‘You can take a horse to water but you can’t make it drink’: Exploring children’s engagement and resistance in family therapy

Abstract

Children’s engagement and disengagement, adherence and non-adherence, compliance and non-compliance in healthcare have important implications for services. In family therapy mere attendance to the appointments is no guarantee of engaging in the treatment process and as children are not the main initiators of attendance engaging them through the process can be a complex activity for professionals. Through a conversation analysis of naturally occurring family therapy sessions we explore the main discursive strategies that children employ in this context to passively and actively disengage from the therapeutic process and investigate how the therapists manage and attend to this. We note that children competently remove themselves from therapy through passive resistance, active disengagement, and by expressing their autonomy. Analysis reveals that siblings of the constructed ‘problem’ child are given greater liberty in involvement. We conclude by demonstrating how therapists manage the delicate endeavour of including all family members in the process and how engagement and re-engagement are essential for meeting goals and discuss broader implications for healthcare and other settings where children may disengage.

Introduction

Children and adolescents' disengagement from clinical services is a significant problem with cancelled appointments, failure to attend and drop-out all being costly for health services (Kazdin, Holland and Crawley, 1997; Wang, Sandberg, Zavada, et al, 2006), and frustrating for therapists (Werner-Wilson & Winter, 2010). Typically children are not the main initiators of help-seeking and neither are they the main determinants of attendance (Wolpert & Fredman, 1994), as it is usually the parents who take responsibility to bring the child to therapy (Hutchby, 2002) and make treatment decisions (Tan, Passerini and Stewart, 2007). In essence, there is an institutional expectation in therapy to speak about one's problems and this incitement to speak depends on the client's willingness to comply (Silverman, 1997). Although the parent can physically bring the child to therapy, whether that child will engage with the therapeutic process and work towards goals and resolution is not so straightforward.

Non-compliance of children in medical and therapeutic contexts is prevalent (Richman, Harrison and Summers, 1995), with non-completion rates being quite high, for example in child psychotherapy (Pina, Silverman, Weems, Kurtines, et al, 2003). The accomplishments of therapeutic aims, therefore, are dependent upon the child's cooperation in the production of talk about therapeutically relevant issues (Hutchby, 2002). Child engagement requires a commitment from both the parent and the child (Day, Carey, and Surgenor, 2006). This is because although research illustrates that the greater the involvement of the child the greater the therapeutic change (Chu & Kendall, 2004), parents need to be actively involved to sustain any change (Boggs, Eyberg, Edwards, et al, 2004).

Mental health treatments for young people are usually delivered within the context of families (Tan et al, 2007), with family therapy being one arena for families to work through their problems. Concerns have been raised however about the increase in the number of families dropping out of family therapy and failing to receive the services they need (Topham & Wampler, 2008). Ostensibly a key focus for family therapy is to provide a forum through which the child's perspective can be aired (Strickland-Clark, Campbel and Dallos, 2000) but problematically children and adults have different levels of cognitive and linguistic competence and this creates a challenge for mutual exchange (Lobatto, 2002). Lobatto argues that it is difficult therefore for the therapist to create an atmosphere which is inclusive of all parties as therapy tends to be predominantly adult led, and has potential to contribute to attrition rates.

Research illustrates that children want to be included in therapy in a meaningful way (Stith, Rosen, McCollum, et al, 1996) but the presence of their parents can inhibit their conversational contributions (Beitin, 2008; Strickland-Clark et al, 2000). For example, children in family therapy speak less than their parents (Mas, Alexander and Barton, 1985), are interrupted more frequently (O'Reilly, 2008), and yet when interrupting are treated in negative ways (O'Reilly, 2006). Research indicates that young people are particularly difficult to engage in therapy and creating an alliance with them is especially challenging (Thompson, Bender, Lantry et al, 2007). In family therapy the parents and the therapist may seek to engage in the institutional tasks of therapy such as identifying and finding solutions to the problems presented, but notably children may not understand or wish to go along with this, and may actively seek to avoid participation (Hutchby & O'Reilly, 2010). Alliance between clients and therapists is, therefore, considered essential to the therapeutic process (Aspland, Llewelyn, Hardy et al, 2008), and has been an area of interest in relation to

establishing reliable methods of measurement (Pinsof, Hovarth and Greenberg, 1994). Understanding therapeutic alliance is considered particularly important for understanding treatment outcomes (Thomas, Werner-Wilson and Murphy, 2005). Unlike didactic therapy situations, family therapy invokes additional challenges as the therapist considers how to foster alliances with multiple members with different motivations and problem definitions (Escudero, Friedlander, Varela and Abascal, 2008). If therapists base their decisions on input from the parents alone, however, they risk missing problems that matter to the child and may alienate or fail to engage the child (Hawley & Weisz, 2003).

This disengagement or resistance to therapy is potentially averted by increasing therapeutic alliance (Frankel & Levitt, 2009), but if alliance is not maintained then rupture in the relationship may occur. Ruptures in the therapeutic alliance are defined as the deterioration in the relationship between the therapist and the client which may lead to dropout and treatment failure (Safran & Muran, 1996). It is important to understand dropout in order to reduce an inefficient use of resources in mental health (Masi, Miller and Olson, 2003), and the ruptures that frequently precede attrition. Ruptures can be recognised predominantly in changes of behaviour such as withdrawal and confrontation (Safran, Muran, Samstag et al, 2001) and may arise from unvoiced disagreements about the tasks and goals of therapy (Aspland et al, 2008). Therefore, if the therapy is to progress, the therapist needs to attend to both the parental and child perspectives, because if one party perceives the therapist to not understand them and their problems they may disengage (Hawley & Weisz, 2003).

Although family therapists have developed strategies for engaging children in the therapeutic process we have a limited evidence base for how children experience therapy or how they engage with it (Strickland-Clark et al, 2000) or disengage from it. Analysis of the behaviour

of children and families in therapy can be useful for predicting therapeutic outcomes (Kazdin, Marciano and Whitely, 2005). The aims of this paper, therefore, are to explore how children's behaviour is an indicator of engagement and disengagement patterns thus enabling recognition of when and how these patterns occur in practice. Additionally we investigate how therapists manage any potential ruptures in alliance with children and consider how they reinstate engagement. Exploring the disengagement strategies of children in family therapy has potential to facilitate the recognition of early indicators of potential ruptures in alliance and both prevent and manage their occurrence.

Methods

For this research we utilise a qualitative framework to explore the different ways children attempt to disengage from family therapy.

Recruitment and participants

Our data for this project was provided by a team of systemic family therapists based in the United Kingdom. Actual family therapy sessions were video-recorded, totalling approximately 22 hours of therapy with four different families. These families have been assigned the pseudonyms of Clamp, Niles, Bremner and Webber. Two therapists took part in the research and were assigned the pseudonyms of Joe and Kim. The four families included in the data corpus were White British, from the Midlands and typically from lower socio-economic groups.

A convenience sampling method was employed with the first four families with capacity and providing consent being recruited to the study. The only exclusion criterion was parents with mental health problems that were judged to impair capacity to consent. Sampling occurred within the allocated 9 months for data collection. Sampling was appropriate to the

methodological framework and issues of saturation are not intrinsic to the approach with its deductive discursive epistemology (O'Reilly & Parker, 2012 a). As a deductive mode of enquiry the premise of CA is that the micro-mechanisms of talk in the smallest sample can shed light on general principles of all aspects of language. This means that the notion of saturation is not inherent in this methodology.

The Clamp family constituted, the father (Daniel/Dan), the mother (Joanne), the uncle (paternal sibling Joe), and three children; Phillip (aged 13) the referred child, Jordan (aged 9) having both physical and mental health difficulties and Ronald/Ron (aged 6) having a learning disability. Member of the Bremner family were, the mother (Julie), the maternal grandmother (Rose), and two children; Bob (aged approximately 8 years) the referred child with Asperger's syndrome and Jeff (approximately 6 years) who had developmental delay. The Niles family consisted of the mother (Sally), Alex (father to two, step-father to two children) and four children; Steve (14 years) the referred child, suspected ADHD, Nicola (12 years), Lee (8 years) and Kevin (3 years). Members of the Webber family were, Patrick (Step father to two, father to two children), the mother (Mandy), and four children; Daniel (15 years) the referred child with special educational needs, Adam (19 years), Patrick (10 years) and Stuart (8 years).

Each of these four families remained in family therapy and with mental health services more generally after the data collection period was completed. The actual outcomes of treatment, therefore, were not actively pursued as relevant to the research question. The data were transcribed in accordance with the analytic method and Jefferson guidelines were followed (Jefferson, 2004). See table 1 for detail.

INSERT TABLE ONE HERE

Conversation analysis

A distinct feature of conversation analytic (CA) work is its focus on the action orientation of talk (Hutchby & Wooffitt, 2008). Through analysis, the sequential organisation of talk is explored to explicate the social actions being performed (Sacks, 1992). For example the semantic sentence ‘what are you doing this evening?’ could perform a variety of social actions depending on the context. It may be a simple question or it could be performing the social action of a pre-enquiry to an invitation or request. Social processes are revealed through close attention to sequential analysis of conversational turns which illuminates the way in which the participants in the interaction respond to prior turns. The reliability of this method is not constituted in the analysts’ interpretations of the participant’s talk, but in line with ethnomethdological principles, is grounded in the participants own responses.

This method has great potential for illuminating insights into healthcare interactions as it enables the identification of patterns of behaviour (Drew et al, 2001). As CA has grown in popularity it has illustrated some of the fundamental organisational features and interactional processes in medical settings (Pilnick, Hindmarsh, and Gill, 2010) and is used to examine the ways in which clinical processes are interactionally constituted in therapy (Georgaca & Avdi, 2009). For this paper the two authors initially independently scrutinised the data corpus for the identification of social actions pertinent to the research question. During the second phase these social actions were jointly explored through a more detailed sequential analysis to secure inter-rater reliability. This process allowed the authors to explicate the emergent patterns of social process requiring further analytic attention, as is consistent with the CA methodology.

Ethics

During this project we employed the Principlist approach to ethics, incorporating the four core principles of autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2008). What this meant in practice was that informed consent was collected from all necessary parties, anonymity was maintained, confidentiality assured and data were stored securely.

Analysis

By using conversation analysis to investigate the performative actions in institutional talk, our analysis revealed four social processes at work within the dynamics of the family unit during the practice of family therapy. First children display passive and active disengagement from the therapeutic agenda. Second, children attempt to express autonomy and evade adult impositions. Third, siblings are afforded greater liberty in their attempted disengagement. Finally, therapists use validation as a technique to reinstate engagement in the therapy process.

Social process one: passive and active disengagement from the therapeutic agenda

In this section we provide a series of extracts which present a continuum of social actions displayed by the children as a way of disengaging from therapy. These range from a behavioural passivity through to direct active verbal resistance. We illustrate that children passively disengage (through inattention), passively resist (when they do not attend to a direct question, or attempt at engagement), and actively resist (when they directly refuse to answer, or fail to comply with a request).

Extract one: Clamp family

```
Dad:    I don't think Jordan understands what you're on about
        either (.) to be honest
FT:     Yeah
Dad:    I think Phil[lip(       )
Ron:               [Heh h[eh heh heh ((Ron is jumping))
Jordan:               [heh heh heh heh ((Jordan is jumping))
Dad:    ↑Will you stop jumpin'
(2.0)
Dad:    come on
(1.0)
Ron:    There's no chairs
FT:     What happens when they do this at home? (1.0) If the
        three of them were kind of jumping around at home what
        would happen
Dad:    I'd tell 'em to stop
```

Disengagement from therapy can be simply inattention to the process. By removing themselves from the therapeutic conversation, children display passive resistance to the social process. The children's laughter and jumping on chairs (lines 5&6) occasion the father to suspend therapy to attend to Ron and Jordan. Sequentially this rupture affords an opportunity for the therapist to initiate a topic shift (Jefferson, 1984) and to make the behaviour of the children therapy-relevant (line 12).

Extract two: Bremner family

```
Gran:   so it doesn't make any difference t' 'im at a:ll (.) and I ask
        'im why 'e's horrible to ↑mummy and basically 'e does it
        because 'e knows, hh it gets to 'er
FT:     Is that what he said?
Gran:   ↑Yeah
Bob:    Get off ↑that
Jeff:   E::y I want t' ↑play with that
FT:     So how was it [at Christmas?
Bob:                  [Well get me one
Jeff:   I want to play with the (black b[locks)
FT:                                     [↑Bob (.) how [was it at
        Christmas?
Bob:                                                  [I got it first
Gran:   Hey
Mum:    Who had them first?
Bob:    ↑ME
```

This extract illustrates that children display more active strategies for inattention than simply passively disengaging themselves from the conversation. Here Bob's attention actively moves from the therapy process to an alternative activity, playing with children's building blocks. By actively attending to the building blocks and the on-going dispute with his brother,

Bob passively resists attending to the question posed by the therapist *'Bob, how was it at Christmas?'* (line 8, 11). Notably the therapeutic conversation involved negative descriptions of Bob's behaviour toward his mother (lines 1-3) from which Bob disengaged by actively verbally diverting the adults' attention to the play. This, like in extract 1, results in a topic shift as they discuss possession of the toy blocks.

Extract three: Clamp family

```
FT:     Will you come and >play with someone< out 'ere?
        (0.6)
FT:     you can bring your ↓crisps
Ron:    Na::h
Mum:    Na::h?
FT:     0No?0
Ron:    ((shakes head))
FT:     Alright then
Mum:    ↓Na::h
FT:     Let's see if we can find someone((therapist stands and leads
        the child to the door))
```

Extracts one and two illustrated that the continuation of therapy is displayed as the primary objective of the adult parties, and disruptions to this process are treated as interference. Here the continuation of therapy requires the child to leave the therapeutic space due to the delicate nature of the topic (paedophilia[i]). Research illustrates that delicate inappropriate topics require careful management in the therapeutic conversation (O'Reilly & Parker, 2012, b) and here the therapist works to remove the child from the overhearing position he is currently in. Interestingly when the child answers the question with the dispreferred response (Pomerantz, 1984) '*nah'* (line) both the mother and the therapist question this. They repeat the response '*nah?'*, *'no?'* but the questioning intonation implies that the response ought to be revised. This occasions a downgraded, less emphatic version of the refusal as Ron shakes his head. Although acknowledged by both the therapist *'alright then'* and the mother '*nah'*, the therapist enforces his original request from line 1, by actively and physically taking the child out of the room (line 10).

Extract four: Bremner family

```
FT:     S::o Bob would you like [t' tell me why mummy's in a ↓mood
Bob:                            [No ↑I'm not in the mood ta tell
        (0.4) you (.) mummy can (.) she's the one in the mo:od .hh she
        can tell ya
Mum:    0Mummy can't 0 say anythin' ((Mother is crying softly))
Bob:    You can
Jeff:   'e's be:en naughty
```

There are occasions in therapy where a therapist will use active engagement strategies to involve the children in the process and here the therapist uses first person selection *'Bob'* (line 1) to directly address the child. Ostensibly saying *'would you like'* offers Bob a choice to provide an explanation for the mother's visually obvious negative affective state. Notably, because the therapist is looking at Bob, addressing him by name, and emphasising '*you'*, it is problematic for Bob to display passive inattention, and therefore necessitates a more active response. In this case, Bob interrupts the therapist during her question and actively refuses to comply with the request *'no'* (line 2) offering a justification '*I'm not in the mood'* (line 2) and a candidate alternative respondent *'mummy can'* (line 3). Although Bob references the mother as the next speaker, her distressed state occasions a minimal refusal *'mummy can't say anything'* (line 5) which is audibly quieter, and in turn precipitates a self-selected answer to the question from Bob's sibling, Jeff.

Social process two: Expressing autonomy and evading adult impositions

There are two ways in which children express their wish for autonomy to disengage from the therapy. First they attend to the present interaction, making requests to cease participation, and second, they orient to future sessions by expressing desire not to continue attending. Building upon the previous analysis we demonstrate examples of children displaying active resistance to the process of therapy by initiating requests to disengage.

Extract five: Niles Family

```
Steve:  I'm bored (0.4)↑Can I 'ave me 'phone on?
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```
Mum:    No (.) you are[not allowed t'
Dad:                  [You are not allowed t' turn y'r 'phone on >in
        the< 'ospital
Mum:    >'cause they< interfere wiv the computers
Dad:    You could kill someone if <you interfere> with the machine
Steve:  Can't I jus'
Mum:    <↑Get your feet off that table>
Steve:  Can't we jus' (.) >can we go 'ome<
        (1.4)
Mum:    ↑No
```

In this extract Steve's request to turn on his mobile telephone is an attempt to actively disengage from the therapy. This potential alternative activity is rebuffed by the parents who collaboratively account for the refusal by orienting to institutional rules imposed by hospitals. By illustrating to Steve that there are potentially severe consequences of his action *'you could kill someone'* (line 6), they not only provide good reason not to allow the phone to be turned on, but also mitigate parental responsibility for the denying the request. Notably this account does not attend to the potential social action being performed by Steve, of active disengagement. This intersubjective misalignment occasions a second attempt to disengage from Steve, *'can't I just'* (line 7) and *'can we go home'* (line 9). At this point this is simply declined without any explanation '*no'* (line 11). Parental imposition is not always without explanation and in extract six the parents position the child himself as the reason why disengagement is not possible.

Extract six: Niles family

```
Steve:  Can't we jus' go?
Dad:    Pardon?
Steve:  I want to ↓go
Dad:    No (.) we're 'ere to get you sorted out kid (0.2) I reckon
        bo:ot (.) >boot camp< will sort you out
```

In this extract the child actively expresses autonomy to disengage from the therapy by requesting that the family leave *'can't we just go?'* (line 1). The father's signal for not hearing the request, affords the opportunity for the child to reiterate it. However the request is upgraded by the footing shift (Goffman, 1981) from 'we' to 'I', and the removal of the minimiser 'just'. The direct way in which the child's expressed choice is reformulated '*I*

want to go' (line 3) not only occasions a refusal, but also an account from the father. This account positions Steve as the problem which necessitates Steve's attendance.

Extract seven: Bremner family

```
FT:     ↑So (.) will you >come back again< (.) and see me again in
        fo:ur weeks?
Bob:    No
FT:     ↑Oh I think ↑so
Bob:    I will not
FT:     ↑Can you bring me >a nice picture< of ↑Darth (0.2) of e::rm (.)
        Star wars (.) the characters .hh
Bob:    I don't know how to draw them
```

The literature on preference organisation in adult-to-adult interactions illustrates that when questions such as the one offered by the family therapist are asked, they are designed to elicit a 'yes response' (Pomerantz, 1984). Pomerantz notes that when adults offer a dispreferred response, it is notably marked by pauses, prefaces and accounts. Although Bob's response is semantically congruent with the therapist's turn in the sense that he applies the same modal verb, *'will you come'* (line 1) *'I will not'* (line 5), his response lacks any normative social conventions of a dispreferred response. While the therapist's question has the illusion of offering choice *'will you come back again'* (line 1) her next turn *'oh I think so'* (line 4) dispels this possibility as she orients to the expectation of his return. This illustrates the adult's imposition of expected attendance overriding the child's autonomy to choose disengagement from further sessions. The restriction of autonomy to choose to attend future sessions is expressed more explicitly in the following extract.

Extract eight: Niles family

```
Dad:    We'll see you in four weeks >sometime I know you< want
        yo(h)ur t(h)ea
FT:     ↓No it's not that >I mean I<
Steve:  ↑I don't want to come anymore
FT:     I would re::ally like you to come ↑Steve >because I
        think<
Mum:    You don't 'ave much ↑choice Steve 'cuz I'm bringin' ya
        'til [we <get t' the bottom> of this hhh
```

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

In this extract not only does Steve express a preference to disengage from the current therapy session, but he also expresses a clear desire not to attend any future sessions *'I don't want to come anymore'* (line 4). This attempt at autonomy is met with two different types of responses from the adults in the room. Initially the therapist affirms his desire for Steve to attend '*I would really like you to come'* (line 5), which indicates a personal preference. In contrast, the mother's response imposes a restriction of his liberty *'you don't 'ave much choice'* (line 7) and enforces her parental authority *'I'm bringing ya'* (line 7). Notably, the mother does provide a caveat to the imposition by demonstrating a time limit on attendance *'til we get to the bottom of this'* (line 8). Despite this account, Steve's option for choice becomes further limited by the therapist aligning with the parents. Therapeutically, alignments between therapists and all parties, including children, are important for therapeutic processes (Parker & O'Reilly, 2012), but here the therapist has actively disaligned from the child which is strengthened with the category use of 'adults'.

Social process three: The negotiable liberty of the sibling

Illustrated previously, despite active and passive attempts at disengagement, parental imposition has dictated that the child identified as requiring help continues to attend therapy. However the necessity for siblings to attend appears to be something open to negotiation with the therapist. This demonstrates that it is not simply the category of 'child' in contrast to 'adult', or 'therapist' in relation to 'client' that defines the direction of autonomy and authority. The other children within the family are afforded a different degree of choice regarding engagement than the 'problem child'.

Extract nine: Niles family

423
424FT: We'll see ↑you in fo:ur weeks ↓then
425Dad: She said she <don't want to> come again (.) didn't ya?
426Lee: I don't wanna come again
427Steve: Oh shu[t up moanin'
428Kevin: [I *don'[t *want to *come ag(h)ain
429FT: [I find it helpful <what you say> hhh it's
430 be:en re::ally helpful today (.)I know it's (.) this
431 isn't what anyone would cho:ose to do >I mean< I
432 understand that
433 (0.8)
434FT: but (.) it'd be nice if you'd ↑come
435Dad: ↑Come on then
436Nic: ↑Oh
437FT: and I hope you a:ll 'ave a re::ally nice Easter
438Mum: 0and you 0
439
440At the end of this therapy session the therapist offers a candidate closing comment *'we'll see*
441*you in four weeks then'* (line 1). The assumptive element of this closing statement
442problematises the pronoun 'you' by raising the possibility of Nicola's non-attendance *'she*
443*said she don't want to come again'* (line 2). The father here legitimises the possibility of
444Nicola's non-attendance by voicing her preference, and notably the other siblings, Kevin and
445Lee, use the opportunity to attempt to express their autonomy. By interrupting the children,
446the therapist focuses attention on responding to the older sibling (Nicola), directly. He
447acknowledges her choice *'it isn't what anyone would choose'* (line 8) and validates the value
448of her contribution *'I find it helpful what you say'* (line 6). By saying '*it'd be nice if you'd*
449*come*' (line 10), the therapist maintains the scope for autonomy but clearly defines a
450preference for attendance. This contrasts significantly with previous extracts where the
451'problem child' is clearly given no choice in the matter of attendance.

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

FT: >I mean< this isn't compulsory for anybody (.)

As in extract nine, the father here raises the issue that one sibling in the family has a preference not to attend the therapy. The father's account hinges on the discrepancy between being physically present and actual engagement in the therapeutic process. What he highlights is that even if they brought Adam to therapy, he would not actively engage by communicating with the therapist about events relevant to the 'problem child', Daniel '*he won't never ever speak about that'* (line 3). Interestingly this account for possible non-attendance is not utilised for the situations where the 'problem child's' attendance is questioned or raised. Although in this extract the therapist states that therapy is not '*compulsory for anybody',* the lack of choice for some children is clearly marked with parental imposition, as highlighted earlier.

Social process four: Validation as a technique to create or reinstate engagement

Problematically, where parents impose attendance on their children and those children resist or disengage from therapy, it can create difficulty for meeting therapeutic goals. There is an onus therefore on the therapist to take responsibility for recognising the probability that children may not be willing participants, and to utilise strategies to create or facilitate their engagement. One of the ways in which this can be achieved is the circumspect use of validation as a clinical intervention. By acknowledging and validating the potential challenges for the child such as boredom, the unpleasantness of listening to certain descriptions and events particularly when related to them and their behaviour, and the uncertainty of what might happen, the therapist creates a space for the child which enables them to feel accepted.

Extract eleven: Niles family

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

This extract demonstrates the complexity of using validation as an engagement technique. Paradoxically the therapist here does not initially attend to the overtly expressed feeling conveyed by Steve *'I'm bored'* (line 2), but does attend to the implicit implication that Steve is finding therapy uncomfortable by directing his question specifically to Steve. Notably the child's two attempts to disengage from the therapy, *'I'm bored'* (line 2), and interruptively, *'I wanna go home'* (line 6) are not attended to by the therapist as he pursues his line of enquiry. While children's interruptions are typically ignored (O'Reilly 2006), the validating social action of the therapist's turn in this instance is designed to address the potential difficulty for the child in hearing the negative descriptions of his behaviour. This redress of a potential social breach (Parker & O'Reilly, 2012), of repairing the imminent rupture created by talking about Steve in a negative way, takes precedence over attendance to the process of the child's interruption. Validation of the child's difficulties in engaging in the process of therapy can be in itself a way of engaging the child.

Extract twelve: Clamp family

FT: I wuz also thinkin' >one of the things< we were
thinkin' for you Phillip was (.) we did ↑a lot of
talkin' abo::ut
(1.2)
FT: some of the things that YOU ↑do (.) that yer ↑mum
an' ↑dad aren't too happy about >an' I guess< I
jus' wanted t' say that ↑I ↑know that it's re::ally
difficult t' sit there and ↑listen an' yer dad
mentioned it as well that (.) you kind of sit and
listen in
(1.4)
FT: and one thing I didn't ask about is the things that
you're really GOOD at

In this therapy session where multiple family members are present including the parents, three children and the uncle Joe, the use of recipient selection *'you Phillip'* (line 1) may be significant in securing the child's attention. This may function to prohibit other members from contributing and selects Phillip as the intended audience. The therapist uses a series of conversational processes, beginning with acknowledgement of the family's discussions about Phillip, validation of the difficulty for Phillip in listening to those discussions and culminating in attempts to reengage him in the therapy. The therapist begins with a reformulation of the series of negative ascriptions of Phillip and his behaviour that have characterised the preceding conversation. The therapist acknowledges his contributions to this talk by stating *'we did a lot of talkin' about some of the things that YOU do'* (lines 3-5) which is an inclusive footing position. However, there is a footing shift (Goffman, 1981) immediately following this as the therapist positions the judgement of Phillip's behaviour with his parents *'yer mum and dad aren't too happy about'* (line 6). This sequential shift in alignment from talking with the parents moves from 'we' (the three adults), to 'they' (the parents), to an alignment with Phillip as he moves to engage Phillip more directly by acknowledging how he might feel about those discussions *'It's really difficult t' sit there and listen'* (lines 6-7).

Extract thirteen: Webber family

```
FT:     ↑what we're hopin' t' achieve and >I know that< you're
        lookin' uneasy already Da(h)niel
Mum:    Heh he[h heh
FT:           [I know that this isn't easy stuff for you to talk
        about >is it<
        (0.6)
FT:     especially with your parents (0.2) present. but but we
        kindda had an <idea that>
        (0.6)
FT;     actually it's re::ally important <for us all> to be able
        to talk about as well
        (1.2)
```

The same three processes of acknowledgement, validation and engagement, are also visible in this extract. The therapist displays an interpretation of Daniel's non-verbal behaviour as indicative of his affective state *'you're looking uneasy already Daniel'* (line 2). This is followed up with the use of validation as the therapist comments on the difficult nature of the conversation and the difficulty Daniel may experience in contributing '*this isn't easy stuff for you to talk about'* (line 4). The encouragement to engage Daniel is presented inclusively with a statement that it is *'important for us all to be able to talk'* (line 10).

Discussion

The aims of this paper were to illuminate through empirical analysis some of the ways in which children attempt to resist and disengage from family therapy, and also which interventions from therapists are helpful in seeking to manage these processes. Our analysis revealed four social processes that relate to children's disengagement. Social process one considered how children's disengagement from therapy can be active or passive: passive disengagement was characterised by inattention to the therapeutic process; passive resistance was characterised by active attention to alternative activities; and active disengagement was displayed by verbally refusing to answer questions directed specifically to them. Social process two considered how children expressed their autonomy and evaded adult impositions. These were expressed verbally, conveying a desire to cease therapy either in the present moment or in the future, and were set up as contrary to adult expectations and wishes. Social process three considered the role of other family members in therapy, specifically exploring the more flexible obligations of attendance of siblings. Social process four explored how therapists attempt to create engagement or re-engage a child to repair any rupture that may have occurred.

591Adult and children's adherence to treatments is considered to be an important aspect of
592healthcare (Osterberg & Blaschke, 2005). Research has focused heavily on children's
593adherence to pharmaceutical treatment programmes with non-compliance having serious
594consequences for children's health (Butler, Roderick, Mullee et al, 2004; Osterberg &
595Blashke, 2005). Compliance with medical treatments has clear physical benefits to the child
596which become visible during the course of interventions and has potential to encourage future
597engagement with medical services. Importantly non-compliance in the talking therapies is
598less visible as the child is ostensibly present in the therapy which indicates immediate
599adherence. Problematically, the mere presence of the child does not guarantee their
600participation and this potentially renders the therapy ineffective. For example, using a
601medical metaphor, if a child hides medication under the tongue and later spits it out the
602treatment will not be effective; in therapy, without active engagement in the process of
603therapy, the intervention will not achieve its outcomes. Furthermore, not only will the
604therapeutic process be rendered ineffective, but it may also have an iatrogenic effect. As the
605children are listening to negative descriptions of them, which is common in family therapy
606(Parker & O'Reilly, 2012), without recourse to contribute their own perspective, this may
607have a potentially damaging impact.
608
609The literature indicates that we have a limited evidence base regarding how children engage
610with therapy (Strickland-Clark et al, 2000) and one way to explore this important issue is to
611investigate how children resist and disengage in practice. It is evident that analysis of the
612behaviour of children and families in therapy can be an important aspect of predicting
613outcomes (Kazdin et al, 2005). Our analysis illuminates the range of behavioural and verbal
614indicators of how children withdraw from the therapeutic process and how this is managed by
615the adults. Research with adult participants indicates that they withdraw or disengage from

therapy when they sense something threatening developing, and use disengagement as a way of stalling discussion which may result in criticism from the therapist (Frankel and Levitt, 2009). Parental criticism of children in therapy through the positioning of the child as the problem can lead to them being talked about in a derogatory way (O'Reilly & Parker, 2012, b). Sociological research illustrates that children possess social competencies of greater sophistication than is typically assumed (Hutchby, 2002; Hutchby & O'Reilly, 2010) and therefore disengagement from therapy could be understood as a mechanism for managing criticisms.

An understanding of children's contributions to family therapy through qualitative analysis facilitates an understanding of the process through which children disengage from services. This understanding of disengagement is useful in informing the broader context of attrition as cumulatively these disengaged moments can contribute to the failure of the therapy as a whole. This has important implications given that families are offered therapy to assist them when they experience violence, breakdown or juvenile delinquency (Hutchby & O'Reilly, 2010) and thus failure in therapy has potential wider social consequences. To avoid dropout from family therapy it is important to consider the role the child plays. It is necessary to achieve more than just the physical presence of the children, but to prevent, recognise and manage disengagement while maintaining alliance with both the parents and children. Quantitative scales, such as the CTAS-R (Pinsof, Hovarth and Greenberg, 1994), have been designed to measure the possible discrepancies in strength of alliance between individuals in couples therapy (Knobloch-Fedders et al, 2004). The advantage of using conversation analysis to investigate alliances in family therapy is that it relies on observable data as opposed to self-reports and allows the analyst to examine alliance processes as they occurs in practice. Our analysis illustrates that validation as a way of recognising the difficulty for the

child has potential to circumvent disengagement or facilitate re-engagement. The therapist therefore has some responsibility for attending to the passive and active disengagement strategies of the child in terms of recognising their occurrence and attending to the non-verbal indicators. This can be a complex task when the parents are especially active and it is easy to overlook the passive disengagement of quieter children.

By applying a micro-analytic approach to the social processes inherent within naturally occurring family therapy sessions, we are able to explicate the nuances of the interaction. This has allowed us to interrogate the sequential nature of therapeutic interactions in a way that highlights the process of children's resistance and disengagements. This has important implications for exemplifying wider social processes in order to broaden our understanding of approaches that may facilitate engagement. Families are an important social institution and our findings suggest that the mere presence of the child within the family unit does not necessarily equate to active involvement in family processes.

There are some limitations with the conversation analytic approach to data analysis, for example, while suggestions are made, the power to implement these recommendations lies with those who commission and practice (Antaki, 2011). It can be difficult, however, for family therapists as consumers of research evidence to engage with and implement strategies due to barriers such as time and resources (Kosutic, Sanderson and Anderson, 2012). Nonetheless research evidence is necessary for informing change and improving services and our analysis provides a benchmark for understanding the process of adult-child alliances in a family therapy setting. These principles also translate to other domestic situations, for example in family disputes, in terms of how children may competently resist alliance with or disengage from the family unit. Our findings also have broader implications for

understanding children's compliance and engagement in other institutional settings such as education. In the classroom it may be helpful to consider similar patterns of how children's physical presence does not necessarily equate to their active engagement with pedagogy. Arguably therefore the strategies children use for resisting and disengaging from education may not be that different from therapy and thus this could be a useful area for exploration in future research.

The task for the therapist is to actively encourage engagement with the child and to circumvent disengagement and dropout regardless of the therapeutic model they adhere to. This can be a delicate endeavor as it is necessary to maintain alliances with both parents and the children, who may hold contradictory positions. It is clear that to yield the benefits of therapy, there is a requirement for children to do more than simply attend appointments, but to also be actively involved in the process.

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[i] Note that prior to the sequence displayed here the parents were reporting a story about the children's uncle Joe being arrested for child sex offences some years ago and that social services have recently raised this as an issue

[ii] Here they are referring to the fact that Adam was victim of sexual abuse from his biological father and the father was arrested, charged and sentenced for child abuse. Adam then went on to be an abuser of Daniel, who is now engaging in inappropriate sexual behaviour with his younger sibling Stuart. This suggests a cycle of behaviour and thus Adam's attendance and engagement could be potentially beneficial.