The Negotiation of Blame in Family Therapy with Families Affected by Psychosis

Professional Doctorate in Systemic Psychotherapy

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Abstract

Despite wide agreement in the systemic field that therapists should take a non-blaming stance, historically there has been little exploration of how this stance is achieved in practice. The difficulty in knowing how to put 'non-blaming' into practice is further heightened by competing models of intervention with families affected by psychosis. This study contributes to a body of literature that is concerned with how complex issues of morality are achieved dialogically by considering how family therapists manage the tension of intervening to promote change whilst maintaining a multi-partial, non-blaming stance.

Two therapies carried out with families affected by psychosis are analysed using the methods of Conversation Analysis (CA) and Membership Categorization Analysis (MCA). In both therapies the sequences examined are drawn from the second session of therapy where explicit blaming events occur. By examining blaming events chronologically through the course of a session the study shows how the rules about the way blame is talked about are achieved interactionally.

The analysis demonstrates that systemic theory's emphasis on the importance of being non-blaming is grounded in a sophisticated understanding of the threat blame poses to co-operation and agreement. In both therapies, the delicacy and ambiguity with which blame is treated serves to enable the conversation to continue without withdrawal. However the cost of ambiguity is a possible misunderstanding of the intent of the speaker. The resulting misalignment, where it continues over several turns and sequences, leads to explicit blame becoming relevant as a solution to a redundant pattern of interaction.

The findings indicate that the management of blame requires both the exploration of blame and its interruption when emotions and conflict run

high. The former enables understanding and movement towards therapeutic goals while the latter is necessary to promote therapeutic and family alliances. An unintended consequence of the injunction to be non-blaming might be the premature closing down of topics, militating against problem resolution.

The study concludes that CA and MCA offer a wealth of knowledge about mundane conversational practices that can be applied fruitfully to systemic therapy process research, teaching and supervision.

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Chapter 1

Background to the study

My motivation for this research is rooted in a clinical conundrum which sparked my interest at the beginning of my training as a systemic therapist. As a trainee I learned that we should try to diffuse blame in families and offer a non-blaming therapy. The very first family in my training group was highly critical and blaming. I used all the systemic techniques available to me. I used circular questions, I reframed, looked for unique outcomes, the team reflected, we drew geno-grams, we sculpted, yet all my techniques seemed to fail. I (secretly) blamed family members for persistently blaming or (overtly) blamed myself for not being good enough. Sometimes I felt blamed by my colleagues for either not taking a stand (colluding) or for taking a stand (blaming).

As so often in my work a paper came along to help. John Stancombe and Sue White (2005) published their exploration of how therapists and families manage blame. Their findings resonated with my experiences and I stopped thinking of these types of impasse as my failure of technique and became interested in the dilemma. How do we, as members of a wider culture where blame permeates every sector of life manage the discourses of 'no blame' in our particular sub-culture of systemic psychotherapy?

Having qualified I returned to work in the NHS as a family therapist in an adult mental health context. Much of my work involves families where a member has experienced psychosis. An underlying question in much of the work with such families is 'is this person mad or bad'? Different theories about the cause of psychosis have different repercussions for family members. If we correlate childhood trauma with psychosis what might we be thinking about *this* father *here* in front of us, is he to blame? And if this person has a diagnosis of schizophrenia does it mean she is not to blame

when she shouts at her mum? Might it also mean that no-one listens to *what* she is shouting? So when we start to talk about different ideas about what the problem is and what caused it the stakes are high. People's identities are at stake. This thesis documents my exploration of blame in therapy with families affected by psychosis and shows how blame is an important tool in the construction and maintenance of morality and identity.

Although there is a strong theoretical basis to systemic therapy's adoption of a non-blaming stance there is little research into how systemic therapists deal with blame. Most of the research into blame is within the field of cognitive psychology and attribution theory. This research examines blame as an interactive achievement, how speakers infer blame and respond to blaming inferences and what they are trying to achieve by such actions. By examining the micro-processes of talk in a family therapy setting I show how systemic theory is put into practice. My chosen research methodology, the application of Conversation Analysis and Membership Categorisation Analysis to therapy process, does not have a strong tradition within the systemic field. I demonstrate how these methodologies, strongly established in the discipline of sociology, have much to offer systemic therapists within the domains of clinical work, research and teaching.

The study you see here was not the one I originally intended but evolved over time in response to the material gathered and my increasing interest in what CA and MCA could achieve. The original design included follow up interviews with families involved, and one of these interviews was conducted prior to the change of design. Despite the interview not being used as originally intended, the family's report of their subjective experience had an important influence on the research. I have therefore included a coda to the thesis which offers another perspective through

which to reflect on the findings. A brief history of the project has also been provided in Appendix A

The research questions

How do family therapists do 'non-blaming' in their routine practice?

Families often come to therapy with contested explanations for the difficulties they are experiencing. They often hope for an expert opinion on whom or what is to blame for their difficulties (Stratton, 2003a; Stancombe and White, 1997). Despite wide agreement in the systemic field that blame is unhelpful (Watzlawick *et al.*, 1974; Hoffman, 1995; Selvini Palazzoli *et al.*, 1980) historically blame has not been an area of debate in the literature. Apart from some notable exceptions (cf. Bowen *et al.*, 2002, 2005; Stratton 2003a, 2003b; Stancombe and White, 2005; Furlong and Young, 1996; Friedlander *et al.*, 2000; Wolpert, 2000) there is little discussion about what constitutes blame, how to define it, what blame does and how to engage with it. Blame poses a dilemma for systemic therapists. It is a linear explanation that fits in a positivist epistemological frame, one eschewed by cybernetic, constructivist and social constructionist explanations. As Stratton says:

> The systemic movement developed in opposition to approaches to therapy that were founded in physical science, and which conceptualise illness and cure primarily in terms of linear causal sequences. In rejecting such simplicities, systemic family therapy has often not so much said 'it is more complex than that' as 'lets not go there'. (Stratton 2003a, p.136)

Stancombe and White (2005) demonstrate how blame is a feature that permeates Family Therapy and that therapists have to actively work to manage their own and family members blaming. This study extends the work of Stancombe and White and others to examine the procedures

systemic therapists use to manage blame in an adult mental health context.

How do systemic therapists manage blame in the context of families affected by psychosis?

In an adult mental health setting the injunction for a 'no blame' culture is further heightened by competing models regarding work with families affected by psychosis. In the field of family interventions in psychosis two key theoretical approaches dominate, Family Therapy (FT) and Family Management (FM). Where FM holds a biological model of causation FT maintains an interactional understanding. An illness model is one way to claim a non-blaming orientation towards individuals and families and notions of circular causality another, but each have their costs. To be mentally ill liberates one from all sorts of common social responsibilities. However it confers responsibility to co-operate with expert opinion on what to do to get better and can have the unintended consequence of marginalisation from the social world. Theories that privilege social constructions of mental illness generally remain agnostic to diagnostic categories and will be more interested in meaning and interaction. However families may experience interest in family interaction as blaming the family for the psychosis. This study examines how families and therapists negotiate different causal explanations for difficulties and their implications for speakers' identities.

How do therapists manage the competing institutional tasks of decreasing blame and increasing agency in their routine practice?

A key tenet of all therapy, albeit through diverse means, is to increase understanding of our thoughts, feelings and behaviours and the impact of these on others with a view to change. Through this increased understanding our choices are emphasised and therefore our agency (or responsibility) for our actions. Any therapy within the context of mental health services then runs the gauntlet between these two competing tasks,

decreasing blame and increasing agency. These are essentially moral issues. This study demonstrates how therapists manage the tensions between emphasising moral agency and personal choice while at the same time avoiding blame for actions that transgress social norms.

How do family therapists manage the tensions of negotiating conflicting versions of events without allocating blame?

In family therapy further tensions arise in managing different and often conflicting versions of events. Family members presenting with difficulties often produce different descriptions of events in such a way as to persuade the hearer that their behaviour is reasonable and the other's not. Thus accepting one person's version often implies that the other is at fault and vice versa. In an individual psychotherapy, a therapist working with a woman who lays the blame for her depression at the door of her husband can take time to explore the client's version of events until she feels the therapeutic relationship is robust enough for the client's responsibility for the state of affairs to be challenged. However, if the client's husband is in the room with her, the therapist must find a way of aligning with *both* the wife's *and* the husband's conflicting versions of events if the therapist wants the husband to ever come back. This study examines how therapists manage the task of developing a therapeutic alliance with family members presenting different versions of events while also maintaining a non-blaming stance.

The study contributes to a body of literature that is concerned with how complex issues of morality are achieved dialogically. The conclusions of the research are that the tasks of negotiating what the problem is and who or what is responsible for it are replete with inferences of blame. By examining blaming events chronologically through the course of a session I have been able to show how the rules about the way blame is talked about are achieved interactionally. The systemic therapists and families in the study are highly attuned to moral issues which the therapists generally

approach through cautious and indirect means. When a prevailing misalignment occurs between the tasks different speakers are trying to achieve, less caution is shown and explicit blame is made relevant. I show how both therapists and families draw on identity categories of illness and wellness to imply or contest inferences of blame at different times to achieve different things. I demonstrate how the therapists and families may ignore, mitigate, exonerate or imply blame as part of the process of negotiating what kind of talking constitutes family therapy. I describe how blame can be both a cause and a solution to an interactional problem and what is at stake is not the eradication of blame but the question of what is deemed reasonable blame and reasonable agency within this local context. Through this means I show how the institution of systemic family therapy both constitutes and is constituted by the local moral order. I argue that the concepts of misalignment and repair within CA mirror the broader concepts of rupture and repair in the therapeutic alliance literature. I suggest that CA can illuminate the complex dialogical processes by which the therapeutic alliance in multi-party therapy is negotiated. I also argue that CA and MCA offer a wealth of knowledge about mundane conversational practices that can be applied fruitfully to systemic therapy process research. Finally, I recommend CA and MCA as useful tools in teaching and supervision to enable clinicians to heighten their awareness of the micro-processes of communication and their inescapable role in the creation of the moral order.

Organisation of Chapters

Chapter 2 - Literature Review

Chapter 2 sets out the rationale for the study in the context of the relevant theory and existing research. Part 1 introduces how blame has been theorised in the field of family work, both in the family management and systemic literature. The discussion traces the key theoretical models influencing contemporary family therapy in the UK today and their

conceptualisation of the therapist's stance in relation to neutrality. This forms an introduction to the institutional backdrop of the therapy sessions analysed. The aim is to illuminate the theories that inform therapists practice in the context of systemic work with psychosis. Part 2 reviews the relevant research literature, briefly sketching findings from attribution and expressed emotion studies before narrowing focus onto therapy process research.

Chapter 3 - Methodology

Chapter 3 is concerned with methodological issues and is divided into three parts. Part 1 introduces the epistemological and methodological terrain. Part 2 introduces the methods of CA and MCA in some detail. My aim is to explain the methods sufficiently for those unfamiliar with them to follow the analysis and evaluate its claims. In Part 3 the design and execution of the study is detailed.

Chapters 4 and 5 - Data analysis

Chapters 4 and 5 present the findings from the analysis of two therapies carried out with two families affected by psychosis. In both therapies the sequences are drawn from the second session of therapy where explicit blaming events occurred. My approach to this analysis has been akin to the archaeology of a blaming event. Rather than examining many blaming events to identify general features, I have painstakingly dug down to uncover the specific structures of these two events. The analysis shows the practices by which participants in family therapy co-construct the way in which a blaming event unfolds.

Chapter 6 - Discussion

Chapter 6 concerns the clinical implications of the findings and draws out the conclusions and recommendations for clinical practice, teaching and further research. I suggest that CA *complements* systemic theory by detailing how therapists are influenced both by theory and by feedback.

The analysis demonstrates that systemic theory's emphasis on the importance of being non-blaming is grounded in a sophisticated understanding of the threat blame poses to co-operation and agreement. The therapists in this study demonstrate that blame is seen as a prompt to action. In both therapies, the delicacy and ambiguity with which blame is treated serves to enable the conversation to continue without withdrawal. However the cost of ambiguity is a possible misunderstanding of the intent of the speaker. The resulting misalignment, where it continues over several turns and sequences, leads to explicit blame becoming relevant as a solution to a redundant pattern of interaction.

I suggest that the management of blame requires both the exploration of blame and its interruption when emotions and conflict run high. The former enables understanding and movement towards therapeutic goals while the latter is necessary to promote therapeutic and family alliances. An unintended consequence of the injunction to be non-blaming might be the premature closing down of topics, militating against problem resolution. If we think of blame as having an important social function then it opens up the question of what *kinds* of blame are deemed reasonable or not in any therapeutic encounter. CA and MCA are shown to be powerful tools with which to illuminate the complexity of how this is achieved in practice.

Coda

Finally, the coda provides a commentary from one of the families who participated in the research. It serves as a warning against becoming too wedded to our hypotheses, as a clinician or as a researcher.

Chapter 2

Introduction

This chapter sets out the rationale for the study in the context of the relevant theory and existing research. Part 1 sets out a discussion of how blame has been theorised in the field of family work, both in the family management and systemic literature. I go on to discuss the link between blame and personal agency within the frame of dialogical and narrative theory and practice. Part 2 reviews the relevant research literature, briefly sketching findings from attribution and expressed emotion studies before narrowing focus onto therapy process research. The aim of this chapter is to provide an argument for the relevance of the study of blame to contemporary systemic practice and to show that a small scale and intensely detailed study such as this is an effective way to capture the subtlety of the blaming and mitigating practices with which participants negotiate the therapy encounter.

Part 1 - Theoretical Literature

Blame

> blame: n & v ● v tr. 1 assign fault or responsibility to 2 (foll by on) assign the responsibility for (an error or a wrong) to a person etc. ● n 1 responsibility for a bad result: culpability 2 the act of blaming or attributing responsibility... (Thompson, 1995, p.134)

The first problem in theorising blame is defining it. The ubiquitous use of blaming terminology in common discourse confuses the picture. It might be understood as a feeling, an action or a belief[1]. For blame to be given

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[1] This is reflected in the research where difficulties in operationalising blame lead to a wide range of definitions. (cf. Wolpert, 2000; Stratton *et al.,* 2003a; Bowen, 2005)

there must be both an attribution of responsibility and moral censure. Differentiating between responsibility and blame can be tricky. If a mother says "I'm exhausted because my son kept me up all night crying" she attributes responsibility to the son for the sleepless night. Only if she criticises him for doing so, perhaps due to weakness of character or deliberate intent will she be blaming him. Family therapists are well aware that blaming is not always explicit. The context of the conversation, body posture or tone of voice might subtly imply blame where none is explicitly spoken (Bowen *et al*., 2005; Wolpert, 2000).

What is the function of blame?

Blame can be seen to have different functions from different perspectives. At an interpersonal level the functions of blame have been identified variously as evasion of responsibility, managing feelings of helplessness, dealing with feelings of anxiety, avoiding emotional pain, communicating needs or sense of helplessness, keeping a conversation moving or bringing about closure (Furlong and Young, 1996). The culture of psychotherapy is broadly predicated upon beliefs that people must take responsibility for making changes in their beliefs or behaviour, or accept what they can't change, so that they can live more easily in the world. In the context of psychotherapy, blame is often seen as a way of pushing responsibility away, of denying personal agency, and as such unhelpful (Shapiro, 2006). Concepts of blame and personal agency then are inextricably linked.

At a cultural level Douglas (1992), an anthropologist, argues that types of blaming and associated systems of justice are symptoms of the way that society is organised. Every society has a set of possible causes for a negative event from which plausible explanations are chosen. From these follow a fixed repertoire of obligatory actions. An example might be if a child steals from a neighbour. The community will look for who is to blame for the theft. Different moral codes will lead to different attributions. The injunction not to steal implicates the child. Beliefs about appropriate

parental control may place the blame at the parents' door. Alternatively moral codes about humility and prudence may lead people to blame the neighbour for bragging about the amount of cash he has. Each criticism would lead to different types of reparative action. From this perspective blame can be seen to be a necessary part of the definition of the limits of acceptable conduct within a system. Blame indicates that the limits are being contested and either they or the contesting behaviour need to be modified.

The negative impact of blame

Furlong and Young differentiate between criticism and blame in an interpersonal context by defining blame as that which is concerned with damning the person not just the behaviour:

> It is this depersonalising, dehumanising quality that distinguishes blame from constructive criticism. The fact that the quality of denigration may not be intended by the blamer, or even be objectively observable to a third party, is irrelevant. If the effect of an exchange is that the personhood of the "blamee" is effectively disputed, this can be understood as an episode of blaming. (Furlong and Young 1996, p.194)

This definition points to the complications involved in researching blame. If it is neither intentional, nor even observable to a third party, yet is experienced as blame by the recipient, then how can we recognise it at all? One clue to the nature of the blame is marked by the emotions that accompany it, the manner in which blame is delivered or received if you like. For instance the subjects of blame, either by self or others, often experience feelings of shame and guilt (McNab and Kavner, 2001). In the field of cognitive psychology Obuchi *et al*. (2004) suggest that blame is the cognitive component of anger. Blame is the judgment that the person deserves punishment and anger is the negative affect that accompanies

this attribution. Feelings of hopelessness are also common. By placing responsibility for the fault firmly outside oneself a sense of powerlessness often ensues (Gotlib and Abramson, 1999).

Blame in the context of families experiencing psychosis.

Family interventions in psychosis can be broadly separated into systemic family therapy (FT) and family management approaches based on psycho-education (FM), each of which conceptualise causality differently. While FT is founded on theories of mutual influence and applicable to any context, FM models explicitly adopt a biological understanding of psychosis and draw on behavioural and systemic ideas in order to influence family interaction. Historically, both FT and FM models are associated with concepts that have been interpreted as blaming of parents, especially mothers, respectively, the Double Bind and High Expressed Emotion.

The double bind

Arguably, the very foundations of systemic therapy are located in the seminal paper "Towards a theory of Schizophrenia" (Bateson *et al.*, 1956) where the authors first introduced the double bind theory. The paper was an early attempt by the authors to articulate an explanatory model of psychopathology and human interaction based on cybernetic epistemology. Despite the authors' caveat that the concept of the double bind was a partial and somewhat simplistic account of just one part of the extraordinary complexity of family interaction, it was interpreted by others as describing a series of unidirectional and intentional acts that caused schizophrenia. The paper was part of an on-going research project that spanned ten years or so. Those familiar with the concepts the team were grappling with would find it difficult to see the concept of the double bind as a linear and causal relationship (Cullin, 2009). Nevertheless, by locating the double bind principally in the mother's communicative behaviour and describing the recipient as the "victim" the authors do seem to invite such

an interpretation. The influence of this paper led to a view of systemic family therapy for psychosis as blaming of families, especially parents and in particular mothers. For instance MacFarlane and his colleagues in their review of the literature on family interventions say:

> Family psycho-education originated from several sources in the late 1970s. Perhaps the leading influence was the growing realization that conventional family therapy, in which family dysfunction is assumed and becomes the target of intervention for the alleviation of symptoms, proved to be at least ineffective and perhaps damaging to patient and family well-being. (MacFarlane *et al.*, 2002, p. 255)

This view of systemic family therapy hardly fits with contemporary theory and practice, yet it persists, and in my experience continues to be a barrier to the provision of systemic family therapy in adult mental health services in the UK today.

High expressed emotion

FM models evolved out of studies of the effect of the family context on the course of schizophrenia and specifically out of research that connects the emotional climate of a family with relapse (Kuipers *et al.*, 2002). The concept of Expressed Emotion (EE) (Brown *et al.*, 1962; Brown and Rutter, 1966) refers to a measure that shows a correlation between critical, hostile or over involved family interactions with relapse rates in family members diagnosed with schizophrenia (Bebbington and Kuipers, 1994). 'Critical' and 'hostile' families are those where blaming is prominent. EE is not a causal explanation, rather a snapshot of the emotional climate of the family. Like the double bind theory, the authors never claimed that high EE caused schizophrenia, yet popular interpretations of this literature have led to parents being blamed, if not for causing the original illness then at least for relapse. Studies have shown that the relationship of EE to family functioning is more complex. For example Mcfarlane and Cook (2007)

argue that EE tends to develop over time and emerges as a consequence of the psychotic experience rather than having a causal relationship to it. Studies of EE in professional care groups support this argument, showing that similar patterns of EE develop in the relationships of staff working with psychotic patients (Barrowclough *et al.*, 2001; Tattan and Tarrier, 2000).

Family Management solutions to blame.

The most common FM models in use are based on a combination of biological, behavioural and systemic ideas with a strong emphasis on psycho-education. FM approaches emphasise that psychosis is an illness like any other and therefore not the fault of patient or their parents. The most common explanation offered is the stress vulnerability model (Zubin and Spring, 1977). Families are reassured that EE does not cause psychosis but does have an influence on relapse rates. Various skills such as communication and problem solving are then taught with the explicit aim of reducing EE and relapse. There has been a gradual shift of emphasis over time from more behavioural approaches to an emphasis on cognitive appraisals (NICE 2009). Most models consider the effect of blame on the family. For example one of the leading models in the UK emphasises the importance of taking an explicit non-blaming stance from the outset to enable families' engagement, implying that unless this is explicitly stated, then families are likely to feel blamed (Falloon *et al.*, 2006).

However an unintended consequence of the 'illness like any other' explanation seems to be greater stigma for both patients and families. Cross cultural studies show that where the biomedical view of mental illness predominates so does stigma and social exclusion. It seems that where mental illness is seen as connected to trauma, emotion or spiritual matters, then those suffering are seen as less different from the rest of the population and as a result less frightening (Bentall, 2003; Read *et al.*, 2006; Watters, 2010).

Despite the emphasis on *not* blaming the family, anyone working in an adult mental health setting will be familiar with discussions about 'enmeshed' or 'overprotective' mothers or 'distant' fathers with an implicit and sometimes explicit view that the professionals need to rescue the patient from a toxic family environment. Carers continue to report feeling responsible for both onset and relapse of psychosis (Corrigan and Miller, 2004) and sometimes blamed by mental health workers (Gonzalez-Torres *et al*., 2006).

Critique of the 'cause or effect' debate

The debate about whether HEE causes psychosis or psychosis causes HEE serves to obscure a more complex picture. For instance a growing body of literature demonstrates a strong correlation between child abuse and psychosis and between the content of delusions and the actual experience of abuse (Dillon, 2010; Read, 2007). These findings challenge the disease model of psychosis by reframing delusions as a meaningful response to trauma. The potential negative implications of these findings for families are summed up by a representative of Rethink in the press:

> The mental health field has been here before. The anti-psychiatry movement of R D Laing rejected the concept of schizophrenia as an illness and set out to blame the parents...[Lets not] resurrect a sterile 40 year old debate" (Pinfold, 2005, quoted in Johnstone, 2009, p. 185)

Johnstone argues that the use of the word trauma to summarise a whole range of damaging experiences that children and adults can experience shifts focus away from other, more mundane damaging experiences, such as long term, serious communication difficulties. In addition, it tends to obscure wider social issues also correlated with the incidence of psychosis, such as poverty and racism. This position allows for the experience and meaning of trauma to be context dependent and the conceptualisation of cause and effect as multi-faceted and interdependent. Some families

may have a style of relating which is physically and/or emotionally abusive, and this will have an effect on the child's developing brain, the way they make meaning, express distress and communicate with others. Other, non-abusive families may be affected by traumatic circumstances. The consequent distress may be expressed through psychosis which then impacts negatively on the families' communication style and emotional climate.

Summary

So far I have argued that blame is a concept that is part of day to day life and yet sometimes hard to pin down as an observer. In a social context it delimits the bounds of acceptable behaviour. In an interpersonal context we are beginning to tease out the complexity of differentiating between constructive criticism and destructive criticism (blame). In individual therapy, blame of others is often seen as a block to the institutional task of increasing personal agency. In family therapy Furlong and Young (1996) differentiate blame from constructive criticism by means of the effect on the personhood (identity) of the recipient. Criticism that is heard to be demeaning or unfair leads to emotions such as anger and shame which may reduce peoples' ability to engage in useful therapeutic work. We can link these ideas to the research into High Expressed Emotion where we have robust evidence that critical and hostile expressions of emotion negatively affect relapse rates in people with schizophrenia. One key aspect of the FM approach to reducing blame is to locate the cause of the problem firmly outside the family, in something beyond their control. Although the intervention implicitly suggests that family communication style and problem solving capacities are lacking, the rationale offered is that this is due to the effect of the illness. Thus the illness model implicitly absolves all family members from blame. The potentially negative consequence of this conceptualisation is that the patients lived experience may be obscured. Abusive relationships in the family, chronic communication problems or other traumatic circumstances that give

meaning to psychotic experience is less relevant than the treatment of the illness. In this way both the impact of social factors and the concept of the patient's personal agency is undermined. In addition the 'illness as any other' argument seems to have the further consequence of social exclusion.

Neutrality, Curiosity and Multi-Partiality – Systemic solutions for blame.

Introduction.

It is not possible to do justice to the full range of theoretical influences on the systemic therapist's stance towards blame within the constraints of this thesis. The main thrust of this review of theory is an examination of the notion of neutrality and its evolution through the history of systemic theorising. My rationale for this is that arguably, the paradox of blame in the systemic field became fore-grounded as the stance of the therapist shifted from that of expert to that of non-expert, from technician to collaborative conversationalist. For this reason I have chosen to focus on the concept of neutrality and its evolution into curiosity and then multi-partiality. These concepts reflect the key theoretical influences on contemporary systemic therapy in the UK, the Milan Systemic, Dialogical and Narrative frameworks.

I argue that the notion of neutrality as both an ethical principle and pragmatic position continues to influence systemic practitioners approach to blame, partly due to the continued importance of Milan Systemic ideas in the UK context. I will also turn to a concept that is entwined with that of blame, the question of personal agency, and consider how this is accounted for in contemporary systemic thinking. I argue that as the dominant metaphor has shifted from system to narrative so personal agency has been fore-grounded. I therefore frame my discussion of agency within the narrative framework.

First order theories - Neutrality

It is widely agreed that the beginnings of family therapy emerged out of a dissatisfaction with psychoanalytic models that dominated the field at the time where the cause of psychological distress was seen as hidden deep within the individual psyche. In the 1960's two groups of therapists focussed their attention on the centrality of relationships in understanding symptomatic behaviour. The strategic school took a particular interest in how faulty problem solving became embedded in relationship (Watzlawick *et al.*, 1974) Meanwhile the structural approach developed ideas about dysfunctional family structures which militated against 'normal' individuation and communication (Minuchin, 1974). What each of these had in common was the notion of the therapist as expert who could accurately diagnose the problem and deliver the correct treatment. Thus, although 'joining' the family was emphasised as essential in order to invite their co-operation, theoretically, family members' emotional responses were largely overlooked. Whether they felt blamed or not by the therapist was of less interest than changing their faulty logic or structure.

The Milan group combined both these perspectives suggesting that symptoms were the result of individuals maintaining behaviour designed to manage other family relationships, but which had escalated beyond the behaviour's original usefulness (Campbell, 2003). Hoffman (1998, p.145) explains the adoption of the cybernetic metaphor as an attempt to get away from the "blame and change" mind set:

> Mental illnesses are indeed mental, in that they are at least 90% made up of blame, or causal attributions felt as blame. (Hoffman 1995, p. 391)

Much of the work of family therapy then has been directed at shifting ideas about where the responsibility for problems lies. The cybernetic metaphor brought with it a dilemma. The concept of circularity negates

the assumption of blame in that we cannot isolate a single cause for a problem except as an artefact of our own observation. However, neither can we fail to create a punctuation at the point of observation. Any suggestion for change implies that that particular punctuation has been isolated as the cause. It is therefore next to impossible not to experience a request for change as a statement of blame. The Milan group placed therapist neutrality (Selvini Palazzoli *et al*., 1980) as one of the three foundational concepts of the systemic approach. The stance of neutrality was an attempt to counter the negative effects of blame by inviting therapists to give equal weight to the views of every member of a system. Cecchin's definition of neutrality for instance was that every family member should feel that the therapist was on his or her side by the end of a session (Campbell, 2003). The assumption was that everyone was doing the best that they could, given their position within mutually reinforcing feedback patterns. Hoffman suggests that the whole technology of paradox in the early years was an attempt to remove the attribution of fault buried in attempts to elicit change and escape the blame game. When families' causal explanations were sought the aim was less to understand them than to shake them up and introduce new ones. Again the emphasis was on the system, feelings such as anger and motivations such as righting wrongs were seen as unimportant to the systemic project (Krause, 1993).

However, family therapists work in an arena where evaluation of behaviour is of great interest both to the family and to social institutions. Glaser's resolution to the issue of therapist neutrality in the context of child abuse was to argue for a separation between the contexts of legislation and therapy. Therapists then could be shielded from their personal judgments by statutory child protection legislation for, "These are the arenas....for apportioning judgment and blame" (Glaser, 1991, p.152-3). By separating out the context of legislation from the context of therapy, therapists could

be free to be curious about the family's subjective experience and beliefs. Hypothesising behind the screen allowed:

> the therapist and team to become aware of and articulate feelings, prejudices and judgments […] unless these are articulated, the therapist will not be free to attend to the family's perceptions. (Glaser, 1991, p. 156)

The separation of what Stancombe (2002) refers to as therapists' front stage and backstage work takes on an almost cathartic air, implying that therapists can somehow shake off judgments and enter the therapy room with a carefully crafted intervention that can incorporate everyone's position in a blame free way. However Glaser fails to account for the production of values within the institutionalised practices of therapy itself (Hare-Mustin, 1994). She also implies that if therapists free themselves of their own judgements they will not be perceived by the family as judging them. Stancombe and White (2005) show that while family therapists work hard to create a blame free intervention for public consumption, families are highly attuned to any verbal or non-verbal cues that may imply concealed blame.

Second order theories - Irreverence and curiosity

Influenced by Bateson's later ecosystemic ideas, constructivism, feminism and post-modern theories second order cybernetics questioned the very possibility of therapist neutrality (Campbell, 2003; Dallos and Draper, 2005; Flaskas, 2011). Feminists argued that neutrality led to the implication that perpetrators and victims of violence were equally responsible (Goldner, 1985a, 1985b; Mackinnon and Miller, 1987). The central dichotomy between the feminist and cybernetic positions is pertinent to the issue of blame. A pure systemic therapy would focus on finding ecological balance, even at the expense of individuals and as such would be *amoral*. The feminists argued that to take a neutral position was essentially to

uphold the status quo. To claim neutrality obscures an essentially political position which upholds patriarchal values that are *immoral* (McConaghy and Cottone, 1998). Thus the positive cultural function of blame is demonstrated as that which defines the type of society we wish to live in.

The influence of constructivist ideas focussed attention on how meaning was created both within the family and within the family/therapist system. Maturana (1988) posited that instructive interaction is not possible. An actor can never predict how the receiver of the action will understand and respond to the act. The therapist then cannot claim to be a neutral observer or design interventions to achieve a specific end. The concept of the observed system was replaced by that of the observing system. Thus the focus of therapy was redefined as the *interplay* between the beliefs and prejudices of therapist and family. The combination of these ideas led to Cecchin *et al*. (1992) replacing the concept of neutrality with that of curiosity combined with irreverence. Irreverence denotes the stance of consistently interrogating every theory, assumption and belief that we hold in a spirit of curiosity. There is an acknowledgement that some beliefs are more useful than others and we have the right as therapists to hold our beliefs strongly as long as they are open to scrutiny and reconsideration.

They give an example where a therapist who believes talking and co-operation is better than violence reaches an impasse in therapy with a violent couple. Although the violence stops the woman is furious because the perpetrator has not been punished. The therapist owns his uncertainty and admits his belief, suggesting the couple not see him for six months so he can "cure myself of my prejudice" (Cecchin *et al*., 1992, p. 29). Rather than enter into dialogue about their different constructions of the therapy encounter then the therapist

> constantly undermines the patterns and stories constraining the family, promoting uncertainty and thus allowing the clients system an

opportunity to evolve new beliefs and meanings...." (Cecchin *et al.*, 1992, p.9)

While the position of irreverence moves us closer to an exploration of the values underpinning blame the emphasis is still on the therapist acting on the family to undermine their beliefs. The inference is that although therapists cannot *not* take a position, they should somehow move to an alternative as soon they notice. However, where we might conceivably imagine curing ourselves of a prejudice against punishment, could we conceive of curing ourselves of the prejudice against sexual intercourse between adults and babies except in the most abstract and theoretical manner? Thus the contribution of personal and social values to the production of values in the therapy room is still not fully accounted for.

Third wave theories - Not knowing and multi-partiality

Second order cybernetics marked the beginning of what has come to be known as the 'Post Milan' school. Contemporary Milan systemic theory continues to evolve, drawing on a range of theories (cf. Bertrando, 2007) and remains highly influential in contemporary practice in the UK. From the 1990s onwards the other dominant theoretical influences on practice stem from dialogical, social constructionist, and narrative ideas. Although there are differences between the theories, there are many commonalities, of which the greatest is the prominence of language and meaning making in conceptualisations of how human problems are both constructed and resolved. There is a great deal of cross fertilisation between the theories which makes strict distinctions difficult. For the purposes of this paper I will subsume the influence of social constructionism within the dialogical and narrative schools. My justification for this is that the key social constructionist scholars influencing the systemic field, Kenneth Gergen and John Shotter, are drawn on extensively by both dialogical and narrative theoreticians and perhaps more importantly, my argument would not be enhanced particularly by further distinctions. So, I will begin by tracing the influence of

dialogical theories on the concept on neutrality and then, within the narrative frame, continue the discussion by shifting focus to the concept of personal agency, a concept that becomes more prominent as the metaphor of system is replaced by that of language.

From Curiosity to Not knowing

Anderson and Goolishian (1988) introduced dialogical theory to the field with their concept of human systems as linguistic systems. They eschewed any attempt at hypothesising on the therapist's part, be it neutral or curious, due to its potential for hidden moral evaluation. Dialogical theories emphasise that nothing we say has meaning in itself except in response to other utterances, both in the moment and in the history of dialogues in particular types of conversations (Maybin, 2001). With every utterance we position ourselves within a discourse and offer a limited choice of positions from which to respond. In monological conversation the speaker refers to inner thoughts to give meaning to things and the other becomes fixed in a pre-conceived position. To avoid this, therapists should avoid any hypothesis, but instead take a collaborative stance in the spirit of conversational partners (Anderson and Goolishian, 1988; Anderson, 2001).

> Not knowing requires that our understandings, explanations and interpretations in therapy not be limited by prior experiences or theoretically formed truths, and knowledge. (Anderson & Goolishian, 1992, p. 28)

Thus 'not knowing' becomes a way of maintaining a non-hierarchical and non-blaming stance. Criticisms of the approach follow a now familiar refrain. That a) it is impossible not to be influenced by preconceived ideas b) in the attempt to shed power (and blame) therapists again fall into the trap of treating all positions as ethically equivalent and c) power is not something that can be shed but remains present in the institutionalised structures of therapy. In an attempt to address such questions dialogical

therapists have moved towards the concept of bringing their thoughts and feelings into the therapy more explicitly (cf. Rober, 2002, 2005a, 2005b). Not knowing has been replaced by the concept of 'multi-partiality'. For instance Rober separates out the listening and speaking acts of the therapist, locating 'not knowing' as oriented to the act of listening while advocating a reflective stance to consider the position from which we are responding. At about the same time as Anderson and Goolishian were disseminating their model and Tom Andersen (1987) was developing his highly influential reflecting team practices, Seikkula and his colleagues were developing another approach drawing on dialogical principles, the Open Dialogues approach in Finnish Western Lapland (Seikkula and Arnkil 2006). Open Dialogues is possibly as close to the ideal of multi-partiality that practice can achieve. Open Dialogues brings the entire multi-disciplinary team together to discuss their ideas, prejudices, theories and concerns with the families and social networks of a person in psychiatric crisis. The therapist's task is not to rid himself of his own feelings and values but to bring them into dialogue. The aim is not to privilege any story over another and in this way to bring alive the possibility of different understandings within the encounter. The dialogical approach emphasises the inevitability of misunderstanding in any situation. Tolerating uncertainty is a central theme. However, some authors suggest uncertainty is not helpful to families. That uncertainty about the cause and outcome of psychosis can lead to families feeling blamed (Smith *et al*., 2007)**.** In an encounter following dialogical principals the therapist's task is to listen to how utterances are taken up. If someone appears to have inferred some blame then it is the therapist's job to bring it into the conversation, but not to move to diagnosis or other practices that move to certainty too quickly.

Like Andersen, both Rober and Seikkulla are more concerned with *the practice* of therapy rather than constructing another theoretical model:

> ...I see dialogue as simply something that belongs to life, not as a special therapeutic method. And this means all psychotherapies have to be dialogic if they are to be successful in bringing about the positive changes that psychotherapists seek. (Seikkulla, 2001, p. 179)

The Open Dialogue approach to psychosis is immensely important, research shows a remarkable reduction in the incidence of schizophrenia in Finnish Western Lapland (Seikkula, 2006). However, although the dialogical stance of the therapist is important, the defining characteristic of Open Dialogues is the organisation of the mental health system itself.

The dialogical movement then is getting close to the practical dilemmas of therapists regarding both the recognition and response to the effects of utterances in the moment. It also acknowledges the inevitability of taking a position in relation to any utterance made. However by eschewing any theory of change beyond dialogue itself and claiming dialogue not as a form of therapy but as 'a way of life' Seikulla (2011) sidesteps how therapists decide *which* voices in the 'polyphony of voices' they will take up and why. Dialogue itself is seen as the healing element within *any* therapy. Yet different therapeutic models will guide the therapist towards those voices they will prefer over others. Yet again we return to the familiar dilemma, do we enter into dialogue with the paedophile or do we enter the monological domain of ascribing blame for actions we find untenable.

In summary, the concept of neutrality has evolved over time and been shaped by different theoretical models. Despite the theoretical challenges addressed in the literature, in practice some version of neutrality, as a means of avoiding blame, has endured as a canonical professional ethic to which systemic therapists should aspire (Stancombe and White, 2005). Part of this ethic is the ability to tolerate uncertainty and avoid fixed meanings. However this is difficult, if not impossible, to achieve as a single therapist and the best we can do is remain alert to our prejudices. Rober

expands on this, drawing attention to our stance as a therapist during the acts of both listening and speaking. Seikkulla's additional solution is to work with the whole team and whole social network, thus bringing multi-partiality live into the room and beyond. However, some families experience uncertainty itself as unhelpful. In the final part of this section I will continue to address the contribution of the third wave theories by shifting the focus a little and looking at the other side to the coin of blame, the concept of personal agency.

The construction of personal agency

Inextricably entwined with notions of blame and responsibility are concepts of personal agency. The level of culpability for an action will be contingent upon evaluations of the person's perceived intention, motivation and awareness of possible consequences. Without agency there is no blame and like blame, and for the same reasons, the concept of personal agency creates problems for systemic theorists. I will not examine the history of systemic theorising about agency here as it reflects the tensions already discussed. Suffice to say that by concentrating on organisation and structure rather than meaning, individual motivation was deemed unworthy of consideration (Krause 1993). Where causality is circular, individual agency, whether praise or blameworthy, becomes inconceivable. With some notable voices of caution (cf. Speed, 1996; Frosh, 1997; Kraemer, 1997), family therapy largely signed up to narrative, dialogical and social constructionist theories. The focus of attention shifted from patterns of behaviour to patterns of language and meaning. The shift in focus on the storied self shifted the individual to the foreground (Minuchin, 1998) and an interest in conceptualising personal agency within a narrative frame (White, 2004, 2007).

Despite an emerging movement away from the central metaphor of language and towards embodied experience (Shotter, 1993), linguistic

systems, narrative and dialogue remain the dominant conceptual frameworks in contemporary systemic practice.

The narrative self

Narrative therapy covers a range of different ideas and practices that hold in common the centrality of narrative in the construction of meaning. Indeed, the idea of the narrative self, and personal agency, is central to dialogical, social constructionist and narrative inspired forms of therapy. As the metaphor of the narrative has risen in popularity and rivalled the metaphor of the system, so the individual story has moved into the foreground. Personal agency, as in traditional individual psychotherapies, has become an area of therapeutic interest. However, the conception of personal agency is located in a socially or dialogically constructed domain rather than the individual mind or psyche. For instance Anderson and Goolishian (1990) suggest that problems gain their meaning when they diminish our sense of agency and personal liberation. Seikkulla (2011, p.185) argues that "our clients have regained agency in their lives by having the capability of dialogue".

Let's turn now to the form of narrative therapy developed by one of its most influential architects, Michael White. White explicitly adopts a Foucauldian notion of power to critique traditional psychology and psychotherapy. After Foucault, he suggests that the "internal state psychologies" (White, 2004, p. 85) are significant systems in the maintenance of social norms through modern power. In contrast to traditional forms of power which operate through familiar structures of coercion and restriction, modern systems of power are conceptualised as operating through people's active participation in judging themselves and others through social norms. White takes issue with the humanistic assumptions of the self that lie at the heart of the majority of contemporary psychological practices. These models essentially aim to free the core self from pathologies or disorders in the form of unconscious defences,

cognitive distortions, emotional dysregulations or deviant behaviours. Once freed from these constraints by the proper treatment, the individual can experience and interpret the world correctly and make active, rational, responsible choices. Personal agency then can be evaluated in relation to how well the person's internal representation of the world fits with reality. White argues that this deficit model of what it means to be human diminishes the power of ordinary people to express and practice their personal agency. It limits the range of identity positions open to people.

> People are induced to actively participate in the judgement of their own and each others lives according to these ideals. These ideals for personhood are represented by all those contemporary norms about what it means to be a 'real' or 'authentic' person. (White, 2002, p. 43)

Personal agency then is an important aspect of narrative practice, with the embedded assumption that the person can escape the oppressive positioning of certain discourses by actively choosing another. For instance, Freedman and Coombes (1996, p. 97) describe the construction of an "agentive self" where the person can inhabit a constitutive as well as constituted subject position. The therapist's role is to enable "conversational practices that are richly describing of peoples' lives that open more options for action in the world rather than fewer", (White, 2002, p. 900)

Inspired by White, Jenkins (1990) applies narrative theories to the sphere of domestic violence. Male violence is seen to be constructed through gendered discourses that limit the possible identity positions couples can inhabit. Perpetrators of violence are enabled to take responsibility for their actions through bringing to awareness alternative story lines and identity positions. Blame becomes relegated to the sphere of normalising discourses which trap both men and women in certain ways of living and

responsibility (or agency) is enacted through choosing alternative, non-violent identities.

Guilfoyle suggests that a common position in Narrative texts is the assumption that agency means the capacity to choose or reject different discourses in different contexts. However, this is problematic. If a person can choose the discourses that form them then that person must exist separately from those discourses. He traces this tension to the work of Foucault himself:

> Foucault did not leave us with an explicit, well developed account of the active subject who a) exists simultaneously within the context of power/knowledge dynamics and b) is distinguishable from the sovereign subject he had already rejected. (Guilfoyle, 2012, p. 633)

So the metaphor of social discourse brings with it a similar dilemma to that of the metaphor of system. The problem of the discursive, deconstructed self leads us to the problem of a discursive determinism where people become subject to pre-existing discourses. If there is no agency, there is no blame, but without agency there is no power to effect change.

Guilfoyle's solution is to distinguish between negative and positive aspects of resistance to dominant discourses.

> ...negative resistance can be seen as resistance that precedes discourse but lacks its own positive discursive contents, while positive resistance is the meaning-making activity that follows acts of negative resistance. (Guilfoyle, 2012, p. 635)

So, the initial act of resistance is not the stepping into an alternative discourse, but the refusal of an existing one. A purely discursive view of the subject fails to account for our corporeality. Resistance can be located in

the embodied self and offer a momentary escape from discourse. The initial act of refusal does not require an alternative narrative, but without an alternative narrative there would be an absence of meaning and social connectedness. This absence produces movement towards discourse once more. This might be towards the original opposed discourse or it might be towards an alternative narrative. To remain a participant within "the human social-communicative space, the person who resists must be re-storied; become a subject once more." (Guilfoyle, 2012, p. 636). Thus Guilfoyle sees the positive aspect of resistance as the act of reconstituting the subject within socially meaningful alternative stories.

Therapy as a site of moral negotiation

The particular challenge the post-modern epistemologies pose to therapy is this. If therapy is a site for the production of social values then it becomes less science and more rhetoric, the art of persuading to a particular point of view (Klaushofer, 2007). Therapy becomes about finding forms of thinking and acting in ways that are morally acceptable to all, including the therapist (Rikonen and Smith, 1997). Family therapy's answer has been to strive towards the ethic of multi-partiality. However, how this stance is achieved in practice is problematic. How do families recognise 'not knowing' and 'multi-partiality' and what if they draw on a different ethic? Stancombe (2002) argues that the 'not knowing' position as practiced in contemporary therapy merely obfuscates the inevitable moral judgements we make as therapists in our day to day practice. He suggests that contemporary practice tends to show an essentialist and cognitive notion of narrative that eschews its performative nature. The focus is on uncovering marginalised stories as if they exist outside the therapy room, as if we have a free choice over those stories we wish to inhabit or proffer. The therapist's part in constituting this story remains on the whole unexamined. If as a discipline we have incorporated narrative ideas into our practice, with their accounts of language as being inseparable from politics and ideology, then *every* utterance we make can be seen as imbued with

moral implication. Stancombe persuasively demonstrates that neutrality is an interactional achievement rather than a personal stance. Therapists try to conceal their judgements by working up neutral versions behind the screen to present to the family, yet the family is highly attuned to any sign of evaluation, verbal or non-verbal, through omission or commission.

Summary

The aim of this section has been to sketch the key theoretical debates available to contemporary systemic therapists regarding the management of blame and to highlight the areas where theory fails to fully address the practical moral decisions therapists make on a day to day basis. As a student I was introduced to, and encouraged to practice, concepts and techniques from all the theoretical models mentioned above and more. This thesis traces my attempt to find my own path through these overlapping but often conflicting territories. I have described how the tension between theories of mutual influence and ideas about personal responsibility has been an area of debate throughout the development of family therapy. The ethic of impartiality, be it termed neutrality, curiosity, not knowing, or multi-partiality, has been a consistent theme, particularly of second and third wave practices, yet how to achieve it remains a question of debate.

To add yet more complexity to the mix, the therapists represented in this research explicitly adopt an integrated FT and FM model. Indeed some authors suggest integrating the two models (Lobban *et al*., 2005). Burbach and Stanbridge (1998, 2006) suggest that integrating a circular view of causality with FM approaches enables an exploration of family dynamics which may contribute to the maintenance of the problem. Although the theoretical explanations, and indeed conflict between the two camps, would suggest that FM and FT models are radically different, practice is often less clear cut. In day to day practice the line between models is muddier than between manualised versions of therapy designed for

research trials (Bertrando, 2007). In my experience of working with and supervising both FT and FM practitioners, biological and interactional understandings are woven into conversations in both settings. Family therapists sometimes set tasks which look very similar to FM tasks. Despite FM approaches being designed to be delivered in specific ways, in practice practitioners often go off piste to fit the model to the family. However, it remains the case that the epistemological foundations of the two approaches are in direct contradiction and just how integration of diverse models gets done in practice is unclear.

I suggest that *any* theoretical model has its gaps and contradictions. Therapists are not only influenced by professional theories but also personal, political and cultural beliefs which will inform their practice. Families too will bring a range of beliefs which will influence the negotiation of what the problem is, who is responsible and what can be done about it. However, there is often a gap between therapists and families expectations of the 'unwritten rules' of the therapeutic encounter. Where therapists are trained to be impartial and uncertain, family members may want an expert to tell them what or who is to blame. This study illuminates how therapists and families co-operate in making sense of therapy, filling in the gaps in the unwritten rules together, and in that process, negotiating what is judged as reasonable and unreasonable behaviour.

Part Two - The Research Literature

Introduction

Part 2 concerns the relevant research literature, briefly sketching findings from attribution and expressed emotion studies before narrowing the focus onto therapy process research. I introduce relevant studies in family therapy using similar sorts of research methodologies, such as discourse analysis and discursive psychology. By the end of this chapter I hope to have sketched the terrain sufficiently for the reader to understand the context and rationale of the study before turning to Chapter Three where the method and design will be described in detail.

Attribution research

Research into blaming in interpersonal communication has its strongest tradition within the field of attribution theory (Gotlib and Abramson, 1999). Attribution research shows a correlation between families with problems and blame. For instance, in a review of the literature Corcaran and Ivery (2004) suggest that parents who maltreat children tend to explain childrens' behaviours as due to dispositional and stable causes. Because these parents tend to see their children (and not themselves) as responsible for their problems they often drop out of therapy (Morrissey-Kane and Prinz, 1999). Attribution theory is located predominantly within the discipline of cognitive psychology and causal attributions are often interpreted in isolation. However, as I have described above, blame is a difficult concept to pin down outside the context of a relationship.

Expressed emotion research

FM approaches have been designed specifically to reduce HEE in families based on robust evidence that HEE is correlated with relapse. However, exactly what elements of family intervention make a difference is unclear Kuipers (2006). The NICE guidelines reflect this uncertainty.

With regards to the training and competencies required by the therapist to deliver family intervention to people with schizophrenia and their carers, there was a paucity of information reported throughout the trials. Consequently, the GDG were unable to form any conclusions or make any recommendations relating to practice. However, the GDG acknowledge that the training and competencies of the therapist is an important area, and one that warrants further research. (NICE, 2009, p. 242)

Research into expressed emotion has moved beyond the diagnostic category of schizophrenia and has been shown to be relevant to a range of psychological difficulties, including bi-polar disorder (Kim and Malkowitz ,2004) and depression (Hooley and Teasdale, 1989). Calam *et al.*, (2002) have shown parental EE on the critical and hostile dimensions to predict failure to engage in child mental health services. A number of studies have shown that families' appraisals of their problems have an impact on EE. Families in similar situations can experience the burden of care as greater or lesser, and their expressed emotion be higher or lower, depending on their explanations for their problems. Lobban *et al.*, (2005) show a correlation between relatives who are highly critical and those who perceive symptoms to be under the control of the patient. They propose that EE measures might most usefully be defined as an indirect measure of coping mediated by relatives' beliefs about the factors influencing the patients' behaviours. Thus attributions of responsibility and blame are linked with EE.

EE and systemic family therapy

Bertrando *et al.*, (2006) researched the effects of systemic family therapy on Expressed Emotion in families affected by psychosis. Their study of a manualised systemic therapy achieved outcomes comparable to those reported by FM models. The authors highlight the question of what it is that makes FI's effective:

> ... psychoeducational intervention stresses the biological determinants of illness and the need for the patient to 'be a patient', whereas systemic intervention attempts to relocate symptoms in a network of relationships and to reinstate them in the family's story and development. In both cases, however, family members' emotions can be given a name and a meaning, and so be modified or reduced. (Bertrando *et al*., 2006, p. 98)

The effects of blame in family therapy

Research into family therapists' perception of blaming events shows blame is seen to reduce engagement in therapy both when parents feel blamed (Furlong and Young, 1996; Wolpert, 2000) and when parents blame the child for difficulties (Wolpert 2000). It is also seen to interfere with problem solving capacities (Friedlander *et al*., 1994). Families that persistently blame pose challenges to the stance of therapist neutrality and to their ideals about how therapy can help (Bowen *et al*., 2005; Newman *et al*., 2013). The participants in Newman's study adhere to an integrated FM/FT model in their work with families affected by psychosis. The findings are therefore particularly relevant to this analysis, evidencing the theories that guide therapists' practice in this particular work context. Blame was identified as the most challenging aspect of the work, with therapists reporting that family members blame each other, themselves and professionals. Clinicians felt that blame was a major factor for families dropping out of therapy. Therapists believed that the main tools they used to avoid blame were,

- exploratory conversations that encouraged multiple points of view
- circular rather than linear explanations
- the stress vulnerability model (Zubin and Spring, 1977)

Blame as an interactional phenomenon

Two main types of therapy process research are represented in the literature. Although some form of categorization is always necessary, the

two strands are differentiated by those that attempt to identify and code blaming attributions according to decontextualised observational coding schemes (cf. Friedlander *et al.*, 2000; Besharat *et al.*, 2001; Stratton *et al.*, 2003; Wolpert, 2000) and those that adopt an interactional approach where the focus is on the *performance* of blame *contingent* upon context (Stancombe and White, 2005).

Bridging attribution and interaction theories, Stratton *et al.,* (2003a, 2003b) developed a measure, the Leeds Attributional Coding System that encompasses an interactional component. They identified those attributions (global, stable, internal, personal and controllable) that constitute characterological blaming as particularly negative in its impact and difficult to diffuse. Where the identity of the person as a whole seems to be criticised rather than their behaviour or indeed one aspect of their perceived personality, then the negative impact of blame is increased. So, where the *identity* of the person is at stake, the impact increases. Their research is interesting in its potential practical application in therapy. It indicates that by shifting the attribution in just one domain, for instance from intentional to unintentional action, the impact of blame can be softened.

The limited therapy process research into therapists *responses* to blame in Family Therapy show that therapists demonstrably view blame as a prompt for action (Friedlander *et al.*, 2000, Stancombe and White, 2005). The research therefore shows that systemic therapists not only take blame seriously in theory but also in practice. Friedlander found that the most frequent response of therapists to blame was ignoring or diverting. This did not mean that therapists did nothing when a blaming event happened. Indeed in every instance some form of diversionary tactic was employed, the most frequent of which was focusing on the positive. Other tactics included interruption, highlighting neutral information, and redirecting the topic of conversation. Reframing was another common response. Other

less frequent categories of response were acknowledging the blame (while not agreeing with it) or challenging it directly.

They found no difference in families' responses to different therapist strategies, including direct challenges, although they did find that blaming statements were reduced within four out of seven sessions the more frequently the therapist responded to them. Melidonis and Bry (1995) found that the effect of ignoring negative attributions and focusing on exceptions was to decrease blaming in solution focused therapy sessions. Stancombe and White (2005) however found that by responding in a way that displayed neutrality towards blaming statements, strategies such as those described in both studies above, systemic therapists paradoxically invited more. The effect of therapist responses on the family then is open to debate. One reason for these different findings may be the difficulties in operationalizing the concepts of blame and neutrality. For example, in the studies cited above Friedlander *et al*., depend on a strict coding of explicit attribution of fault that includes causal factors of a dispositional or intentional element while Stancombe and White lean on a more context dependent co-constructed notion of blame. Freidlander *et al*. also acknowledge that although they note the effects of therapist responses on families, the focus of their study was on therapist responses. However it may also be that the effects of different therapist strategies will be different according to the local context, the meaning created between *this* therapist and *this* family at *this* time.

Those adopting an interactional approach to psychotherapy research are interested in how such concepts such as change (Frosh *et al*., 1996; Couture and Strong, 2004), alliance (Sutherland and Couture, 2007), personal agency (Kurri and Whalstrom, 2005; Guilfoyle, 2002), pathological identities (Avdi, 2005) and neutrality (Stancombe 2002, Stancombe and White, 2005) are interactionally achieved. In her review of Conversation Analysis (CA) and Discourse Analysis (DA) studies of Family Therapy

specifically, Tsielou (2013) identifies a mere 24 studies in all, most of which use a hybrid DA approach drawing on Discursive Psychology (DP) and CA. Many of these studies analyse a single case, sometimes just one or two therapy sessions, in order to elucidate the complex practices involved in the development of a piece of social action. It is in this tradition that this study resides. The following studies are particularly relevant to my analysis.

Stancombe and White (2005) have demonstrated how family therapists take care to work up "non-blaming" interventions in response to blaming events in the family *and* in the therapy team. They demonstrate how neutrality is interactionally achieved. In other words, the therapist cannot achieve neutrality unless the participants co-operate by showing that *they agree* his or her actions are neutral. Thus neutrality will be constructed between therapist and family in context. If this is the case then it makes sense that different therapist responses will have different effects at different times with different families. Similarly, different families will have different effects at different times on the therapist. Like Stratton (2003a) Stancombe and White urge systemic therapists to talk with families more explicitly about moral judgments because a) families are highly attuned to any tacit evaluation and b)tacit evaluations are inevitable.

In a study of a single couple therapy session Kurri and Whalstrom show how therapist's moral reasoning is woven around two intersecting ethics, those of individual autonomy and relational responsibility. They demonstrate that therapists responded to blaming accounts by shifting the focus on to the blaming spouse to "give accounts of their deeds or thoughts *within the conversation*" (Kurri and Whalstrom, 2005, p. 363). Therapists showed a negative moral evaluation of blaming talk by topicalising it. In other words, therapists do not remain neutral to blaming talk and imply fault by asking the blamer to account for their actions. This brings us to the consideration of agency in the literature.

Agency research

I have argued that personal agency is an important theme in psychotherapy in general and in family therapy has taken centre stage within the narrative and constructionist models. Thus the effects of hegemonic discourses on notions of subjectivity and agency have been an area of research interest (Avdi, 2005; Guilfoyle, 2002; Kogan and Gale 1997). In a domestic violence counselling context, Kurri and Whalstrom (2005) have shown that 'agentless talk' is a prompt to action for therapists. They argue that counsellor's have to manage a tension between the normative moral rule 'domestic violence is wrong' and the professional ethic of respect for the client's autonomy. This study of a single counselling session shows the function of delicacy in the therapist's management of the tension between pursuing a moral position condemning domestic violence whilst simultaneously avoiding blaming the client for choosing to remain in the relationship.

Madill and Doherty (1994) in a study of a single session of an individual psychodynamic therapy note the therapists reframing of a client's choice from one determined by obligation into one of personal desire (you did what you wanted then). Thus the therapist implies it is not only possible but desirable to act autonomously and constructs a problem suitable for his therapeutic aims. In the family therapy literature two studies are of particular relevance. Guilfoyle's (2002) analysis of two therapy sessions highlights the dilemmas faced by a constructionist therapist's preference for stories of personal agency. Guilfoyle, both therapist and researcher in this case, challenges parents exonerating explanations of their child's behaviour as 'unconscious', and thus beyond his control by re-formulating it as intentional. Thus, the costs of the behaviour being seen as blameworthy are weighed up against the gains of it being open to the possibility of change. He highlights the particular problem this poses to narrative therapists who *in theory* critique those notions of self-contained

individualism which are a dominant feature of contemporary Western culture, while *in practice* privilege stories of self-containment and personal agency. Parker (1992) suggests that this problem may be compounded by the difficulty of communicating different models of subjectivity in a language structured by dualist conceptions. Avdi focuses on the effects of diagnosis in the construction of identity. In his study of a twelve session therapy with a family whose child has a diagnosis of autism he argues that the therapy is successful on the grounds that his analysis has:

> traced shifts in the way that the child's difficulties are talked about, from a dispositional to a relational understanding and from a non-agentic to agentic formulations regarding the child's behaviours. (Avdi 2005, p. 506)

By deconstructing a medicalised, pathological identity the therapist both normalises behaviour but also runs the risk that behaviour previously seen as 'not his fault' is redefined as intentional, with all its connotations of responsibility and blame. Thus both the above studies demonstrate that at times therapists' interventions could be read as *more blaming* when in pursuit of a particular therapeutic goal.

Summary

I have sketched the rich history of systemic theory and practice knowledge available to systemic therapists regarding the management of blame. I have then reviewed the relevant research regarding the impact and management of blame in family therapy. I have shown how the research into EE clearly demonstrates a correlation between blame and psychological distress. The combination of EE measures and attribution research show evidence that beliefs about the cause of the difficulties, and especially *discrepancies* in beliefs are pertinent. Thus research into the effects of causal explanations that are blaming, both on families and on families' engagement in therapy, supports the notion that blame is

unhelpful. The limited research into blame in family therapy confirms that therapists experience blame both as a challenge to their ideals and practice and as a prompt to action. However the effects of those actions remain unclear. Comparison of studies that attempt to code blame externally is hampered by lack of consensus regarding the operationalisation of the concept. This is because blame cannot be fully understood when abstracted from its interactional context.

Within the tradition of micro-analytic studies of therapy process, there are a handful of studies examining blame in family therapy. These studies, using methods that foreground the interactional construction of social phenomena, enable a detailed examination of the subtlety with which blame may be implied or inferred. Studies of the construction of agency in therapy are also relevant to the discussion of blame. The limited research available indicates that therapists prefer 'agency talk', where clients claim responsibility for their actions. One cannot have agency without responsibility, and responsibility for negative events potentially implies blame. Focusing on increasing agency then may increase blame, while decreasing blame may diminish agency. The interactional studies described above give a rich description of the discursive practices utilized by therapists to manage the tensions of decreasing blame and increasing agency in routine practice across a range of therapeutic modalities. They offer a glimpse of some interesting phenomena that deserve further examination. For example, how non-blaming is achieved interactionally (or not) in systemic family therapy, how family therapists display their moral evaluation of blaming accounts and accounts of personal agency and how these evaluations are taken up by family members. This study sets out to illuminate how therapists and families make sense of family therapy together, particularly how they negotiate what is judged to be reasonable blame, and reasonable agency, within the context of family therapy for families affected by psychosis.

In the next chapter I will describe my chosen method to explore these ideas further.

Chapter 3

Introduction

Chapter Two concerned the context and rationale for the questions the study sets out to answer. Despite a clear consensus across disciplines that blame is unhelpful, and evidence that therapists are prompted to action by blame, research into blame in therapy has been hampered by difficulties in operationalising blame as a concept. What interests me is *how* therapists and families recognise this phenomenon of blame that is so hard to operationalise and *what* they do to display that recognition to one another. This chapter details the method used to address those questions. Following a brief summary of the aims of the study Part 1 scopes the relevant epistemological and methodological issues. The methods of CA and MCA are then described in some detail. The aim is to familiarise a reader new to these methods sufficiently to enable a critical examination of the analysis that follows. In Part 2, the practical design of the study is described, including a discussion of ethical considerations. In short, the study comprises an analysis of selections from the transcripts of two therapy sessions, using Conversation Analysis (CA) and Membership Categorisation Analysis (MCA).

The aims of the study - What kind of talking is acceptable here?

If blame is seen as a social action then the relevant question becomes how do people perform blame? Also, how do others recognise the performance of blame and understand what social action it is intended to achieve? I have described how some researchers have studied blame from this bottom up approach, examining the sequential construction of blaming events in situ. This study adds to this body of work and approaches it from a particular angle. How does blame get performed within the context of family therapy for psychosis and how do both families and therapists show their evaluation of blame as either being socially

acceptable or unacceptable under the circumstances? This encompasses the question of how participants negotiate the unwritten rules about what kind of conversations are relevant. The focus of the analysis has been on what interactional practices are deployed to imply blame, how those implications get taken up, resisted or transformed and what the interactional consequences are of such practices. This illuminates how participants in therapy collectively agree what actions are understood to be blaming and whether those actions are deemed acceptable or not. The analysis of blame has led to a further, linked consideration. How personal agency is constructed in relation to practices of blaming and mitigation. My main theme of enquiry then is how family therapists, in the context of family work with families affected by psychosis, manage the institutional tasks of decreasing blame and increasing agency within family talk.

Part 1- Epistemological and Methodological Issues

Introduction

This section describes the rationale for the method of analysis. I will begin by locating this study in the context of psychotherapy research in general. I will go on to outline the epistemological foundations of CA and MCA, their key concepts, their strengths and their weaknesses. I make the case that CA and MCA together offer an analytic tool well suited to my research interest.

Psychotherapy outcome and process research in a modernist frame.

Psychotherapy research largely falls into two strands, outcome research and process research. Psychotherapy outcome research has predominantly been concerned with answering questions such as which therapy works best for whom. The randomised, controlled trial exemplifies this position, requiring large sample sizes, control groups and therapy manuals in order to eliminate variables and isolate cause and effect.

Psychotherapy process research is more concerned with examining *how* therapy works. Much of traditional therapy process research is located within an empiricist tradition, using a variety of quantifiable measures to claim objectivity and reliability. Stiles and Shapiro (1989) liken these types of studies to psychopharmacological research. They try to identify the 'active ingredients' of therapy, such as advice giving, which are seen to be delivered to the client within 'fillers' which are inert. Both process and outcome research in this tradition view values and subjectivity as potentially clouding our view of reality and therefore as problems to be eradicated in the pursuit of truth (Guba and Lincoln, 1985). The difficulties encountered in eliminating the subjective are met by honing the tools of research. So a researcher in this tradition would work hard to operationalise the concept of blame so that it could be identified objectively by observers and be replicable across studies regardless of other variables. In these types of studies context is something to be controlled.

Psychotherapy process research in a post-modern frame

Some authors argue that it is impossible to differentiate the 'ingredients' of therapy as if they were objects that can be delivered by therapists irrespective of context and relationship (Elliot *et al.*, 1999). Instead they advocate a focus on the micro-processes of therapy, building understanding of how therapy gets done in context. In these studies then context is something to be analysed as indistinguishable from the active ingredients of therapy. This study sits within this latter tradition. The aim is to show how *these* participants manage blame in *this* context, in order to build a picture of practices which illuminate micro-theories in use.

Discourse research

As systemic theory has developed over time, so too the field of qualitative research has increasingly focused on how everyday realities are brought into being in and through social interaction. It is difficult to imagine the study of social interaction without paying attention to how we use

language to achieve things. The common ground for all *discourse* research then is an interest in language in use, or "the study of human meaning" (Wetherell, 2001, p. 3). This fits the movement in therapy *process* research towards a post modern frame, the study of the contingent and interactional nature of therapy (Burck, 2005). This common interest in language and context has meant that Discourse Analysis (DA) has been taken up by systemic practitioners to examine both the macro and the micro-processes of the therapy encounter (Roy- Chowdhury, 2006; Frosh *et al*., 1996; Burck *et al*., 1998; Stancombe and White, 1997; Guilfoyle, 2002).

Discourse analysis

The field of DA contains numerous, often competing methods, based on a bewildering array of ontological, epistemological and methodological assumptions. The most distinct division within discourse research is between ethnomethodologically inspired methods such as Conversation Analysis (CA) and Post Structuralist methodologies such as Critical Discourse Analysis (CDA) and Foucaldian Analysis (Wetherell, 1998). The tension between the different approaches is well documented (cf. Billig, 1999; Schegloff, 1997, 1998, 1999; Wetherell, 1998). Proponents of CDA stress the reproduction of power and social inequality through discourse as well as the historical processes through which such practices have emerged. In contrast, CA researchers interest lies in describing the "conversational 'machinery' through which social action emerges" (Holstein and Gubrium, 2011, p. 343). A key difference, hotly debated by members of each camp, is the extent to which analysts are justified in using information from outside the text to analyse the text (Antaki *et al*., 2003; Wetherell 2001). Holstein and Gubrium (2011) neatly describe Foucauldian inspired researchers as privileging 'the what' or 'discourses-in-practice' while ethnomethodologically inspired practitioners privilege 'the how' or 'discursive practice'. Some forms of discourse research attempt to bridge the two by combining the fine grained analysis of CA with more macro discourse work (cf. Wetherell and Potter, 1992; Parker, 1992; Billig, 2001).

Derek Edwards and Jonathan Potter (1992) introduced the term Discursive Psychology (DP) to differentiate their approach from the broad spectrum of DA studies. Edwards and Potter are most interested in re-examining traditional psychological explanations from a discursive action perspective. While the term DP has been used to encompass a variety of methods (Edwards, 2005a), this study is most closely aligned with the work of Edwards and Potter. For example Edward's (2005b) analysis of complaints shows that the attribution of fault is not simply a matter of cognition, but that the production of a complaint is highly sensitive to the context in which it is produced. Rather than treating language as representative of cognitive processes DP,

> applies the basic principles of conversation analysis, with a view to discursive psychology's central concern with how psychological characteristics […] are handled as part of talk's performance of social actions. (Edwards, 2005, p.8)

In other words we anticipate and signal how we wish the complaint to be received as complaints have implications for how the characteristics of the complainer will be judged as well as those complained about.

In the next section I will describe the theoretical foundations of CA and MCA. I will then go on to describe each method and their key analytical concepts, starting with CA.

Conversation Analysis

The origins of CA

The origins of CA and MCA lie within the discipline of sociology, specifically in ethnomethodology. The focus of ethnomethodology lies in the social analysis of the situated, practical reasons for social actions (Garfinkel, 1967). In any interactional setting, all participants have ways of making

sense of and organising their everyday life. For Garfinkel, language and social interaction were the practices by which both social institutions and the moral order were constituted. People act, and account for their actions on the basis of their tacit knowledge of shared understandings of how people *should* act, the local moral order. Thus the management of everyday, mundane affairs is essentially a process of moral positioning and repositioning. Conversation Analysts study the systematics of social interaction through language, which they term 'talk-in-interaction'[2].

Antaki (1994) also traces the influence of pragmatics on the development of CA. Grice (1975) argued that in order to understand one another's intentions, speakers are guided by an underlying principle of co-operation. We assume that the maxims of relevancy (each turn will relate to that which has gone before), clarity (we will attempt to be concise and to the point), truthfulness (we will say as much as necessary to not misdirect) and quantity (say no more and no less than is necessary) are the common ground by which we construct and infer meaning. These tacit assumptions are not prescriptive but normative, and through their deployment a multiplicity of meanings can be achieved with great economy. So for instance the phrase "The dog looks happy" can be understood to infer more than a wagging tail if said immediately after "Where has my dinner gone?" Similarly irony depends for its meaning on the assumption of truth when the same utterance is made of a trembling dog following the vet's receptionist's "Next".

The foundation of CA as a discipline

Harvey Sacks and his collaborators Emmanuel Schegloff and Gail Jefferson drew these strands together in the 1960's and 1970's to develop a method of analysing language as a form of social action. Sacks died in 1975, and

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[2]   Talk-in-interaction includes language and language like symbols, gestures, postures, facial and verbal expressions, anything which may ascribe meaning to ongoing interaction.

much of his original work, which laid the foundations of CA, exist only in the form of his lectures which were later collected together and published (Sacks, 1995). Schegloff, Jefferson and other CA researchers have continued to develop and extend the approach.

Schegloff argues that the very roots of human sociality lie in:

> ...those features of the organization of human interaction that allow the flexibility and robustness that allows it to supply the infrastructure that supports the overall or macrostructure of societies in the same sense that roads or railways serve as the infrastructure for the economy... (Schegloff, 2006, p. 70)

He argues that "talk-in-interaction" provides this infrastructure and:

> the organisation of interaction needs to be -and is- robust enough, flexible enough, and sufficiently self-maintaining to sustain social order at family dinners and in coal mining pits, around the surgical operating table and on skid row ... in every nook and cranny where human life is to be found. (Schegloff, 2006, p. 71)

The CA project then is the analysis of naturally occurring conversation in order to describe how the organisation of talk-in-interaction, is both manifested in and reproduces social structure. Levinson (2006, p. 39) describes conversation analysis as one discipline among many, all researching aspects of what he calls "the human interaction engine", universal properties that underpin human interaction.

What is CA?

Following Grice, CA posits that in order to understand one another people have to have some shared assumptions about the underlying rules of interaction. Although language dominates social interaction, the crucial actions being performed are nearly always indirectly conveyed. To do this

the signals have to be recognisable, to have some order. CA's aim is to elucidate those rules, or generic practices, by which we signal to one another our intentions. It does this by observing recurring patterns of interaction and then working out what these patterns achieve,

> to take what people are doing, that is saying, not-saying, saying something in a particular manner, at a particular moment., etc., *and try to find out the kind of problem for which this doing might be a solution.* (ten Have 2007, p.16, my italics)

Two domains of CA

Ten Have differentiates between two domains of CA.

1)   The empirical analysis of large quantities of data to establish regular patterns of interaction and uncover tacit procedures or technologies in use. Over the years CA has developed a large body of work describing these organisational practices.

2)   The elucidation of, "the *endogenous logic* that provides for the sense of the (inter) actions, as part of a lived moral-practical order", (ten Have 2007, p. 38)

It is important to stress here that CA's project is not to develop a generalised theory of interaction but by elucidating the technologies of talk CA tries to show:

> the inherent theories-in-use of members practices as *lived orders*, rather than trying to order the world *externally* by applying a set of traditionally available concepts … (ten Have, 2007, p. 34)

The tension in CA is managing to uncover the orderliness of talk while eschewing generalised theories of communication and maintaining the stance that order is co-operatively produced at the local level. CA

concepts should not be understood as causal rules but rather as normative orientations of participants that can be used as flexible resources for social action. This tension, to both look for pattern and avoid a formal external coding system explains CAs close attention to detail. It is in the orientation of the interlocutors that the local order is both produced and displayed. The researcher, as a member of the same language system as the objects of study, will bring their own 'membership competencies' to the analysis but it is the interactants own understandings, as displayed in their utterances, that are both the object of study and the key resource for validation of the analysis.

The building blocks of CA

Four fundamental, interlocking organising activities have been identified within the CA literature. These comprise turn taking practices, sequence organisation, repair practices and the organisation of turn design.

Turn taking

Sacks *et al*. (1974) observed that overwhelmingly in conversation only one person speaks at a time with minimal gap or overlap between different speakers. Schegloff claims the ubiquity of turn taking to be fundamental to social interaction.

> What is at stake in "turn taking" is not politeness or civility, but the very possibility of coordinated courses of action between participants (e.g., allowing for initiative and response)- very high stakes indeed. (Schegloff, 2006, p. 72)

A number of organising practices allow for speakers turns to be changed smoothly. For example, speakers orient to a possible change of speaker at the end of a Turn Construction Unit (TCU). A TCU is marked by its adequacy to achieve an action. It might be a sentence, a single word or a nod of the head. The end of any TCU is termed a Transition Relevance

Place (TRP). At each TRP there are three main ways that the next turn is allocated. The present speaker can select the next, a speaker can self-select or the present speaker can continue. These options are hierarchically organised where other selection is preferred over self selection and speaker continuation least preferred. CA has elucidated numerous patterns of sequence structures that are designed to check if conditions are favourable for a suspension of turn taking procedures. For instance, different 'pre-sequences' that serve to check if conditions are favourable to permit the speaker to continue through a series of TRPs without interruption, perhaps to tell a joke or a story. Other structures contain repeated sequences (chaining rules) such as question and answer sequences where the norm prevails that a questioner has "a reserved right to talk again… *And,* in using the reserved right he can ask a question", (Sacks, 1972, p. 343).

How the speakers co-operate will both create and depend upon how speaking rights are negotiated, how speakers display their orientation to who has the right to extended turns and who does not. The normative procedures of turn taking can be oriented to by different speakers to achieve different ends in different contexts. For example, in this study therapists are shown to use the structural properties of questions to achieve certain institutional ends.

Sequence organisation

This is one of the aspects which fits systemic therapy so well and offers such a powerful tool for the analysis of psychotherapy practice. CA views every utterance as produced in relation to what has gone before and as projecting (or limiting) the possibilities of what can come after. Every utterance is seen as both context dependent and context renewing. Meaning is tied inextricably to the position of the utterance in unfolding talk, its 'sequential implicitiveness'.

The adjacency pair

The adjacency pair (AP) is the basic sequence unit and analytical tool, the second pair part being heard as relevant to the first pair part. Essentially the first speaker's utterance is designed both to show the next speaker what they are doing and project certain sorts of possible responses. The next speaker can then respond either in the way the first speaker implied, or not. The way the second speaker responds will then be open to interpretation. If the second pair part is not heard as both relevant and fitting then this is seen as an accountable matter. For example, social norms related to 'saving face' provide for an invitation to be accepted unless there are good reasons not to accept. For this reason, refusing an invitation is usually marked as 'dispreferred'.

Preference organisation

Confusingly, preference organisation in CA has nothing to do with individual choice or desire. Even more confusingly preference is used to denote two linked but slightly different meanings. The first use is where preference refers to findings that project empirically which alternative is most frequent and therefore expectable. So by studying many instances of invitations, CA shows that the most frequent response is acceptance. Acceptance then is the preferred (expected) response to an invitation. The second use of preference refers to structural properties of responses that *mark* actions as normatively positive (preferred) or negative (dispreferred). A preferred action is that which interactants display as the *expected* positive action by means of delivery that is fast, brief and requires no further explanation. A dispreferred action is marked as such by pauses and hesitancy of speech, often accompanied by an account for the reasons of refusal as being outside ones control. To refuse an invitation *without* these markers will be open to (usually negative) interpretation. Thus interactants can choose *not* to mark a refusal as dispreferred to achieve a social act, perhaps to show that the invitation breaks a social norm or that the invited is angry with the inviter.

Repair organisation

> If the organization of talk in interaction supplies the basic infrastructure through which the institutions and social organization of quotidian life are implemented, it had better be pretty reliable, and have ways of getting righted if beset by trouble. (Schegloff, 2006, p. 77).

Repair organisation refers to those practices which enable any kind of trouble, (misunderstandings, mishearings, misalignments) to be dealt with. Practices of repair are found to occur immediately after a trouble source is identified. Repair is preferred in the next available turn and self repair is preferred over other repair with recipients of trouble talk regularly holding off to allow the other to correct the trouble themselves. Schegloff suggests that this co-operative attunement to the immediate repair of any misunderstanding is the main guarantor of intersubjectivity and common ground in interaction. Thus recipient design (see below) organises the talk in such a way as to be understood by its recipients while repair practices "provide resources for spotting, diagnosing and fixing trouble" (Schegloff 2006, p.79). For this reason repair is omni-relevant, it can occur at any point in talk and continuers such as 'uh-huh' are markers that display repair is *not* necessary at this point (Schegloff, 1982).

I have found the management of misalignment (see below) and repair of particular interest in relation to sequences of blame.

The organisation of turn design

Turn design refers to practices that shape utterances in particular ways to achieve certain actions. Recipient design for instance refers to the shaping of an utterance in such a way as to be understandable by *this* recipient in *this* context, given the pre-suppositions of the speaker regarding the kind of knowledge the recipient might have. For instance reference to persons involves practices of minimisation (say the least necessary) and recipient

design (use of assumed knowledge such as a first name), (Sacks and Schegloff, 1979). People can be referred to correctly in many different ways but these two practices combined lead to the most economical means of reference without recourse to repair. Preference organisation (discussed above) is another strand of turn design, where utterances are shaped to display normative assumptions.

So there are many alternative ways to say something, and the choices made are made to perform a particular action with particular people in a particular context. Each choice normatively offers certain available responses and constrains others. Hearers will be attuned to these choices, interpret them in particular ways and make their choices in response, which offer certain possibilities and constrain others for the first speaker. Misalignment may occur when one speaker designs a turn to, for example, imply a fault (you shouldn't have bought me that), but the recipient may (deliberately or mistakenly) receive it as gratitude (No really it was nothing). Here practices of repair will become relevant if the conversation is to go on smoothly. So through this turn by turn shaping of talk in interaction the local moral order is created.

Summary

The aim of CA is to bring to awareness the ordinary everyday practices that form the infrastructure upon which social life is built. Over the last 50 years or so, CA as a discipline has focused on uncovering these basic practices of talk-in-interaction and has developed a large corpus of established findings and robust analytical tools in the process. I have briefly summarised the key organising activities that have been identified within the CA literature, turn taking practices, sequence organisation, repair practices and the organisation of turn design. Pure CA scholars across the world continue to examine ordinary conversation within and across different language groups and add to our understanding of these organising practices.

Critiques of CA

Critics of CA suggest that by focusing on the 'how', the technicalities of conversation, the 'what', the cultural resources that guide and limit what can be talked about are left unaccounted for, and those cultural resources highlighted are frequently those utilised in the maintenance of inequality, injustice and oppression. Critical psychologist Michael Billig (1999, p. 550) suggests that CA assumes that conversation is a neutral place "in which equal rights of speakership are often assumed" and is thus incompatible with any type of critical analysis. He suggests for example that CA's stricture to stay tied to participant orientations precludes analysis of gender issues unless specifically oriented to by participants themselves. Wetherell concurs, "The trouble with conversation analysts is that they rarely raise their eyes from the next turn in the conversation" (Wetherell, 1998, p. 402). Thus the on-going divide between practitioners of CDA and CA positions one as a pedantic, overly technical and sterile exercise, devoid of critical thinking and the other as imposing pre-existing political theories on the data in a profligate manner.

Feminist scholars such as Elizabeth Stokoe and Celia Kitzinger argue that CA is highly compatible with feminisms concern for representing women's own understandings of the world. Stokoe suggests that CA shares constructionist approaches interest in illuminating participant orientations to 'doing' gender. CA helps to move away from essentialist notions of gender and "the ideological assumptions of the analyst and shift towards a focus on members' common sense knowledge about gender" (Stokoe, 2000, p. 560). Kitzinger argues that CA can illuminate the unspoken as well as the spoken:

> …it would be unbearably limiting to use CA if it meant that I could only describe as 'sexist' or 'heterosexist' or 'racist' those forms of talk to which actors orient as such. Indeed it is *precisely the fact that sexist,*

heterosexist and racist assumptions are routinely incorporated into every-day conversations without anyone noticing or responding to them that way which is of interest to me. (Kitzinger, 2000, p. 171, italics in original)

She argues that CAs concern with the small details of talk is valid because:

these apparently tiny and insignificant details *are relevant to the participants* in the conversation, and systematically affect what they do next, and how they do it. If we want to understand what people are saying to one another [...] we [...] *have to attend to their talk at the same level of detail as they do.* (Kitzinger, 2000, p.173)

Holstein and Gubrium (2011) urge a respect for and differentiation between the two enterprises, while at the same time recognising the limitations of each. They suggest that both are necessary and run on parallel paths, with one elaborating the historical contingencies and the other the real time processes by which social actions are rendered visible. For one 'context' means the historical social setting in which talk takes place, for the other 'context' is limited to the preceding turn or sequence. Neither are interested in generating explanatory theories, the 'why' if you like, but both are concerned with describing how explanatory theories in use (e.g. why does psychosis happen?) might come into being and "documenting the practiced stuff of such realities" (Holstein and Gubrium 2011, p. 345). They suggest that the origins of CA contained this important balance between the 'hows' and the 'whats' of social interaction which has got lost as Conversation Analysts, "...have increasingly restricted their investigations to the relation between social practices and the immediate accounts of those practices" (Holstein and Gubrium, 2011, p. 344).

They suggest that:

> Sacks in particular understood culture to be a matter of practice, something that served as a resource for discerning the possible linkages of utterances and exchanges. (Holstein and Gubrium, 2011, p. 343)

My solution to this problem is to follow Holstein and Gubrium's lead and return to Sacks' method of studying cultural resources through MCA.

Summary

The main criticism of CA then is that it has become so technical that it can't see the wood for the trees. The key debate is in the definition of what constitutes 'context' and how it is accounted for, with some authors suggesting that CA has defined context so narrowly that it obscures vital resources relevant to its understanding. The problem is in how to analyse these discursive resources without imposing the researchers pre-conceived ideas. One solution is MCA. Before elaborating the discipline of MCA, in the following section the difference between CA and Applied CA is discussed.

Applied CA

In this study I do not claim to add to the body of knowledge that pure CA is amassing. Instead I utilise the existing knowledge produced by CA scholars and *apply* it to my particular field to see what knowledge can be produced which may be of use to the systemic discipline.

There is now a growing field of Applied CA which is concerned with how day to day conversational practices are put to use to achieve institutional aims. Heritage suggests three main features of institutional talk:

1) Institutional interaction normally involves participants in specific goal orientations which are tied to their institution relevant identities: ...

2) Institutional interaction involves special constraints on what will be treated as allowable contributions to the business at hand.

3) Institutional talk is associated with inferential frameworks and procedures that are particular to specific institutional contexts. (Heritage, 1997, p. 163-4)

Certain institutional settings have been more widely researched, for example, medical settings (Maynard and Heritage, 2005; Heritage and Maynard, 2006; Heritage and Sefi, 1992; Stivers, 2005), news interviews (Clayman, 1988, 1992), and mediation sessions (Garcia, 1991; Greatbatch and Dingwall, 1997; Stokoe, 2013). However, until recently, psychotherapy has been largely overlooked in the CA literature (Peräkylä *et al.*, 2008). CA takes an agnostic position towards espoused theories of change in therapy, its focus being on 'why that now?' rather than 'does this work?' Its unique contribution to therapy process research lies in its attention to detail which shines a light on how therapists and clients deal with interactional dilemmas that the broader beam of theory fails to illuminate. CA's great strength is in describing how mundane conversational practices are harnessed in the pursuit of institutional ends and how theory is accomplished in practice. For example, in his study of systemic approaches to HIV counselling Peräkylä showed not only that practitioners did achieve the interactional consequences that their theory claimed, it also demonstrated that:

…the counsellors' own practice is even more sophisticated than their theory: in a most systematic way they prepare their clients for hypothetical questions concerning the future, through careful means of topic elicitation and topic development. (Peräkylä, 1995, p. 333).

He then suggests a useful application of these findings, "The importance of this preparatory work could possibly be given specific attention in the teaching of counselling skills", (Peräkylä 1995, p. 333)

Silverman in another study of HIV counselling perturbs the conventional understanding of empathy as the skill of the counsellor to attune to the patients feelings, but instead demonstrates empathy to be an interactional achievement:

> The skills of the counsellors we have examined in these extracts are not primarily based on owning a special (professional) body of knowledge. Instead, such skills depend upon the apparatus of description that is publicly available to everyone – including clients… (Silverman, 1997, p. 221)

He goes on to say, "The distinctive character of counselling arises in the systematic deployment of this apparatus in encouraging the client to talk", (Silverman 1997, p. 221).

Silverman argues that it is less useful to think about good and bad counselling practice and more useful to think about the *functions* of communication sequences in a particular institutional context, thus bringing to light both the unacknowledged skills of practitioners as well as the unintended consequences of their actions. Antaki's (2008) elaboration of the different practices therapists use to formulate clients talk is a good example of this. He shows how therapists use formulation in such a way as to ostensibly merely paraphrase the client's previous utterance but in fact subtly shift the meaning towards their institutional ends. This work elucidates how even the most collaborative of therapists will inevitably delete, select and transform clients' accounts in the routine interactional management of the session, thus bringing to light the way therapists influence talk towards their own agenda. McMartin (2008) shows the other side of the

coin in her work on clients' *resistance* to therapists' aims, through the examination of the receipt of 'optimistic questions' in narrative and solution focussed therapies. She shows how the day to day management of both troubles talk and praise pose interactional dilemmas for narrative and solution focussed therapists whose optimistic questions can be oriented to by clients as either missing the point or an invitation for self-aggrandisement.

CA studies show that participants routinely orient to a medical consultation in a systematic way. These insights have been useful in training in medical practice (Maynard and Heritage, 2005). Psychotherapy is a far more diverse field than medicine and thus less likely to show systematic patterns of orientation. However, the studies described above, and others, begin to add to our understanding of how practices central to different therapeutic models get done. Thus we can see how *applied* CA renders the institutional context visible in situated talk in a way that pure CA does not. Furthermore, applied CA is highly relevant to the examination of how therapists and family members use mundane interactional practices to offer and resist blaming accounts.

Stocks of interactional knowledge

Peräkylä and Vehviläinen (2003, p. 729) suggest that the knowledge base of many professions is made of "normative models and theories or quasi-theories about interaction". These norms and theories are disseminated in texts, through teaching and supervision. They term these theories and norms Stocks of Interactional Knowledge (SIKs). In family therapy for instance we have SIKs such as circular questioning or externalising, which describe certain interactional practices and locate those practices within particular theoretical frameworks. SIKs are concerned with explaining, legitimising or opposing existing practices. In contrast CA is concerned with uncovering regularities in interaction. CA researchers have had little interest in practitioners' own theories, while "practitioners view their practice and their own actions through and in terms of them", (Peräkylä

and Vehviläinen, 2003, p. 728). Thus CA findings tend not to resonate with the professional groups they study. Peräkylä and Vehviläinen call for a dialogue between CA researchers and professionals. They suggest that:

> CA has a *critical task* in pointing out the simplified or empirically unsustainable assumptions of the SIKs. However, it also has a *complementary task* in providing more detailed or concrete descriptions of known practices and in showing new practices or functions. Accomplishing these tasks does not compromise the strictly empirical stance of CA studies, but it may be vital for the wider social relevance of the CA enterprise. (Peräkylä and Vehviläinen, 2003, p. 747)

Thus Peräkylä neatly sums up the purpose of this study; to critically examine and provide a detailed description of how we put one element of our systemic SIKs into practice, the practice of managing blame.

Summary

Applied CA is a linked but distinct discipline which is concerned with showing how those generic practices uncovered by pure CA work in institutional contexts. It renders visible the way institutional aims are accomplished in situated talk and, as Peräkylä suggests it is particularly relevant to the study of psychotherapy processes. In this study I use not only sequential analysis but also Membership Categorization Analysis.

Membership Categorisation Analysis

Within the CA field there is a growing interest in reviving the discipline of MCA as a means of analysing how socio-cultural knowledge can be accounted for in talk in interaction (Stokoe, 2012). Sacks was interested in understanding the interactional rules through which culture is both generated and recognised. He developed two interrelated methods of analysis, sequential analysis and membership categorization analysis. The

former has been widely taken up and dominates contemporary CA, while MCA has been largely overlooked. Where sequential analysis is concerned with the structuring and organisation of talk in interaction into systems whereby participants manage such things as turn taking and repair, MCA focuses on taken for granted knowledge of the world, especially the practices by which people and their actions are evaluated. Like sequential analysis MCA is concerned with the *underlying rules* which allow us to understand one another. Its concern is with uncovering the *generic practices* that are embedded in, and by which people mobilise, shared knowledge and the common sense workings of society.

> MCA gives researchers with a primary interest in topical [...], rather than sequential issues an empirically tractable method for studying those issues, as members', rather than analysts' categories. (Stokoe, 2012, p.278)

In the following section, I will briefly sketch the main analytic concepts that have informed this research in order to enable a critical reading of the analysis.

Membership categorisation device

A MCD is a "collection of categories for referring to persons, with some rules of application" (Sacks, 1995, Vol.1, p. 238). The MCD then is the apparatus by which categories are understood to belong to a collection. For instance 'family', includes the categories mother, father, child etc. Within devices, various rules of application (below) are utilised to achieve different categorial tasks.

Standard relational pair (SRP).

Common sense understandings of the category collection set up expectations of member categories in relation to each other, so within the device 'family', SRPs such as husband/wife, mother/child occur which

describe *normative* relationships. By invoking such pairs the speaker draws on culturally shared inferences about the obligations and rights of each member with *associated expected actions,* otherwise known as category bound activities.

Category bound activities (CBA).

A CBA is any activity linked in situ to a category. An activity such as 'feeding' is a CBA that could be linked to a variety of member categories such as mother, zoo keeper, pet owner, farmer. For the purposes of this explanation let's choose two, those of mother and pet owner. Each of these belongs to a SRP, mother/child and owner/pet. Marion is a mother who has a baby called Katherine (nicknamed Kitty), and a kitten Tabatha (also referred to as Kitty). Yes it's laboured but bear with me. If someone said "Marion is feeding Kitty" both SRP's mother/child and owner/pet are relevant, the recipient of the food would remain uncertain and we may need to ask for clarification which Kitty is Marion feeding? Imagine though that we are told "Marion is breastfeeding." We automatically assume that the baby is being fed. 'Breastfeeding' is a CBA linked pretty exclusively to the category 'mother' and the SRP mother/child. It is not linked to the SRP owner/pet. Were we to discover that Marion was breastfeeding the kitten, we would make certain assumptions about her actions which might be regarding her motives (to shock) or her character (she's eccentric) or her mental health (she's delusional). In any case such actions, which transgress a social norm, will be an accountable matter and will lead us to infer certain attributes, otherwise known as category bound predicates.

Category bound predicates. (CBP)

Cuff (1993) developed Sacks work to show how members actively create and modify different versions of SRPs to achieve different actions. So, interactants use common understandings of different categories in order to negotiate what *type* of member one is, a *good* mother, or an *eccentric* cat owner. However, it is important not to confuse all attributes with CBPs.

Only if the attribute is part of a category in use is it a CBP. In other words it is the action to which an attribute is put that makes it a CBP. For example, Marion is also fair haired but this attribute is irrelevant to the particular CBA in use, that of feeding and the member categories it evokes.

CBAs and CBPs feature strongly in the analysis that follows.

Duplicative organisation

This refers to categories that work together in a team like way, for instance a football team.

> The categories in such collections in such MCDs may have, as a feature, numerical restrictions such as 'no more than one goalie at a time,' or 'no more than one husband/ wife at a time'. If the numerical restriction is met, categorizing several persons with categories from such an MCD is likely to be heard as treating them as co-incumbents of the same team; that is, referring to 'the father, the mother, the son and the daughter' will be heard as referring to the members of the same family, not the father from one family and the son from another. (Schegloff, 2007, p. 468)

The economy rule

While any person can be a member of innumerable categories, at the core of competent talk is the capacity to apply only those categories that are necessary to achieve the task at hand and to combine categories in recognisable ways. Often a single category is sufficient. Marion is a mother, a cat owner, and the CEO of a multi-national company. 'Breastfeeding' will clearly imply that the relevant member category is mother while 'attending a shareholders meeting' will evoke her role as a CEO. The important point here is that if one member category is enough, when two or more are used, then why?

The consistency rule

If two or more categories are used next to each other and they belong to a standard collection such as family then they are heard as coming from the same device. Imagine I am introducing myself in a workshop, the first 3 participants introduce themselves as a psychologist, a teacher and a social worker, would I introduce myself as a wife or a therapist? If I describe myself as a wife, what inferences might the others make about me? In this instance the collection in use is profession. In a carers meeting however, the member categories wife, sister, husband etc. would *not* follow the duplicative organisation rule, but the consistency rule because the collection in use would be 'carers' *not* 'family' and the collection 'carers' does not have a team like character.

Hearer's maxims.

These can be understood as the consequences of the rules of application in the form of instructions for hearing a category term used by another and which of the alternative ways of hearing should be oriented to. The hearer's maxim for the above then is:

> …if two or more categories are used to categorize two or more members of some population, and those categories can be heard as categories from the same collection, then: hear them that way. (Stokoe, 2012, p. 281)

Disjunctive categories

Jayussi's (1984) work on disjunctive categories builds on Cuffs work to elucidate how the practices of categorization underpin the construction of the moral order. When two categories are in use, such as in 'breastfeeding at the shareholders meeting' Marion's moral accountability would be in question *because this behaviour is not the norm* and because member categories are *hierarchically arranged* in different contexts. "Asymmetric category pairings … generate conflicting characterizations of the same

person (Lepper, 2000, p. 36). Remember the economy rule, because two categories are referred to we need to ask what action is being performed. Which member category is invoked will imply different category bound predicates. In this scenario we can imagine a feminist argument drawing on the member categories 'mother' and 'woman' to construct Marion's identity as a *good* mother and equal rights *activist*. Others might draw on the normative behaviours of the category 'CEO' and construct the identity of a CEO who is at best 'distracted' or 'lacks judgement' and should be putting the needs of the company before her baby. Disjunctive categories can be (and are) deployed to infer and resist blame. Member categories are 'inference rich' and store "a great deal of the knowledge that members of society have about the society" (Sacks, 1992, p. 41). Categories can be implied, inferred, resisted and denied by mentioning category incumbent features. This makes their use flexible and ambiguous. It is their very ambiguity which enables interactants to test out how inferences might be received and pursue or abandon certain actions.

Summary

MCDs are central to analysing how members make sense of one another by drawing on common sense knowledge of what people are like and how they behave. They are the rules by which inferences are managed and utterances understood and, like CA, are both context dependent and context renewing.

Critique of MCA

Sacks work on Membership Categorisation has not been taken up by scholars in the same way as sequential analysis, largely because of the perceived ambiguity of member categories which has led MCA to be seen as too interpretive:

> It is because multiple MCDs are available with their multiplicity of categories that relevance is the issue, and how categories and their

MCDs become relevantly oriented to becomes a key topic for inquiry. (Schegloff, 2007, p. 475)

Schegloff points to the problem that categories are repositories of social knowledge and will therefore be 'obvious' to the researcher, but:

The 'obviousness' of it is not the investigator's resource, but the investigator's problem. […]. It can thereby become a vehicle for promiscuously introducing into the analysis what the writing needs for the argument-in-progress. To avoid this, there must be analysis to show the claim is grounded in the conduct of the parties, not in the beliefs of the writer. (Schegloff, 2007, p. 476)

Thus the arguments against MCA resemble those against DA. An additional difficulty is where sequential analysis has developed a large corpus of empirical findings, the MCA corpus is less sophisticated, leading Schegloff (2007) to argue that its lack of development precludes its incorporation within current CA practice. Stokoe (2012) argues that the fact MCA has been neglected does not mean that it should continue to be so. She calls for a revival of the method within (or without) the CA community with a view to building a corpus of MCA principles to complement existing CA work. Fitzgerald (2012) warns against MCA following this corpus building route and suggests MCA's relative simplicity is its strength. Whitehead (2012, p. 338) suggests that Stokoe "somewhat underplays the extent to which recent conversation analytic work has attended to categorial matters", and cites a range of CA practitioners who have successfully incorporated the two.

What MCA offers is the discipline of tying the categories in use to the empirical data *as far as members practices allow*. Stokoe suggests it is not the job of the analyst to be more specific about categorization practices than the members themselves and it is the very inference richness of

categories that gives them their defeasability. What MCA does offer is a set of practices which orient the researcher to the way *these* participants use categories in interaction. Schegloff for instance draws our attention to the temptation for the researcher to see any attribute as a category in use:

…parties to talk-in-interaction can and do discriminate between attributes and categories, so analysts should not simply treat the former as virtually doing the latter. (Schegloff, 2007, p. 482)

Whitehead agrees with Schegloff's pursuit of empirically grounded analysis but argues that the on-going debate endangers the research itself:

I am not overly concerned about whether my contributions are characterized as exemplifying a CA or MCA approach, or both. I am concerned, however, with whether my work is faithful to the empirical details of the data on which it is based, and whether it makes a contribution to the understanding of social organisation broadly, and the social categories and talk-in-interaction in particular. (Whitehead, 2012, p. 341)

Fitzgerald celebrates both CA and MCA as *"aids to a sluggish imagination* which produce 'reflections through which the strangeness of the world can be detected' (Garfinkel, 1992, quoted in Fitzgerald, 2012, p. 308). It is this pragmatic position that I assume. As a relatively novice researcher I could spend years reading competing claims for the superiority of one method over another by scholars far more knowledgeable than I. CA appeals to me because its discipline is indeed an aid to my sluggish imagination, but, as an anxious soul, keen to do things correctly I could lose my way by getting *too* caught up in identifying formal features of talk. MCA adds an additional layer by examining taken for granted knowledge. Its relative simplicity offers flexibility to examine identity work but also retains that discipline of participant orientation which, for me, helps to make the familiar strange. Also, as a systemic therapist, how could I resist testing Lepper's claim that the application of MCA coupled with the sequential

analysis of CA, offers a unique contribution in recognising that "*the phenomenon we are dealing with -context- is neither structure nor process, but both*" (Lepper, 2000, p. 58, italics in original).

Summary

I have argued that one of the reasons that it is difficult to research blame as an objective phenomenon is because its production and meaning is tied inextricably to its social context. Rather than de-contextualise the phenomenon of blame, I have therefore turned to a form of research which conceptualises subject and object as inextricably linked. Discourse analysis, like contemporary systemic theories, has turned to language as a key medium through which social actions are performed and social institutions co-constructed. This mutual concern with language makes for a good fit with the field of family therapy process research. There are many and various forms of Discourse Analysis which broadly fit within two camps (although many have a foot in both). Some forms of Discourse Analysis focus more on wider historical processes and the production of power relationships; others take a narrower focus and examine the local practices of talk in interaction through which social actors co-construct social institutions. It is this latter tradition that best fits my question, and I have turned to a form of analysis that sits within an ethnomethodological frame.

So, I locate this study in the realm of therapy process research, using the discourse research methods of Applied CA and MCA. I have summarised the key analytical procedures that I used in the analysis of the therapy sessions. I argue that this choice of methods offers a way of getting at *this* question in a way that I hope will illuminate something of interest in *this* data.

Part 2 – The Design of the study

Introduction

This section concerns how the research questions, the review of the literature and the methodological considerations combine into a specific design for the study. The recruitment and selection of participants, the collection and transcription of recordings of therapy sessions and the selection of data for analysis are described. Issues of ethics and reflexivity are discussed. Finally, the aims of the study are summarised to provide the context for Chapters 4 and 5, in which the results of the analysis are described.

The research site and participants

The research site was chosen because of its reputation as a service specialising in work with families affected by psychosis. The therapists adhered to a model of family work that combined systemic and family management elements.

Therapists

I recruited three experienced systemic therapists working with families accepted for systemic therapy where the experience of living with psychosis was part of the reason for referral. Only two of the three therapy teams successfully recruited families willing to be included in the research which I have called Therapy 1 and Therapy 2.

Each therapy was delivered by a separate team of therapists, each team comprising one qualified systemic psychotherapist and one other therapist. The other therapists are adult mental health professionals who have undergone a minimum of one year's additional training in a method designed for working with families affected by psychosis, incorporating systemic and family management theories and accredited by the Association for Family Therapy. In both Therapy 1 and Therapy 2, T1

denotes the qualified systemic psychotherapist and T2 the allied mental health professional.

Families

'Family' means more than one adult engaged in the therapy, but could include any combination of family members or members of the referred persons' close network. Because the sample is small I did not prioritise attempts to represent difference. Both families who participated in the research are couples, each couple including one person with lived experience of psychosis. For reasons of confidentiality names and possible identifying factors have been changed, although the salient features, such as caring for dependent children or not, have been retained. For example, in Therapy 2, Mandy has a number of psychiatric diagnoses, the particular combination of which may reveal her identity to those involved in her care. For this reason I have omitted a detailed description of the diagnoses of both Janet and Mandy but have retained those that are pertinent to the research question. My rationale for this is that these diagnoses carry with them taken for granted knowledge that is used by participants to produce social actions within the texts analysed.

Therapy 1

The couple are Janet and her husband Steven. Janet has a diagnosis of bi-polar affective disorder and she has a history of recurrent psychotic episodes and hospital admissions. Steven is in paid employment. Janet has been in paid employment most of her adult life but in the last three years has not.

Therapy 2

The couple Mandy and her husband Kevin have been referred for family work following Mandy's most recent psychotic episode. Mandy has gathered a number of diagnoses over the years, one of which is

schizophrenia. Kevin describes himself as Mandy's main carer. They have a number of school aged children.

Ethical issues

I was aware that for families, knowing that the therapy would be taped and examined might increase their anxieties. On the other hand, it is part of common practice in many family therapy teams to tape family therapy sessions for clinical, research and training purposes. In this sense, I was confident that the therapists would be familiar with and sensitive to the ethical issues involved when gaining consent for taping. In addition, I met with the therapists to talk through with them the particular issues concerned with recruitment of families for research purposes and ensured that they felt confident to address these with the families they recruited. For example, ensuring families were aware that their refusal would not in any way affect the service they would be given. I was also conscious that the follow up interview could segue into unforeseen, potentially painful areas (Hollway and Jefferson, 2000) and therefore arranged that families could be referred back to the therapy team if they wished. As well as potential harm to participants it is equally important to consider the potential benefits. Procter and Padfield (1998) found that research participants on the whole found their experience enjoyable because they believed the subject to be worthwhile and also they enjoyed the opportunity to talk to a genuinely interested audience. This certainly appeared to be the case with the family that I did interview. The change in design of the study (see Appendix A) raised a further ethical issue for me. How could I do justice to the family who offered the follow up interview? It seems important that the interview is represented in the thesis, despite the change in design.

For therapists, issues of anonymity are equally important. Although systemic therapy is a much more public endeavour than many therapies due to our routine use of teams, screens and recording equipment, the intense

scrutiny of a researcher may leave the therapist feeling exposed and open to criticism. As a therapist engaged in a large research trial myself I sometimes wonder what researchers will make of the recordings of my own work and if I will be found wanting. It is the very gap between what our theories say we should do and how we actually manage the cut and thrust of the real therapy encounter that I am interested in. My aim in this study is to uncover the local logic of talk, not judge whether it is good or bad. However neutral I intend my analysis to be however, I am well aware that my observations might be received by participants as critical or just plain wrong. On the other hand, one of the great strengths of our training is that we become familiar with watching ourselves and others in practice and discussing alternative perspectives as an integral part of our work. Thus I believe that the therapists who participated were able to make an informed judgement about the risks they exposed themselves to, and I am grateful to them, and to the families who participated.

Informed consent

All respondents were given a written explanation including the process and purpose of the research and the limits of confidentiality (Appendix B[3]). They were informed that they could withdraw from the research at any time. Written consent for the taping and transcription of therapy sessions, follow up interviews plus possible future publication was obtained.

Ethical approval

The therapies were carried out within the NHS and the study was rigorously examined and ratified by the relevant national and local ethics committees to ensure that informed consent, information security and safety issues were paramount. (Appendix F)

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[3]   I have omitted any reference to the location of the study, including the location of the REC and NHS Trust logos, to protect the anonymity of the participants.

Data collection and analysis

Therapists made audio recordings of all therapy sessions with families. I wanted the therapy to be as naturalistic as possible and therefore asked the therapists to work according to their usual practice. Four sessions in all were recorded, the first two sessions from each family. Both families ended therapy after two sessions. One family agreed to a follow up interview which I audio recorded. All tapes were transcribed following a modified version of CA conventions based on those initially developed by Jefferson (2004) (Appendix E). Influenced by Stancombe (2002) I subjected each transcript of the therapy sessions to an initial turn by turn analysis, coding turns as potentially blaming, mitigating or exonerating as follows:

- Explicitly blaming – unambiguously allocating responsibility for a negative event.

- Potentially blaming – referring to a negative event with some causal implications.

- Mitigating - implying some responsibility for a negative event but with extenuating circumstances.

- Exonerating – implying a causal relationship to a negative event but with no responsibility, or fault, implied.

I was highly inclusive with these codes, many of which overlapped. For instance one turn might be coded as both blaming *and* mitigating, eg. (*we:ll Kevin Kevin is stressed with me (1) and right (1) he's stressed with the ho:use and stuff but he just wont ↑say it and it makes me cross cos I I ↑know he i:s*) (Therapy 2 lines 247-249). Here fault can be seen to be attributed to Kevin for not admitting stress, but mitigation may be implied due to the speaker claiming to be the cause of his stress. If blame could be read as implied in Turn 1, but not responded to as such in Turn 2, then Turn 1 would be coded as potential blame. This initial coding helped me to begin to see the range of potentially blaming turns, some very subtle as well as the numerous different ways that they could be taken up. The sequences I

had identified as explicitly blaming or potentially blaming were then independently reviewed by peer researchers. There was strong agreement in identifying explicit blaming sequences while the potentially blaming sequences were open to debate and different interpretations.

I then selected one sequence from each therapy that was unanimously identified by peer researchers as explicitly blaming. Both these sequences occurred in the second therapy session. I subjected the transcripts from both these sessions to further analysis, influenced by ten Have's (2007) suggested model. This involved tracking back through the transcript of the entire session to identify the sequential processes within which these 'blamings' were nested. I worked through the transcripts in terms of the four interlocking procedures of turn-taking organisation, sequence organisation, repair organisation and the organisation of turn-design. I then used another layer of analysis, Membership Categorisation Analysis to explore how therapists and family members utilise socio-cultural knowledge to ascribe identity categories in the achievement and resistance of blaming.

The research falls in the tradition of a single case analysis, in this instance a comparison of two cases. Single case analysis in CA has a long legacy following Sacks (1992) original lectures. It involves examining a single conversation or section of one in order to track in detail the various conversational strategies which inform and drive its production. The advantage of a single case analysis is that it can show the development of a piece of social action as it develops over a series of turns and sequences of turns (Sacks 1979; Schegloff, 1987, 1988, 1992; Hutchby and Wooffitt, 1998; Antaki and Horowitz, 2000; Antaki *et al.*, 2004). I have come to think of this as akin to an archaeological process, digging down from the blaming event to uncover more and more layers of context and meaning.

Reflexivity and self-reflexivity

One of the dangers of trying to build theory from the analysis of micro processes is that the very activity of looking for the phenomena to be studied will increase the likelihood of finding them (Seigfried, 1995). Byng Hall suggests that "A theory can be a story to oneself wrapped up in a story to others", (Byng Hall, 1998, p. 136). My personal stories about blame as well as my training as a systemic therapist inevitably influence what I see. My job as a researcher is to make my thinking and practice transparent and open to challenge. I have been drawn to the discipline of CA as a means of helping me to get beyond my immediate assumptions through rigorous attention to empirical data. This process in itself can reveal some of the tacit assumptions, both helpful and unhelpful, that I may share with others of my profession. Nevertheless, we can never be free of preconceptions, and to help me to become aware of and challenge my inevitable biases I used colleagues in the research community at the Tavistock Clinic to help me review my work at frequent intervals. The most powerful tool available to qualitative researchers however is to make our work as transparent as possible, and in Chapters 4 and 5 readers can judge the validity of my findings for themselves.

Summary of the aims and design of the study.

Sacks has shown how in ordinary conversation participants are concerned with presenting themselves as ordinary people doing whatever we would expect ordinary people to do. When people breach these norms they are held accountable, and if their account fails to fit a local evaluation of reasonableness then other inferences can be made, such as incompetence or intentional malice. Blame is an important tool in the construction and maintenance of moral order.

Arguably, families come to therapy when they have failed to negotiate what constitutes reasonable behaviour, or at least failed to find a way to live with their differences. In therapy we can expect couples who are

presenting with difficulties to produce different descriptions of events in such a way as to persuade the hearer to different moral evaluations of the same event, presenting themselves and others as reasonable or not according to their particular interactional task at the time. Participants are highly attuned to perceptions of their moral standing. The problem is that to preserve one's own moral standing in a dispute often involves ascribing blame to the other, thus threatening their moral standing which they will work hard to defend. Participants in therapy, in common with members of any social institution, have to maintain relationships in order for the conversation to continue, and for relationships to be maintained, they have to find ways of keeping the conversation going. The following analysis examines how this is achieved in practice.

Systemic therapists, whose job is to help people successfully negotiate their relationships in one way or another, approach blame with caution. However, as ordinary conversationalists we have a wide range of strategies with which to achieve blaming without resorting to explicit accusation with its concomitant danger of conflict and communication breakdown. The flexibility of our conversational procedures enables us to attribute or avert blame in a myriad of more or less subtle ways, to check if someone is willing to listen, to hint, to withdraw an inference if the context feels hostile, to avoid answering, to change the topic or to counter attack. Conversations flexibility also means that our intentions are always open to differing interpretations and interactional problems often occur. Often, subtle inferences of blame are readable only within the context of the relationship, and innocent comments may be read as blame because people are speaking and listening from different contexts. It is in how participants take up a comment that they display how they have interpreted what has been said. Two therapy sessions have been selected, each containing a blaming event. Each session has then been subjected to a turn by turn analysis using CA and MCA. The analysis shows the co-production of a context where the blaming event in question is made

relevant. What is constituted as *reasonable* blame is shown to be a local matter, co-constructed through talk-in-interaction.

The data analysis.

In CA, as in systemic therapy, interactional problems can be seen as the result of interactional solutions that members have locally produced. In the following two chapters I show how CA and MCA illuminate how explicit blame is prompted by a recurring misalignment between different parties about the legitimacy of a particular topic and how it should be resolved. Explicit blame then can be seen as a solution to an interactional problem whose particular meaning can only be understood within its local context. I will also show how a set of linked sequences from a single session can also be seen as part of a set of sequences that link conversations beyond the boundaries of the session between the couples and their social networks.

Chapter 4

Introduction

This is the first of two chapters presenting the results of the analysis. Each chapter examines the construction of a blaming event in the second session of two separate therapies, Therapy 1 in Chapter 4 and Therapy 2 in Chapter 5. The presentation of the material follows a similar format in each chapter. Both chapters are divided into three parts, each part concerned with an excerpt of transcript selected from a different stage of the therapy session concerned. These excerpts are then divided into a number of smaller segments, interspersed with the analysis and commentary. This is to enable the reader to follow the detail of the analysis more easily. For example, Part 1 of this chapter contains a single excerpt of transcript which begins 12 minutes into the session. The excerpt is presented in 5 sections, each section following directly from the previous one, with no turns omitted unless otherwise stated. Part 2 contains an excerpt beginning twenty seven minutes into the session, divided into 4 sections and so on. The original line numbering of the entire transcript has been retained to orient the reader to the place of each section in relation the whole. The selected excerpts of transcript are presented in their entirety in Appendix C.

Where extracts from the sections are included as part of the commentary itself, the number in brackets refers to the line number in the transcript, eg. (*how you live your life*)(111). Very occasionally, line numbers are omitted where they do not appear to contribute to the orientation of the reader to the part of the transcript being discussed.

In this chapter, Part 1 shows how an unresolved misalignment of goals between participants creates a context for an explicit blaming later in the session. Part 2 demonstrates how the blaming event unfolds and can be understood as an attempted solution to the problems set up by the earlier misalignment. In Part 3 a third, brief sequence from the final stages of the

session shows that the misalignment is related to a disagreement about the goals and tasks of therapy that precedes the therapy session itself.

The Therapy Context

The family

The couple are Janet and her husband Steven. Janet has a diagnosis of bi-polar affective disorder and she has a history of recurrent psychotic episodes and hospital admissions. Steven is in full time paid employment. Janet has worked most of her adult life but in the last three years has been unemployed.

The therapists

T1 is an experienced, qualified systemic psychotherapist. T2 is a mental health professional who has also completed a minimum of one year's specialist family therapy for psychosis training. T1 is male, T2 female.

The context of the data selected.

The excerpt begins about twelve minutes into the second therapy session. Present are two therapists T1 and T2, and the couple. In the initial meeting (not included), the therapists gathered information about the couple, their family, the history of Janet's difficulties and current circumstances. There has been a gap of several weeks between this session and the first, during which Janet has experienced another psychotic episode. The initial part of this session is taken up with talking about what Janet and Steven noticed triggered the episode and what helped Janet to recover. The conversation has flowed smoothly, with all participants seemingly aligned to the task of elucidating factors that helped Janet to notice her symptoms quickly and take action to prevent hospital admission. In systemic terms the therapists could be described as having been engaged in the task of thickening stories of strength, resilience and agency regarding her speedy recovery.

Part 1

The construction of an interactional problem

The analysis begins with a detailed examination of the very first sequence[4], lines 111 to 116. I will argue that these initial two turns form the basis for a misalignment between the interactional tasks of the participants. This misalignment encompasses a key recurring theme which links sequences over the course of the therapy which builds to create a local context in which an explicit blaming event takes place.

Accounting for 'not going back'

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111   T1   So have you adjusted what you d:o during the da:y or how you live your life as
112        part of this (.) process of getting better?
113   J    Well I did go voluntary today I done one day today I thought I'd go and see
114        how I get on (.) and I was just basically walking around a furniture shop
115        with a can of ha ha u(h)m (.) ↑cleaner (.) n I thought this int me (.) I'm
116        worth a bit more than this (.) so I'm not goin ↓back.
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T1's question introduces the topic of how Janet takes responsibility for her own recovery (line 111). Conversation analysts have examined the constraining nature of such pre-suppositional questions in different institutional contexts such as the courtroom (Drew 1992), news interviews (Clayman, 1992, 1998) and counselling and therapy (Peräkylä, 1995; MacMartin, 2008). Their rhetorical force depends upon the implication of the embedded proposition, in this case that to adjust what you do during the day or how you live your life *is* part of a process of getting better. Within this lies an implication that not to do so would be accountable and

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[4]   The beginning of a sequence in CA is marked by a turn in which one of the participants initiates an action which is taken up by recipients. Its end is marked by the place where participants are no longer responding to that action. Different CA practitioners use the term sequence differently with some limiting it to the smallest possible sequence, an Adjacency Pair, while others incorporate lengthier segments of talk and topic sequences (ten Have 2007). I will draw on both meanings during the course of the analysis, but here I am referring to a question and answer adjacency pair.

as such invites (or in CA terms 'projects') agreement. The accounts literature uses the term 'account' in different ways. Following Antaki (1994) I am using the term to include any explanations called forth by the hearer's interpretation of the previous turn to *require* some form of explanation. Janet's response (lines 113-116) is delivered in a dispreferred turn shape which shows that she has understood the implication and that her decision not to go back requires justification. There are a number of features that mark Janet's awareness of the potential interactional trouble her response may elicit. She opens her response with 'Well', a preface often used to signal a dispreferred response or disagreement (Pomerantz, 1984). She aligns with T1's invitation to describe how she has adjusted what she does during the day (*I did go voluntary[5] today*) (113) and then provides an account to justify her decision not to return. Atkinson and Drew (1979) in their study of court procedures show that accounts justifying subsequent events are often found as a defence after a perception of failure to take action. Her account is peppered with hesitation and laughter tokens frequently associated with marking a turn as dispreferred.

Membership category devices- What kind of person doesn't go back?

MCA helps us to understand the moral implications contained in this question answer sequence. Member categories serve as the repositories of social knowledge upon which we draw to describe people and their actions. These are combined with rules of application in what Sacks (1992) terms Membership Categorization Devices (MCDs). Just prior to this sequence, participants have been discussing a recent psychotic episode and what has helped Janet to recover. The MCD in use is 'illness' and more specifically 'mental illness'. T1 then introduces two alternative versions of the Category Bound Activity (CBA) 'getting better'. The first, 'adjusting what you do during the day' is an expectable activity for anyone who has been ill, in order to meet social obligations to do their best to recover. His

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[5] "Voluntary" is heard as voluntary work.

subsequent upgrade of (*how you live your life*) (111) could be heard to imply a more serious and enduring category of illness of which mental illness is generally understood to belong. Patients have the right to be helped, balanced by the duty to do all in their power to get better, and the more serious the illness the more radical the lifestyle adjustment that may be required.

In Janet's response (*Well I did go voluntary today I done one day today I thought I'd go and see how I get on*), the CBA 'voluntary work' is produced as a version of the CBA 'getting better'. Janet thus demonstrates how she has met her obligation as a member category 'patient' to adjust her life in order to recover. However, Janet then constructs her account for why she has chosen *not* to continue with this obligation, (*and I was just basically walking around a furniture shop with a can of ha ha u(h)m (.) ↑cleaner*)(114). This description serves to transform the CBA voluntary work from a 'process of getting better' to a process that diminishes ones sense of self-worth through activity that is neither socially valued nor generally seen as a site for developing skills and confidence. Unpaid work that fails to give either support or satisfaction is commonly seen as exploitative or demeaning. Janet validates this reading of her account by her subsequent claim (*I'm worth more than this*) (115). Thus we can see the CBA voluntary work evaluated as either *good* voluntary work (that which can be used as a process of getting better) or *bad* voluntary work (that which is exploitative or demeaning). Cuff (1993) built on Sacks work to show that Standard Relational Pairs (SRP) such as employer/employee have numerous versions available to hearers to subvert the action of the speaker. To make what is being said intelligible the SRP is not enough. Identities have to be specified further, what *kind* of employer/employee are they?

Janet's account achieves a description that presents her as a particular version of employee, one with mental illness who is willing to meet her

obligations as a patient but justified in reneging on them in this case due to the inadequacy of the work for her needs.

Thickening the story or justifying the action?

In systemic terms T1 can be seen to be continuing his project of helping Janet to thicken her story and make visible the small adjustments she has made in her life that have been helpful. The construction of the question *(have you adjusted what you d:o during the da:y or how you live your life)*(112-113) is an example of the kind of narrative practice where 'intentional state understandings of identity' (White, 2007, p.100) are highlighted; the construction of the 'agentive self' (Freedman and Coombes, 1996, p. 97). Janet's choice of response aligns with the structural properties of the question in describing such an adjustment but *misaligns with the therapists design* in that she describes a failure to adjust successfully. Rather than thicken the story of the achievement of her goals she describes her failure. Her account is designed to show that the failure is through no fault of her own, her lack of agency.

Marking trouble -What constitutes a reasonable account?

The session continues:

117	S	hhhhh well I said to Janet I said it's a confidence builder
118	T1	mm
119	S	I know she's sayin its all men there at work obviously but there's different
120		days int [there
121	J	[>yeah I ↑didn't mean it like that< (.) what I'm sayin is it was all
122		men when I went for a coffee (.) it'd be nice if there was a lady there but
123		.hhh I felt like I'm worth more than this basically you know if you like
124		↓summin don't you
125	T2	mmmm
126	T1	So you didn't feel you fitted in there very well?
127	J	↑Yeah I think I was all right but I- in myself I thought I think I'm worth a bit
128		more than this hm hm

129	T2	mhm do you think it was something to do with it jus- the first day, that they
130		thought they'd kinda give you something easy to do the first day or d'you
131		[know
132	J	[>no I just thought it weren't me< (.) what I was doin really
133	S	How would you feel if some of your mates came in n you were there cleanin
134		(.) would you get em<u>barr</u>assed by that?
135		(2)
136	S	Is that part of it?
137	J	↑No I'm just saying I- I just feel it wasn't for me. I don't think I'd like to do
138		that all the time.

Accounts do interactional work, but the work they do may be received as insufficient to their task (Buttney, 1990). An important feature of member categories is that they have associated a range of predicates which will be heard as an explanation for actions. However, hearers must find a relevant fit between the description of activities and the implied identity. If not, inferences can be made either about the action (is it good or bad, normal or abnormal) or about the speaker. For instance is the story told sufficient to the task? If not then inferences will be made about the speaker's intentions.

In the next turn, Steven's response shows both his reception of Janet's account as insufficient and that this has been discussed before (*well I said to Janet*) (117) followed by (*I know she's saying*) (119). I will return to the significance of the re-occurrence of a pre-existing conflict below, for now lets look at how the session unfolds. Steven fails to respond to Janet's claim that she is worth more than that and instead offers an alternative account for her not going back, that she feels uncomfortable with men. He introduces another version of 'getting better' by referring to the CBA of (*building confidence*) (119). 'Building confidence' within the MCD mental illness is generally associated with obligations to overcome discomfort through perseverance (think of all the self help books concerned with

feeling fear and doing it anyway). Janet's implication that the work was demeaning or exploitative, a morally worthy reason for not going back, is undermined by Steven's implication that an alternative version of the SRP employer/employee is relevant. Not bad employer/good employee but good employer/uncomfortable employee. Within the MCD gender, and social knowledge about gender relations, it might be expectable for a lone woman to feel uncomfortable in exclusively male company and Steven's (*obviously*) (119) claims this as unquestionable knowledge. The effect of Steven's response is to both contest Janet's account and offer an alternative, socially acceptable reason for her decision. However, his next utterance, (*theres different days int there*) (119-120) implies she is acting too hastily as she has not yet tested if other women *do* work there. Thus the moral weighting subtly shifts to good employer/bad employee. Janet denies this as a relevant feature with an 'agreement-prefaced disagreement' (Pomerantz, 1984). She softens her disagreement by conceding (*it'd be nice if there was a lady there*) (122) but restates her claim (*I'm worth more than this*) (123) as her reason for not going back. She then adds (*you know if you like something don't you*) (123-124). Drew and Holt (1988) show how idiomatic expressions are often positioned sequentially to summarise a complaint in an environment where the recipient's affiliation to the complaint is in doubt. The rhetorical force of maxims such as these are shown to be especially resistant to challenge as they invoke a kind of vague common knowledge, devoid of specifics that are open to question. The negative interrogative 'dont you' strongly projects an affirmative answer (Heritage, 2002). So Janet can be seen to be both resisting the force of Steven's claim and limiting further opportunities for exploration.

Pursuing alternative reasons

T1's next turn displays his alignment with Steven's search for an alternative reason to Janet's stated one. Heritage and Watson's (1979) influential work has shown how formulations serve an important role in the achievement of

institutional tasks. Their findings have been confirmed and elaborated in the study of different tasks formulations achieve in psychotherapy (Antaki, 2008). Formulations immediately follow a person's turn and ostensibly give the gist of what that person has said by selecting elements of a person's account, deleting others and presenting it as merely a summary of that person's words. In this way they limit relevant answers to either agreement (I did say that) or disagreement. By deleting Janet's reason (*I'm worth more than that*) T1 ties his formulation to her modified agreement with Steven that (*it'd be nice if there was a lady there*) and transforms it into (*So you didn't feel you fitted in there very well?*) (126). Janet resists this interpretation with another agreement prefaced disagreement, (*↑yeah, I thought I was alright*) (127) and restates (*I think I'm worth a bit more than this*). T2 then joins in the quest (lines 129-130). She embeds the suggestion that Janet has been given this task because it was her first day and wonders if (*they thought they'd kinda give you something easy to do the first day*) (130) thus aligning with Steven's 'building confidence' version of 'getting better'. Janet disagrees this time in *preferred* turn shape, thus displaying less concern for mitigating interactional trouble. Steven's next turn, a question containing an embedded suggestion *(How would you feel if some of your mates came in n you were there cleanin (.) would you get em<u>barr</u>assed by that?)* (133-134) strongly projects an affirmative answer. Janet's lack of response with a two second pause therefore displays 'trouble'. If we consider the potential implication in Steven's version of employee, one who refuses to work due to pride, we can perhaps understand Janet's lack of response as an avoidance of conflict. Her choice is to agree, thus potentially acceding to a morally dubious position, to disagree and by doing so orient to an argument (see below), or to choose not to take up her turn. Steven orients to potential conflict by mitigating his previous implication (*Is that part of it?)*(136) offering an opportunity for Janet to both agree to his version *and* offer alternatives. Janet again resists agreement but also offers a way out of incipient conflict

by offering unelaborated, formulaic responses designed to close down the topic (*I just feel it wasn't for me*)(137). Idiomatic expressions are often used to terminate a topic co-operatively as the recipient can affiliate with the idiomatic expression if not the task in hand (Drew and Holt, 1988)

The relationship between Janet and the rest of the participants is becoming increasingly marked by opposition and incipient conflict, with Janet repeatedly displaying her resistance to exploring this topic further while the rest seem concerned to work out a solution. How come?

Misalignment - Troubles telling or help seeking?

Schegloff (2006) has termed the persistent effort to maintain a particular direction as 'an interactional project'. A clue to how the participants get into this redundant pattern may relate to the participants misalignment regarding their interactional projects. Jefferson and Lee (1992) show how the preferred response to 'troubles telling' in mundane conversation is emotional reciprocity, often in the form of a story of a similar trouble by the hearer. The identities of troubles teller and troubles hearer in this context are symmetrical, in that their roles are usually interchangeable. In what Jefferson and Lee call a 'service encounter' the troubles teller and troubles hearer roles are asymmetric, with the expectations of troubles hearer (service provider) being help giving and the troubles teller as help seeking. Interactional trouble occurs when the troubles teller and troubles hearer are talking from different contexts. It was Janet who first used the CBA voluntary work as her choice of activity within the process of getting better. Her announcement that she was not going back then was heard as a problem. T1 has heard this account as 'help seeking' and it is towards this asymmetric paradigm that T1 and T2 continue to orient. Janet however seems to resist the problem solving activity that casts her into the category of help seeker.

Unhappy incident reports

Pomerantz's work into the attribution of responsibility has demonstrated that a standard way of apportioning either praise or blame:

> is with a construction in which the candidate praised/blamed party is referenced in subject position with an active predicate. That is the candidate praised/blamed party is formulated as *an actor agent performing a blameworthy/praiseworthy action.* (Pomerantz, 1978, p. 116, italics in original)

In contrast, an 'unhappy incident' is reported in such a way that the event is not linked with an actor/agent but as something that just happened and most frequently, in an unelaborated way.

> By reporting an unhappy incident as an announcement, a speaker reserves accounts of the background, setting, circumstances etc. for subsequent turns. It is in these subsequent turns that the allocation of responsibility is routinely oriented to. (Pomerantz, 1978, p. 117)

and crucially for this analysis, "Such deliveries may occasion subsequent searches for 'responsible' parties", (Pomerantz, 1978, p. 116). Furthermore these requests routinely transform them from an incident that happened to an incident that happened as a result of an action performed by someone *before* the unhappy incident occurred. Thus, "A device for allocating blame involves treating an event, eg. an 'unhappy incident' as a consequent event in a series",(Pomerantz ,1978, p. 119).

So we can see that by delivering a story of an 'unhappy incident', (*I was just basically walking around a furniture shop with a can of ha ha u(h)m (.) ↑cleaner*') Janet creates a context which *routinely* invites participants to seek who is to blame. Thus the procedural rules that underpin ordinary conversation can act as a track along which the conversation will

ordinarily run until either the conclusion made relevant by that rule is met or participants display, *and are understood to be displaying*, that this track is not taking us in the right direction. T and T2 are co-operating with the performative force of Janet's telling of an unhappy incident in their search for the responsible agent and the possible reasons for Janet *being given* the task of cleaning. This is not to imply a deterministic interpretation of conversation. The projected response is a) always open to different interpretations and b) participants can always choose to do the expected or not. Janet may have unintentionally invited an exploration of why she was given an unsuitable task, and certainly her subsequent replies indicate that she does not wish to pursue this line of enquiry, yet the others choose to pursue it. *Why* they choose to pursue it remains opaque at present. At this point, S's project seems aligned to that of T1 and T2, although later events show his project to be slightly different in design.

Explaining or explaining yourself.

So why did Janet make relevant her decision not to return to the voluntary work in answer to T1's question? The answer might lie in Steven's turn (*well I said to Janet I said*) (117) which displays that Janet is recycling a pre-existing conflict between them. Janet's response to T1s question is perhaps presenting her version of events first, in a bid for the therapists' support. The CA literature on argumentation makes a useful distinction between "explaining and explaining oneself" (Antaki and Leudar, 1992, p. 181) the former being an utterance designed to explain the relationship between one thing and another (explanation as answer) and the latter designed to persuade the other to the validity of ones argument (explanation as claim backing). In CA arguments, like all conversation, are essentially co-operative. By this I mean that the management of disagreement follows certain structural procedures which conversational partners both orient to in order to interpret each others moves (Pomerantz, 1984). If all utterances are constructed within certain procedural and categorial assumptions which, if accepted, give them validity, then to offer or seek an explanation

holds within it certain expectations about what constitutes a valid explanation. Validity might rest on assumptions of personal knowledge or impartial observation for example. Antaki and Leudar argue that explanations as answers refer to descriptions of causal relationships where the validity of the claim is not expected to be disputed. The explainer is assumed to have reasonable grounds for the claim and is not expected to be distorting that claim for their own ends. The key focus of the conversation is non-dialogical in that it is concerned with affairs external to the conversation itself. Explanations as claim backing display a concern with dialogical matters, whether the hearer finds the explanation persuasive or not. What is made relevant concerns one's status as a socially rational agent within the conversation. All explanations have both these properties in common and so it is to the pragmatic performance of the explanation that we look to differentiate between the two. One of the main keys to unlocking the meaning is "*the assumed agreement on, or quarrel about, the state of affairs being explained.*" (Antaki and Leudar, 1992, p. 186, italics in original).

In family therapy, families often present with troubles that they hope the therapist will adjudicate, preferably on their side. In this case it seems the therapists hear Janet's response in the frame of 'explanation as answer', and they join with Steven in what they assume is a search for the *cause* of the problem. The problem as they see it is that Janet thought that voluntary work would fit her chosen route for getting better but either the nature of the task, or Janet's perception of the task, needs adjustment. It seems that all participants are working from an assumption that work *is* a CBA relevant to the process of getting better. T1, T2 and Steven seem to be adhering to a 'building confidence' version and trying to persuade Janet that the voluntary work fits her chosen goal and can be adjusted. Meanwhile Janet is drawing on another version 'some work is demeaning' and is trying to persuade the others that this work is not relevant to the process of getting better. As Jayussi (1984) demonstrates, different versions

have different identity implications. For Janet, if the former prevails then she can be found culpable for not going back, while the latter absolves her of her obligation to return. The therapists are facing an interactional problem, do they co-operate with problem solving activity (aligning with Steven) or with closing down the topic (aligning with Janet). Both therapists in this sequence adopt a problem solving stance. Janet's attempts to close the topic show a sequential transition from mitigated to unmitigated disagreement displaying increasing potential for conflict both between the couple but also between Janet and the therapists. In therapy terms, this poses a potential threat to both the alliance between the couple and to the therapeutic alliance.

Attempting a repair

139	T1	I- I don't want us t- to kind of (.) I don't want you to feel we're trying to >get
140		at you or anything like that< but I'm feeling a- a bit the <u>same</u> as Steven
141		and I guess a-as <u>you</u> Mary I'm thinking I'm sure this isn't your permanent
142		(.) role in life its not something you're going to do f-for↑ever its like a
143		stepping stone (.) its just something to get you back into the (.) ↑swing of
144		things=
145	J	=I found it boring to be honest (.) it was just cleaning heh heh I thought I do
146		enough of that at home basically (.) I thought here I go again

In CA repair refers to any action that is focussed towards resolving interactional trouble in order to maintain co-operation of participants in the ongoing conversation. In systemic therapy, a routine task is to maintain a therapeutic engagement with each member of the family and to remain neutral to conflicting positions. This potential conflict prompts T1 to action and he makes a formulation which ostensibly summarises the interactional process. He begins by topicalising Janet's resistance with (*I- I don't want us t- to kind of (.) I don't want you to feel we're trying to >get at you or anything like that*)(139). He marks this as a 'delicate issue' with his halting delivery. Research into the organisation of 'delicacy' (Maynard

1991; Silverman 1997) shows how in certain situations it is functional to proceed with caution. By accounting for this line of questioning, he anticipates and counters the potential accusation of 'getting at' J. T1 goes on to justify their joint activity by spelling out the version of the CBA 'getting better' implied in previous turns with idiomatic formulations (*a stepping stone*) (142) and (*get you back into the (.) ↑swing of things*)(143). Idioms are frequently used in environments of potential conflict as their general character enables a conflicting position to be offered without directly accusing the other (Drew and Holt, 1988)

Doing neutrality

In systemic terms T1 can be seen as making his position transparent. By clarifying the intent of his questions he offers the possibility of the position he is taking to be questioned. In CA terms we can see identity work in action. The CBA 'getting at' in the context of family therapy implies a coercive version of the member category 'therapist'. T1 displays the normative understanding that therapists should be neutral by displaying that a deviation from neutrality is accountable. In this case, T1's account justifies what might appear to be seen as a partisan alliance with Steven. By marking the issue as delicate, he *displays* a collaborative stance, one where Janet's agreement with the process is important. In this way, despite T1's acknowledged alignment with Steven, the *normative* assumption of neutrality is maintained. This is achieved by accounting for his actions as motivated by their assumed shared task, that of 'getting better'.

However, Janet continues to resist T1's stance as helper and the question, answer sequence continues until it is interrupted by Steven in line 153.

Conflict

153 S   =>to be fair Janet< we were in town last week weren't we (.) we went into this
154   foundation shop dint we (.) where you worked n we see the woman behind
155   the desk (.) and Janet she put her application form in and Jan said like

156		she'll come up and have a little taster day and she said y'know what d'you
157		wanna in the shop, you can work the tills, do what you like n Jan said I'll
158		do a bit a cleaning she said [indecipherable]
159	J	[**well yeah, they** give me a choice yeah but I found it boring [basically
160	S	[**theres**
161		**other jobs** to do there Janet in the shop besides cleaning
162	J	well I was bored, I do that every day [of the week
163	S	[frinstance
164	T1	so you <u>cho:se</u> to do cleaning
165	J	↑<u>yeah</u> yeah
166	T1	it wasn't that they exp<u>ec</u>ted you to do cleaning
167	S	No
168	J	<u>No no no</u> not at all but I just thought this int me
169	T1	So what <u>would</u> be you
170		(3)

Steven begins this turn with the phrase (*To be fair*), a rhetorical device that both positions him as an objective observer and acts as a pre-sequence marking an upcoming story. The denouement of the story is that Janet had chosen to do the cleaning (lines 157 to 158), a claim which is in opposition to Janet's prior implication that she was *given* a job unworthy of her. Janet's confession (***Well yeah, they** give me a choice yeah*) fails to justify her complaint (*but I found it boring*). This is demonstrated by Steven's response (***theres others jobs** to do there Janet in the shop besides cleaning*) (106-107), implying that if cleaning is boring then Janet could choose another occupation.

Argument or conflict

In CA, argument or conflict is minimally defined as a three part sequence. If speaker A's utterance is contested by speaker B, A can either make a concessionary move or counter oppose B. An argument remains latent until the third move constructs it as such (Norrick and Spitz, 2008). In ordinary conversation disagreement is marked as dispreferred. It is usually

mitigated by reluctance markers and pushed back into the turn construction following an initial agreement. In conflict sequences the preference structure is reversed. Participants emphasise the oppositional character of their turns by a lack of hesitancy, affective displays (such as raised tone of voice), overlapping speech and dissent markers. Once an argument is under way, the preference for disagreement means that conflicts tend to take on a life of their own. Speakers orient to the preference structure to give meaning to their responses meaning that even conciliatory moves are often interpreted as oppositional (Kotoff, 1993). Thus agreement in preferred turn shape will be read as oppositional making it difficult to escape from conflict without explicit markers such as 'OK, I see your point' or 'let's agree to disagree'. Strong agreement tends to hold a 'yes but' kind of quality, evident in Janet's agreement prefaced disagreement in line 159. In this sequence we see a shift from agreement prefaced disagreement (line 159) to disagreement (line 162) delivered with no hesitation. Overlapping talk is a feature and voices are raised as participants mark mutual orientation to incipient conflict.

Empirical evidence for systemic theory and practice

CA reveals the structural processes by which conflict sequences are initiated and maintained and how, once started, they are difficult to interrupt. Thus once conflict is established, exit from conflict and the re-establishing of agreement is much more difficult to achieve. In the systemic literature Bateson's (1980) work on schismogenesis described these as symmetrical patterns of communication. So CA offers further empirical evidence for systemic theory and good reason for the routine therapeutic practice of the interruption of escalating symmetrical arguments.

In this case the conflict is interrupted by T1 who indexes Janet's choice as 'news' (*so you* cho:se *to do cleaning*)(164) and spells out the implication contained in her previous account (*it wasn't that they expected you to do the cleaning*) (166). So in this way T1 implicates Janet as potentially

culpable because she has *failed to disclose her choice* in this matter and therefore implied someone else was to blame. Thus T1 marks a change of context in his understanding of Janet's initial response to his question from non dialogical to dialogical. He moves from the context 'explanation as answer' where the state of affairs being described was not questioned but the *reason* for that state of affairs. Now it is Janet's *description* of that state of affairs which is made relevant as questionable.

T1 solves this problem by making relevant Janet's choice with a direct challenge (*so what would be you*) (169). This marks the start of a new sequence. T1 shifts the context from past, being *given* the wrong job to future, how to *choose* the right job. Thus Janet's agency is made relevant. However, the puzzle of why Janet chose this account of voluntary work as a version of the CBA getting better remains unexamined. Janet's continued resistance to this problem solving stance is marked by a 3 second pause preceding her response (*I don't know*).

Repair

182 T1   you said um (1) did you say I'm <u>wor</u>th more than that?

183 J   Well <u>I</u> think I am than running round with a [duster

184 T1   [So <u>I</u> think that's good (.) I like to

185   hear you saying [that

186 J   [I felt a bit how can I put it (.) they were very <u>nice</u> to me

187   don't get me wrong, very helpful (.) but I really felt like £I'd really

188   lowered me standards from what I us(h)ed to be£

I have omitted a few lines between the last section of transcript and this. In line (182) we can see T1 initiating a new sequence by referring back to Janet's earlier claim (*I'm worth more than that*)(182) and positively connoting it. This offers an opportunity for Janet to elaborate her problem, that she felt she had lowered her standards. The focus in the next phase of the session is an elaboration of the history of Janet's employment history. All participants collaborate on eliciting and telling stories which give

evidence for Janet's identity as a hard working and diligent employee who has persevered in the face of mental illness and the negative effects of medication. Thus the preference structure for agreement is restored and conversation continues with few markers of trouble until some 27 minutes into the session, which is where Part 2 begins. Before moving on to the second extract of transcript I will summarise the findings so far.

Discussion

This extract of transcript is significant because it partly creates the context for an explicit blaming later in the session (see Part 2). I have shown how a misalignment emerges between Janet and the other participants, how participants orient to this misalignment and the interactional resources they deploy to avoid overt conflict and blame. The key conflict between Janet and the other parties involves the construction of Janet's rights and responsibilities in relation to 'getting better'. This includes her implied responsibility to adjust what she does during the day as part of the process of 'getting better'. It also includes her rights and responsibilities in the present moment of therapy and her obligations to co-operate with the therapeutic task in hand.

The therapists' interactional project

In the above analysis we can see each participant pursuing distinct interactional projects concerned with the goals and tasks of the session. In other words, what is the problem, is it relevant to talk about it here, who is to blame and what should be done about it.

I have shown that T1 started with a routine systemic task, thickening the story of Janet's strengths and resilience in pursuit of recovery from a psychotic episode. Janet's description of voluntary work as one of her chosen routes to recovery, foiled by being given boring work, was read as a request for help rather than an argument to support a claim. Thus the therapists seem to orient to the goal of resolving the problem of Janet

being given an inappropriate task. They are clearly attuned to Janet's resistance to this task but her idiomatic and generalised responses leave *the meaning of her resistance* open to interpretation and so the therapists continue their problem solving activity in the absence of a clear cue as to what else they should be doing. Two concepts from CA, troubles telling and unhappy incident reporting help us to understand the influence of normative responses in making decisions about how we move on in a conversation. Thus the combination of unhappy incident reporting and the way troubles are normally heard in a service encounter coupled with the ambiguity of Janet's closing down responses, may have led the therapists to continue the project of problem solving despite their displayed awareness of interactional trouble.

Janet's interactional project

The embedded suggestion in T1's initial question, makes it difficult for Janet not to offer an example of what she is doing to aid her recovery. In this sense T1's question sets the trajectory of the sequence. However, recipients always have choices about how they co-operate with the speakers design. Janet seems to have another goal altogether to that assumed by the therapists. She presents her version of a trouble, (I tried to adjust my life, it didn't work and I'm not going back through no fault of my own) in order to seek third party validation for her decision. As the session unfolds we can see that her version of the trouble is contested by Steven. Where T1 and T2 hear the troubles telling as an invitation to problem solve, Janet appears to have told the trouble in order to elicit a sympathetic hearing from the therapists. However, by offering the topic in response to T1s question about getting better, Janet invites the problem solving activity but then fails to co-operate with it in a way that is satisfactory to the others. Failing to provide an adequate account promotes further searches and they all get trapped in a redundant question answer sequence which becomes more and more conflicted. When T1 and T2 seem to affiliate with Steven's version, Janet unsuccessfully attempts to close down the topic.

Steven's interactional project

Steven is aware from the start that Janet chose cleaning and thus his continued offering of alternative reasons for not going back can be read as displaying that her stated reason is irrelevant. Steven's goal then seems to mirror Janet's, seeking third party validation for his version of the trouble, but in his case the direct opposite of J, the reasons why she *should* go back. In this sense his questions can be read as embedded arguments delivered to persuade Janet to return to the shop. However, his task, although ostensibly similar to that of the therapists is in fact different. Steven's task is that of *questioning Janet's claim* while the therapists task is of *uncovering the facts*. This misalignment of tasks remains obscure to the therapists until Steven reveals the 'fact' of Janet's choice and as a result highlights her agency in the construction of the trouble she is reporting.

Constructing a non-blaming therapy

All participants deploy a number of interactional resources to persuade one another to their position. The whole sequence is showing a preference not to blame, with Steven holding back his 'incriminating evidence' thus offering Janet several opportunities to confess that it was her who was responsible for choosing the cleaning in the first place. Only through failing to self-repair (or confess, or self-blame) does Janet invite blame from others. In terms of the socially prescribed norms that govern talk then she is failing in her social obligation to provide just enough information (the economy rule) to enable us to infer what is going on but sufficient (the relevancy rule) to represent the world accurately.   MCA helps us to identify how different social knowledges are drawn upon to account for actions and ascribe different moral identities. Is Janet a good patient fulfilling her obligations to get better? Are the therapists good therapists, helping Janet to resolve her difficulties or bullying therapists who are 'getting at' Janet? Neither Steven nor Janet challenge therapist neutrality by for instance explicitly asking for their opinion or questioning their stance. Thus the CBA of neutrality associated with the member category 'therapist'

is actively constructed by the actions of all participants, and therapist actions are evaluated through that lens.

It is because Janet implies another is at fault that Janet becomes culpable for an interactional omission which is made explicit by the therapist (*so you cho:se to do cleaning [...] it wasn't that they expected you to do cleaning*)(164-166). This is read as a misrepresentation of the facts by omission. Perhaps to avoid blame for this omission, the therapist shifts focus from the past to the future. The exploration has been 'How come they gave it to you?' Now Janet's agency in the matter has been revealed the question could turn to 'How come you chose it?' or even 'How come you chose to talk about this now?' Instead the question the therapist puts is 'What would you like to do instead?' By this means the therapist avoids exploring Janet's agency for a negative event in the past or her agency for the act of omission in the current conversation, both acts being potentially blameworthy. Instead T1 focuses on Janet's agency in a hypothetical future. This focus fits with the institutional task of privileging the construction of the agentive self towards an assumptive goal of 'getting better'.

In Part 2, I will show how the failure to negotiate the discrepancy between the goals of the different parties leads to overt conflict later in the session.

Part 2

Introduction

Part 2 picks up the conversation midway through the therapy and shows how a blaming event is used as a solution to an interactional problem.

The context

This section occurs 27 minutes into the session. Following the sequence described in Part 1 the therapists orient to Janet's repeated claim that she is worth more than this and a different area of exploration opens up. Janet and Steven offer descriptions of Janet as a hard working woman despite obstacles of ill health and strong medication. The therapists ask questions that invite elaboration of Janet's strengths. The conversation is marked by co-operation and collaboration in the construction of Janet's identity as diligent and persevering. Immediately preceding this section T2 references care work as satisfying because it can help people. Janet agrees but also says that she cannot return to care work because she is vulnerable to relapse if stressed. So as we rejoin the conversation the CBA 'work' is again linked to the MCD 'mental illness' and different *types* of work are implicated with relation to 'getting better' or 'getting worse'.

Recycling the argument

481	T2	yeah mmm (1) .hhh I suppose I was just (.) I was thinking in relation to the
482		charit:y shop(1) was it a charity shop you volunteered in this morning?
483	J	yea:h. yeah
484	T2	cos you don't (1) you don't see the people that you're <u>helping</u> do you cos it is
485		a <u>really</u> <u>worthwhile</u> job cos you are raising money for ↑<u>charity</u> and it's a
486		really good thing to do but you're not actually
487	S	[mmm
488	T2	[in touch with the people you're <u>helping</u>
489	J	↑£I did meet an old lady today she asked if they had a reclining cha(h)ir in(h)
490		the shop=

491	T2	=Oh r(h)ight!=
492	J	=↑I says it's my first day but as far as I'm a(h)ware there's not£
493	T2	heh heh
494	S	She says there is one but I'm (h) sat in it
495		[laughter]
496	J	[<u>I explained I was cleaning</u> and I think hang on I do that twenty four
497		seven at home really
498	T2	yeah↓
499	J	<u>clean</u>, <u>clean</u>, <u>clean</u>

In line 481 T2 begins a formulation designed to link Janet's immediately preceding talk with the earlier topic of voluntary work discussed in Part 1. She starts her turn with the pre-sequence (*I was thinking*)(481). This serves both to request the floor for an extended turn and also to herald a formulation or interpretation of previous talk. She asks the rhetorical question (*was it a charity shop you volunteered in[...]*) which links upcoming talk with the earlier conversation and indeed *only makes sense* in relation to the earlier sequence. This is important. My claim that the meaning of this turn *depends* on the context of the sequence in Part 1 is the validation for my claim that these sequences say something about the turn by turn construction of the subsequent blaming event over separate but linked sequences. The formulation of the question serves three purposes. It elicits Janet's co-operation by projecting agreement. It formulates the relevant Category Bound Predicate as 'Charity' in relation to the shop (rather than other possible attributes such as 'big' or 'furniture'). This serves as a platform for the second part of her argument. It also serves to position her argument as a natural upshot of what Janet has previously implied, that she enjoys caring for people. The start of T2's next turn (*cos you don't (1) you don't see the people that you're <u>helping</u> do you*) (484) refers back to Janet's immediately preceding talk (not shown) concerning the job satisfaction associated with care work. She does this by implicitly comparing care work which has direct contact with its

beneficiaries and charity work which does not. Thus the CBA 'helping', and the SRP's helper/helped, are drawn upon to link both activities. The MCD made relevant here is 'illness' with types of work being versions of the CBA getting better (or worse). T2 makes very explicit her evaluation of these types of work with (*it is a* _really_ _worthwhile_ *job cos you are raising money for* ↑_charity_ *and it's a really good thing to do*)(485-486). Thus Janet would remain the incumbent of the member category helper despite not being in direct contact with those she helped, the performative force of which is to construct an honourable motive for Janet to reconsider work in the shop and crucially therefore to undermine Janet's previous argument that the job is unworthy of her.

The costs and benefits of ambiguity

Janet's introduction of humour in the next turn displays both her understanding of and rejection of the performative force of T2's project. Although the member category (*old lady*)(489) might fit the type of beneficiary T2 is implying, the CBA 'looking for a reclining chair' evokes an old lady with choice and leisure rather than one in need. Janet thus effectively subverts T2's action by shifting the SRP helper/helped to that of sales assistant/shopper. T2 receives the joke with laughter tokens and Steven co-operates with Janet in extending the joke (494). Norrick and Spitz (2007) show how humour is often used to mitigate potential hostility and avert conflict. However, due to its ambiguity its intent is open to interpretation and can equally be seen as provocative. Steven's extension of the joke to imply Janet is sitting doing nothing (line 494) potentially mitigates offence but could equally be heard as an implication that Janet is lazy, which in this context could also be heard as blaming. Janet's next turn supports the view that in this case humour was heard as potentially derogatory. Interrupting the laughter, in a loud voice Janet recycles and upgrades her earlier account for not going back to the charity shop with an extreme case formulation (Pomerantz, 1986) (_I explained I was cleaning_ _and I think hang on I do that twenty four seven at home really_) (496-497).

Janet utilises the CBA 'cleaning' and associates it with the notoriously unrewarding and undervalued task of housework, thus contesting both Steven's implication (in jest) that Janet might be lazy and T2's ascription of the work being valuable. Janet's response displays the possibility of incipient conflict, while T2's soft, downward inflected (*yeah*) (498) displays avoidance of conflict (in CA terms agreement proferred in a dispreferred turn shape heralds concession). Janet reinforces her account by loudly repeating (*clean, clean, clean*)(499), an extreme case formulation often used to back an argument where opposition is expected.

Making the implicit explicit

500	T1	But ↑ if if you'd said something else when they asked you what would you
501		like to do today (1) and you said give me ↑<u>anything</u> but cleaning cos I do
502		enough of that at home=
503	J	=it <u>was me</u> that said cleaning=
504	T1	=I wonder what they would've <u>given</u> you=
505	S	=yeah=
506	T1	=and I wonder what you'd be saying now.
507	S	That's what I said (.) in a way John coming up in the car this afternoon (1)
508	T1	mmhm
509	S	didn't I?
510		(1)
511	S	in a way

This oppositional sequence becomes the context into which T1 responds with an extended turn that leads to an explicit blaming. Let's look at how this blaming gets constructed. T1 begins his turn with (*But*) (500), indicating a challenge to Janet's account. He goes on to construct a rhetorical question that projects agreement that Janet chose to do the cleaning. Structurally, he matches Janet's utilisation of an extreme case formulation (*give me anything but that*) (502) which serves to upgrade the force of his argument. At the next TCU, with latched talk, Janet concedes (*it <u>was me</u> that said cleaning*)(503). T1's question was recognisable as a rhetorical

question that was incomplete. Latching in this case may indicate either strong agreement or a shift in preference organisation heralding argument. The proof is in how Janet continues her response.

Two domains of accountability

What is T1 doing here? First he makes relevant the inadequacy of Janet's account given that she had asked to do cleaning. He draws attention to the consequences of her actions in two domains. Firstly the *causal* connection, out there, between her choice (her agency) and the work she was given. Secondly the *interactional consequence*, here and now, of her account for her choice. Thus he offers a direct and unequivocal challenge to Janet to offer a different account for her actions.

Although this challenge is directed to Janet, it is Steven who responds. Steven warrants his agreement with T1 with a description of an earlier conversation with Janet where he said the same thing. He upgrades his argument with a negative interrogative (*Didn't I*) (line509) which projects agreement. The power of the structural properties of a question/answer adjacency pair means that Janet's refusal to answer strongly displays opposition, especially because the projected answer is apparently merely confirming the facts. Thus Steven draws on the epistemic authority of the professional to back his claim. However in the face of Janet's refusal to reply his immediate downgrading of his claim (*in a way*) (511), can be seen as an attempt to avoid potential conflict.

Blame as an invitation to take responsibility

T1 makes relevant Janet's response with an upgrading of his challenge.

512	T1	cos <u>you don't know</u> what else they might have offered you
513	S	mm
514	T1	they might have said ↑would you like to do this or this (.) and you might have
515		<u>picked</u> one of those (.) and come back and said >cor I've never done that
516		before<or >that was quite interesting cos we did such and such and<(2)

517		<u>you</u> picked the boring one didn't you
518	J	[I ↑did
519	T1	[and you have no one to blame but yourself really
520	J	[no, no, that's ri↑ght.

Note how, in contrast to her lack of agreement with Steven, and less explicitly with T2, Janet responds in the affirmative to T1's two rhetorical questions which spell out in turn Janet's agency and culpability very explicitly (*<u>you</u> picked the boring one didn't you*) (517) and (*you have no one to blame but yourself*)(519). I will return to the consequence of this point later, for now let's continue with the sequential analysis to see the upshot of this exchange.

521	S	I said on the way coming up is there any girls at <u>all</u> work in there,
522	J	↑<u>Its not the point</u> its all men but I just felt (.)
523	S	bu- but ↑say you worked tomorrow >for a couple of days< and there
524		was two <u>women</u> (.) there aswell (.) you'd feel more <u>com</u>fortable wouldn't
525		you
526	T2	mmm, mm
527	J	But I'm not going <u>back</u> there really so that's that (.) theres no good
528		going on about ↑ i(h)t
529	T2	[ha ha ha]
530	T1	is that right↓
531	J	I've made me ↑mind up
532	T1	Really (1)£ is this the Janet that you know Steven?£
533	S	Yes (1) she tries it once (.) if it's no good (.) never go back (2)
534	T1	ri:ght
535	S	But I think it's a bit more determination I think you need on your part

Janet has now explicitly accepted the blame for choosing the cleaning role. Thus implicitly her account for not going back is *also* revealed as wanting. Steven orients to this with a re-cycling of his earlier project (*is there any girls at <u>all</u> work in there*) (521) persuading Janet to return to the shop.

Janet however interrupts with (*it's not the point*) (522) thus explicitly rendering Steven's interactional project as irrelevant. Steven pursues his argument with a hypothetical situation using a rhetorical question to project agreement which Janet again contests and makes an explicit bid to finally close the topic with (*But I'm not going <u>back</u> there really so that's that (.) theres no good going on about ↑i(h)t'*) (lines 526-527)

Doing neutrality -The co-construction of power

CA has shown that in general conversation, agreement is preferred over disagreement and disagreement is displayed as dispreferred. Unmarked disagreement such as this then marks a shift in the usual preference structure. The different construction of Janet's responses to Steven, T1 and T2 illuminate how participants are co-operating with the maintenance and creation of hierarchical differences in who has the power (right and obligation) to say what to whom. Janet most frequently mitigates her disagreements with the therapists, thus avoiding direct conflict with those who, through their position as expert have greater speaking rights. This is reciprocated by T1 and T2 who frequently mark their contributions as delicate. It is noticeable that T2 makes more effort to mark her contributions as delicate than T1. This may display an asymmetric relationship between T1 and T2 marking T1's relative seniority in terms of his professional role. T1 certainly contributes far more to the therapy than T2, and in Therapy 2, the contributions from the *qualified* family therapist also far exceed those of her co-therapist. Thus the imbalance can be read as a co-operative display of who has greater epistemic rights. When Janet undermines with humour the delicacy with which T2 attempts to recycle the topic of returning to the shop, T1 displays his power to formulate 'the facts'. Janet agrees with T1 (*no, no, that's ri↑ght*) (520), yet when Steven picks up the topic and pursues it, Janet responds with unmitigated disagreement (*theres no point going on about it*) (527) showing their relationship to be more symmetrical. In ordinary conversation, once the preference structure has changed to one of argument, a *strong*

agreement usually marks opposition. Thus Janet's strong agreement with T1 (a 'yes but' form of answer), in lines 518 and 520 foreshadows her complaint to Steven. T1 and T2 have consistently displayed alignment with Steven regarding the interactional task in hand. Janet's response therefore implicates both T1 and T2, *but without direct confrontation*. In this way Steven is directly accused of partiality while the therapists' positions of neutrality, though implicated, remain unchallenged.

Janet's laughter token at the end of this utterance, its reciprocation by T2 and the 'smile voice' T1 produces in line 531 shows all three to be engaged in the mitigation of this conflict. T1's question (*Is this the Janet you know?*) (531) may have been designed as an idiomatic marker to display co-operation with the end of the topic, requiring merely a rueful "yes" from Steven. Steven however, orients to the conflict with Janet in his response, and evokes the CBA 'tries it once [...] never go back' thus offering an explanation based on a description of a character type, that of someone who gives up too easily. Jayussi (1984) shows how character type categories can be used as rhetorical devices similar to those of idioms in their generality. By positioning someone as 'a type' it is harder to refute the accuracy of the claim. Thus T1's question (*is this the Janet you know*) offers an opportunity for Steven to make relevant a disjunctive category from that constructed immediately preceding this sequence. From Janet as hard worker to Janet as someone who gives up too easily. Dersley and Wootton (2001) show that this kind of complaint, that calls into question someone's moral character, is most likely to end in physical or verbal withdrawal or violence. I suggest that it is this argument that is the reason why Janet chose the example of voluntary work in the first place. Her argument was designed to invite T1 to join her in persuading Steven that she does *not* give up too easily. This may account for her withdrawal from the argument earlier on. Instead the therapists pursuit of the topic, and the question (*is this the Janet you know*) has inadvertently opened a slot for

Steven to explicitly blame Janet and the relationship between Janet and Steven is increasingly threatened.

Discussion

In Part 2, we can see how T2 rekindles the task of persuading Janet to return to the charity shop which Janet emphatically resists. Where Part 1 was marked by the avoidance of conflict, here the conflicting positions and their implications for the evaluation of Janet's character are explicitly revealed.

Two questions emerge when considering this blaming event. Firstly, why do the therapists keep returning to this vexed question which seems to hurtle towards a trajectory of blame. Secondly how does a therapist, working within a model which urges non-blaming, get to a point where saying "you have no-one but yourself to blame" makes sense. These are skilled, experienced and respected practitioners who have signed up to a non-blaming model, yet this phrase, taken out of context could appear to be (and some might argue is) an example of 'unsystemic' practice. Yet any therapist will have had the experience of reflecting on a session and thinking, why did I say that? CA, through its explication of the underlying rules of interaction, helps to illuminate such questions. What was the problem for the therapists that such a blaming event solved?

In Part 1 I have shown how Janet's production of an 'unhappy incident' invited a problem solving stance from the therapists. I have also shown that the context of a service encounter made relevant 'troubles telling' as a request for help. The ambiguity of Janet's responses, the use of idiomatic expression, the lack of detail in her account makes the design of her responses opaque to her interlocutors. Thus although T1 and T2 are aware of incipient interactional trouble the *nature* of that trouble is not clear, making relevant their continued search for the responsible party. Blaming of self (ie. confession or apology) is routinely preferred in ordinary

conversation over other blame (Pomerantz 1979). Steven's delay in disclosing the information regarding Janet's choice can be understood as offering her the opportunity to confess. Only when his account is offered, which satisfies the search for the responsible party, does the sequence end. It is then that Janet's claim, 'I'm worth more than this', is made relevant and the next task, what type of work *would* suit Janet is launched. However, the puzzle of *why* she rejected the job, given that she was allocated the very task she requested, remains unresolved. T1 defuses potential conflict, and avoids blame, by aligning with Janet, highlighting her search for a job worthy of her and obscuring her responsibility for choosing the job she complains about. In sequence 2, T2 reintroduces the topic and subtly challenges Janet's claim that it is unworthy of her. I suggest that two elements of Janet's subsequent responses make T1's explicit blame relevant. Firstly, it is Janet's reiteration of an explanation that has already explicitly been judged as irrelevant. Secondly, Janet's response implies that it is *T2's* contribution that is irrelevant and does so *without* delicacy.

The various functions of blame in argument.

I have shown how two different domains of culpability are made relevant, that of how Janet has acted in the events being presented and how Janet is accounting for that action in the present moment. I will now introduce some additional concepts from the CA literature relating to the structure of arguments.

Let's turn again to the sequence in Part 2. T2 reintroduces the question of Janet's return to the shop. She ties her claim that working in a Charity shop is worthwhile with Janet's immediately preceding talk about care work. We can read this as contesting Janet's earlier claim 'I'm worth more than this' as a relevant explanation for not going back. Thus T2 makes relevant the insufficiency of Janet's account. I now want to turn to some of the CA

literature regarding what is variously termed conflict talk or arguing to illuminate what happens next.

The structure of arguments

All conversation is seen as constitutive of social structure, but argument can be seen as a major site where social worlds and social structures are negotiated (Muntigl and Turnbull, 1998). I have discussed how conflict is defined in CA as a three part turn, A makes a claim, B opposes, A counters B. The practices available for deployment in these turns are many and have different implicative consequences. Muntigl and Turnbull show how these practices can be broadly grouped into four turn types each of which is more or less oriented to mitigating or aggravating the dispute. Of these turn types the irrelevancy claim is most aggravating because it attacks a fundamental social skill, that of making competent contributions to a conversation, which effectively shuts down negotiation. In other words, irrelevancy claims are more potentially damaging to the identities of the participants and to their relationship. How might these findings help us to understand what is going on in Part Two?

What kind of talk is reasonable here?

Janet's response to T2's claim in the form of a joke could be heard as an irrelevancy claim. It potentially ridicules T2's argument in a way that fails to mitigate potential damage to the relationship. Janet's delivery of her next turn *(I explained I was cleaning and I think hang on I do that twenty four seven at home really)*(496) is in preferred turn shape, and the recipient design is ambiguous. It may be addressed to Steven's joke immediately preceding her turn but may equally be addressed to T2, and certainly T2's downward deflected, mitigating 'yeah' (498) warrants this reading. However, Janet does not tie her response to the design of T2's serious intent, that the work is worthwhile, and in this sense Janet displays her evaluation of T2's argument as irrelevant. Within the MCD therapy it is a therapist's right to question the validity of a client's claim but clients are

generally not expected to question therapists. Where T2 withdraws from incipient conflict with an agreement marker it is T1 who mirrors Janet's tone with an unmitigated challenge to the relevancy of Janet's argument (line 500). In this way T1 upholds the relevance of his colleague's question and challenges Janet's dismissal of it.

This unusually explicit challenge then is made relevant by;

- Janet's transgression of the maxim of truthfulness (we will say as much as necessary to not misdirect)
- Janet's implied questioning of the competence of T2
- Janet's resistance to acknowledging her responsibility for her actions, with the consequent implication that someone else is responsible.

Thus the tacit local moral order of the therapy session is both revealed and constructed by the shared assumptions that these actions warrant justification.

In Part 3 I will show how this blaming is inextricably tied to the negotiation of tasks that participants are engaged in.

Part 3

Introduction

Part 3 presents a brief extract of transcript from the final part of the session. This reveals an unspoken difference between the family members regarding their goals for therapy, which helps to make sense of the session as a whole.

The context

This extract occurs thirty nine minutes into the session. Following Janet's explicit avowal that she is not going back to the charity shop the conversation again turns to what other forms of work might suit her. So although the task has moved away from the specifics that prevent Janet from returning to the charity shop, the broad topic and assumed goal remains the same, the exploration of the obstacles that prevent Janet from returning to work. The pros and cons of kitchen work and hotel work are discussed. This section shows T1's attempt to change the topic. Immediately prior to this extract Janet has made a joke about taking a break at work.

The problem of agreeing on the problem.

703	T1	well if you work hard and have a little break that's jus (1) hhh I was just thinking
704		T2 um (.) we were going to ask you y'know (.) whether you've had further thoughts
705		about (.) how best we can u:se these sessions (.) u:m (.) have you had (1) either your
706		own thoughts about it or have you had any conversations about that (.) I know that
707		you having had this set back and getting ill again (.) is yknow (.) probably got in the
708		way of some of that but (.) have you given that some thought? (2) How we can best
709		help you?
710		(3)
711	SI	think really the best thing I think is really t-to find a bit of work (.) for Janet an-
712		give her a bit more confidence (.) that's what I want to get out of this (.) as well as
713		[undecipherable] (2) what do you think?

714		(2)
715	J	↑ye↓a↑eh
716		(4)
717	S	cos you're always tryin (.) putting yourself ↑down cos (.)
718	J	but I've always been a people pleaser as well haven't I
719	S	mm
720	J	I always please other people so I want to really do somethin that's gonna (2) that I
721		want to do.
722	T2	mm
723	J	not that I sort of gotta (.) do this for the sake of doing it (.) that's how I look at
724		it
725	T2	that's important isn't it mm

In lines 703 and 704 T1 links his turn with Janet's joke (not shown) by referring to taking a break and then heralds a change of topic by addressing his colleague directly (*I was just thinking T2*) and referring to an earlier agreement between the therapists (*we were going to ask*). He then ties this session to the end of the last therapy session by asking Janet and Steven (*whether you've had any further thoughts about how best we can use these sessions*)(705). At the end of their last meeting the therapists had asked Janet and Steven to discuss, and write down, what issues they hoped to address in therapy. In lines 706 to 710, possibly because there is no immediate take up at the first TRP following his question, T1 delicately offers Janet's illness as a possible reason why they may not have completed this task. The long pauses in lines 710 and 713 indicate some trouble and Steven's response in the singular (*I think really the best thing I think is really t-to find a bit of work (.) for Janet*)(711) implies either that they have not discussed it or that they have been unable to come to an agreement. Steven's goal is clear and unequivocal, what he wants from therapy is for Janet to get a job and gain some confidence. The two second pause before Janet's response to his question indicates trouble. The agreement she offers in an extenuated and modulated tone

(↑ye↓a↑eh) (715) indicates at best partial agreement. Following a long pause, where Janet chooses not to elaborate, Steven again proffers the rationale for his goal (*cos you're always putting yourself down*). Janet's response (*but I've always been a people pleaser*) (718) and (*I want to really do something that's gonna (2) that I want to do*) (720) implies that their goals are different. T2 validates Janet's position in line 725.

I have omitted about 3 minutes of talk where T1 also validates Janet's position and then turns to whether or not they have managed to complete some forms concerning their hopes from therapy. Janet and Steven can't remember where the forms are or what they said and T1 suggests that the difficult time they have had because of Janet's relapse makes this entirely understandable. He also talks about how impressed T1 and T2 have been in the way they handled this relapse. Janet then offers an alternative topic

782 J   I do sometimes though feel with that illness problem you get treated
783   differently as well from certain people (1) I know you do cos it affects
784   your mo:ods, the way you look (.) and even people can look at you and say
785   phor, your not happy again today

This leads to a discussion about how Janet's wider family have not invited her to a party and how hurt and angry she feels about it.

Summary and Discussion of Therapy 1

These extracts show how an unresolved difference between the couple about their goals for therapy has influenced their talk throughout the session. Where Steven's goal is to persuade Janet to return to work, Janet's interest is in *resisting doing things she does not want to do*. Where Steven's stated goal is about action, Janet's stated goal is about resistance. T1s initial query in Part 1, about how Janet has adjusted her life as part of the process of getting better is a routine systemic question designed to uncover stories of strength and resilience. In this case it provides a slot for

Janet to defend herself in a pre-existing conflict with Steven. Her resistance is cloaked in co-operation with Steven's goal and her aims and desires are presented ambiguously. This means that the therapists interpret her goal of resistance as a goal of action thwarted by an obstacle. They therefore see their job as helping her to overcome this obstacle and unwittingly appear to join with Steven in a goal that Janet has set out to resist. *Janet's agency then has been expressed in the act of resistance in the session itself.*

The continued misalignment in the session is not revealed until the therapists explicitly ask the couple what they want to talk about in therapy. Janet's stance *(I want to really do somethin that's gonna [...] that I want to do)(726-727)* is validated by T2 (*that's important isn't it mm*)(730) and later by T1 (not shown). This serves to further repair the conflict described in Part 2. Janet now seems to have provided a rationale for not going back which satisfies the therapists. When the therapists pursue the question of what Janet wants to talk about directly, Janet tentatively raises the issue of the painful personal consequences of mental illness. This leads to further talk about how people see her and respond to her differently and how her extended family has excluded her (lines 782-785).

Summary

This chapter has shown how a misalignment of goals between participants creates a context for an explicit blaming. I have suggested that Janet introduced the topic of 'not going back' to pursue an argument with Steven while the therapists read it as a request for help. As the therapists pursue problem solving, Janet tries to close down the topic. However her reason for doing so remains opaque. When Steven reveals the reason, the therapists note Janet's failure to disclose her choice but to avoid implications of blame, do not enquire why. When T2 reintroduces the unresolved puzzle, Janet repeats a claim already noted to be insufficient to the task. T1's explicit blame can be understood as an attempted solution to a repeated misalignment by holding Janet responsible for the

way she talks in the session. I introduce the concept of explaining versus arguing as an important factor in the misalignment of goals and also suggest that Janet's resistance to the topic can be understood as an expression of agency within the session. Part 3 shows that misalignment is related to a disagreement about the goals and tasks of therapy that precedes the therapy session itself.

In terms of systemic therapy this shows the difficulties encountered in negotiating goals where different versions of events exist. The therapists seem to be trying to work on a problem that Janet offers, and the ambiguity of Janet's responses serves to perpetuate the misalignment. A question remains about why Janet should present her agency with such ambiguity.

I will return to this discussion in Chapter 6. First I will present an analysis of a blaming event selected from the second therapy, where these themes are further elaborated.

Chapter 5

Introduction

In this chapter the analysis of Therapy 2 is presented. A similar format to Chapter 4 is followed, starting with an introduction to the therapy context before presenting the analysis in three parts. The excerpts are all taken from the second session. For ease of reference, the excerpts are divided into smaller sections followed by an analysis. Within each part, each smaller section of transcript follows contiguously from the previous one, with no turns omitted. Each section retains the original line numbering of the transcript of the entire session.

The selected excerpts of transcript are presented in their entirety in Appendix D

The Therapy Context

The family

The couple Mandy and her husband Kevin have been referred for family work following Mandy's recent psychotic episode. Mandy has gathered a number of diagnoses over the years, one of which is schizophrenia. Kevin describes himself as Mandy's main carer. They have a number of school aged children.

The therapists

T1 is an experienced, qualified systemic psychotherapist. T2 is an experienced mental health professional who has also completed a minimum of one year's specialist family therapy for psychosis training. Both are female.

The context of the data selected.

Present are two therapists T1 and T2, and the couple, Mandy and Kevin. The initial meeting (not included) had been dominated by a history taking

format, where the therapists systematically gather details about each member of the family, their relationships with each other and their extended family and social networks. Following the initial meeting, the couple missed one appointment. They had also forgotten about this present meeting, but following a telephone call from the therapists earlier, they had managed to attend. The confusion and rush had led to an argument between the couple on their way to the session. The first twelve minutes of the session are taken up with talking about the difficulties the couple have had in juggling numerous hospital and other appointments for different members of the family and agreeing that they would value a text message reminder. This is done with great delicacy on all sides to avoid blame but does not form part of this analysis.

Part 1

The construction of an interactional problem

This excerpt begins about twelve minutes into the session.

222	T1	so how are you feeling at present Kevin coming along today with all that
223		going on and
224	K	∘I don't mind coming along∘
225	T1	rig(h)ht
226	K	[not worried]
227	T1	[o(h)k u:m (1) an-and are you feeling Ok cos as as <u>Ma</u>ndy was
228		saying she can be quite [.hhh
229	K	[yeah, yeah its hard
230	T1	[<u>hard</u> on you]
231	M	[You have] been stressed
232	K	yeah
233		(1)
234	M	He has been stressed (.) he he just wont he just wont say [he wont be honest

The transcript begins immediately after the exchange of telephone numbers marking the end of the discussion about arranging further appointments. T1 opens a new topic with (*so how are you feeling at present Kevin coming along today with all that going on*) (222). 'So' at the start of a sentence often marks the return to the business at hand following a diversion (Bolden 2009). T1 ties her turn to their earlier talk by enquiring about the effect on Kevin of the argument described earlier. Therapists routinely package previous talk and present it in a way that makes it a legitimate topic for therapy (Antaki, 2008). Here we see T1 making relevant both Kevin's feelings and the earlier argument as a suitable topic for discussion. Kevin's response (∘*I don't mind coming along*∘) (224) resists the performative force of the question. T1's laughing acknowledgment tokens, (*rig(h)ht*) and (*O(h)K*), display her receipt of his response as misaligned. Laughter as a conversational phenomenon is often associated with displaying affiliation, where preference is for it to be done together. Where laughter is not reciprocated then it is usually followed by repair (Jefferson *et. al.,* 1987). T1's laughter here can be seen as an affiliative move. She pursues her question by indexing Kevin's feelings (*are you feeling OK*) and then offering a repair by accounting for the reason for her enquiry (*cos as as* <u>Ma</u>*ndy was saying she can be quite .hhh [...]* <u>hard</u> *on you*) (227-230).

Kevin's agreement (*its hard*) (229) is produced through the form of an 'unhappy incident report'. By omitting reference to who or what might be responsible for it being hard, Kevin co-operates with the implication that the situation is difficult while at the same time resists the implication that Mandy is the cause. Mandy takes up T1's project to elicit Kevin's feelings (*you have been stressed*) (231). A statement that does not contain 'news' is heard as a request to offer further information (Pomerantz, 1980). Kevin's minimal agreement is followed by a one second pause (233) indicating that a mere agreement is judged insufficient to the task as participants wait for Kevin to account for his stress. This expectation is made explicit by

Mandy (*he has been stressed (.) he he just wont he just wont say [he wont be honest*) (234).

Negotiating a legitimate topic.

This section reveals participants negotiating what it is relevant to talk about in therapy. T1 and Mandy seem to be pursuing one line of enquiry while Kevin resists it. Throughout this study, the context of therapy is an example of an omni-relevant MCD (Schegloff 2007). Despite no direct reference to therapy, it is the overall organisational resource which underpins the reason why people are involved in the conversation and therefore the MCD from which category memberships are prioritised. Although the interactional rules of a family therapy session are not commonly understood in the way that say, a GP consultation would be, people entering psychotherapy would generally expect to speak about personal matters and in family therapy, family matters. In the context of family therapy the SRP therapist/client invokes category bound activities where a client's obligation would commonly be understood to encompass speaking about their emotional state and family relationships in order to enable the therapist to undertake their obligation to help them. However, the exact nature of the troubles that can legitimately be brought to fulfil these obligations is a matter of local negotiation. Kevin is displaying a problem with the line of enquiry which seems to be inviting his agreement with the implication that he is being negatively affected by Mandy's behaviour. In other words he is avoiding blaming Mandy for being hard on him. However, his reticence creates a context for Mandy to blame him for not fulfilling his obligation as a client to be honest.

Talking versus not talking

235 K   [Yeah I have been its
236   my brother's birthday next week and that (.) an it was his anniversary last
237   month
238 T1   right

239	K	that's not helped
240	T1	is that a wedding anniversary?
241	K	no he died
242	T1	the anniversary of his death
243	K	∘he died∘ (1) once it comes up always I think about him a bit more than
244		normal so
245		(1)
246	T1	and is that what you meant(.) Mandy when you said that Kevin was stressed?
247	M	we:ll Kevin Kevin is stressed with me (1) and right (1) he's stressed with the
248		ho:use and stuff but he just wont ↑say it and it makes <u>me</u> cross cos I I
249		↑<u>know</u> he i:s
250	T1	mm
251	M	but he wont say and he wont get <u>help</u> and then (.) it all just builds up and then
252		there'll be a a <u>mas</u>sive like hum<u>un</u>gous outburst
253	T1	∘right∘
254	M	to the point where like the kids are going up in their rooms or
255	T1	wow
256	M	putting something on really loud because they just cant ↑<u>ta</u>ke it any more they
257		just cant .hhh there've even been times when the kids have actually <u>cried</u>
258		cos theyre just so stressed with it all with us fi:ghting and (1) yknow its
259		just (3) ∘and so yeah∘
260		(2)

K's solution to this problem is to agree that he has been stressed and to offer an alternative account (*Yeah I have been it's my brother's birthday next week and that (.) an it was his anniversary last month*)(235-6). Thus Kevin fulfils his obligation to talk about his stress and address family issues while maintaining his resistance to the implication that trouble in the couple relationship is the cause. He does this by invoking the SRP brother. Grief is the expected reaction to the death of a brother. Thus Kevin offers an account for his stress which is both reasonable and non-blaming of Mandy. Kevin marks the ending of his turn with 'so' (245) Here, of the many

functions of the discourse marker 'so' the marking of causal connections and a bid to close a topic are made relevant.

The expectation of relevance

The pause in line 245 indicates possible trouble, which T1 topicalises with her question to Mandy (*is that what you meant [..]?*), inferring that Kevin's account remains insufficient to the task. Mandy offers the counter claim that Kevin (*is stressed with me [...]stressed with the ho:use and stuff*) (246-249) and furthermore (*he wont say and he wont get help*)(251). Thus the different obligations evoked in the context of therapy change the moral dimensions of talking or not talking. What is proper behaviour is always a local matter, so where not publicly blaming your wife may usually be judged reasonable behaviour, in this context it is not. 'Talking' is one version of the CBA 'getting help' with its implication of the CBA 'getting better'. Those who are stressed (through no fault of their own) and whose stress is negatively affecting their loved ones, become blameworthy if they refuse help to get better. Mandy warrants the seriousness of his failure with an extreme case formulation, (*there've even been times when the kids have actually cried cos theyre just so stressed with it all*) (257), a conversational form often associated with situations of accusing, justifying and defending (Pomerantz, 1986). Within the SRP parent/child the obligation of a parent is to protect their children, not to frighten them. However, note that Mandy positions both herself and Kevin as culpable for fighting. Thus Mandy presents herself as the cause of the stress and claims equal blame for frightening the children however she also presents herself as reasonable through the CBA of confession or admitting fault, thus fulfilling her obligations as a client. Kevin on the other hand is positioned as culpable for not accounting for his stress in a way made relevant in this context and as such resisting help. So, Kevin may be fulfilling his requirement to talk, but not about the things that matter.

Although Mandy addresses her turn (lines 246 to 249) to T1 it can equally be heard as designed for a response from Kevin. The preferred response to an accusation is denial or justification (Pomerantz 1984). The two second pause following Mandy's accusation displays trouble as Kevin chooses not to respond.

Misalignment between the couple

Thus in CA terms we have a trouble, a misalignment between Mandy and Kevin which requires repair in order for conversation to continue co-operatively. In terms of therapy, T1 is faced with a potential therapeutic impasse. Mandy has taken the position that she is the cause of Kevin's stress, making relevant talk about trouble in their relationship. Kevin has resisted explicit agreement or disagreement with Mandy's claim and has shown resistance to opening up the topic. T1's problem is how to move forward in a way that doesn't alienate one party or another while at the same time maintaining a therapeutic focus.

Use of embedded presupposition to repair couple misalignment

```
261  T1      is there any kind of pattern to how (1) frequent things can build up (.) due to
262          kind of stress (.) on you Kevin?
263  K       no its just (1) I always forget to do things n' that then it sort of goes from there
264          al-(.) always forget things and [forget
265  T1                                       [so in in terms of frequency would that be kind
266          of ↑daily or
267  K         [no, it's not
268  T           [or every other day or weekly or?
269  K       its the last two weeks have been the worst cos it seems to be (.) the house has
270          been messed up and things (.) and that stresses me out as well so .hh
271  M       but its (.) its not that I think theres ↑other problems as ↑well because .hh like
272          (1) I think he treats like Alfie different from the ↑girls and so (1) when like
273          hes (1) having a go at Alfie
274  T1      mmm
275  M       yknow I'll I will jump in and (.) and then tha- tha that'll yknow that gets out
```

276   of hand too
277   T1   ∘right∘
278   M   y'know cos sometimes [like

The therapist reformulates the question (*is there any kind of pattern to how (1) frequent things can build up (.) due to kind of stress (.) on you Kevin?*) (261). The embedded proposition in this question, that (*things can build up (.) due to kind of stress (.) on you Kevin*) is not open to debate. The question format makes it difficult for Kevin to answer the question without implicitly agreeing to the embedded assumption. Note that T1 removes any reference to the cause of stress referring instead to (*how (1) frequent things can build up (.) due to kind of stress*). We have seen that unhappy incident reports generally project a search for the cause of the event. By designing her question in this way the therapist offers a way out of the direct confrontation between Mandy and Kevin. She implicitly accepts Mandy's version of events, that rows occur and they are due (at least in part) to Kevin being stressed but she remains agnostic to the cause. She also implicitly rejects Kevin's account (the stress of bereavement) as insufficient, by enquiring into the *pattern* of stressful events that occur. This creates a context which both aligns with Mandy's design to get Kevin to talk more about his stress while offering a wider scope of legitimate responses for Kevin without direct agreement or disagreement that Mandy is to blame.

Misalignment between T1 and Kevin

However, in Kevin's response T1 encounters resistance to her project (*no its just (1) I always forget to do things*) (263). Claims of remembering or forgetting can perform a range of activities in couple therapy, including resisting the therapist's agenda and not wishing to deal with interpersonal issues (Muntigl and Tim Choi, 2010). However, indexing forgetfulness might also relate to the previous sequence (not shown here), where Kevin's poor memory was presented as the justification for the missed appointment. T1

treats Kevin's response as insufficient and upgrades her question by offering a choice of acceptable responses (*so in terms of frequency would that be kind of ↑daily or [...] or every other day or weekly or?*)(265-266). Kevin's subsequent turn is designed to fit better with T1's agenda while still evading the performative force of her question (*its the last two weeks have been the worst cos it seems to be (.) the house has been messed up and things*)(269-270). So Kevin orients to the question of frequency by alluding to the last two weeks and implies a general and fairly innocuous reason (*the house has been messed up*) (269-270). So we can see Kevin evading the therapists' agenda while offering an answer that appears to be at least minimally co-operating with it.

The use of questioning

Systemic therapists frequently work with families where one or more members contribute little to the conversation. A routine way of trying to engage quieter members is to ask choice point questions, projecting a response by constraining answers to the alternatives offered (see lines 265-268). By enquiring into pattern and frequency T1 also shifts the focus away from linear cause and effect and towards relationship. Focusing on feedback and relationship, serves to ameliorate blame. This is an example of T1 drawing on systemic SIKs regarding the use of different forms of questioning to pursue different therapeutic tasks.

Mandy's next turn explicitly challenges Kevin's version (*but its (.) its not that I think theres ↑other problems as ↑well*) (271) and indexes trouble in their relationship as the relevant topic, this time upgrading her complaint. She moves from claiming joint culpability for arguments to allocating the blame to Kevin (*[...]when like hes (1) having a go at Alfie [..] yknow I'll I will jump in and (.) and then tha- tha that'll yknow that gets out of hand too*)(272-276). Thus within the SRP parents, Mandy's responsibility to protect her children is presented as a reasonable, while Kevin's (*having a go)* is implicated as unreasonable. The ensuing arguments (*that'll yknow that*

gets out of hand too) are presented as agentless. So although Mandy neither claims responsibility nor blames Kevin the implication is that they are the result of his unreasonable and her reasonable actions.

Good talking and bad talking

```
278  M     y'know cos sometimes  [like
279  T1                           [SO HOW KEVin reacts can then lead to you to react
280  M                                                                   [yeah
281  T1                                                                   [in a
282        particular kind of way too [Mandy
283  M                          [cos sometimes like he's like inappropriate in what
284        he says (1) he can be really nasty to Alfie and he just wont accept it when I tell
285        him
286  K     no it [indecipherable  ]
287  M           [its like the girls have a lot of leeway
288  T1    .hhhh I've got a suggestion is that we ↑don't try to get into too much detail (1)
289  K     yeah
290  T1    beca:use what we would hope to do over yknow a series of appointments is
291        that we can kind of look at the details of (.) yknow these kind of examples but
292        in a kind of (1) y'know if that's the kind of thing you want [to look at
```

Mandy's blaming of Kevin prompts T1 into a less tentative strategy than her previous formulation. She interrupts Mandy in a loud voice and offers the formulation (*SO HOW KEVin reacts can then lead to you to react [...] in a particular kind of way too Mandy*)(279-282). T1's interruption seems designed to assert the relevance of her interactional project (pursuing the topic of relationship) over Mandy's (pursuing a complaint). In terms of her therapeutic agenda this is a clear example of the therapist highlighting the circular nature of their difficulties in order to diffuse or avert further blame. By not marking the interruption as dispreferred T1 can be seen to be claiming asymmetric speaking rights, in other words, claiming her power and authority as a therapist. As a therapist it is more acceptable to interrupt clients than the other way round. However, Mandy barely pauses

for a peremptory (*yeah*) and continues in overlapping talk upgrading her complaint further with an extreme case formulation (*he can be really nasty to Alfie*)(284). Kevin now responds with direct opposition (*no it*), although his words, are indecipherable as she overlaps him with further elaboration of his unfairness (*its like the girls have a lot of leeway*) (287) drawing on the SRP parent/child, and obligations of parents to treat children fairly, to infer Kevin's culpability and her justification to (*jump in*) to protect Alfie.

Potential conflict

The opposition between Kevin and Mandy has escalated over a series of turns, starting when Mandy offered Kevin the opportunity to account for his stress himself. When he fails to do so she offers a series of incrementally upgraded complaints in the face of Kevin's continued resistance. She begins by blaming herself for causing stress, then blames Kevin for not getting help, then implies shared blame for arguments that upset the children, and finally attributes blame to Kevin alone for treating the children unfairly. The implication that he is an unfair parent seems to provoke Kevin into his first firm contradiction which signals a potential conflict sequence.

Repair

This unequivocal blame and display of conflict again prompts T1 to action. This time T1 makes an explicit move to define what sort of talking is appropriate (*.hhhh I've got a suggestion is that we ↑don't try to get into too much detail (1) beca:use what we would hope to do over yknow a series of appointments is we can kind of look at the details of (.) yknow these kind of examples but in a kind of (1) y'know if that's the kind of thing you want [to look at*)(288-292)

T1's somewhat ambiguous turn could be understood as aligning with Kevin, implying that talking about problems is unhelpful. Kevin's ready agreement in line 288 perhaps shows he hears it as such. The implication is that getting

into detail may be more appropriate later (*over yknow a series of appointments*). Notice how T1 phrases what details should be delayed (*the details of (.) yknow these kind of examples*). In CA terms we can see her marking her contribution as 'delicate'. T1's caution displays her consideration that her previous interruption of Mandy and subsequent suggestion may be heard negatively, perhaps as treating Mandy's contribution as irrelevant or even culpable. She demonstrates concern not to offend and also that her suggestion is tentative and open to negotiation. She chooses a morally neutral phrase (*these kind of examples*) thus neither aligning with Mandy's description of conflict nor with Kevin's strong resistance to such a definition.

'Doing' collaborative

T1's avoidance of terms like argument, conflict or problem reflects a common systemic SIK, that of avoiding problem talk. The function of delicacy could also be read as a particular type of CBA within systemic therapy. Consider for instance if T1 had said instead "I would like us to stop talking about this now because it is unhelpful. We'll come back to it later". This would imply a very different type of therapist to that constructed by T1's hesitant approach. T1 is showing the *type* of therapist identity she is projecting and the type of talking that is relevant. Through these means the construction of a collaborative therapist, and collaborative therapy, is achieved. Furthermore, by interrupting at this moment, the main function of the therapist's intervention is to interrupt a conflict sequence to prevent it from escalating.

So far I have argued that the participants are negotiating what *kind* of talking is relevant to this context and what implications this has for their identities. Kevin has shown a marked resistance to talking about feelings and relationships. How can he maintain the identity of a reasonable client while preserving his avoidance of the topics the therapist and Mandy seem to see as relevant? Mandy has shown that she sees the problems in

their relationship as relevant, how can she persuade Kevin and the therapist to her agenda without being seen as unreasonable? T's questions and formulations so far have demonstrated that feelings, relationships, self-blame and the effects of arguments invite questions, probes and formulations from her but repeated other blame is explicitly (if delicately) diverted. T1 then seems to be presented with a therapeutic dilemma, how to encourage Kevin to talk and prevent Mandy from making inflammatory accusations. Both tasks are necessary for talk to continue and resolution to be reached. However the first might invite inferences from Kevin that she is intrusive, while the second might invite inferences from Mandy that she is controlling.

Self-blame

293	M	[I just think stress
294		is everything to do with me yknow I stress him out (.) right (.) he has to do
295		school run [and
296	K	[oh I don't [indecipherable]
297	M	[and look after the kids and yknow I have panic attacks daily
298	T1	mmm
299	M	right not just one neither (1) and they can be like (.) I can just be sitting there
300		watching the telly and I'll ju- it just comes on and so Kevin constantly like
301		watching me to make sure I'm not self ha:rming [or er
302	T1	[so we're talking about a lot
303		of stress aren't we on a kind of daily basis [an
304	K	[yeah I suppose yeah
305	M	yeah if I start self harming Kevin starts like safe proofing the house and
306		everything
307	T1	mm
308	M	and taking stuff away=
309	T1	=the obvious things away (.) that you might hurt yourself with
310	M	yeah
311	T1	yeah
312	M	so (.) I suppose .hh its like someone looking after a toddler isn't it.

313 K   °no I don't think its like that°

314 T1   mm

315 K   I ↑wanna look after you I like it (1) its stressful yeah so °I like doing it°

316   (2)

Mandy responds by blaming herself (*I just think stress is everything to do with me yknow I stress him out (.) right (.) he has to do school run [and*) (293). Kevin tries to contest Mandy's claim in overlapping talk (296) but Mandy continues with an extended turn in which she elaborates the stresses that she sees as relevant, her panic attacks, Kevin having to look after the children, and make sure that she is not self-harming (293 - 308).

So we can see that T1's suggestion (*that we ↑don't try to get into too much detail*) has been heard by Mandy as an invitation to change the topic rather than the amount of detail. T1s response, (*so we're talking about a lot of stress aren't we on a kind of daily basis*) (302-303) which ostensibly summarises Mandy's turn, in effect answers the question she put to Kevin earlier (*is there any kind of pattern to how (1) frequent things can build up (.5) due to kind of stress (.) on you Kevin?*)(261-262). Kevin's agreement in the next line (*yeah I suppose yeah*) supports that reading. T1's formulation successfully invites Kevin to move towards an agreement with Mandy, that her behaviour *does* cause stress. In line 305 Mandy continues with her description of her stressful behaviour and Mandy and T1's latching talk demonstrates T1's receptiveness to *this* kind of detail (Mandy *and taking stuff away [...] the obvious things away (.) that you might hurt yourself with*) (308 – 309).

Identity categories

Let us compare the membership categories implied before and after T1's intervention. Just before, Mandy was drawing on the SRPs parent/parent and parent/child. The SRP parent/parent is symmetric, with equal duties and obligations while parent/child is asymmetric, with each member

having different rights and responsibilities. Mandy constructed herself as an equal to Kevin, assuming her right to defend her child against Kevin's unreasonable parenting. Thus the details of description in this case were used to ascribe Kevin the qualities of bad parent and justify Mandy's actions. Following T1's intervention Mandy draws on a different set of CBAs to describe Kevin, doing the school run, looking after the kids and then safe-proofing the house. So Kevin is ascribed the identity of responsible parent and Mandy, within the SRP parent/parent as not only failing to fulfil her obligations but making unreasonable demands. She confirms these implications with (*so (.) I suppose .hh its like someone looking after a toddler isn't it.*) (312). The descriptive detail is used in the service of mitigating Mandy's failings and warranting Kevin's moral worth. The CBAs 'panic attacks', 'self-harm' and 'safe-proofing' imply the SRP patient/carer within the MCD mental illness. Patient/carer is another asymmetric pair, where Mandy is fulfilling her duties as patient to get better (by talking about her difficulties) and Kevin is fulfilling his duties as carer to look after her. T1 then can be seen to encourage details that exonerate and praise, while details that blame and justify are discouraged.

Kevin responds (∘*no I don't think its like that*∘ *[..] I ↑wanna look after you I like it (1) its stressful yeah so* ∘*I like doing it*∘)(313). Thus Kevin has now explicitly conceded that Mandy's behaviour is stressful but, despite this, he wants to be a carer. The two second pause is difficult to read. Kevin has directly addressed Mandy and Mandy therefore has the right to the next turn. However, participants might be waiting for Kevin to elaborate further. This marks a disturbance in preference organisation, with conflict interrupted and all parties recalibrating to begin a new sequence.

Therapist repair of the couple alliance

317 T1   We talked (1) I don't know ho:w how clearly you remember the conversations
318   we had last time
319 K   not very much (.) I'm getting a really bad memory [actually I] forget

320	T1	[ha ha]
321	M	We was talking about when we first met
322	K	>yeah, yeah, yeah that's right yeah<
323	T1	Cos yknow I think you were touching on there Kevin that that you y-you kinda
324		like (.) wanting
325	K	[yeah yeah]
326	T1	[to help Mandy (.) and that even if its stressful its something
327		that yo-you do
328	K	yeah
329	T1	and you're the(h)re
330	K	[yeah]
331	T1	[you(h)re h(h)ere u:m but I think yknow that's kind of what
332		Mandy's also saying .hh theres a lot of things which happen just on a daily
333		↑basis .hhh involving you, involving the children, involving how (.) you
334		react or how Mandy's reacting that either one of you will react to .hhh
335		which actually can be a lot of stress
336	K	yeah it can be actually um
337	T1	and you've talked a bit about a lot of your kinda role has been as a carer.hh
338	K	yeah=
339	T1	=over the years you know to your mum an:d=
340	K	=yeah=
341	T	=and to Mandy when you got together and(.) yeah so its something which
342		you've become used to doing
343	K	yeah
344	T1	ha ha ha and in many ways you've elected to do you've chosen to do
345	K	yeah
346	T1	haven't you
347	K	yeah
348	T	and that's important to not lose sight of.
349	K	∘I like it∘
350	M	its hard because I feel like I don't show Kevin enough affection (1)

T1 solves the problem by supporting Kevin's claim that he wishes to care for Mandy by constructing a long formulation for which she draws from their first meeting (not included), the upshot being that caring is something Kevin has (el<u>ect</u>ed to do you've <u>chos</u>en to do) (345). Thus T1 makes relevant Kevin's choice to be a carer, and shifts the responsibility to Kevin as a responsible agent rather than a passive victim of Mandy's behaviour. Mandy's response mirrors this shift, by claiming responsibility for a negative event rather than blaming Kevin (*its hard because I feel like I don't show Kevin enough affection*) (351).

Discussion

Doing systemic- how systemic therapy is talked into being

I have shown how T1 packages previous talk of an argument and the feelings evoked in order to introduce them as a topic suitable for therapy. Thus T1 displays key elements of a systemic therapy. That therapy is a place to explore relationships and feelings, and that the experiences of all family members are relevant. Mandy co-operates by talking about relational difficulties and stress. However, the therapist encounters a difficulty. Kevin doesn't talk easily while Mandy talks readily, and furthermore Mandy is highly critical of Kevin's reticence. Mandy's main complaint can be summarised thus; Kevin's stress causes arguments and despite Mandy being the cause of the stress he is to blame because he will not admit his difficulties and get appropriate help. The therapist is faced with two problems. How does she encourage Kevin to talk, a minimal requirement for a talking therapy, without being perceived as favouring Mandy's position? Also, how does she stop Mandy from blaming Kevin without causing offence to her?

What is the problem?

T1 uses the structural properties of questions to pursue answers from Kevin that fit with her therapeutic agenda. By means of these questions she

demonstrates which answers are seen to be relevant and which not. She embeds the pre-supposition that arguments do occur due to stress and by demonstrating her curiosity about these arguments, displays that these are a relevant topic to the task in hand. However she resists Mandy's linear, blaming explanations and favours those answers that imply the reciprocal nature of Kevin and Mandy's relationship. By these means T1 successfully achieves Kevin's agreement that stress does build up and arguments do occur, while also enabling him to avoid specifically blaming Mandy. Thus the task of constructing a relational problem suitable for family therapy is achieved.

Who is to blame?

Once a problem is identified, the next task is to work out who or what is responsible for it in order to resolve it. As T1 pursues the challenge of gaining Kevin's co-operation in admitting to an interactional problem, so Mandy co-operates by elaborating her complaints. As Mandy builds her complaints against Kevin her descriptions become increasingly blaming. Explicit blame prompts T1 to interrupt the complaint sequence. Following T1's delicately and somewhat ambiguously worded invitation not to go into detail Mandy changes tack, and rather than blame Kevin she blames herself. T1 encourages details of Mandy's illness and the effect on Kevin. T1 then has used her authority as a therapist to sanction Mandy's contributions that blame Kevin and encourage Mandy's contributions that blame her-self. Pomerantz has shown that in routine conversation, 'self-depreciation' usually invites a reversal of preference structure, where agreement is dispreferred:

> If criticizing a co-conversant is viewed as impolite, hurtful or wrong (as a dispreferred action), a conversant may hesitate, hedge, or even minimally disagree rather than agree with the criticism. (Pomerantz 1984, p. 81)

Self-blame then projects disagreement in general conversation. In a therapy context however, the usual preference structure is overturned and self-blame projects further exploration. This fits with a common therapeutic theme of the importance of taking responsibility for one's actions, with self-blame potentially seen as a first step towards change. T1 displays the relevance of Mandy's self-blame to the local context by her take up of the topic. However, self-blame has problematic implications for Mandy's identity which she mitigates with descriptions of her mental illness. As Mandy co-operates with accounts that become increasingly self-blaming Kevin challenges her, warranting his disagreement by agreeing that he does get stressed and then arguing that it is his choice to look after her. T1 then packages the talk in this sequence and in a prior session in order to formulate the natural upshot of the talk to be:

- there is an interactional problem caused by stress

- stress is caused by Mandy's behaviour

- Mandy's behaviour is not under her control (and therefore she is not to blame)

- Mandy is not to blame for Kevin's stress because he chooses to place himself in this position

- Kevin is not to blame because the stress is enough to make losing one's temper reasonable.

How do we talk about it?

By interrupting and mitigating blame T1 has successfully interrupted a conflict sequence and enabled the conversation to continue in a way that strengthens the alliance between the couple. Alternative narratives and identities are constructed for Kevin, from an unfair father and argumentative husband to a diligent father and caring husband. T1 has displayed impartiality by firstly aligning with Mandy and pursuing responses from Kevin despite his resistance. She has then aligned with Kevin and stopped further exploration of the topic as it has become too critical.

Within the session Mandy has displayed her engagement with the process of therapy with her ability to claim her speaking rights and the topics she brings. Kevin however has shown resistance to the topic under discussion in his minimal responses. T1's packaging of Kevin's contributions from the previous session then could also be seen as a way of displaying her understanding and empathy towards Kevin as a means of building an alliance with him.

The delicacy with which T1 interrupts blame displays respect for the relevance of the topic. She implicitly proscribes blame by suggesting not going into too much detail now but also suggesting they will come back to this subject in time. The formulation offers a means to close the topic while paying attention to the moral identities of both Kevin and Mandy. Thus the therapist implicitly proscribes blame in a non-blaming way.

What are the consequences?

T1's formulation seems to resolve the threat to the couple alliance that blame and conflict bring. However the solution depends on Mandy being seen as not responsible for her actions. Also Kevin's behaviour is only deemed reasonable due to the weight of his burden of care. Mandy's complaint that Kevin neither talks about nor gets help for his stress has been largely evaded. Agency has been evoked in terms of Kevin's choice to be there but neither Kevin nor Mandy are held accountable for their behaviour. T1 has done most of the work to reformulate Kevin's position and although Kevin has agreed with this reformulation, he has actually contributed little to the conversation.

As we will see in Part 2, rather than the problem being resolved it will emerge later in the session in another form.

Part 2

Introduction

Part 2 picks up the conversation midway through the session and shows how the unresolved problem in Part 1 leads to a misalignment between Mandy and T1. The transcript can be found in Appendix D, sequence 2.

The context of the data selected.

This sequence occurs 40 minutes into the session. Between this and the first sequence the conversation has turned to an exploration of why Mandy finds it difficult to show affection to Kevin and the effects of her early history on her current mental health and relationships. Just prior to this sequence Mandy has been describing a history of severe physical and sexual abuse, partly perpetrated by her mother.

Shaping a systemic explanation

700	T1	.hh So coming back to th- the question Mandy how does (.) those experiences
701		affect you in the present in terms of (.) <u>how</u> you are trying to cope and deal
702		with (1) events in your life and (.) how that fits in with your stress levels.
703		How-how do you [make sense] of that.
704	M	[U::m] I'm doing a lots of work with Anne at
705		the moment I'm trying to deal (.) cos I am an emotional personality
706		disorder but that is because of how I've been brought up
707	T1	mm
708	M	So I try and focus on my feelings a <u>lot</u> (.) to try and show Kevin some love an-
709		(.) ∘and some compassion and that∘.
710	T1	So having those experiences (.) a lot of your growing up years (.) ha- makes
711		you feel that you <u>don't</u> show that kind of c-care and (.) love <u>to</u> Kevin
712		towards Kevin.
713	M	Sometimes I feel that with my mouth (.) sometimes I <u>catch</u> myself thinking
714		God I'm turning into my mum? because she was- <u>she</u> was vicious with her
715		mouth (.) and I <u>hate</u> myself for that
716	T1	So you find yourself reacting in ways you don't

717	M	°yeah°
718	T1	that you'd kind of experienced yourself
719	M	°yeah°
720	T1	others people other people being (.)[yeah?]

T1 formulates Mandy's previous talk to package it into a task that fits a common therapeutic agenda, how the past (*those experiences*) (700) affects Mandy (*in the present*) (701). T1 frames her question in terms of strengths rather than problems (*in terms of (.) how you are trying to cope and deal with (1) events in your life*) and ordinary human experience (*and [..] your stress levels*) rather than diagnostic categories. The one second pause before the phrase (*events in your life)* may indicate T1 searching for a neutral word. Mandy has been talking about abuse in her family and her own experience of Schizophrenia, which she has unambiguously named as a diagnosis with which she agrees (not shown). Due to the sequential placement of this formulation, we can see how T1 makes two MCDs, 'the family' (*those experiences*), and 'mental illness' (*stress*) relevant but in a rather ambiguous manner.

The costs and benefits of ambiguity

The cost of utterances that are designed to be ambiguous is that they can create a problem for the hearer to know how to take them up. The benefit is that they can offer the hearer an opportunity to interpret the speaker's intent in a variety of ways. T1's language places both experience and stress within the realms of ordinary human experiences that go to make up types of personhood. In this way she is opening up the possibility of different narratives and identities for Mandy. Imagine if T1 had instead said "So in terms your abuse, how are you dealing with present problems like your arguments, schizophrenia and self-harm. How do you make sense of that?" By making the formulation ambiguous T1:

- avoids judgement and overt causal connections

- offers a formulation that reframes Mandy's extraordinary experience as ordinary

- offers Mandy a choice about whether she wishes to accept the causal connection subtly implied

This is an example of the therapist opening up different narrative possibilities for Mandy, and through her lexical choices moving away from a diagnosis driven story to one of ordinary human experience.

Doing non-blaming

Mandy's response draws on the CBA 'therapy' (*lots of work with Anne*) (704). Anne is a therapist and therapy here is a version of the CBA 'dealing with'. She is trying to deal with the membership category (*emotional personality disorder*) (705) which fits within the collection 'psychiatric diagnoses' which belong to the MCD 'mental illness'. This psychiatric diagnosis is of the type caused by (*how I've been brought up*) (706). By adding this description Mandy is implying differentiation from other diagnoses. 'How I've been brought up' then is a CBA made relevant by the MCD Mental Illness. How Mandy is trying to deal with mental illness then is to (*focus on my feelings a lot (.) to try and show Kevin some love an-(.)∘ and some compassion and that∘*) (708-709). So the CBAs 'focusing on feelings' and 'showing love and compassion' are versions of the CBA 'getting better' or perhaps in this case 'coping better' within the MCD 'mental illness'. They could equally be read as CBAs within the MCD 'family' as what *should* happen in families. Recovery from mental illness becomes interwoven with transforming trans-generational patterns from abuse to love within a family, a belief that clearly fits with the systemic project. T1's next formulation in line 710 emphasises the connection between Mandy's childhood experience and her claim that she does not show enough love to Kevin. This invites further elaboration from Mandy (*Sometimes I feel that with my mouth (.) sometimes I catch myself thinking God I'm turning into my mum? because she was- she was vicious with her*

mouth (.) and I hate myself for that) (713 -716). Note Mandy's self-repair where (*sometimes I feel*) is changed to (*sometimes I catch myself*). This serves to mitigate the culpable action of 'being vicious with ones mouth' with the implication that it is something that has 'just happened'. The responsible agent becomes the Mandy who both 'catches herself' and 'hates herself' rather than the Mandy who is vicious. T1 responds with another formulation which emphasises the systemic theory that relationship patterns are transferred across generations and maintains the structure of Mandy's construction of something that 'just happens'(*So you **find yourself** reacting in ways you don't [..] that you'd kind of experienced yourself [..]*) (my emphasis). Mandy's soft agreement tokens during this formulation and overlapping "yeah" at the beginning of her response shows strong agreement.

Constructing responsibility without blame.

Mandy and T1 thus co-construct a causal explanation for Mandy 'being vicious with her mouth' which *both* holds her responsible for her behaviour *and* absolves her of blame. Apart from general norms that verbal abuse is seen as reprehensible, Mandy has already implied that 'showing love and compassion' is a CBA she is striving for as a means of getting better. It is also a CBA connected with how families are expected to behave. 'Being vicious' is a mark of not getting better (being ill) *and* of replicating socially proscribed behaviours in families. Thus Mandy's moral standing rests on her *not* being responsible for her culpable behaviour (constructed as the result of illness caused by abuse) but *being* responsible for 'catching herself' and striving to do something different. This double description, displays a routine systemic practice of separating the problem from the person that serves to both decrease blame and increase agency.

Upgrading an agreement or recycling a complaint?

721 M   [yeah] I'll ↑be honest with you (.) I I really

722   <u>pun</u>ish Kevin I <u>do</u>. yknow I'm absolutely sur↑prised he's still with me to

723		be honest with you. I mean I-I suppose I abuse ↑Kevin. I've se<u>ver</u>ely
724		abused him.
725	T1	mm
726	M	He's always there to take the brunt of it when my schizo↑phrenias bad
727		y'know? he's the one who takes the brunt of it.
728		(2)
729	M	sh- He (h) don(h)'t ↑say anything he always says I don't care, I don't care.
730		(2)
731	K	[indecipherable]
732	T1	I mean <u>clearly</u> (.) Kevin what Mandy has experienced is [absolutely horrific]
733	K	[yeah yeah definitely]
734	T1	[isnt it]
735	K	[yeah]↑<u>yea</u>h
736	T1	a:nd um (1) I-I guess she's usin:g (.) strong words isn't she like
737	K	yeah
738	T1	y'know I guess I:: ab<u>use</u> Kevin is whats she saying
739	K	yeah
740	T1	i-is that how you experience it?
741	K	.hh ∘no- not all the time I mean ↑sometimes its: its bad but (1) dunno? Its∘
742	T1	You don't kind of th-think of in those terms yourself
743	K	∘no∘
744	T1	a-as abuse or
745	K	Dunno? I don't think so
746	T1	Ha, ha
747	K	∘don't know∘
748	T1	No (.) you don't.
749		(1)

Mandy continues, *([yeah] I'll ↑be honest with you (.) I I really <u>pun</u>ish Kevin I <u>do</u>. yknow I'm absolutely sur↑prised he's still with me to be honest with you. I mean I-I suppose I abuse ↑<u>Ke</u>vin. I've se<u>ver</u>ely abused him.)*(721-724). Mandy upgrades her description from the CBA 'vicious with her mouth' to 'abuse' within the MCD family. She places herself firmly in position of agent, and consequently, as culpable. The level of her abuse is such that by any

normal standards within the SRP couple she has infringed her right to their continued relationship. However, while claiming the identity of abuser Mandy also defends herself against it by displaying both her recognition of and tacit agreement with the socially proscribed nature of her behaviour. Mandy then shifts the context by evoking the MCD 'mental Illness' (*He's always there to take the brunt of it when my schizo↑phrenias bad y'know?*)(726). Mandy's culpability is mitigated by the membership category 'schizophrenic', shifting her from category of abusive (culpable) wife to mentally ill (exonerated) wife. So both Mandy and Kevin become constructed as victims of the abuse that schizophrenia causes.

Trouble

The two second pause in line 728 indicates some trouble regarding turn take up. Mandy has constructed herself as severely abusing Kevin and so Kevin would usually have a 'right to reply'. Mandy validates this reading with (*sh- He (h) don(h)'t ↑say anything*)(727), presenting Kevin's silence as a complainable. Schegloff (2005) defines complainables as those tentative, often ambiguous utterances that are designed to test how a complaint may be received. Mandy's elaboration (*he always says I don't care, I don't care*) (727) further compounds the complaint that Kevin's lack of resistance to her abuse is accountable. So we can see how Mandy's description of her abuse of Kevin is an upgrading of her earlier confession that she causes stress to Kevin (see Part 1). It is designed with the same intent, to invite Kevin to talk. Mandy's laughter tokens are somewhat ambiguous. They may mark this is a delicate matter and an attempt to mitigate potential conflict. On the other hand they may be read as displaying frustration and even contempt.

Mitigation as repair

Mandy's complaint is followed by another two second pause before Kevin's response (so quiet it has not been possible to transcribe). The pause indicates some trouble and despite being unable to hear Kevin's response

we can see from its shape it is brief and therefore resisting Mandy's invitation (or challenge) for him to speak. T1's response confirms this reading of an impasse between Kevin and Mandy. She attempts a repair by questioning Mandy's description of her treatment of Kevin as abuse. She uses an extreme case formulation (*absolutely horrific*) (732) to describe Mandy's experience in a rhetorical question designed to elicit Kevin's strong agreement, which she readily receives in overlapping talk. Her next turn (*usin:g (.) strong words [...]I:: ab<u>use</u> Kevin is whats she saying*)(738) is designed to compare Mandy's experience of abuse with her claim that she abuses Kevin. The comparison implies that while Mandy's experience was absolutely horrific, Kevin's experience is not. Thus the preferred answer to her question (*i-is that how you experience it?*) is 'no'. Kevin marks his answer as dispreferred by an audible intake of breath, a very quiet negative agreement followed by a mitigated disagreement (*hh °no- not all the time I mean ↑sometimes its: its bad but (1) dunno? Its:°*) In lines 742 to 745 T1 pursues his agreement but Kevin continues to resist the force of her formulation with weak agreements and (*don't know*)(747), which T1 finally acknowledges (*No (.) you don't*)(748).

The benefits and costs of mitigation

By comparing Mandy's experience of childhood abuse with her description of abusing Kevin, T1 is attempting to mitigate the culpability of Mandy's actions. She does this by implicitly invoking the comparison between the asymmetric SRP parent/child with the symmetric SRP husband/wife. The abuse of a child by a parent is commonly seen as worse than the abuse of an adult by another adult. By mitigating the severity of the abuse the therapist is also mitigating Kevin's culpability for failing to stand up for himself. In systemic terms T1 is reframing the meaning of the behaviour by changing the context. However, by questioning Mandy's use of the term abuse in this way the therapist also potentially questions Mandy's standing as a competent judge of reasonable and unreasonable behaviour. A further problem created by T1's attempted resolution of the

impasse is that it places Kevin in a bind. To agree with T1 means he exonerates Mandy's behaviour, the very position which Mandy has complained about. Kevin resolves this interactional problem by saying (*dunno?*) a strategy commonly used to avoid potential conflict. (Muntigl and Tim Choi, 2010)

Repairing the consequence of mitigation

750	T2	↑I̲ sort of get a sense you're quite frus↑trated that Kevin doesn't react to that.
751	M	yeah
752	T2	I-I it feels ju- listening to you explain it Mandy it s̲o̲u̲n̲d̲s̲ like you're really
753		l̲o̲o̲king fo:r .hhh some sort of reaction for Kevin not to just keep t̲a̲k̲ing
754	M	[yeah]
755	T2	[the things] that you deliver.
756	M	.hhh sometimes I've w̲a̲n̲t̲ed Kevin to b̲e̲a̲t̲ me, I've w̲a̲n̲t̲ed him to I think I n- I
757		n̲e̲e̲d̲ him to .hh yknow=
758	T2	=because?
759	M	because um praps I-it'll make me a better p̲e̲r̲s̲o̲n
760	T1	∘right∘
761		(2)

T1's attempted repair is met with a one second pause, marking trouble. T2 takes up the turn, (*I-I it feels ju- listening to you explain it Mandy it s̲o̲u̲n̲d̲s̲ like you're really l̲o̲o̲king fo:r .hhh some sort of reaction for Kevin not to just keep t̲a̲k̲ing [..] [the things] that you deliver*)(750-755). She ties her turn with Mandy's complaint and constructs a reinterpretation (Bercelli *et al.*, 2008). Reinterpretations differ from formulations in that the therapist explicitly adds something of their thoughts rather than (purportedly) merely presenting a summary of the clients talk. T2 invokes the SRP couple, where it is reasonable to be frustrated if ones partner fails to react to them. Thus Mandy has the right to a response from Kevin, to be stood up to and dealt with as an adult. Both are constructed as responsible agents and as such Mandy can be heard as culpable for her actions and Kevin as culpable for his passivity. Mandy shows her agreement with this by upgrading her

complaint against Kevin with (.*hhh sometimes I've wanted Kevin to beat me, I've wanted him to I think I n- I need him to .hh yknow=*) Pomerantz (1984) shows how agreements of assessments are often produced by a stronger term. In response to T2's (*because?)* she offers the explanation, (*because um praps i-it'll make me a better person*).

Claiming agency

Let's look at how Mandy constructs this rather extraordinary claim. She draws on the CBA punishment as a version of 'getting better' (*make me a better person*). Punishment might relate to the judicial system or to other institutions such as the family and its use here is somewhat ambiguous. Mandy uses it to construct a complex position where she both claims responsibility for her action by declaring her need for punishment while at the same time mitigating it by implying a subordinate position, like that of a child. Children not taught by their parents how to behave cannot be held responsible for their actions. Thus the MCD family is made relevant as she implies that Kevin's failure to discipline her has deprived her of the opportunity to become 'a better person'. However, Mandy is not a child and even if she were, within current white western social norms, beating a child would not be seen as reasonable. Gender identity categories may also be inferred. The implication that Kevin's lack of response is culpable evokes patriarchal category identities where men are sometimes obliged to give women a slap to bring them to their senses. However, again within current white western social norms this would not be judged reasonable behaviour. Violence towards women and children is formally sanctioned within the law. Similarly within the MCD mental illness, Kevin as a carer would not be expected to beat a patient, regardless of provocation. So the activities and category memberships Mandy draws on are not the social norm, and as such we would expect Mandy's account to be heard as problematic. We will examine the interactional consequences of these claims later, first let us try to make sense of this sequence.

The importance of context and sequence

One explanation, one that seems to inform T1's response to Mandy, is that Mandy is replicating relational patterns learned in her family of origin. The CA literature offers another (not mutually exclusive) explanation. Emmerson and Messenger (1977) point to the role of complaints in the social construction and management of troubles. Perceptions of something wrong are put into language as the first step to mobilising remedial action. Complaints serve to define what the trouble is and persuade third parties to a particular version of events. Formulating any event is contingent upon the interactional context, designed for particular recipients and their anticipated knowledge and beliefs. The complaint then is an emergent product of social interaction. What CA brings to our understanding of the complaint is the importance of sequential meaning. What has gone before in this conversation will influence the way that this utterance is constructed. Thus the meaning of the complaint depends on what has gone before.

Immediately preceding this sequence, Mandy has been describing her mother as a woman who punished Mandy by smashing her hand with a hammer and who sold her for sex to the highest bidder. She has also described both her father and herself as schizophrenic. Then T1 asks her how she makes sense of her current life in the context of her early experiences. We have seen how the MCDs 'family' and 'mental illness' are both made relevant. Mandy builds her case by drawing on the MCD 'family'. This carries with it associated duties of care, but also transgressive associations, the CBAs of abuse and violence carried out behind closed doors.

T1's questions funnel Mandy's responses into a formulation that links Mandy's current experience with that of her past, a common therapeutic convention. Mandy co-operates with T1 by drawing on the version of

family where the rights and obligations expectable are those of punishment and submission rather than love and care. Mandy then connects her own current behaviour with that of her mothers, (*sometimes I catch myself thinking God I'm turning into my mum? because she was- she was vicious with her mouth*) (714-715) and thus builds the argument that she abuses Kevin. So the extremity of her formulation should not be taken as a representation of her beliefs alone but as a communication whose meaning has been forged within the sequential context of the conversation.

Explaining or explaining oneself

Let us return to the differentiation between "explaining and explaining oneself" (Antaki and Leudar, 1992, p. 181) the former being an utterance designed to explain the relationship between one thing and another (explanation as answer) and the latter designed to persuade the other to the validity of one's argument (explanation as claim backing). The former is concerned with affairs external to the conversation itself, the latter with whether the hearer finds the explanation persuasive or not. What is made relevant concerns ones status as a socially rational agent within the conversation. One of the main keys to unlocking the meaning is "*the assumed agreement on, or quarrel about, the state of affairs being explained.*" (Antaki and Leudar, 1992, p.186, italics in original).

With this in mind let us return to Sequence 1 to see what connections can be made. The gist of Mandy's complaints against Kevin in Part 1 were sequentially built in the following way,

(*He has been stressed (.) he he just wont he just wont say [he wont be honest*) (234)

(we:ll Kevin Kevin is stressed with me (1) and right (1) he's stressed with the ho:use and stuff but he just wont ↑say it and it makes me cross cos I I ↑know he i:s) (247-249)

(I think he treats like Alfie different from the ↑girls) (272)

(he can be really nasty to Alfie) (284)

As Mandy's blame of Kevin increased, T1 intervened, and a new sequence began. If we read Mandy's complaint in the context of this earlier sequence we can see how an unresolved conflict in Part 1 is recycled in an intensified form.

(we:ll Kevin Kevin is stressed with me (1) and right (1) he's stressed with the ho:use and stuff but he just wont ↑say it and it makes me cross cos I I ↑know he i:s)(247-249)

has been upgraded to:

(I abuse ↑Kevin)(722)

(He (h) don(h)'t ↑say anything he always says I don't care, I don't care.) (726-7).

Extreme case formulations

So as to legitimize a complaint and portray the complainable situation as worthy of complaint, a speaker may portray the offense and /or the suffering with Extreme Case formulations. (Pomerantz, 1986, p. 227-8)

Where the speaker expects some resistance to the complaint a worst case scenario is often presented in order to make a case. We have seen that

Mandy has good reason to expect her portrayal of the trouble to be resisted by Kevin. This explanation then can be read not as principally concerned with affairs outside the conversation (childhood abuse causes Mandy to abuse Kevin) but as a warrant for Mandy's claim that the troubles in their relationship need to be talked about. She does this by firstly producing the complaint to fit the context constructed by T1's question, emphasising the effect of the past on the present. Then Mandy re-produces her complaint in a manner that fits the context constructed by T2's question, privileging the effect of Kevin's withdrawal on her.

Let me be very clear here. I am not suggesting that Mandy has a strategic plan. Neither am I suggesting that the impact of abuse on her is not real. Mandy has available to her narrative constructions that should not be available to anyone. She has them because people did terrible things to her. Her history is written with scars on her skin and recounted by the voices in her head. I am arguing that we should be careful in interpreting what is said as representing what is in her *mind* without carefully examining the other conversationalists' part in its construction. Why have these particular discursive resources been chosen now?

Discussion

What is the problem?

At first Mandy and T1 seem to be in agreement about the problem they are addressing, the effect of the past on Mandy's current mental health and behaviour. However, as the sequence unfolds we can see that Mandy is focusing on a different problem, Kevin's lack of response to her.

Who is to blame?

This second excerpt of transcript begins with T1 pursuing a common therapeutic task, making sense of current events in the context of patterns of thoughts, feelings and behaviours learned in the past. Systemic thinking posits that such patterns are not intrinsically good or bad but more or less

useful in any given context. Once established, interactional patterns have a self-reinforcing nature and can be difficult to change. However, when contexts change, patterns that were helpful can become problematic. One of the tasks of the therapist is to help people to adapt their habitual patterns to new circumstances in order to move on in their lives. Here we can see how T1 is creating a platform for exploration of this concept first by asking Mandy to reflect on how her past affects her present and then reinforcing this link in her subsequent formulations.

This demonstrates a routine systemic (or perhaps common psychotherapeutic) means of ameliorating blame. By emphasising how present behaviours, no matter how unreasonable, make sense in the context of what has come before family members (patients, clients, analysands) can be offered an explanation which mitigates culpability while at the same time offering a rationale for change.

What is reasonable blame?

Initially Mandy and T1 appear to be aligned as Mandy explains that she is trying to change her relationship patterns and show more affection to Kevin. However at times she worries she is too like her mother. As she warrants her claim, so the descriptions of her behaviour become more extreme. Mandy's claim that she abuses Kevin prompts T1 to challenge her description (lines 732 to 749). By comparing Mandy's childhood experience with that of Kevin's adult experience T1 reframes the term abuse to something less severe and thus mitigates blame. Reframes are a common tool of the systemic therapist, changing the meaning of a word or concept by changing its context. Thus T1 demonstrates what she judges to be reasonable blame in this context.

What are the consequences of mitigation?

T1 then is working hard to uphold Mandy's moral standing through mitigation. However, by mitigating Mandy's culpability T1 displays that she

judges Mandy's claim to be exaggerated. This potentially undermines Mandy's position as a credible person. Mandy's agency is questioned, both in the sense that she cannot be held responsible for her actions due to the severity of her abuse, and that the abuse has rendered her incompetent to evaluate what constitutes abuse and what doesn't. In this case the cost of mitigating blame is to be positioned as socially incompetent. T1 also tries to recruit Kevin to her project of challenging Mandy's claim. However if Kevin agrees with T1 he will be displaying the very behaviour Mandy is complaining about (*he always says I don't care, I don't care*) (729). He resolves this dilemma by claiming ignorance.

Misalignment- different problems require different solutions

One of the reasons for this impasse seems to have been a misalignment between Mandy and T1's interactional projects. Where T1 is foregrounding the effect of Mandy's past on her present relationships Mandy is foregrounding the problem of Kevin's lack of response to her. T1 reads Mandy's contribution as 'explanation as answer', explaining why her current behaviour is reasonable given the extremities of her past. Mandy however is talking from the domain of 'explanation as claim backing' where Kevin's lack of response can be judged unreasonable given the severity of her abusive behaviour towards him.

Realignment- redefining the problem

T2 steps in to breach this impasse and reinterprets Mandy's contribution as 'explanation as claim backing'. As well as acknowledging Mandy's intent she also re-interprets Mandy's complaint drawing on a common systemic concept, the pursuit and withdrawal cycle. As one partner pursues the other for a response, the other becomes increasingly withdrawn, leading to increased pursuit and so on in a redundant repetitive pattern. These sequences demonstrate the construction of a pursuit and withdrawal cycle within the micro process of the therapy session itself, with Mandy pursuing Kevin for a response and Kevin resisting.

T2's contribution thus serves to align with Mandy by indexing Kevin's lack of response as the topic while also emphasising the circular nature of the problem. Mandy and Kevin become equal partners with choices about whether they continue to pursue and withdraw. In this way their agency and responsibility is highlighted.

Team work

In both therapies, the qualified systemic therapists contribute a great deal more talk than their co-therapists. In this case T2's intervention interrupts T1's interactional project in a way that helps to repair a misalignment between Mandy and T1. Mandy strongly agrees with T2s formulation; however her elaboration of that agreement, that she would like Kevin to beat her causes another 'trouble' which results in further misalignment.

In Part 3 we will see how the problem of continued misalignment is solved by explicit blame, and how the pursuit and withdrawal cycle is interrupted sufficiently for Mandy and Kevin to pause and face one another in the session.

Part 3

Introduction

This final excerpt of transcript follows directly, with no omissions, from that analysed in Part 2. The rationale for breaking the sequence at this point is to highlight a kind of change of gear in the interactional process. The reasons for and consequences of this gear change are the main theme of this part of the analysis. This excerpt begins at line 762 where T1 shifts her stance towards Mandy to pursue a particular interactional project. I begin with a brief resume of the talk immediately preceding this extract and have included lines 759 – 761, discussed in Part 2, for ease of reference. The analysis shows how an explicit blaming event serves as a solution to a recurrent misalignment between T1 and Mandy. Finally, I draw the threads of all three sequences together with a particular focus on the impact of the therapists' interactions on blame.

The context of the data selected.

In Part 2 we have seen how a misalignment between T1 and Mandy has led to an impasse. T2 has intervened in such a way as to reframe the problem to one of Mandy seeking a response from Kevin. Mandy agrees with T2's reading and upgrades her agreement with the claim that sometimes she wishes Kevin would beat her. T2's enquiry (*because?*) elicits Mandy's explanation (*it 'll make me a better person*) (759).

From opposition to conciliation

759	M	because um praps I-it'll make me a better <u>pers</u>on
760	T1	∘right∘
761		(2)
762	T1	<u>and having Kevin (.)</u> beat you (.) would that be: moːre of the ↑old
763		pattern or moːre of something <u>diff</u>erent happening in your own mind.
764		(2)
765	M	.hh no it would jus- I don't know I ↑just- I just <u>feel</u> it would just make me a

766		better person.
767	T1	mmm
768	M	um
769	T1	its interesting what you're saying cos you're <u>loo</u>king for somethi:ng <u>diff</u>erent
770		to be happening like being a better person(.) I guess its an aspiration its
771		something you strive for (.) yeah?
772	M	◦yeah◦
773	T1	cos you're saying you don't <u>fee</u>l you're a very good person
774	M	◦no◦
775	T1	how you think, or how you feel, or how you behave at times
776	M	yeah no I'm not a good person
777	T1	but what you're ex<u>pec</u>ting from Kevin i:s (.) you said <u>ear</u>lier that Kevin is the
778		first person who <u>hasn</u>'t abused you
779	M	◦yeah◦
780	T1	but what you're <u>expec</u>ting from Kevin is almost to respo:nd back with
781		physical abuse
782	M	◦yeah◦
783	T1	to make you kind of <u>bet</u>ter (.) but actually it would be part of what would have
784		been happening bef<u>ore</u> (1) of what you'd expect from people that people
785		abuse you.
786	M	◦yeah◦
787	T1	◦yeah?◦
788	T1	But its interesting what Jan was asking before isn't it that you are expecting a
789		<u>diffe</u>rent response from Kevin.

The pause in line 761 shows some problem encountered by participants with how to go on. Two issues seem relevant. One is that of structure, the other of moral evaluation. The structural problem is concerned with the management of question and answer adjacency pairs. Generally, the person who asks a question, in this case T2 has a right to the next turn following the reply. T1's acknowledgement of Mandy's response effectively interrupts the question chain and creates some ambiguity about next turn speaking rights. The problem posed for the therapists is how to take up *this*

claim. T1 has clearly displayed access to greater speaking rights throughout the session evidenced by the frequency of her contributions compared to T2. Here we can see how T2 co-operates with this asymmetric pairing by ceding her turn to T1.

The strategic use of questions

Within the institution of therapy, therapists have rights to question while clients have the duty to respond, and to respond truthfully (Labov and Fanshell, 1977). Therapists hold the power to control the conversational contributions of others in the exchange, and questioning plays an important role in the management of the session (Gale, 1991; Bartesaghi, 2009; Peräkylä, 1995). Also, by virtue of their claims to professional knowledge, therapists have the power to interpret what is going on. In systemic therapy, questioning as a therapeutic tool forms a central component of the therapists' SIKs. The Milan associates conceptualisation of 'circular questioning' as the chief means of adhering to the three guiding principles of hypothesising, circularity and neutrality (Selvini Palazzoli *et al.*, 1980) and Tomm's (1987a, 1987b, 1988) subsequent work, elaborating a taxonomy of questioning strategies, have had a major influence on the development of systemic theory and practice in the UK. In this sequence T1 can be seen to use the constraining power of questions to pursue her interactional project.

T1 re-contextualises Kevin beating Mandy by comparing it to Mandy's previous story of abuse (*and having Kevin (.) beat you (.) would that be: mo:re of the ↑old pattern or mo:re of something different happening in your own mind*) (762). By comparing Mandy's previous account of being beaten, which she has condemned as morally wrong, with her claim to want to be beaten now, it would be very hard for Mandy not to agree that it is more of the old pattern. The natural upshot of this question is that to expect Kevin to beat her would *also* be morally wrong. However, disagreement is interactionally tricky and where therapists have

asymmetric rights to the interpretation of family troubles, doubly so. In systemic terms this is an example of a fairly routine strategic question, where the therapist is not really asking a question so much as making a point. Mandy marks her response as dispreferred, first by a long pause and then (*.hh no it would jus- I don't know I ↑just*) (765). Note that she immediately follows her disagreement with 'I don't know' thus mitigating her challenge to T1's rights to specialist knowledge. She continues (*I just feel it would just make me a better person*). This is an example of what Labov and Fanshell (1977) call an A-event statement, where the claim is based on personal knowledge not usually seen as accessible to others, and therefore more difficult to refute. Where therapists have more claim to interpretative rights, clients have more rights to personal knowledge including thoughts, feelings and events. Mandy thus uses her feeling as a legitimate warrant for her disagreement with T1. T1 pursues her re-interpretation by means of a series of rhetorical actions over a number of successive turns each of which make relevant Mandy's assent.

Upgrading the argument

T1 begins by constructing an argument which is ostensibly the natural upshot of Mandy's earlier talk, (*its interesting what you're saying cos you're looking for somethi:ng different to be happening like being a better person(.) I guess its an aspiration its something you strive for yeah?*)(769-771). Mandy offers a soft minimal agreement (∘yeah∘). T1 then transposes Mandy's previous words (*I just feel it would just make me a better person*)(765) to a different context *(cos you're saying you don't feel you're a very good person*). The emphasis on 'feeling' serves to undermine Mandy's implied claim that she *is* a bad person who *feels* that she can be made better and makes Mandy's *badness* a debatable matter. Following another minimal negative agreement token (∘no∘) T1 pursues her argument by separating evaluations of good or bad from Mandy as a person (the MCD types of person) and locates them in types of action (*How you think, or how you feel, or how you behave at times*) (775). This serves an

important therapeutic function. Mandy is categorizing herself as the type of person who is bad. CBA's then become tied to the category bad person so that even ostensibly neutral actions may be judged as potentially self-serving or suspicious due to the constraints of the category in use. By placing CBA's in the forefront, T1 makes possible alternative member categories within the MCD 'types of person'. T1 thus achieves the systemic idea of separating the person from the problem with a view to deconstructing totalising descriptions and making possible alternative identity positions.

Resistance

Mandy counters the mitigating effects of T1s turn with an agreement prefaced disagreement, (*yeah no I'm not a good person*)(776). She resists T1's move on two grounds, first by implying it is not *just* a feeling but a fact and, secondly, that it is her personhood not her behaviour that is relevant. T1 treats Mandy's response as irrelevant, instead pursuing her own argument (*but what you're ex<u>pect</u>ing from Kevin i:s)*(780). At this point T1 self- repairs, embedding her argument in Mandy's prior words and seeking her agreement *before* pursuing her argument (*you said <u>earl</u>ier that Kevin is the first person who <u>hasn</u>'t abused you*)(777). Although this is a statement rather than a question it follows the same procedural rules as a question/answer adjacency pair by strongly projecting an answer in the next turn (Schegloff 1984). Mandy co-operates with a minimal agreement token and T1 then goes on to conclude her argument (*but what you're <u>expecting</u> from Kevin is almost to respo:nd back with physical abuse [..]to make you kind of <u>bet</u>ter (.) but actually it would be part of what would have been happening bef<u>ore</u> (1) of what you'd expect from people that people abuse you*)(780-785). T1 responds to yet another minimal agreement token from Mandy with a tag question (◦*yeah?*◦) designed to confirm Mandy's agreement before continuing.

T1 counters Mandy's claim that she is a bad person by implying that Mandy's *thinking* is faulty. Mandy is positioned as the passive recipient of family interactions which she replicates without full understanding or agency. Mandy's responses to T1's argument are ambiguous. In this case, T1's argument takes the form of a re-interpretation. Bercelli *et al.,* (2008) have shown that therapist reinterpretations are similar to therapist formulations in that they both refer to personal events that clients have greater access to. However because reinterpretations explicitly propose views that are additional to or different from those that the client has said, client agreement or disagreement is necessary to warrant the reinterpretation. Where a minimal agreement token then is commonly sufficient following a formulation, therapists often pursue more extended agreements with reinterpretations.

So, T1 is constructing an argument in such a way as to make it difficult for Mandy to disagree without infringing both the procedural rules of the question/answer sequence and the normative rules of the therapy encounter. T1 greatly constrains what is possible for Mandy to answer in the next slot. Thus Mandy's minimal agreements in this context cannot be read as agreement with T1's interpretation so much as co-operation with the structural properties of the talk. By establishing a structural dynamic in which Mandy's answers have the *appearance* of agreement, T1 can continue within the institutional aim of persuading Mandy towards a different way of thinking. T1's next turn (*But its interesting what Jan was asking before isn't it that you are expecting a <u>differ</u>ent response from Kevin*) (788) is evidence that T1 has not heard Mandy's responses as sufficient to the task in hand.

Rupture

790 M   I ↑wish he would <u>speak</u> like I'm re(h)ally frustrated now cos he just
791   wont speak .hh
792 K   [indecipherable]

793	M	[and I just really want him to speak I really .hh I don't <u>want</u> him to
794		spare my feelings <u>I</u> [<u>want him to sit there and say right</u>]
795	K	[I'm <u>not</u> <u>I'm not</u>] I don't like it at ↑all
796	M	.hhh this is this and that is that and I- I get cross with her cos of this or
797	T	mm
798	M	[I jus-]
799	K	[No I ↑don't] like it obviously
800	M	it's like I feel like I'm layin I'm layin all my stuff <u>bare</u> here
801	T1	yes
802	M	and (.) he's not givin- he's not he's not giving ↑anything and its just like .hhh I
803		don't ↑<u>know</u> how he feels I don't ↑<u>know</u> w-what he thinks I cant (.) and
804		<u>that really</u> inf- <u>infuri</u>ates me because .hhh I just feel like I'm on m-my own
805		in this group be↑cause hes not .hh hes not <u>giving</u> anything

M's interruption of T1 and abrupt shift of topic (*I ↑wish he would <u>speak</u> like I'm re(h)ally frustrated now cos he just wont speak .hh*) (790-791) displays the strength of Mandy's disagreement with the relevance of T1's line of questioning. To end the question answer sequence involves breaching a number of procedural and normative rules, firstly to stop answering questions, secondly to interrupt the therapist's turn and thirdly to introduce a new topic, thus overturning the usual weight of the asymmetric relationship. In CA terms this marks a trouble which in mundane talk signals the requirement of repair in order to move on smoothly. In therapeutic terms it marks a rupture in the therapeutic alliance that may require repair for therapy to continue effectively.

When solutions become problems and vice versa

How did this breach of the norms come to be relevant? What was the problem T1 was trying to solve by her insistence on this reinterpretation and what problem did it set up for Mandy that made her overturning of the local order seem reasonable?

Mandy's choice of 'beating' as an activity associated with 'getting better' is a strong challenge to the institutional norms of therapy and as such poses a dilemma for the therapists. Do they accept this as an argument which warrants exploration or take a position against it? However, directly contradicting a client's view does not sit easily with a systemic therapists 'neutral', 'not knowing' and/or 'collaborative' stance. In CA terms we know that a contradiction might be seen as a first move in a conflict sequence, one that orients participants towards disagreement. In systemic terms, an escalating symmetrical pattern is one which therapists have been trained to avoid. Thus T1 delicately constructs her argument to avoid the procedural structure of a conflict sequence by utilising a question/answer sequence that projects agreement. By using Mandy's previous utterances to warrant her argument, T1 strongly projects agreement which in turn invites a display of collaboration. By building her argument from judicious selections of Mandy's previous words she makes it difficult for Mandy to disagree without calling her own words into question. At the same time, T1 constructs her position as morally neutral, merely re-interpreting 'the facts' as Mandy has told her. Also, by attending to Mandy's past abuse as the reason why she should erroneously believe beating is good, T1 mitigates the culpability of making a statement that transgresses what is seen to be normal.

The structure of T1's argument serves to severely limit the relevant responses available to Mandy. So we can see a recurrence of the misalignment of tasks between T1 and Mandy, where Mandy speaks from the position of claim backing but T1 responds to her as if she were speaking from a position of explaining the facts. Mandy's abrupt change of topic serves to display Mandy's evaluation of T1's pursuit of her agreement as irrelevant. Instead Mandy makes relevant another topic, and one that she has raised before.

Re-negotiating the problem

Mandy recasts her complaint in a way that is unequivocal in design. (*I ↑wish he would speak like I'm re(h)ally frustrated now cos he just wont speak .hh [....] [and I just really want him to speak I really .hh I don't want him to spare my feelings I [want him to sit there and say right]*) (790-794)

Mandy's increasingly extreme descriptions of Kevin's failure to respond have been building evidence for the claim that Mandy makes explicit here. She draws on the MCD 'therapy' to imply that she is working hard to comply with expectations (*it's like I feel like I'm layin I'm layin all my stuff bare here*) (800) while Kevin fails to meet them. Furthermore her anger is justified (*because .hhh I just feel like I'm on m-my own in this group be↑cause hes not .hh hes not giving anything*)(804-805). Kevin's disavowals (*I'm not I'm not] I don't like it at ↑all*) (795) and again in line 799, mark a conflict sequence between Mandy and Kevin, evidenced by interruptions, raised voices and overlapping talk. This prompts T1 to action.

806	T1	.hhh Part of what's going on he:re is that we're actually (.) yknow meeting and
807		we're all being polite. Which is if we ↑all talked at the same time (.) none
808		of us would hear what the ot(h)her pe(h)rson was saying and .hhh um it
809		would be very hard to make ourselves heard .hh so theres a kind of social
810		etiquette isn't [there]
811	K	[yeah]
812	T1	that we take turns [to .hh]
813	M	[yeah]
814	T1	either speak, ask questions, or actually say how it is fro:m each of our points
815		of view .hhh so I guess as ↑you're saying things its very hard for you
816		Kevin to actually say something [or respond]
817	K	[yeah]
818	T1	but what we would ↑hope to do is gi:ve (.) both of you time to kind of think
819		about what the other person (.) has said [um
820	K	[yeah I ↑know its bad bu- when she

821		says things then I will say things to ↑her (.) like horrible thin:gs an-
822	T1	mm
823	K	ju- then after things have settled down I'll feel really <u>bad</u> because (.) I've
824		started s-<u>swe</u>aring at her and calling her horrible na:mes
825	T1	mm
826	K	makes it a lot worse I think (.) cos I said it
827	T1	∘right∘ so sometimes if you <u>do</u> react back to .hh Mandy an:d <u>verbally</u> you-
828		you're saying nasty things?
829	K	yeah
830	M	ve-<u>very</u> rare though (.) that probably happens like(.) twice a year?
831	T1	[m↑hm]
832	M	[if that]
833	K	I feel <u>bad</u> because I don't think I should be .hhh saying anything because of
834		what shes been through
835	T1	right (.) so in your <u>own</u> (.) for your own self Kevin actually that doesnt feel
836		like an OK thing to do.
837	K	yeah, yeah
838	T1	∘yeah∘
839	K	sometimes you just can't help an- it just happens so .hh h

In lines 806 to 810 T1 diverts Mandy's demand for Kevin to speak with this description of the interactional process, a description which is at apparent odds with what *is* actually happening. Why *this* now?

Repair

A rupture signals repair, both in mundane talk and in therapy. T1 responds to this trouble and abandons her task of re-interpreting the content of Mandy's explanation, instead re-aligning with Mandy's interactional project. She achieves this by indexing therapy process issues, 'how we talk in therapy' as the relevant topic. Yet, where Mandy implies Kevin is culpable for not talking, T1 implies Mandy is culpable for talking in the wrong way, a move that is potentially risky to the therapeutic relationship. However, the manner in which T1 constructs this challenge to Mandy not

only mitigates potential blame it also serves to avoid further conflict. How does she achieve this?

Initially T1 draws on the language of ordinary conversation to evoke common social norms of turn taking 'being polite' and 'social etiquette' to evoke a moral order in the therapy context where (*we take turns [to .hh]* […] *either speak, ask questions, or actually say how it is fro:m each of our points of view)*(812-815). This description evokes an ordinary, conversational relationship with equal rights and responsibilities. T1 draws on her authority as a therapist to make explicit that interruption and loud voices are not a reasonable expectation in the therapy context but she does this in a way that minimises the asymmetry in the relationship. In this way she projects a collaborative rather than authoritarian stance. She then offers an account for her actions further mitigated by laughter tokens *(if we ↑all talked at the same time (.) none of us would hear what the ot (h)her pe(h)rson was saying)*(807-808). This description of 'what we are doing' makes relevant Kevin and Mandy's transgression of these rules through interruption and overlapping talk without explicitly saying so. In CA we know that accusation most frequently invites denial. By describing the ideal of a polite conversation as 'what we are doing' T1 thus projects agreement and shifts the structural properties of the talk. Furthermore, T1's turn shifts accountability for the transgression of the rules from Kevin to Mandy (*as ↑you're saying things its very hard for you Kevin to actually say something[or respond]*(815-816). Thus we can see T1 returning to the systemic idea of circularity, this time highlighting that the more Mandy complains the harder it is for Kevin to respond.

As Mandy has repeated and upgraded her complaint against Kevin over the three sequences, culminating in this angry outburst against him, so T1 has repeated and upgraded her responses to Mandy's complaints, culminating in this explanation of the type of talk that she deems acceptable within a therapy context. The delicacy with which she does

this enables the conflict to be interrupted and achieves exactly what T1 says she wishes to do *(but what we would ↑hope to do is gi:ve (.) both of you time to kind of think about what the other person (.) has said [um]* (818-819). She opens a space for Kevin to respond.

Resolution

K's response sums up his dilemma (*yeah I ↑know its bad bu- when she says things then I will say things to ↑her (.) like horrible thin:gs an-[...] ju- then after things have settled down I'll feel really <u>bad</u> because (.) I've started s-<u>swe</u>aring at her and calling her horrible na:mes [...] makes it a lot worse I think (.) cos I said it*)(820-829)

Kevin displays how the disjunctive categories of husband/carer create a practical moral problem for him. When he responds to Mandy as a husband, within the symmetric pairing husband/wife, it is acceptable to respond to complaint with complaint. However, as a carer complaining about a patient for behaviour that is not their fault is not reasonable. Thus Kevin makes explicit his dilemma both inside and outside the therapy room. The severity of Mandy's abuse, and her illness, serves to absolve her of responsibility and thus of blame for her unreasonable actions. However, if she is not responsible for her actions then she cannot be held to account and thus he cannot respond to Mandy's demand to hold her to account.

Discussion

In Part 3 we have seen how a sustained misalignment between Mandy and T1 is solved by Mandy's explicit blame of Kevin. Mandy's argument, that Kevin *should* talk about their difficulties rests partly on the severity of the abuse she gives him. T1's mitigating explanations in effect undermine Mandy's argument. Mandy's angry outcry and explicit blame of Kevin act as a solution to a redundant pattern of interaction between T1 and Mandy by making explicit the purpose of her argument, that Kevin is reneging on

his responsibility as a client in therapy *and*, by implication, that T1 is failing to get the point.

The interactional problems

Mandy's interactional problem seems to be how to persuade participants to her position that Kevin is failing to respond to her adequately, while also co-operating with the interactional rules of therapy that are being constructed between them. T1's interactional problem seems to be how to respond to Mandy's claim, one that transgresses social and institutional norms, while showing respect for Mandy, rejecting the moral implications of her claim and displaying a neutral stance.

The attempted solutions

Mandy's claim that beating can be an acceptable means of improvement prompts T1 to action. The therapist counters Mandy's claim by highlighting the logical flaws in Mandy's argument while also offering an explanation for Mandy's claim which fits the therapy agenda. She exonerates Mandy from any potential culpability for holding such transgressive beliefs by locating them as the result of childhood abuse and mental illness. T1 maintains a position of neutrality by embedding her argument in a re-interpretation of Mandy's previous talk. However, the cost of mitigating blame is to position Mandy as socially incompetent.

The consequences

M's complaint against Kevin, that he is not participating sufficiently in the therapy, has an additional meaning given its sequential placement. It can also be heard as an indirect complaint against T1 and the irrelevance of her lengthy interpretation. The effect is that T1 changes tack and realigns more closely with Mandy's interactional project by topicalising talking. We can also see a repeated pattern of interaction threaded through all the sequences. Where the interaction between Kevin and Mandy becomes more conflicted and emotionally heated, so T1 interrupts the

accusation/denial patterns by talking about talking. In this case her intervention seems to interrupt the pattern sufficiently for Kevin to shift from conflict to co-operation and make a conciliatory move towards Mandy that serves as a closing to the opening of Mandy's interactional project in Part 1. He acknowledges her complaint as valid and offers a relevant explanation by explicitly talking about his dilemma.

The effect of T1's use of the routine systemic strategy of 'talking about talking' is to interrupt a conflict sequence and provide a context where the alignment between all parties is more favourable. In the following discussion I will consider how the therapists' interventions over the three sequences have contributed to this alignment.

Summary and Discussion of Therapy 2

Negotiating goals

In Part 1 of this Chapter I argued that Mandy and Kevin seem to have different ideas about what they want to achieve in therapy. Mandy wants to talk about the arguments between them and specifically wants Kevin to account for his behaviour. Kevin actively, although not explicitly, resists Mandy's goal. In effect, his goal in this session appears to be to deny or minimise the arguments and avoid talking about anything contentious. I have shown that T1's interactional project initially aligns with Mandy's. She encourages Kevin to talk, arguably because in any form of talking therapy a basic requirement is that participants talk, at least a little. Furthermore the talk needs to be relevant to the institutional agenda of family therapy, typically about relational difficulties. However, as Kevin minimises the problems in response to T1s enquiries, so Mandy upgrades her complaints against Kevin. The consequence of T1 aligning with Mandy in pursuing talk about the problem of arguments and the reasons for those arguments, is

the construction of a context which makes relevant Mandy's blaming of Kevin.

T1 utilises the identity positions of patient and carer to absolve both of responsibility for their arguments, laying the blame on the stress of illness. The consequence of her formulation is that it resolves the immediate conflict *at the expense of further exploration of the problem*. The sequence shows the negotiation, and particularly T1's influence upon the negotiation, not only of what kinds of problems are relevant to talk about but also *what kinds of talking are acceptable*.

Responses to blame and self-blame

T1 responds to blame by selecting from Mandy's complaints to highlight a *circular* pattern of interaction between Mandy and Kevin. Thus she locates the blame not in Mandy or in Kevin but in the interaction, a SIK fundamental to the systemic project. When this fails to interrupt an emergent pattern of blame and denial between Mandy and Kevin, T1 intervenes to change the topic to 'talking about talking'. This interrupts the pattern of blame and denial and Mandy responds by changing her stance to one of self-blame. She posits a potential explanation for Kevin's behaviour that it is her fault because she is ill. Where T1 has repeatedly intervened to divert or reframe blame talk, she receives self-blame talk (or confession) with invitations to expand, thus displaying a preference for confession over blame. Mandy's confession invites co-operation from Kevin with a reciprocal confession that yes he does get stressed but as he wants to care for Mandy he doesn't mind. T1 chooses to emphasise the veracity of his account by drawing on material from their first meeting as evidence and the conflict is ostensibly resolved. The findings of CA, that in mundane talk accusation projects denial and confession projects mitigation, are reflected in T1s actions. I suggest the systemic SIK that therapists should interrupt blame talk and invite responsibility talk are located in an implicit

understanding of these interactional processes that are grounded in practical knowledge.

Explaining or arguing

In Part 2 of this chapter I argue that Mandy reintroduces her goal, but in another guise, one that fits the emergent local rules of what kind of talking is reasonable here. She does this by fitting it to the context of the immediately preceding conversation, the effect of childhood abuse and mental illness on her current behaviour. She introduces the topic again from the position of confession, thus linking it with the closing of the sequence described in Part 1. In this case I show that T1 and Mandy become misaligned in their interactional projects. The distinction between 'explaining' and 'explaining oneself' is particularly pertinent to the meaning of the subsequent interaction. I show that where Mandy can be understood to be reintroducing the topic of Kevin's failure to sufficiently account for his actions, T1 is interpreting Mandy's account as an explanation for how things are. T1 uses a range of systemic techniques, circular questioning, reframing and strategic questions, to mitigate Mandy's self-blame by re-describing her claims *as the consequence of illness and abuse*. However, as a result she also places Mandy in the position of an unreliable witness, unable to fully differentiate bad behaviour from abuse. The more T1 mitigates Mandy's claims, the more Mandy upgrades her culpability. T1 is misaligned with Mandy and seems to be replicating the position which Mandy complains Kevin repeatedly takes. T1 fails to hold Mandy to account for her actions, and, for a moment, Kevin has the opportunity to watch this interaction unfold before him.

Team work

The other participant in this interaction, largely silent throughout these selections, T2, is also watching. Her observation is an important one that helps to create a relevant context for Mandy's outcry a few turns on. Her

formulation, that Mandy is seeking a reaction from Kevin, is validated by Mandy's strong agreement, but *the nature* of that agreement, that she wants Kevin to beat her, presents the therapists with a further dilemma, do they accept this claim, investigate it, ignore it, divert it or challenge it? Failure to challenge such a claim might be heard as a tacit acceptance of it. T1 chooses to challenge it. As a result, T2's project of highlighting the interactional process issues between Mandy and Kevin is diverted and the misalignment between Mandy and T1 continues. However, T2's observation perhaps provides the context for Mandy's subsequent interruption, 'I wish he would speak' which, *both* puts her goal explicitly back on the table *and* serves to mark T1's interactional project as irrelevant. The ensuing accusation/denial pattern between Mandy and Kevin is again interrupted by T1 with 'talking about talking'. It is following this that Kevin shares his dilemma; he does agree with Mandy that her behaviour feels abusive, he does lose his temper with her, but how can he justify his complaints against her when she has had such a brutal childhood? This account seems sufficient to Mandy, T1 and T2 and interrupts the redundant pattern of pursuit and withdrawal.

The therapeutic dance

If we were to distil the interaction still further, a step by step pattern seems to emerge, a movement between parties of alignment and misalignment as different interactional projects are pursued and responded to. T1 first aligns with Mandy and sustains exploration of the problem against resistance from Kevin. Problem exploration invites blame. T1 quickly intervenes with a range of mitigating and exonerating practices. If these fail and conflict seems immanent she evokes her authority as a therapist by explicitly, if delicately, setting rules about 'how we should talk' that proscribes blame and conflict. Mitigation seems to align closer with Kevin's interactional project, of avoiding problem talk, but also leads to premature resolution of the problem.

When Mandy re-introduces the topic, the alignment displayed between Mandy and T1 as they co-construct a blameless identity for Mandy diverges as their different interactional projects develop. Where T1 is orienting to explanation, Mandy orients to claim backing and an argument ensues between T1 and Mandy. The more T1 mitigates, the more Mandy upgrades her culpability. Kevin becomes a witness to this argument, which mirrors that between Mandy and him. T2's observation of the process temporarily interrupts the escalating pattern and aligns with Mandy. However she concedes the floor back to T1 to challenge a further upgrade of Mandy's argument. Finally Mandy's outcry, 'I wish he would speak' ties back to T2's observation of the process, releases T1 and Mandy from a redundant argument and returns Kevin to the field. The established pattern of accusation and denial resumes and T1 again interrupts by 'talking about talking'. This finally creates a context for Kevin to concede and offer a resolution.

I suggest that it is these step-by-step moves, exploration leading to heightened emotion, followed by mitigation and softening of emotion, followed by further exploration and so on, that enables Mandy and Kevin to interrupt their usual pattern sufficiently to move to a different solution (albeit, like most solutions, temporary). Furthermore, it is the ability of the therapist to take a different stance, to misalign with at least one party, which enables exploration of different versions of events to occur, and the ability to repair that misalignment, repair the therapeutic alliance, get back in step, that enables the conversation to continue. What all the above sequences demonstrate is the complexity of the practices involved in such an endeavour.

Essentially, if the therapist didn't mitigate, the conflict might become so intense no resolution could be reached. If the therapist didn't pursue exploration of the problems *despite* resistance, the participants would

remain stuck in redundant patterns. It is in the careful management of the tension between the two that resolution occurs.

In the following Chapter I will draw together the threads from the analysis of both therapies to consider their implications for practice.

Chapter 6

Introduction

This final chapter is concerned with the implications of the analysis for clinical practice and future research. My purpose in bringing together the disciplines of CA and Family Therapy has been to see how CA can help therapists to better understand the practical management of blame in family therapy. In the two preceding chapters I have described an analysis of two explicit blaming events in two family therapy sessions. I traced the history of the interactional trouble for which each explicit blaming event became an attempted solution in order to describe in detail the conversational strategies which informed and drove the production of the blame. The main thrust of the analysis has been to examine how the therapists put their skills in the management of blame into practice and the consequences of those practices for the on-going interaction. Blaming implications are demonstrably present in the talk of both the therapists and the family members. I argue that implications of blame are not just an indication of interactional problems, but are also utilised *as solutions* to interactional problems. In Therapy 2 for instance I have argued that the therapist's mitigation of blame led the conversation away from the problem Mandy was pursuing and Mandy's explicit blame of Kevin became a way of Mandy staking her claim for *her* agenda to be followed, with great success. In Therapy 1 a redundant interactional pattern was ended when the legitimacy of Janet's *account* of the problem was challenged by the therapist's explicit blame. Of course there are many and varied solutions to such an impasse and this solution may not be one that you, or I, or indeed the therapist himself believes is the best.

The aim of the research has been to investigate the following questions:

- How do family therapists do 'non-blaming' in their routine practice?

- How do family therapists manage blame in the context of families affected by psychosis?

- How do therapists manage the competing institutional tasks of decreasing blame and increasing agency in their routine practice?

- How do family therapists manage the tensions of negotiating conflicting versions of events without allocating blame?

The chapter is divided into three parts. In Part 1 the findings are discussed in 4 sections, each section relating to one of the questions above. In Part 2 the clinical implications of the study are considered. Part 3 concludes with a discussion of the study's strengths and limitations and recommendations for future research.

Part 1 – A summary of the findings

How do family therapists do 'non-blaming' in their routine practice?

I have suggested that unlike more formal institutional settings, such as a GP consultation or a court room, in therapy there are no *explicit* social norms for participants to know how they are expected to behave. Participants locally and collaboratively avoid certain forms of interaction and choose others within the bounds of cultural and institutional expectations. For therapy to be more than just having a conversation, the conversation needs to achieve certain institutional goals, minimally, some form of change that helps people to move on in their lives. Different types of therapy will have different theoretical and practical knowledge which shapes those institutional goals. For therapists the norms and practices described in textbooks and taught in their therapy training make up their Stocks of Interactional Knowledge (Peräkylä and Vehviläinen, 2003) which form the background to what kinds of conversations are deemed relevant. We understand what we are doing in terms of our theories. Other cultural

norms inform how families understand therapy and how therapists understand families. So although participants locally and collaboratively avoid certain forms of interaction and choose others, this is not done within a vacuum, institutional and cultural expectations form the boundaries of what is possible. A common expectation would be that therapists make judgements according to professional expertise rather than personal values. Within Family Therapy there exist strong institutional norms that proscribe blame and these resonate with general *cultural* expectations about the proper behaviour of therapists. I have argued that a tension exists between the task of negotiating what a legitimate problem is (and by implication the legitimate goals of therapy) and the stance of impartiality, or being non-blaming. This is because in the process of agreeing a legitimate problem, certain causal explanations will be implied or inferred and these causal explanations will have implications for who is to blame and what needs to change. Change carries with it both a potential implication of fault and expectation of remedial action, what Hoffman (1995) calls the blame and change mind set. In both Therapy 1 and 2 I have shown how participants negotiate these tensions in pursuit of agreement about what problems are relevant to talk about, what explanations are deemed reasonable and how talk about these problems should be conducted. In pursuit of these goals the following conversational practices emerge as recurrent patterns of interaction.

The co-construction of a non-blaming therapy - therapists

Constructing good intent

The therapists display assumptions of good intent. In Therapy 1 for instance, T1 and T2 construct Janet's reasons for not going back as due to a misunderstanding about her needs. She is not to blame but others have given her the wrong task. In Therapy 2 T1 reconstructs Mandy's description of Kevin treating the children unfairly as due to stress, not to ill intent. This bias towards health rather than pathology, solution rather than problem,

could be seen as a CBA associated with family therapy within the broad systemic field.

Treating blame as a delicate matter

The therapists are highly attuned to the possibility of being seen as blaming. They predominantly show caution in making implications that can be heard as blaming. Utterances which contain *the potential* for blame to be heard are overwhelmingly marked as dispreferred, thus displaying that blame is a 'delicate matter' (Silverman 1997). For instance T1 inoculates himself against Mandy inferring blame with this hesitant conversational move (*I-I dont want us t-to kind of (.) I dont want you to feel we're trying to > get at you*) (Therapy 1 line 139).

Avoiding further exploration of contentious topics.

When topics are raised which are potentially blaming the therapists frequently intervene to refocus the topic to a less contentious area. For example, in Therapy 1, when Steven discloses that Janet chose the work she is complaining about, T1 does not explore why she kept this information to herself, but instead shifts tack to explore what kind of work she would like to do. One possible reason for this might be that if he did follow this line of enquiry it would highlight fault on her part and possibly be received as blaming. However, by avoiding the topic of her agency, the question remains unresolved.

Reformulating linear explanations into circular ones.

Therapy 2 in particular shows the utilisation of a number of practices to reformulate linear, blaming explanations into explanations that privilege mutual influence and responsibility. This includes:

- circular questions - (*is there any kind of pattern to how (1) frequent things can build up*) Therapy 2 line 261

- formulations - (*SO HOW KEVin reacts can then lead to you to react in a particular kind of way too*) Therapy 2 line 279

- reinterpretations - (*but what you're <u>expecting</u> from Kevin is almost to respo:nd back with physical abuse to make you kind of <u>bet</u>ter (.) but actually it would be part of what would have been happening bef<u>ore</u> (1) of what you'd expect from people*) Therapy 2 line 776.

Interrupting and implicitly proscribing blaming interactions

When the above practices fail to avert a pattern of accusation and denial between family members in Therapy 2, T1 explicitly interrupts and redirects the topic to 'talking about talking'. So explicit blame prompts the therapist to initiate a conversation about what kind of talking is acceptable, with the implication that blame talk is not (Example 2 line 288 below)

Suggestions disguised as questions

In both therapies, therapists produce a stance of neutrality through the use of questions containing embedded suggestions. For example, in Therapy 1 T1's embedded suggestion that adjusting one's life *is* part of the process of getting better achieves the action of highlighting Janet's responsibility to do something in the guise of an impartial question. In Therapy 2 T1 sets up a contrast between Mandy's experience of childhood abuse and her description of her behaviour towards Kevin as abuse, with the clear implication that one does not equate with the other. T1 then asks Kevin if he experiences Mandy's behaviour as abuse. Designing questions in this way greatly limits the range of relevant answers and thus enables the pursuit of a particular argument while preserving the appearance of neutrality for the questioner.

The co-construction of a non-blaming therapy - Family members

Blame between family members

Therapists cannot construct a non-blaming therapy alone. Family members must display their *hearing* of an utterance as non-blaming for it to be established as such. This analysis shows that how family members manage

blame differs according to whether they are responding to each other or to the therapists.

Treating blame as a delicate matter

Both families, initially, also display a preference not to blame. For instance in Family 1 Steven delays his disclosure that Janet chose the task of cleaning. Steven thus offers several opportunities for Janet to take up the less culpable option of self-repair prior to his disclosure of the trouble source. Similarly in Therapy 2, Mandy initially introduces Kevin's stress as the trouble she wishes to address, a trouble far less culpable than her later complaint that he treats the children unfairly. Family members in these sessions therefore also display that blame is a delicate matter.

Building a case for blame

In both therapies, family members appear to build their case for blame over several turns and sequences. In Therapy 2 I have argued that Mandy builds her case against Kevin step by step, beginning with self-blame (he is stressed because of her behaviour), then blaming Kevin for not getting help (however he is reneging on his responsibility to manage his stress), then sharing blame for the arguments that ensue and finally blaming Kevin alone for treating the children unfairly. It is when Kevin repeatedly fails to take up her invitations for him to discuss with her the nature and cause of the problem, that the delicacy with which she displays blame diminishes. Similarly, in Therapy 1, Steven continues to offer possible mitigating explanations for Janet's decision not to go back to the charity shop. It is when Janet repeatedly resists discussing these possible explanations that he blames her (*Yes (1) she tries it once (.) if it's no good (.) never go back (2) [...] But I think it's a bit more determination I think you need on your part*) (Therapy 1 line 533). Thus family members show a preference to avoid explicit blame by their delay in using it as a conversational procedure. The subtle implication of blame, in the guise of simply reporting facts, positions the blamer as a neutral reporter, with no stake or interest (Edwards and

Potter 1992). Building a case in this way then constructs explicit blame as the justifiable last resort of a reasonable person.

Family member's responses to blaming implications

Displaying conflict

The most common responses to implications of blame between family members are claims of irrelevance, denial and withdrawal.

Example 1 - Irrelevance, (Therapy 1)

153	S	=>to be fair Janet< we were in town last week weren't we (.) we went into this
154		foundation shop dint we (.) where you worked n we see the woman behind
155		the desk (.) and Janet she put her application form in and Jan said like
156		she'll come up and have a little taster day and she said y'know what d'you
157		wanna in the shop, you can work the tills, do what you like n Jan said I'll
158		do a bit a cleaning she said [indecipherable]
159	J	[**well yeah, they** give me a choice yeah but I found it boring [basically
160	S	[**theres**
161		**other jobs** to do there Janet in the shop besides cleaning
162	J	well I was bored, I do that every day [of the week

Example 2 - Denial, (Therapy 2)

283	M	[cos sometimes like he's like inappropriate in what
284		he says (1) he can be <u>really nasty</u> to Alfie and he just wont accept it when I
285		tell him
286	K	no it [indecipherable]
287	M	[its <u>like the girls</u> have a lot of leeway
288	T1	.hhhh I've got a suggestion is that we ↑don't try to get into too much detail (1)

Example 3 - Withdrawal, (Therapy 1)

504	T1	=I wonder what they would've <u>given</u> you=
505	S	=yeah=
506	T1	=and I wonder what you'd be saying now.
507	S	That's what I said (.) in a way John coming up in the car this afternoon (1)

508	T1	mmhm
509	S	didn't I?
510		(1)
511	S	in a way

Where irrelevancy claims and denial occurs further accusation most frequently follows. In Example 1, following Janet's irrelevancy claim (line 159) Steven upgrades his accusation (line 160). In Example 2, Kevin's denial (line 286) is followed by a further complaint by Mandy (line 287). In Example 3, the sequential implication of Steven's rhetorical question (line 507) is that Janet has no right to complain about a job she has chosen. Janet's silence (line 510) is a withdrawal from the topic which marks trouble in how to move on in the conversation.

All three forms of response display that the previous turn has been heard as blaming and that the recipient is either engaging in, or withdrawing from a disagreement. Thus participants display a stance of conflict. Where conflict occurs, therapists are generally prompted to action (Example 2, line 288)

Displaying co-operation

In contrast, responses to *therapists'* utterances that contain implications of fault are more varied. In Example 4, explicit blame from T1 is received by Janet with marked agreement.

Example 4 - Agreement, (Therapy 1)

519	T1	[and you have no one to blame but yourself really
520	J	[no, no, that's ri↑ght.

I have argued that this agreement, due to its sequential placement in a conflict sequence, presages opposition, but that opposition becomes manifest only in response to Steven's turn (see below). While denial and disagreement occurs it is more likely to be marked as dispreferred, and

withdrawal is less common. So even when therapists utterances can be heard as implying blame, family members are less likely to respond to them as an accusation. Therapists' utterances then are most often responded to *as if* they are neutral observations regardless of implications of fault.

Example 5 - Disagreement, (Therapy 1)

```
523  S     bu- but ↑say you worked tomorrow >for a couple of days< and there
524        was two women (.) there aswell (.) you'd feel more comfortable wouldn't
525        you
526  T2    mmm, mm
527  J     But I'm not going back there really so that's that (.) theres no good
528        going on about ↑ i(h)t
```

Example 6 - Irrelevance, (Therapy 2)

```
788  T1    But its interesting what Jan was asking before isn't it that you are expecting a
789        different response from Kevin.
790  M     I ↑wish he would speak like I'm re(h)ally frustrated now cos he just
791        wont speak .hh
792  K                   [indecipherable]
793  M                   [and I just really want him to speak I really .hh I don't want him to
794        spare my feelings I [want him to sit there and say right]
795  K                       [I'm not I'm not] I don't like it at ↑all
796  M     .hhh this is this and that is that and I- I get cross with her cos of this or
```

In each therapy I suggest that where there is a conflict between a family member's version of events and the therapists' version of events, the conflict with the therapists is expressed indirectly through conflict with the family member. In Example 5 line 527, Janet's complaint is said in direct response to Steven, although it could be read as equally directed to T1 and T2. Similarly, in Example 6 line 790, Mandy's complaint is directed to Kevin, but its sequential placement serves to mark T1's interactional project as irrelevant. I suggest that one of the reasons for this is linked to Member Categories. In their selection of accounts members draw on shared

understandings about the way a competent person should behave under given circumstances. Beyond the particular institutional norms of systemic therapy in prescribing impartiality, we also have wider cultural norms that inform how we interpret actions. The Member Category 'therapist' brings with it Category Bound Activities of neutrality which inform family members interpretation of the meaning of the therapists response. Of course, within that CBA are different *versions* of therapist, good or bad, partial or impartial, and therapists actions will be interpreted accordingly. However to imply that a therapist is partial would have far more serious social implications than to accuse a partner of partiality. Families co-operate in the construction of a non-blaming therapy by responding to therapists *as if they hold a neutral stance* even when their talk can be inferred as blaming. I have argued that therapists display assumptions of good intent in family members. Here we can see family members displaying assumptions of good intent in therapists. This does not mean that the parties *believe* the good intent displayed. However I am claiming that co-operation between the therapists and family members in the display of good intent enables the conversation to continue.

The social function of treating blame as a delicate matter.

CA shows that blame, of self or other, upsets the usual preference structure and disagreement is preferred. Once the preference structure is re-organised in this way, disagreement becomes expected. Thus the sequence of blame and denial takes particular effort to disengage from. Concessions need to be marked as dispreferred for them to be understood as such (Antaki 1994). One explanation for this is that if someone has been maintaining a particular argument, then to suddenly accede has implications for their moral standing. Inferences might be made regarding their character, such as being fickle or deliberately provocative. It is expected that people will display hesitancy in making concessions in arguments to protect their moral standing as competent social actors. If in everyday conversation blame projects denial and conflict, displaying a

cautious approach to blame makes sense if arguments are to be avoided. If we assume that these families have agreed to therapy because they want to resolve difficulties, then showing caution in apportioning blame displays good will, and potentially ameliorates conflict.

Another mundane concern in everyday conversation is what Potters and Edwards (1992) call managing stake. If we are seen to have an interest in the matter discussed then our portrayal of the facts will be more open to question. Presenting facts *as if one is impartial* is a conversational strategy used to validate claims (Pomerantz, 1984). The institution of therapy carries with it additional expectations of professional neutrality. Heritage (2002, p. 1430), discussing the news interview, demonstrates how "interviewees collude in a fiction that questioning is objective", despite the questions being slanted in different ways. Due to the 'ideology of neutrality' Heritage argues that participants are highly attuned to whether the question is hearably neutral or asserting a point of view. Thus, although news interviewers inevitably slant questions in different ways, they do so with displayed caution which rarely invites challenge from the interviewee. Where the norm is for news interviewers to promote arguments, the expectation is for therapists to resolve them. What participants in both contexts share is an interest in presenting 'the facts' as neutrally as possible in order to present as competent social actors. In both these therapies, participants display an orientation towards neutrality and avoidance of blame. Ambiguity serves to delicately test reactions to potentially blaming constructions and avoid the conflict that explicit blame usually projects. However, the more delicate the implication, the more ambiguous the meaning and misunderstanding can easily occur. Explicit blame becomes relevant only where more implicit strategies have failed. The positive aspect to ambiguity is the more ambiguous the recipient design, the less constrained are possible responses. The 'not knowing' approach of dialogical practice, prescribed as tentative in tone and manner (Anderson 1997) therefore shows a sophisticated grasp of the interactional

opportunities doing 'not knowing' opens up. It enables the conversation to continue in a way not dominated by the speaker. Ambiguity does not mean an absence of moral implication, but those implications will be more subtle and open to interpretation and less likely to project opposition.

How do family therapists manage blame in the context of families affected by psychosis?

A further recurrent feature of the management of blame in these sessions is the practical use of the Member Categories of Patient and Carer and associated Category Bound Activities.

In Therapy 1, T1's question at the beginning of the transcript embeds a suggestion that getting better involves an adjustment of what you do during the day. Janet's response essentially offers an account for why she hasn't made such an adjustment. The shared assumption that work is an activity that promotes recovery is bound to the category of patient and *social* knowledge regarding good patients (who try to get better) and bad patients (who don't). T1 and T2's interpretation of Janet's complaint as a request for help to return to work rests on normative assumptions that work *is* a means to recovery. Imagine for instance if Janet had said that she had decided to adjust her life by consulting a local witch who had invited her to attend a magical healing ceremony daily, but Janet had decided she was worth more than that and she wasn't going back. How likely is it that the therapists would have pursued this as a legitimate problem to solve without exploration of Janet's beliefs about magical ceremonies? Thus the analysis shows how wider institutional norms about how patients achieve recovery permeate the session through the *absence* of questioning work as a legitimate means to recovery. In this case, not returning to work has implications of fault *because* of Janet's category membership of patient. She can be justified in not going back if the work does not meet the appropriate conditions for recovery, and T1, T2 and Steven all work hard to find these conditions, offering numerous alternative justifiable reasons for

not going back. Thus they all show a preference to avoid blame. However, because Janet *chose* the work that she later rejects as unworthy of her, and she fails to co-operate with providing an explanation deemed sufficient to meet her obligations as a patient, she becomes culpable.

Therapy 2 reveals the complexity of member categories in use to achieve different actions at different times. T1 frequently utilises the member category of patient to absolve Mandy of culpability for unreasonable behaviour. Similarly she utilises the member category of carer to absolve Kevin of culpability for not standing up to Mandy's unreasonable behaviour. However, by exonerating Mandy's behaviour due to illness, she also undermines Mandy's argument that Kevin *should* respond to her as a responsible adult. The crux of the argument between Kevin and Mandy rests on the complementary but competing obligations between husband and wife and patient and carer. Example 7 illustrates the complexity with which these competing categories are used to pursue particular arguments at particular times.

Example 7 - Member Categories in use (Therapy 2)

721	M	[yeah] I'll ↑be honest with you (.) I I really
722		pun<u>i</u>sh Kevin I <u>do</u>. yknow I'm absolutely sur↑prised he's still with me to
723		be honest with you. I mean I-I suppose I abuse ↑<u>Ke</u>vin. I've se<u>verely</u>
724		abused him.
725	T1	mm
726	M	He's always there to take the brunt of it when my schizo↑phrenias bad
727		y'know? he's the one who takes the brunt of it.
728		(2)
729	M	sh- He (h) don(h)'t ↑say anything he always says I don't care, I don't care.
730		(2)
731	K	[indecipherable]

Mandy's incumbency of the category membership wife is implied in lines 721 to 724 and tied to her turn in 729 to imply Kevin's culpability for *not* holding her to account for her abuse. However, she also exonerates herself from blame by evoking the member category 'schizophrenic' in line 726, thus implying her behaviour is outside her control. These disjunctive categories are put to flexible use to both blame and exonerate turn by turn. Although T1 is drawing on the member category patient in order to mitigate blame, in this case, the category undermines rather than supports Mandy's agency. T1's reading of abuse as a CBA connected with the category patient, rather than wife, may have been influenced by cultural norms regarding gender. Had Kevin said he abuses Mandy, I wonder if T1 would have been less likely to move towards mitigating his claim rather than investigating what he meant? In western cultures domestic violence is more commonly seen to be the preserve of husbands towards wives.

How do family therapists manage the competing institutional tasks of decreasing blame and increasing agency?

Both therapists and families can be seen to draw on different member categories at different times to negotiate reasonable blame and reasonable agency. The rights and obligations associated with different categories are brought into play in pursuit of particular actions. These therapists overwhelmingly attribute positive events to the actions of the individuals concerned, and negative events to circumstances beyond the individual's control. The member category patient is frequently used to imply such circumstances. The therapists then seem to privilege agency talk when talking about positive events in the past and present and when talking about a hypothetical future. The exception to this is when *the interactional rules within the session itself are contested*. So parties are generally held responsible for the way they talk in the session.

For example in Therapy 1 the therapists initially attempt to exonerate Janet from potential blame through the assumption that circumstances beyond

her control are preventing her from returning to work. When Steven discloses Janet's responsibility for choosing the task she complains of, the therapists introduce a different topic, what job she would choose instead. Thus the therapists choose not to pursue the topic of her responsibility for this negative event. They do however highlight her personal agency in a hypothetical future by topicalising the type of job she would choose instead. Her responsibility for failing to represent the world accurately is implicitly marked, but not topicalised. It is Janet's *repetition* of her complaint, implying that someone else was to blame for what was in effect her choice, that prompts T1's response *([...]you have no one to blame but yourself really)* line 519. Thus her duties and obligations as a competent and reliable conversationalist are made relevant.

In Therapy 2, T1 exonerates Mandy of blame for her behaviour by explaining it as the consequence of her childhood abuse and mental illness, circumstances beyond her control. Similarly she exonerates Kevin for his behaviour by locating it in circumstances beyond his control, stress due to Mandy's illness. Agency is highlighted with regard to Kevin's choice to care for Mandy and Mandy's choice to cope differently with the effects of her illness on her relationships. However, the consequence of positioning Mandy as ill and therefore not responsible for her actions is to call into question Mandy's capacity to represent the world accurately. For instance rather than being curious about why Mandy describes her behaviour towards Kevin as abuse, T1 implies that the description itself is inaccurate. The cost of exoneration in this case is to undermine Mandy's right as a wife to call her husband's lack of response to account. I have shown that an unintended consequence of this mitigation of blame through a denial of agency is that Mandy escalates the negative descriptions of her behaviour. The more T1 tries to persuade Mandy that she is not responsible, the more responsibility M claims. The resulting descriptions then are not simply a representation of Mandy's view of the world but are designed to

persuade T1 to her position. It is when Mandy blames Kevin explicitly, that T1 brings Mandy to account for the way she is speaking in the session.

Resistance as an expression of agency

I show that in both these sessions the therapists align initially with Steven and Mandy, both of whom pursue problem topics. By their take up of these topics the therapists demonstrate them to be appropriate to the institution of therapy, and Kevin and Janet's minimal responses as wanting. Kevin and Janet are treated as passive participants that the therapists are actively attempting to engage. However if we were to view both Kevin and Janet's resistance to the topic as an expression of agency it might make alternative strategies more relevant. For example, in Therapy 1 Janet's agency is expressed by,

1)   not going back.

2)   resistance to the *questioning of her account* for not going back.

However, *she obscures her own agency* by failing to disclose that the choice not to go back was hers, and subsequently failing to justify that choice. An interesting question to ask is *why it made sense to Janet to obscure her agency in this case*. I suggest that the absence of questioning about the merits of work reveals a powerful social norm regarding its value. Janet's choice to not go back contravenes this norm, making ambiguity and closing the topic a solution to avoid censure. As soon as the therapists become aware of Janet's agency in this matter, they too close the topic, asking instead about what she would choose in the future. I argue that one of the functions of this move is to avoid highlighting her agency in *relation to a negative event* and instead highlight her agency in relation to a hypothetical positive outcome. That it *is* a negative event is not questioned, and as a result the reasons for Janet's choice remain unquestioned. Janet later says *(I want to really do somethin that's gonna (2) that I want to do)* lines 725-726, which perhaps throws light on *her act of resistance* as the first step in adjusting her life as part of a process of getting

better. She has not yet formed an account of what she wants to do, but she knows what she *doesn't* want to do. If the norm of employment becomes open to examination then the repertoire of possible interpretations of not going back becomes greater and a different trajectory for the conversation is opened up.

Differentiating explanation from argument

In both therapies I suggest that Janet and Mandy are presenting their accounts from the stance of *explanation as claim backing* and the therapists respond as if they speaking from a stance of *explanation as answer*. The key difference depends on "*the assumed agreement on, or quarrel about, the state of affairs being explained*" (Antaki and Leudar, 1992, p.186, italics in original). In each case explicit blame seems to occur where the therapists and participants are misaligned in this respect *over a series of turns*. In Mandy's case, T1's mitigation of Mandy's self-blame invites Mandy to elaborate her descriptions of being abusive in order to further her argument. In Janet's case, the therapists problem solving stance leads to Janet's withdrawal, and the more they problem solve the more Janet withdraws. The therapists, whether intentionally or not, became embroiled in an argument each of which are ended following a blaming event.

How do family therapists manage the tensions of negotiating conflicting versions of events without allocating blame?

I have shown that in these two sessions, family members have initially presented conflicting versions of events delicately, displaying a preference to avoid blame. However, as disagreement continues then the complaints are upgraded and blame is implied. I have argued that family members display two main responses to blame, denial or withdrawal. Both create problems with how to go on. Denial is one way to co-operate with an on-going interaction, but the structural properties of conflict lead to redundant patterns of accusation and denial militating against problem resolution. Withdrawal from the argument avoids the often heated and

emotional exchange associated with conflict but is equally ineffective in promoting change and resolution of the problem.

In each therapy, the therapists have utilised a range of conversational practices (described in the sections above) in order to pursue their goals. However, the consequences of their actions are unpredictable. Their problem is how to manage the tension of keeping the conversation going. The pursuit of problem resolution risks being heard as blaming while the interruption of blaming talk risks premature resolution of the problem and the maintenance of the status quo.

The co-construction of legitimate problems and goals

In each therapy I have shown that family members present different versions of events and these different versions influence, and are influenced by their goals. By 'goal' I am not merely referring to the intentions a person may bring with them into the session. Participants may come to therapy hoping for a particular outcome. For instance, in Therapy 1, in response to T1's question about their hopes for therapy, Steven clearly states that a good outcome for him would be if Janet returned to work in the charity shop. While Steven's goal is to get Janet to return to work, Janet's goal appears to be *the resistance* of his project.

In Therapy 2, Mandy's stated goal is to talk about relational problems. Kevin's goal appears to be the resistance of Mandy's project. Both sets of therapists are faced with a similar dilemma; Kevin and Janet wish to terminate a topic while Mandy and Steven wish to pursue it. In each case the therapists must make a judgement about whether the topic in question is relevant to their goals as therapists and how to manage the diverging goals of each couple.

There are also more implicit goals that shift and change in relationship to one another as the conversation unfolds. These are linked to the design of

particular utterances and sequences of utterances that pursue a particular action. For instance, in Therapy 1 I suggest that Janet's goal in presenting her story about the shop in response to T1's question is to persuade the therapists, and Steven, that she has good reason not to return there. I show that her account was forged partly in response to T1's question but also in response to an argument between Janet and Steven that preceded the therapy session. So while T1's interactional project is to problem solve, Janet's interactional project is to persuade. Throughout Chapters Four and Five I have referred to these types of goals as 'interactional projects', following Schegloff (2006). The concept of stance (Du Bois, 2007; Du Bois and Karkkainen, 2012) adds another dimension to our understanding of how participants negotiate what it is reasonable to talk about:

> Stance is a public act by a social actor, achieved dialogically through overt communicative means, of simultaneously evaluating objects, positioning subjects (self and others), and aligning with other subjects, with respect to any salient dimension of the sociocultural field. (Du Bois, 2007, p.163).

An important element of the concept of stance is that of affect and emotion. In CA, people are seen to have a range of affective displays open to them from which they can draw to achieve interactional tasks. The term alignment is generally associated with the display of semantic convergence where affiliation is concerned with the display of affective or emotional concerns (Du Bois 2012). The concept of stance weaves the two together. Evaluations and affective displays go hand in hand. For example a smile as the wrapping paper falls away displays a different evaluation of the gift revealed than that of a frown. Stance leads to a more dynamic understanding of alignment, not as a dichotomous 'for or against', but as:

> …a subtly nuanced domain of social action, in which speakers negotiate along a continuous scale the precise nature of the relation

between their presently realised stance and a prior stance, whether overtly expressed or left implicit by another. (Du Bois, 2012, p. 440)

In this data set, displays of heightened emotion are evident, especially where conflict sequences occur. It is these sequences that most frequently prompt therapist intervention. Participants can be seen to negotiate legitimate goals through a process of evaluating their own position in relation to their perception of the other's stance towards them in an on-going conversation.

In both therapies the therapists take up the problematic topics and pursue them as relevant despite resistance. In each case then talking about a problem is privileged over the avoidance of problem topics. However, in both therapies the therapists display sensitivity to the differing stances of the participants, sometimes aligning with one party, noting resistance or heightened emotional affect from the other and recalibrating their stance in response. We can see the therapists offering, or attempting to elicit, alternative explanations for events in order to move participants away from more polarised positions.

For example, in Therapy 1 T1's question *(So have you adjusted what you d:o during the da:y [...]as part of this (.) process of getting better?)* (line 111), is designed with the goal of inviting a description of Janet's agency in her own recovery, a routine systemic practice. Janet's account for not going back to the shop is heard as a *description of the world* and Janet is positioned as a help seeker. Thus the therapist's initial stance within the unfolding conversation is one of joining Janet in problem solving. The therapists overarching goal could be read as enhancing Janet's agency by helping her to think about ways to achieve her assumed goal of working in the shop. Janet's initial stance however appears to be *making an argument* for not going back and positioning the therapists as potential allies in her argument with Steven. Steven's stance mirrors Janet's. He too is

making an argument and he does this by implying that Janet's *account* is wanting. The therapists' stance of problem solving and Steven's stance of challenging Janet's account *appear* to be aligned. However they each question her account from separate positions, each of which have different consequences for Janet's identity. In response, Janet shifts her stance towards the therapists. Rather than allies in her endeavour they appear to be more closely aligned with Steven in persuading her to return to the shop. In response her next interactional project is to terminate the topic. By doing so she can be seen to be withdrawing from an argument with Steven and signalling that T1 and T2's questions are irrelevant. T1 notices this apparent misalignment and he remarks on it (*I don't want you to feel we're trying to >get at you or anything like that*) (Therapy 1, line 139). Thus, on a turn by turn basis, we can see T1 pursuing the resisted topic while displaying a sensitivity to Janet's position and the possibility of blame.

Similarly, in Therapy 2, T1 pursues a topic introduced by Mandy which is resisted by Kevin. Rather than allow Kevin to avoid the topic of relational difficulties T1 embeds non-blaming causal explanations for those difficulties within her questions (*Cos yknow I think you were touching on there Kevin that that you y-you kinda like (.) wanting [...] to help Mandy*) (Therapy 2, lines 323-326). Thus both therapists show that the discussion of problems is a legitimate goal of therapy, while the avoidance of talking about problems is not.

The co-construction of legitimate talk.

These therapists both show that problems are a legitimate topic of conversation. However, therapists also showed that *how* people talked about problems was a matter of concern. All participants show caution in apportioning blame. More explicit blaming explanations are displayed as dispreferred by therapists. For example by reframing to a circular explanation (*SO HOW KEVin reacts can then lead to you to react [..] in a particular kind of way too Mandy*) (Therapy 2, line 279-282) or directly

commenting on how talk should be conducted (*I've got a suggestion is that we ↑don't try to get into too much detail*) (Therapy 2, line 288).

Sometimes causal explanations for negative events are made relevant, for instance in response to Janet's 'unhappy incident report' which prompts the therapists to locate the cause of the problem in order to solve it. When negative events in the past are talked about, responsibility talk is generally avoided, or mitigating explanations are preferred. For instance, in response to Janet's implication that the charity shop had been responsible for giving her a job unworthy of her T2 suggests (*do you think it was something to do with it jus- the first day, that they thought they'd kinda give you something easy to do the first day*) Therapy 1 lines 129-130.

The exception to this is when the interactional rules of the session itself are transgressed. I have argued that T1's utterance (*and you have no one to blame but yourself really*) (Therapy 1 line 519) was prompted by Janet's repetition of an explanation that *had already been judged as irrelevant to the task in hand in this conversation*. In this way he makes explicit Janet's contravention of a mundane interactional rule, that she withheld information pertinent to the proper interpretation of events.

In Therapy 2, T1 also holds Mandy responsible for the way she talks, but in a less explicit manner than the example above. She does this by interrupting Mandy when her blaming of Kevin becomes more extreme by making explicit acceptable ways of talking. For instance (*I've got a suggestion is that we ↑don't try to get into too much detail*) (line 288) and (*[...] if we ↑all talked at the same time (.) none of us would hear what the ot(h)her pe(h)rson was saying[...]*) (lines 807-808). Through sequential analysis I have argued that the meaning of this in context is that T1 is proscribing 1) blaming details and 2) conflict talk.

In both therapies then, family members are held responsible for the way they talk in the session.

Summary

I argue that the disciplines of CA and MCA reveal the strategies used by participants in both therapies to negotiate blame delicately, and to collaborate on the production of a non-blaming, impartial therapy. Therapists can be seen to put mundane conversational practices into action in pursuit of institutional goals including:

- Constructing good intent
- Treating blame as a delicate matter
- Avoiding further exploration of contentious topics
- Reformulating linear explanations into circular ones
- Interrupting and implicitly proscribing blaming interactions
- Embedded suggestions

When negative events in the past are talked about, responsibility talk is generally avoided, or mitigating explanations are preferred. Personal agency is generally highlighted when talking about positive events or hypothetical future events.

Family member's responses to blaming implications differ depending on whether the implication is made by a family member or a therapist. Family members blaming implications are generally treated as partial, therapists implications as impartial. However, in both therapies, sequential analysis reveals implications of *therapist* partiality embedded within responses to family members. In other words, where the therapist and family seem aligned in their interactional projects, resistance to that project is more explicitly articulated towards another family member rather than the therapist. However, because of the presumed alignment between the therapists and family member's stance, the therapist is also implicated.

Families and therapists treat blame as a delicate matter. The case for blame is built over time. It is when the ambiguity with which delicacy is performed leads to a misalignment of interactional projects that explicit blame becomes a relevant solution. I highlight the misalignment between the stance of explanation as claim backing and explanation as answer as an important factor in the production of explicit blame.

A further recurrent feature of the management of blame in these sessions is the practical use of the Member Categories of Patient and Carer and associated Category Bound Activities to mitigate blame. This may show the influence of Family Management theories on these therapists practice. Further research would be necessary to determine if this is common practice for systemic practitioners who do not *overtly* integrate FM theories into their practice.

I have shown that both sets of therapists prefer the discussion of problems over the avoidance of talking about problems. I suggest that therapists select topics recognisable as the proper subject of family therapy to pursue, despite resistance. In both therapies I show that resistance to the topic signals a misalignment of interactional projects, and that therefore being alert to markers of resistance is important to repair misunderstandings and misalignments.

In Part 2 I will elaborate the implications of these findings for systemic practice.

Part 2

Implications for clinical practice

Tolerating blame to increase understanding

As a therapist I am left wondering what might drive those misalignments between therapist and family members described above. I suggest that the broad injunction to be non-blaming may militate against therapists' consideration of the many subtleties and functions of blame. If we think of blame as having an important social function then it opens up the question of what *kinds* of blame are deemed reasonable or not in any therapeutic encounter. By framing the question in this way it can help the therapist to think about the moment to moment evaluations they are making, the stance they are taking and their power to shape clients narratives. An unintended consequence of the injunction to be non-blaming might be the premature closing down of topics. Frosh (2013, p. 21) warns against "trying to be too ameliorative, too helpful, even, perhaps, too *therapeutic* in one's approach." By this he means moving too quickly towards offering an ameliorating narrative at the expense of staying with the distress and pain one might see. He suggests there is a tension between the former, what he calls the therapeutic (and what I will call ameliorative) and the latter, the analytic, or deconstructive. In both the therapies in this data set, it appears that essentially *ameliorative* aims lead to misalignment.

In Therapy 1, the aim is to move towards the resolution of a problem. In Therapy 2 the aim is to soften the emotional consequences of blame, self or other. T1's reaction to Mandy's claim that she abuses Kevin was constructed in the context of Mandy's description of her own appalling childhood abuse, and her motive is to produce an ameliorative narrative. However, the outcome is to miss Mandy's point. Mandy is claiming

responsibility for her actions, *for a reason*. By doing so she claims her position (for the moment) as a wife (albeit an abusive wife) and not, as a patient. She is seeking Kevin's response as a husband not as a carer. These identity positions are laden with negative emotions and moral implications, but amelioration moves away from resolution. In some ways it mirrors the very thing Mandy complains of in Kevin, responding to her as someone not responsible for their actions. In this sense it moves away from a proper understanding of the problem.

Stancombe and White (2005) and Stratton (2003a) call for therapists to be more explicit about their moral positions in therapy. This study poses the question of whether injunctions to avoid blame may influence systemic therapists to privilege the ameliorative over the deconstructive positions, perhaps moving quickly to solve problems or avoid blame at the expense of understanding. This is not a simplistic call in support of allowing blame to go unchecked. I have shown that we have a wealth of clinical research into the negative effect of critical and hostile atmospheres in families. CA also has a wealth of empirical evidence that upholds the pragmatic import of interrupting blaming sequences. When blame is allowed to continue unabated, disagreement is preferred and unproductive conflict or withdrawal is predictable. In Therapy 2, as will be revealed in the Coda, arguments have led to physical violence. It is therefore important that families feel they can trust the therapist to manage the sessions in a way that maintains emotional and physical safety. However, I am interested in how systemic therapists find *the balance* between the ameliorative and deconstructive. This data set shows how the move towards premature resolution of the problem invites more blame. Blame in this sense then acts as a check to the therapists' ameliorative moves and invites them back towards the deconstructive. If we think of blame as *co*-constructed then it opens up the question of the function of *this* blaming statement *now*. In an attempt to ameliorate emotionally painful topics and avoid conflict, therapists might be driven towards solutions too quickly. Perhaps tolerating

a little blame enables the therapist to understand the family members experience more fully.

Repair and the therapeutic relationship

Increasing interest in the role of common factors in family therapy (Sprenkel and Blow, 2004; Sprenkle, Davis and Lebow, 2009) has stimulated research into the association between therapeutic alliance and change within the field. Most of the research on therapeutic alliance is focussed on individual therapy settings drawing on Bordin's (1979) concept of three key elements,

- bonds – relating to qualities of trust and attachment between client and therapist
- goals – relating to shared goals
- tasks – relating to compatibility regarding the major activities involved in therapy

There is robust evidence that the quality of the therapeutic relationship predicts therapeutic change over a range of different therapy models (Horvarth and Bedi, 2002; Horvarth and Symonds, 1991). An important strand in the literature for this study is an interest in how therapists deal with ruptures in the therapeutic alliance. In individual psychotherapy, Safran and Muran (2006) describe a rupture as a negative shift in the relationship which can vary from momentary miscommunications to major difficulties and impasses that lead to drop out. Ruptures in the alliance are seen as a possible threat to good outcome if not attended to, but if attended to effectively, offer an opportunity for greater learning and change. In a study of couple therapy for depression, Kuhlman *et al.* (2013) found that a good therapeutic alliance rating in one session was correlated to increased client well-being in the following session. They suggest that a reciprocal relationship between alliance and well-being exists, with greater subjective well-being predicting a good alliance and a good alliance predicting greater subjective well-being in a virtuous circle. This suggests

that if therapists can notice and attend to ruptures in the alliance *within the session*, then better outcomes may be predicted.

In family therapy the concept of the therapeutic alliance is complex. The therapist has more than one person to make an alliance with, often with different levels of motivation and high levels of conflict. Furthermore, the nature of the alliance *between* family members is also seen to affect outcome (Friedlander *et al.,* 2006, Horvarth and Symonds, 2004). Glebova *et al.* (2011) found the greater the rift in the family alliance prior to therapy, the greater the drop-out rate. Escudero *et al.* (2008) found that both a shared sense of purpose within the family and a sense of safety regarding talking in the family were central to good outcome. This supports the importance of therapists' attention to the negotiation of shared goals and to managing blame from the outset.

If we consider the tension between what Frosh terms the therapeutic (ameliorative) and the deconstructive positions in terms of rupture and repair of the therapeutic relationship, tolerating blame might enable a fuller understanding of the difficulties but threaten a rupture in the alliance, either in the therapy/family system or in the family system itself. Similarly prematurely moving toward the ameliorative position might threaten the negotiation of shared purpose or goals. In family therapy, with multiple alliances to attend to, ruptures in alliances are inevitable. What is most important is how these ruptures are managed and repaired. CA provides us with an established corpus of data from which we can learn about the markers and mechanisms of misalignments. This can help us to attend to ruptures in both the family alliances and the therapeutic alliance, to promote learning and change rather than impasse or drop out.

The concepts of explaining versus arguing

This study shows that blaming statements are not simply descriptions of events or value judgements, but can perform a range of actions, including

arguing a position and interrupting a redundant interactional pattern. I have argued that an unacknowledged misalignment between participants has contributed to an increase of blame. In both examples therapists respond to an argument *as if* it is an explanation, while their contributions are responded to *as if* they are arguing a position. There are no easily definable rules for differentiating between explaining and arguing in situ. The differentiation depends on whether the explanation is heard as contentious or not. In therapy, it is likely that differing interpretations of events have brought families to therapy in the first place. However, even in the most disputatious of families, the assumed agreement, or not, about the state of affairs being explained will differ according topic. A person describing an event from an explanatory stance may be more open to considering alternative versions of events (such as the mitigating and problem solving strategies followed by the therapists in this data set) than a person describing an event from a stance of argument. If this were the case therapists would be advised to pay close attention to feedback regarding the stance and interactional aims of the blamer and adjust their responses accordingly. Similarly, given that family members will more readily display conflict towards other family members while treating therapists turns as impartial, therapists would do well to consider whether a rupture in the alliance between family members might also display a potential rupture in the alliance with the therapist. Where the therapist might be understood to be more closely aligned with the stance of a particular family member then, a complaint directed to that family member may contain an embedded complaint against the therapist themselves.

I do not wish to imply that therapists can analyse every conversational move for their performative force whilst at the same time responding spontaneously in the therapy session. In the to and fro of conversation these practices are the invisible machinery by which we make meaning

and not readily open to scrutiny. Neither do I wish to imply a simplistic division between the acts of explaining versus arguing. However I do believe that the *concept* of explaining versus arguing is a useful one for the therapist to hold in mind. The concept of preference structures and how argument projects disagreement is also helpful to keep in mind when caught in a 'yes but' conversation. By attuning our listening ear to moves of resistance for instance it may help us to remember that language both *constructs* reality as well as *describes* it. If we bring to the foreground of our minds some of the tacit rules by which we signal resistance to the performative action of a turn in talk, we can ask ourselves 'why that now?' What argument have we become embroiled in, intentionally or unintentionally? This might help us to check more frequently and transparently what different people are trying to achieve at different times and help us consider our own stance. Do we want to 'repair', or do we want to stay with this misalignment for a particular purpose?

Implications for teaching and supervision

Contemporary interest in dialogical theory and positioning draws our attention to the micro-processes of therapy and the construction of reality through dialogue. Seikkula (2011) for example emphasises the ordinary and everyday aspects of interaction as the foundation of psychotherapy and suggests that our theories may at times get in the way of therapeutic practice. Perhaps it is when our theories prevent us from listening to feedback that misalignments may occur.

Conversation Analysis is a difficult discipline to master, requiring familiarity with a large body of work. It would be unrealistic to expect trainee therapists to become competent conversation analysts. However, I believe that the contribution of Conversation Analysis to the understanding of how every-day and institutional conversational practices work is of enormous relevance to systemic therapists. We share an interest in how we do things with language. Conversation Analysis offers an established discipline that

illuminates the way in which we both create and respond to context through talk. Systemic therapy is founded on the principle that by influencing the context of meaning we can help families to overcome impasses and move on in their lives. It seems to me that the systemic discipline has largely overlooked a research methodology that could make a great contribution to our understanding of therapy process. For example, we have a particularly rich body of literature on different types of questioning which are designed to do particular types of things. Circular questions, solution focussed questions, and externalising questions to name but a few. In much of the literature case studies showing the use of these questions are glossed, with tidied up transcripts which are easier to read and understand, but also edit out the richness and messiness of ordinary therapy talk. In Therapy 1 I showed that the question T1 poses is designed to elicit an alternative, solution focussed narrative, but Janet responds with a different goal in mind. Her resistance is signalled in numerous small details, which would be edited from a glossed account. Detailed examination of real talk, how our questions are designed and how family members respond to them, could be of enormous benefit in raising therapists awareness of the nuances of different question design. For instance McMartin (2008) shows how trainees repeatedly recycled optimistic questions regardless of their clients' rejection of them. Where CA complements and supports systemic theory is in focusing our attention on feedback.

Our discipline has always valued the taping of therapy sessions to aid reflection on our work. The particular insights of CA could enhance reflexivity by raising students awareness of features of talk which signal emerging misalignments. Stokoe (2011, 2013) has implemented a teaching programme for family mediators where she demonstrates common interactional troubles that occur, based on findings from a large corpus of data of family mediation session. She has found that the provision of transcripts alongside audio tapes enhances students understanding of the

importance of small, seemingly inconsequential hesitancies, pauses and overlaps which otherwise may go overlooked. I believe a similar programme for systemic therapists would greatly enhance therapists' awareness of the way their interactions inevitably constrain family members' possible responses and to be alert to how family members co-operate with or resist those constraints.

Part 3

The Strengths and Limitations of the Study

This final part of the thesis concerns a critical analysis of how well the study achieves what I set out to do. I begin with a brief summary of the rationale for a close analysis of a small number of therapy sessions and what it has been possible to achieve, before highlighting its limitations. I go on to consider implications for future research.

Does the method fit the questions?

I have argued that any negative event and causal attribution is potentially blaming, but that there is a difference between the critical quality of attributions of responsibility and attributions of blame. It is when some moral failing is implied or *inferred* that the potentiality of blame is manifested. Some scholars have tried to operationalize these differences for research purposes and for example, confined the definition of blame to explicit attributions of fault of a dispositional or intentional nature. However, I have followed a model where the potentiality of blame is included in the analysis and subtle implications of blame can be attended to. My rationale is that it is impossible to know, outside the immediate context, whether an utterance implies blame or mere responsibility. Similarly it is impossible to anticipate whether an implication of responsibility will be taken up as blame by the recipient. This study shows how moral failing can be subtly implied and subtly defended against in ways that more rigid definitions may overlook. Thus it is through the examination of the delicacy with which blame can be implied and the subtlety with which it can be defended against that the richness and complexity of the work that goes into constructing a non-blaming therapy is described. The purpose of the study is to enrich our understanding of how this potentiality is made manifest or ameliorated in situ, and to think about the intended and unintended

consequences of different actions, rather than to verify or counter existing theories.

I demonstrate that implications of blame, mitigation and exoneration were subtly evoked as part of the process of negotiating a legitimate topic for therapy which held consequences for the moral identity of the participants. Different goals have different implications for what or who needs to change which has the potential to evoke what Hoffman (1998, p. 145) calls "the blame and change mind set". I show that in relationships that extend over time, blamings that happen in the therapy session can be seen as the closing of a sequence that occurred before the family entered the therapy room. I therefore show how these therapists join a system and influence the trajectory of sequences of blame that have opened prior to the meeting. What I have been particularly interested in discovering is what interactional problems these blaming events are designed to solve. Although the specific ways these unfold are unique to the particular participants in these two sessions, nevertheless I believe we can legitimately speculate about common problems they may be addressing. This is because the participants share a common context which brings with it multi-layered normative expectations, both cultural and institutional. They are all engaged in a service encounter, where the therapists are delivering systemically informed therapy to families affected by psychosis.

The exaggerating effects of micro-analysis

Analysis of this type has inherent exaggeration effects (Stancombe and White, 1997). The painstaking analysis of recipient design can be read as if participants are consciously and deliberately planning moves in the moment. For example the analysis of Mandy's use of the member categories patient and wife to construct an argument could be read as particularly Machiavellian and disrespectful of Mandy's experience. It is important to understand that CA does not suggest any motivation or intent in the conversational strategies people use. Instead it is the very invisibility

of the rules by which we make sense of the social world which gives CA its methodological potency. It is the participants' agreement about the horror of Mandy's real life experience of abuse and mental illness that gives credibility to the member categories in use. Also, the selection of segments for analysis was inevitably driven by my research question. This can give the impression that the therapy sessions represented were filled with blame, argument and incipient conflict. In fact, these segments form a small part of four sessions rich with a variety of themes.

Strengths and limitations of the sample size

This study does not claim to add to the CA corpus of general patterns of interaction. In a study of this size the focus must be on the construction of a *local* moral order, rather than trying to make broader comparisons. However single case analysis sits in a strong tradition within CA since Sacks original lectures, where a general case is made by appeal to one exemplar case. Elliott *et al*. (1999) argue that the value of any scientific method is in its ability to provide useful answers to the questions that motivated the research in the first place. I am claiming that this level of inclusivity, and CA's particular method of identifying phenomena, next-turn-proof, has offered a useful way to answer the question of how families and therapists manage blame together.

Limitations in the use of audio recording

Talk-in-interaction is just one part of how we communicate. Gestures, eye movements, facial expressions and other embodied expressions are important in constructing social meaning together. In a study of blame, where emotional expression is an important resource for communicating moral judgement, video recordings would have enhanced the analysis. However, I wanted the recordings to be as naturalistic as possible and as therapists usually visited families in their homes audio recordings were opted for.

Limitations in the consideration of the social GRRAACCES[6]

One of the great strengths of systemic theorising has been its consideration of the politics of therapy and the influence of inequalities of power on the families we see. We have a strong tradition of critiquing discourses of power, known within the field by the acronym of the GRRAACCES. The more critical forms of discourse analysis fit these interests well and may account for their popularity with systemic practitioners as research methods. Discourse analysis allows for the search for analytic categories that interest us as a starting point of the analysis. In CA the starting point of analysis is in participant orientation, next-turn-proof. The discussion concerning the construction of power in Therapy 1[7] is an example of how this starting point influenced the analysis. In Therapy 1, T1 is male and T2 female. It is T1, a man, who speaks most and who takes up the right to hold Janet to account. This raised the question about social expectations of men and women and how this might affect the delicacy with which male and female therapists approach blame. I became interested in whether gendered power could be discerned in the orientation of participants to speaking rights. I wondered if this could be demonstrated both in terms of frequency of turns but also turn shape. Are women therapists more 'delicate' in their responses to blame and if so, could this be accounted for by 'doing' gender? In Therapy 2, where both therapists are female, the qualified therapist *also* dominated the therapy and held Mandy to account for her actions. Although she does not use explicit blame as T1 does in Therapy 1, she does frequently interrupt Mandy, especially in the first session (not shown in data set). Thus, this data *shows* participants orienting to professional seniority where the orientation to gendered power remains a question. It does not mean that it is not there, but this data set does not give sufficient evidence to show that *for the participants* it was a relevant matter. Kitzinger (2000) argues that it is the very invisibility of

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[6]   GRRAACCES is an acronym for Gender, Race, Religion, Age, Abilities, Culture, Class, Ethnicity and Sexual orientation. Burnham (1993)

[7] see Chapter 4 page 115

gendered power to participants themselves that shows its pervasiveness. However to demonstrate that gender influenced these participants responses to blame differently, further studies would need to show generalised patterns, something that this study cannot claim to do.

How has CA contributed to further understanding of systemic SIKs?

> CA has a *critical task* in pointing out the simplified or empirically unsustainable assumptions of the SIKs. However, it also has a *complementary task* in providing more detailed or concrete descriptions of known practices and in showing new practices or functions. (Peräkylä and Vehviläinen, 2003, p.747)

Our theories are founded on a sophisticated grasp of the complexity of communication and the impossibility of *controlling* how others will understand and respond to our actions. However, we have a strong body of theory and practical techniques upon which to draw to *influence* how our therapeutic moves might be taken up. Exactly *how* therapy is achieved however depends on responses to feedback. In this study, CA *complements* systemic theory by detailing how therapists are influenced by both theory and feedback.

The strength of this study is in showing the *development* of a piece of social action. The analysis shows the reality of the cut and thrust of a therapy session in real time, with real people thinking on their feet, trying to communicate, or not communicate what they are thinking and feeling, trying to persuade, trying to understand, avoid an argument, start an argument, trying not to offend, realising they've been misunderstood, making false starts, trying again and so forth. It is, like all therapy and indeed all human communication, messy and unpredictable and full of mistakes and misunderstandings. CA and MCA show us the remarkable sophistication of those practices we use to make sense of the world

together and, as family therapists, how we hone those practices in particular ways to achieve particular therapeutic goals.

Through the discipline of sequential analysis participants are shown to subtly imply blame, mitigate and exonerate as part of the production of the local moral order in therapy. We can see the contest over moral identity played out. I have taken two instances where participants are explicitly orienting to a blaming event and have shown how the meaning of events cannot be fully understood within the context of the prior turn only. As we trace the origins of these sequences I show that they are the culmination of sequences that emerged earlier in the session. The explicit blaming events therefore can be understood as the closings of sequences that opened many turns before. My approach to this analysis then has been akin to the archaeology of a blaming event. Rather than examining many blaming events and the ground immediately surrounding them to identify general features, I have painstakingly dug down to uncover the specific structures of these two events and how the turns that constructed them fit together. What it shows is the practices by which participants in family therapy sessions co-construct the way in which a blaming event unfolds.

This analysis shows that the systemic SIK of being non-blaming is grounded in a sophisticated understanding of the threat blame poses to co-operation and agreement. The therapists in this study demonstrate that blame is seen as a prompt to action. In both therapies, the delicacy with which blame is treated serves to enable the conversation to continue without withdrawal.

Implications for future research

Stancombe and White (1997) analyse a segment of transcript where indirect and ambiguous blaming is negotiated in a family therapy session. They pose the question that this may be an extreme case,

"unrepresentative of normal talk in family therapy sessions." This study shows further evidence of such talk. Further studies of blame in family therapy in different settings are necessary in order to build a body of generalizable findings.

Further studies on the relationship between blame and the therapeutic alliance and/or therapy outcome are necessary. A recent randomised controlled trial into the effectiveness of family therapy in the treatment of young people who self-harm (Boston *et al.*, unpublished manuscript) may make this more practically possible. Robust measures will enable researchers to differentiate families according to both outcome and therapy alliance measures. For example, families could be selected on the basis of good and poor therapeutic alliance ratings and the management of blame compared. A particular focus could be on how the management of blame is associated with misalignment and how these misalignments are repaired or not. Further research is necessary on the incidence of blaming events over time in families with good and poor outcome to establish if the amelioration of blame is correlated with outcome.

I have shown that when blame of self or other is 'doing' claim backing, mitigation seems to invite an upgrading of the blame in order to produce further evidence for the argument. This poses the question, if blaming statements are presented primarily from the stance of explanation, would mitigation be received into a more favourable context? Would it be received as a possible alternative version of events rather than as a counter argument? This variable may have some bearing on the conflicting research findings discussed in Chapter 2. Some studies show therapist interventions lead to more blaming in the session and others indicate therapist interventions lead to less. If this were the case therapists would be advised to pay close attention to feedback regarding the stance and interactional aims of the blamer and adjust their responses

accordingly. Further research into how therapists notice and respond to the stance of the blamer would be useful.

Coda

As an experienced systemic psychotherapist it is impossible for me to view these transcripts as a naïve researcher. For instance, I can see in the construction of many of the questions uttered by the therapists the legacy of our shared training. This has both positive and negative consequences. I may have an insider's understanding which helps me to see the institutional influences on the design of the therapists' utterances. On the other hand I may 'find' those institutional influences in the data where none exist or other influences are more relevant. One experience that really helped me to hold this bias in mind was a follow up interview held with one of the participant families. The original aim was to interview all participating family members; however I only succeeded in interviewing Family 2. The aim was to find out whether families' narratives about the cause and explanations for problems had changed, and if so, whether they thought therapy had influenced those changes.

The family had disengaged after two sessions and I wondered what had gone wrong. I imagined the therapy had failed to meet their expectations in some way. Compared to my own practice, T1 had a fairly directive style, especially in the first session (not shown). In that session T1 had often interrupted Mandy, diverting her from problem talk in order to take a family history. In the second session, this was less pronounced but nevertheless T1 frequently reframed or diverted Mandy's complaints. I wondered if Mandy had felt shut down in some way or that the problems she wished to discuss were avoided.

I selected a couple of extracts from the recording of session 2 to play to the family (excerpts from Chapter 5 Part 1 and Part 3). However, despite my search for anything negative in their experience of therapy, both Mandy and Kevin maintained that not only had the therapy helped at the time but one year later it continued to have a profound impact. What they

thought had changed was their capacity to communicate without frequent arguments and physical violence from Mandy towards Kevin. They thought the therapy had helped them to listen and understand one another better, and, importantly for Mandy, that Kevin had 'found a voice'. They told me that they found the second session difficult emotionally. However, despite the emotional content they found the therapists style calming which enabled them to say things without arguing. The moment in Part 3 of therapy two, when Mandy wishes Kevin would speak and he responds was remembered by them as a significant moment. It was not that they had said new things, but that they said things *differently*. The consequence was that they thought they did not blame themselves or each other so much. Their reason for not continuing with the therapy was because they had so many other appointments they had to attend at the time, appointments that Kevin for the first time was contributing to. In other words they did not withdraw because they had *not* got what they wanted; they withdrew because they had *got enough* of what they wanted.

This interview challenged my preconceptions and helped me to look at both therapies anew. For instance, when I first examined the transcripts of Therapy1, I had been surprised by T1's phrase 'You have no-one to blame but yourself'. It seemed to break the golden rule of being non-blaming and I wondered if it may have influenced the family's withdrawal. The family did not wish to engage in a follow up interview and so we will never know their view. However, because the subjective experience of Family 2 had confounded my pre-conceptions I realised that my assumptions about Therapy 1 were equally questionable. This helped me to differentiate between the two positions of therapist and researcher a little more clearly. It also helped me to value the CA mantra of 'Why that now? as a guiding principle, both in terms of the 'human interaction engine' of conversation as well as trying to understand the institutional aims of the therapists. In this

case I think the therapists interrupted Mandy and Kevin enough to listen to each other differently and pursued topics enough for more information to be heard. This seems to have enabled Mandy and Kevin to adjust their stance towards one another and create different meanings.

Conclusion

I introduced this study with a story about my motivation to undertake it. My desire to understand how we, as members of a wider culture where blame permeates every sector of life manage the discourses of 'no blame' in our particular sub-culture of systemic psychotherapy. I wanted to understand more about how systemic therapists deal with the practical moral dilemmas they face in day to day practice. Essentially, I wanted to become a better therapist. During the process of the research my relationship with blame has changed. I feel more confident in my clinical decisions when faced with blame, more able to reflect on the process and less liable to be reactive. I am more alert to the subtleties of blame and its interactional consequences. I do not claim to be analysing and planning every move in the cut and thrust of the session. The conversational strategies I am responding to or using in the moment to moment interaction of the therapy remain largely beyond my conscious comprehension. However, I am quicker to notice when certain generic forms of conversational practice occur. I am alert to 'unhappy incident reports' and the projected search for a culprit. I am aware of shifts in preference structure from agreement to disagreement and more conscious about my decision making processes when this happens. I may allow an argument to continue in order to try to understand the moral positions people take up, or I may interrupt it in order to cool things down and help the conversation to continue. I am more alert to the impact of irrelevancy claims and characterological blaming and aware that these predict withdrawal. I will use these as cues to deconstruct the values that underpin peoples strongly held positions. I am particularly alert to the

preference shape of responses to my contributions. The tiny pause and downward inflection of a 'yes' in response to my question is more likely to make me pause and reconsider the quality of agreement. I often reflect on the interactional process in the session. When working in a team, in an observing position, I believe I listen with a more acute ear to the social action performed by a conversational strategy and think about what problem this is solving for the person. When working alone, or in front of the screen I am of course mostly responding intuitively to what has been said or done and the emotions in the room. However CA offers another perspective for reflecting on what happened after the event, an additional part of the knowledge and practice base upon which intuition rests. The discipline of CA enhances self-reflexivity.

I hope that this research will offer other family therapists alternative ways of thinking about their relationship to blame and how they manage blame in their practice.

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Glossary

Adjacency Pair	A two part sequence in which the first pair part makes relevant the production of a second pair part such as question/answer, greeting/greeting
Affiliation	Displaying emotional understanding or support
Alignment	Displaying that the topic or interactional project is relevant
Category Bound Activity (CBA)	Any activity linked in situ to a category drawing on culturally shared inferences regarding the obligations and rights of each member and associated expected actions.
Category Bound Predicate (CBP)	The use of common understandings of different categories in order to negotiate what *type* of member one is, for example good or bad, competent or incompetent.
Collection	The situated rules by which member categories are heard to belong together, such as 'family' or 'patients'.
Conflict	In CA, conflict (or argument) is minimally defined as a three part sequence. If speaker A's utterance is contested by speaker B, A can either make a concessionary move or counter oppose B. An argument remains latent until the third move constructs it as such.
Consistency Rule	In MCA if two or more categories are used next to each other and they belong to a standard collection such as 'family' then they are heard as coming from the same device.
Conversation Analysis (CA) (Applied)	The application of CA to particular contexts or practical interests.
Conversation Analysis (CA) (Pure)	The study of naturally occurring talk-in-interaction.
Disjunctive Categories	Asymmetric category pairings hierarchically arranged in different contexts to generate conflicting characterisations of the same person.
Duplicative Organisation	A collection of member categories treated as a unit or team, not as individuals. For example, when talking about a mother, father and child it will be expectable to think about them as coming from the same family.

Economy Rule	While any person can be a member of innumerable categories, at the core of competent talk is the capacity to apply only those categories that are necessary to achieve the task at hand and to combine categories in recognisable ways.
Extreme Case Formulation	"So as to legitimize a complaint and portray the complainable situation as worthy of complaint, a speaker may portray the offense and /or the suffering with Extreme Case formulations". (Pomerantz, 1986, p. 227-8)
Formulation	Formulations immediately follow a person's turn and ostensibly give the gist of what that person has said by selecting elements of a person's account, deleting others and presenting it as merely a summary of that person's words.
Interactional project	The persistent effort to maintain a particular topic or direction of talk-in-interaction (Schegloff, 2006)
Member	Incumbent of a member category in use.
Membership Categorisation Device (MCD)	A "collection of categories for referring to persons, with some rules of application" (Sacks, 1995, Vol.1, p. 238)
Preference Organisation	In CA preference is used to denote two linked but slightly different meanings. 1. findings that project empirically which alternative is most frequent and therefore expectable. 2. structural properties of responses that *mark* actions as normatively positive (preferred) or negative (dispreferred).
Recipient Design	The shaping of an utterance in such a way as to be understandable by a particular recipient in a specific context, given the pre-suppositions of the speaker regarding the kind of knowledge the recipient might have.
Reinterpretation	Therapist reinterpretations are similar to therapist formulations in that they both refer to personal events that clients have greater access to. However because reinterpretations explicitly propose views that are additional to or different from those that the client has said, client agreement or disagreement is sought. (Bercelli *et al.*, 2008).

Repair	In CA repair refers to those practices which enable any kind of trouble, (misunderstandings, mishearings, misalignments) to be dealt with. Practices of repair are found to occur immediately after a trouble source is identified.
Sequence	The beginning of a sequence in CA is marked by a turn in which one of the participants initiates an action which is taken up by recipients. Its end is marked by the place where participants are no longer responding to that action.
Sequence Organisation	In CA every utterance is produced in relation to what has gone before and projects or limits the possibilities of what can come after. Meaning is tied to the position of the utterance in unfolding talk, its 'sequential implicitiveness'.
Standard Relational Pair (SRP)	In MCA common sense understandings of the category collection in use set up expectations of member categories in relation to each other, for example within the device 'family', SRPs such as husband/wife, mother/child occur which describe *normative* relationships. By invoking such pairs the speaker draws on culturally shared inferences about the obligations and rights of each member with associated expected actions, otherwise known as category bound activities.
Stocks of Interactional Knowledge (SIK)	The institutional norms and practices described in textbooks and taught in professional training which guide practitioners expectations regarding the range of interactional practices and types of conversation deemed relevant (Peräkylä and Vehviläinen, 2003)
Transition Relevance Place (TRP)	The end of any TCU (see below) is termed a Transition Relevance Place. At each TRP there are three main ways that the next turn is allocated. The present speaker can select the next, a speaker can self-select or the present speaker can continue.

Troubles Telling	In mundane conversation the preferred response to troubles telling is emotional reciprocity. The identities of troubles teller and troubles hearer in this context are symmetrical, in that their roles are interchangeable. In a 'service encounter' the troubles teller and troubles hearer roles are asymmetric, with the expectations of troubles hearer (service provider) being help giving and the troubles teller as help seeking (Jefferson and Lee 1992).
Turn Taking	Overwhelmingly in conversation only one person speaks at a time with minimal gap or overlap between different speakers. A number of organising practices allow for speakers turns to be changed smoothly. For example, speakers orient to a possible change of speaker at the end of a Turn Construction Unit.
Turn Construction Unit (TCU)	A TCU is marked by its adequacy to achieve an action. It might be a sentence, a single word or a nod of the head.
Tying Rules	The means by which one part of a conversation is linked to another.
Unhappy Incident Report	An 'unhappy incident' is reported in such a way that the event is not linked with an actor/agent but as something that just happened and most frequently, in an unelaborated way. It is frequently used as a device for allocating blame in that "By reporting an unhappy incident as an announcement, a speaker reserves accounts of the background, setting, circumstances etc. for subsequent turns. It is in these subsequent turns that the allocation of responsibility is routinely oriented to" (Pomerantz, 1978, p. 117)
Utterance	A unit of speech which fulfils an action, from a single word to a group of words or sentences.

Appendices

Appendix A

The history of the study

The study was originally designed to investigate therapy sessions of three families, each with a member where one had lived experience of psychosis, with three therapy teams, each containing a systemic psychotherapist. I intended to listen to tapes and identify sections where the negotiation of blame was evident, transcribe the relevant sections and subject them to a discourse analysis focussing on how blame, accountability, responsibility and exoneration for events were achieved. Following the end of therapy I planned to interview families and subject the ensuing transcripts to a narrative analysis. The focus was on whether, over time, the construction of blame became modified and whether families connected these changes to their experience of therapy.

Finding a site where therapists and families agreed to the research *and* completed therapy proved difficult. More than two years after receipt of ethical approval for the study I had collected four therapy sessions in all and one follow up interview. During this time I transcribed the therapy sessions in full, using a 'rough' transcription (ie not including all the details a CA transcript would entail). I identified blaming sequences, got excited that blame was evident from the outset, checked out my findings with my colleagues and impatiently waited for more data. As I waited for the 'real' data to be collected I played around with the transcripts I had and became interested in the Conversation Analytic end of the spectrum of discourse analytic methods. I began to examine sections of the transcripts that I had dismissed as irrelevant. For instance I had dismissed one section as a pre-amble to the therapy proper, a rather rambling discussion concerning a missed appointment and the setting up of another. As I examined it from a sequential, rather than a topical, perspective I began

to see a complex and delicate negotiation about who was to blame (the therapists for not attending to the families needs, the patient for her illness, the husband for forgetting?) and what I will call identity work (a caring therapist, a neglectful husband, a responsible patient?) This led to a recalibration of my work. I looked at the transcripts through a different lens, shifting focus from topic (a blaming event) to sequence (is this a complaint, how is it being taken up) and identity ascription (what member category is being implied and what are the consequences?) When two of the three therapists recruited to the study told me they were leaving it made more sense to me to follow this new interest and change the focus of the analysis. This made the one follow up interview I had recorded difficult to include in a meaningful way. However, despite the interview not being used as originally intended, the family's report of their subjective experience had an important influence on the research. I have therefore included a coda to the thesis which offers another perspective through which to reflect on the findings.

Appendix B

Participant Information Sheet (Family)

Research Title: How do family therapists help families make sense of the difficulties of living with psychosis?

Thank you for agreeing to take some time to find out more about this research. This information sheet will tell you:

- Who is responsible for the research.

- What the research is about.

- How the research will be carried out.

- Possible disadvantages of participating in the research.

- How the research may be of benefit.

- What will be required of you if you agree to participate.

- What will happen to the information we collect about you.

If you decide you would prefer not to take part in the research it will not affect your treatment in any way.

Who is responsible for the research?

My name is Sarah Amoss and I am a family therapist who works in the NHS in London. Many of the families I work with have been affected by psychosis and I have become interested in finding out more about what therapists do which families find helpful or unhelpful. I am carrying out this research as part of the Doctoral Programme within the Tavistock and Portman NHS Foundation Trust.

What is the research about?

In my experience, when families come to therapy they are often trying to make sense of a difficult situation. They are frequently trying to work out who or what is responsible for their difficulties in order to help them to move on. Sometimes, different family members have different explanations for

the cause of their problems and are hoping that the therapist can help them to throw some light on the situation. This research is designed to help us to find out more about how therapists respond to different explanations, particularly those that may appear critical, and the effects of different responses.

How will the research be carried out?

I will be analysing recordings of the family sessions of three different families with three different therapy teams. I will then interview the families about their experience.

Part 1- The Family Sessions

The first part of the research will involve audio recording your family sessions. I will then listen to those recordings and transcribe sections that are relevant. I am interested in finding out how therapists respond to different sorts of explanations and for this reason the focus of the first part of this research is mainly on the therapists.

Part 2 – The Research Interview

The second part of the research will involve a research interview. After 10 family sessions, or following your final session, whichever is the sooner, I will meet with you for about an hour and ask you some questions. I am interested in how you experienced the family sessions and whether you think they have affected your explanations for things or not.

What are the possible disadvantages of participating in the research?

The research interview may lead you to think about issues that you might have found embarrassing or upsetting either in your family sessions or in your life. As someone who works with families affected by psychosis I am familiar with supporting families in talking about difficult issues. You will be free to answer the questions or not as you wish. Also, if you find the interview difficult you will be able to withdraw from it. The [name of service] will meet with you following the research interview if you would like to.

How will the research be of benefit?

The [name of service] has agreed to take part in this research because it is committed to providing the best service possible. The aim is to understand more about helpful and unhelpful ways of responding to families. I hope that this research will help not just the [name of service] in [region] but other family workers and therapists to improve their practice. We would therefore be grateful for your help. However, we also know that people who take part in research often find it interesting to talk with an outsider who is really curious about their experiences and so we hope it might also be something you might enjoy too.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by [name] Research Ethics Committee.

If you agree to take part in this research you will be agreeing to two things.

1.   You will be giving permission for me to listen to the recordings of your family sessions. I will be transcribing parts from your sessions which are relevant to the research question.

2.   After family sessions have ended, or after 10 sessions whichever is sooner, I will arrange to meet with you as a family for a research interview lasting about an hour. In this meeting I will ask you some questions about your experience of therapy. I will record our conversation and transcribe it. The findings from the research will then be written up and published in a doctoral thesis and possibly elsewhere.

Confidentiality

Part 1 - The Family Sessions

The research does not affect the usual rules of confidentiality that your therapist will have explained to you as a user of the [name of service]. All audio recordings will be encrypted for additional security and kept

securely according to [name] NHS Foundation Trust policies. A copy of the audio recording will be transferred to an encrypted memory stick and sent securely to me at the Tavistock and Portman NHS Foundation Trust where I will upload it onto their equipment temporarily in order to transcribe it. When I have transcribed and anonymised the data the copy of the recording will be destroyed.

Part 2 - The Research Interview

The research interview will be different from your family sessions. What you say in the research interview will not be fed back directly to the [name of service] unless you ask me to do so. However, should you say something that makes me concerned that someone is at serious risk of harm I will need to inform the [name of service] or another member of your direct care team, whichever you prefer.

When the audio recordings are transcribed, all names and anything that might identify you will be changed to ensure anonymity. However, the very detailed nature of this type of research means that even anonymised material may be recognisable to family or friends. For instance I might use a short section of the transcript to illustrate a point and even though all your personal details have been changed, your family or close friends might be familiar with the story you tell or a particular way of speaking. At the end of the study audio recordings and transcripts will be kept securely and destroyed after two years. I will be publishing the results of the research in a doctoral thesis and possibly elsewhere. I will ensure that you will not be identifiable in any published material.

You will be free to withdraw from the research at any time.

If you would like to speak to me directly to discuss any aspects of the study please contact me. If you would prefer, your therapist will answer any questions you may have.

Thank you,

Sarah Amoss
Systemic Psychotherapist

Contact Details

If you have any questions about the research process please contact me directly:

Sarah Amoss

Tel: 07592404818 / 020 8521 3635 E-mail: sarahamoss@e17.waitrose.com

If you have any concerns or complaints about the research please contact the research supervisor:

Bernadette Wren (Consultant Psychologist)

Tel: 020 8938 2298 E-mail:BWren@tavi-port.nhs.uk

Participant Consent Form (Family)

Research Title: How do family therapists help families make sense of the difficulties of living with psychosis?

Name of Researcher: Sarah Amoss

Please tick the boxes to show you have read and understood the information and then sign.

☐ I confirm that I have read and understood the Participant Information Sheet (Family) dated 18/07/2010 (version 3). I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

☐ I understand that my participation is voluntary, that I am free to withdraw from the research at any time, without giving any reason and that this would not affect my treatment in any way.

☐ I give consent for my family sessions to be audio recorded and for these recordings to be made available for the above research.

☐ I understand that data collected during the study, may be looked at by individuals from the Tavistock and Portman Centre (the academic institution overseeing the project), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

☐ I understand that I will be contacted after 10 sessions, or following the end of family sessions, whichever is sooner for a research interview and that this interview will be audio recorded.

☐ I understand that information from the research interview will not be fed back to the [name of service] or other members of the care team unless I wish it to be. The exception to this would be if the researcher becomes concerned that someone is at serious risk of harm. In this case she will inform a member of the direct care team.

☐ I understand that all recorded and transcribed material will be kept securely and following the end of the research will be destroyed after two years.

☐ I understand that personal details will be changed in order to protect my anonymity in all published material relating to this project.

Name of Participant	Date	Signature

Name of person taking consent	Date	Signature

Position

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in patient file.

Participant Information Sheet (Therapist)

Research Title: How do family therapists help families make sense of the difficulties of living with psychosis?

Thank you for agreeing to take some time to find out more about this research. This information sheet will tell you:

- Who is responsible for the research.

- What the research is about.

- How the research will be carried out.

- Possible disadvantages of participating in the research.

- How the research may be of benefit.

- What will be required of you if you agree to participate.

- What will happen to the information we collect about you and your clients.

Who is responsible for the research?

My name is Sarah Amoss and I am a family therapist who works in the NHS in London. Many of the families I work with have been affected by psychosis and I have become interested in finding out more about what exactly therapists do which families find helpful or unhelpful. I am carrying out this research as part of the Doctoral Programme within the Tavistock and Portman NHS Foundation Trust.

What is the research about?

In my experience, when families come to therapy they are often trying to make sense of a difficult situation. They are frequently trying to work out who or what is responsible for their difficulties in order to help them to move on. Sometimes, different family members have different explanations for the cause of their problems and are hoping that the therapist can help them to throw some light on the situation. This research is designed to help

us to find out more about how therapists respond to different explanations, particularly those that may appear critical, and the effects of different responses.

How will the research be carried out?

I will be analysing recordings of the family sessions of three different families with three different therapy teams. I will then interview the families about their experience.

Part 1- The Family Sessions

The first part of the research will involve audio recording your family sessions. I will then listen to those recordings and transcribe sections that are relevant. I am interested in finding out how therapists respond to different sorts of explanations and for this reason the focus of the first part of this research is mainly on the therapists.

Part 2 – The Research Interview

The second part of the research will involve a research interview with the family. After 10 family sessions, or following the final session, whichever is the sooner, I will meet with the family for about an hour and ask some questions. The interviews will focus on family members' experiences of their family sessions and whether they have affected their beliefs about what has caused their difficulties.

What are the possible disadvantages of participating in the research?

<u>Therapist participants</u>

In addition to your routine work with families you will be required to explain the research to families, tape the family sessions and ensure that the data is kept securely and uploaded to the Trust network. You will also be required to offer a family session following the research interview if the family requests one.

<u>Family Participants</u>

The research interview may elicit issues that are embarrassing or upsetting. As an experienced psychotherapist I have the skills to support people should they become upset during the interview. The family will be able to answer questions or not as they wish and will have the right to withdraw from the interview. Following the interview the family will be given the opportunity to be referred back to the therapy team if they wish.

How will the research be of benefit?

"Research is needed to identify the competencies required to deliver effective family intervention to people with schizophrenia and their carers." (NICE 2009)

Part of my motivation for this research is that I think that dealing with contested causal explanations is a particularly challenging aspect of our work and one that is under theorised. I hope that this research will help us to understand more about helpful and unhelpful ways of responding to families' attributions of responsibility.

I hope that if you decide to participate you will benefit from the opportunity to reflect on your clinical work that tapes and transcripts offer. Tape review was something that I found invaluable during my training but sadly have little time for in my current work setting.

I hope that families will find it useful to tell an interested outsider about their experience of therapy. The research interview will be confidential but I will ask the family if they wish any of the material that emerges to be fed back directly to the therapy team. The family will be informed that should any information emerge that indicates a serious risk of harm the direct care team will be notified.

Who will be included in the study?

Participant Inclusion Criteria (Therapist)
Each therapy team will comprise one qualified systemic psychotherapist and one colleague with an accredited training in family intervention.

<u>Participant Inclusion Criteria (Family)</u>

The family must have been assessed as suitable for and have been offered family sessions routinely.

All family members must be over 18.

The family must contain at least one member who has experienced a psychotic episode.

The presenting issue must involve the family's experience of living with psychosis in some way.

All members of the family must give written consent to tapes of the sessions being used for research purposes and to being interviewed following their family sessions.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by [name] Research Ethics Committee.

If you agree to take part in this research you will consent to the following:

3. To discuss the project with families who meet the inclusion criteria and ensure that they are aware that their agreement or refusal to take part will in no way affect their treatment. If the family agrees, to give them the Participant Information Leaflet (Family) and inform them that I am available to discuss the research further and answer any questions they may have. If they prefer to talk with you, to ensure that the family understands what is required of them with particular regard to issues of confidentiality and information security.

4. To ensure that all family members involved in the therapy have given informed consent and signed a consent form.

5.   To be responsible for the audio recording of sessions. If audio recording takes place in families' homes it may require some adjustment to usual seating patterns to ensure the recording is audible.

6.   To make a note following each session to indicate whether the session included "responsibility talk".

7.   To ensure that all recordings are kept securely in accordance with [name] NHS Foundation Trust policies and that the recording is uploaded to the Trust Network for access by the researcher.

8.   After therapy has ended, or after 10 sessions, I will be interviewing family members. The therapy team will need to make available a follow up session to any family member that requests one in order to process any issues or concerns that may emerge through the research interview.

Confidentiality

When the audio recordings are transcribed, all names and anything that might identify you will be changed to ensure anonymity. At the end of the study audio recordings and transcripts will be kept securely and destroyed after two years. I will be publishing the results of the research in a doctoral thesis and possibly elsewhere. I will ensure that you will not be identifiable in any published material.

You will be free to withdraw from the research at any time.

Contact Details
If you have any questions about the research process please contact me directly:
Sarah Amoss (Systemic Psychotherapist)
Tel: 07592404818 / 020 8521 3635 E-mail: sarahamoss@e17.waitrose.com

If you have any concerns or complaints about the research please contact the research supervisor:
Bernadette Wren (Consultant Psychologist)
Tel: 020 8938 2298 E-mail:BWren@tavi-port.nhs.uk

Participant Consent Form (Therapist)

Research Title: How do family therapists help families make sense of the difficulties of living with psychosis?

Name of Researcher: Sarah Amoss

Please tick the boxes to show you have read and understood the information and then sign.

☐ I confirm that I have read and understood the Participant Information Sheet (Therapist) dated 18/07/2010 (Version 3). I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

☐ I understand that my participation is voluntary, that I am free to withdraw from the research at any time, without giving any reason and with no detriment to my employment.

☐ I give consent for the family sessions to be audio recorded and for these recordings to be made available for the above research.

☐ I understand that relevant sections of data collected during the study, may be looked at by individuals from the Tavistock and Portman Centre (the academic institution overseeing the project) from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

☐ I understand that I will be responsible for the safe keeping and uploading of the audio recordings of the family sessions in accordance with the [name] NHS Trust Information Governance Policy, IM&T Security Policy and Bespoke Software Policy (pending approval). I have been provided with an opportunity to read and discuss the relevant sections of these policies and understand my responsibilities.

☐ I understand that recordings and transcripts of my therapy sessions will be made available to me for clinical purposes.

☐ I understand that in order to use these recordings and transcripts for teaching or research purposes I will be required to seek further

permission from the families involved, and in the case of research, to seek approval from the Research Ethics Committee.

☐ I understand that all recorded and transcribed material will be kept securely and following the end of the research will be destroyed after two years.

☐ I have been informed that my personal details will be changed in order to protect my anonymity in all published material relating to this project.

Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature

Position

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in patient file.

Appendix C: Transcripts Chapter 4

Sequence 1 Therapy 1

111	T1	So have you adjusted what you d:o during the da:y or how you live your life as part
112		of this (.) process of getting better?
113	J	Well I did go voluntary today I done one day today I thought I'd go and see how I
114		get on (.) and I was just basically walking around a furniture shop with a can of ha
115		ha u(h)m (.) ↑cleaner (.) n I thought this int me (.) I'm worth a bit more than this
116		(.) so I'm not goin ↓back.
117	S	hhhhh well I said to Janet I said it's a confidence builder
118	T1	mm
119	S	I know she's sayin its all men there at work obviously but there's different days int
120		[there
121	J	[>yeah I ↑didn't mean it like that< (.) what I'm sayin is it was all men
122		when I went for a coffee (.) it'd be nice if there was a lady there but .hhh I felt like
123		I'm worth more than this basically you know if you like ↓summin don't you
124	T2	mmmm
125	T1	So you didn't feel you fitted in there very well?
126	J	↑Yeah I think I was all right but I- in myself I thought I think I'm worth a bit more
127		than this hm hm
128	T2	mhm do you think it was something to do with it jus- the first day, that they
129		thought they'd kinda give you something easy to do the first day or d'you
130		[know
131	J	[>no I just thought it weren't me< (.) what I was doin really
132	S	How would you feel if some of your mates came in n you were there cleanin (.)
133		would you get em<u>bar</u>rassed by that?
134		(2)
135	S	Is that part of it?
136	J	↑No I'm just saying I- I just feel it wasn't for me. I don't think I'd like to do that all
137		the time.
138	T1	I- I don't want us t- to kind of (.) I don't want you to feel we're trying to >get at
139		you or anything like that< but I'm feeling a- a bit the <u>same</u> as Steven and I guess a-
140		as <u>you</u> Mary I'm thinking I'm sure this isn't your permanent (.) role in life its not

141		something you're going to do f-for↑ever its like a stepping stone (.) its just
142		something to get you back into the (.) ↑swing of things=
143	J	=I found it boring to be honest (.) it was just cleaning heh heh I thought I do
144		enough of that at home basically (.) I thought here I go again
145	T1	Ye:ah and there wasn't a social side to it either=
146	J	=not really
147	T1	The question is whether that's (.) what they would expect you to do next time=
148	J	=mm
149	T1	Did they say anything to you like next time we'll show you how to do this
150	J	[oh they were
151		helpful they were helpful you know but I jus:t=
152	S	=>to be fair Janet< we were in town last week weren't we (.) we went into this
153		foundation shop dint we (.) where you worked n we see the woman behind the
154		desk (.) and Janet she put her application form in and Jan said like she'll come up
155		and have a little taster day and she said y'know what d'you wanna in the shop, you
156		can work the tills, do what you like n Jan said I'll do a bit a cleaning she said
157		[indecipherable]
158	J	[**well yeah, they** give me a choice yeah but I found it boring [basically
159	S	[**theres other**
160		**jobs** to do there Janet in the shop besides cleaning
161	J	well I was bored, I do that every day of the week[of the week
162	S	[frinstance
163	T1	so you cho:se to do cleaning
164	J	↑yeah yeah
165	T1	it wasn't that they ex<u>pec</u>ted you to do cleaning
166	S	No
167	J	<u>No no no</u> not at all but I just thought this int me
168	T1	So what <u>would</u> be you
169		(3)

Sequence 2 Therapy 1

481	T2	yeah mmm (1) .hhh I suppose I was just (.) I was thinking in relation to the charit:y
482		shop(1) was it a charity shop you volunteered in this morning?
483	J	yea:h. yeah
484	T2	cos you don't (1) you don't see the people that you're <u>helping</u> do you cos it is a
485		<u>really</u> <u>worthwhile</u> job cos you are raising money for ↑charity and it's a really good
486		thing to do but you're not actually
487	S	[mmm
488	T2	[in touch with the people you're <u>helping</u>
489	J	↑£I did meet an old lady today she asked if they had a reclining cha(h)ir in(h) the
490		shop=
491	T2	=Oh r(h)ight!=
492	J	=↑I says it's my first day but as far as I'm a(h)ware there's not£
493	T2	heh heh
494	S	She says there is one but I'm (h) sat in it
495		[laughter]
496	J	[<u>I explained I was cleaning</u> and I think hang on I do that twenty four seven at
497		home really
498	T2	yeah↓
499	J	<u>clean</u>, <u>clean</u>, <u>clean</u>
500	T1	But ↑ if if you'd said something else when they asked you what would you like to
501		do today (1) and you said give me ↑<u>anything</u> but cleaning cos I do enough of that at
502		home=
503	J	=it <u>was me</u> that said cleaning=
504	T1	=I wonder what they would've <u>given</u> you=
505	S	=yeah=
506	T1	=and I wonder what you'd be saying now.
507	S	That's what I said (.) in a way John coming up in the car this afternoon (1)
508	T1	mmhm
509	S	didn't I?
510		(1)
511	S	in a way
512	T1	cos <u>you don't know</u> what else they might have offered you

513	S	mm
514	T1	they might have said ↑would you like to do this or this (.) and you might have
515		<u>picked</u> one of those (.) and come back and said >cor I've never done that before<or
516		>that was quite interesting cos we did such and such and<(2) <u>you</u> picked the boring
517		one didn't you
518	J	[I ↑did
519	T1	[you and have no one to blame but yourself really
520	J	[no, no, that's ri↑ght.
521	S	I said on the way coming up is there any girls at <u>all</u> work in there,
522	J	↑<u>Its not the point</u> its all men but I just felt (.)
523	S	bu- but ↑say you worked tomorrow >for a couple of days< and there was two
524		<u>women</u> (.) there aswell (.) you'd feel more <u>com</u>fortable wouldn't you
525	T2	mmm, mm
526	J	But I'm not going <u>back</u> there really so that's that (.) theres no good going on about
527		↑ i(h)t
528	T2	[ha ha ha]
529	T1	is that right↓
530	J	I've made me ↑mind up
531	T1	Really (1)£ is this the Janet that you know Steven?£
532	S	Yes (1) she tries it once (.) if it's no good (.) never go back (2)
533	T1	ri:ght
534	S	But I think it's a bit more determination I think you need on your part

Sequence 3 Therapy 1

703	T1	well if you work hard and have a little break that's jus (1) hhh I was just thinking
704		T2 um (.) we were going to ask you y'know (.) whether you've had further
705		thoughts about (.) how best we can u:se these sessions (.) u:m (.) have you had (1)
706		either your own thoughts about it or have you had any conversations about that (.) I
707		know that you having had this set back and getting ill again (.) is yknow (.)
708		probably got in the way of some of that but (.) have you given that some thought?
709		(2) How we can best help you?
710		(3)
711	S	I think really the best thing I think is really t-to find a bit of work (.) for Janet an-
712		give her a bit more confidence (.) that's what I want to get out of this (.) as well as
713		[undecipherable] (2) what do you think?
714		(2)
715	J	↑ye↓a↑eh
716		(4)
717	S	cos you're always tryin (.) putting yourself ↑down cos (.)
718	J	but I've always been a people pleaser as well haven't I
719	S	mm
720	J	I always please other people so I want to really do somethin that's gonna (2) that I
721		want to do.
722	T2	mm
723	J	not that I sort of gotta (.) do this for the sake of doing it(.) that's how I look at
724		it
725	T2	that's important isn't it mm

Appendix D: Transcripts Chapter 5

Sequence 1 Therapy 2

222	T1	so how are you feeling at present Kevin coming along today with all that going on
223		and
224	K	∘I don't mind coming along∘
225	T1	rig(h)ht
226	K	[not worried]
227	T1	[o(h)k u:m (1) an-and are you feeling Ok cos as as Mandy was
228		saying she can be quite [.hhh
229	K	[yeah, yeah its hard
230	T1	[hard on you]
231	M	[You have] been stressed
232	K	yeah
233		(1)
234	M	He has been stressed (.) he he just wont he just wont say [he wont be honest
235	K	[Yeah I have been its my
236		brother's birthday next week and that (.) an it was his anniversary last month
237	T1	right
238	K	that's not helped
239	T1	is that a wedding anniversary?
240	K	no he died
241	T1	the anniversary of his death
242	K	∘ he died∘ (1) once it comes up always I think about him a bit more than normal so
243		(1)
244	T1	and is that what you meant(.) Mandy when you said that Kevin was stressed?
245	M	we:ll Kevin Kevin is stressed with me (1) and right (1) he's stressed with the
246		ho:use and stuff but he just wont ↑say it and it makes me cross cos I I ↑know he i:s
247	T1	mm
248	M	but he wont say and he wont get help and then (.) it all just builds up and then
249		there'll be a a massive like humungous outburst
250	T1	∘right∘
251	M	to the point where like the kids are going up in their rooms or
252	T1	wow

253	M	putting something on really loud because they just cant ↑take it any more they just
254		cant .hhh there've even been times when the kids have actually <u>cried</u> cos theyre
255		just so stressed with it all with us fi:ghting and (1) yknow its just (3) ∘and so yeah∘
256		(2)
257	T1	is there any kind of pattern to how (1) frequent things can build up (.) due to kind
258		of stress (.) on you Kevin?
259	K	no its just (1) I always forget to do things n' that then it sort of goes from there al-
260		(.) always forget things and [forget
261	T1	[so in in terms of frequency would that be kind of -
262		↑<u>dai</u>ly or
263	K	[no, it's not
264	T	[or every other day or weekly or?
265	K	its the last two weeks have been the worst cos it seems to be (.) the house has been
266		messed up and things (.) and that stresses me out as well so .hh
267	M	but its (.) its not that I think theres ↑other problems as ↑well because .hh like (1) I
268		think he treats like Alfie different from the ↑<u>gir</u>ls and so (1) when like hes (1)
269		having a go at Alfie
270	T1	mmm
271	M	yknow I'll I will jump in and (.) and then tha- tha that'll yknow that gets out of
272		hand too
273	T1	∘right∘
274	M	y'know cos sometimes [like
275	T1	[SO HOW KEVin reacts can then lead to you to react
276	M	[yeah
277	T1	[in a
278		particular kind of way too [Mandy
279	M	[cos sometimes like he's like inappropriate in what he
280		says (1) he can be <u>really nasty</u> to Alfie and he just wont accept it when I tell him
281	K	no it [indecipherable]
282	M	[its <u>like the girls</u> have a lot of leeway
283	T1	.hhhh I've got a suggestion is that we ↑don't try to get into too much detail (1)
284	K	yeah

285	T1	beca:use what we would hope to do over yknow a series of appointments is that
286		we can kind of look at the details of (.) yknow these kind of examples but in a kind
287		of (1) y'know if that's the kind of thing you want [to <u>look</u> at
288	M	[<u>I just</u> think stress is
289		everything to do with me yknow <u>I</u> stress him out (.) right (.) he has to do school
290		run [and
291	K	[oh I don't [indecipherable]
292	M	[and look after the kids and yknow I have <u>pan</u>ic attacks daily
293	T1	mmm
294	M	right not just one neither (1) and they can be like (.) I can just be <u>sitt</u>ing there
295		watching the telly and I'll ju- it <u>just comes on</u> and so Kevin constantly like
296		watching me to make sure I'm not self ha:rming [or er
297	T1	[<u>so we're talking</u> about a lot of
298		stress aren't we on a kind of daily basis [an
299	K	[yeah I suppose yeah
300	M	yeah <u>if I start self</u> harming Kevin starts like safe proofing the house and everything
301	T1	mm
302	M	and taking stuff away=
303	T1	=the obvious things away (.) that you might hurt yourself with
304	M	yeah
305	T1	yeah
306	M	so (.) I suppose .hh its like someone looking after a toddler isn't it.
307	K	∘no I don't think its like that∘
308	T1	mm
309	K	I ↑<u>wan</u>na look after you I like it (1) its stressful yeah so ∘I like doing it∘
310		(2)
311	T1	We talked (1) I don't know ho:w how clearly you remember the conversations we
312		had last time
313	K	not very much (.) I'm getting a really bad memory [actually I] forget
314	T1	[ha ha]
315	M	We was talking about when we first met
316	K	>yeah, yeah, yeah that's right yeah<
317	T1	Cos yknow I think you were touching on there Kevin that that you y-you kinda like
318		(.) wanting

319	K	[yeah yeah]
320	T1	[to help Mandy (.) and that even if its stressful its something that yo-
321		you do
322	K	yeah
323	T1	and you're the(h)re
324	K	[yeah]
325	T1	[you(h)re h(h)ere u:m but I think yknow that's kind of what
326		Mandy's also saying .hh theres a lot of things which happen just on a daily ↑basis
327		.hhh involving you, involving the children, involving how (.) you react or how
328		Mandy's reacting that either one of you will react to .hhh which actually can be a
329		lot of stress
330	K	yeah it can be actually um
331	T1	and you've talked a bit about a lot of your kinda role has been as a carer.hh
332	K	yeah=
333	T1	=over the years you know to your mum an:d=
334	K	=yeah=
335	T	=and to Mandy when you got together and(.) yeah so its something which you've
336		become used to doing
337	K	yeah
338	T1	ha ha ha and in many ways you've elected to do you've chosen to do
339	K	yeah
340	T1	haven't you
341	K	yeah
342	T	and that's important to not lose sight of.
343	K	∘I like it∘
344	M	its hard because I feel like I don't show Kevin enough affection (1)

Sequence 2 Therapy 2

700	T1	.hh So coming back to th- the question Mandy how does (.) those experiences
701		affect you in the present in terms of (.) how you are trying to cope and deal with (1)
702		events in your life and (.) how that fits in with your stress levels. How-how do you
703		[make sense] of that.
704	M	[U::m] I'm doing a lots of work with Anne at the
705		moment I'm trying to deal (.) cos I am an emotional personality disorder but that is
706		because of how I've been brought up
707	T1	mm
708	M	So I try and focus on my feelings a lot (.) to try and show Kevin some love an-(.) ◦
709		and some compassion and that◦.
710	T1	So having those experiences (.) a lot of your growing up years (.) ha- makes you
711		feel that you don't show that kind of c-care and (.) love to Kevin towards Kevin.
712	M	Sometimes I feel that with my mouth (.) sometimes I catch myself thinking God
713		I'm turning into my mum? because she was- she was vicious with her mouth (.)
714		and I hate myself for that
715	T1	So you find yourself reacting in ways you don't
716	M	◦yeah◦
717	T1	that you'd kind of experienced yourself
718	M	◦yeah◦
719	T1	others people other people being (.)[yeah?]
720	M	[yeah] I'll ↑be honest with you (.) I I really
721		punish Kevin I do. yknow I'm absolutely sur↑prised he's still with me to be honest
722		with you. I mean I-I suppose I abuse ↑Kevin. I've severely abused him.
723	T1	mm
724	M	He's always there to take the brunt of it when my schizo↑phrenias bad y'know?
725		he's the one who takes the brunt of it.
726		(2)
727	M	sh- He (h) don(h)'t ↑say anything he always says I don't care, I don't care.
728		(2)
729	K	[indecipherable]
730	T1	I mean clearly (.) Kevin what Mandy has experienced is [absolutely horrific]
731	K	[yeah yeah definitely]

732	T1	[isnt it]
733	K	[yeah]↑<u>yeah</u>
734	T1	a:nd um (1) I-I guess she's usin:g (.) strong words isn't she like
735	K	yeah
736	T1	y'know I guess I:: ab<u>use</u> Kevin is whats she saying
737	K	yeah
738	T1	i-is that how you experience it?
739	K	.hh ∘no- not all the time I mean ↑sometimes its: its bad but (1) dunno? Its:∘
740	T1	You don't kind of th-think of in those terms yourself
741	K	∘no∘
742	T1	a-as abuse or
743	K	Dunno? I don't think so
744	T1	Ha, ha
745	K	∘don't know∘
746	T1	No (.) you don't.
747		(1)
748	T2	↑<u>I</u> sort of get a sense you're quite frus↑trated that Kevin doesn't react to that.
749	M	yeah
750	T2	I-I it feels ju- listening to you explain it Mandy it <u>sounds </u>like you're really <u>look</u>ing
751		fo:r .hhh some sort of reaction for Kevin not to just keep <u>tak</u>ing
752	M	[yeah]
753	T2	[the things] that you deliver.
754	M	.hhh sometimes I've <u>wanted</u> Kevin to <u>beat</u> me, I've w<u>ant</u>ed him to I think I n- I
755		<u>need</u> him to .hh yknow=
756	T2	=because?
757	M	because um praps I-it'll make me a better <u>person</u>
758	T1	∘right∘
759		(2)

Sequence 3 Therapy 2

761	(2)	
762	T1	[and having Kevin (.) beat you (.) would that be: mo:re of the ↑old pattern
763		or mo:re of something different happening in your own mind.
764		(2)
765	M	.hh no it would jus- I don't know I ↑just- I just feel it would just make me a better
766		person.
767	T1	mmm
768	M	um
769	T1	its interesting what you're saying cos you're looking for somethi:ng different to be
770		happening like being a better person(.) I guess its an aspiration its something you
771		strive for (.) yeah?
772	M	°yeah°
773	T1	cos you're saying you don't feel you're a very good person
774	M	°no°
775	T1	how you think, or how you feel, or how you behave at times
776	M	yeah no I'm not a good person
777	T1	but what your expecting from Kevin i:s (.) you said earlier that Kevin is the first
778		person who hasn't abused you
779	M	°yeah°
780	T1	but what you're expecting from Kevin is almost to respo:nd back with physical
781		abuse
782	M	°yeah°
783	T1	to make you kind of better (.) but actually it would be part of what would have
784		been happening before (1) of what you'd expect from people that people abuse
785		you.
786	M	°yeah°
787	T1	°yeah?°
788	T1	But its interesting what Jan was asking before isn't it that you are expecting a
789		different response from Kevin.
790	M	I ↑wish he would speak like I'm re(h)ally frustrated now cos he just wont speak .hh
791	K	[indecipherable]

792	M	[and I just really want him to speak I really .hh I don't <u>want</u> him to spare
793		my feelings I [<u>want him to sit there and say right</u>]
794	K	[I'm <u>not</u> <u>I'm not</u>] I don't like it at ↑all
795	M	.hhh this is this and that is that and I- I get cross with her cos of this or
796	T	mm
797	M	[I jus-]
798	K	[No I ↑don't] like it obviously
799	M	it's like I feel like I'm layin I'm layin all my stuff <u>bare</u> here
800	T1	yes
801	M	and (.) he's not givin- he's not he's not giving ↑anything and its just like .hhh I
802		don't ↑<u>know</u> how he feels I don't ↑<u>know</u> w-what he thinks I cant (.) and <u>that really</u>
803		inf- in<u>furi</u>ates me because .hhh I just feel like I'm on m-my own in this group
804		be↑cause hes not .hh hes not <u>giving</u> anything
805	T1	.hhh Part of what's going on he:re is that we're actually (.) yknow meeting and
806		we're all being polite. Which is if we ↑all talked at the same time (.) none of us
807		would hear what the ot(h)her pe(h)rson was saying and .hhh um it would be very
808		hard to make ourselves heard .hh so theres a kind of social etiquette isn't [there]
809	K	[yeah]
810	T1	that we take turns [to .hh]
811	M	[yeah]
812	T1	either speak, ask questions, or actually say how it is fro:m each of our points of
813		view .hhh so I guess as ↑you're saying things its very hard for you Kevin to
814		actually say something [or respond]
815	K	[yeah]
816	T1	but what we would ↑hope to do is gi:ve (.) both of you time to kind of think about
817		what the other person (.) has said [um
818	K	[yeah I ↑know its bad bu- when she says
819		things then I will say things to ↑her (.) like horrible thin:gs an-
820	T1	mm
821	K	ju- then after things have settled down I'll feel really <u>bad</u> because (.) I've started s-
822		<u>swe</u>aring at her and calling her horrible na:mes
823	T1	mm
824	K	makes it a lot worse I think (.) cos I said it

825	T1	°right° so sometimes if you <u>do</u> react back to .hh Mandy an:d <u>ve</u>rbally you- you're
826		saying nasty things?
827	K	yeah
828	M	ve-<u>very</u> rare though (.) that probably happens like(.) twice a year?
829	T1	[m↑hm]
830	M	[if that]
831	K	I feel <u>bad</u> because I don't think I should be .hhh saying anything because of what
832		shes been through
833	T1	right (.) so in your <u>own</u> (.) for your own self Kevin actually that doesnt feel like an
834		OK thing to do.
835	K	yeah, yeah
836	T1	°yeah°
837	K	sometimes you just can't help an- it just happens so .hh h

Appendix E: Transcription Symbols

This set of symbols is based on Jefferson's method as simplified by ten Have (1999). I have further simplified the timing of pauses to 1 second intervals.

(1)	A pause of 1 second
(.)	A pause of less than 1 second
=	Latching together of utterances, or continuation of a turn across lines
[ ]	The onset and end of a section of overlapping talk
.hh	Speaker in-breath
hh	Speaker out-breath
wo(h)rd	Breathiness (or laughter or crying) within a word
wor-	Cut-off of the preceding word or sound
::	Stretching of the preceding sound
!	Animated intonation
?	Rising intonation
,	Falling and continuing intonation
.	Stopping fall in tone
£word£	Material delivered in a "smile" voice
↑↓	Strong upward/downward intonation of following sound
wo: rd	Weaker upward intonation before underlined colon
<u>word</u>	Slightly louder word or sound
WORD	Significantly louder word or sound
°word°	Significantly quieter word or sound
>word<	Talk produced noticeably more quickly
<word>	Talk produced noticeably more slowly
( )	Unclear fragment of speech
(word)	Transcriber''s guess at an unclear fragment

Appendix F: Ethical Approval

NHS Regional Ethics Committee Approval 1

<div align="right">

[Name] REC
[address]

Telephone: […]
Facsimile: […]

</div>

23 July 2010

Ms Sarah Amoss
Vicarage Lane Health Centre
10 Vicarage Lane
Stratford
London
E15 4HD

Dear Sarah

Study Title:	**How family therapists help families make sense of the difficulties of living with psychosis.**
REC reference number:	**10/H0107/47**

Thank you for your letter of 20 July 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date	
Investigator CV	1	10 June 2010	
Protocol	1	10 June 2010	
Supervisor CV	1	10 June 2010	
REC application			
Covering Letter		20 July 2010	
Interview Schedules/Topic Guides	1	10 June 2010	
Participant Information Sheet: Therapist	2	18 July 2010	
Response to Request for Further Information		20 July 2010	
Participant Information Sheet: Family	2	18 July 2010	
Participant Consent Form: Therapist	2	18 July 2010	
Participant Consent Form: Family	2	18 July 2010	
Referees or other scientific critique report		10 June 2010	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| **10/H0107/47** | **Please quote this number on all correspondence** |

Yours sincerely

Dr [Name]
Chair

Email: [identifiable email]

Enclosures: "After ethical review – guidance for researchers" *SL- AR2*

Copy to: *Eilis Kennedy*

NHS Regional Ethics Committee Approval 2

NRES [name]

[address]

Tel: […]
Fax: […]

08 July 2011

Ms Sarah Amoss
Brent Adult and Family Psychotherapy Service
103 Chestnut Avenue South
Walthamstow
London
E17 9EJ

Dear Ms Amoss

Study title:	**How family therapists help families make sense of the difficulties of living with psychosis.**
REC reference:	**10/H0107/47**
Amendment number:	**2**
Amendment date:	**04 July 2011**

Thank you for your letter of 04 July 2011, notifying the Committee of the above amendment.

The amendment has been considered by the Chair.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The new and amended documents received were as follows:

Document	Version	Date	
Participant Information Sheet: Family	3	04 July 2011	
Notification of a Minor Amendment	2	04 July 2011	
Covering Letter		04 July 2011	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0107/47: Please quote this number on all correspondence

Yours sincerely

[name]
Committee Co-ordinator

E-mail: […]

Copy to: *Dr Bernadette Wren, Tavistock and Portman NHS Trust*
Ms Eilis Kennedy, Tavistock and Portman NHS Trust

NHS Trust Site R&D Approval Letter

[name] NHS Trust [logo]

[address]

Tel:[…]

Fax: […]

Our ref: […]058

11th July 2011

Ms Sarah Amoss
Brent Adult and Family Therapy Service
103 Chestnut Ave South
Walthamstow
E17 9EJ

Dear Ms Amoss

Study Title:	How family therapists help families make sense of living with psychosis
REC Reference:	10/H0107/47
Amendment number:	2
Amendment date:	04 July 2011

I am pleased to advise you that I have reviewed the amended documents (listed below) for the above study and I am happy for [name] NHS Foundation Trust to continue to be a site for this project.

Document Name	Version Number
[name] REC Revision Letter	July 2011
Participant Information Sheet: Family	3

Yours sincerely

[name]

Research and Development Lead

[Trust Logo]

University Research Ethics Committee Approval

Ms Sarah Amos
103 Chestnut Avenue
South
Walthamstow
London
E17 9EJ

27 February 2014

Dear Miss Amos

University of East London/The Tavistock and Portman NHS Foundation Trust: research ethics
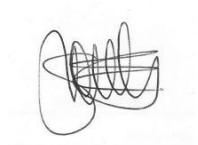
Study Title: The negotiation of blame in family therapy with families affected by psychosis

I am writing to inform you that the University Research Ethics Committee (UREC) has received your site approval letter from NHS […] and your NHS letter stipulating the conditions of approval for the study that had to be met, which you submitted to the Chair of UREC, Professor Neville Punchard. Please take this letter as written confirmation that had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been granted. However, this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely

pp: Catherine Fieulleteau
Ethics Integrity Manager
For and on behalf of
Professor Neville Punchard
Chair of the University Research Ethics Committee (UREC)

Tel.:   020 8223 6683 (direct line)
E-mail: c.fieulleteau@uel.ac.uk
c.c.   Mr Malcolm Allen, Dean of Postgraduate Studies, Tavistock and Portman NHS
        Foundation Trust
        Mr Will Bannister, Associate Director, Education and Training, Tavistock and
        Portman NHS Foundation Trust
        Professor John J Joughin, Vice-Chancellor, University of East London
        Professor Neville Punchard, Chair of the University of East London Research Ethics
        Committee
        Dr Alan White, Director of the Graduate School, University of East London
        Mr David G Woodhouse, Associate Head of Governance and Legal Services

Sacks, H. (1995) *Lectures on Conversation. Volumes 1 and 2.* Blackwell:

Oxford.