FT setting, particularly looking into how a problem narrative and blame and responsibility are negotiated (O'Reilly, 2014; Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016; Sinclair & Monk, 2004; Stancombe & White, 1997). Tseliou (2013) provides a systematic review highlighting the applicability of both conversational analysis and DA in the study of FT clinical talk. Both are qualitative approaches which fit with the epistemology of systemic practice, i.e. social constructionism (Gale, 2010). There are many variants under the umbrella of DA differing slightly in their methodology, perspectives, and theories, but all sharing the idea that language and its socio-political and historical context provides the means through which we construct our realities (Willig, 2008). For this reason, DA provides

a relational approach to the study of psychological phenomena, and it is in this respect that it fits with the social constructionist epistemology of FT (Diorinou & Tseliou, 2014; Patrika & Tseliou, 2016).

Discursive psychologists look at how individuals use language to negotiate social interactions in order to attain interpersonal goals (e.g. attribution of blame and responsibility) (Potter & Wetherell, 1987; Willig, 2008). The authors of much of the early DA literature, Edwards and Potter (1992; 1993), do not view language as an objective and transparent means of conveying information. Instead, they acknowledge that the way in which an individual uses language to communicate an explanation of an event has powerful social implications and can be viewed as a social act. They also propose that these social acts can be studied through the use of DA.

We might view SHB as a social act in itself because, as I discussed earlier on, SHB can often serve the function of communication (Laye-Gindhu & Schonert-Reichl, 2005). DA of FT can explore the meanings given to the 'social act' of SHB and the consequences these generate.

### **Discourses of Responsibility in Family Therapy**

During the initial sessions of FT, the therapist is aiming to assess the difficulties that the family members are experiencing and, in doing so, a problem narrative is generated (Carr, 2016). The problem narrative can be defined as the story that an individual holds about what has happened; what the problem is and why it occurred. It might be that the family members narratives are similar and cohesive, or that they differ and clash. On occasion, a shared problem narrative can limit opportunities for change. For example, it has been found that within families of individuals with a psychiatric diagnosis, an important part of the clinical work was allowing for a deconstruction of dominant accounts which maintained a problematic, pathological view, with the aim of allowing for less problem focused narratives to evolve (Avdi, 2005). Such research highlights the importance of the negotiation of the problem narrative within a FT setting.

Included in the negotiation of the problem narrative are the attributions of responsibility for the family's difficulties (Friedlander, Hetherington, & Marrs, 2000; O'Reilly, 2014; Patrika & Tseliou, 2015, 2016). Some studies have highlighted how families can enter therapy with powerful narratives of responsibility. For example, studies have found that families can enter therapy with a narrative that places the cause of their difficulties with the family member who experiences the psychological symptoms (Parker & O'Reilly, 2012; Patrika & Tseliou, 2015; Wolpert, 2000). Family Therapists would not share a view of such linear narratives and instead take a more circular perspective, in which psychological distress is relational (Tseliou, 2014). It is for this reason that FT takes a non-blaming or non-pathologizing stance to psychological symptoms, and why therapists take on the difficult task of deconstructing narratives which blame or place sole responsibility for change with one family member.

Studies have gone some way to show the complex ways in which the negotiation of responsibility for family difficulties occur, particularly in the presence of a child (Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016). Patrika and Tseliou (2015, 2016) highlight how blame can often be placed with the child with the psychological symptoms, and how the parents may struggle with the acceptance of responsibility. They also describe how therapists attempt to generate an alternative discourse to the often linear and problem focused attributions that the families enter with, and that the therapists occasionally find themselves misunderstood, with family members feeling blamed as a result (Patrika & Tseliou, 2015).

O'Reilly (2014), used a method of DA called the discursive action model (DAM) to explore discourses of blame and accountability in FT. They found that parents used a variety of discursive devices that they drew on to attribute blame to their child. Amongst these discursive devices was the use of a psychiatric or diagnostic interpretative repertoire (IR) which located responsibility for the family's difficulties with the child's intrapsychic qualities. IRs are described as being "recurring patterns of word use, imagery and ideas within talk" (Taylor, 2001, p. 26). They are used to generate a shared understanding

amongst individuals, for example, a shared understanding of a diagnosis. I go on to explain more about IRs in the next chapter.

In their research, which also uses the DAM, Parker and O'Reilly (2012) describe a process in which parents negotiate blame and accountability for a child's behaviour by first attempting to engage and recruit the therapist into their account of events. They also illustrated how the presence of a child can disrupt this process. Parents drew on discursive devices, such as active voicing, descriptions, and providing evidence, in order to strengthen their claims. When the child was present, the child challenged any alignment between the therapist and parents by denying their parents' claims. The therapist then worked to engage the child whilst, simultaneously, managing the risk that they are seen as disbelieving of the parents' story.

Carr (2016) explains that reframing a problem as "shared challenges", to which a family can collectively find a solution, is often the focus of the engagement phase of FT. Gale (2010) describes how clients accessing FT may enter therapy hoping to persuade the therapist of their narrative of the problem. Therefore, how the therapist responds to claims of responsibility and facilitates the negotiation of the problem narrative, will impact greatly on their therapeutic alliance, and possibly the outcome of therapy. It is clear that families often enter therapy with problematic discourses and that these are not easy to reframe and negotiate (Stancombe & White, 1997; 2005).

Many studies have demonstrated that responsibility plays an important role in FT, and that the therapist's responses to discourses of responsibility can have an impact on the therapeutic relationship (Gale, 2010; Stancombe & White, 1997; 2005). The studies above provide their findings as either themes across all of the families in their data set (Parker & O'Reilly, 2012; O'Reilly, 2014; Patrika & Tseliou, 2015; 2016) or as a single case study (Diorinou & Tseliou, 2012). Although studies which synthesise their data set provide a description of common discourses that a therapist might encounter, they omit the details around the evolution of each narrative of responsibility. Single case studies (e.g. Diorinou



& Tseliou, 2012) do provide rich description of the nuances of one evolution of responsibility. However, they cannot make the claim that the evolution of responsibility that they present is found commonly across multiple families. Research is needed that looks at these processes *within* and *across* families.

### **Attribution Theory**

I have already illustrated how different meanings are attributed to the act of SHB and how these meanings are shaped by the socio-political and historical context that the individual is coming from. I have also highlighted how families often bring of stories of responsibility to a FT setting. Attribution theory attempts to explain how and why we assign meaning to our own and others' behaviour, including causal explanations and responsibility. It is concerned with how an individual perceives, gathers and combines information about a social situation to form a judgement on a number of attributions (e.g. cause, responsibility and blame) (Fiske & Taylor, 1991). Attributions for the responsibility, blame or cause behind an event can involve internal factors (e.g. an individual's beliefs, personality or motives) or external factors (e.g. a situation outside of an individual's control) (Heider, 1958). This refers to the locus of the attribution. Attributions are also constructed in terms of their perceived stability and controllability and are said to have a role in affective states (Weiner, 1985). They are related to experiences of self-esteem, pity, shame, guilt, gratitude, hopelessness and anger (Weiner, 1985) and, for this reason, they can influence an individual's experience of mental health.

It is not unusual that attributions should form part of a narrative or story that an individual holds when entering FT; any explanation of an event or issue involves attributions. When we experience an event that triggers a strong emotional response in us, we look for something or someone that is responsible for that response. Campbell et al. (1994) suggests that this is a "survival mechanism"; we look to assign "meaning for what is happening and course of action to change the situation" (p. 11). Assigning cause or responsibility is therefore a form of problem solving, but when each individual is trying to solve a problem

in their own interests, it leaves the problem unsolved (Anderson, Goolishian, & Winderman, 1986).

In keeping with the social constructionist stance that I have outlined above, we might assume that the socio-political, cultural and historical context from which an individual is perceiving mental health, would shape the attributions that they form about it. Discursive psychologists explain that an individual can hold multiple meanings (attributions being encompassed in this) for a certain thing (e.g. mental health) at any one point (Edwards & Potter, 1992). Different attributions for the cause of and responsibility for mental health symptoms can be held simultaneously, can contradict each other and can be deployed based on the individual's motives (stake in the interaction) at the time. The attributions that are made will influence an individual's experience of mental health (either their own or someone else's) and their actions towards it. Attribution theory explains the different types of attribution that an individual might hold and deploy, e.g. internal, external, stable, controllable (Heider, 1958). However, it assumes that attributions are held, like constants such as values or beliefs, and it cannot account for changes in the attributions that people make; it does not explain why people make certain attributions in certain contexts.

Much of the literature that I have presented in relation to attributions in FT, deploys terms such as responsibility, accountability and blame (e.g. O'Reilly, 2014; Patrika and Tseliou, 2016). Patrika and Tseliou(2016) explain that, in their paper, they had "loosely deployed" (p. 117) these terms and that is it important to think about how these concepts are theoretically defined and used. Provencher and Fincham (2000) distinguished between three different types of attributions. The three categories were cause, responsibility and blame; "causal attribution corresponds to the factors that produce an event, responsibility attribution implies a judgement regarding an individual's accountability for the event and blame attribution refers to an evaluative judgement concerning the implicated individual's liability for censure" (p. 899). It is important to make this distinction between different types of attribution here, as it is the attributions of responsibility my research focuses on, i.e. responsibility for SHB. I explore how individuals negotiate responsibility for previous SHB,

and how responsibility for future events is negotiated, i.e. responsibility for future SHB and for making changes that aim to reduce the likelihood of SHB occurring again.

It is, however, extremely difficult to examine one of the three types of attributions without the need to comment on the others. The concepts are not entirely distinct and overlap may be observed. For example, if an individual is held responsible for the cause of an event, they may also feel blamed or be blamed.

### **Implications of Assigning Responsibility**

Attribution of responsibility to the individual with psychological symptoms may serve to perpetuate their symptoms. Feelings of self-blame may be elicited, in an individual, if they are presented as responsible for the maintenance of their own or their family's difficulties or for the events that led up to the difficulties. Self-blame has been identified as a contributing factor to SHBs. For example, in an investigation into the effect of childhood maltreatment on NSSI, Swannell et al. (2012) identified self-blame as an underlying process and highlighted the importance of addressing this process in therapy, suggesting cognitive therapy as a means of modifying self-blaming cognitions.

In her exploration of the effect of attributions made by family members of individuals experiencing enduring mental health conditions, Robinson (1996) looked into the relationship between the varying causal attributions and perceived family functioning. Identified causal attributions were "God", "biology", "heredity", "chance" or "people-based". The only causal attributions associated with perceived poor family functioning were the 'people-based' ones. These attributions were associated with anger, guilt, bitterness or resentment. She did, however, acknowledge that people with a tendency to blame others may also have a pessimistic outlook on family functioning.

Causal attributions and the sense families make of mental health has an impact on the individual's experience of their symptoms and on family functioning. However, there is an absence in the literature investigating family member attributions of responsibility for SHB specifically, and how these discourses might be managed within a therapeutic setting.

Family Therapists hope, throughout therapy, to find a balance between the multiple discourses of responsibility within a system. The ways in which they negotiate narratives of responsibility should adhere to the systemic principles of achieving multi-partiality, and not being seen to take the side of any one family member in particular (Selvini, Boscolo, Cecchin, & Prata; 1980; Stancombe & White, 2005). They hope to find a balance between the individual's symptoms and/or difficulties in family functioning being completely uncontrollable, unstable and due to external/ environmental factors, and the symptoms/ difficulties being predictable and influenced by one 'responsible' individual. It is a complex process by which this occurs and my research aims to shed some light on the multiple discourses that arise, how family members and the therapist negotiate these, and how people react to the deconstructing and shaping of dominant responsibility discourses.

### **Rationale for this Research**

It is clear that the attribution of responsibility plays a significant role in how individuals experience mental illness (e.g. Swannell et al., 2012) and it is evident that the negotiation of responsibility forms a significant aspect of FT (Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016). However, studies that go some way to explaining how this occurs (Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016) have considerably broad samples making the results difficult to apply to a single population.

With regards to FT interventions for adolescents who engage in SHB specifically, Amoss, Lynch and Bratley (2016) have already highlighted that, during the SHIFT trial, powerful feelings of blame were encountered. Although they describe some ways in which the therapist responded to these, particularly in their reflective conversation, a detailed analysis of how a therapist may encounter and negotiate powerful narratives of blame and responsibility with families experiencing SHB, has not yet been explored.

Within a FT setting, there are many factors that may affect the ways in which stories are negotiated. 'Talk-in-interaction' (Schegloff, 1980) is a term coined to express how our talk, including its verbal and non-verbal features, comprises social action and interaction. This

‘talk-in-interaction’ is a complex process that happens extremely quickly, and with the potential for meaning being missed or misunderstood. These moments can leave behind residual emotion and helpful narratives may become harder to negotiate within a family. It is, therefore, important to investigate the means by which the attribution of responsibility is negotiated within families, how the therapist and reflecting team can work towards more helpful problem narratives, and how we can identify these ‘more helpful narratives’.

Previous literature using DA to look at the ‘talk in interaction’ in FT have highlighted the importance of therapists evaluating their practice and developing their reflexivity (Patrika & Tseliou, 2016; Sinclair, 2007). Patrika and Tseliou (2016) emphasise the potential usefulness of DA in shedding light on the details of the negotiation of blame, responsibility and accountability. They suggest that, by looking into the blaming sequences present throughout FT, how they evolve and how they are handled by the therapist, questions around ‘the difference that makes the difference’ (Bateson, 1979) might be answered.

My research intends to provide some insight into ‘the difference that makes the difference’ in the negotiation of responsibility in FT.

## **Aims and Research Questions**

### **Aims**

The overall aim of my research is to provide insight into how a therapist might encounter and negotiate stories of responsibility within a FT setting for adolescents who engage in SHB. It is the hope that this will provide a reflexive account for therapists to refer to when thinking about how they might encounter and respond to powerful narratives of responsibility.

### **Research Questions**

The primary question that I consider is:

- How is responsibility for SHB negotiated between the therapists and family members in FT for adolescents?

Within this, I will think about:

- How individuals manage their stake/ interests in the exchange and what this tells us about their needs.
- The discursive devices, repertoires and constructions that individuals draw on to manage this.
- What opportunities that the above processes open up and close down (within the exchange and beyond the therapy context).

## **CHAPTER TWO: METHOD**

I begin this chapter by presenting my chosen method of analysis and the rationale behind this. I then go on to explain where the data for my research were obtained from and the methodological considerations regarding my sample. This is followed by an outline of my procedure, including my analytical steps, and I conclude with a commentary on my quality assurance, including my own positioning and reflective process as a qualitative researcher.

### **Choice of Method**

#### **Theoretical Rationale for the Chosen Method**

My research does not aim to answer questions or hypotheses by quantifying data; instead it looks to explore the interactions between families and therapists and identify patterns within these interactions. Qualitative methods of analysis are concerned with generating new understanding about the ways in which people experience the world and construct their understanding of it (Elliot, Fischer & Rennie, 1999), and so a qualitative method was most appropriate for my focus. There is a range of qualitative methods of analysis suitable for a range of different types of research questions, and so it was important to consider which method of analysis was most appropriate when answering my particular research question.

My research question focuses on language as a social act; how people use language to negotiate responsibility within a FT setting. It is concerned with relational processes, rather than individual participants cognitions and attitudes. DA is focused on language as a relational process, rather than language as a way of exploring individuals' cognitions and experience. Methods such as grounded theory (GT) and interpretative phenomenological analysis (IPA) better answer research questions which aim to investigate cognitions and experiences, categorising concepts such as people's beliefs and attitudes about a particular topic. To use methods such as GT or IPA would be to see language as representative of an individual's experience in a way that is independent from the context of the talk. It would

not wholly consider language as a social act; an important aspect of family interaction. Whereas GT and IPA believe that remembering and reporting through language offer us a window into an individual's cognition (Willig, 2008), DA is underpinned by the assumption that these types of talk perform 'social acts' and are referred to as 'activity sequences' to reflect this (Edwards & Potter, 1992). As highlighted in my introduction, the social constructionist epistemology of DA is shared by systemic practice and is effective in exploring features of talk within a FT setting (Gale, 2010). DA has been used to explore how discourse occurs within FT settings, allowing clinicians to identify patterns in their own and others discourse so that they can be addressed (Burck, 2005). I, therefore, decided that DA was most suitable for answering my research question and that it fit with the relational and social constructionist epistemology of FT.

### **Historical and Theoretical Underpinnings of Discourse Analysis**

DA is concerned with the construction of social reality through language and is critical of the cognitive approach to research (Willig, 2008). It is not a method of analysis that gives a prescriptive set of steps, instead it provides a guiding set of principles, grounded in social constructionist theory (Edwards & Potter, 1992).

Potter (2001) provides an account of how Wittgenstein (1953) and Austin (1962)'s thoughts around the philosophy of language provided the foundations from which DA ideas were developed. Wittgenstein was a philosopher who first critiqued the idea of cognitivism. Contrasting to a cognitivist view, in which language provides a representation of mental objects consistent across individuals and context, he suggested that this was not the case and that language performs a range of context-dependent activities. In 1962, Austin then put forward his theory of 'speech-acts'. He suggested that no matter how we might categorise the talk of individuals, e.g. accounts, statements, descriptions, they all perform actions. He proposed that, in order for the speech-act to achieve its purpose, a set of conditions must be in place; 'felicity' (truth) conditions. These are the contextual conditions that need to be present in order for the speech to be used in the way that it was intended.



It was not until the 1970s that concepts of Wittgenstein (1953) and Austin (1962) began to influence the work of social psychologists, as they started to challenge cognitivism and its taken-for-granted nature in psychology (Gergen, 1973). Then, in the 1980s, the idea that language is in fact 'productive', in that it constructs versions of reality which are context dependent and action oriented, really began to take hold in the field of psychology. The popularity of this school of thought was catalysed by Potter and Wetherell's (1987) publication of *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. This book outlines their critique of cognitivism and began to lay out the principles of discursive psychology alongside transcripts that had been analysed using a DA approach. Later, Edwards and Potter (1992; 1993) would begin to outline the discursive action model (DAM); a specific model falling under the DA umbrella.

### **Discursive Action Model**

There are multiple methods of analysis that come under the umbrella of DA. The methods overlap but have different foci and are suitable for different types of research questions. I chose to use DAM outlined in Edwards and Potter's (1993) *Language and Causation: A Discursive Action Model of Description and Attribution*. It was introduced as a conceptual framework for research into attributions and highlighted some features that are central to participants' discursive practices. The DAM investigates how discursive practices perform particular actions and provides a structure centred around three major principles: Action, Fact and Interest, and Accountability (Edwards & Potter, 1993). This element of structure was important to me when I was choosing my method of analysis. As someone new to DA, I found it helpful to have some key principles around which I could structure a framework for my analysis.

Each of the three major principles has three components, outlined in table 1 (Edwards & Potter, 1993). Talk is suggested to be action-oriented. Actions such as blamings and defendings serve different functions dependent on the context of the talk. The focus of the DAM is to illuminate how psychological phenomena, such as attribution, are designed and

organised, within the talk, to perform specific actions and functions; what they aim to achieve. The DAM proposes that accounts are rhetorically organised in a way that manages the stake or interest of the individual producing the account, and that there is a range of discursive devices which are employed in order to construct reports as factual. Accountability is suggested to be negotiated at the two different levels shown in table 1.

I go on to explain, in more detail, how the principles of the DAM informed my analytical process later on in this chapter.

Table 1

*Major principles and components of the discursive action model (Edwards & Potter, 1993).*

Major principles	Components
Action	<ol style="list-style-type: none"><li>1. The focus is on action, not on cognition.</li><li>2. Attributions are discursive actions.</li><li>3. Attributions are situated in activity sequences such as those involving invitation refusals, blamings and defences.</li></ol>
Fact and Interest	<ol style="list-style-type: none"><li>4. There is a dilemma of stake and interest, which is often managed by doing attribution by means of factual reports and description.</li><li>5. Reports and descriptions are therefore constructed and displayed as factual items by a variety of discursive devices.</li><li>6. Reports and descriptions are rhetorically organised to undermine alternatives.</li></ol>
Accountability	<ol style="list-style-type: none"><li>7. Reports attend to agency (causality) and accountability in reported events.</li><li>8. Reports attend to the accountability of the current</li></ol>

speaker's action, including those done in reporting.

9. The latter two concerns are often related, such that Component 7 is employed for Component 8, and Component 8 is employed for Component 7.

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Initially derived to study the action of attribution, this particular model of DA seemed most relevant when choosing a method for studying the negotiation of responsibility. As I spoke about in my introduction, attributions are a component of the way in which we make sense of and trade responsibility through language. In their description of the DAM, Edwards and Potter (1993) explain that “attributions are situated in activity sequences such as those involving invitation refusals, blamings and defences” (p. 24). Refusals, blamings and defences are just some of the actions we might expect when individuals are negotiating responsibility through language. The model also refers to accountability, a concept related to positions of responsibility.

### **The Use of Clinical Discourse from Therapy Videos**

In order to investigate how responsibility is negotiated as part of the problem narrative in FT, I used live FT videos. The use of live therapy videos in research provides naturally occurring and authentic discourse in line with the requirements of a DA. Not only is the use of live clinical discourse beneficial in that it fits with a DA, but it ensures validity for the applicability of any findings.

An alternative approach would have been to interview young people who have engaged in SHB, their families and the therapists on their experience of the negotiation of the problem narrative in FT, including their perceptions of the attribution of responsibility and any attempts to change/ diffuse this. This would, however, have posed multiple problems due to the interviews' interactional nature. Potter and Hepburn (2005) provided an overview of contingent (avoidable) and necessary (unavoidable) problems in research using interviews. Contingent problems, to which there are often straightforward solutions, highlight how

interview research is often tailored in a way that ignores the impact of the interviewer and the interaction set up as a whole, e.g. the deletion of the speech of the interviewer. The necessary problems are inherent to all interview set ups and impact greatly on the validity of the interpretation of the interview talk. The four problems listed, by Potter and Hepburn, are:

- (1) the flooding of the interview with social science agendas and categories;
- (2) the complex and varying footing positions of interviewer and interviewee;
- (3) the possible stake and interest of interviewer and interviewee;
- (4) a drag toward cognitive and individual explanations. (p. 291)

Such implications mean that data gained from interviews are confounded by the interaction with the interviewer and we cannot make assumptions on how the interview set-up effected and guided the discourse of the interviewee's responses. The use of live therapy as data will provide discourse that is true to a FT intervention and is free from the social impact of an interview set up.

## **Sample**

### **The Self-Harm Intervention: Family Therapy Trial**

The data set from which I have sourced my video data was collected as part of the "Self-Harm Intervention- Family Therapy (SHIFT)" trial (Cottrell et al., 2018b; Wright-Hughes et al., 2015). This was a randomised controlled trial, investigating the efficacy of FT for adolescents who have engaged in SHB, when compared to TAU. The main outcome of interest was whether repetition of SHB, leading to hospital admittance, occurred within the 18 months following their allocation to either of the two groups. Families were allocated to either FT or TAU at random. Those allocated to the FT arm of the trial attended a total of 8 FT sessions each lasting around an hour and fifteen minutes and they attended on an, approximately, monthly basis. Qualified, registered Family Therapists delivered an adapted version of the Leeds Family Therapy and Research Centre (LFTRC) Systemic Family

Therapy manual (Pote et al., 2000; Wright-Hughes et al., 2015). This manual was developed using participants who were practitioners at the LFTRC, whose form of FT has grown out of the Milan school (Boscolo, Cecchin, Hoffman, & Penn, 1987). Pote et al. (2000) explain that the contributing therapists “would now describe their practice as being influenced by Post-Milan and Narrative Models” (p. 6). This type of systemic FT is largely representative of practice across the world. The existing LFTRC Systemic Family Therapy manual was updated to make sure that it was suitable for delivering FT to families following an episode of SHB (Cottrell et al. 2018a).

For the families where consent was obtained, all FT sessions were video recorded so that they could be assessed for intervention fidelity and used in future research.

My research, therefore, uses ‘secondary analysis’; a method through which data existing from a prior research trial is used to investigate research aims that are distinct from the aims of the original study (Heaton, 2003). This method is cost-effective, makes use of data sets which are underused and eliminates any burden that would be placed on further participants being recruited into another research trial.

### **SHIFT inclusion criteria.**

In the above literature review I have highlighted the varying definitions of SHB within the literature. Most of the recent literature adopts the concept of NSSI and its definition; since its addition to the DSM-5 (American Psychiatric Association, 2013). However, SHB is defined by the SHIFT trial, as “any form of non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, jumping from a height, and running into traffic), regardless of motivation or degree of intention to die” (Wright-Hughes et al., 2015, p. 2). This definition differs from NSSI in that some incidents of self-injury may have been done with suicidal intention. This study will, therefore, apply beyond the boundaries of NSSI to those who may have acted with suicidal ideation. This seems sensible as, previously, SHB and suicide attempts have been found to overlap significantly (Nock et. al, 2006).

Participants in the SHIFT trial were identified from 40 Child and Adolescent Mental Health Services (CAMHS), within the National Health Service (NHS), located in one of three areas: Yorkshire, London and Greater Manchester. Each of the families was selected subject to a set of inclusion and exclusion criteria, which are outlined in the Screening and Eligibility checklist document (see appendix A). All adolescents were aged between 11 and 17 years old and were required to have experienced at least two episodes of SHB. SHIFT recorded the ages of the adolescents in terms of whether they fell within an 11-14 or 15-17 year old age range. Out of the families who were randomly selected for my research sample, 4 of the adolescents fell into the 15-17 age range and one fell into the 11-14 age range. One adolescent was male and four were female.

### **Access to the Video Data**

In order to access videos from the SHIFT data set, I was required to submit a research proposal to the Clinical Trials Research Unit (CTRU) at the University of Leeds. The CTRU held the data and acted as gatekeepers for anyone wishing to use the videos for future research. This was then reviewed by the SHIFT panel and access to these videos was granted by Professor David Cottrell who is Chief Investigator for the SHIFT trial.

### **Sample Size and Selection of Sessions**

I analysed videos from five families. There are no strict guidelines on how to calculate a sample size for qualitative research, only that a sufficient number is used to answer the question. Previous research looking at responsibility and related concepts, such as blame, in FT have used similar sample sizes to the current project (Patrika & Tseliou, 2015, 2016). Furthermore, there have been multiple Doctorate of Clinical Psychology theses that have used DA and have yielded meaningful results from similar sample sizes (Brady, 2011; Brown, 2014). These can be found on the White Rose E theses website. It was, therefore, decided that a sample size of five was sufficient enough to answer the research question and manageable within the time constraints of a Clinical Psychology doctoral thesis.

The five families whose video data I used for analysis were randomly selected, by the statistician in the CTRU, from those families on the SHIFT trial who were assigned to the FT treatment. 832 young people were randomised into the trial in total, 415 of whom were assigned to the FT arm. Of those 415 families, there were 165 where all of the following criteria were met:

- The family had attended both the first and second session at least.
- Both sessions had been recorded.
- There was consent for the recordings to be used in future research.
- The DVD recordings of the sessions had been received by CTRU and uploaded to their s:drive, or received but not yet uploaded by the CTRU.

This 165 formed the data set from which my data were randomly selected by the statistician. Initially, I had considered if I should manipulate my sample so that it contained specific demographics, e.g. an even number of male and female young people. It felt that there were many factors that I could have controlled for, within my sample, but no clear rationale as to why I would need a sample of specific demographics. I decided that my research questions could be answered regardless of the demographics of the families.

The literature points to the formulation of the problem narrative happening in the engagement phase of the FT process (Carr, 2016). The formulation of the problem narrative should be rich in terms of attributions, the construction of facts and interest, and the negotiation of responsibility within this. For example, individuals begin to assign causal attributions for past and present problems and instances of blaming and refusals of accountability begin to occur. I, therefore, chose to focus my analysis within the first two sessions of FT.

### **Inclusion of the Reflecting Team Conversation**

FT sessions provided as part of the SHIFT trial followed the conventional format, which includes the 'reflecting conversation' (Dallos & Draper, 2010). The reflecting conversation (between the reflecting team members) and the following conversation between family

members, forms an important part of the therapeutic process. Once invited into the therapy room from behind the one-way mirror, the reflecting team begin by having a conversation, in front of the family, in which they share their ideas about and reflections on what they have heard in the session so far. The intention is that the process encourages multiple perspectives and meanings to be shared. New ideas are introduced to the family, some of which they may identify with and others they may not (Andersen, 1987). These conversations may provide new perspectives on any responsibility that was being negotiated during the therapy prior to the reflecting team conversation. Therefore, I felt that, in addition to the talk between the therapist and family members, it would be worthwhile to explore how the reflecting team's conversation takes place and how the family responds to this.

The reflecting conversations, within the SHIFT trial, included a variety of formats. All reflecting conversations were held between two professionals. Most of the reflecting conversations that I viewed within my data comprised both the therapist, who had been in the room interviewing the family, and one other reflecting team member who had been behind the one-way mirror. It was less frequent that the reflecting conversation did not include the therapist as one of the two reflecting team members but, on these occasions, the conversation was held between two reflecting team members who had been behind the one-way mirror.

## **Ethical Considerations**

### **Clearance**

As the data are held by the University of Leeds and I could not have any contact with service users, I was required to apply for ethical approval via the School of Medicine Research Ethics Committee within the Faculty of Medicine and Health. I was granted ethical approval on the 21<sup>st</sup> July 2017, reference number: MREC16-142 (see appendix B for approval letter).



## **Consent**

The SHIFT trial researchers were responsible for the original consent process and there was no supplementary process required for me to access the data. Families who were assessed as suitable by local CAMHS clinicians were introduced to the trial and provided with the trial information sheet which explained: the purpose of the study, what FT is, the difference between FT and TAU, and the process should they wish to take part in the study. Any families who were interested in being part of the trial were asked for their consent for a member of the SHIFT trial research team to contact them. They were then given the opportunity to discuss and ask questions about the trial with a member of the team before giving their consent to take part. Informed consent was sought from the young people and family members taking part in the trial. Participants (young people and family members) were asked to complete a consent form on which they were also asked if they gave consent for their therapy videos to be used in future research. Those who gave consent to their videos being used in future research formed the pool of participants from which my data set was selected. A blank copy of the parent/ carer consent form is provided in the appendices (see appendix C). The SHIFT trial sought consent via email from each of the participating therapists, for their videos to be used in future research.

## **Maintaining Confidentiality**

- Transcription was carried out by a previously approved and recommended transcriber. The selected transcriber was required to sign a confidentiality agreement (see appendix D), and to complete Information Governance and Data Security Training stipulated by the CTRU at the University of Leeds.
- On completion of the relevant training and confidentiality forms, my transcriber and I were granted access, by the CTRU, to a specific folder on the university's secure drive in which my video data were held.
- The videos were only accessed via an approved login at a computer located in a private room and headphones were used whilst watching the videos. This provided a

confidential space in which the potential for another individual to view the video accidentally and without authorisation was removed.

- All transcripts are anonymised by:
  - The use of fictitious names (pseudonyms).
  - Omitting/changing any potentially identifying contextual information, e.g.: names of schools, home location and any nearby landmarks, places of work, recreational organisations that participants attended.
- Electronic copies of transcripts were stored securely on the university m: drive.
- Paper transcripts will be shredded on completion of my doctorate, and any electronic transcripts will be transferred to the course's s: drive where they will be held for 3 years.

## **Managing Risk**

As the video data for my study have already been collected as part of a previous trial, there were no risk issues involved regarding the participants. Any risk issues had previously been resolved as part of the SHIFT trial. However, due to the live-therapy nature of the video data, some considerations were made around the small risk of the researcher or transcriber experiencing vicarious distress. The content of the videos are emotive with families describing, in depth, their traumatic experiences. I was supported by my research supervisors, who provided a space in which I was able to reflect on any emotional reaction to the video content. I checked in regularly with my transcriber, who was also offered this kind of support should she need it. I can report that these problems did not arise.

## **Procedure**

### **Transcription of Video Data**

The visual nature of the data meant that I spent some time considering which type of transcription would be most appropriate in answering my research questions. Multimodal

methods of transcription were considered but decided against. Multimodal DA appears to be a method of DA which is used when verbal language (whether audio/ transcribed) is not the primary data source (e.g. using videos and multimodal DA to study how students learn a trade, Chan, 2013). It is used when visual data, e.g. children learning a hands on skill, is of concern. For my research project, the visual data was supplementary but not necessary, and just because the other semiotics were not included in the initial transcript, it did not mean they were lost from the analysis. I was able to review the transcripts alongside the video data and added annotations where visual data changed or clarified meaning.

When considering transcription conventions there is a need to get a balance between what should be represented within the transcriptions in order for the question to be answered, whilst ensuring that the transcripts are still readable. The inclusion of fine details, such as intonation and timings, can lead to transcripts becoming difficult to read. They can also mean lengthy waiting times for transcripts to be produced. As I was able to watch the videos and make notes on the transcripts, as an ongoing process throughout my analysis, I did not need the finer details, such as intonation and tone. Whilst watching the videos, I made a note of any significant features in the speech that I felt were relevant when answering my question, e.g. when someone spoke whilst laughing. In order to answer my question, my transcripts needed to include all the content of the speech, i.e. what has been said. Therefore, interruptions and moments where people were speaking over each other were included within the transcripts.

### **Transcription conventions.**

YP: Young Person

M: Mum

D: Dad

SD: Step Dad

T: Therapist

RTM: Reflecting team member

[X]: Anonymised name or place (e.g. school)

[???]: Indistinguishable speech

(xxx): Actions/expressions/gestures

(.) (..) (...): Pauses of up to 1 sec, 1-2 sec and 2-3 sec +, respectively

## **Analysis**

Guidance on the general process and concepts of DA were drawn from Lyons and Coyle (2007), Potter and Wetherell (1987), and Willig (2008). Guidance on the concepts used specifically when using the DAM was found in the outlines provided by Edwards and Potter (1992; 1993) and Horton-Salway's (2001) example of the DAM in use. I begin by describing the overall process of a DA and then move on to explain my analytical steps, as informed by the DAM.

Willig (2008) describes some broad "procedural guidelines for the analysis of discourse" (p. 99). She explains that the investigator first reads the transcripts (or watches the videos) with the purpose of experiencing it rather than analysing it. This is then followed by the 'coding' of the data in which material is selected, from the text or videos, for analysis. Coding is done with the research questions in mind; both Willig (2008) and Potter and Wetherell (1987) highlight the importance of including all instances related to the topic, and those that the researcher believes may be vaguely related to the topic, at this point. The relevance of certain extracts can be refined as the analysis takes shape. Once coding is complete and the researcher is familiar with the data sample, the analysis takes place. The researcher must look at how the discourse constructs objects and subjects and how language and its constructs vary across individuals, and in their consequences (intended or otherwise). (Willig, 2008, p. 100).

The following steps provide an overview of my analytical process. It is important to note that DA does not follow as a linear step-by-step process and each of these steps were revisited at different stages, and as the analysis became more refined.

1. I began by watching each of the therapy videos, in turn, and identifying all extracts which appeared to be concerned with the negotiation of responsibility. This was done inclusively, meaning that I included extracts where responsibility was being spoken about or traded both explicitly or implicitly. Instances where responsibility was being spoken about explicitly included causal attributions for both past and present difficulties within the family and discussions about change. Many change discussions were linked to the causal attribution discussions; who has made a change and how has this impacted on the family, both positively and negatively. Change discussions, that were future oriented, included talk about what needs to change within the family and who is responsible for this change. The instances where responsibility was being spoken about, or traded, implicitly were harder to pin down. I included extracts in which I noticed that individuals seemed to be constructing their own identity as someone who was either responsible or irresponsible, without making explicit attributions for particular events. I also included instances where individuals seemed to be constructing another individual's identity as responsible or irresponsible in the same way.
2. I experienced delays, out of my control, in getting my transcriber access to the video data. This meant that I had longer than I had initially planned with the data in video format only. To put this time to good use, I spent a lot of time familiarising myself with the data. Whilst watching the videos, I noted down my initial impressions and ideas including emotional reactions to the video content. As part of this, I noted how the discourses in the videos played a part in any emotional reactions. These were kept within my reflective journal (discussed below) and referred to at future points in my analysis. Watching all of the videos in the data

sample allowed me to hold an awareness of the data sample as a whole and to consider any potential cohesion and overall themes.

3. Once she had been granted access, the selected extracts were transcribed by the professional transcriber. As I received the transcripts, I conducted the following analytical steps for one family at a time. This allowed me to explore the stories of each family in depth, identifying patterns and differences within families before moving on to identify patterns and differences across families.
4. Once I had received each transcript, I watched the video again. This allowed me to add, to the transcript, any additional information that I felt made the transcripts more representative of the live video data. This included notes on embodied action, e.g. laughter and facial expression, and notes on context, i.e. what was being spoken about in the previous section of talk if it had not been transcribed. I was also able to transcribe any additional video data that I deemed to be relevant on this second viewing.
5. I then read and re-read through each of the transcripts, recording my initial ideas in regards to the research questions. I recorded my impressions of what attributions of responsibility seemed to be being made and by whom, what positions of responsibility people seemed to be trading (taking on/ putting others in) and how other members of the therapy session responded to this.
6. After I had recorded my initial impressions and thoughts in relation to my research questions, I moved, iteratively, through a series of questions (see figure 1) that I had formulated based on the concepts highlighted in the DAM. To move from the general principles of the DAM to this set of questions I consulted existing literature, which had used the DAM as a method of analysis (Edwards & Potter, 1992; 1993; Horton-Salway, 2001; Patrika & Tseliou, 2015; 2016), looking for themes in how they had used the principles to answer their research questions. The themes that I found the literature addressing were:
  - The actions which were being performed by the talk of individuals.

- I generated questions which focused on how people trade responsibility through these actions.
- How accounts were constructed and attended to by speakers in order to build their 'cases' and how dilemmas of stake and interest were managed within this.
  - I generated questions which focused on how individuals hold and manage their stakes and interests in terms of responsibility.
- How individual's constructed their own identities and the identities of others.
  - I generated questions which focused on how constructed identities place people in positions of more or less responsibility.
- How individuals respond to the actions of others, and how the actions of individuals close down or open up opportunities for others to respond in certain ways.
- The discursive devices that are employed when constructing accounts and performing actions.

I moved through the questions a number of times for each pair of transcripts.

7. Once I had felt I had reached a saturation point with the pair of transcripts for one family (in that I was not noticing any new patterns), I then had a list of actions for each family member, and a list of the stakes that they appear to be managing. I viewed these as 'micro-actions' and 'micro-stakes'. In order to generate the main actions and stakes which provided the structure for my results I looked for themes amongst these 'micro-actions and stakes' for each individual; looking at what overall action each of the smaller actions was achieving and the overall stakes that they were managing.
8. I also recorded the actions through which individuals responded to the actions of others so that I was able to see the 'negotiation' of responsibility, rather than just a number of separate actions. Once I had determined the main actions and responses

for one family, I then moved on to analysis point 4 for the next pair of transcripts. See appendix E for an example of my annotated transcripts.

9. Once I had completed steps 4-8 for each family, I then revisited the data sample as a whole to look in more depth, at the similarities and differences across the families. During this step of my analysis I noticed that, as well as the nuances of the negotiations within each family, there were some commonalities across the whole data sample. As a result, I decided to present my findings as both a series of case studies and a summary of commonalities.



The questions below formed the framework for my analysis. Although I generally began by thinking about the first two questions in this list, the questions were not attended to in this sequence. I moved around the questions with more fluidity than linearity.

- What is being spoken about both explicitly and implicitly? (Including past and present causal attributions and responsibility for change)
- What is the action being performed by the talk? What is being done with what is being said (including the construction of facts, the trade of responsibility, and the management of stake and accountability within this)?
- What is 'at stake' for the individual? What have they got to lose/ gain? What do they risk?
- How is this related to the construction of identities and how are these identities related to positions of responsibility?
- Do individuals create certain identities, for themselves, and what responsibilities do these identities hold? Do they position others in ways that construct them as more or less responsible? How are identities created and positions of responsibility traded?
- What responses do certain actions, accounts and positions allow for? How do/ can other speakers respond?
- What are the patterns within and between speakers (consistency)? What are the differences within and between speakers (variance)?
- How is this done? What rhetorical devices do individuals use? Are any particular interpretative repertoires drawn from?

*Figure 1.* The guiding questions that I generated, based on the Discursive Action Model.

### **Interpretative repertoires.**

Interpretative repertoires (IRs) are described as being “recurring patterns of word use, imagery and ideas within talk” (Taylor, 2001, p. 26). They were first spoken about by Gilbert and Mulkay (1984) who, when exploring participants’ understanding of what is entailed in scientific work, found that there were two distinct ways in which the participants spoke about this. These two different patterns were then labelled IRs. The examples found in Gilbert and Mulkay’s research were the “Empiricist Repertoire” and the “Contingent Repertoire”. In the empiricist repertoire participants drew upon discourse that presented scientific work as generating findings that are independent from any influence of the researcher. The contingent repertoire, on the other hand, used discourse that contrasted with this view and drew on the principle that the scientist’s insight, beliefs, actions and personal characteristics may influence the scientific process.

Edley (2001) explains that identifying IRs is a gradual process that comes with the researcher becoming more and more familiar with their data. Eventually the researcher begins to recognise patterns within the speech; the recurring metaphors, images, figures of speech, choices of words around a certain topic. Once I was able to identify IRs in this way, I was able to consider how different IRs were being used and to what effect.

### **Identities.**

The DAM views identities as the products of discourse (Horton-Salway, 2001). They are seen as constructs which are ‘talked up’ within speakers’ accounts and in the context of the specific conversation. The construction of identity is seen, according to the DAM, as having specific interactional purposes within the context of that conversation. Identities are constructed through versions and accounts, which are rhetorically positioned against or alongside alternatives (Horton-Salway, 2001). DA provides a framework from which we can explore how identities are relationally achieved and negotiated, and to what function/consequence. I explored the different identities that family members constructed for themselves and others within the talk, and the functions and consequences of different identities. It was particularly interesting to note the contrasting identities constructed *within*

individuals and the context in which different identities appeared to perform different purposes.

## **Quality Control**

Assuring quality within qualitative research is a complex task and there have been multiple guidelines around how to achieve this (Elliot et al., 1999; Tracy, 2010). Although guidelines appear to differ somewhat throughout the literature, many have highlighted the importance of self-reflexivity within qualitative research as a whole (Elliot et al., 1999; Tracy, 2010) and with DA in particular (Bucholtz, 2001). As Gale (2010) points out, there is no neutral position from which we can conduct the analysis of talk in interaction. It is important for the researcher to consider their ‘position’ in relation to the research project; their “subjective values, biases and inclination” (Tracy, 2010, p. 840). By ‘turning inward’ (Bucholtz, 2001, p. 181) and reflecting on our own experiences and assumptions, and how they might influence the findings of the research we are carrying out, we are able to make ourselves a visible part of the research process. In doing so, we can also seek to minimise the impact of our ‘position’ on the findings we produce.

### **Reflexivity in systemic research.**

Reflexivity is particularly important when conducting research using live FT videos. It is likely that researchers will make their own assumptions about the validity of the accounts of certain family members, based on their own experience (Stancombe & White, 1997), and we are likely to identify with some family members more than others. It is, therefore, important for researchers to be mindful of their own responses to the talk within the family so that they can develop a non-judgmental, analytical gaze (Gale, 2010). I found it helpful to note down, in my ‘reflective journal’ (see below) any preconceptions that I had about what the video data might contain, based on my own experiences as both a family member and a therapist, so that I could critically reflect on these.

### **My position as a researcher.**

I am a third year Trainee Clinical Psychologist and completed this research project as part of my Doctorate in Clinical Psychology. I have an interest in child and adolescent mental health and I have worked with children and families both as an Assistant Psychologist and throughout my doctoral training. My interest in the experience of SHB was sparked whilst I worked on a psychiatric intensive care unit for adolescents. The negotiation of responsibility for 'keeping safe' was explicit on a ward where risk-management was a crucial part of the work. Many of the adolescents on the unit engaged in SHB and there appeared to be a variety of functions that the behaviour served, but what was most striking was the variety of reactions and responses that the behaviour induced in professionals. A variety of causal attributions were attributed to both the SHBs and other difficulties that the young people were experiencing, some of which, I felt were quite persecutory at times.

I wondered how these narratives were generated outside of the unit, within the family of an adolescent who engages in a SHB. What sense did the family make of the SHB and why it was happening? During my training I spent time working within an adult FT team. I noticed some powerful discourses of responsibility, guilt and blame within families. Although this was not FT for adolescents and the focus was not on SHB, I wondered how families might blame members for the occurrence of SHB and where responsibility might be located. These past experiences contributed to what I expected to see within my data sample. I was surprised to see that explicit blaming of the young person did not happen as much as I had expected. I had to be reflexive and consider my prior assumptions so that I was not searching for certain things, such as blaming, within the data.

As a Trainee Clinical Psychologist, I am trained in formulating clinically and it was important for me to manage the impact of my position as a therapist on my role as a researcher. I took the time to notice when I had begun (without intention) to generate hypotheses about a family's difficulties including various causal attributions. I also noticed that, whilst watching the video data, I was not attending to what the therapist was saying as much as I was attending to what the family members were saying; I realised that I had

placed myself in the role of the therapist. I had to maintain awareness of this throughout my exploration of the data so that I did not slip from a researcher to a therapist role and, subsequently, miss important elements of the therapist's speech.

### **Use of a reflective journal.**

I incorporated my reflections into the research process by keeping a 'reflective journal', in which I noted any thoughts and emotional reactions that I experienced whilst interacting with the data. In doing so, I was able to keep track of various feelings towards and assumptions about the data that arose throughout the process so that they did not affect the validity of my findings.

I asked myself a number of questions whilst completing the analysis of my data, which allowed me to maintain a reflexive stance, noting down responses in my journal for later reference:

- Am I watching the videos/ reading the transcripts from the position of a researcher, or are other positions more salient (e.g. therapist, daughter, friend)?
- Which family member, or therapist, am I paying most attention to and why? Am I taking sides? Antaki, Billig, Edwards and Potter (2003) explain that by over-identifying with the viewpoint of a particular speaker and potentially taking sides, within DA, we run the risk of under-analysing the data.
- What has surprised me and what hasn't? Why is this? What assumptions had I made?

Ultimately, this type of question allowed me to consider whether there might be other ways in which I could interpret the data. I found that it was important to notice and note down times that I experienced strong reactions to the talk. For example, whilst watching the videos and reading the transcripts for one of the families, I found that I had a strong emotional reaction to the mum's explicit blaming of the young person for their familial difficulties. Once I noticed this reaction, I was able to recognise that I had aligned with the young person and was viewing her mother's actions through the lens of the young person. This had limited my view of the mother's actions and, on realising this, I was able to widen

my focus; I placed myself in the position of the mum and considered what she might be responding to. I considered whether she was defending herself and protecting her identity as a mum, rather than actively seeking to blame the young person.

### **Validity.**

Reflexivity goes some way to ensuring that the findings of the research are valid and not constrained by the influence of the researcher's experiences, knowledge and assumptions. Here I explain the other ways through which I aimed to improve the validity of my results.

I met regularly with my research supervisors, throughout my analysis stage. This meant that they could oversee the findings, as they emerged, and were able to check the credibility of my analysis as recommended by Elliott et al., 1999). They posed questions that, on occasion, challenged my existing interpretation of the data and led me to new ideas/ further analysis of the data.

Potter and Wetherell (1987) suggest that, to produce valid findings during DA, the researcher must seek to identify any exceptions to any patterns that they have noticed. They must look for differences within the data, not just similarities. The aim is to achieve 'coherence' (p. 170) in which there are no 'loose ends'. By examining exceptions and noticing different patterns in the data, the explanatory framework is expanded and refined.

Due to delays with transcription, I spent a lot of time with the first pair of transcripts which came with both benefits and costs. It allowed me to familiarise myself with the process of DA and refine the analytical steps that I described above. On the other hand, it meant that I had to ensure that I did not get stuck on the patterns that I had become so familiar with when analysing the first family, particularly when time pressures became greater. I had to ensure that I was maintaining reflexivity and looking for difference within the data, not just focusing on patterns that confirmed those that I had already identified. Potter and Wetherell explain that this is important because "false starts occur as patterns appear, excitement grows, only to find that the patterns postulated leaves too much unaccounted, or results in an equally large file of exceptions" (1987, p. 168).

### CHAPTER THREE: ANALYSIS

In this chapter I provide an action oriented interpretation of the talk, as a series of case studies, paying particular attention to stake and interests of responsibility.

For each of the families, I begin by providing an outline of the predominant features of the negotiation of responsibility over their two initial sessions. I then present the main actions through which this happens. For each of the actions, I begin by outlining who was doing the action and the stake(s) that they were managing. For ease of reading the text, *actions are presented in bold italics* and the individual's stake in the talk is underlined. I then present an extract, from the transcripts, which illustrates the action(s) and I discuss how the negotiation of stake and responsibility takes place within that particular example of the talk. As part of the 'how' the negotiation takes place, I outline various discursive devices which are used in the negotiations and the functions that they serve. I then go on to think about the implications of the action and the result of the negotiation in terms of positions of responsibility that individuals are left in.

After providing a series of five case studies, I summarise the commonalities which I found across families and within particular 'types' of participant, i.e. parents, young people and therapists.

I have chosen to provide pseudonyms for each of the family members and therapists, in order to make the extracts feel 'alive' whilst maintaining anonymity. Again, for ease of reading I will include labels in the transcript extracts to indicate who is who (i.e. T, YP, M, D, SD and RTM; see transcription conventions for more clarification). I have included a key of 'who's-who' at the bottom of the page.

## **Family 1: Mina and Nita**

### **Mina and Nita: A Pen Portrait**

Mina (YP) attended both sessions with her mum, Nita (M). Mina fell within the 15-17 year old age bracket and was still at high school. They were seen by Beth (T) who was joined by two reflecting team members on both occasions. Mina was referred to the service after her mum had noticed that she had been cutting as a form of SHB. During the first session, Mina was very quiet and described herself as shy. Nita did most of the talking in the first session. The second of the sessions had a different feel to the first with Mina contributing much more and seeming more confident in giving her opinion. Much of the talk was focused on the wider family dynamics and the impact of the absence of Mina's dad.

### **Overview**

The predominant theme that we see throughout the two sessions, is Nita's (M) ideological dilemma of viewing Mina (YP) as an adolescent but, at the same time, wanting her to be more "mature" in her response to the family's current financial difficulties; Mina engaged in SHB after being told about these and having to change school due to a lack of money. Implicitly, Nita constructs SHB as an immature response.

Nita's contradictory views are evident throughout the two sessions. She draws upon a repertoire of immaturity and adolescence when referring to some of Mina's actions (e.g. "she stormed upstairs and sort of did the teenager-y sort of-"). She also uses the action of ***asserting her authority*** to take on a responsible, mothering protector role and, as a result, constructs Mina as someone who cannot look after herself without the help of her mum. She explicitly references her view that Mina is unable to cope with the ongoing difficulties and "adult stuff". The result is that a 'teenage identity' is constructed for Mina and Nita is placed in the 'responsible parent' role. A 'teenage identity' is one that holds limited responsibility for their own actions and so Mina is left without full responsibility for



keeping herself safe. Mina contributes to this narrative by *laying blame* with her mum for her distress:

- 1 Beth (T): (to Mina) Okay. And what sort of situations is it that arise  
2 that mean that you then think about hurting yourself?  
3 Mina (YP): When my mum tells me stuff about money-  
4 Beth (T): Okay.  
5 Mina (YP): –and I’m upset with my friend, or they’re upset with me.  
6 Beth (T): So with your mum, when your mum’s talking about money  
7 difficulties. Anything else your mum can talk about that  
8 will make you think about self-harming?  
9 Mina (YP): Just like- adult stuff (.) bills and work.

Through the action of *blaming*, Mina absolves herself of responsibility for her previous SHB and of responsibility for knowing about particular family matters in the future. She explicitly references “adult stuff” (line 9), presenting such business as ‘not for her’, implicitly stating that she is *not* an adult (an identity which holds higher levels of responsibility than a ‘teenage identity’).

Nita’s dilemma of *constructing Mina as immature*, yet *requiring maturity* from her, is evident throughout the two sessions. Beth, the therapist, responds in a way which *acknowledges the presence of this dilemma*, particularly in this stage of Mina’s development. She creates a space in which the family can move forward regardless by undermining Nita’s requirement of maturity whilst validating her attunement to Mina’s needs.

### Requiring Maturity

Nita (M) uses the action of *requiring maturity* to manage the risk that she is blamed for having misjudged Mina’s (YP) ability to cope with the family’s difficult circumstances and the risk that she holds all the responsibility for ensuring that Mina does not engage in any future SHB. In *requiring maturity* from Mina, Nita wants her to take responsibility for her

responses to things that are going on in her environment. The extract below shows a section of talk in which Nita describes her response after Mina told her that she had been upset by Nita telling her about their financial difficulties.

- 1                    Nita (M):        Yeah, I thought actually: “Okay, Mina if she’s got  
2    something to say will say it to me.” So, I had to adhere to it  
3    straight away, although I was a bit angry in the fact that  
4    she’s quite mature in other things-
- 5                    Beth (T):        Yep.
- 6                    Nita (M):        -but yet in the thing that I felt I needed more kind of  
7    understanding of in the sense that, you know, obviously she  
8    says to me: “Oh, people go off on holiday, they do this and  
9    they do that,” and sh- we just can’t do that.
- 10                  Beth (T):        Yeah.
- 11                  Nita (M):        We can barely kind of make ends meet.
- 12                  Beth (T):        Hmm.
- 13                  Nita (M):        I just wanted her to be aware as she’s growing older that  
14    she will need different things that she’s needed in the past,  
15    and I can’t always accommodate them as speedily as she  
16    wants me to.

In lines 1 to 3 Nita explains that, when Mina told her that she did not want her mum to speak to her about their money troubles any more, she adhered to this straight away. She explains this before going on to express her own emotions. By organising her account in this way, she ensures that Beth knows that regardless of her emotions, she acted in the best interests of her daughter. The use of a qualifier in line 3 (“a bit angry”), manages any potential judgement that she had a disproportionate reaction to Mina’s requests. Nita appears to be ***attempting to recruit*** the therapist into seeing her difficult position through the use of emotive language and an extreme case formulation (Pomerantz, 1986) in line 11 (“we can barely make ends meet”). This statement situates Nita’s anger and ***provides an***

*Key: Mina= Young Person, Nita= Mum, Beth= Therapist, Cathy= Reflecting Team Member*

***explanation*** for why she felt she needed to tell Mina about their finances, decreasing the chance that both her actions and her anger are viewed as unreasonable.

Twice, in the above extract, Nita makes reference to Mina maturing (line 4: “she’s quite mature in other things” and line 13: “she’s growing older”) and she explains that she needed more understanding from Mina which is framed as the ‘mature response’. It seems that, at this point in her adolescence, Mina is ***constructed as holding positions of both immaturity and maturity*** and, as a result, is ***simultaneously blamed and absolved of responsibility*** for her SHB. This leaves Mina and Nita in a position in which they are unclear, and not in agreement, on how much responsibility Mina should take for her actions in the future.

Beth (T) responds by ***acknowledging this dilemma*** and attempting to ***facilitate collaboration*** between Nita and Mina to ascertain what should be done by who, in the future. The extract below follows on from the above in a linear fashion:

- 17 Beth (T): Yeah, okay. (To Mina) So it sounds as though your mum  
18 was giving you an explanation why things weren’t the same  
19 as your more wealthy friends?  
20 Nita (M): Hmm.  
21 Mina (YP): Yeah.  
22 Beth (T): So that explanation, is that what you’re also saying- it was  
23 too much information?  
24 Nita (M): Yeah (nods)  
25 Beth (T): So how- it seems like that’s a delicate balance then-  
26 Nita (M): Yeah.  
27 Beth (T): -because it sounds as though what you were doing was  
28 maybe something that you, Mina, you maybe needed to  
29 know about?  
30 Nita (M): No-yeah (nods)  
31 Beth (T): So, Mina, how would it have been- how could you- what  
32 could your mum have done differently? So that you could

*Key: Mina= Young Person, Nita= Mum, Beth= Therapist, Cathy= Reflecting Team Member*

- 33 understand what the differences were in your finances to  
34 your more wealthy friends, but without feeling worried  
35 about it?
- 36 Mina (YP): I don't think she could have done it in another way-
- 37 Beth (T): Oh (both M and T laugh)
- 38 Mina (YP): -it's obviously, like, a hard-ish topic so I think she did  
39 handle it well but it just didn't really click with me, that-

In line 25, Beth makes explicit reference to the dilemma that Nita and Mina face (“a delicate balance”) in order to *validate both family members' experience* and *acknowledge the difficulty* that they have. In line 28, Beth uses the word “maybe” so as not to be seen as taking Nita's side in this discussion; she is offering the suggestion (that Mina needed to know about the finances) tentatively. She then *invites* Mina to suggest how her mum could have done things differently.

In line 36, *Mina closes down Beth's invitation* to generate new information about what Nita could do better in the future. This makes it impossible for a change to be agreed, leaving Nita in a position of restricted agency; she cannot change her behaviour to get a better outcome (i.e. no SHB).

In line 39, Mina uses the phrase “just didn't really click with me” to describe her experience of learning about the family's financial difficulties. This is a vague description which does not give details about what was difficult and led to her engaging in SHB. This *restricts the knowability* of her experience (an action which I will explore in more depth in my next case study). By *restricting the knowability* of her experience, Mina *closes down Beth's invitations* for the family to problem solve. In this instance, the family's agency in making helpful changes in the future remains restricted.

### **Validating Attunement in order to Undermine the Request for Maturity**

Throughout the two sessions, Beth (T) *empathises with the dilemma*, of immaturity vs. maturity, and draws upon repertoires of both to allow Mina (YP) to occupy the two positions of child and adult simultaneously; e.g. “those grown up things” vs. “one of the things that changes is that you’re maturing and looking back with a bit more maturity”.

Beth *validates Nita’s (M) attunement* in relation to Mina’s needs whilst also *undermining her request for maturity* in this instance. This allows Beth to hand Nita the responsibility for not “burdening” Mina (line 11) with “adult talk” (line 6), whilst managing the risk that Nita feels undermined in her role as a parent. Beth recognises Nita’s efforts as a mum, but simultaneously explains what she did not quite get right.

- |    |            |  |
|----|------------|--|
| 1  | Beth (T):  | Oh, good! Your mum, she’s got a good knack of working    |
| 2  |            | out, sometimes, what you need- is that right?            |
| 3  | Mina (YP): | Yeah (nods)  |
| 4  | Beth (T):  | So how has it been that although your mum can respond so |
| 5  |            | well to this and (to Nita) when you started having the   |
| 6  |            | ‘adult’ talk you then realised was too much for Mina-    |
| 7  | Nita (M):  | Hmm (nods)   |
| 8  | Beth (T):  | -how (-) how did you manage that Nita, did you work out  |
| 9  |            | -going back to then when you realised that that was too  |
| 10 |            | much for Mina- what did you notice about Mina that made  |
| 11 |            | you realise you were burdening her? Did she tell you?    |
| 12 | Nita (M):  | Yes, she’s very verbal (Mina laughs a little)            |

Beth begins by *praising* Nita’s “knack of working out” what Mina needs, in order to protect Nita’s position as an ‘attuned mother’. Beth *highlights and encourages* Nita’s skills in responding to her daughter regardless of her ‘teenage’ or ‘mature’ identity. In lines 8-11, Beth repeatedly uses “you” plus an action (e.g. “you notice”) to *emphasise Nita’s active role and ability* in responding to Mina’s distress. However, the use of the word

“sometimes”, in line 2, highlights that Nita’s attunement is not always consistent. This allows Beth to *undermine Nita’s request for maturity*, constructing it as a ‘blip’ in her attunement, thus managing the risk that Nita views this as an attack on her role as a ‘good mum’.

In line 6, Beth refers to the family’s financial difficulties as “adult talk” which *validates Mina’s experience* and view that this information was not suitable for her. With this validated, Mina has agency in determining what family matters she is required to have knowledge of. Beth also *highlights the active role that Mina had in communicating her distress*. By acknowledging the importance of Mina’s role in her mum’s ability to respond effectively, Beth diffuses responsibility to Mina too.

In the first session, the reflecting team also *validate Nita’s attunement* whilst *undermining her request for maturity*: “It’s just really positive to hear how um- I’m going to sensitively use the word ‘attuned’- Nita is and sort of aware and to what’s going on for Mina. And Nita has been able to make some adjustments already and sort of recognising some of the conversations that they’d had about money and how that was affecting her, and just to hear how sensitive she’d been to making those sort of changes”. Words, such as “attuned”, “sensitive”, “adjustments” and “recognise”, *highlight Nita’s ability in responding* to Mina’s needs, whilst also *highlighting what she needed to change*. With Nita’s attunement validated, she is left in a position of agency in the future. A position in which she has the ability to respond to Mina’s needs in ways that reduce the risk that she engages in future SHB.

In session 2, the reflecting team work to further increase Nita’s agency by acknowledging her needs:

- 1 Cathy (RTM): And, um, I was interested –like you said- about the
- 2 different things that she’s been thinking about and one of
- 3 the things we heard is actually letting her mum know when
- 4 she’s feeling that anger and there seems to be something

5 between feeling angry and in pain and the self-harm.

In line 3, Cathy (RTM) *acknowledges* that there are times in which a parent may not know how their child is feeling and that there are times in which Mina might need to let her mum know how she is feeling. This manages the risk that Nita holds all the responsibility for knowing how her daughter is feeling without them having had a conversation. They *hand Mina responsibility* for communicating with her mum.

### **Summary**

By the end of the two sessions, both Mina (YP) and Nita (M) have moved in terms of their positions of responsibility. Beth (T) and Cathy (RTM) have managed the risk that Nita feels criticised for expecting too much of Mina whilst *acknowledging Mina's needs* as an adolescent. Nita is handed responsibility for not expecting too much of Mina in terms 'maturity'. They also *acknowledge Nita's needs* in that she cannot know what Mina needs, in terms of support, without being told. Mina is left holding responsibility for communicating her needs to her mum. This, in turn, would increase Nita's agency, and therefore, responsibility for responding appropriately.

## Family 2: Kelly and Stacey

### Kelly and Stacey: A Pen Portrait

Kelly (YP) attended both sessions with her mum, Stacey (M). Kelly was the only young person in my data sample who fell within the 11-14 year old age bracket. They were seen by Julie (T) who was joined by the same reflecting team member on both occasions. Kelly had been cutting herself and it transpired, through the course of the first session, that she had attempted to commit suicide when she was younger. Stacey spoke much more than Kelly in their initial session, and Kelly seemed to feel more comfortable making contributions in the second session. Stacey and Kelly joked with each other within the session and appeared to share a dark sense of humour.

### Overview

During both their first and second sessions, Stacey (M) manages both her own and Kelly's (YP) responsibility for Kelly's SHB through the action of *undermining Kelly's rationality*. She uses an IR of irrationality to *construct Kelly's identity* as irrational and vulnerable. Kelly *aligns with this identity* through the action of *restricting knowability* which functions to *close down any narratives* which might contradict the narrative of irrationality. I explain below how the two of them construct Kelly's identity as irrational and vulnerable and in doing so restrict her agency and, therefore, her responsibility to keep herself safe. Throughout both sessions, Julie (T) works to *challenge Kelly and Stacey's narrative of Kelly's irrational nature*. I describe the actions through which Julie achieves this throughout the two sessions.



## **Undermining Rationality**

Stacey (M) carefully manages the risk that she is seen as not having done enough to minimise her daughter's distress by *constructing her identity as a 'protector'*. The justification for this 'protector' role comes as Stacey constructs Kelly (YP) as vulnerable through the action of *undermining her rationality*. In the extract below, the family are discussing an ongoing court case for an assault that Kelly had recently experienced.

1                   Stacey (M):     We did with the CID officer a few weeks back and even he  
2    agreed, because of her state of mind- Obviously [CAMHS  
3    worker] had already contacted him. He agreed it was- It  
4    was best for Kelly but not really best for case, like- (..) It's  
5    her mind that's in-

Stacey positions Kelly as an individual who has become irrational and unpredictable in response to events which are external to the family. The use of the term "state of mind" (line 2) draws upon the IR of irrationality. It is a term used within the legal system when referring to *mens rea* (the extent of criminal intent, Edwards, 2008) and is used to absolve individuals of responsibility for their actions; e.g. "they were not in their right mind". It implies that the individual is not currently capable of making sound decisions. By positioning her daughter as someone who is unable to make thought through decisions, *Stacey absolves Kelly of responsibility* for keeping herself safe. With Kelly placed in this position, Stacey holds all the responsibility for protecting Kelly; the position of 'rational-protector' opens up and allows for Stacey to construct her identity as such.

The DAM explains that we treat the accounts of others as motivated by self-interest. Stacey manages the risk that she is seen as acting within her own interests (by not letting Kelly go to court) through the way in which she rhetorically organises her account. Just before this extract, Stacey explained that she would have liked Kelly to go to court to testify in an ongoing trial. She then goes on to explain that she decided that Kelly should not go to court; the extract above shows Stacey summarising that conclusion. By organising her account in

*Key: Kelly= Young Person, Stacey= Mum, Julie= Therapist*

this way, Stacey pre-empts any counteracting argument that might suggest that she acted in her own interests and not Kelly's. She also draws upon the discursive device of category entitlement (Potter, 1996), by bringing in the CID officer (line 1) to build credibility of the claim that her decision is not "best for the case" (line 3-4) but it is best for Kelly due to her vulnerability. This gives strength to Stacey's argument that she is acting within Kelly's best interests and not her own; giving veracity to her identity as a protector.

I noted in my reflective journal that, whilst speaking about extremely emotive content, Stacey maintains an element of stoicism. This contributes to her construction of her identity of 'rational-protector' and someone who is not vulnerable. In the interest of not being held responsible for the social and environmental factors that led to Kelly's SHB, Stacey gives various, detailed accounts of how she has been protecting her daughter. This repertoire of protection closes down the opportunity for the discussion of things that could change within the family; things that could be done to keep Kelly safe. Furthermore, with Kelly and Stacey placed at polarities of 'irrational-vulnerable' and 'rational-protector', Kelly's agency to make informed decisions and act on them is restricted. An example of this is when Stacey states that she "can't put her through a trial". This choice of words constructs Kelly as someone who is passive to the actions of others (in this case her mum's) and her restricted agency leaves her in position of having less responsibility in making changes in the future.

The extract below follows the above in a linear fashion and shows how the therapist responds to Stacey's "state of mind" narrative.

- 6 Julie (T): (to Kelly) And when your mum says about state of mind,  
7 do you know what she's meaning by that?  
8 Kelly (YP): Yeah (awkward smile)  
9 Julie (T): What's she meaning Kelly?  
10 Kelly (YP): I'd rather my mum say.  
11 Stacey (M): No, you have to say.  
12 Kelly (YP): A bit suicidal.

*Key: Kelly= Young Person, Stacey= Mum, Julie= Therapist*

Giving Kelly's current experiences the label of "state of mind" leaves them without any detailed description and her experiences remain relatively unknown. This means that any knowledge about changes in her own behaviour and the behaviour of others which would be helpful, is also left unknown. Therefore no one holds the responsibility in making these changes. This works against Stacey's stake of being the 'protector' of her daughter; she is unable to know what she can do to 'protect'.

In lines 5 and 6, Julie (T) *attempts to explore Kelly's understanding* or experience of this "state of mind" with the possible intention of unpicking what this entails and of generating new meaning in line with systemic principles (Burck et al. 1998). By asking Kelly this, Julie *gives her the agency and responsibility for naming or describing her own experience*. When Kelly *refuses the therapist's invitation* to answer this question, Stacey *encourages her to answer* for herself (lines 9 and 10). This is not something that Stacey has done prior to this instance. Previously, she had accepted Kelly's invitations to answer for her, but this time she appears to be aligning with Julie's intentions of giving Kelly the responsibility to name her own experiences. Stacey and Julie appear to be sharing the interest that Kelly is given a chance to take more responsibility for her own experience and actions.

In line 11, Kelly names her experiences. Although we can see her reluctance to do so and her attempts to minimise her distress ("a bit suicidal"), the naming of her experience makes it more knowable and paves the way for further exploration throughout the session. It also gives Kelly ownership of this experience as it has not been verbally constructed *for* her.

The actions of *restricting* and *increasing knowability* run throughout the two sessions and so I explain these in further detail in the section below.

### **Restricting Knowability vs. Increasing Knowability**

Kelly (YP) *aligns with the position of 'irrational-vulnerable'* by constructing herself as someone who is passive to their own actions and experience. Kelly *closes down the therapist's invitations* to explore her own thoughts and feelings in relation to her actions

and, in doing so, constructs herself as passive and rejects responsibility for her actions. Often Kelly does this by responding to the therapist’s questions by saying “I don’t know”, but in the extract below she does this less explicitly and I explain how she *restricts the knowability* of her experience through her choice of words.

By *restricting the knowability* of her experience and decisions in this way, an identity of irrationality and unpredictability is left without contradiction; no patterns (rationality and predictability) in her behaviour are identified. As I explained above, if experiences are left unknown and without an explanation, then any understanding of what needs to be done or changed in the future is restricted; responsibility for our future actions is tied in with how we make sense of the past.

One way in which Julie (T) *attempts to deconstruct* the narrative of Kelly’s irrationality is by working to *increase the knowability* of her experiences. Julie tries to limit the risk of Kelly being seen as unable to make her own decisions and as a result being left with no responsibility or agency to make changes or look after herself in the future. In the extract below, Julie is asking Kelly about her behavioural responses to her emotions.

- 1 Julie (T): Music and art. So, what do you- how do you decide when  
2 to go and listen to some music or do some artwork as  
3 opposed to sort of, like-
- 4 Kelly (YP): When I find paper and pens and my phone-
- 5 Stacey (M): No, she means-
- 6 Julie (T): Yeah, what would make you decide to go and listen to  
7 music or do some art instead of say-
- 8 Stacey (M): After she’s flipped.
- 9 Kelly (YP): Yeah.
- 10 Julie (T): Usually after you’ve flipped? (Stacey nods) Right, okay.  
11 And what happens then, after you’ve flipped?
- 12 Kelly (YP): I just get my phone and just grab [? an app?] and just draw.

Key: Kelly= Young Person, Stacey= Mum, Julie= Therapist

- 13 Julie (T): Okay. Is that something you'd do instead of self-harm?  
14 (Kelly nods, but Stacey is shaking her head) Yeah? No?  
15 Stacey (M): (Looks over to Kelly) I'd say she does a bit of both at the  
16 same time, really.  
17 Julie (T): Yeah? Okay.

In line 1, Julie was going to say something before changing her wording to “decide”, suggesting she chose this word intentionally. Julie could have said “when do you go to your room?” and instead she chose the word “decide” and continues to draw upon an IR of capacity, consciousness and deliberate acts in an attempt to explore Kelly’s active role in her behaviour. In lines 4 and 12, Kelly *refuses Julie’s invitation* to consider her active role in her behaviour by omitting any details of antecedent thoughts or feelings. The repeated use of the word “just” in line 12, minimises the role that Kelly had in these actions and leaves the process unknown. She presents her actions as something that “just” happen.

In line 6, we see that Julie barely changes the wording of her question to imply that Kelly’s previous answer was not sufficient; she wants to know how the decision is made. In line 8, we see Stacey (M) respond to this question with the ‘irrational’ IR that we saw in the previous section. The choice of the word “flipped” comes with connotations of a lack of control, similar to “state of mind”.

By the end of this extract Julie’s *attempt to explore Kelly’s thoughts and choices* are brought to a close and she does not pursue the line of enquiry. It seems that Julie’s attempts are disrupted by Stacey’s interjection and disagreement with Kelly’s account. However, throughout the two sessions, Julie continues to use an IR of capacity, consciousness and deliberate acts. In doing so she *invites exploration around Kelly’s decision making* and she is able to introduce a narrative which contradicts irrationality; one in which actions are thought through and rational. A narrative in which both Kelly and Stacey are capable of rational actions increases Kelly’s agency and diffuses responsibility. *Increasing the knowability* of Kelly’s experience also means that areas in which change would be both

beneficial and possible can be highlighted. By making this knowable, Kelly and Stacey's agency in making this type of change is increased.

### **Diminishing Difference**

Finally, through the action of *diminishing difference* between Stacey (M) and Kelly (YP), Julie (T) is able to illustrate that they do not need to occupy polarities of 'irrational-vulnerable' and 'rational-protector'. This functions to illustrate that one person does not have to look after the other and that they can both take responsibility in making decisions which will be of benefit to both themselves and the other. This manages the risk that Kelly is placed in a position in which she has no agency in stopping her SHB and the risk that Stacey holds all the responsibility in the future.

Julie attempts to do this in the first session ("I'm sort of thinking about how we- How everybody gets looked after") but quickly moves away from this idea, possibly because the idea that Kelly might have agency in this is too different from the narrative that surrounds it at the beginning of their sessions. During the second session, Julie revisits "how everybody gets looked after" after Stacey positions herself in a more vulnerable position than she had done previously and the narrative shifts slightly. The extract below follows Stacey's explanation of how she finds it hard to hear the details of Kelly's assault as she had something similar happen to her when she was younger. It illustrates how Julie works to *draw similarities* between Stacey and Kelly and, in turn, *diffuse responsibility* for "looking after" each other.

- 1 Julie (T): Okay. So, by not talking to you about it Kelly is-
- 2 Stacey (M): She's protecting me.
- 3 Julie (T): -she's protecting you in some way, and she's trying to be
- 4 like you and deal with it herself. Although she's able to
- 5 deal with it differently- But then (to Kelly), sometimes that
- 6 the lashing out has happened for you too, hasn't it? (Kelly
- 7 smiles as if to agree)

*Key: Kelly= Young Person, Stacey= Mum, Julie= Therapist*

- 8 Stacey (M): Hmm.
- 9 Julie (T): Yeah.
- 10 Stacey (M): See me and Kelly are the same in many different ways but I  
11 can cope with things (.) and Kelly she can't.
- 12 Julie (T): So, you can cope with things, in terms of not lashing out, if  
13 you don't- If you're not really hurt by them-
- 14 Stacey (M): (nods) Hmm.
- 15 Julie (T): -or really know about them? But in a sense, I guess- Did  
16 you do a lot of lashing out when this happened to you?  
17 (Stacey slowly nods) Yeah. So, you're not lashing out at  
18 the moment because here's some more important things  
19 that Kelly isn't sharing with you?
- 20 Stacey (M): (nods) Um-hmm.
- 21 Julie (T): Okay. (To Kelly) But that leaves you a little bit on your  
22 own with them? Do you feel a bit on your own with some  
23 of the things that have happened? (Kelly shakes head)
- 24 Kelly (YP): No, I Talk to someone else about it
- 25 Julie (T): Do you? Who do you talk to?
- 26 Kelly (YP): Friend at school

Julie uses phrases such as “she’s trying to be like you” (line 4) and “you too” (line 6) to *highlight similarities* between Kelly and Stacey. She also uses the term “lashing out” on four occasions (lines 6, 12, 16 and 17) drawing on similar ‘loss of control’ connotations that Stacey had previously used when describing the actions of Kelly; Stacey had previously referred to her as having “flipped”. Stacey manages the risk that she is also seen as vulnerable and out of control by repositioning herself as strong and able and Kelly as unable and needing to be taken care of (line 11). This, in turn, manages the risk of losing her role as the “protector” of her daughter.

In lines 15-19, Julie goes on to highlight the conditions of times when Stacey is able to make good decisions. This introduces the idea that our ability to make a 'good decision' is not stable and that there are conditions which make this more or less possible. This then functions to further *validate Kelly's response to the events* that surround her and *deconstruct a narrative of irrationality*. This extract ends leaving Kelly in a powerful position, in that she has made a decision that has been in the best interests of the family, and we might infer that her perceived agency in making her own decisions is increased as a result.

### **Summary**

At the beginning of the two sessions, Stacey (M) and Kelly (YP) enter with a narrative in which Stacey holds all the responsibility for making choices which will keep Kelly safe. However, with Kelly restricting the knowability of her experience, Stacey's agency in doing so is restricted. Julie (T) works to deconstruct this narrative by *increasing the knowability* of Kelly's experience and by *diminishing the difference* between Kelly and Stacey in terms of their 'rationality'. By the end of the second session, both Kelly and Stacey have shifted in their positions of responsibility. Although Stacey still appears to be taking the lead in making decisions for Kelly, Kelly is contributing to decision making discussion (e.g. around her attendance at school). It appears that they no longer occupy such extreme polarities of 'irrational-vulnerable' and 'rational-protector'.



### **Family 3: Kirsty and Nicole**

#### **Kirsty and Nicole: A Pen Portrait**

Kirsty (YP) attended both sessions with her mum, Nicole (M). Kirsty falls within the 15-17 year old age bracket and still attends high school. They were seen by David (T) who was joined by the same reflecting team member on both occasions. Unlike the sessions with the other families in this data sample, SHB was spoken about very little. This was because Kirsty did not want to speak about it in front of her mum and felt uncomfortable talking about it with the therapy team. There were, therefore, limited details as to what had brought the family into the SHIFT trial in the first place but it appeared that Kirsty had cut herself as a form of SHB in the past. The main focus of the sessions was on Kirsty and Nicole's relationship as they were struggling to get along. Both Kirsty and Nicole contributed their accounts and opinions to the sessions, and discussions became heated at times.

#### **Overview**

Throughout the two sessions, there is a lot of discussion about who is responsible for the difficulties in Kirsty (YP) and Nicole's (M) relationship. Kirsty appears to *share this responsibility* with her mum, whereas Nicole appears to *resist accountability*. Although their actions are different, both Kirsty and Nicole appear to be managing the risk that they are seen as the cause of all the family's difficulties. If one of them is seen as the sole cause of the family's difficulties they may also be seen, as a result, as the one who holds all the responsibility to make changes which will improve their situation. David, the therapist, and the reflecting team respond to this by appearing to align with Kirsty in *assuming a shared responsibility* in an attempt to diffuse any responsibility for change between the two of them. I explain the ways through which these actions occur using the extracts below.

## Sharing Responsibility vs. Resisting Accountability

Throughout the two sessions, Kirsty (YP) attempts to *share the responsibility* for things that have happened in the past and for changes which are required in the future. She repeats phrases such as “I’ve blatantly said I’m taking *part* of the blame” and “It takes *two* to argue; two to fight; two for an argument to start”. Phrases like this explicitly state that her intention is not to attribute sole responsibility to her mum. She is *attempting to share/ diffuse it*. The three part list used in the second statement functions to make her argument sound particularly complete and convincing (Potter, 1996), serving as an *attempt to recruit* both Nicole (M) and David (T) into her way of viewing her situation.

Nicole responds to Kirsty’s action by *resisting accountability*. She appears to accept some responsibility for the arguments which she has with her daughter, but defends against any claims that she is accountable as the cause of these arguments: “I’ve got a little part of blame in it because there’s times when I just can’t take it anymore and I shout back at her”. In statements like these, Nicole has accepted that she plays a part in the arguments, but *presents Kirsty as the cause* and the one who should provide an account of why the arguments happen (Kirsty is held accountable).

They both appear to be attempting to minimise the risk that they are seen as the cause of the family’s difficulties so that they do not hold *all* the responsibility to make the changes that would improve their situation. We might also speculate that Nicole is attempting to minimise the risk that she is seen as a ‘bad parent’; one who causes her daughter distress which leads to her SHB.

The extract below illustrates Kirsty’s attempts to *share responsibility* with her mum, and Nicole’s responses to this.

1	Kirsty (YP):	I take responsibility for everything that I do, I have done in
2		the past at CAMHS. You always act saying it’s her that
3		needs the help, it’s you as well, even CAMHS says it’s
4		you.

Key: Kirsty= Young Person, Nicole= Mum, David= Therapist, Lynne= Reflecting Team Member

- 5 Nicole (M): Well-
- 6 Kirsty (YP): It's you that needs help, you.
- 7 Nicole (M): Well, the woman did explain that other family members (.)
- 8 can come with her as well.
- 9 Kirsty (YP): Yeah, I'd have my sister to come next time.
- 10 Nicole (M): Well, I think your sister would tell just the same story,
- 11 wouldn't she?
- 12 Kirsty (YP): No, she says we're as bad as each other. (Nicole shakes her
- 13 head) I swear, ring her right now mum. She says we're just
- 14 as bad as each other, I've even got a text (pick up her bag)
- 15 just to prove- do you want me to?
- 16 Nicole (M): Past text.
- 17 Kirsty (YP): No, from last week! She said: "All the time you're as bad
- 18 as each other, I'm not taking sides."
- 19 Nicole (M): Yeah. She'll take sides-
- 20 Kirsty (YP): She says-
- 21 Nicole (M): She won't take sides to your face but she's said that she's
- 22 had enough of the way you're treating me.
- 23 Kirsty (YP): She said you were hard to live with and that's why she
- 24 got out as soon as she could (.) that's what they all said.

In lines 1 and 2, Kirsty uses the two extreme case formulations (Pomerantz, 1986) ("everything" and "always") to assert her claim that she has acknowledged anything that she could be held responsible for and that it is her mum who is yet to "take responsibility". Here Kirsty pre-empts any counter argument, from her mum, which would suggest that she is attempting to get her mum to take responsibility for things which Kirsty, herself, is responsible for; she has taken "responsibility for everything that" she does. In order to support her claim, Kirsty draws on corroboration from CAMHS professionals who, belong to a category of 'experts' who may be entitled to decide who is or is not responsible for a

family's difficulties. This category entitlement (Potter, 1996) functions to legitimise the reasons behind Kirsty's action of *sharing responsibility*. Nicole *resists accountability*, not by refuting the opinion of the 'experts', but by acknowledging their advice and posing a slightly different take on it; that "other family members" can come with Kirsty to therapy. This does not discount the 'expert' advice, which might feel risky to Nicole, managing the risk that she is seen as unaccepting of the advice of others. Instead she widens out the responsibility by shining the spotlight on the whole family, not just herself. Her statement also does not include why it would be beneficial for family members to attend the therapy and places Kirsty at the centre of the therapy process ("come with *her*"). This *counteracts Kirsty's claim* that CAMHS suggested it is Nicole "that needs the help". It is important to consider this statement from Kirsty, made in line 6, within the context of the therapy process and in front of a therapist who could provide "the help". She may be attempting to facilitate an alignment between herself and David, who might support her position that her mum needs help.

In lines 8-17, Kirsty then attempts to legitimise her claims by drawing on the opinions of her sister to insist that both she and her mother hold responsibility ("as bad as each other"). Her appeals of honesty ("I swear"/ "just to prove") aim to manage the risk that her claims are found to be unbelievable (O'Reilly, 2014). In lines 16-17, the active voicing (Wooffitt, 1992; Potter, 1996) functions to shift the footing (also seen in line 23) of this particular claim to Kirsty's sister. As a result Kirsty is not responsible for this claim (Potter, 1996) and it cannot be refuted on the grounds that it serves Kirsty's own interests.

Kirsty's *appeals for her mum to share the responsibility* for change are rejected by Nicole. This *closes down* any opportunity to have discussions about what they are both able to change in order to improve their relationship and potentially reduce Kirsty's SHB.

### **Assuming Shared Responsibility and Deconstructing Blame**

David (T) responds to this by *assuming shared responsibility* in order to prevent the narrative remaining as one in which only Kirsty (YP) holds the responsibility to make

positive changes in the future. He also uses the action of *preventing blame* to ensure that, as a result of assuming a shared responsibility, neither Kirsty or Nicole (M) feel blamed.

The following extract follows the one above in a linear fashion:

25 David (T): So the idea that you're both saying: "We can take  
26 responsibility for things. That we both put something into  
27 arguments" (..) Yeah? Is that something- (to Kirsty) you're  
28 saying you've had help in the past, you've been the  
29 CAMHS in the past, is there a point to it? Yeah?

David's use of active voicing (lines 25-27) to summarise what he has heard from Kirsty and Nicole, seems to function to make his conclusion more plausible. It gives the impression that he has *actually* heard them say this. The word "both" is something that he draws upon throughout the two sessions and appears to function to shift the conversation to a place where Kirsty and Nicole have the shared interest of making positive changes in the future.

Shortly after, he *attempts to deconstruct any narratives* in which one family member is to blame:

1 David (T): Can I just understand- what's going to make this different  
2 from stuff that you've had in the past? Because if the stuff  
3 you've had in the past doesn't work, it hasn't been helpful,  
4 what's going to make it different?

In line 3, he chooses the phrase "it hasn't been helpful" to describe their previous experience of CAMHS. The word "it" serves to externalise any perception of failure of previous therapy attempts. This constructs an account in which neither of them are to blame. "It" is to blame; the therapy itself.

David uses his own category entitlement of 'professional expert' to present his understanding of family difficulties: "I suppose my understandings of families and how they work is that often people have very different points of view because they have their own

experiences and see if from where they are. And that doesn't necessarily mean that one is right and one is wrong, it just means they experience things in different ways". Here, he explicitly accounts for the disagreements between Kirsty and Nicole, *validating their position* and giving a 'professional, expert' explanation for such an experience, one that is not particular to their family nor blaming of either of them as individuals.

David then summarises chosen aspects of both Kirsty and Nicole's talk to propose a future oriented goal that they may be able to align with: "You're *both* saying that you want your relationship to be better". He has *assumed a shared responsibility* for this goal by suggesting that they have both said it for themselves.

He then goes on to further *prevent blame* by generating external attributions which then provide the reason for why they are experiencing difficulties. I.e. domestic violence from Kirsty's dad which they have both experienced: "I'm just sort of thinking about the legacy of the violence that you both experienced from your dad and that that sort of sense of- That often leave's people feeling lots of anger, and lots of upset, and lots of things about how relationships work. Feeling that they're to blame for things, being told that they're to blame for things, you know, perhaps that's often one of the things- And I don't know if that's true for you, I don't know if that's what happened for both of you in your relationship".

During these first two sessions, David's attempts to diffuse responsibility appear to be rejected by Nicole. In session two, the reflecting team returns to the externalising, described above, in a further attempt to *prevent any feelings of blame* whilst *acknowledging a shared responsibility for improving the difficulties in their relationship*:

1                   Lynne (RTM): I was kind of thinking about, um, patterns about how we  
2   get into ways of doing things and ways of being with each  
3   other and, um, most of the time you don't notice that we're  
4   doing that thing. And, uh, I was thinking about (..) how  
5   Nicole's kind of story really, about how she grew up and  
6   that relationship and (.) it wouldn't surprise me, it doesn't

- 7 surprise me that you have to protect yourself in some way-
- 8 David (T): Um-hmm.
- 9 Lynne (RTM): And I think that you kind of- might be like hedgehogs, curl  
10 up and the prickles come out, and you-
- 11 David (T): The world is a dangerous and scary place.
- 12 Lynne (RTM): Yeah, so you have to protect yourself, I think that- you  
13 know- in no way am I blaming Nicole, I think you do what  
14 you have to do to survive really and I'd say you have to do  
15 that. I was wondering about how-how Kirsty could help her  
16 mum with that, um, because I think sharing, um- I think if  
17 you've got into that way of surviving for so long then it's  
18 very difficult to move out of that.

Lynne (RTM) draws upon an IR of survivorship to absolve Nicole of any blame for the difficulties in her relationship with Kirsty. She repeats the words “protect” (lines 7 and 12) and “survive” (lines 14 and 17), and uses the metaphor of the hedgehog (lines 9-10) to suggest that Nicole has acted in the only way that she could, considering the circumstances. Lynne even states that “most of the time you don't notice that we're doing that thing” to further manage the risk that Nicole feels blamed for the family's current difficulties. Lynne *shares some of the responsibility with Kirsty*, in lines 15 and 16, when she suggests that she could help her mum move out of this pattern of relating.

It may be that when feeling blamed, Nicole or Kirsty might feel reluctant to acknowledge their role in the family's difficulties and their responsibility for making changes. If this were the case, preventing blame would aim to move them into a position where they are more able to accept shared responsibility and, therefore, talk about the changes each of them can make.

Both David and the reflecting team return to the idea that we can only change things about ourselves and not about anyone else over the course of the two sessions. For example,

Lynne says: “So Kirsty is not going to be able to change her mum, it’s impossible, the only person that can change is herself and if Kirsty can be different then Nicole can be different, if Nicole is different then Kirsty can be different...”. In doing so, she *makes Kirsty and Nicole’s dilemma explicit*; their dilemma of wanting the other to make changes but not being able to influence this themselves. This allows the therapist to discuss what changes each of them are able to make, therefore, hold responsibility for.

### **Summary**

Throughout the two session, David (T) and Lynne (RTM) appear to align with Kirsty’s (YP) interest of wanting to share responsibility for the ongoing difficulties between herself and her mum. It appears that it is Nicole (M) who is being asked to shift her position of responsibility the most in this family, as Kirsty has already acknowledged that she holds some responsibility for making changes, whereas Nicole has not. David and Lynne recognise the risk that Nicole may feel blamed, because they are asking her to shift her position of responsibility significantly, and manage this by *deconstructing blame*.

By the end of the two sessions, it appears that Nicole is still *attributing accountability to Kirsty* for the family’s difficulties. She *closes down opportunities for discussions* about what she could do differently with claims that Kirsty would not respond well to those changes, e.g. “I’d say in a way, Lynne was right cos’ one (.)- One hundred percent of me wanted to grab her and give her a hug and, you know, I’d expect- Forty percent expected for her to go “f-off will you?!”. As a result, Kirsty is left as the one who acknowledges her position of responsibility, whereas Nicole does not.



## **Family 4: Lou and Hannah**

### **Lou and Hannah: A Pen Portrait**

Lou (YP) attended her first session with her mum, Hannah (M) and for their second session Lou's step-dad, Neil (SD), joined them. Lou falls within the 15-17 year old age bracket and still attends high school. They were seen by Ed (T) who was joined by a different reflecting team member on each occasion. Lou had been cutting herself for a while and had recently presented at A&E following an overdose. She took a further overdose in between the first and second sessions. Much of the talk was centred around determining the intent of Lou's overdoses. Speculation was that she wanted to "escape" difficult feelings and Lou explained that she had not wanted to die. Lou explained that she found communication difficult and this was evident throughout the session as she often requested that her mum speak for her. She did not, however, appear shy and was able to contribute some of her own ideas, particularly in the second session. During the second session Hannah and Neil provided an open account of Lou's most recent overdose whereas Lou found this more difficult and deferred to her parents to give an account.

### **Overview**

Throughout the two sessions, Hannah (M) performs a number of actions which serve to question Lou's (YP) ability to make independent and reasonable decisions in relation to her own wellbeing. Lou is constructed as holding responsibility for her previous SHB, but her agency in making 'good' decisions in the future is restricted. I begin by explaining Hannah's actions, then I go on to explain how Ed, the therapist, responds to this.

I then go on to illustrate how Lou *refuses to tell the 'story'* of her own overdose, functioning to minimise her stake in the events and responsibility to keep herself safe, in the future. Neil (SD) and ED (T) work together to ensure that Lou's voice is part of this account, in an attempt to increase her stake in the events and risk management in the future.

*Key: Lou= Young Person, Hannah= Mum, Neil= Step Dad, Ed= Therapist*

## **Doubting a Reasonable Explanation**

Through the action of *doubting a reasonable explanation* for Lou's (YP) SHB, Hannah (M) manages the risk that her parenting is seen as a causal explanation for Lou's SHB, whilst seeking permission to not understand why it did happen.

- 1            Hannah (M):    ... there's lots of other different methods of releasing that  
2    tension. Um, (.) and (.) sorry, this is actually quite difficult  
3    for me, because I've been brought up in care-
- 4            Ed (T):            Hmm.
- 5            Hannah (M):    -I was surrounded by self-harm. I didn't self-harm but I  
6    was surrounded by it and (.) in a way you could see a logic  
7    to it (Ed nods) because of what those children had been  
8    through and I'm finding it difficult because it makes- at the  
9    moment I'm trying to find the logic in why my daughter is  
10    self-harming.

In the extract above, Hannah gives an account in which she has attempted to understand the reasoning behind Lou's SHB in relation to her own experiences of being around others who have also engaged in SHB. By explaining that she has tried to understand the explanation behind Lou's SHB, Hannah removes the possibility of the criticism that she has not attempted to understand and improve her daughter's situation, whilst also giving weight to the possibility that there is, in fact, no reasonable explanation for Lou's SHB.

Hannah works further to *invalidate the possibility of a reasonable explanation* by presenting an extreme case formulation (Pomerantz, 1986) as an example of what *would* be a reasonable explanation for the occurrence of SHB. In lines 3-7, Hannah presents the experience of being brought up in care as a 'logical' reason for SHB, and then goes on to present her contrasting experience of "trying to find the logic" in her daughter's SHB. This contrast functions to suggest that Lou has not experienced anything so 'extreme' and therefore does not have an obvious, easily 'found' explanation for her SHB. Furthermore,

*Key: Lou= Young Person, Hannah= Mum, Neil= Step Dad, Ed= Therapist*

by highlighting the fact that Lou has not been brought up in care, Hannah implicitly claims that she has done a better job of parenting for Lou than was the experience of the other children she knew who have engaged in SHB. Hannah appears to be managing the risk that her parenting is attributed causal explanation for her daughter's distress.

In lines 5 and 6, Hannah's account illustrates a choice that she has made for herself in the past; 'I didn't self-harm but I was surrounded by it'. In doing so, she *invalidates one possible explanation* for Lou's SHB; one in which she engages in SHB because she is "surrounded by it". This further contributes to the narrative that Lou's reasons for her SHB are not easily understood.

Hannah draws upon an IR of logic, an example of which we can see in the above extract. The use of the word "logic" implies that there is some decision making behind Lou's SHB whether or not it is deemed reasonable or understandable by others. There are occasions in which Neil (SD) *corroborates Hannah's narrative* of an existing but unknown explanation for Lou's SHB. Together they *construct Lou's reasoning as mysterious* and there are occasions in which Hannah *attempts to recruit the therapist* into this narrative. For example, Hannah says to Ed (T), when talking about an overdose which Lou has taken, "you'll understand why I have no understanding in my mind of what is going through my daughter's head".

By presenting Lou as holding this 'mysterious logic', they *attribute her responsibility* for her actions; she has made considered decisions whether they are unable to understand this or not. Simultaneously, Hannah and Neil are absolved of responsibility. They have attempted to understand why Lou does the things that she does but have constructed themselves as being helpless; if they cannot understand her logic then they are left being unable to help.

The following extract comes shortly after the above and illustrates the therapist's response to Hannah's action of *doubting a reasonable explanation* for Lou's SHB:

1                   Ed (T):           (to Hannah) So you're hoping to explore some things about  
2   alternatives when there's stress around?

Key: Lou= Young Person, Hannah= Mum, Neil= Step Dad, Ed= Therapist

- 3 Hannah (M): Yep.
- 4 Ed (T): And sort of think about understanding for Lou or for you-
- 5 Hannah (M): Yeah.
- 6 Ed (T): -how to deal with that.
- 7 Hannah (M): Yep.
- 8 Ed (T): And you're saying there's (.) there's these escape things
- 9 which, um (.) taking paracetamol-
- 10 Hannah (M): Yeah.
- 11 Ed (T): But then there are stress things which you're saying are a
- 12 distraction?
- 13 Hannah (M): Yes.

In lines 4 and 6, Ed makes explicit reference to a need for “understanding” and “deal[ing]” with “stress”. He links the two processes together in a way that suggests that there is a need to “understand” in order to be able to “deal” with “stress”. He also names both Lou and Hannah when referring to the need for understanding, acknowledging that a shared understanding is important. He responds to Hannah’s previous claims of not understanding her daughter’s experience by validating the knowledge that she does hold, in lines 8 to 12. This functions to validate Hannah’s understanding of Lou and her experiences and behaviour and, therefore, validates Hannah’s agency in acting in accordance with Lou’s experiences.

### **Implying Independence/ Giving Approval**

Throughout the two sessions, there are two actions performed by Hannah (M) which appear to have contradicting functions. The first of the two actions is that Hannah *implies Lou’s independence*. This suggests that Lou (YP) is able to take responsibility for her own actions; however, this is counteracted by Hannah’s simultaneous action of *giving her approval* which functions to close down the opportunity for Lou to make decisions which are not approved by her mum. It appears that Hannah wants Lou to feel like she can be

*Key: Lou= Young Person, Hannah= Mum, Neil= Step Dad, Ed= Therapist*

responsible for making her own decisions, but that she would like for her to make the 'right' decisions. I will illustrate using the extract below how these actions, when performed in synchrony, function to restrict Lou's agency and responsibility in making her own choices.

1                 Hannah (M):   Coming here was voluntary. When she was meant to go to  
2                                 [name of mental health organisation], which was voluntary,  
3                                 that's when she took the calculated paracetamol overdose.  
4                 Ed (T):           Right, okay.

To give context to the above extract, it is important to explain that Lou had been asked to attend a previous appointment at a different mental health organisation some time before being enrolled onto the SHIFT trial. Lou had taken an overdose the morning of the appointment and explained that she did this because she did not want to go to the appointment. Here we see Hannah explaining Lou's decision to attend today's FT session.

Hannah uses the word "voluntary" when describing Lou's decision to attend both the current FT session and her previous appointment with another mental health professional. It is important to note here that this is the third and fourth time that Hannah has used the word "voluntary" within the same account (not all of it is shown by this extract). This is a word that implies an amount of independence, and action without any external pressures. It seems important that she asserts that Lou was able to make her own choice about the appointments. In doing so, Hannah promotes Lou's agency but also manages the risk that she is seen as having insisted that Lou attended these appointments, and the risk that she is attributed blame for her prior overdose.

The extract below follows on in a linear fashion:

5                 Hannah (M):   So, I knew the fact that she was going to come here, or was  
6                                 okay to come here, that's all I could think about, I was so  
7                                 proud that she actually accepted that this was a good thing.  
8                                 For her to- For her to actually be sitting here meant she  
9                                 accepted it could be a good thing.

*Key: Lou= Young Person, Hannah= Mum, Neil= Step Dad, Ed= Therapist*

- 10 Ed (T): (nods) Right.
- 11 Hannah (M): Because we know she has ways of avoiding things (Lou  
12 laughs quietly in the background) if she doesn't.

In contrast to constructing Lou as independent, Hannah restricts the choices that Lou 'should' be making through the act of *giving approval* which functions to condone certain behaviours and assert her own authority. In order to *give her approval*, Hannah repeatedly draws on an IR of parental pride. "Proud" (line 7) is a powerful form of parental approval and functions to reinforce and shape behaviour. The function here is to condone certain choices that Lou has made, and may have the longer lasting function of shaping her choices in the future, particularly with regards to attending appointments. Hannah also draws upon the words "accepted" (line 7) and "avoid" (line 11) to further emphasise the choices that she deems to be the 'right' ones. "Accepted" implies that she gave in to something, or someone, and contradicts the narrative that Lou was acting voluntarily.

As a result of *giving approval*, Hannah holds responsibility for approving actions which will be in the 'best interests' of Lou; Lou is not able to take responsibility for her own actions.

Again, the extract below follows the above in a linear fashion:

- 13 Ed (T): Okay. (To Lou) So if you hadn't wanted to come, you  
14 could have told your mum that you didn't want to come?  
15 Or you could have done something else to make sure it  
16 didn't happen?
- 17 Lou (YP): Yeah.
- 18 Ed (T): So that's right (..) and your mum says it was a compliment  
19 saying it's not dreadfully bad. Would you let us know if it  
20 gets dreadfully bad? Will that be something you'll say?
- 21 Lou (YP): Yeah, yeah, I'll sort it out.
- 22 Ed (T): (Amused, half-laughing) You'll sort it out?
- 23 Hannah (M): That's not what I want to hear! (laughs, rubs forehead) (to

- 24 Lou) You might be thinking something else in the back of  
25 your head but can you put that across the way you mean it,  
26 please?
- 27 Lou (YP): No, I didn't mean like (...) - I'm alright.
- 28 Ed (T): Okay. But if at some stage it does get dreadfully bad, will  
29 you let people know that?
- 30 Lou (YP): Yeah.
- 31 Ed (T): And that might be letting your mum know, or that might be  
32 letting me know.

Here we see how Ed (T) responds to the actions, of Hannah, which have restricted Lou's agency and, therefore, her responsibility in making her own choices. Ed appears to be *handing Lou responsibility* here but, at the same time, he also stipulates what the 'right' actions would be.

Ed repeatedly wonders if Lou will "let people know" if she is finding the sessions difficult (lines 14, 19, 29, 31 and 32). He is attempting to manage the risk of Lou engaging in future SHB or taking an overdose. Through this question ("Would you let us know if it gets dreadfully bad?"), Ed acknowledges that Lou's voice is important and *hands her responsibility* for communicating how she is feeling about attending FT. However, by asking Lou whether she would do this action specifically, he is suggesting that this is the 'right' thing to do. This is emphasised at the end of the extract when Ed ends with a statement, rather than a question, to finalise what he believes Lou's action should be. Lou is left with the responsibility for "letting people know" when she is feeling distressed, but her agency in making this decision has been taken away.

This extract exemplifies an ideological dilemma of the therapist. Here we can see that Ed has recognised the need for Lou to take responsibility for actions that will work to prevent or reduce her SHB. However, Ed occupies the role of 'responsible clinician' and, therefore, holds some of the responsibility for managing the risk of Lou taking an overdose again. This

means that he cannot hand Lou and her family full responsibility for keeping herself safe; holding some responsibility is inherent in his role as a clinician.

### **Refusing to Tell the ‘Story’**

Throughout the two sessions, Lou (YP) repeatedly *refuses to give her version of events* and, therefore, manages the risk that her role in the reported events is seen as greater than that of her parents’. This means that her mum and step-dad are required to provide their accounts and versions of what has happened within the family, including details of times that Lou has either taken an overdose or engaged in SHB. The result is that Lou does not have ownership of these stories and her role in them is no greater than that of her parents’. This leaves Hannah (M) and Neil (SD) with increased stakes in the events, and Lou with a decreased stake and therefore less responsibility.

Below I present extracts from a section of talk in which Lou is being asked by Ed (T) to describe the events surrounding the overdose that Lou took between sessions one and two. Lou begins by refusing to give her own account and instead suggests that her “mum can do it”. Throughout the two sessions, Lou *constructs her identity* as being someone who is not good at talking and her mum as someone who is better at this. This functions as a reason for not producing her own account and, instead, relying on her mum’s.

With Lou pleading with her mum to describe the events surrounding her most recent overdose, Ed, Hannah and Neil all align in *requesting that this version of events comes from Lou*. This is different from instances previous to this, in which Hannah has accepted Lou’s requests to speak for her. It seems important, to Lou’s parents and Ed, that this particular story is told by Lou and not by her parents.

- |   |           |   |
|---|-----------|---|
| 1 | Lou (YP): | Yeah, but mum’s good at that kind of stuff.                   |
| 2 | Ed (T):   | Hmm. What I noticed last time is I think that you’re really   |
| 3 |           | good at that stuff too, it may be harder for you to get there |
| 4 |           | sometimes, maybe bit more of a struggle but you’ve made       |



- 5 some lovely descriptions of things.
- 6 Neil (SD): The thing is, Lou, asking your mum to describe it, it's not  
7 really going to be helpful because there's a lot of things  
8 happened that your mum won't know about because you  
9 were alone. So, you need to describe what happened from  
10 your point of view so we understand it, because all we  
11 know is what the ending was, we don't know why you  
12 did what you did, nor what you did. Do you understand?

The extract above illustrates how Ed and Neil work together to **encourage Lou to give her version of the events**. In lines 2-5, Ed uses *praise* as a resource for *validating Lou's communication skills* and *challenging the narrative* in which she is not good at talking. Neil then goes on to explicitly state the value of having Lou's account; to understand her point of view and why she did it. Only Lou can be responsible for providing the information which will lead to this shared understanding and a way of moving forward. By refusing to take ownership of the story, Neil and Hannah are acknowledging that they do not have all the information and cannot, therefore, be responsible for 'fixing' the situation.

Eventually, Lou begins to tell her story but omits details around her thoughts and feelings, only giving details that her mum and step-dad are already aware of; she begins with the statement "I managed to get an allergic reaction to a cannula". The following extract illustrates Ed's response to Lou's omission of these relevant details:

- 1 Ed (T): This is really tough, isn't it, for you? (...) And I guess I'm  
2 just wondering about (.) how much (..) some of this talking  
3 about things about overdose; things about what were you  
4 thinking of; what were you planning; what you were  
5 hoping would be the result, it's really tough to talk about,  
6 isn't it?
- 8 Lou (YP): Yeah.

- 9 Ed (T): Yeah, and (.) I know your mum will be able to tell me, you  
10 know, what happened during the day that she saw and that  
11 she's found out about but she won't be able to tell me what  
12 you were hoping would happen from taking an overdose,  
14 will she? She might be able to guess-
- 15 Lou (YP): I just think she should go first.

Ed's repeated use of the pronoun "you", throughout this extract, highlights Lou's ownership of this story and *hands her responsibility* for giving her account. By drawing on a repertoire of intent, using words such as "thinking" (line 4), "planning" (line 4) and "hoping" (lines 5 and 12), Ed stipulates the kind of details that he would like to know and make available to Hannah and Neil. In doing so, Ed emphasises only Lou can be responsible for providing the information which will lead to a shared understanding of her experiences at the time in which she took the overdose. This shared understanding would ultimately mean a diffusion of responsibility in making positive changes in the future.

### **Summary**

Lou (YP) is *attributed responsibility for her actions*, by Hannah (M) and Neil (SD); they convey that she had thought her actions through, but that they are unable to understand her reasoning. This lack of knowledge, about what led Lou to take an overdose, leaves them with limited agency in making changes which would prevent it from happening in the future. Ed (T) attempts to explore Lou's experiences in order to make this information available to Hannah and Neil.

By the end of this session, Ed's *attempts to reach a shared understanding* of Lou's difficulties have been closed down, by Lou. This ultimately closes down the opportunity for the family to share the responsibility for making positive changes going forward as they are unable to know what these positive changes would look like.

## Family 5: Cal, Anne and Fred

### Cal, Anne and Fred: A Pen Portrait

Cal (YP) attended both sessions with his mum, Anne (M), and Dad (D), Fred. They were seen by Alan (T) who was joined by the same reflecting team member on both occasions. Cal fell within the 15-17 year old age bracket and was just about to start college. He had been seen by CAMHS after he had been cutting himself. It also transpired, over the course of the first session, that he had ligatured and had released himself from the ligature. His parents were not aware of this and described it as coming as a “shock”. Cal, Anne and Fred contributed equally to the session but the flow of the session seemed to rely on the therapist’s questions as they did not often voluntarily offer their own accounts or ideas. Alan wondered if the family found this type of communication in the session quite difficult and, subsequently, much of the talk centred on the family’s ways of communicating.

### Overview

Throughout the two sessions, Anne (M) and Fred’s (D) action of *claiming unawareness* (which I go on to describe in depth) functions to distance themselves from Cal’s SHB and subsequently absolve them from any accountability for not preventing it. Cal and his parents generate a linear explanation for Cal’s distress one which lies outside of the family. His SHB is attributed to his “grief” around his breakup with his girlfriend. Throughout the two sessions, when asked by Alan (T) what they would like to get out of the session, they each provided an answer which *locates the reason* for why they are here, and the responsibility for any change within Cal.

Cal’s response:

- 1 Alan (T): (to Cal) What do you want to get out of coming here, Cal?
- 2 Cal (YP): (head in hand) Uh, (...) um (..) I mean, it’s not really, like,
- 3 about moving on as a family or anything like that, it’s (..) I

Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist

4 just want to get through, uh, how I am feeling.

Anne's response:

1 Alan (T): (to Anne) What about you Anne, what would you like to  
2 get out of coming?

3 Anne (M): Um, to get to a position where Cal was (..) happy and safe  
4 and not (.) even thinking about self-harm or suicidal  
5 thoughts, to get- so that was all in the past that he had that  
6 pain (..) that there was, um, that he really believed that life  
7 was better and he could see a future for himself, seeing all  
8 sorts of other relationships.

Fred's Response:

1 Alan (T): What about you, Fred, what would you like to get out of  
2 coming here?

3 Fred (D): I'd like to know that Cal is happy, um, (..) and that he (.)- if  
4 he is upset or anxious or depressed in the future –um,  
5 because that's quite possible-

6 Alan (T): Hmm.

7 Fred (D): -people get upset and anxious and depressed all the way  
8 through their lives- that he has some tools or (.)  
9 mechanisms, if you like, to get through it.

The second session follows a period of time in which Cal has not engaged in SHB. Through the action of *owning success*, Cal contributes to the narrative that his SHB is not a family matter, .e.g.:

1 Alan (T): Has it surprised you that you haven't hurt yourself?

2 Cal (YP): Uh (..) um, not really surprised it was just- I don't know, it  
3 didn't feel any different to my- 'cos, I guess because I  
4 didn't really stress myself that much.

5 Alan (T): Alright.

*Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist*

6 Cal (YP): 'Cos I was (coughs) either acting on it quickly by doing  
7 something active, or practising banjo.

Cal holds the responsibility for having made the changes which have led to him stopping his SHB. Although this is understandably spoken about as a positive outcome for Cal and his family, this leaves Cal in a position where he holds all the responsibility for 'keeping himself safe' in the future. This is because he has managed without any changes being made by his parents in this current instance.

Overall, a narrative is constructed in which Cal holds responsibility for his previous SHB, and for maintaining his progress so far. On the other hand, his parents have had no agency in 'keeping him safe' and, therefore, are absolved of any responsibility for his SHB. I present, below, the actions through which Cal, Anne and Fred create this narrative and the actions, through which Alan responds in an attempt to diffuse the responsibility.

### **Claiming Unawareness**

Anne (M) and Fred (D) collaborate to *claim an unawareness* of Cal's (YP) SHB. This manages the risk of any judgement that they knew about Cal's SHB and were unable to prevent it. They manage the risk of being seen as having failed in some way, or of feeling that they have failed in some way. They will not be seen as responsible for and do not need to feel responsible for something that they did not know was happening. The extract below shows how they co-construct a narrative in which they did not realise the extent of Cal's distress.

1 Alan (T): And what have you noticed about Cal's mood in the last  
2 few months? (..)

3 Anne (M): Um, I think for me, most of the time he has seemed fine  
4 and then occasionally (.) angry, urm, and sort of snappy but  
5 only in a typical teenage way. And then (.) there have been  
6 a number of occasions when he's come and found me sort

- 7 of in the evening and got very upset and cried a lot.
- 8 Alan (T): Hmm. Right.
- 9 Anne (M): Urm, and not wanted to talk about it.
- 10 Alan (T): Okay.
- 11 Anne (M): You know, just sort of being very sad.
- 12 Fred (D): I was just concerned, I've not been aware of anything really
- 13 different from our older children
- 14 Alan (T): Right.
- 15 Fred (D): Um, I know that basically he'd been in to see Anne but
- 16 usually by that time I'm in bed.
- 17 Alan (T): Right.
- 18 Fred (D): So, I've erm, I've not seen him upset, very upset.

In line 5, Anne attributes Cal's expression of distress to "typical teenage" behaviour, to begin to account for why she did not realise the extent to which he was upset. She then explains that Cal did come and find her when she was upset (lines 5-7), ensuring that she is not judged to be unapproachable. Whilst she ensures this, she also acknowledges that Cal was visibly upset and that she knew about it, risking the judgement of "why didn't she do something?". She manages this risk in line 9 when she hands Cal the responsibility for not talking to her about how he was feeling. Anne also *minimises her impression of Cal's distress* in line 11 through the use of "just sort of" before going on to say "very upset".

Fred joins in to explain that he was also unaware of Cal's distress in lines 12, 16, and 18. He *excuses himself from accountability* for not noticing by claiming that he was "in bed" when Cal appeared most upset. He also draws upon the same "typical teenage" IR as Anne in line 13, claiming that he did not think Cal's behaviour was any "different from our older children", further *excusing himself* for not noticing the extent of Cal's distress.

The result is that Anne and Fred are excused from any judgement that they have failed to prevent Cal's SHB. If they were unaware of the extent of Cal's distress, then they did not

have any agency in improving his situation and, therefore, held no responsibility to improve his situation.

In a later section of the session, whilst Anne and Fred are continuing to stress the fact that they were unaware of Cal's SHB, they both draw upon emotive language to illustrate their reaction to learning about Cal's SHB:

- 1 Anne (M): It's very difficult to hear (.) sad (Fred nods)
- 2 Alan (T): Hmm. Same for you Fred?
- 3 Fred (D): (sighs) Yeah, it's, uh (.) shocking-
- 4 Alan (T): Hmm.
- 5 Fred (D): -actually, yeah (nods)
- 6 Anne (M): And scary as well.
- 7 Alan (D): Hmm (nods)

*Expressing their emotional reaction* to finding out about Cal's distress manages the risk that they are seen as 'bad parents' who did not notice because they did not care. By stating their distress and state of "shock", they are *excusing themselves* from already having a plan around how to help Cal. They are reiterating that they have only just found out about Cal's SHB and have not had chance to fully process this and plan accordingly. They therefore hold no responsibility to have decided on or carried out any plan to manage Cal's distress.

### **Forcing Visibility**

Alan (T) responds to Anne (M) and Fred's (D) 'unawareness' through the action of *forcing visibility*. Alan attempts to increase Cal's (YP) parents' knowledge about his experiences and SBH in order to increase their agency and therefore responsibility in keeping himself safe. This manages the risk that Cal is left in a position in which he holds sole responsibility for keeping himself safe.

The extract below shows a moment in the first session where Alan is working to *force the visibility* of the SHB itself.

*Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist*

- 1 Alan (T): And when you were at the height of your cutting was that  
2 every day or several times a day?
- 3 Cal (YP): Um, I'd say about twice a day.
- 4 Alan (T): For most days?
- 5 Cal (YP): Yeah.
- 6 Alan (T): Do people around you notice or are you good at disguising  
7 it?
- 8 Cal (YP): Um, like, someone in school noticed and they brought it up.
- 10 Alan (T): Hmm.
- 11 Cal (YP): Um, yeah, uh- (...)
- 12 Alan (T): So did it bleed or did it or was it just kind of showing  
13 blood, if that makes sense?
- 14 Cal (YP): Uh, yeah, it bled.
- 15 Alan (T): Did you look after your cuts or did you just like to see the  
16 blood, let it bleed a bit?
- 17 Cal (YP): Um, (..) if it bled to a point where I thought it was a bit  
18 much-
- 19 Alan (T): Alright.
- 20 Cal (YP): -then I'd, like (..) um (..) put [?] over it, make it numb.
- 21 Alan (T): Right. And no-one spotted this at home? (Anne shakes  
22 head) You managed to keep it fairly quiet, yeah? (...) What  
23 about- did you cut anywhere else on your body, your legs  
24 or-?
- 25 Cal (YP): Nowhere else.

Throughout this extract, particularly in lines 12 to 18, Alan is questioning Cal in a way that produces a vivid description of his SHB; making it more visible to Anne and Fred who have, so far, been unaware of it. Speaking about SHB in this explicit way makes it more tangible and knowable, increasing Anne and Fred's awareness of it. It also serves to make

*Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist*



the SHB more 'real' for Anne and Fred, who are only just learning about its presence. Anne and Fred's awareness of SHB and therefore agency in noticing it increases as a result.

In line 22, Alan manages the risk that Anne and Fred feel blamed or guilty for not noticing something which may now feel more 'visible' as a result of this section of his and Cal's description. He *acknowledges Cal's role in keeping it (SHB) quiet* and, therefore, restricting Anne and Fred's agency in helping him as a result. Alan *absolves Anne and Fred of responsibility* for not noticing Cal's SHB (handing this to Cal) whilst, simultaneously, *handing them responsibility for noticing in the future*. It appears that Alan is *rescuing* Anne and Fred from feeling responsible for what they cannot change and also from feeling helpless in the future.

## Rescuing

*Rescuing* appears to be the main action through which Alan (T) manages the risk that Anne (M) and Fred (D) feel criticised or responsible for Cal's (YP) SHB. The extract below shows part of a discussion around how Cal and his parents do not speak together that much.

- 1 Fred (D): -um, (...) but, yes, the fact that we're here perhaps suggests  
2 that we haven't communicated verbally as well as we might  
3 have needed to with Cal.
- 4 Alan (T): Well, it's not a kind of, um, you're not here because you  
5 don't talk about it- of course there's lots of families who do  
6 do lots of talking, but they still come here so it's not a  
7 criticism or a deficit that you've come here, is it really?  
8 Um, and sometimes people communicate without words, I  
9 think because you can understand behaviours and, um, the  
10 non-verbal things that families do. So it's not just about the  
11 words. What I'm interested in thinking about it is I think  
12 it's good to have a bit of a healthy kind of scepticism about  
13 talking therapies and things, it's a useful position to hold

Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist

14 (Fred nods head). (to Anne) What's it like for you Anne?

15 Do you kind of share that, those views?

Fred begins by tentatively suggesting that they haven't communicated with Cal as much as they "needed to". It appears that he is *questioning* whether himself and Anne should accept some of the responsibility for speaking to Cal more than they do already. Through the use of the words "perhaps" (line 1) and "might" (line 2), Fred invites Alan to either agree or disagree with this self-depreciative statement.

What follows, in lines 4 to 13, shows Alan *rescuing* Fred, and implicitly Anne, from this self-deprecation, managing the risk that they feel blamed and responsible for not having spoken with Cal and subsequently prevented his SHB. In lines 6 to 7, he explicitly references concerns that they may have about why they are in FT; that they feel criticised or deficient as parents. He then goes on to explain why this is not the case. Here, Alan's primary stake is to diffuse any perceived blame and to maintain a therapeutic relationship with Anne and Fred. This stake competes with one in which he is aiming to create a narrative of shared responsibility for communication. It appears that Alan has made a decision to preserve the therapeutic relationship in this instance.

Alan's action of *rescuing* opens up the opportunity for Anne to disagree with Fred. Anne goes on to *excuse* both herself and Fred of responsibility for not having spoken with Cal about how upset he has been. She explains that "I just keep on talking and it doesn't go anywhere" and "I find it hard and I think I would like there to be a little bit more talking with the children -or with kids particularly- um (.. sighs) if that- but I want that to be sort of natural- rather than- because my experience has been when I first attempted that at different times with different children, has it kind of ends up questioning sessions". Anne removes the possibility of the criticism that she has not tried to communicate with Cal, by constructing an "I've tried" narrative.

Anne further *excuses* Fred from not having communicated with Cal by attributing this to Fred's intrapsychic qualities. She describes herself as "more comfortable with talking and

*Key: Cal= Young Person, Anne= Mum, Fred= dad, Alan= Therapist*

less comfortable with physical communication” and explains that Fred is “opposite” to her in that way. Anne constructs Fred as someone who finds talking difficult and Fred *corroborates* this: “I think it is (.) difficult, I’m probably still not very easy with it”. However, Fred does this tentatively and leaves open the possibility that this is not a stable trait of his; that he could take some responsibility for communicating with *all* his children more often. For example, “I think I’m probably far more talkative now than I used to be” acknowledges that his ability to be “talkative” is not fixed and that he has agency in changing this. Throughout this interaction, Alan has managed the risk that Anne and Fred feel criticised for not having communicated with Cal, which allows Anne to *hand Cal the responsibility* for communicating his distress with his parents.

### Summary

By the end of the two sessions, Anne (M) and Fred (D) are in a position where they hold more knowledge and understanding about Cal’s (YP) SHB. Whilst managing the risk that Anne and Fred feel criticised for not having noticed Cal’s SHB or having communicated with Cal about his distress, Alan (T) *closes down the opportunity* for Anne and Fred to explore how they might go about communicating with Cal more often. At the end of the two sessions, Alan asks Cal “how would you let them [his parents] know? Is it kind of up to them to just know these things, that you’ve got through it, or-?”. Alan’s question implies that it is Cal’s responsibility to communicate his distress or reassure his parents that he is not engaging in SHB.

It appears that, although Anne and Fred hold more knowledge about Cal’s SHB, Cal is the one who is *handed responsibility* and *also takes responsibility* (through the action of *owning success*) for making changes.

## Summary of Findings Across the Data Sample

So far, I have presented my data as five separate case studies to allow me to illustrate five different negotiations of responsibility. Across these five different negotiations, there are features which are shared by the different ‘types’ of participant (i.e. parents, young people and therapists). These features make members of one ‘type’ of participant seem more similar to each other, than they do to members of other ‘types’ of participant. I explain these common features in this section with a focus on how they help us to understand the stakes being managed by particular ‘types’ of participants.

### Parents

The main stake that each of the parents appear to be managing is the risk that they are viewed to be ‘bad parents’; that they are in some way responsible for the distress that their child is in or that they have not done enough to prevent it. Nita (M, family 1) manages this risk by claiming that Mina (YP) has had an unreasonable reaction to her actions and is *requiring maturity* from her. Stacey (M, family 2) manages the risk by *undermining the rationality* of Kelly (YP) in order to assume a protector role. Nicole (M, family 3) *resists accountability* when it is implied that she holds some responsibility for her ongoing relational difficulties with Kirsty (YP). Hannah (M, family 4) manages the risk that herself and Lou’s (YP) step-dad (Neil) are viewed to have failed in understanding their daughter’s actions through her action of *doubting a reasonable explanation* for Lou’s (YP) SHB; she explains that they have attempted to understand but have been unable to. Anne and Fred (M and D, family 5) manage this risk by *claiming that they were unaware* of Cal’s distress and subsequent SHB.

As well as through the above actions and sometimes as part of these actions, parents appear to manage the risk of being held responsible for their child’s SHB through the use of external attributions (outside the participants’ control). For example, in family 1, Nita (M)

attributes causal responsibility to when Mina (YP) “had to stay off school because the fees weren’t being paid. And the fees weren’t being paid because the father wasn’t paying me”.

**External attributions.** In terms of the other four families, Stacey (M, family 2) attributes causal responsibility to the perpetrator of Kelly’s (YP) assault, the school and the “bullies”. Nicole (M, family 3) appears to attribute causal responsibility for her relational difficulties with Kirsty (YP) to her own past experience of domestic violence, from both her father and her ex-partner. Although these difficulties were once located within the family, they are no longer and are outside of the control of both Nicole (M) and Kirsty (YP). Hannah (M, family 4) attributes causal responsibility to Lou’s (YP) ongoing CAMHS assessment and the teachers at her school. Anne and Fred (M and D, family 5) attribute causal responsibility to Cal’s (YP) break up with his ex-girlfriend. Each of these attributions relates to a person or people outside of the family. They appear to be laying blame on people, rather than things (such as drugs, health, exam pressure). This is important, as people can hold responsibility, whereas ‘things’ cannot. The parents therefore cannot hold full responsibility if part of it has been attributed to someone else.

Although external attributions for the cause of the young person’s SHB function to manage the risk that parents are viewed as responsible, they may also function to reduce the family’s perception of the agency that they have in making any changes to improve their situation. For example, Nita (Mum, family 1) explicitly makes reference to her lack of agency in changing the external cause of Mina’s (YP) distress: “I’ve only got a certain amount of pennies and so there’s nothing I can do”. I go on to explain, later on in this section, how the therapists work to increase the families perception of the agency that they have in changing their situation.

**Interpretative repertoires of immaturity and maturity:** Another way in which the parents managed the risk that they are viewed as responsible for their child’s distress was through the use of IRs of immaturity and maturity. An IR of immaturity and adolescence is present throughout all the families which I have presented. In family 5, Anne (M) draws

upon an IR of teenage behaviour to absolve herself and her husband of responsibility for not noticing their son's SHB. More commonly, an IR of immaturity and adolescence functions to absolve the young person of responsibility for keeping themselves safe and opens up space for the parent to assume the 'protective parent' role. For example, Stacey (M, family 2) draws upon an IR of teenage immaturity which contributes to her action of *undermining Kelly's (YP) rationality*:

- 1               Stacey (M):     Um, it's like last night she had a bit of a huff and a puff so  
2                                'bang bang' up the stairs, slamming her door-
- 3               Julie (T):     Yeah.
- 4               Stacey (M):     You know, the doors aren't like the old house, these are  
5                                proper solid wooden doors. And this was over earphones  
6                                [Kelly laughs].
- 7               Julie (T):     Okay.
- 8               Stacey (M):     Because earphones go downstairs in the living room.  
9                                Nobody else will touch her earphones because they will get  
10                               (.) [??] They weren't in the living room, so because I did  
11                               not hear: 'bang, bang, bang' –normally I would go (makes  
12                               a hand gesture of swift movement) after her and say: “What  
13                               are you doing that for?” This time I just went and shut the  
14                               living room door and I sat downstairs to eat. And I did that  
15                               the first time she'd [?had a fuss about?] and I could hear  
16                               then 'bang, bang, bang' in the bedroom and I was thinking:  
17                               “Is she waiting for me to go up?”

In lines 1 and 2, the choice of language that Stacey (M) uses to describe Kelly's (YP) behaviour generates connotations of a 'stropky teenager'. Stacey (M) positions Kelly (YP) as an adolescent, who is responsible for disruptions around the house, and who needs her mum's help in matters which Stacey (M) presents as trivial. In lines 4 and 5, Stacey (M)

describes Kelly's (YP) reaction to losing her earphones. The choice of the word "and" in line 5, rather than "because" suggests that Stacey (M) does not think that Kelly's (YP) behaviour could be reasonably caused by the loss of her earphones; suggesting that she is behaving irrationally. Meanwhile, Stacey (M) positions herself as someone who has recognised what needs to happen when Kelly (YP) is behaving like a 'stropky teenager', and as someone who is responsible for making things run smoother. She repeats the phrase "bang, bang, bang" (in lines 2, 11 and 16), placing emphasis on the claim that she is responding to Kelly's (YP) "huff and puff", 'stropky teenage' behaviour. This appears to be in the interest of positioning herself as the 'protective parent'. By assuming the 'protective parent' role, parents counter any claims that they do not care for their child; that they are a 'bad' parent.

During my case presentation of family 1, I explain Nita's (M) ideological dilemma of viewing Mina (YP) as a child yet *requiring maturity* from her. Nita (M) draws upon a repertoire of immaturity and adolescence to create a teenage identity for Mina (YP), which absolves Mina (YP) of responsibility for her actions, whilst allowing Nita (M) to take on a 'protective parent' role.

In contrast to this, Nita (M) also draws upon an IR of maturity when describing Mina (YP). By constructing Mina's (YP) identity as mature, Nita (M) provides a rationale for why she thought it was appropriate to speak to Mina about their financial difficulties, absolving herself from any accusations that she behaved inconsiderately. Overall, Mina (YP) is constructed as holding two positions; one of immaturity and one of maturity. This is an ideological dilemma that leaves the family in a position where the young person's identity, and therefore role of responsibility, is ambiguous.

Interestingly, the use of both IRs of immaturity and maturity by a parent, is not particular to the case of family 1 (Mina and Nita). In family 4, Nicole (M) draws upon both IRs to perform the action of *accusing* Kirsty (YP):

1                      Nicole (M):     She's nearly sixteen years of age and she wants everything

2 put in her hand.

Vs.

1 Nicole (M): She's fifteen and I'm an adult and she permanently talks

2 like that to me.

In both of the above examples, Nicole (M) is **accusing** Kirsty (YP) of something. In the first example, Nicole (M) is accusing Kirsty (YP) of relying on her mum even though she is “nearly sixteen”. In the second example, Nicole (M) accuses Kirsty (YP) of speaking to her in a way which is not appropriate considering their age difference. In example 1, Nicole (M) uses Kirsty's age (YP) as an identity of implied maturity. She is suggesting that Kirsty (YP) should be acting in a more ‘mature’ way considering the fact that she is “nearly sixteen years of age”. In example 2, Nicole (M) uses Kirsty's age (YP) as an identity of implied immaturity. She suggests that Kirsty (YP) should not be speaking to her in the way that she does because she is “an adult” as opposed to Kirsty (YP) who is “fifteen” and a child.

By **accusing** Kirsty (YP), through the use of IRs of both immaturity and maturity, Nicole (M) builds a case against any claims that she is solely responsible for their relational difficulties.

### **Young People**

Each young person, apart from Cal (YP, family 5), appears to **restrict the knowability** of their experiences which limits knowledge on what can be done to improve their situation and, therefore, their responsibility in making changes. The therapists respond with attempts to **increase the knowability** of the young person's experiences to manage the risk that their experiences remain unshared and the family's agency is restricted as a result.

I make reference to this in family 1 (Mina and Nita) and explain the function of these actions in depth in family 2 (Kelly and Stacey). Similarly to Kelly (YP) in family 2, both Kirsty (YP, family 3) and Lou (YP, family 4) use the phrase “I don't know” which restricts the knowability of their experience. The intended function of the ‘I don't know's is not



clear; they may feel uncomfortable talking about their experience for a number of reasons, or they may feel that they do not know the answer to the question at that point. Having said this, they still serve to limit knowledge on what can be done to improve their situation and, therefore, their responsibility in making changes. Both therapists (David, family 3 and Ed, family 4) respond in a way which functions to question whether the young person actually does not know and encourages them to elaborate.

An example from family 3:

- 1 David (T): (To Kirsty) What was that like for you?  
2 Kirsty (YP): Don't know.  
3 David (T): You don't know? (...) "Don't know" because that's all you  
4 had or "Don't know" because it was not something you  
5 want to think about or remember about?  
6 Kirsty (YP): Don't really want to talk about it.

An example from family 4:

- 1 Ed (T): Is that something you'd like to be able to do?  
2 Lou (YP): Probably. Probably safer but- don't know.  
3 Ed (T): You don't know?  
4 Lou (YP): (To Hannah) I suppose I have tried other stuff haven't I?  
5 (Hannah gestures as if to say "I don't know"). To get away  
6 from stuff but (-)  
7 Ed (T): And how well do those things work?  
8 Lou (YP): Not well.

In the first example that I present here, David's (T) efforts to *increase the knowability* of Kirsty's (YP) experiences, beyond her "I don't know", is *restricted* further by Kirsty (YP). However, he does make available the useful information that Kirsty's (YP) experiences are difficult for her to talk about. In the second example, Ed's (T) efforts lead to further exploration of Lou's (YP) experiences.

Although Cal (YP, family 5) does not *restrict the knowability* of his experience in the same way as the other young people, it appears that his parents have entered FT with little knowledge at all about his SHB and by *owning his 'success'* he limits the need for his parents to know any more about his experience. The stake which Cal (YP) is managing seems different from the other young people. He appears to be *claiming independence and responsibility for keeping himself safe*. To manage the risk that Cal's (YP) experiences remain unknown to his parents and reduce the perception that Cal (YP) holds sole responsibility for keeping himself safe, Alan (T) uses the action of *forcing the visibility of SHB*.

By increasing the availability of information on the experiences of all family members, in particular those of the young person, the family have agency in determining what changes should be made and can share responsibility for these in the future.

### **Therapists and Reflecting Team Members**

The main interest of the therapists (including the reflecting team members) appears to be equalising the agency of all family members in being able to make changes that would ultimately lead to a decrease in SHB. With everyone holding positions of agency, they also hold responsibility for making those changes. The therapists appear to be working to *diffuse responsibility* between all family members. The action of *increasing knowability* is just one way in which the therapists achieve this interest. Other actions are *encouraging and praising* and, *repositioning the difficulty as family and future oriented* which I go on to describe below. Whilst working to create a shared sense of agency between all family members, the therapists also manage the risk of the occurrence of any future SHB and the risk that any one family member feels blamed during the session, particularly as a result of the therapist's actions.

**Encouraging and praising:** Similarly to the validation that Nita (M, family 1) receives from both the therapist (Beth) and the reflecting team member (Cathy), the therapists across

the data *encourage and praise* the families' efforts throughout the therapy process. For example, as highlighted with family 4's (Lou and Hannah) case study, Ed (T) uses praise as a resource for validating Lou's (YP) communication skills and deconstructing the narrative in which she is not good at talking. In family 5 (Cal, Anne and Fred), reflecting team members use *praise* to recognise the family's efforts within the sessions and *encourage open communication* in the future: e.g. "what I'm struck by today is kind of how hard people seem to be working".

O'Reilly (2014) explained that praise is used in FT to maintain a therapeutic alliance in order to manage the risk that the family do not attend any further appointments. Although this may be true, *encouragement and praise* also serves to validate the family's ability to engage and make use of the sessions, thus increasing their perceived agency and therefore responsibility in attending the sessions.

**Repositioning the difficulty as family and future oriented:** I explained above that parents tend to manage the risk of being seen to be responsible for their child's SHB by locating causal attributions for SHB, as external to the family, i.e. past events. This leaves the family with little agency in improving their situation. In order to increase the family's perception of agency in making improvements, the therapists use discourse which is future focused and places control within the family. For example: "Kelly if there were less conflict between the two of you, what would you hope for more of?" (Family 2, Kelly and Stacey); "Do you want to do more talking as a family- not particularly here but at home as well?" (Family 5, Cal, Anne and Fred) and; "I suppose what you're both saying is that you want to get on better, and that you want to have a better relationship. Yeah?" (Family 3, Kirsty and Nicole). In this final example, the therapist (David) uses a confirmation- expecting tag question (Antaki, Young, & Finlay, 2002); "Yeah?". Such questions serve to encourage a confirmatory answer; in this case David (T) is encouraging Kirsty (YP) and Nicole (M) to agree on and take responsibility for the family and future oriented goal of having a "better relationship".

**Risk management:** At points throughout the initial two sessions, the therapists take responsibility for assessing the risk of the young person repeating SHB and for beginning to generate a risk management plan. For example:

- 1 Beth (T): Before you go (to Nita) are you happy about the  
2 arrangements for managing any concerns?  
3 Nita (M): Yeah. I’ve taken those on board and, you know, I’ve  
4 listened, so-  
5 Beth (T): You clearly do listen very carefully and, you know, that’s  
6 going to be a real strength in the work, but also Mina it’s  
7 great to know that you’ve found something that can distract  
8 you from hurting yourself, your mum’s going to check that  
9 you’ve got an elastic band-  
10 Nita (M): Um-hmm.  
11 Beth (T): -if it got too difficult you would speak to your mum, if the  
12 feelings were getting stronger, is that the agreement we  
13 have? (Mina nods) And do you confidently think you can  
14 carry through that agreement? (Mina nods)

Here we see Beth (T) confirming a risk management plan at the end of their first session. In lines 5 to 9 we see, again, the use of praise to *validate* Mina (YP) and Nita’s (M) abilities in an attempt to increase their perception of agency in implementing the proposed “agreement”. During this type of interaction, the therapist is *inviting the young person and other family members to take responsibility* for coming up with helpful actions and, therefore, responsibility for implementing them outside of the therapy room.

Risk management interactions contribute to the therapist’s action of *repositioning the difficulty as family and future oriented*. They often focus on the interactional style between the parents and young people (as with the above example). The therapists present changes in

communication styles as being beneficial for family functioning and, therefore, the young person's distress and distress tolerance.

**Diffusing blame:** Whilst the therapists are working towards shared agency between family members, they are also working to ensure that any blame is diffused and that no one family member is left feeling solely responsible for past events. For example, in Family 5 Alan (T), through the action of *rescuing*, absolves both Anne (M) and Fred (D) of blame for not talking with Cal (YP) enough. Although he absolves Anne (M) and Fred (D) of blame, he does not place the blame anywhere else. In family 1, the reflecting team work, through the action of *acknowledging Nita's (M) needs*, to ensure that she does not feel blamed by Beth's (T) action of *undermining her request for maturity*.

The diffusion of blame, mainly through the use of empathy, provides a space in which responsibility for the existence and improvement of difficulties can be repositioned as being within the family, whilst also maintaining a therapeutic relationship.

### **Summary in Relation to the Primary Research Question**

My primary research question asked **how responsibility for SHB is negotiated between the therapists and family members in FT for adolescents**.

I found that parents entered therapy with actions that appeared to be managing the risk that they are seen to be the cause of their child's distress or for not having prevented it. The various actions, through which the parents managed this stake, restricted their own agency or their child's agency in making changes which would reduce the occurrence of future SHB. Many of the young people restricted the knowability of their experiences which limited their parent's agency in knowing what would be helpful changes to make, in order to reduce their distress in the future. Overall, the actions of both the parents and the young people closed down opportunities in which the family could achieve shared responsibility for implementing changes which would reduce the occurrence of SHB.

The therapists responded with a range of actions that appeared to be working towards a narrative in which all family members are able to take responsibility for knowing what positive changes would look like and putting these into action. As the therapist's interest, of achieving a narrative of shared responsibility, is in competition with the parent's interest of not being judged to be a 'bad parent', the therapists also used a range of actions to provide an empathetic space. This managed the risk that any family member felt blamed and the risk that the therapeutic relationship experienced a rupture as a result.

### **Reflections on the Analytical Process**

As I spoke about in chapter 2, I noted down my reflections whilst watching the videos, reading the transcripts and reading the surrounding literature. Reflections included: emotional reactions to content; notes on salient themes; personal reflections about the research process. At various points throughout my analysis, I looked back through my journal to see what I had noted earlier on. I found that the reflections which shaped my analysis the most were the ones in which I had had an emotional reaction to the content. These reactions led me to align with certain family members. Whilst aligning with one family member, I was able to appreciate their stake and was less likely to consider the stakes of other family members. My reflective journal served as a reminder to move out of these alignments and consider the stakes which may have been present for other family members. I have included photos of extracts from my journal in the appendices (see appendix F).

## CHAPTER FOUR: DISCUSSION

In this final chapter, I begin by summarising the findings of my analysis and then considering how these relate to the wider theoretical literature, and the existing literature looking into narratives of responsibility in FT. I then consider the strengths and limitations of my research before talking about the clinical implications of the findings and identifying avenues for future research.

### Summary of the Findings

The overall aim of my research was to provide insight into how a therapist might encounter and negotiate stories of responsibility within a FT setting for adolescents who engage in SHB. The primary question that I considered was ‘how is responsibility for SHB negotiated between the therapists and family members in FT for adolescents?’. Within this, I thought about: how individuals manage their stake/ interests in the exchange and what this tells us about their needs; the discursive devices, repertoires and constructions that individuals draw on to manage this; the opportunities that the above processes open up and close down (within the exchange and beyond the therapy context). These aims have been addressed through the use of a DAM method of analysis, which revealed that a variety of actions were used to manage individual stakes and negotiate different narratives of responsibility across the five families. The narratives of responsibility related to previous and *future* SHB, i.e. causal attributions for the SHB and responsibility to make changes which could impact on the frequency of SHB in the future.

The analysis also revealed that particular ‘types of participant’ enter FT with different stakes in terms of the attribution of responsibility. The parents’ stake appears to be managing the risk of being seen to be a ‘bad parent’; one who is responsible for their child’s distress or for not having prevented it. Most of the young people appear to be managing the risk of being

responsible for making changes in the future. Whilst managing these stakes, the family members restrict their own and each other's agency in making helpful changes.

It is the interest of the therapists to reposition the family difficulties as "shared challenges" (Carr, 2016). In order to achieve this, therapists appear to be working towards a shared sense of agency between all family members and, therefore, shared responsibility in making positive changes throughout. Consequently, the therapists' stake in the therapy process competes with those that the family members enter therapy with.

As the stake and, therefore, actions of the therapists are in competition with those of the family members, the negotiation of a narrative in which agency and responsibility are shared is a delicate one. The therapists manage the risk that, whilst perceptions of responsibility may shift, no family member is left feeling blamed or solely responsible for SHB. The therapists were found to use actions such as praising and rescuing, in order to provide an empathetic space in which difficulties can be repositioned as shared by the family.

My research contributes to the existing body of research illustrating that negotiations of responsibility are one of the most important aspects of the talk within FT (Friedlander et al., 2000; O'Reilly, 2005, 2007, 2014; Patrika & Tseliou, 2015, 2016). I discuss the main findings of my research in this chapter and how they relate to existing theoretical and research literature.

### **Parents: Mitigating Responsibility**

Although my research focuses on FT for SHB specifically, the findings are comparable to the existing literature which looks at FT more generally. Previous research looking into the negotiation of responsibility in FT has found that families enter therapy with linear causal attributions about the family's distress (O'Reilly, 2007, 2014; Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016). This research found that family members held the



‘identified patient’ responsible for familial difficulties. Where the ‘identified patient’ was the young person, parents appeared to be managing the risk of being seen as a ‘bad parent’ by laying blame on the young person (Parker & O’Reilly, 2012; Patrika & Tseliou, 2015, 2016) and their mental health (O’Reilly, 2014).

These overt blaming discourses were not often found in my analysis. Based on the existing literature, this was something that I found surprising. Nicole (M, family 3) blames her daughter Kirsty for familial difficulties, and Nita (M) accused Mina (YP) of acting in an immature way by engaging in SHB, whereas the remaining families in my data sample did not appear to blame the young person. This finding fits with existing literature that finds that, when searching for a causal explanation, parents of children who are engaging in SHB tend to blame themselves (McDonald, O’Brien & Jackson, 2007). McDonald et al. (2007) found that mothers, whose child had engaged in SHB, held a sense that their own experiences and the emotional ‘fallout’ from these had led to their child’s SHB.

Although overt blaming of the young person did not often take place, responsibility for familial difficulties and/ or for the young person’s SHB was occasionally placed with the young person. For example, Cal (YP, family 5) was attributed responsibility for not communicating with his mum in a way that might have helped her to understand his distress; Lou (YP, family 4) was attributed responsibility for her ‘thought through’ actions and acting in a way that her parents could not understand and, therefore, not prevent. This was just one of the ways in which parents managed the risk that they are viewed to be ‘bad’ parents and responsible for their child’s distress.

Family life has been widely considered significant to an individual’s experience of mental health (Jones & Warren-Adamson, 2002) and, for SHB in particular, there is often the belief that young people who engage in SHB come from ‘dysfunctional’ or abusive families (Hurd, Wooding, & Noller, 1999; Sansone, Sansone, & Wiederman, 1995). This is sometimes, but not always, true (Meekings & O’Brien, 2004) and, considering these beliefs, parental attempts to absolve themselves of responsibility are unsurprising as they may have

felt under the scrutiny of professionals. McDonald et al. (2007) interviewed mothers of adolescents who had engaged in SHB. They found that, on discovering that their child is engaging in SHB, mothers felt inadequate as parents and were afraid that they would be judged harshly by others. This finding of McDonald et al.'s supports my finding of parents managing this risk of being judged.

McDonald et al. (2007) found that mothers were left with feelings of guilt and shame. Lewis (1998) explained how perceived responsibility is central to shame; when people are perceived by either themselves or others to hold responsibility for their condition, they are more likely to experience shame. Perceptions of responsibility not only involve the perceptions of others, but personal perceptions of responsibility. During a time which has been found to be a traumatic experience for parents (Raphael, Clarke, & Kumar, 2006) they may also be managing their own feelings of responsibility and 'self-scrutiny', as well as managing judgements of responsibility from others.

Another common way in which the parents, in my research, managed the risk of being seen as a 'bad parent' was by assuming a 'protector' role. This is a finding of my research, which is not spoken about by the more general FT research literature, and we might consider it an artefact of the 'risky' nature of their child's distress. It is linked to McDonald et al.'s (2007) finding that mothers became hypervigilant after discovering that their child was engaging in SHB. Similarly to Nita (M, family 1) asking Mina (YP) to leave her door open, and Hannah (M, family 4) checking Lou's computer, the mothers in McDonald et al.'s study reported reading their child's journals, emails, removing computer use and keeping their child in communal areas of the home.

Although many of my findings are closely related to and are supported by those of McDonald et al.'s (2007) study, from a DA perspective, a critique of their findings is that that the mothers' reports may have been confounded by the interview context. What they will have voiced in the interview will have served particular actions and managed particular stakes within that context. What they expressed may not actually have provided an accurate sense of the meaning that they have made from their experiences. Due the use of live data,

the findings of my study are arguably more credible as they are not filtered through the context of an interview, and more compelling as the positions of each party can be seen and are considered.

### **The Therapist's Challenge**

The overall goal of FT for adolescents who engage in SHB, is to attend to family functioning in a way that would subsequently reduce the distress of the young person and therefore SHB. The therapists in the SHIFT trial were trained in the use of a version of the LFTRC Systemic Family Therapy Manual (Pote et al., 2000; Cottrell et al., 2018a), which had been adapted for use with families following an episode of SHB. They administered FT according to this manual and adherence was checked through a variety of means.

The LFTRC Systemic Family Therapy manual proposes that therapists should aim to develop family members' understanding of their problem narratives and patterns of relating, through linear and circular questioning, with the goal of reframing any problematic narratives (Pote et al. 2000; Pote, Stratton, Cottrell, Shapiro & Boston, 2003). The aim of systemic FT is to treat the family as a whole and to move away from family culture and practices which place responsibility for individual and family difficulties (and therefore recovery) with one family member (Tseliou, 2014). The focus of the engagement phase of FT is often to reframe a problem as "shared challenges" to which all family members hold responsibility for finding a solution (Carr, 2016). The LFTRC Systemic Family Therapy manual describes this as "enhancing mastery" in which "family members take responsibility for their own roles and actions, and for the process of change" (Pote et al., 2000, p. 40).

My analysis shows a variety of actions through which the therapists work to achieve narratives of shared responsibility, and how the stakes of the parents and young people can often create barriers to this. This contention between what is at stake for the therapists and for the family members makes the therapy process difficult to navigate.

My research contributes to the growing body of literature which focuses on how systemic therapists work discursively to achieve relational stories of responsibility when faced with linear or blaming narratives (Friedlander et al., 2000; O'Reilly, 2014; Patrika & Tseliou, 2016). For example, Friedlander et al. (2000) found that the discursive strategies that therapist's used were: challenging blaming constructions or attempting to re-frame them, and ignoring or diverting the topic when faced with linear, blaming narratives.

Therapists attempt to deconstruct linear narratives of blame, whilst maintaining what is discussed in the theoretical literature as either neutrality (Selvini et al., 1980) or multi-partiality (Anderson & Goolishian, 1988). My analysis evidenced that, whilst attempting to achieve neutrality (Pote et al. 2000), therapists often used *praise* and *absolution*; actions which carry judgement and depart from neutrality. It seems that, in the context of FT, therapists carry some power in that they are often assumed, by the family, to have the 'moral authority' to determine who is to blame and who is not to blame. In the case of my analysis, they also appear to carry the 'moral authority' to validate parenting skills. These 'departures' from neutrality appear to occur in response to the stake of the individual, and function to maintain a therapeutic relationship. For example, *praise* of parenting skills occurs in response to the parents' interest of anticipating and managing the risk of criticism from the therapist.

Furthermore, in order to achieve a sense of shared responsibility it appears that sometimes one family member is required to 'shift' their position more than other family members. For example, in the case of Kirsty (YP, family 3) and Nicole (M), the therapists *aligned* with Kirsty to ask Nicole to move to a position of shared responsibility. This departure from neutrality attempted to work towards a narrative of shared challenges in which no one family member was to blame. In order to ensure maintain a therapeutic relationship with Nicole, the therapists *deconstructed blame*.

The difficulty in achieving neutrality has been widely considered by existing literature looking into discourses of blame and responsibility (Anderson, 1986; Stancombe & White,

2005; Patrika & Tseliou, 2016). Patrika and Tseliou (2015, 2016) argue that, by attempting to introduce a relational attribution for the young person's difficulties the therapist may construct a problem definition which is decoded, by the family, as an attribution of blame or responsibility to other family members (as we see in Kirsty and Nicole). This places the therapeutic relationship at risk.

The therapeutic relationship has been found to be linked to good outcomes in FT. For example, Quinn, Dotson, and Jordan (1997) used the Interpersonal Psychotherapy Alliance Scale (IPAS) developed by Pinsof and Catherall (1986) to explore the multiple alliances between the therapist and family members present in a FT context. They found that the higher the family members rated their relationship with the therapists on the IPAS (the better their view of the relationship), the better their outcome in therapy. It is, therefore, important for the therapist to consider how they might achieve their goal of a relational problem definition (Carr, 2016; Tseliou, 2014) whilst also managing delicate and subtle issues of responsibility so that no family members feel blamed, while all feel that they hold agency to change their current situation. My analysis highlighted that therapists attempt to do this by *repositioning responsibility against a back-drop of empathy*, which is something that O'Reilly also evidenced in their 2014 study. It is important that therapists recognise and respond to the stake of each family member, and the actions that these stakes generate, in ways which build and maintain the therapeutic alliance.

## **Adolescence and Responsibility**

Another key finding of my research was the use of IRs of immaturity and maturity which were used to construct the young person's identity. It was not that particular young people were constructed as immature and others as mature, but that all young people were constructed as both immature and mature at different points through the two sessions. It was more predominantly parents who drew upon these IRs when positioning the young person, but on occasion the young person also contributed to the construction of their identity in this

way. It appeared that constructing the young person as either immature or mature served different functions, depending on what the parent was hoping to achieve (their stake) at the time, e.g. accusations from Nicole (M, family 3), making space for a protector role by Nita (M, family 1).

Immature and mature identities can be classed as social categories which hold different levels of social responsibility. In their article titled *“Less guilty by reason of adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty”* Steinberg and Scott (2003) comment on the diminished decision-making capacity present in adolescence. They argue that adolescents are of ‘psychosocial immaturity’ when compared to adults. In their review, they provide an evidence base which suggests that, although adolescents may be evidenced to have similar cognitive capacities to adults, the outcomes of their decision making are influenced more greatly by a number of ‘psychosocial factors’. These ‘psychosocial factors’ were listed as: “a) susceptibility to peer influence, (b) attitudes toward and perception of risk, (c) future orientation, and (d) the capacity for self-management” (p. 1012). It is suggested that experience of these factors grows in adulthood and the choices of adults are subsequently less affected by them. ‘Adolescence’ is, therefore, argued to be a social category that holds “less responsibility” than adults for their actions.

Social categories are a type of IR that can be actively drawn on to claim social responsibility and absolve an individual of it. For example, Schubert, Hansen, Dyer, and Rapley (2009) explored how individuals, who had a diagnosis of ADHD and used amphetamines illicitly, accounted for any of their own behaviour which had been deemed problematic. They found that the social category of ‘adult ADHD patient’ was used as a medical diagnosis which absolved them from social and behavioural responsibilities. Similarly to the findings of Schubert et al.’s (2009) study, I found that IRs were deployed in order to construct social categories that hold different amounts of social responsibility; ‘immature-adolescent’ and ‘mature-young adult’. Adolescents are viewed at times as still being childlike and immature,

and at the same time as holding new levels of maturity. In my data sample, a repertoire of immaturity was drawn on to absolve the adolescent of responsibility and a repertoire of maturity was used to hand them responsibility for their actions.

This is a time of transition for both the adolescent and the parents and, with the young people simultaneously holding positions of maturity and immaturity, it becomes difficult to assess the appropriate level of responsibility that should be attributed to them. In terms of a period of transition for parents, they may experience competing stakes of wanting their child to grow up and take responsibility for their actions, whilst still wanting to hold on to some control over their actions. As parents give up control over their child's actions they may be left feeling accountable whilst they cannot be responsible for them. This dilemma might account for the deployment of both immature and mature IRs by the parents.

Erikson (1963; 1968) talks about the transition from childhood to adulthood in terms of the psychosocial stage of development called "identity vs. identity confusion". This is stage 5 of his model of 'psychosocial stages of development', occurring from ages 12 to 18. It is during this stage that the adolescent is learning what roles and responsibilities they will have as an adult, as they examine their own identity. Whilst adolescents explore this, they may occupy different roles of responsibility. I should note, here, that a social constructionist perspective would state that these 'identities' are 'rhetoric' rather than 'reality' and do not remain fixed between contexts.

In their review of adolescent development, Christie and Viner (2005) explain adolescence in terms of the biopsychosocial model. This acknowledges that, as well as the biological influences such as puberty, development in adolescence also has psychological and social influences. They critique Erikson's (1963; 1968) psychosocial stages of development for a lack of emphasis on the child as part of a system, arguing that any physical and psychological development (internal) will interact with social (external) factors. It is in this respect that the biopsychosocial model of development also fits with a systemic view on adolescence.

Christie and Viner (2005) explain that the psychological and social development of an adolescent will largely depend on sociocultural and environmental influences. As Steinberg and Scott (2003) highlight, it is the level of psychosocial maturity that an adolescent holds which will make their decision making different from adults. As this psychosocial maturity is dependent on dynamic factors which will be experienced by each adolescent in a different way, it is impossible for parents and therapists to determine an adolescent's psychosocial maturity based on their age alone. This makes it extremely difficult for them to assess the level of responsibility that an adolescent should be attributed for their own actions: Mina (YP, family 1) and Nita's (N) sessions provide examples of this.

### **Agency, Responsibility and Attribution Theory**

I have made reference to the relationship between agency and responsibility throughout my analysis and discussion, and I have placed emphasis on the therapists' efforts to achieve a shared sense of agency between all family members in order to increase their responsibility in making changes. As this link is so central to my findings, I feel that it is important for me to briefly elaborate on it here.

Haggard and Tsakiris (2009) explain that "the experience of agency refers to the experience of being in control of both one's own actions and, through them, of events in the external world" (p.242). In terms of my research project, the "event(s) in the external world" is the occurrence of SHB. Through the actions of the therapist, it is hoped that all family members feel that they can put actions in place which would influence the occurrence of SHB; that they are in control of making positive changes and share responsibility for doing so.

Much of the literature, that highlights how individuals who have held agency for their actions are held responsible for those actions (e.g. Lagnado & Channon, 2008), focuses on actions that have happened in the past. The focus of the therapists in my data sample is on establishing perceived agency for *future* events. It could be argued that if family members



hold agency and do not make positive changes, which they may feel responsible for future SHB.

Therapists work to create a sense of shared agency within the family system by shaping attributions of responsibility for their difficulties. Attribution theory (Heider, 1958) explains how individuals make attributions (e.g. internal and external) in order to make sense of the world. However, it ignores the social processes of attributions which I have highlighted through my findings; it appears that individuals deploy particular types of attribution to manage their stake within this FT context. For example, parents deployed external attributions to manage the risk that they are view to be ‘bad parents’, whereas the therapists worked towards attributions of cause and responsibility which were internal to the family system by *repositioning the difficulty as family and future oriented*. They worked to create a narrative in which responsibility was attributed as being held within the family, rather than with external or environmental factors, whilst managing the risk that no one family member felt that they had been attributed full responsibility.

Whereas attribution theory places emphasis on the cognitive function of attributions for an individual making the world ‘predictable’ (Heider, 1958), my research highlights the social and relational function of attributions. It shows that attributions can shift; they are not fixed and can be deployed to achieve different effects.

DA can, therefore, help us to understand why people make the attributions that they do, why people may hold contradicting ‘attribution narratives’, and how these may be deployed to perform ‘social actions’ and manage particular stakes dependent on social contexts.

## **Strengths and Limitations**

### **Strengths**

**Originality:** The main strength of my research is its novelty. There are a number of studies which look into FT, more broadly, and at concepts related to responsibility such as blame

and accountability (O'Reilly, 2014; Parker & O'Reilly, 2012; Patrika & Tseliou, 2015, 2016). My research is the first piece of research which uses video data of live FT to explore how responsibility for SHB, specifically, is negotiated. I consider the perspectives of all participants and the interplay between their different, sometimes, competing actions and stakes. My findings evidence common stakes and narratives of responsibility that families of adolescents who engage in SHB tend to enter therapy with and how therapists begin to work towards narratives of shared agency and responsibility.

Most of the existing research, on discourses of responsibility in FT, provide their findings as themes across all of the families in their data set (Parker & O'Reilly, 2012; O'Reilly, 2014; Patrika & Tseliou, 2015, 2016) or only provide an analysis of a singular case study (Burck et al., 1998; Diorinou & Tseliou, 2012). The former provides a broad snapshot of a range of actions that a therapist might encounter, omitting the nuances of single case studies, whereas the latter illustrates the actions in only one negotiation. Neither illustrate how a range of different negotiations occur and how a range of responsibility narratives evolve over time. My research provides detailed accounts of five very different negotiations of responsibility, allowing any readers to consider a range of actions and narratives that they may encounter. Through the different case studies, my research also evidences the dilemma of competing stakes that the therapists consistently faced, highlighting the importance of considering this in any FT intervention.

**Method:** Another strength comes from the appropriateness of my choice of method. The DAM looks beyond what is being said, into what is being done with what is being said. It explores how language is used by individuals, as a social tool, to achieve different actions and manage their particular stakes and interests. It is for this reason that it fits so well with the study of FT; a relational intervention which takes place through interactions between both the therapists and family members. During these interactions, each member is performing a set of actions in order to manage their stake in the therapy process. The DAM can, therefore, shed light on what these actions are and who appears to be managing what

stake. Through the use of the DAM, my research has moved from ‘what’ is being said in FT, to ‘how’ individuals work at achieving their individual interests during the therapy process.

The use of live video data meant that my results are based on what actually happened within the therapy room, rather than relying on accounts from therapists or family members which could ultimately have been skewed by the research process. As I had access to the video data, I was able to watch the videos alongside my transcripts. Being able to add annotations of gestures or tone of voice (such as mumbling or laughing), allowed me to ensure that what was presented as text, was an accurate representation of the video.

The DAM is a method of DA which is less commonly used. My research has demonstrated that it is a method which can be used to deconstruct common discourses and processes in FT to yield interesting results. Its structure is useful for DA novices and could be adapted to be used in clinical supervision. I discuss this in more depth later on in this chapter.

**Sample:** Elliot et al. (1999) explain the importance of ‘situating the sample’ of a research project so that the reader is able to assess who the findings are applicable to and whether they relate to their own practice. I have gone some way to situate the families of my sample through the use of pen-portraits,. Furthermore, the Screening Form and Eligibility Checklist provided by SHIFT (appendix A) give further details about the characteristic of the data set from which my sample was selected. As for the therapists in the trial, each was a qualified Systemic Family Therapist, who had trained in the UK, and held a Master’s degree in FT (see Cottrell et al. (2018a) for more details on the backgrounds of the therapists).

Family Therapist readers are also able to judge whether the FT used in this study is similar to their own and, therefore, whether the findings are transferrable to their practice. Each of the therapists joining the SHIFT trial received training in the adapted version of the LFTRC Systemic Family Therapy manual (Pote et al., 2000). The LFTRC manual is available online and the adapted version is available on request from the SHIFT trial team at <http://medhealth.leeds.ac.uk/SHIFTManual> (Cottrell et al., 2018a). Adherence to the manual

was assessed through recordings of therapy sessions, specialist review, formulation letters and clinical supervision (Cottrell et al., 2018a).

**Transparency:** Both Tracey (2010) and Elliot et al. (1999) highlight the importance of self-reflexivity in qualitative research. They suggest that qualitative research of high quality shows ‘transparency’ of the reflexive process (Tracey, 2010) and evidence of the researcher owning their own perspective (Elliot et al., 1999). This allows the reader to consider how the researcher’s position may have influenced their understanding of the data, and to consider what any alternative interpretations might be. In order to own my perspective and make the influences of my position as transparent as possible, I provide reflections throughout and extracts from my reflexive journal (see appendix F).

Tracey (2010) and Elliot et al. (1999) also suggest that providing rich description of the analytical process and findings, and grounding any findings in examples from the data goes some way to assert the credibility of the findings. I have explained, in depth, my analytical process to make this as transparent as possible. This also aids the reader in replicating my analytical process should they hope to. I have also provided many extracts from my data sample to illustrate how I came to the findings and to allow the reader to consider how they may have reached alternative conclusions.

### **Limitations**

In line with a social constructionist epistemological stance, I am not claiming that I have made the ‘true’ interpretation of the data. My analysis will have been influenced by my position and prior experiences. It is the hope that I have produced a reflexive account that clinicians can use when thinking about how they might encounter and respond to powerful narratives of responsibility. It may be that, when reading this paper, different individuals have different interpretations of the extracts based on their own experience and context. I go on to detail my own personal reflections later on in this chapter.

The sample of my study was limited by the eligibility criteria stipulated by the SHIFT trial (see appendix A.2) when they first collected the video data. For example, adolescents who were placed in short-term foster care were not eligible to take part in the SHIFT trial. Therefore, families where parental responsibility may be shared, and subsequently experienced differently, were not included in this study. Furthermore, as ‘looked after children’ are a key clinical population in which a high prevalence of SHB has been evidenced (Harkess-Murphy, MacDonald, & Ramsey, 2013), it would be important to consider how responsibility is negotiated within family contexts that are different from the ones presented here.

My study uses only the initial two sessions of FT and does not explore any of the later FT sessions to know how the negotiation of responsibility evolved over the therapy process and whether discourses of responsibility on entry into FT were very different to those at the end. It also does not look at any of the outcome data which was gathered as part of the SHIFT trial. I cannot, therefore, make any claims about whether the therapists’ actions lead to narratives of shared responsibility overall and whether they were linked to positive outcomes for the family. However, this was not the aim of my research. My case presentations and findings are meant to provide a reflexive account for clinicians when thinking about how they might encounter and respond to powerful narratives of responsibility.

The context of the SHIFT trial itself could be considered a limitation of my research. Lots of the problem talk is centred around the young person and their SHB, so the problem narrative is quite focused on the young person. This means that there may be problems with extrapolating the results of my analysis to other FT settings in which the focus is not on the SHB of one individual, but a more broad focus on wider familial difficulties.

## **Clinical Implications**

The use of discursive approaches to study FT allows us to pay attention to how family members manage their stake and identities within the therapeutic environment. My research moves from the 'what' is discussed in FT and 'what' narratives are present, to the 'how' this is constructed and negotiated. The potential clinical implications for FT, and systemic therapy more broadly, are that it allows therapists to reflect on how family members might manage feelings of responsibility, how they as the practitioner might negotiate these, and how this impacts on the therapeutic relationship. Families entered therapy with a variety of stories of responsibility, but the dilemma of the therapist was consistent; how do they consider the interests of family members, and achieve a narrative of shared agency and responsibility whilst maintaining a therapeutic alliance.

The therapist's interest, of working towards a narrative in which all family members hold responsibility for making changes, links directly to the LFTRC Systemic Family Therapy Manual. The manual suggests that Family Therapists should work to enable "family members [to] take responsibility for their own roles and actions, and for the process of change" (Pote et al., 2000, p. 40). It would be helpful for the manual to include reference to the fact that family members may enter therapy with interests which compete with the therapist's and that, in particular, any parents involved may be managing the risk that they are judged as responsible for their child's distress. The Family Therapist should be mindful of the challenge of managing any feelings of blame, whilst working towards a narrative of shared responsibility, in order to preserve a good therapeutic alliance. I explain later about how the DAM could provide a useful tool for identifying and attending to the stakes of family members in a FT setting, particularly when the therapist is feeling 'stuck' or there is a rupture in the therapeutic relationship.

The interest of the therapist, of achieving shared responsibility, is not solely applicable to FT, but to systemic therapy more generally. The finding that parents enter therapy managing the risk that they are judged to be responsible for their child's distress may also apply more

widely, to any framework that involves working with families. Fostering a space of empathy, through actions such as encouragement, praise and validation, applies beyond the FT context when thinking about how a therapist might manage competing stakes.

Also applicable to systemic interventions, more broadly, is the therapist's action of increasing the knowability of an individual's experience. Where a therapeutic intervention involves members of an individual's system, it is important that all members of this system have agency in making positive changes. In order to implement these, knowledge around what these might look like is essential.

My findings illustrate how important it is for the therapist to notice and respond to the individual stakes, and subsequent actions, of individual family members. I have also demonstrated that the DAM provides a useful structure for analysing processes in FT. It would be helpful to consider how the principles of the DAM might be adapted and utilised, in clinical supervision or training, in order to identify the stakes and actions of family members. This might be particularly useful when the therapist is feeling 'stuck', when there has been a rupture in the therapeutic relationship, or when there are concerns that the therapeutic relationship is at risk. During FT training, this might mean examining sections of therapy recordings. The therapist could reflect on their own actions at the time and their stake that was behind these actions, the actions and stakes of the others in the room, and how these might have 'clashed'.

In this particular context treatment for SHB, parents appear to be managing the risk of judgement from professionals, which may be influenced by feelings of guilt and shame. It is essential that any professionals who work with adolescents who engage in SHB and their families, do not contribute to the existing stigma attached to the parents (Hurd et al., 1999; Sansone et al., 1995).

Amoss et al. (2016) highlight the powerful narratives of blame and responsibility that a therapist may encounter within FT for SHB. Although my research does not aim to make any claims about how effective FT is as an intervention for SBH, it could be argued that FT

helps to shift such narratives which may be problematic. For example, deconstructing narratives which place blame or responsibility with one individual and moving towards narratives in which the agency of all family members in making positive changes is increased.

My findings illustrate the dilemma that parents and therapists face when determining the level of responsibility which can be held by adolescents. In terms of responsibility, it is important to consider the developmental stage of the young person and what might be expected of them. However, considering the dynamic nature of psychosocial development between different adolescents this is not a simple task of clinicians. My analysis suggests that the parents may restrict their adolescent's responsibility by protecting them, and the therapist's job is to increase the adolescents perceived agency in keeping themselves safe. On the other hand, parents may ask their adolescent to demonstrate levels of maturity which are beyond their developmental stage. In these instances, the therapist must attempt to negotiate expectations to a place where responsibilities are shared appropriately.

## **Reflections**

As I mentioned in my section above on the strengths of my research, different individuals and professionals are likely to have their own, personal reflections whilst reading my paper. Here I outline some of the reflections that I recorded in my reflective journal, whilst completing this piece of research.

Throughout my analysis, I noticed that it was easier for me to identify the actions and the stake of the therapists than it was those of family members. My position as a therapist might have made their actions and stake more 'visible' to me. I reflected on the clinical implications of this; during therapy, the stakes of the family members may not always be immediately obvious. My analysis shows how important it is for therapists to consider the stakes of family members during therapy and whether their intentions, as therapists, contend with these. I considered how it would be helpful, in my own practice, to take the time to



take the position of the family members who I work with in order to try and make their stakes more 'visible'.

In terms of my own personal reflections on my own clinical practice whilst conducting my analysis, I was particularly drawn to thinking about the action of *rescuing* and instances in which it may have a negative impact on the therapy process. I considered my emotional reaction to the content of some of the sessions and how I had been struck by the stories of what the families had experienced prior to entering therapy. I reflected on how this might draw me to *rescuing* family members so as to alleviate them from any further distress caused by feelings of guilt or failure. I thought about how, although the positive consequences may outweigh any negative consequences in some instances, the action of *rescuing* may close down lines of possible exploration. In the case of Ed (T) *rescuing* Anne (M) and Fred (D) from feelings of blame, he appeared to close down an avenue of exploration; one which may have led to them taking responsibility for communicating with Cal (YP) about his feelings more often. However, to explore this avenue at this point may have led to a rupture in the therapeutic relationship if Anne (M) and Fred (D) had felt accused by Ed (T). Reflecting on this highlighted to me how important it is to consider our actions as therapists and how we maintain a balance between working towards the overall goal of therapy and maintaining a therapeutic alliance.

I also reflected on the ideological dilemma of the 'responsible clinician'. It was necessary for the therapists in my sample to assess for risk and generate risk management plans with the family. At times this felt as though the therapist was being more directive than explorative. In these times, the young people held less agency in making their own decisions about their care. I wondered how responsible they felt for implementing these plans as compared to if they had come up with them entirely by themselves. I also wondered whether this dilemma was more salient here, than in other FT contexts, due to the higher levels of risk associated with SHB.

## **Avenues for Future Research**

Much of the negotiation of responsibility centres around the therapists' attempts to create a shared sense of agency in making changes for the family. It would be interesting for future research to focus on the final appointments in the FT process, where sessions might be less focused on generating a problem narrative and more focused on any changes that have been made within the family system and how they might maintain these. By exploring how positions of responsibility are constructed and negotiated later on in the therapy process, research might shed light on narratives of responsibility that are linked to positive changes within the family system.

As I mentioned earlier, the current project does not take into account any of the outcome data which were collected as part of the SHIFT trial. It would be interesting to explore how different narratives of responsibility are linked to different therapy outcomes. As outcome measures were collected by the SHIFT trial (e.g. Beck Scale for Suicide Ideation, Beck & Steer, 1991), it would be economical to use this data set for this purpose. However, these outcome measures focused on the emotional wellbeing of the adolescent and their SHB. Only one parental questionnaire was administered, which was the General Health Questionnaire (Goldberg & Williams, 1978).

With FT being a relational intervention, it would be useful to explore whether narratives of shared responsibility and agency are linked to outcomes of family functioning. Fortune et al. (2016) suggested, based on their findings which I outline in chapter 1, that family based treatments for SHB should have a focus on promoting adaptability, attachment, and cohesion and support within the family. The SCORE-15 measures family functioning and change (Stratton et al., 2014) and its items could be linked to these concepts e.g.: "We are good at finding new ways to deal with things that are difficult"; "When one of us is upset they get looked after within the family"; and "Each of us gets listened to in our family".

Having said this, as one of the aims of FT is to “enable the family members to take responsibility for their own roles and actions, and for the process of change” (Pote et al., 2000, p.40), it is also important to consider that a narrative of shared responsibility itself might be a ‘good outcome’.

As I highlighted above, it is important for the therapist to recognise and respond to the stake and actions of family members in order to develop and maintain a therapeutic alliance. With the importance of this process highlighted, it would be worth paying further attention (possibly through the use of DA) to the ways in which this process happens in FT.

The DAM places less focus on the wider socio-political context of the language used than other strands of discursive psychology, e.g. Foucauldian DA. As current models of FT do pay attention to the wider issues of societal context, culture, gender, sexuality and ethnicity (Stratton, 2016), it would be interesting to consider how different narratives of responsibility are linked to the wider socio-political contexts. This might include looking at why particular discourses and repertoires of responsibility hold different amounts of power in a FT context. For example, in my introduction I spoke about how the social construction of gender is said to influence SHB (Shaw, 2002). It would be interesting to explore how societal influences, such as gender ‘norms’, play a role in the construction of responsibility for SHB.

## **Conclusion**

My research uses the DAM to explore how responsibility for SHB is negotiated within a FT setting between adolescents, parents and therapists. It highlights that responsibility is one of the most important aspects of the talk in the initial FT sessions and shows how family members stakes can compete with the therapist’s goal of achieving a narrative of shared responsibility. I have suggested a number of clinical implications of my findings including

the use of the DAM as a clinical tool in FT practice. The findings of my research are novel, but also indicate avenues for further exploration.

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## APPENDICES

### Appendix A: SHIFT Screening and Eligibility Checklist

#### A.1 Screening Form

	<b>FORM 01</b> Page 1 of 2	<b>Screening Form</b>
Please also add this screening number to the Consent to Researcher Contact form		Screening number <input style="width: 50px;" type="text"/>
<b>To be completed by the CAMHS Team for ALL young people referred to CAMHS following an episode of self-harm</b>		
Today's date <input style="width: 100px;" type="text"/>		
Name of this CAMHS <input style="width: 150px;" type="text"/>		CAMHS number <input style="width: 50px;" type="text"/>
Would the young person also be followed up in this CAMHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, in which CAMHS would the young person be treated?		
CAMHS name <input style="width: 150px;" type="text"/>		CAMHS number (if applicable) <input style="width: 50px;" type="text"/>
<b>Young Person's Details</b>		
Age <input style="width: 20px;" type="text"/> years      Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity <input type="checkbox"/> White <input type="checkbox"/> Mixed – White and Black Caribbean <input type="checkbox"/> Mixed – White and Black African <input type="checkbox"/> Mixed – White and Asian <input type="checkbox"/> Other mixed background		
<input type="checkbox"/> Asian – Indian <input type="checkbox"/> Asian – Pakistani <input type="checkbox"/> Asian – Bangladeshi <input type="checkbox"/> Other Asian background		
<input type="checkbox"/> Black – Caribbean <input type="checkbox"/> Black – African <input type="checkbox"/> Other Black background <input type="checkbox"/> Chinese <input type="checkbox"/> Other ethnic group <input type="checkbox"/> Not stated		
<b>Current Self-harm Episode</b>		
Date of self-harm event <input style="width: 100px;" type="text"/>		Date of referral to CAMHS <input style="width: 100px;" type="text"/>
Where was the young person referred from? Please tick ONE box and provide details as appropriate:		
<input type="checkbox"/> Hospital: Date of admission to A&E <input style="width: 100px;" type="text"/>		<input type="checkbox"/> GP: Date seen by GP <input style="width: 100px;" type="text"/>
<input type="checkbox"/> School <input type="checkbox"/> Other		
Please state name of the referring place if known (and give the address if it is a GP):		
<b>Description of Episode</b>		
Type of self-harm: <input type="checkbox"/> Poisoning <input type="checkbox"/> Cutting <input type="checkbox"/> Other self-injury, specify <input style="width: 100px;" type="text"/>		
<b>Severity of Current Self-harm Episode</b>		
<b>Treatment required:</b> <input type="checkbox"/> None <input type="checkbox"/> Minimal (e.g. check BP, dry dressing on cut or burn) <input type="checkbox"/> Significant intervention (e.g. parvolex for paracetamol, glue, suturing, steri-strip for cuts) <input type="checkbox"/> Intervention potentially life-saving (e.g. ventilated, exploration of wounds under GA)		<b>Hospital care:</b> <input type="checkbox"/> Discharged from A&E <input type="checkbox"/> General admission <input type="checkbox"/> ICU/HDU/other specialist unit (e.g. burns, neurosurgery) <input type="checkbox"/> N/A – Community referral
		<b>Number of Known Prior Episodes of Self-harm</b> <input type="checkbox"/> None – Ineligible <input type="checkbox"/> ≥1 – Number of episodes, if known: <input style="width: 50px;" type="text"/>
<b>Please turn over and complete the Eligibility Checklist for all young people screened</b>		
Completed by: <input style="width: 150px;" type="text"/>		Date <input style="width: 100px;" type="text"/>
Form continues on next page		
Please complete and return to CTRU, University of Leeds (please see Investigator Site File for full address). Telephone: 0113 343 9242 Fax: 0113 343 1471		
For office use only	Computerised Date      Initials	Verified/Checked Date      Initials

## A.2 Eligibility Checklist



**FORM 02**  
Page 2 of 2

### Eligibility Checklist

#### Eligibility Criteria

Please tick yes/no to the following questions. If any shaded boxes are ticked, the young person is ineligible.

Inclusion		Yes	No	Exclusion		Yes	No	N/A
1	Is the young person aged 11–17 years?	<input type="checkbox"/>	<input type="checkbox"/>	8	Is the young person currently at serious risk of suicide?	<input type="checkbox"/>	<input type="checkbox"/>	
2	Has the young person engaged in at least one previous episode of self-harm prior to current presentation by self-injury or self-poisoning (or both)?	<input type="checkbox"/>	<input type="checkbox"/>	9	Is there a current ongoing child protection investigation within the family, which would make treatment (TAU or FT) difficult to deliver?	<input type="checkbox"/>	<input type="checkbox"/>	
3	Is recent self-harm a key feature of presentation?	<input type="checkbox"/>	<input type="checkbox"/>	10	Would the young person not ordinarily be treated in generic CAMHS but rather by a specific service?	<input type="checkbox"/>	<input type="checkbox"/>	
4	Is the presenting episode due to alcohol or recreational drugs? If yes, did the young person explicitly state that he/she was intending self-harm?	<input type="checkbox"/>	<input type="checkbox"/>	11	Is the young person pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you intend to offer CAMHS follow-up for self-harm?	<input type="checkbox"/>	<input type="checkbox"/>	12	Is the young person already being actively treated in CAMHS?	<input type="checkbox"/>	<input type="checkbox"/>	
6	Does the young person live with his/her primary care-giver?	<input type="checkbox"/>	<input type="checkbox"/>	13	Is the young person in a children's home or short term foster placement?	<input type="checkbox"/>	<input type="checkbox"/>	
7	Do both the young person and primary care-giver have sufficient proficiency in English to contribute to the data collection required for the research?	<input type="checkbox"/>	<input type="checkbox"/>	14	Does the young person have moderate to severe learning disability or lack capacity to comply with trial requirements?	<input type="checkbox"/>	<input type="checkbox"/>	
				15	Is the young person involved in any other research projects – currently or within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	
				16	Is the young person's sibling either a SHIFT trial participant or actively receiving family therapy within CAMHS?	<input type="checkbox"/>	<input type="checkbox"/>	

#### Confirmation of Eligibility and Consent

Is the Young Person eligible for trial entry?  
(i.e. no shaded boxes are ticked)

Yes → Please discuss the trial with the family, (at the first follow-up appointment), provide them with the **Participant Information Sheets** and ask that they sign the **Consent to Researcher Contact** form if they are interested in taking part.

Has the **Consent to Researcher Contact** form been signed?

Yes

No, but gave verbal consent

No, did not give consent →

No

Why?

Not approached; Why?

Did not attend follow-up appointment

Refused; Who refused?  Parent/ care-giver  Young Person  Both

Reason for declining participation, if known;

\*Written consent should be obtained wherever possible. Where not possible, verbal consent **MUST** be documented in the young person's notes.

Name of CAMHS clinician undertaking eligibility assessment:

CAMHS clinician signature:

Date:

**Last Page** ■

Please complete and return to CTRU, University of Leeds (please see Investigator Site File for full address). Telephone: 0113 343 9242 Fax: 0113 343 1471

For office use only	Computerised	Verified/Checked
Date	Initials	Date
		Initials

## Appendix B: Ethical Approval Letter



UNIVERSITY OF LEEDS

Faculty of Medicine and Health Research Office  
School of Medicine Research Ethics Committee (SoMREC)

Room 9.29, level 9  
Worsley Building  
Clarendon Way  
Leeds, LS2 9NL  
United Kingdom

☎ +44 (0) 113 343 1642

21 July 2017

Miss Rebecca Anderson  
Doctorate of Clinical Psychology  
Leeds Institute of Health Sciences  
Level 10, Worsley Building  
Clarendon Way  
LEEDS LS2 9NL

Dear Rebecca

Ref no: **MREC16-142**

Title: **Negotiation of Responsibility in FT for Self Harm in Adolescents**

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you:

Document	Version	Date Submitted
IRAS Ethics Form	1.0	10/04/2017
HRA Opinion Email trail	1.0	07/06/2017
Transcriber Confidentiality Statement Version 2 310517	2.0	07/06/2017
PIS ICD_ Young Person_ V7.0_01.08.2013	7.0	10/04/2017
ICD Recording FT Sessions_ V3.0_2012.02.14	3.0	10/04/2017
PIS ICD_ Adults_ V7.0_01.08.2013	7.0	10/04/2017
01 & 02 Screening v6.0	6.0	10/04/2017
Method Version 1 27.02.17	1.0	10/04/2017

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information ([fmhuniethics@leeds.ac.uk](mailto:fmhuniethics@leeds.ac.uk))

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

**Please note:** You are expected to keep a record of all your approved documentation, and all other documents relating to the study, including any risk assessments. These should be kept in your study file, which should be readily available for audit inspection purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

## Appendix C: SHIFT Consent Form

### Parent / Guardian Consent Form for the SHIFT Study

A research project comparing self-harm treatments:  
family therapy or usual treatment

Young Person's ID:	Young Person's Initials:
Young Person's Date of Birth:	

1. I confirm that I have read and understand the Information Sheet dated 1<sup>st</sup> August 2013, version 7.0 for this study and have had the opportunity to ask questions.
2. I understand that our participation is voluntary and that I and my son/daughter are free to withdraw at any time without giving any reason and without our medical care or legal rights being affected.
3. I understand that other members of my family might be involved in the study therapy sessions, but that no identifiable information about them will be held as part of the research project, without their consent.
4. I understand that my son / daughter's medical notes and social care records will be looked at by the Researcher to collect data for the purposes of this study and I give permission for this.
5. I understand that my son / daughter's medical notes, social care records, and data collected during the study may be looked at by other authorised individuals from the research team, the Sponsor (University of Leeds), the NHS Trust and the Ethics Committee in order to check that the study is being carried out correctly. I give permission, provided that strict confidentiality is maintained, for these bodies to have access to these records for this study and any further research that may be conducted in relation to it.
6. I understand that even if we withdraw from this study, the data collected from me and my son / daughter will be used in analysing the results of the study. I understand that my identity will remain anonymous.
7. I agree to allow any information or results arising from this study to be used for healthcare and / or medical research purposes including monitoring the safety of the treatment that my son / daughter will receive. I understand that our identity will remain anonymous.
8. I agree for my son / daughter's details (which will include name, date of birth, NHS number and address) to be registered with the NHS Information Centre so that information about his / her health status may be obtained by the research office (the Clinical Trials Research Unit, University of Leeds) if necessary.
9. I agree that my son / daughter's GP, or any other clinician treating him / her, will be notified of our participation in this study.
10. I understand that a copy of this consent form will be sent to the Research Office (the Clinical Trials Research Unit)
11. I agree to us taking part in this study.

For young people under 16 years

I agree to my son / daughter being contacted directly (by text, phone call or email) by the Researcher (please tick yes or no) Yes No

Optional consent

If we are allocated to receive family therapy, I agree to the therapy sessions being recorded and understand that these recordings will be seen by our therapists and their supervisors, and possibly by members of the research team. Yes No

PARENT / CARE-GIVER:

\_\_\_\_\_  
Name of parent / care-giver (IN CAPITALS)      Date      Signature

RESEARCHER:

\_\_\_\_\_  
Name of Researcher      Date      Signature

## Appendix D: Transcriber Confidentiality Agreement

### Confidentiality Statement for Transcribers

#### Doctorate in Clinical Psychology Training Programme

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants.

In concordance with the BPS ethical guidelines, the D.Clin.Psychol programme requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

#### **General**

- 1) I understand that the material I am transcribing is confidential.
- 2) The material transcribed will be discussed with no-one.
- 3) The identity of research participants will not be divulged.

#### **Transcription procedure**

- 4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.
- 5) I will ensure that video-recordings (accessed via the secure drive) cannot be overheard/ viewed by others and that transcripts, or parts of transcripts, are not read by people without official right of access.
- 6) I will be supplied with an encoded USB, by the researcher, and will store all transcribed data on this device. No transcripts will be stored locally on the computer that I am working from.
- 7) This USB will be returned to the researcher, and no copies will be made.

**Signed.....Date.....**

**Print name.....**

**Researcher.....Becky Anderson.....**

**Project title...The negotiation of responsibility within family therapy for adolescents who self-harm....**



### Appendix F: Extracts from my Reflective Journal

I feel a bit cringed out by some of the YPs attempts to make jokes. I am feeling this as someone who is outside of the therapeutic situation. Those who are more involved might feel a different way towards attempts to deflect conversation or minimise the seriousness → does the therapist feel frustrated, anxious. Do parents feel anxious, embarrassed, amused? Can't make assumptions. How does the Ps or Ts stake/interest change in response? At all?

*Why is she doing this? Protecting herself?*

459 → Reflections few days after watching final session:

Found this families session really hard to watch. Felt frustrated with mum as she appeared to deflect any kind of negotiation from therapist (attempts to diffuse blame away from child) → what is my frustration about?

↳ make sure it doesn't cloud my analysis.

When watching the video for 1<sup>st</sup> session for 00345 with transcript

Felt different from just reading the transcript. Felt more like YP wanted mum to take stage than it did when just reading the transcript. Why did I have this reaction when presented just with text? → when watching, it felt that YP "handing over" to mum.

301418 00435 session 2

I felt a bit annoyed at the constant repetition of how dad was doing a good job of listening. It felt like they were trying to give balance but if it were in mum + YPs shoes I would have felt resistant → are they? , or are they not?

↳ can't let my feelings mean I make assumptions about the impact of this.