"She needs a smack in the gob": negotiating what is appropriate talk in front of children in family therapy

Abstract

Tackling the day-to-day challenges of family therapy can prove difficult for professionals. A particular issue arising in family therapy is the notion of what is appropriate for children. Families report events from their social world, 'out there' to the therapy, 'in here'. There are occasions where the content is 'adult' in nature and this has to be managed in front of the children. On other occasions family members use derogatory or negative descriptions of their children and the children are present. Drawing upon naturally occurring family therapy sessions, we present a discourse analysis of how this is managed through a range of discursive resources. We show that adult family members construct what is inappropriate for children to be exposed to by positioning blame with others. This has implications for how family therapists deal with inappropriateness when children are present while maintaining the equilibrium of therapeutic alliances.

Suggested running head: 'not in front of the children'

Introduction

The form and composition of the family is something that varies across cultures and changes over time (Gillis, 1997). The idealised nuclear family unit has been viewed as the backbone of social morality, but families are not straightforward institutions and the family can experience problems (Hutchby & O'Reilly, 2010). As such family therapy grew out of psychiatry in response to the growing rates of juvenile delinquency and divorce; in a bid to pay particular attention to the family and was a consequence of increasing social needs (Broderick & Schrader, 1981). Within family practices and through social interaction children are given implicit and explicit messages about what constitutes right and wrong; about moral reasoning and virtues (Ochs & Kremer-Sadlik, 2007). In other words, society is both reflected in and constituted by the family and family practice. Although there is a wealth of philosophical literature that discusses the configuration of morality and there is a significant developmental literature on the acquisition of moral behaviours, there has been little research regarding how morality is enacted and socialised through family interactions involving children (Ochs & Kremer-Sadlik. 2007).

One way of exploring how morality is enacted and socialised is through the study of accounts. An account can be part of a conversational sequence that signals a breach. Accounts then are designed to mitigate or deny moral charges associated with the breach (Sterponi, 2009). Being accountable to others indicates that persons can be held responsible for their actions and in social situations accounts emerge in the form of excuses, apologies, defences, justifications and explanations (Buttny 1993). By studying these types of accounts we can yield an insight into the culture's taken-for-granted assumptions related to morality (Buttny, 1993). Accounts then are functional as language is rhetorically utilised to shape how

others view us and view our actions (Duck & Pond, 1990). In other words, if a person's actions are inconsistent with the positive identity they are constructing, an account may function to mitigate the action and 'save face' (Goffman 1999).

Notably mitigating responsibility for moral breaches in this way cannot only be managed by blaming family members, but also through positioning blame with outside agencies. This negotiation of responsibility is central in family interactions and an important feature of family therapy. The family therapy ethos acknowledges that individuals may present dysfunctional behaviours, but view this as a function of a wider social context; in the first instance, the family unit. The therapeutic intervention is as such designed to address the dysfunctional aspects of the family, rather than focussing on individual pathology. In therapy the therapist relies both on displays of behaviour from family members in the here and now, and also reports from family members regarding the outside social world and events. The conversational floor in therapy is open to all family members to introduce topics. The content and delivery of such reports provide the therapist with information about outside functioning of the family, but problematically some of these reports may be less appropriate for children to hear.

Managing the presence of children

During interaction, parents and therapists monitor what is being talked about so as to manage the degree of openness in the talk to optimise therapeutic value and decrease potential harm. Triadic questioning is common in family therapy and has been described as 'gossiping' due to the nature of talking about an individual(s) present in the room (Penn, 1982). As such therapists are tuned into the concept of an 'overhearing' audience and are able to use this is

positive therapeutic way. This shows that therapists are sensitive to the presence of children in the room and therefore, conscious that they can not only be talked about by parents, but also topics raised in front of them may not be developmentally appropriate. While childhood and children's competence is socially constructed, there is a normative positioning of children as limited in competence, with a conception of childhood as a time of innocence and as such it is expected that young children should be protected from being exposed to certain topics of conversation; such as sex (Hutchby & Moran-Ellis, 1998). Clearly this has to be managed even more delicately with children who have been exposed to abuse or other traumas.

In family therapy, the therapist thus has the challenge of managing the types of conversations permissible, whilst at the same time fostering openness and family interaction. The therapist has a role to align equally with all family members to facilitate inclusion. This requires a balance of respect for parental authority with professional responsibility. This means that managing the interaction may be difficult for the therapist, but not taking action may result in collusion with permitting potentially harmful narratives (Wilson, 1998). As such the therapist needs to recognise the social and cultural boundaries that the family bring and note the effects that the dynamics of the family have on therapeutic progress. In this paper we consider how appropriateness of topic and moral breaches are constructed and dealt with and how accountability functions to manage identity. Our concern is not to pass judgement on what constitutes good or bad therapy. Neither is it our concern to consider the effectiveness of therapy or the value of different approaches. Rather, like Labov & Fanshel (1977) our focus is on the actual therapeutic conversations to consider the ways in which families construct and defend their moral accountability and appropriate talk in front of children.

This paper, therefore, has two central aims. First we explore how families talk about their social worlds 'out there' by re-telling events and narrating instances of what they construct as inappropriate for their children. Second we examine how these discourses are managed 'in here' within the therapeutic context by all parties.

Methods

For this study we utilise a qualitative, discursive approach to explore the ways in which family members and family therapists co-construct their identities and formulate moral positions in relation to what constitutes appropriate talk and behaviour in front of children.

The discursive approach

While there are many qualitative approaches available for studying family therapy, discourse analysis is methodologically congruent with family therapy theory and practice (Roy-Chowdhury, 2003). Within the broad field of discourse analysis there are a number of different discourse approaches and for our analysis we follow Edwards and Potter (1992) which has the benefit of drawing upon the principles of conversation analysis to elucidate the nuances of interaction. This form of discourse analysis has a commitment to study talk in social practice with an emphasis on the rhetorical organisation of language (Potter, 1997). The advantage of using a discourse approach with conversation analysis is it enables the analyst to explore the moment-by-moment accomplishment of interaction. This enables the analyst to view the contribution of each participant within the therapy from their respective positions (Roy-Chowdhury, 2006). Using discourse analysis allows for a rigorous analytically and empirically grounded account of the data.

Setting and context

The data corpus for the project was provided by a family therapy centre based in the UK. For the project we were provided with video-taped sessions of naturally occurring family therapy sessions, totalling approximately 22 hours of therapy. The data are provided by two therapists who gave informed consent and four families with pseudonyms of the Clamp family, the Bremner family, the Niles family and the Webber family (see table one). All four families were White British, from the Midlands and from lower socio-economic backgrounds. In keeping with the deductive discursive epistemology sampling is appropriate and issues related to saturation are not intrinsic to the approach.

The family therapy team who provided the data are systemic family therapists who specialise in working with families of children with mental health problems and disorders. The family therapy team provided video-taped naturally occurring family therapy sessions for research. These video-taped sessions are routinely collected as part of reflecting practice and for training purposes and were not primarily collected for research purposes. For this paper we draw upon the data from four families and two therapists, Joe and Kim.

INSERT TABLE ONE HERE

The video-taped data was subjected to transcription in accordance with the analytic method and Jefferson guidelines were followed (See Atkinson & Heritage, 1999). Please refer to table two for basic transcription notation.

Ethics

This research complies with the BPS code of ethics for conducting research with human participants. Professionals provided consent and video-tapes were provided for the four families who provided signed informed consent. Data was protected and anonymity was ensured through transcription.

Analysis

There are two layers that emerge from the data in the context of constructing appropriateness of topic and behaviour in front of children. Firstly we consider how members manage what happens 'out there' in the family's social world by using four rhetorical resources; informational, locational, temporal and personal contextual factors. Secondly we consider how these issues from in the social world are managed 'in here' within the therapy. Through this emerges rhetoric of responsibility for negotiating what the children should be privileged to hear.

PART ONE: REPORTING WHAT HAPPENS 'OUT THERE' IN THE MEMBER'S SOCIAL WORLD

A significant part of family therapy is to provide a space for family members to report events from their social world that impact upon family functioning. Through these reports parents can and do narrate events in a way that shows that these are considered by them to be inappropriate for their children to be exposed to. Notably, however, these reports are offered to the therapist in front of the children and therefore, re-expose them to the 'inappropriate'

talk/events. By integrating the informational, locational, temporal and personal factors the parents highlight this inappropriateness.

Extract 1:

1 Dad: I think it might ['ave been cause the police =

2 Mum: [and last night

3 Dad: = arrested me 'at the house and everythin' they do

4 it <at the wrong time> when the kids are there and

5 that ↓lot

6 FT: I think >for all of you< it's been a very difficult

7 time and e::r

Clamp family (session 7)

In this extract the parents demonstrate to the therapist the inappropriateness of external agencies in their behaviour; making relevant the presence of their children. The therapist, notably does not comment on this inappropriateness but reformulates a more therapy relevant position, focusing on the family's experience, *'I think for all of you it's been a very difficult time'* (line 6). The parents, however, strategically report the inappropriateness of the external agencies, positioning it as a central concern. By highlighting the informational (what is inappropriate) as being '*arrested*' (line 3) intrinsically linked to the locational (where it took place) '*at the house'* (line 3) and positioning the relevance of the temporal (when it occurred) '*at the wrong time'* (line 4) functions to position the personal (who performed the act) the '*police*' (line 1) as accountable and responsible whilst mitigating the arrest itself. In other words, the father shows that it is not the arrest that is objectionable, rather the presence of the children that makes it morally accountable. These four factors, therefore, work to preserve the

identity of the parents as good parents and manage to position blame with others in society. This paper now addresses each of these factors in turn.

Informational contextual factors

While there are debates and children's policies and guidelines that aim to guide parents and professionals as to what is appropriate for children, ultimately, in therapy, the morality and appropriateness of topics is negotiated in situ by the present members. As such, in therapy, members orient to 'what' information is and is not appropriate for children to hear.

Extract 2:

1 Dad: she <turned round> and told my brother <in front of
2 the three children> (.) <that 'e cannot 'ave
3 anythin' t' do wiv ↑my children because 'e 'as sex
4 with children>
5 FT: ↓Right

Clamp family (session 6)

In most cultures there is a common sense notion that children should be protected and in some countries there is legislation to govern that. Here in extract 2, the father positions the social worker as morally culpable through reporting the topic of conversation as being inappropriate for children to be exposed to. He constructs the topic of '*sex'* and sexual offending as adult in nature and shows that the problem is that this topical discussion took place in front of their children.

Locational contextual factors

While what is said or done in front of children is a primary concern for members, this is often associated with the location of the event.

Extract 3:

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1  Mum:      the babby comes out with the eff word and =
2  FT:       = yeah sure
3  Mum;      Yer know
4  Dad:      ↑Yeah but now 'e's coming out wi- w↑anker
5                 .................... (7 lines omitted) .......................
6  Dad:      when h' wuz at 'is Nan's (.) 'is 'is da- 'is
7            granddad wuz playin' around and he said "you fuckin'
8            wanker" to his granddad .hh and 'e got banned from
9            the house
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Niles family (session 1)

The inappropriate behaviour in this extract is constructed as being displayed by the eldest child (aged fourteen). This is directly reported as swearing *'eff word'*, and '*wanker*' which is treated as complaint worthy because it is in front of the *babby',* the youngest child (aged three) as this is being imitated. It is further problematised by the location in which it occurs. In formulating place, a speaker has to engage in a degree of membership analysis of the hearer, and his/her competence in that category, in order to properly formulate a referent location (Schegloff, 1972). In other words, the person being spoken to (in this case the therapist) is normatively expected to have an understanding that grandparents' homes command a certain type of behaviour, because most cultures have an expectation of respecting older generations. As such deviations from this normative expectation become accountable and noteworthy. Here the father draws attention to the noteworthy relevance of

the place, by demonstrating a breach of what should go on there, and this taking place in front of the younger children.

Temporal contextual factors

When relevant, members also draw upon the rhetorical resource of timing as a way of building their point. By constructing when the behaviour/talk occurs can function to highlight the inappropriateness of it while positioning blame with that agent for failing to protect children.

From extract 1

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1  Dad:      = they do it <at the wrong time> when the kids are
2            there and that ↓lot
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Referring back to the arrest taking place within the family home, the father shows that the action of arrest is not necessarily inappropriate rather it is the timing of the arrest that is problematic. By informing the therapist that the children were at home at that time (line 1) makes problematic the ‘when’.

Personal contextual factors

The therapeutic arena is a place where it is expected that sensitive topics of conversation are managed and during conversations, responsibility and accountability negotiated. Notably,

through reporting inappropriateness, the members manage to position responsibility with external agencies or others; thus orienting to the 'who' is at fault for a moral breach.

Extract 4:

1 FT: …. that actually <social services> would like him
2 out the ↑way
3 Dad; That's what she turned round [and told 'im in front
4 of the kids
5 Mum: [Yes (.) that's what
6 Joan Karr ↑told 'im (.) she told 'im t' <get out of
7 the house>

Clamp family (session 7)

While parents can and do use multiple discursive resources to construct blame and deflect personal responsibility, a common account used is to hold others such as outside agencies responsible (Godwin 2004). Collaboratively, members in this extract build an account that positions the social worker as accountable for children overhearing inappropriate talk. This is in response to the therapist's formulation of their preceding construction of events *'that actually social services would like him out the way'* (lines 1-2). The parents confirm the therapist's understanding of the situation and move to construct the individual social worker culpable for the act, by first referring to 'she' (line 3) and then specifically naming her (line 6). This, therefore, identifies her as personally responsible for failing to protect the children by allowing them to overhear her inappropriate language. While potentially conceivable that the social worker was unaware of the children's presence, the complaint is continued in extract 5 in a way that demonstrates that her inappropriateness was sometimes directed specifically towards the children.

Extract 5

1 Dad: and she said beware (.) >and the words she said as

2 well< (.) beware >of your dad as well<

3 (2.0)

4 Dad: why they n:eed t' beware of me <I don't know>

5 (1.0)

6 Dad: she ne:eds a smack in the ↑gob

Clamp family (session 8)

The recipient of the reported speech is indexicality identified by the phrase *'your dad'* (line 2) which indicates that the addressee's were the children. The father suggests that the warning she provides to the children against him,*' beware of your dad as well'* (line 2) is not only inappropriate but also unjustified *'why they need to beware of me I don't know'* (line 4). Missing from this sequence is the therapist's contribution which is markedly absent. In conversation pauses between turns signify potential trouble or disagreement (Pomerantz, 1984). The two second pause in line 3 and the one second pause in line 5 have the effect of him continuing to promote his point of view with increasing effort. This culminates in his assertion that *'she needs a smack in the gob'* (line 6). While colloquial in nature, the phrase orients to the need for the social worker to cease talking.

It is especially notable in our examples from part one that the reporting of these inappropriate events is unfolding within the family therapy. What this means is that many of the examples that are constructed as inappropriate when overheard 'out there' are being reported again in front of the three children. As such the inappropriateness extends beyond 'out there' and becomes an 'in here' issue for the parents and therapist to deal with.

PART TWO: MANAGING APPROPRIATENESS IN THE THERAPY CONTEXT

In the therapy setting the parents report the out there events, thus repeating the conversations that they construct as inappropriate for the children to hear. In addition to re-enacting issues from the out there environment, as part of the therapeutic process parents talk about and to the children in ways that may be perceived as problematic.

Extract 6:

Dad: get some medication or somet t' calm 'is temper down (.) cuz ['e's ↑schizo

Niles Family (Session 1)

Extract 7:

Mum: t' sort of 'elp Jeff because he's so handicapped

Bremner Family (Session 1)

Extract 8

Dad: ↑you jus' sit there like a cabbage

Niles Family (Session 2)

These extracts contain descriptions of the children that could be culturally deemed to be quite derogatory and inappropriate terms. Using phrases such as *'schizo'*, *'handicapped,* and *'cabbage'* in other settings might be challenged and considered offensive. In therapy, however, these terms are used by the parents to position and describe the child in some manner in front of the children being described. The therapeutic relationship is central for

effective therapy (Roy-Chowdhury, 2006) and by challenging the descriptions put forward by families this relationship may be jeopardised.

Extract 9

1 Gran: he (0.2) shouts at ↑Julie he hates her .hh <she’s
2 lazy>(.) <she neve::r does what ↓he ↓wants> and just
3 FT: U↓hum,
4 Gran: lays >int’< ‘er and she’s ↑had it a::ll we:ek

Bremner Family (session 1)

Extract 10

Mum: <he was touchin’ our Stuart up> and >you know< when he’s been doin’ it ‘cause he’s got an erection all the while
FT: Yeah
Mum: and he’s bloody embarrassin’

Webber Family (Session 2)

Family members do, however, go beyond single descriptors to build a picture of the child for the therapist. In extracts 9 and 10, narratives include examples of the extreme negative behaviours of the children. This is potentially problematic is not that the family are reporting this to the therapist, but the children are present as overhearing audiences. Thus children are not only exposed in therapy to narratives about inappropriate topics from the family’s social world, but are also exposed to overhear potentially shaming, undermining or distressing

comments about them. Validating each person's point of view is an important part of the family therapy process. However, a delicate balance needs to be managed by the therapist in maintaining an equal therapeutic alliance with each member to elicit as much information as possible about the family's problems while considering their role in protecting the most vulnerable members of the family group.

Who takes responsibility?

Families bring to therapy their 'troubles talk' and the therapist responds in a way that strengthens the family's engagement (Roy-Chowdhury, 2006). This means that the therapist is charged with responsibility for engaging all members of the family, including the children.

Extract 11

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1  FT:      if Steve just thinks that he's comin' 'ere for us to
2           'ave a go at 'im is he gonna wanna be here and is he
3           gonna want t' be involved.
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Niles family (Session 3)

One way that the therapist manages the continued talk about the child's behaviour and the reported events considered inappropriate for the child to overhear, is to attend to how the child might be experiencing these conversations in the 'in here' context of the therapy. One way of engaging the child in therapy is to provide the child with a 'voice' and to offer a version of the potential perception of what has been said. By constructing Steve as interpreting the parental narratives as having *'a go at him'* it gently challenges the kind of language that the parents have been using to describe events.

Extract 12:

1 FT: 'cause >I mean< Steve was arguing back with you then
2 and an- I have to say I've never heard Steve argue
3 back with you (.) before (.) not with me sittin'
4 here not with me present

Niles family (session 1)

Typically in therapy the therapist is not frequently privileged to directly witness examples of the behaviours that are reported. Thus, parents by necessity report examples of external events from their social world to support their claims. The therapist in this extract orients to the unusualness of the 'out there' behaviour occurring 'in here' in therapy. Trouble sources that emerge in therapeutic conversations are points at which culture and power are enacted (Roy-Chowdhury, 2006). The therapist has opportunities at these times to utilise 'therapy' role as a mechanism for empowering the child to contribute. Alternatively, the therapist may suggest that it would be in the child's best interest to be removed from the conversation.

Extract 13:

1 FT: ↑Can I jus' (.) is it ↑alright for us t' >talk about
2 this<
3 Dad: ↑Not really not with Ronald being ↓'ere

8 lines of talk omitted for readability

4 FT: Right (.) can I? (.) >I mean I it< [sounds like
5 quite an <important conversation>
6 Mum: [He said (.) if
7 ↑we'd give ↓'im

8 Dad: ↓Hu::m

9 FT: can I ask if = see if <one of my colle:agues> could

10 ↑sit

11 Dad: ↑Yeah

12 FT: with (.) with Ronald and er::m

13 Dad: ↑Yeah

14 FT: Cuz I’m not sure ‘e should hear ↑this

Clamp family (session 6)

An important issue for the therapy in this example is the questioning of appropriateness given the child’s presence in the room. Prior to this extract, the father’s narrative contained information regarding events about paedophilia and sexual offences; refer to extract 2. During this narrative the therapist intervenes by raising the question of appropriateness of topic to the parents (line 1). What is notable here is the way this is delicately managed without usurping parental authority. The therapist designs his turn as a question, as a way of checking the appropriateness of topic, and the presence of such a question functions as a proposition that the topic is potentially inappropriate. The turn is designed to highlight the issue as potentially problematic without directly constructing it as such. In conversation there is a notion of preference organisation whereby agreement is the preferred response (Pomerantz, 1984). What this question achieves is an agreement from the father in the sense that he agrees that Ronald’s presence is indeed problematic given the nature of the topic being discussed.

What is interesting in this narrative is that despite agreement with the therapist’s turn, the parents continue to present information about the topic of sexual offending and at line 4, the

therapist reiterates his earlier problematizing of the topic. In this turn series he upgrades the need for Ronald to be removed and proposes a solution so that the talk can continue without his presence. In the absence of immediate uptake from the parents, the therapist makes a move to using first person referencing *'cuz I'm not sure he should hear this'* (line 14) to indicate what he believes to be appropriate. While in this extract the therapist takes responsibility to remove the child from the session, an alternative is to suggest postponement of the discussion around the specific topic to another session.

Extract 14

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1  FT:      ….. we can do this next time
2  Dad:     >Yeah I think so< 'cause 'e don't understand anyway
3           but (.) whatever like >yer know<
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Clamp family (session 8)

In this extract the notion of competence of the child is utilised by the father in response to the therapist's suggestion *'we can do this next time'* (Line 1). While agreeing with the possibility, the father provides an account as to why this may not be necessary *'he don't understand anyway'* (line 2). By positioning the child as not understanding the adult topics, implies that the conversation could continue in front of the child.

Discussion

This study demonstrates the sophisticated range of skills required of family therapists and shows the complexity of managing family dynamics. Therapy does not unfold in a vacuum and as such the clients bring issues from 'out there' in their social worlds to the 'in here' context of therapy. By reporting events from the social world, there are occasions when

topics of conversation may be more ‘adult’ in nature and our analysis reveals how this is delicately managed during the therapeutic interaction.

Analysis highlights two key areas. First we have shown that families report events from the outside world and orient to the inappropriateness of some of those events. Second analysis demonstrates that outside worlds are brought into the ‘in here’ therapy context. When negotiating what is and what is not appropriate for children to witness and overhear, the members make reference to four elements of the outside social world; the informational (what is said/done), locational (where it is said/done), temporal (when it is said/done) and personal (who it is said/done by). These ‘outside’ references are utilised rhetorically within the therapy as a way of managing blame and accountability. One way in which this is achieved is by contrasting their own behaviour with the behaviour of outside agencies such as the police and social services.

Within the situated discourse of the family therapy setting we identified three significant issues. First by repeating the constructed inappropriate events from ‘out there’ within the therapy in front of the children the parents in effect re-expose their children to what they complain was originally inappropriate. Second they themselves use terminology about their children which is potentially derogatory in front of the children being described, which has been found previously (O’Reilly, 2005). Finally in light of these discussions, data reveals how therapists manage the delicate balance between parent responsibility against their own professional responsibility to protect children from being an audience to particular topics and language.

Historically there has been a shift from pathologising the individual to locating responsibility for socially undesirable within the family system (Barker, 1998). Our analysis demonstrates that family members resist accepting this positioned responsibility. At times parents locate the problem back with the individual child, but this is somewhat problematic given the child's presence and possible denials (Godwin, 2004; O'Reilly 2005). Within healthcare the clinical governance agenda requires the development of evidence-based practice and methods to evaluate clinical practice (Roy-Chowdhury, 2003) and this paper provides empirical data which demonstrates families do not passively receive treatment but are dynamically engaged in the process. This is consistent with claims that families and therapists actively co-construct meaning (Roy-Chowdhury, 2003).

To date, there has been little research exploring how morality is enacted and socialised through family interactions involving children (Ochs, and Kremer-Sadlik, 2007). Our analysis builds up the evidence base on socialised morality as it demonstrates what parents consider to be appropriate for child audiences to hear in that context. Normatively in our culture it is considered inappropriate for children to be exposed to topics, such as sex (Hutchby and Moran-Ellis, 1998) but our analysis reveals that appropriateness is contextualised with 'where, when and who'. In our data, parents make relevant additional contextual factors such as who was speaking, when the topic was discussed and where it occurred to manage the socialised morality.

Wider implications for practice

When engaging with the family system work needs to be done to facilitate change without colluding with a particular version of events or descriptions of people. What is notable from our analysis is that therapists resist collusion with the parents by addressing process rather

than content. Making references to the ‘here and now’ in therapy rather than agreeing or disagreeing with the formulations offered by the parents, is a mechanism for therapists to maintain respect for parental authority. At the same time, this also enables them to take some responsibility for the protection of the children. Therapists can resist moral judgement based on their own versions of what is right and wrong by taking a meta-perspective to circumvent this problem. In this way moral issues can be dealt with delicately without undermining parental authority, without damaging the progress of therapy, or damaging relationships with families.

Part of the role of a systemically informed therapist is to facilitate movement in the disturbed family system towards systemic health (Atkinson & Heath, 1990). Atkinson and Heath show that to achieve this, the therapist should not remain passive but equally need to take care not to purposely move the family in a particular direction based on their own knowledge or intention. This is particularly important to consider when there are differences in culture or background between the family and the therapist. As a reflective practitioner, the therapist’s role is to be sensitive to the ways in which through therapeutic discourse, culture and power are evoked, managed and negotiated (Roy-Chowdhury, 2003). The culturally sensitive therapist will be aware both of their own position on what constitutes appropriate topics or ways of speaking while being able to consider the differences that may be evident through their clients’ discourses. Therapists thus need to attend to their own assumptions about what could or should be talked about in front of children. Part of the purpose of therapy is to elicit family stories in the family’s own language as this conveys an understanding of family functioning and feelings. For example, when parents employ potentially derogatory terms, such as ‘schizo’ to describe their children, the therapist should hear this as a culturally and

therapeutically situated description. Culture is not static, but its relevance is co-created within the therapy and is multilayered and dynamic.

In reality the therapist takes responsibility for making decisions regarding the types of topics that are discussed in front of children and therapists manage this in practice. This raises the interesting question, ‘who takes responsibility for the children while they are in therapy?’ The therapist does not have authority beyond the therapy room, but still has access to narratives related to what happens in the families’ social world. This social world unfolds through therapeutic interactions and in front of the children and the therapist has to use judgement related to his/her version of appropriateness. Protecting children from exposure to potentially harmful narratives has to be a priority for therapists (Wilson, 1998). As such they have responsibility to protect children without imposing moral judgements whilst maintaining the equilibrium of therapeutic alliance.

It is evident therefore, that during the progress of therapy there may be incidents that require clinical intervention whereby the therapist needs to assert their status as therapist. This asserting of therapist authority has potential to threaten the equilibrium of therapeutic alliance. One way of managing this equilibrium and taking responsibility when necessary is by embedding strategies within normal practice. For example, during the initial family therapy session and during the ‘contractual’ discussion that sets up the framework of forthcoming sessions, the therapist could introduce the issue of potential delicacy of inappropriate talk in front of children. By setting up boundaries and raising the issue early on in the relationship, it usefully becomes a reference point when required later on.

Concluding remarks

In conclusion, this paper shows the challenges that family therapists face in their work. In the therapy context families bring narratives relating to outside events, some of which may be considered inappropriate to discuss in front of the children. What is and is not appropriate is not fixed, rather it something that the therapist and family work together to create. In reality the therapist and parents may hold differing views regarding appropriateness and our analysis shows that attending to process, instead of content, facilitates the management of these complex issues. One of the strategies utilised by parents to manage this complexity is to resist responsibility by developing accounts that locate blame with others. To ensure therapeutic progress the therapist may need to challenge some of this deflection of blame but this needs to be handled sensitively as not to shame them and use strategies that allow them to maintain 'face'. This paper shows that it is possible to maintain a therapeutic alliance and still manage the protection of children.

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