Conversation analysis and family therapy
a narrative review

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Conversation Analysis and Family Therapy: A Narrative Review

Abstract

Conversation analysis (CA) can provide insight into interactional micro-processes of family therapy. Past reviews of CA and family therapy have focussed on methodology without descriptions of research findings, reducing the likelihood that the findings of CA research are employed to guide practice. This narrative review provides therapists with a description of CA findings that can inform family therapy practice. Systematic searches of databases, individual journals, and citation analyses were completed in April 2018 resulting in 25 articles for review. The findings of this narrative review were summarised around three areas: Family members’ talk about each other, therapists’ responses to the family, and the use of reflecting teams. The use of reflecting teams and various conversational devices may help engage multiple participants. Future CA research into family therapy could focus on longer sequences, the overall structural organisation of sessions and the interactions of multiple therapists.

Practitioner Points

- Conversation analysis can provide practitioners with insights into the interactional micro-processes occurring in family therapy that can inform and guide future practice.
• Micro-interactions between therapists and family members can indicate something about their relative perspectives towards sensitive topics, blame and accountability, and the position of children in the therapy session

• Blaming talk creates a dilemma for therapists when attempting to simultaneously maintain neutrality and engagement

• Family therapists utilise various conversational practices to respond to difficult conversations while still maintaining engagement and collaboration

• The use of reflecting teams may help to acknowledge and engage multiple family members

Introduction

Talk is one way that people negotiate and coordinate their interactions. Conversation analysis (CA) is the study of this talk-in-interaction. It describes and analyses how spoken interaction is structured and how sequences of talk coordinate actions. CA has a number of features that make it distinct from other approaches that study language and social interaction (Sidnell & Stivers, 2013). Conversation analysts study talk occurring in naturalistic contexts, utilising data from audio and video recordings of real-life interactions. CA then employs a unique method of data transcription to capture the features of conversation, such as pauses, prosody and intonation (Hepburn & Bolden, 2013). The analysis focuses on describing and explicating normative structures, and how particular conversational practices achieve social actions. CA’s standard of proof requires that analytic claims are grounded in the orientations of the participants (Wooffitt, 2005). This means that analytic claims are based on the observable details of the talk and how participants display their orientations or understandings of the talk, rather than by reference to internal states, motivations, or analyst-driven invocation of social structures and discourses.
CA has a particular interest in conversational structures and actions. The best understood conversational structures are normative expectations. Language has a set of normative expectations that participants orient to, and manage at a local level, in order to maintain conversational order. These structures include a system for turn-taking (including speaker selection and transition to next speaker), repair organisation (how misunderstandings are clarified), and sequence organisation (how paired parts of talk, such as question-answer, greeting-greeting, request-compliance, are developed). Another area of interest is the analysis of actions, i.e., the goal-oriented reasons embodied via people’s observable conduct (see Enfield & Sidnell, 2017; Levinson, 2013). Talk is a vehicle for action, and particular conversational practices for speaking (e.g. word and grammar choice) can be utilised in order to achieve particular goals. CA describes how certain practices achieve certain actions through analysing sequences of talk with reference to how participants respond and orient to them. It should be stressed that, for CA, understanding talk requires attention to the sequential context and how participants manage their interaction. An analysis therefore requires attention to the local, sequential context in which it occurs and as it occurs for the participants (Maynard & Clayman, 1991), and not by reference to abstract invariant structures (Button & Sharrock, 2016; Lynch, 2009).

The research objectives of CA have been described in two broad ways (Have, 2007). One, generally called “pure” CA, focusses on describing the features of everyday conversation as described above. Another has been termed “applied” CA. Applied CA can take a variety of forms, but is generally focussed on analysing interactions with a view to specific professional and discipline-specific activities. This is most notably demonstrated in studies of what is termed “institutional talk” such as occurs in the courtroom or news interviews, as well as
health and psychiatric settings (Drew & Heritage, 1992). In psychotherapy, CA has been used to provide greater detail on how psychotherapy techniques are delivered and the interactional functions they serve, and to describe ways that clients respond to interventions. A selection of examples is presented below.

CA has examined the various uses of ‘formulations’ by therapists (Antaki, 2008). These formulations are presented as summaries of what a client has said and invite confirmation or disconfirmation, but they also do other interactional work. Formulations also select and exclude various parts of the client’s talk, thereby providing a way for the therapists to shape clients’ talk and influence the direction of a session.

CA can also describe and identify subtle techniques that are utilised by the therapist that may not be described by current psychotherapy theories. For example, Rae (2008) shows how therapists can use a form of repair called lexical substitution. In these cases, therapists would respecify the client’s talk by offering an alternative word. For example, (Rae, 2008, p. 63):

Client: It feels a little uncomfortable
Therapist: Or a lot uncomfortable

Here the therapist respecifies the client’s “a little uncomfortable” to an upgraded; “a lot uncomfortable”. Rae (2008) describes how this practice can display that the therapist is listening closely and to the client, but also serves to encourage the client to be more explicit about their emotional experience without the use of a direct statement to that effect.
CA has also analysed how clients can show disalignment with therapist questions or formulations. For example, clients may resist the presuppositions of optimistic questions through downgrading the positivity, refocusing to non-optimistic interpretations, redirecting credit to others, or through joking responses (MacMartin, 2008). CA can therefore reveal greater detail about how clients may reject (or accept) therapeutic interventions and promote therapist self-reflection on their practice (Georgaca & Avdi, 2009; Madill, Widdicombe, & Barkham, 2001; Tseliou, 2013). Despite the insights CA can provide on family therapy practice, there does not currently exist a summary or synthesis of the research to date. This means that the results of CA research are generally not readily available for practicing clinicians to consider and relate to their professional activities.

Recent reviews in the field (Ong, Barnes, & Buus, 2019; Tseliou, 2013) have focused on methodological critiques of existing CA and family therapy research without a description or summary of the research findings. This narrative review will therefore attempt the following aims: 1) to systematically search for articles on CA and family therapy; 2) to provide a narrative review including a summary and synthesis of the current findings in the field of CA and family therapy, and; 3) to consider how these findings may inform family therapy practice for clinicians.

**Methods**

This study was designed as a narrative review of CA and family therapy. While there is not currently an agreed upon structure for a narrative review (Ferrari, 2015), there does appear to be a general consensus on what a good narrative review should contain (Derish & Annesley, 2011; Ferrari, 2015; Green, Johnson, & Adams, 2006). These include having a specific research question for the review, clear inclusion and exclusion criteria, a comprehensive
literature search, critical evaluation of the methods and quality of results, a synthesis of the key findings and drawing of conclusions, impact on field, and discussion of the direction that the field needs to take. This review will focus specifically on summarising and discussing the key findings of the articles under review and compliment recent critical methodological reviews (Ong, et al., 2019; Tseliou, 2013).

A systematic search for articles was completed in April 2018. The process included three stages: 1) searches of the databases PsycINFO, PubMed and CINAHL due to their coverage of clinical practice; 2) searches of individual journals in family therapy and linguistics, and; 3) reviews of reference lists, citing references, and ‘similar’ references of each found article using the Scopus citation database. We used the free text search terms “family therapy” and “conversation analysis”.

Inclusion criteria were original empirical research articles published in peer-reviewed journals, exploring family therapy and stating the use of CA exclusively or as part of a wider analysis. This often involved discursive psychology articles that incorporate CA in their analyses. CA and discursive psychology have a number of similarities, with both using naturally occurring conversations, similar transcription conventions, and the use of sequence analysis, sometimes making it difficult to distinguish between the two approaches (Have, 2007; Potter, 2012). But unlike CA, discursive psychology may go beyond an analysis based only on conversational structures to exploring the influence of broader discourses on psychological and social structures (Madill, 2015; Potter, 2012).

All types of family therapy approaches were included, but articles researching couple therapy were excluded in order to more specifically focus on family therapy processes. There was no
limit on age of articles, but only articles in English were included. The search retrieved a total of 25 articles, see Figure 1 for PRISMA statement.

(Insert Figure 1 here.)

The articles were reviewed against the 20-item criteria for qualitative research (Blaxter, 1996, 2013) as well as criteria relevant for CA. The findings of this critical review of methodology can be found in (Ong, et al., 2019). To complement the critical review, the current paper focusses on summarising the research findings and takes the form of a narrative review. All articles were evaluated by at least two reviewers: All articles were reviewed by the first author, with the two other authors each reviewing half of the articles. The key reported findings of each article, as reported in the article’s abstract, results and discussion sections, were noted and discussed in pairs by the respective reviewers. These findings were then compared across articles by the first author. Similar articles were grouped together according to their findings and areas of investigation, as well as areas of agreement, disagreement and complementarity to build a summary of current knowledge of CA and family therapy.

Consistent with the presentation of a narrative review, only the main findings of the review are presented here (Ferrari, 2015). Other areas of investigation, such as the argument for the usefulness of CA research for examining family therapy are included in the summary table (Table 1) but do not form part of this review. The discussion aims to synthesise the presented findings.

**Findings**

Table 1 lists the articles included in this review with a summary of aims, stated method, participants and setting, and main findings. A review of each study’s findings suggested three main areas of investigation: 1. Family members’ talk about each other, particularly in relation
to blame and accountability, interruptions, and protection; 2. Therapists’ management of the therapeutic relationship, in relation to responding to blame and maintaining neutrality, negotiating impasse and advice giving, and maintaining engagement and inviting collaboration and; 3. The use of reflecting teams.

[Insert table 1 here]

**Family Members’ Talk About Each Other**

Research in this area focused on clients and family members and how they spoke about each other and interacted with the therapist. The articles focused on the particular areas of blame and accountability, interruptions, and protection talk.

**Blame and accountability.**

Research on blame and accountability focussed on talk about the identified client, which was overwhelmingly by parents about their children. Parents utilised a range of conversational resources to present themselves as good parents and to avoid any blame or accountability that may be connected to the behaviour of their child. This has been reported as being achieved in two main ways. First, parents can present behavioural examples and dispositional descriptions to emphasise and authenticate the severity of their child’s behaviour (O’Reilly, 2005a; Parker & O’Reilly, 2012). Second, parents can make direct statements about their own good parenting and appropriate responses to their children’s behaviour (O’Reilly & Lester, 2016), and family members can emphasise their reliability as informants (Hella, et al., 2015). Such talk serves to locate blame in the child and represent the parents as reasonable actors and therefore not responsible for their child’s behaviours. Attention is thus directed
away from the relational and interactional patterns that are the focus of family therapy, to problems within a particular individual.

Managing interruptions.
CA research on interruptions in family therapy suggests that interruptions by adults receive different responses to interruptions by children. Adults seem to be able to interrupt or speak for children without sanction, while children’s attempts to interrupt may be ignored or negatively responded to (Hutchby & O’Reilly, 2010; O’Reilly, 2005b). Furthermore, if adults interrupted other adults, there is some recognition of the interruption or even an apology but this did not occur when interrupting children (O’Reilly, 2008). In these sessions, there seems to be differential rights to the conversational floor with greater access granted to adults rather than children.

Protection talk.
Pote, Mazon, Clegg, and King (2011) describe protection talk where family members and therapists protect others’ vulnerability by switching topics, changing the valence of the talk, or shifting focus away from one person. However, therapists can also retain focus on a particular topic in order to further address issues of protection. This research suggests that diverting conversation away from topics may signal avoidance, but it can also serve protective functions for a third party.

In summary, this research shows how family members’ interactions can indicate something about the perspectives of the participants. For example, topic switches can indicate sensitive areas that family members may avoid as a way of protecting each other, talk locating blame in an individual directs the conversation away from relational explanations, and children can
have lesser access to contribute to conversations. These interactions have implications for
therapy as the therapist has a decision to, for example, accept the topic switch or retain focus
on a sensitive topic, accept an individual explanation for problems or propose an interactional
view of a problem, or to focus on adults or actively solicit talk from children. Therapists may
therefore need to be sensitive to how clients are responding to the conversation so that they
can make decisions about the most therapeutically useful direction to take in the interaction.
This creates a dilemma for therapists about how to appropriately respond while still
maintaining engagement and collaboration.

**Therapists’ Responses to the Family**

Much of the CA research on family therapy has focused on the behaviours of the therapists in
relation to particular therapeutic issues. Generally, this seemed to reflect the tension between
directing and guiding clients while still maintaining engagement within the therapeutic
relationship. Therapist responses are discussed below in relation to responding to blame and
maintaining neutrality, negotiating impasse and advice giving, and maintaining engagement
and inviting collaboration.

**Therapist responses to blame and maintaining neutrality.**

Therapists took three main positions in response to blame; alignment, by acknowledging or
stating a belief about the blame (Friedlander, Heatherington, & Marrs, 2000; Parker &
O’Reilly, 2012); disalignment by ignoring and diverting the conversation away from the
blame (Friedlander, et al., 2000; Pote, et al., 2011; Stancombe & White, 2005); or through
neutrality by reframing the blaming talk in ways that are consistent with the frame of family
therapy. Therapists can reframe talk by focussing on emotions, framing the problem in the
context of the relationship, redirecting to talk about resolutions, or using metaphors to expand
the theme of the discussion (Friedlander, et al., 2000; O’Reilly, 2005b). The responses of therapists may therefore indicate their position regarding the blame, even if not stated explicitly.

These studies show ways that therapists work to maintain engagement while still avoiding blaming or inappropriate talk. For example, rather than sanctioning parents’ inappropriate talk directly, therapists can propose that the child’s presence may be problematic, allowing parents to confirm and make arrangements to discuss particular topics without children being present (O’Reilly & Parker, 2014). This potentially allows the therapist to maintain engagement with the parent by not explicitly sanctioning their inappropriate talk, while also reducing the negative effects on the child. But maintaining neutrality is a complicated interactional task. For example, when a therapist attempts to maintain neutrality by topic switches, this can result in a client repeating the blaming talk or adding additional evidence, possibly as a result of not feeling heard or acknowledged (Parker & O’Reilly, 2012; Stancombe & White, 2005). Thus, through actions designed to reduce blaming talk, the therapist may actually increase it.

**Negotiating disalignment and inviting collaboration.**

Client displays of disalignment can signal to therapists impending disengagement, which can in turn elicit attempts to reengage and invite collaboration. Client disengagement could be displayed as direct refusals to participate, requests to terminate sessions, and inattention or not attending to questions (Muntigl & Horvath, 2016; O’Reilly & Parker, 2013). There are also more subtle forms such as pauses before responding, partial uptakes and qualified responses (Couture, 2006; Muntigl & Horvath, 2016).
Therapists’ responses could involve explicitly orienting to the disengagement through acknowledgement of client difficulties and validation (Muntigl & Horvath, 2016; O’Reilly & Parker, 2013). Other therapist responses involved techniques designed to further the conversation, such as forced-choice questions, selective listening and focussing on weak agreements (Sutherland & Couture, 2007). These responses do not directly acknowledge disengagement but instead select relevant parts of the client’s talk that align with the therapist’s therapeutic project and can continue the therapeutic conversation. Alternatively, a therapist can use follow up responses, such as forced-choice questions, that serves to more strongly solicit a response from an ambivalent client.

A series of articles describe a particular model of how a therapist and family move through impasses and the steps involved in therapist advice-giving (Couture, 2006; Couture & Strong, 2004; Couture & Sutherland, 2006). Following an impasse, the therapist elicits and validates the different positions of family members, followed by an invitation to accept a middle ground. Advice-giving added two additional steps. First, the therapist provides small invitations to a middle ground while monitoring the level of uptake by family members. Second, the therapist provides advice, which is accepted when there is a sufficient level of prior uptake by the family. These studies describe how therapy is a dynamic, two-way process. The therapist does not simply provide advice or interventions but monitors and adapts to how the family are responding. Similarly, family members are not passive recipients, but instead display their alignment or dis-alignment to therapist moves that in turn shape how the interaction develops.

When negotiating impasse, giving advice, or to invite collaboration more generally, the therapist can utilise a number of particular resources. These resources could take the form
of enacting hesitation or tentativeness. These included: re-starts; pauses and drawn out words; word choice, such as “I imagine” or “probably”; and voicing opinions with rising intonation, serving to elicit a response (Couture, 2007). These techniques presented the therapist’s suggestions as tentative and contestable, potentially inviting a response from the family. Therapists could also invite collaboration from the family in other ways (Couture, 2007; Sutherland & Couture, 2007). This occurred through addressing multiple parties simultaneously through questions and indirect gaze that were directed at the group rather than a single addressee. Talk could also be addressed to others indirectly through veiled address, or by ambivalent or uncertain talk with pauses, inhalations, and drawn out vowels to ‘fish’ or invite listeners to respond and jointly contribute or elaborate on a topic.

In summary, this research shows how therapists attempt to maintain engagement with multiple family members simultaneously. This can become a difficult task when family members have different perspectives, as agreeing with one perspective may isolate other family members, and remaining neutral may increase the presence of blaming talk by participants not being acknowledged. Therapists’ talk can also be responsive to the family, particularly around impasse and disengagement when therapists can use a variety of techniques to gently introduce new ideas or continue the conversation without directly acknowledging the disengagement.

**Use of Reflecting Teams**

The two studies on the use of reflecting teams looked at two different areas: the transition points in and out of a reflecting team, and how the talk in the main session was discussed in the reflecting team part of the session.
Successful transition in and out of the reflecting team discussion involved setting an agenda and active management of the session structure by the therapist (Parker & O’Reilly, 2013). Successful exits from the main session involved the therapist making preannouncements of upcoming exit and not opening new topics of conversation. Return to the session is more smoothly negotiated by the therapist taking the first turn and providing feedback from the reflecting team. If the family takes the first turn, the conversation may take a different course and not return to the feedback from the reflecting team. So, in order to maintain the structure of a reflecting team session, and a smooth transition between sections, the therapist needs to be proactive in setting up, marking and directing transition points within the session.

Williams and Auburn (2015) examine how talk that occurred in the main part of the session is incorporated into the talk of a reflecting team. This use of the reflecting team differs from that described by Parker and O’Reilly (2013) because the reflecting team conversation is observed by the client and family. In the reflecting conversation, negative descriptions from the family’s discussion were contextualised positively. For example, in the session a father was described as strict and over-protective, while the reflecting team described him as a father that loves his daughter (Williams & Auburn, 2015, pp. 543-545). Reflecting team discussions also tended to omit adult descriptions of difficulties and instead emphasised the viewpoints of the children. This is in contrast to other studies where children seemed to be treated as lesser than adults (O’Reilly, 2008). The reflecting team is also used to authoritatively endorse positive interpretations or resolutions, particularly emphasising hopeful talk and relational descriptions of problems.

In summary, the use of reflecting teams involves a particular session structure requiring an exit from the main part of the session with the family, to a consultation or observation from
the reflecting team, and then transition back to the family. In order to maintain this structure, the therapist needs to take an active role by using preannouncements, closing conversations on exit, and actively setting the topic on return from the reflecting team. The reflecting team can also provide more positive, hopeful and relational descriptions of the family’s difficulties and promote the viewpoints of children, thus potentially maintaining engagement with all family members.

Discussion

The aim of this narrative review was to identify, summarise and synthesise the main findings of research that applies CA to the study of family therapy, and to discuss how this research can inform family therapy practice. The discussion to follow will consider in more detail the main themes raised by this research and particularly the complexities of simultaneously attending to multiple relationships. It will also address how these issues contribute to understanding family therapy, and possible future applications of CA research in family therapy practice.

This review highlights the complexities involved in family therapy, with therapists having to monitor and attend to the engagement of multiple relationships simultaneously. When there is blaming talk, the therapist is placed in a dilemma where acknowledging the blame risks disengagement with the person being blamed, while redirecting blaming talk potentially risks disengagement with the blamer. The articles on blame also highlight issues around the perceived rationale for family therapy. When parents present problems as located within the child this undermines the reason for family therapy, which focuses on relational contributors to problems. Therapists then have to potentially argue for the usefulness of their approach rather than progressing with the work of therapy. Some of these studies describe ways that
therapists negotiate engagement issues, through direct acknowledgment and validation, or attending to parts of the client’s talk that further the progression of the conversation (Muntigl & Horvath, 2016; O’Reilly & Parker, 2013; Sutherland & Couture, 2007). However, it is not clear to what extent clients accept these attempts at engagement, or if they are successful in encouraging acceptance of family therapy principles for parents who present individually-oriented problem formulations.

The work by Williams and Auburn (2015) suggests that the use of a reflecting team may be a way of maintaining engagement with multiple family members and acknowledging quieter voices. Williams and Auburn (2015) showed that a reflecting team tended to focus on the perspectives of children over adults, thus bringing forth potentially overlooked voices. The reflecting team also positively reframed negative descriptions, thus potentially aligning with the subjects of negative descriptions. Considering the contributions of multiple participants simultaneously may be a difficult task for solo clinicians. As observers, the reflecting team may help to ensure that consideration is given to all participants, including those with lesser influence, thus helping to ameliorate any potential alliance breaches. Therefore, therapy with multiple clients may be aided by multiple therapists with multiple perspectives. But care must also be taken with the use of reflecting teams. First, clinicians need to properly explain and prepare families when using reflecting teams to minimise any difficulties in transition points within the session. Second, while reflecting teams can present more positive interpretations and give a voice to quieter participants, they can also make authoritative endorsements or interpretations that may not fit with the experience of the family. Reflecting teams may therefore need to be cautious about the delivery and presentation of their ideas, and therapists may also need to give sufficient time for discussion with the family about reflecting team feedback.
By describing how other clinicians respond to particular situations in therapy, CA can contribute to promoting therapist self-reflection (Tseliou, 2013). One example of this comes from the studies on the role of children during interruptions. A number of articles describe how children can be ignored or spoken for by adults (Hutchby & O’Reilly, 2010; O’Reilly, 2006; Parker & O’Reilly, 2012). This (conceptually at least) conflicts with family therapy approaches that seek the input of all family members and recommend avoiding coalitions or alliances with individuals or sub-groups within a family (e.g., Kerr & Bowen, 1988; Selvini, Boscolo, Cecchin, & Prata, 1980). These CA studies show how this can be a difficult task when interruptions occur, and the therapist has to attempt to maintain some fairness and equality between those present. By being aware of these phenomena, clinicians can reflect on their own responses in similar situations and consider if their own practice aligns with their theoretical approach, preferences, and values.

Of the articles in this review, only seven reported the use of CA exclusively. The majority used CA in combination with other approaches such as discourse analysis or discursive psychology. While there are areas of convergence between these approaches their different methodological practices and standards can generate analytic claims that are different from those generated via CA, such as accounts for findings that appeal to psychological or social explanations. A discussion of these methodological issues are outside the scope of this article but can be found in (Ong, et al., 2019). However, a few points are worth mentioning here. In articles reporting a combination of analytic approaches there was not a clear description of how they were respectively applied nor how the findings were collated. It thus becomes unclear if CA is being utilised aberrantly or if authors are drawing on interpretations offered by other approaches. It is therefore important that when using various forms of discursive
analyses that authors are explicit about how they are each applied and combined in order to maintain transparency and analytic rigor. This review attempts to focus on the findings from a CA perspective, particularly in reference to sequential analysis, and limiting references to analysis through psychological states. We do not wish to undermine the importance of other discursive approaches but to instead describe what can uniquely be offered by CA. A recent special issue of the Journal of Martial and Family Therapy focussed on discursive methods in couple and family therapy research (Tseliou & Borcsa, 2018). The issue includes four articles analysing the same couple session, with each utilising a different discursive approach including CA, discursive psychology, discourse analysis and semantic analysis. This issue provides more detail about the relative application, possible findings, and practical value yielded by these different discursive approaches.

Limitations

This review is limited to published peer-reviewed research articles and may therefore have omitted other important research not published in this format.

CA cannot not provide a ‘how to’ of family therapy. CA research can identify interactional problems and ways that they are negotiated, but it is then up to therapists to critically reflect on how these findings are applicable in their own practice and theoretical frameworks.

This narrative review presents a synthesis of the main findings, and therefore excludes the analytic subtleties included in the individual research papers. This review thus represents some selectivity on the part of the authors to include the main directions and results of this area of research that inevitably excludes certain details.
Future directions

Much of the research on CA and family therapy has tended to focus on the behaviours of either clients or clinicians separately, with less focus on sequences of interactions (Ong, et al., 2019). CA has the ability to describe sequences of interaction and document the trajectories of different conversational practices, thus highlighting both smooth and problematic ways of navigating interactional projects (Stokoe, 2014). Future research may therefore consider longer sequences of interaction with attention to therapeutic or conversational difficulties, and their successful or unsuccessful negotiation. This could provide a more detailed understanding of the progression of therapy, and also provide some further guidance for therapists.

Much of the current research focused on sessions with only one therapist, with only a few studies including sessions with multiple therapists working as co-facilitators or in reflecting teams. The presence of multiple therapists is likely to have unexplored effects on, for example, how therapists manage and structure the session between them. These structural differences have potential unexplored implications for how a therapy session progresses and therefore warrant further investigation.

CA in other contexts has also been concerned with describing the overall structural organisation of interactions. For example, clear structures have been identified in certain healthcare settings (Robinson, 2013), but this has proved to be more difficult in psychotherapy sessions, possibly because psychotherapy and family therapy do not necessarily follow a repeated, transparently specific structure. However, there appear to be interactional tasks and projects that are completed in family therapy and this may be a way of describing structural organisation. One example of this comes from Couture (2006), who
proposes a description of how a therapist and family worked through impasse. It is possible that family therapy involves a series of such tasks, but further research is necessary to describe what these tasks and structures may be, and how they are successfully and unsuccessfully negotiated.

Summary

CA research examining interactions in family therapy is a new but growing area of investigation. Family therapy interactions involve multiple participants with differing goals and perspectives, providing a complicated and rich area for CA research. So far, CA researchers have described how families speak about each other, particularly in relation to blame and accountability, how therapists manage the therapeutic relationship when working through blame, impasse, and giving advice, and how reflecting teams have been utilised. These findings can make therapists more aware of these processes, and may help therapists reflect on their own work, and provide some guidance on how interactional problems may be negotiated. Further research could broaden the range of family therapy processes under analysis, providing clinicians with greater detail into the micro organisation of their interactions with families.

References


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Table 1. Summary of reviewed articles and main findings

<table>
<thead>
<tr>
<th>Reference</th>
<th>Summarised Aims</th>
<th>Stated Methods</th>
<th>Stated Sample (number of sessions, participants, context)</th>
<th>Main findings</th>
</tr>
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<tbody>
<tr>
<td>Couture (2006)</td>
<td>How therapist and family move beyond impasses.</td>
<td>Critical DA/CA</td>
<td>Single session.</td>
<td>Examined ‘forward moving conversations’ after impasse. Therapist used process of discovering different positions of family members and invitation to accept a middle ground. Therapist does this by ‘tentative yet strategic’ (p. 294) statements that are small shifts towards the middle, stopping clients from making extreme statements, offers extreme formulations that are tentative and contestable by family. Family responded with agreement or disagreement, offering information, qualified reformulations, partial uptakes, and listening responses (nods, acknowledgement tokens).</td>
</tr>
<tr>
<td>Couture (2007)</td>
<td>How participants address multiple parties.</td>
<td>DA/CA</td>
<td>As above.</td>
<td>How multiple parties are addressed in family therapy. Packaging talk/recipient design: “perturbed speech pattern” (p. 70) to display caution, invite shared curiosity. Collectively soliciting: Looking down and back and forth at all recipients, veiled address, addressing others as overhearers. Fishing: ambivalent responses to elicit responses by others. Performative advice-giving: Therapist models how to interact through ‘responsive...</td>
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<tr>
<td>Author(s)</td>
<td>Study Title</td>
<td>Methodology</td>
<td>Data Source</td>
<td>Key Findings</td>
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<tr>
<td>Couture and Strong (2004)</td>
<td>How families and therapists move beyond entrenched positions.</td>
<td>As above.</td>
<td>As above.</td>
<td>Similar findings to articles above. How therapist introduces topic, how family negotiate two-way small steps towards a middle ground. Argues that therapists can become more effective by attention to micro-details of conversation.</td>
</tr>
<tr>
<td>Couture and Sutherland (2006)</td>
<td>How the family therapist gave advice to a family.</td>
<td>As above.</td>
<td>As above.</td>
<td>Process of advice giving by therapist. 1. Strategic invitation to a possible middle ground, 2. Uptake by listener, 3. Advice given. Process can be repeated until there is uptake. Therapist uses downgrading practices such as hesitation, questions, sounding tentative and less directive to balance his authority with family’s autonomy.</td>
</tr>
<tr>
<td>Friedlander, et al. (2000)</td>
<td>How expert constructionist and narrative therapists respond to blame.</td>
<td>CA/Grounded theory</td>
<td>Data from 7 narrative/constructivist therapists.</td>
<td>Identified 3 main categories in responding to blame: ignoring/diverting, acknowledging/challenging, reframing. No uniformity in clients’ responses to therapist. Sessions sent in by therapists or</td>
</tr>
<tr>
<td>Study</td>
<td>Research Question</td>
<td>Methodology</td>
<td>Results</td>
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<tr>
<td>Hella, et al. (2015)</td>
<td>How participation of a relative effects the expression of paranoid experiences.</td>
<td>One session.</td>
<td>Psychiatrist, client and family member, negotiating treatment. When doctor and relative talk, client denies symptoms. When client was interviewed he is explicit about symptoms. Psychiatrist uses ‘recycling’ and ‘suspended return’ from earlier in conversation. Relative provides important information but at the risk of moral judgements and creating conflict.</td>
<td></td>
</tr>
<tr>
<td>Hutchby and O’Reilly (2010)</td>
<td>Explore relationship between therapist questions, speaker selection, and family members’ responses.</td>
<td>Multiple sessions 2 therapists, 3 families, 22 hours video.</td>
<td>Identified examples where parents responded when therapist directs a question to the child. Parents could answer before child has a chance to answer or after a pause, or parents asked an alternative question. Proposed two reasons: parents treat children as less-than-full-members, parents are responding to moral implications of therapist’s questions. Parents speak to therapists about bad behaviours of child and not themselves. This can create an accusation-denial sequence between parent and child with parents shifting between addressing therapist and child.</td>
<td></td>
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</tbody>
</table>
between turn-taking and person deixis.

<table>
<thead>
<tr>
<th>Muntigl and Horvath (2016)</th>
<th>How a therapist repairs alliance and how actions relate to therapy principles.</th>
<th>CA</th>
<th>First 5 minutes of demonstration session.</th>
<th>Session of a “master therapist”. Therapist repairs alliance at beginning of session by claiming to be nervous like the client, involves child (i.e. asks her a question) and uses humour. 2 therapists, mother, daughter. Early childhood intervention and education centre.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>O’Reilly (2005a)</th>
<th>Investigate the function of noises for children and adults.</th>
<th>Discursive psychology</th>
<th>Multiple sessions.</th>
<th>Noises used differently by children and adults. Children: orienting to topic, to attract attention and enter the conversation e.g. animal noises, repetition. 2 therapists, 4 families, 22 hours video. Adults: to authenticate and strengthen a point, provides sound imagery and emphasises severity of child’s actions. Only data from 3</th>
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<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Methodology</th>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O'Reilly (2005b)</td>
<td>How families present complaints about professional third parties and how therapists respond.</td>
<td>Discursive psychology</td>
<td>Multiple sessions.</td>
<td>2 therapists (also stated as 1 therapist), 3 families, 22 hours video.  Complaints to therapist about a third-party service. Common pattern of complaints: capsule (summary of the problem, gloss of complaint matter), then an expansion of details. Capsule gloss worked up by something as negative, moral fault is formulated, agency is assigned. Therapist responses: orientating to the unhelpfulness of complaints (redirecting to emotions or agency which is more amenable to therapy), orientating to the expectation of practical assistance (focussing on what will be helpful to discuss in current session), stating what the therapist cannot do.</td>
</tr>
<tr>
<td>O'Reilly (2006)</td>
<td>How children interrupt and how adults respond.</td>
<td>Discursive psychology/CA</td>
<td>Multiple sessions.</td>
<td>2 therapists, 4 families, 22 hours video. Three types: children try to interrupt during a delicate issue but are ignored and fall silent, children try to interrupt during delicate issues and are ignored but persist until a negative acknowledgement is given, children interrupt in a topic relevant way and are attended to.</td>
</tr>
<tr>
<td>O’Reilly (2007)</td>
<td>How family and therapist construct descriptions of ‘naughty’ child.</td>
<td>Discursive psychology</td>
<td>As above.</td>
<td>Term “naughty” has various levels of meaning: euphemistic with minimal assessment, general term with various meanings, non-technical and can be used by all, victimless in basic form but can be upgraded with emphasisers, complex with a variety of meanings depending on the person.</td>
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<tr>
<td>O’Reilly (2008)</td>
<td>To explore ways that therapists interrupt their clients.</td>
<td>Discursive psychology</td>
<td>As above.</td>
<td>When therapists interrupt adults they orient to the interruption and usually apologise. When therapists interrupt children they don’t apologise.</td>
</tr>
<tr>
<td>O’Reilly and Lester (2016)</td>
<td>How parents display their ‘good parenting’ and how blame is managed.</td>
<td>Discursive psychology</td>
<td>As above.</td>
<td>Identifies ways that parents say they are good parents: state that they are good parents, acting in the child’s best interests (with self-sacrifice), coping with the child’s behaviour in appropriate ways (and contrasting with inappropriate ways), appeals to science (biological explanations).</td>
</tr>
<tr>
<td></td>
<td>Passive disengagement (inattention), passive resistance (don’t attend to question or attempts to engage), active resistance (directly refuse to answer or comply). Expressing autonomy and evading adult impositions (requesting to cease session and not wanting to participate in future sessions).</td>
<td>White British Midlands, lower SES.</td>
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<tr>
<td>Therapists use acknowledgement and validation to create or reinstate engagement.</td>
<td>Therapists use acknowledgement and validation to create or reinstate engagement.</td>
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<tr>
<td>O’Reilly and Parker (2014)</td>
<td>How families talk about what is appropriate for children to hear.</td>
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<tr>
<td>Discursive psychology</td>
<td>As above.</td>
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<tr>
<td>People use informational (what is said), locational (where it is said and who is around), temporal (when), personal contextual (who said it and their role) factors to justify inappropriateness of a behaviour.</td>
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<td>But some contradictions as parents re-state inappropriate talk in front of the children, say derogatory things about children.</td>
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<tr>
<td>Therapist can propose that child’s presence may be problematic that allows parents to confirm thus maintaining engagement.</td>
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<tr>
<td>Discursive psychology</td>
<td>As above.</td>
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</tr>
<tr>
<td>Parents align with therapists by: tellings (general descriptions, specific descriptions – to build authenticity, derogatory descriptions), dispositional descriptions, active voicing (to demonstrate parents as reasonable and child’s responses as unreasonable), and evidencing (to substantiate claims). Children can deny accounts about them.</td>
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<tr>
<td>Therapist acknowledges that children are talked about and attempts to engage with them directly, also statements that therapist believes the parents.</td>
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<tr>
<td>Parker and O’Reilly (2013)</td>
<td>How therapists negotiate exit and re-entry to the session. How information from reflecting team is imparted and</td>
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<tr>
<td>CA</td>
<td>As above.</td>
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<tr>
<td>Successful exit from session to reflecting team involves: preannouncement, minimizing the amount of time taken, identifying/creating exit-relevant places (ERPs), and accounting for the departure.</td>
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<tr>
<td>Unsuccessful attempts to exit: attempting to leave at non-ERP and no terminal sequence (pre-closing announcement, candidate resolution, offered to return to subject on return), re-opening conversation.</td>
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</table>
Successful re-entry when therapist takes first turn, provides feedback from team and positive response from family, non-successful when family takes first turn on a different topic, therapist doesn’t refer to team.

<table>
<thead>
<tr>
<th>Pote, et al. (2011)</th>
<th>Develop understanding of vulnerability and protection in intellectual disability.</th>
<th>CA/Thematic analysis</th>
<th>4 video-taped sessions.</th>
<th>All family members used protection strategies of each other through topic switch, reversals of valence (negative to positive talk or vice versa), intensification of positive or negative talk, decentering (shift focus away from one person), continued engagement with topic (by therapist to actively address issues of protection).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stamp (1991)</td>
<td>Demonstrate the value of microanalysis for family interactions, what family means to each participant, to examine.</td>
<td>Microanalysis of conversation CA</td>
<td>Single session. 1:08 minute sequence.</td>
<td>Turn-by-turn account of a segment of interaction. Analysed with reference to interruptions, speaker selection, power relationships. Argue for usefulness of microanalytic approach for therapy and theory. Therapist, mother, son, and daughter.</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Methods</td>
<td>Data Description</td>
<td>Summary</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>Stancombe and White (2005)</td>
<td>How neutrality is produced and resisted.</td>
<td>Range of methods including CA</td>
<td>“Large corpus” – no other details.</td>
<td>Devices therapists use to maintain neutrality both in session and in private discussions. Change subject to save face or blame but runs risk of not hearing blamer who then repeats blaming statements. Re-formulations to package blame and propose therapist non-blaming versions of events, incorporating elements of opposing sides. Two paradoxes that the performance of neutrality reinforces blame and therapists’ impartial versions of family members are worked up through a series of practical-moral judgements.</td>
</tr>
<tr>
<td>Suoninen and Wahlstrom (2009)</td>
<td>How evolving interactional positions frame client identities. Describe identity constructions of fatherhood.</td>
<td>CA/DA/Social constructionism</td>
<td>6 sessions. 6 therapists. One family, parents, son, daughter. Finnish language with English translation.</td>
<td>Proposes notion of interactional positions, provides extracts from sessions and labels the interactional positions and identities present. Multiple identities of father were collaboratively constructed and re-constructed.</td>
</tr>
<tr>
<td>Sutherland</td>
<td>How a therapist</td>
<td>CA</td>
<td>Single session.</td>
<td>Therapist invites collaboration by tentative formulations using pauses, restarts, inhalations,</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>and Couture (2007)</th>
<th>used his expertise with family’s preferences.</th>
<th>Therapist, young person, parents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show usefulness of CA in investigating therapy interactions.</td>
<td>selective listening, attention to weak agreements, and inviting family shifts in meanings.</td>
<td>Father starts using similar techniques to therapist.</td>
</tr>
<tr>
<td>Father starts using similar techniques to therapist.</td>
<td>Post hospital admission.</td>
<td></td>
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</tbody>
</table>

**Viaro and Leonardi (1983)**

To describe “rules of the game” in family therapy.

<table>
<thead>
<tr>
<th>CA</th>
<th>10 sessions.</th>
<th>Describes rights and responsibilities of participants in family therapy sessions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 therapists, students and experienced.</td>
<td>Therapist has the exclusive right to: decide what topic is discussed, who will speak at any moment, interrupt a turn, stop a conversation, put questions, sum up and make organisational glosses.</td>
</tr>
<tr>
<td></td>
<td>Family therapy centre</td>
<td>Family members have duty not to interrupt and right not to be interrupted (except by therapist), can propose themes for discussion and act as therapist’s interlocutor (but therapist</td>
</tr>
</tbody>
</table>
Rules are not explicitly stated but family members conform to the rules through reinforcement from therapist. Therapist can accept or censure rule violations.

<table>
<thead>
<tr>
<th>Williams and Auburn (2015)</th>
<th>CA</th>
<th>5 families, one session from each.</th>
<th>How talk is transformed in main session and reflecting team.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3 therapists (1 male and 2 females).</td>
<td>In the main session: the deletion of negative and introspective positions, the selection of aspects that place the individual in relation to others, and transformation to establish the basis of positive connotation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Systemic family therapy service.</td>
<td>Reflecting session: negative descriptions contextualised positively, adult descriptions of difficulties were omitted, and children’s viewpoints emphasised, relationship descriptions privileged over individual explanations, develop and extend hopeful content.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Can provide voice to unspoken parts of client, or parts client is not willing to express to family members directly.</td>
</tr>
</tbody>
</table>
Records identified through database searching
(n = 41)

Records after duplicates removed
(n = 31)

Records meeting criteria
(n = 11)

Studies included in qualitative synthesis
(n = 25)

Additional records identified through other sources (journal and citation search)
(n = 14)

Records excluded
(n = 20)