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A Discourse Analysis of how Identity and Social Context are Talked About in Family Therapy

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Abstract

With increasing acknowledgement that families' lives are embedded in wider societal, cultural and power contexts, therapists have been encouraged to attend to these contextual factors within the therapeutic interaction. The aim of the study was to analyse the transcripts from three audio-recorded family therapy sessions following a micro-macro analytic approach to discourse analysis. The findings of this discursive analysis highlighted three 'topics of talk' through which families discursively construct and enact their identities at multiple levels of social, cultural and political context. Analysis of the micro-features of the talk attended to the rhetorical strategies, such as interruptions and topic changes, that therapists and families use to construct discursive objects and positions. The macro-analysis highlighted the discursive reproduction of normative culturally and socially embedded assumptions and narratives, such as normative gender roles and individualising accounts of mental health difficulties. The analysis also offered a unique way of attending to how therapists' positional power and therapeutic techniques can unknowingly shape the course of the discursive exchange and impact collaborative practice. Implications for clinical practice are considered, such as therapist reflexivity, and for training programmes and service development, particularly the value of discursive research in bringing a contextual consciousness to these areas.

Keywords: *discourse analysis, family therapy, identity, social context, discursive methodologies, therapist reflexivity*

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Introduction

In this chapter, I set the context for my research on the topic of how identity and social context are talked about in systemic family therapy. To ground the reader, I first detail my epistemological and ontological stance, before positioning myself in relation to the research. I then offer an overview of the topic area, summarising relevant theoretical and research literature to situate the reader in the wider context of the topic area.

Personal and Philosophical Context of the Research

Epistemological and Ontological Stance

In adopting a qualitative approach in this research study, it is important to outline my assumptions about what there is to know (ontology), and how I have come to know about it (epistemology) (Willig, 2019), as these will guide and shape the claims I make in relation to this research about how identity and social context are talked about in systemic family therapy.

In considering my ontology, or what exists and makes up the world, I believe that social "reality" (a contested term and therefore I use inverted commas) is created in our social interactions with others, and that language is a key constituent of these interactions (Gergen, 1999; Vygotsky, 1979). My epistemological position, or the assumptions I make about the nature of knowledge (such as what possibilities it creates and limits, and the processes through which it is acquired or not acquired) seem best aligned with social constructionism. This theoretical framework is concerned with *how* knowledge is constructed, rather than its "truth" and attends to

the social process of this generation (Harper, 2012). Social constructionists therefore are critical of "taken for granted" knowledge and draw attention to the historical and cultural specificity of our understandings of the world and thus, its continual process of reconstruction (Burr, 2015). Language is a key focus in this approach and is viewed as constructive, performative and generative of identity, relationships and institutions (Gale, 2010). Social constructionist thought is also interested in the ways constructions or claims about "reality" are imbued with power and how this serves interpersonal and societal functions.

This epistemological position speaks to me in particular because I see words and language as what shapes our individual and social identities, which itself is context bound and brought about through social interaction. I am interested in how people construct meaning around events using the discursive resources available at the time (Willig, 2013). In taking this epistemological stance, I adopt the assumption that all human experience is mediated by language, and thus that all social and psychological phenomena are constructed in one way or another. This assumption sets the scene for the research that follows.

Situating Myself in Relation to the Research

I have felt very connected to the concepts of identity and social context in differing ways over my life. Growing up in the Republic of Ireland I was acutely aware of the division of the island into Northern (part of the United Kingdom) and Southern (the independent Republic of Ireland) distinct regions on religious and nationalist grounds, following years of struggle for Irish independence from British rule, and that

my experience would not necessarily be the same if I lived across the border. In this context, my awareness of how history, power and social and political institutions shape identity and the context of day-to-day life began to develop.

Later, undertaking a sociology degree, I was drawn to post-modern and social constructionist ideas around race, such as critical race theory that recognises “race” as a political and social construct (Carbado & Roithmayr, 2014); feminist conceptualisations of gender as performative (Butler, 1990); and discourses around sexual health and sexual rights (Connell, 2007). My first experience of political activism in support of Irish women’s reproductive rights and later, same sex marriage rights, happened around this time. These experiences highlighted to me the role of wider societal and institutional discourses in normalising patriarchal and heteronormative structures and values, but equally important, the power of those that are oppressed and marginalised to resist.

Embarking on my psychology training, in the United Kingdom (UK), I felt a disconnection from these wider contextual issues in the therapy approaches and models that I was learning and practicing. In discovering critical psychology and community psychology approaches, I found solace in how they centralised the role of power, moving practice outside the clinic room, and taking action for social justice (e.g., Psychologists Against Austerity, organisations such as MAC UK that deliver multi-level, co-produced interventions with young people to create change in social environments). Furthermore, I also found a connection to systemic family therapy theory and ideas that form part of clinical psychology training, particularly the social

constructionist phases of systemic thinking, in which the sociocultural and political contexts that bring meaning to the lives of families are incorporated into therapy, and the centralising of language and discourse in this process. I was encouraged by the concept of *self-reflexivity* (Burnham, 1993) and developing this skill to better notice when my assumptions were at play in my practice. Through this process however, I also noticed a limitation to my self-reflexivity. How could I really be sure that I am noticing when I am making assumptions? What is telling me, in my interactions with service users, that my practice is or is not collaborative and meaningful to them? These questions and personal experiences have shaped this current research project on understanding how identity and social context is talked about in systemic family practice.

Positionality and Reflexivity

The aforementioned experiences, values and context, along with other aspects of my identity as a White- Irish, heterosexual, middle class, cisgender woman living and working in a Western cultural context, will influence all aspects of the research process that follows. To practice reflexivity, I will be continually reflecting on my social and personal history and the cultural, social and political context in which this research is occurring. Throughout the chapters that follow I will refer to a reflexive research diary (Appendix L) in which I document moments of reflection or detail reasons for certain decisions to support the reader in considering my positionality and its impact on the research process.

Insider/Outsider Researcher

It has been widely discussed how the binary approach to insider/outsider positionality is limiting and simplistic and that these positions should be considered more fluidly and, on a continuum (Dwyer & Buckle, 2009). In the context of this research, my position feels in some "space between" insider and outsider positions (Dwyer & Buckle, 2009, p. 60). For example, while systemic theory and practice is a core competency model in the Doctorate in Clinical Psychology programme (meaning, I need to fulfil a range of systemic therapy competencies over the course of my training placements), at the end of my training, I will not be a qualified systemic family therapist. This 'outsider' position as a trainee clinical psychologist may have implications on how potential family therapist participants respond to invitations to recruitment, perhaps questioning my place to enter the systemic family therapy space as a researcher with a different core training. I do, however, also share other aspects of identity and context with systemic family therapists in terms of working within the same national health systems and services and working therapeutically with families. I believe this insider/outsider position will enable me to approach this research in a way that moves flexibly between these positions and expand rather than limit the interpretations I make. Nonetheless, it is pertinent to acknowledge that I approached this research in my capacity as a trainee clinical psychologist.

Terminology

Relevant terminology that will be used throughout the thesis is described in Table 1. The terms defined below are not intended to be exhaustive but rather my intention is to introduce the key concepts to orient the reader.

Table 1

Relevant Terminology

Identity	While still treated as a "slippery" and "blurred" concept (Wetherell, 2010, p.3), in the broadest sense identity can be conceptualised as the social positioning of self and others that is negotiated and emerges in interaction and is largely co-constructed (Kleinke, Hernández, Bos, 2018).
Social Context	How human activity emerges from and is organised within ecosystems (e.g., family, community, culture) and how these enable meaning making processes and create or limit opportunity (Knudson-Martin, McDowell & Bermudez, 2017).
Discourse;	Language associated with a system of meanings e.g., the discourse of education could include the terminology and theories associated with education; a group of related segments that provide a language for talking about a particular topic at a particular moment in history (Taylor, 2013).
Dominant discourses	Systems of knowledge that define or regulate what can be 'known'. From a post-modern, Foucauldian perspective, such systems of knowledge are often produced through powerful institutions (e.g., government) (Foucault, 1986).
Post Modernism	An intellectual and cultural movement emerging in the mid-20th century characterised by the key claim that reality cannot be

	objectively understood or represented but rather reality is socially constructed through language (Gergen, 2001).
Power	In its postmodern conceptualisation, power is oppressive but also productive, operating in relations between people, institutions and norms, through language. Power and knowledge are inherently linked (Foucault, 1980).
Intersectionality	The idea that race, class, gender, sexuality, ethnicity, nation, ability, and age are not mutually exclusive entities, but they are reciprocally interacting and constructive phenomena that shape complex dynamics of social inequalities (Crenshaw, 1989, 2013).
Narratives	Stories that individuals and families construct to make sense of their experiences, including their identities and relationships (Epston & White, 2023).
Cultural; Social; Political systems	Systems of meaning that describe shared beliefs, values, norms and practices; organised networks or relationships, communities and institutions; structures, institutions and processes through which structural power and oppression is exercised through legal systems, ideologies and policies (Knudson-Martin, McDowell & Bermudez, 2017; McDowell et al., 2005).

Current Social and Political Context in the UK

Given that the central focus of this research concerns identity and social context and pertains to how these concepts are talked about in family therapy in the UK, it feels important to briefly locate the reader to the UK's current social and political landscape at the time of writing. Recent political polling suggests waning support for the incumbent Labour Government from 44% in June 2024 to 24% in April 2025 (POLITICO, 2025), and rising support for the populist far right party, Reform UK, from

14% in June 2024 to 29% in April 2025 (POLITICO, 2025). Divisive public sentiment around issues of immigration and trans and disability rights dominate the media, alongside reports of rising racism and xenophobia. Regarding racism and xenophobia, recent figures indicate that hate crimes on religious grounds increased by 25% during 2023/2024, with half of total hate crimes (52%) recorded as racially or religiously aggravated offences (Home Office UK, 2024). Considering these together, a complex and evolving social and political context seems to surround the UK population.

The March 2025 Welfare Bill brought cuts to welfare payments (personal independence payments) for disabled people, affecting 700,000 families already living in poverty across the country (Ryan, 2025, The Guardian). Poverty is deepening with figures from 2022 indicating that 3.8 million people (including one million children) are unable to meet their basic physical needs of staying warm, dry, clean and fed (Joseph Rowntree Foundation, 2025, UK Poverty). The political and media messaging propagating the idea that immigration needs to be “controlled” to protect against low wages and save the economy abounds (Goodfellow, 2024, The Guardian) despite evidence to the contrary (The Migration Observatory, 2023). The April 2025 Supreme Court Ruling that the legal definition of a woman should be based on biological sex has been regarded as a violation of human rights by members of the LGBTQ+ community and LGBTQ+ charities warn of this ruling leaving members of the trans community in crisis and at risk of further marginalisation and discrimination (Okundaye, 2025, The Guardian).

There is now substantial evidence that social inequality, including poverty, discrimination and marginalisation has significant impacts on mental health (Burns, 2015; Cromby et al., 2013; Garratt, 2022, House of Commons Library). A recent report from mental health charity MIND on race and mental health found that people from ethnic minorities in the UK are less likely to access the mental health care, with some reasons cited as; a lack of trust in the "establishment"; stigma and discrimination from health care services and the Eurocentric framing of mental health (MIND, 2024). Some of the areas of change identified to remedy this included creating support services that are more holistic, intersectional and in partnerships with communities. For other marginalised groups such as people who identify as trans, support services for this community have experienced increasing demand yet research suggests that trans people have been found to experience health inequalities across all health services (Fish et al., 2021). LGBTQ+ communities are also at increased risk of unemployment, violence, discrimination and homelessness (Parsons, 2023, Novarmedia). This brief situating of the UK political and social landscape captures how the social context can have significant influences on how people understand their identities, have consequences for mental health, and how experiences are understood.

Background to the Research Area

In the remainder of this chapter, I will outline the research relevant to this topic area. I will start by situating the concepts of identity and the social context in wider psychological theory and in systemic family therapy theory. The adoption of the social constructionist perspective and the role of language in systemic theory is then

considered, before elaborating on how this epistemological stance has formed the foundation for more contextual and social justice oriented systemic frameworks. The literature around the practice of self-reflexivity in exploring how power and societal and cultural norms enter the therapeutic space will be discussed, before considering the use of discursive methodologies to study systemic family therapy process. I conclude the chapter with a rationale for an extensive review of how the social context has been explored in psychotherapy research and practice.

Situating Identity

Conventional psychological conceptualisations of identity have been understood as a process of developing a "real" or "stable" form of identity based upon early relationships that progresses through a series of psychosocial stages across the lifespan (Erikson, 1968). Social identity theory of Tajfel and Turner (2001) focused identity conceptualisations on how individuals identify themselves based on group membership. Social identity theory posits that individuals define their identities along the social dimension (such as membership in social groups) and the personal dimension (unique personal characteristics that distinguish an individual from others) and that these become more or less salient depending on the context (Howard, 2000). While both these conceptualisations recognise the social and historical context of identity development, these theories have also been criticised for describing identity as something that becomes stable over time, pointing to the constant flux of postmodern societies and suggesting that the idea of personal "sameness" constrains understandings of identity (Schachter, 2004).

Postmodern perspectives consider identity as socially constructed and created through language and in interaction with others (Foucault, 1986; Gergen, 1994; Goffman, 1969), such that individual identity is the by-product of social forces occurring in context (Howard, 2000). From this perspective, identity can be seen as dialogical and relational and constructed through social, cultural and political discourses both current and historical (Howard, 2000; Neimeyer, 2002; Sampson, 1993). More recently, conceptualisations of identity as multifaceted, intersecting and in relation to power and privilege have been elaborated (e.g., Burnham et al., 2008; 2012; Collins, 2015; Crenshaw (2013). Such perspectives are aligned with critical and community psychology approaches as well as post-modern waves of systemic psychotherapy. These ideas have highlighted how aspects of identity may be visible (e.g., my racial identity is White Irish) and voiced (by stating it here) while others may be invisible (e.g., a health condition that is not visible) and unvoiced (by not stating it here). Additionally, these ideas capture the complex ways in which aspects of identity, such as race, gender, socioeconomic status, sexual orientation and ability intersect and manifest unique sources of power, privilege, discrimination and disadvantage (Collins, 2019; Curtis et al., 2020). The intersecting of these aspects of identities has been developed into the acronym 'Social GGRRAAACCEEESSS' (Burnham, 2012) with the intention to offer a framework for therapists for developing awareness and skilfulness in responding to aspects of difference (and sameness) in their work with individuals and families, and a curiosity in considering issues of power, oppression and connection (Birdsey & Kustner, 2020; Nolte, 2017;). The 'social' prefix (suggested by Roper-Hall, 1998) is proposed to represent the socially constructed nature of identity differences.

The social graces framework is now readily incorporated into systemic psychotherapy and clinical and counselling psychology training and supervision (Divac & Heaphy, 2005; Nolte, 2017; Partridge & McCarry, 2017; Totsuka, 2014) to support trainees and practitioners to have conversations about identity salience and the power of identities in relation to themselves and to the service users, and their influence in the therapy and in the world outside the therapy room (LiVecchi and Obasaju, 2018).

Partridge and McCarry (2017) have used the social graces in their training to address inequality and to call for social-political action among therapists in how they challenge dominant social discourses that privilege some and marginalise others (e.g., certain groups being "hard to reach" rather than services being hard to reach due to systemic and institutional racism). Within the wider psychological theory then, identity has shifted from something considered more rigid and final, to, through the post-modern lens, something more fluid, contextual and dynamic.

Situating the Social Context: Perspectives from Psychology Theory

The impact of the social context on individuals, relationships and communities was represented in the ecological approaches of Bronfenbrenner (1977, 1981) which emphasises how psychological development is shaped by multiple social, cultural and political contexts. This ecological model identifies five systems with the individual at the centre: microsystem (immediate environment e.g., friends, family); mesosystem (relationships and interactions between microsystems), exosystem (government policy, community resources) and macrosystem (broader societal and cultural forces). The model suggests that across these multiple levels of systems there is a bidirectional

relationship where people impact, and are impacted by, multiple levels and systems (LiVecchi & Obasaju, 2018). This ecological perspective has been used by community psychology approaches as a framework for understanding systems of structural inequality and oppression and to identify actions in line with social justice principles (Evans et al., 2017).

Critical psychology approaches have also called out traditional psychological theorising that individualises distress through encouraging solutions to be found exclusively within the self or through medicalised constructs (Cromby et al., 2013; Harper, 2016; Patel, 2010). Approaches such as the Power Threat Meaning Framework (PTMF) that attempts to conceptualise an alternative to psychiatric diagnosis have also emerged. The PTMF centralises how power operates in everyday life and the links between distress and social contextual factors such as poverty, inequality, social exclusion as well as abuse, trauma and neglect (Johnstone & Koupa, 2019). It also draws attention to the role of ideological power in how it shapes language, meanings and agendas (Johnstone et al, 2018). In this way, psychological theory and practice is increasingly considering the intersection between social identities and socio-contextual systems that individuals inhabit.

Situating the Social Context: Perspectives from Systemic Theory

Several family therapy 'phases' have emerged over time, each aligning themselves with different theoretical positions and subsequently influencing how each understands and frames the issues that families bring to therapy. Early approaches were rooted in the positivist ideas of the time (1950's-1970's) which viewed the family

as a fixed, self-correcting system and the therapist as the 'expert' outside observer (Rivett & Buchmuller, 2018). More recently, the 'social constructionist' phase (1985-present day) centralised language and power, recognising how oppressive, dominant cultural discourses maintain problems in the family system (Dallos & Draper, 2005). From a social constructionist position, meanings are seen as socially located rather than individual and meaning is guided by the language that is used. Systemic thinking and practice that is grounded in social constructionist theory therefore allows distancing from the idea that mental health problems are individualised, decontextualised phenomena.

Within the systemic field, there has been a call for therapists to address the role of culture and collective meaning making, societal systems and power dynamics more intentionally in their work with families (McDowell et al., 2019; Krause, 2022). Therapists are encouraged to attend to the deleterious effects of prejudice, racism, and oppressive societal systems and practices (Chin et al., 2022; Falicov, 2005). McDowell et al. (2019) has proposed the theoretical framework of 'third order thinking' as a means of embracing an understanding of families and therapists as part of therapeutic processes that are embedded in societal and cultural contexts and power dynamics, and the interaction of a family within these. This framework encourages therapist self-reflection on their own social locations, reflection on the systems of oppression in society (e.g., economic and social inequality) and how societal power hugely influences what therapists look for and see, and in how we engage with families. Similarly, Knudson-Martin, McDowell and Bermudez (2017) have coined the phrase

'sociocultural attunement' to describe a family therapy practice that is aware and responsive to the intersections of societal context, culture and power and positioned to promote equity. The authors argue that therapists must be accountable for how their practices replicate or transform social inequities and to consider how clinical discourse reinforces some social systems at the expense of others. They argue that it is only in this way that clinical practice can be linked to social action and social justice. Furthermore, Afuape and Kerry-Oldham (2022) argue for a more radical systemic approach that draws on the liberation psychology principles of Spanish psychologist, sociologist, theologian and Jesuit Priest, Ignacio Martín Baró. The authors describe this approach as "inherently systemic" in its focus on the impact of the social context in people's everyday lives and in the circular links it makes between action and reflection, or 'praxis', and how only in this interaction can liberation emerge (p. 25).

Thus, in incorporating cultural diversity and social justice frames, family therapists can expand on how they see families by recognising and incorporating into therapy the sociocultural and political contexts that bring meaning to the lives of the families with whom they work (Roy-Chowdhury, 2022). It has been suggested however, that incorporating conversations about such aspects of identity into clinical practice is more complicated than it might seem, as therapists themselves are a part, and products of, social and cultural processes that tend toward universalising, status quo, and privilege (Chin et al., 2022; Roy-Chowdhury, 2022). Pakes and Roy-Chowdhury (2007) describe how the material that informs the lives of therapists are often

unconscious or partly conscious. They ask, “how can we be reflexive about aspects of our culture and knowledge that we are not fully conscious of?” (p. 269).

Self-Reflexivity

The adoption of postmodern and social constructionist frameworks has brought the context of the therapists’ lives more central to the therapy process. For example, therapists are encouraged to think about how they are influenced within the therapeutic system, and how their own familial, personal, and societal experiences and contexts impact on their practice (Totsuka, 2014). This awareness, or self-reflexivity (Burnham, 1993) can allow the therapist to reflect on their own beliefs, prejudices and emotions and use them in therapy to enhance the therapeutic relationship. Therapists are encouraged to integrate issues of difference and social context such as (but not limited to) gender, culture, race, class and sexuality into therapy. In adopting this cultural diversity frame, Falicov (2005) explains how this positions therapists to question their uncritical imposition of mainstream cultural values as well as their personal and conceptual preferences. In addressing racism (including structural racism) specifically, it has been proposed that therapists interrogate the impact of racism in their own lives and relationships (Chin et al., 2022), the privilege and oppression associated with their racial identities, as well as the history and current context of race relations in society (McDowell et al., 2005).

The importance of self-reflexivity in working with cultural difference in therapy has been referred to as “cultural reflexivity” that requires a sensitivity to the ways cultural identities and meanings are negotiated and the processes through which we

engage with “otherness” (Daniels, 2011, p. 105). Systemic research has highlighted that families that experienced the therapeutic alliance (or relationship between therapist and family) as safe and trusting were more likely to talk about cultural differences (Pandya & Herlihy, 2009). Teh and Lek (2018) found that therapists’ who were the same nationality as the family (in this case both British Chinese) supported engagement and had a positive impact on the therapeutic alliance, however despite their similarities, the therapist’s self-reflexivity was still crucial to avoid assumptions being made about the family’s experience. Collins’ (2021) study of how African Caribbean immigrants in the UK communicate their experiences demonstrated how colonial history is key to these stories and she suggests the need for a “self-reflexivity plus” from therapists in which they recognise the relevance of socio-political context, including racism, to the lived experience of black people (p. 122). Researching intercultural couples therapy, Ugazio et al. (2022) suggests that experiences relating to racial discrimination and racial difference can go unvoiced and argue for therapists to address race so that narrated and lived lives do not exist in polarity.

This research highlights the ways systemic practice is grappling with how the therapeutic process can focus on the wider societal and cultural contexts within which it is embedded, and the importance of therapist self-reflexivity and action in this process. As Daniels (2011) summarises: “the ability to communicate across difference involves risk taking and extending ourselves beyond our cultural comfort zone; in fact, these very processes bring forth information about what *are* ‘taken for granted’ comfort zones” (p. 105).

Watts-Jones (2010) conceptualised “location of self”, a practice in which the therapist initiates a conversation with a family about similarities and differences in key aspects of their identity, such as gender, class, religion and race, and proposes that this opens up space for a discussion around how these may influence the therapy process. This practice resonates with ideas of self-reflexivity as it encourages the practice of talking about identities, power, privilege and oppression. The author proposes that oppression pervades through our thoughts and values via institutional and cultural practices and therefore encourages therapists to be curious about how oppression shows up in every family. These ideas appear particularly relevant in recognising how the identities of both the therapist and the individual or family have a myriad of meanings, and power, privilege and oppression attached to them, which affect the individual’s or family’s experience of distress and the therapist’s ability to fully understand the distress (LiVecchi & Obasaju, 2018).

Social Constructionism and the ‘turn to language’

Within the field of systemic therapy, social constructionism is the theoretical frame within which many systemic practitioners and researchers describe their practice (Georgaca & Avdi, 2007; McNamee & Gergen, 1992; Smoliak & Strong 2018; Tseliou et al., 2021). As previously outlined, this epistemology invites a view of identity and experience as socially and relationally constructed through language. Discursive methodologies, located within a social constructionist epistemology, have been used to study the content of texts or talk-in-interaction (e.g., therapeutic dialogue) that occurs in family therapy and is gaining more interest in the field (Teseliou & Borcsa,

2018). Discursive methodologies mostly include conversation analysis and discourse analysis including discursive psychology approaches (Edwards & Potter, 1992; Potter, 2012) and post-structural informed discourse approaches (Parker, 2015). Discursive psychology approaches are considered similar to conversation analysis in which conversation is a form of social activity and phenomena are discursively constructed in ordered and patterned ways (Tseliou, 2017). Post-structural informed discourse analysis focuses on the historical and political context of language use and, drawing on the ideas of Foucault (1986), attends to the power of discourses in their normative and oppressive form (Teseliou & Borcsa, 2018). Furthermore, other researchers (Lee at al., 2018; Roy-Chowdhury, 2007; Wetherell, 1998) have argued for a synthetic approach to discourse analysis that attends to micro-level features of social interaction as well as the wider macro-level social and cultural ideological repertoires that are drawn upon to construct particular versions of reality (Augoustinos, 2013).

Discursive Approaches

Discursive methodologies have been proposed to bring about an understanding of therapy process based on language use and cultural meanings rather than psychological approaches (Madill & Barkham, 1997) and draws into discursive focus how socially available dominant discourses shape the therapeutic encounter, thereby linking the micro-processes of interaction with the wider societal macro-processes (Georgaca & Avdi, 2007). Discursive approaches in their more critical forms (e.g., Foucauldian discourse analysis) can incorporate issues of ideology and power. Discursive approaches have also been suggested to enhance therapist reflexivity –

bringing attention to how meaning is constructed, the effects of their interventions, when assumptions are being enacted and social cultural discourses that may constrain meaning making and collaboration. Discursive methodologies can be applied to interview data (e.g., interviewing a family about their experience of talking about culture in systemic therapy) or they can be applied to "naturally occurring data" such as recordings of naturally occurring therapy sessions.

Discursive research in family therapy

Change process. The majority of discourse analytic studies focus on the conversational exchange between a therapist and an individual or family, the discursive strategies and techniques used by the therapist, and how they impact on the individual's or family's accounts. Discursive researchers have studied various aspects of the therapeutic processes. Studies have looked at the range of discourses employed by families and how, over time, families move from being aligned to one discourse to employing several discourses more flexibly by the end of therapy, indicative of what authors propose as positive therapeutic change (e.g., Diorinou & Tseliou, 2014; Frosh et al., 1996).

Discursive research has also analysed the processes of negotiation within therapy around blame and accountability, often in the process of therapists attempting to move families towards more relational understandings of their difficulties (Burck et al., 1998; O'Reilly & Parker, 2014; Patrika & Tseliou, 2016; Stancombe & White, 1997; 2005). This research around blame and responsibility highlights the complex role of the therapist who actively co-constructs meanings in the discursive exchange, and in

this way calls to question the idea of therapist 'neutrality' (Avdi & Georgaca, 2007). It has also been argued that systemic practitioners' discursive contributions can unintentionally become part of further blaming and risk therapeutic rupture (Patrika & Tseliou, 2016).

The discursive construction and deconstruction of pathologising narratives has also been studied, particularly the process of shifting between internalised discourses to alternative and less totalising discourses (Avdi, 2005; Dallos & Hamilton-Brown, 2000, Mudry et al., 2015), or introducing a normalising narrative (Karatza & Avdi, 2011). Some of these studies have also highlighted the negotiation of agency in this process through the discursive de-centring of dominant medicalised discourse enabling a gradual repositioning of the object - in which the individual's agency is replaced by their diagnostic label - to subject – in which they have a voice (Avdi, 2005; Karatza & Avdi, 2011). These studies again highlight the discursive and relational process in how therapists can invite clients to challenge and examine dominant discourses that are limiting their lives. It has however been highlighted that this requires discursive collaboration with individuals and families, incorporating their meaning making into the process (Mudry et al., 2015; Sutherland & Strong, 2011). Furthermore, the importance of attending to the values and systems of meaning that are embedded in these therapeutic negotiations has also been highlighted, for example, what is considered to constitute 'change' in therapy and how this can also represent social and cultural assumptions (Avdi & Georgaca, 2007).

Power. From a social constructionist perspective, power is perceived as contingent on social processes and is an omnipresent force embedded across all social practices. Foucault (1972, 1992) argued that power and knowledge are inseparable and that people are disciplined through relations of 'knowledge/power' in the form of normative social and linguistic practices that shape and constrain people's actions and descriptions of themselves and the world (Sutherland, 2007). In adopting this post-modern conceptualisation of power, family therapists have prioritised a collaborative positioning in relation to individuals and families (Sutherland, 2007). From this standpoint, the therapist takes a position of participant-observer where they co-create meaning and understanding with people in therapy while also adopting a "not-knowing" (Anderson & Goolishian, 1992) position where they also position themselves as being led and informed by the individual or family (Ong et al., 2023). This positioning has been critiqued because although the therapist's intention is to present their knowledge as relative and contestable (Sutherland, 2007), because power is present in all social roles, structures and in the very discourses that position therapy as helpful – such as that which says therapists are "experts" - power persists (Ong et al., 2023). Therapists have been found to exercise power through selecting topics to discuss (Ong et al., 2021), asking questions (Vall et al., 2018) and offering suggestions or interpretations (Liu et al., 2013; Vaughan, 2004). However, these studies also highlighted how there are nuances in this exercise of power, specifically discursive techniques employed by therapists that downplay their power such as use of tentative or flexible language or incorporating the family's language into their reformulations. Ong et al. (2023) argue that even when therapists attempt to rebalance the power

through longer periods of listening to families and limited responses, power is still being displayed as they are facilitating their agenda of encouraging the family's elaboration.

Smoliak and Strong (2018) suggest that family therapists practice can be enhanced through a "resistance-informed" lens by attending to the ways individuals and families may rhetorically resist. This resistance could be characterised in terms of the families attempting to exercise power in the therapeutic encounter, for example, Avdi (2016) found that a couple rejected the therapists' formulation of them as resourceful, while O'Reilly and Lester (2016) described how parents may discursively resist being portrayed as inferior parents. These studies suggest that power is discursively enacted by both therapists and families and in implicit and explicit ways. It also highlights the tension between the therapist stance as collaborative actor on the one hand, and expert "knowers" on the other hand.

Normative Social and Cultural Assumptions. Systemic researchers are increasingly highlighting the importance of acknowledging the social context and how wider social and cultural discourses enter the therapeutic space, particularly the capacity of language to reproduce normative cultural assumptions in therapy. For example, studies of cross-cultural therapy have found that despite best intentions from therapists to explore subjective meanings families bring to therapy, dominant (Western) discourses can be imposed without awareness and associated values assumed (Pakes & Roy-Chowdhury, 2007; Roy-Chowdhury, 2003; Singh, 2009). Pakes and Roy-Chowdhury (2007) found that constructions of culture elaborated by the

therapist were in terms of artificial dichotomies or an easily definable set of values and actions and how this has a limiting effect in the therapeutic conversation. Research exploring sexism in heterosexual relationships demonstrates how sexism is reproduced through everyday social interaction, such as a husband claiming to enact egalitarianism in his relationship with his wife yet also claiming normative gender roles and how these subtle enactments of sexism can evade the notice of therapists due to the entrenched nature of stereotypical gender norms (Sutherland et al., 2017).

The complexities of power and difference in systemic therapy have been highlighted in the discursive research of Roy-Chowdhury (2006) in relation to the therapeutic relationship, specifically how aspects of difference are manifested in beliefs, attitudes and biases exposed through speech. Singh (2014) in a study with White systemic trainers and trainees found that Whiteness was an 'invisible norm' in which the White therapist did not think about themselves as a race. Their findings suggest that 'race-anxiety' linked to the discourse of 'political correctness may communicate to families that race cannot be addressed but they argue that White systemic therapists must take responsibility for raising issues of race and work on self-reflexivity in relation to their White identity.

Conclusion

In this chapter I have first considered how identity and social context has been conceptualised across psychological and systemic theory and practice. I have detailed the movement toward a more contextualised, power conscious perspective, in which reflecting and formulating about the social context, power and oppression is not

enough, and the call for more liberatory and transformative approaches that link reflection and action. The “turn to language” is then discussed and the contribution of these discursive methodologies in highlighting various aspects of therapeutic process, including change processes, the dynamics of power and how normative socio-cultural assumptions enter the therapeutic interaction.

The research, theoretical frameworks, and the current social and political context introduced in this chapter highlight the importance of contextualising individuals’ and families’ identities and their experiences in the social context in which their lives play out. To date, the field lacks an overview of how the social context has been considered qualitatively in psychotherapy research about psychotherapy practice. An extensive review of qualitative studies on this topic could inform understanding of how these areas have been addressed, and set the foundation for future research, training and practice. Furthermore, qualitative research has the potential to highlight the nuances of the therapeutic process that may otherwise remain obscure, and for advancing knowledge by allowing for thick descriptions from participant perspectives.

Systematic Literature Review (SLR)

In this section I will systematically review the relevant literature, describing how the search was conducted and the studies identified, and outline the inclusion and exclusion criteria that determined selection of the studies. The findings of the review will be summarised, their quality assessed using Tracy's "big tent" criteria (Tracy, 2010), and a thematic synthesis of the studies presented. I will offer conclusions and future recommendations, before finally outlining the rationale, aims and questions of the current research.

The aim of the systematic literature review (SLR) was to answer the following question:

> *What do we currently know about how the social context has been considered qualitatively in psychotherapy research about psychotherapy practice?*

In answering this question, the SLR endeavours to systematically search, appraise and synthesise the research relating to the research question, and thereby provide an overview of the literature in this area to scaffold and set up the current study. It will follow a rigorous approach that allows for replication (Siddaway et al., 2019) and will present literature from both peer reviewed and relevant empirical studies relating to how the social context has been addressed in psychotherapy research and practice.

Methodology

Preliminary Scoping

A preliminary scoping search on how the social context has been addressed in psychotherapy research and practice was conducted (on PROSPERO and Google Scholar) to identify whether the same, or similar systematic reviews had been conducted. When no existing systematic reviews on the same topic were identified, I began the literature searching process. To organise my search strategy, I used the Sample Phenomenon of Interest Design Evaluation Research Type (SPIDER, Cooke et al., 2002) tool (Table 2), recommended for studies using qualitative synthesis, and for review teams with limited resources and time (Methley et al., 2014). A Search Planning Tool (Appendix A) was used to consider potentially relevant search terms, and several pilot searches were conducted to determine the most useful and necessary terms (Appendix B).

Table 2

SPIDER Tool

Sample	Phenomenon of Interest	Design	Evaluation	Research Type
Psychotherapy practitioners and psychotherapy service users	Social Context; Identity	Studies derived from observation and self-report	Discourses/ Language Beliefs Experiences Views	Qualitative

Search Strategy

The first search was conducted on 12th July 2024. The final search was completed on 20th November 2024. The four databases used were *APA PsycARTICLES, CINAHL, Scopus* and *Pubmed*. These databases were chosen due to them including research in the fields of psychology, behavioural and life sciences, allied health, and being multidisciplinary spanning across the social sciences. Email alerts were set up for any studies meeting the search terms. Table 3 introduces the search process and rationale. The searches took place on the following dates: Scopus (31.08.2024); CINAHL Plus (07.10.2024); PsycARTICLES (28.10.2024) and PubMed (20.11.2024).

Table 3

Summary of Search Process

Process	Reflections
The literature search was conducted between July 2024 and November 2024.	Searches were initially not limited in timeframe however as scoping searches progressed, it was decided to limit searches to the last 10 years to capture the recent socio-political contexts shaping psychotherapy research and practice.
Search terms were identified through reading literature on the topics of psychotherapy and social context broadly. In this process common terms used in titles and abstracts were noted.	Discussions with supervisors, colleagues and contacting authors in the field supported this process (e.g., deciphering between how one defines 'social context' and how certain terms are often used interchangeably such as ethnicity and culture). Through my own self-reflexivity, I considered what search terms I was being drawn to and why, and how this impacted on the studies that may or may not be included. Discussions with supervisors helped me notice bias. The decision to include specific qualitative methodologies as search terms was made due to this resulting in a larger return of articles ('qualitative' alone resulted in only 300-600 articles in some databases which was deemed too low a number to ensure relevant articles were captured).
Boolean operators (*AND*, *OR*) were used to combine search terms for each concept. Truncation tools (e.g. cultur*) were applied to ensure possible variations of words were captured.	Conversations with the librarian around use of these tools supported this process of broadening, narrowing and layering search terms and concepts to help refine search terms.
Time was spent exploring how the search terms and the use of filters worked in practice on the different databases.	Each database worked differently, and the addition or omission of certain terms made searches more or less effective. (e.g., filtering by subject area (psychology) in Scopus, reduced returned articles from 3886 to 253).
The final search strategy was decided upon when the combination of identified search terms and filters returned particularly relevant articles.	Given the limited resources available and the timescales of the project, only papers published in English and in the past 10 years were included.

The search terms were split into three concepts that mapped onto the SLR question. The databases were searched using the terms shown in Table 4.

Table 4

Search Terms

Concept 1 – relating to the social context		**Concept 2 – relating to psychotherapy practice**		**Concept 3 – relating to qualitative research**
"cultur*"		"family therapy		"discourse analysis"
OR "social class"		OR "systemic psychotherapy*"		OR "conversation analysis"
OR "class"	AND	OR "couple* therapy"	AND	OR "discursive psychology"
OR "identit*"		OR "clinical psychology"		OR "grounded theory"
OR "gender"		OR "counselling psychology"		OR "ethnography"
OR "rac*"		OR counselling		OR "thematic analysis"
OR "intersectionality"				OR "narrative analysis"
OR "cultural reflexivity"				OR "action research"
OR "reflexivity"				OR "case study "
				OR "interpretative phenomenological analysis"

Screening and Eligibility Criteria

The combined database searches yielded 906 papers. The Covidence Systematic Review tool was used to screen the papers. Covidence detected and removed 166 duplicate articles. Following duplicate removal, all titles and abstracts were reviewed alongside the inclusion and exclusion criteria (Table 5) by myself and a

second reviewer[1]. Discrepancies were related to differing conceptualisations of the *social context* (e.g., gender experience). Discrepancies were discussed and resolved through discussion of individual papers in relation to the inclusion/exclusion criteria and detailing the decision-making process that the reviewers went through. This process resulted in 25 articles selected as potentially relevant. An additional 2 articles were selected via Google Scholar. A total of 27 papers were therefore read and 12 studies were determined to fit the inclusion criteria and included in the review. Therefore, a total of 12 studies were included in the current review. A full breakdown of the process is shown in Figure 1.

Table 5

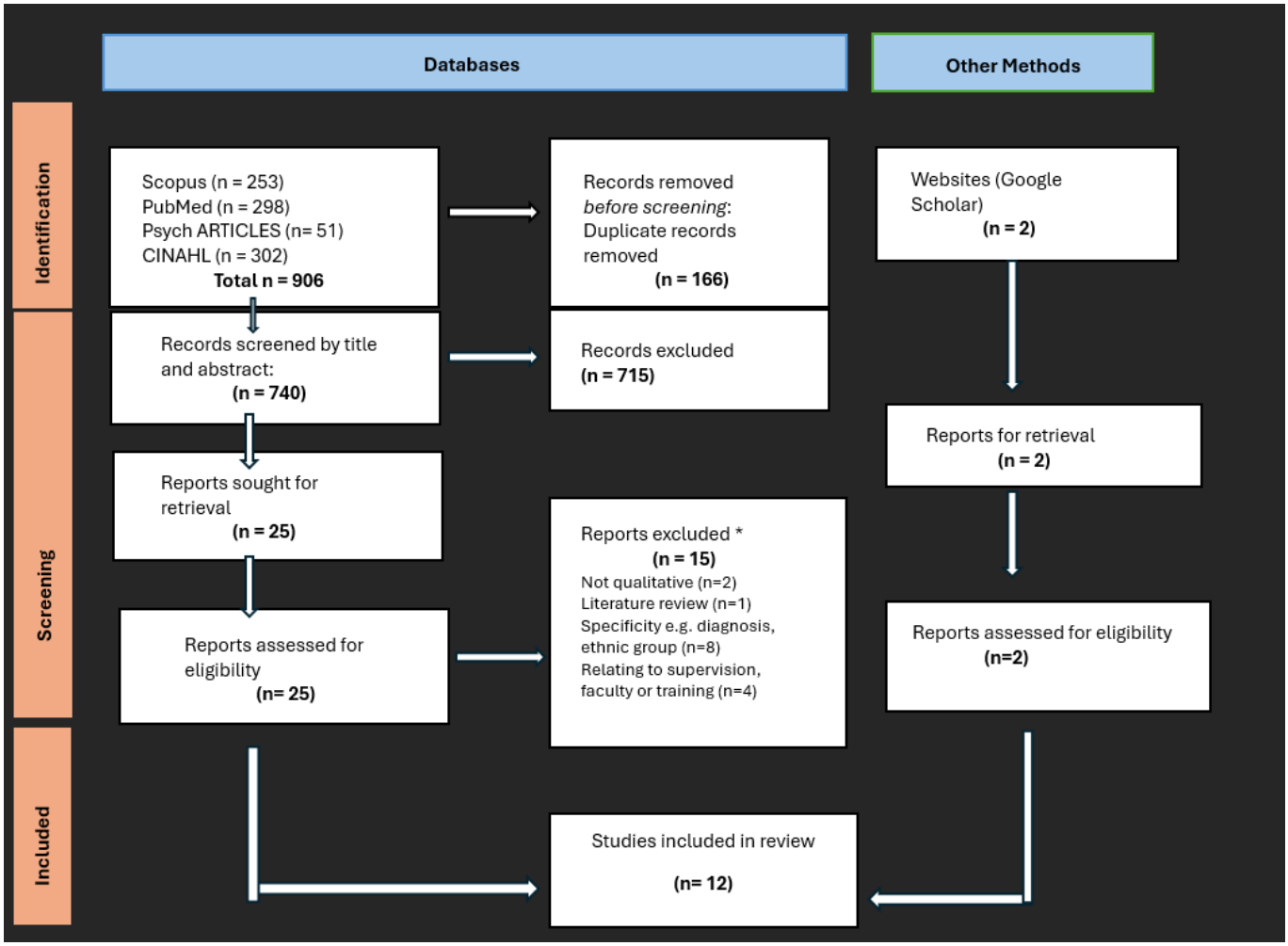
Eligibility Criteria

Inclusion Criteria
Relating to psychotherapy practice and considering issues relating to social context
Peer reviewed and relevant empirical studies
Published in English
Studies from any geographical location
Participants are therapists or therapy users
Published since 2014

Exclusion Criteria
Not concerning psychotherapy practice/ research and issues relating to social context
Not published in English
Quantitative or mixed methods design
Published before 2014
Full text not available online
Relating to teaching or supervision processes
Literature Review / Theoretical Paper
Focus on a specific cultural group
Focus on a specific mental health difficulty

[1] Mr. Simon Taylor, Trainee Clinical Psychologist, University of Hertfordshire.

Figure 1. *PRIMSA Flow Diagram*



Initial scoping of the literature indicated that refining the search to the UK context would limit results and therefore the decision was made to include studies from any geographical location. The reasoning behind the exclusion of studies published before 2014 was to ensure that the reviewed literature reflected psychotherapy research and practice within the recent and current socio-political climate, along with better reflecting the latest conceptual and theoretical perspectives within the psychotherapy field. Studies focusing on trainee therapists, diagnosis (e.g., psychosis) and the experience of one cultural group solely (e.g., Mexican-Heritage) were excluded due to these topics being the focus of the study rather than social contextual issues more specifically. Finally, studies were only included if they were written in English, due to time constraints of the doctoral research process and the financial means required for translation unavailable.

Findings

Overview of the Papers

In total, twelve studies were included in the systematic literature review. All papers were peer-reviewed articles published in academic journals. The context for the studies included systemic psychotherapy (family therapy or couples therapy) or individual psychotherapy. The research was undertaken in the UK (six studies), USA (three studies) and Canada (three studies). Data for the studies was obtained through observational means (video or audio recordings): Cadenhead and Fellin, 2023; Kalaydjian et al., 2024; Knudson-Martin et al., 2021; Lee et al., 2018; Sametband & Strong, 2018; Trevino et al., 2021); self-report (semi-structured interviews): Cotrell-Boyce, 2021; Fox et al., 2017; Yon et al., 2018; Young & Mooney, 2024; or both: Zhu et al., 2023. The decision to include both data from

observational means and interviews was made to allow for increased depth and breadth of research included in the review, capturing both in-session therapeutic dialogue as well as the experiences that may be narrated post-hoc about how the social context has been addressed in research about psychotherapy practice. Discursive analysis and thematic analysis were the most common data analysis methods used, with two studies (Fox et al., 2017 and Knudson-Martin et al., 2021) employing Grounded Theory analysis. Participants included therapists and clients. Demographic information provided indicates that there was ethnic and cultural diversity across participants. Two studies included adolescent participants (Lee et al., 2018 and Sametband & Strong, 2018), with all other study participants adults. No study provided information on the socioeconomic status of the participants. Sexual orientation was only defined in couples therapy studies, with all couple participants in heterosexual relationships. The theoretical underpinnings of the reviewed literature were grounded in social constructionist and interpretivist perspectives.

A Note on Terminology

While 'service user' is the preferred term to describe those that access mental health services and has been used in preceding chapters, the discussion of the SLR studies will use the term 'client' as this was the terminology used in the studies themselves to refer to people accessing mental health services or therapeutic support services.

Table 6

Summary *of Studies used in the Review*

	Author/ Year/ Country	Aims	Sample	Methodology	Key Findings	Strengths (+) & Limitations (-)
1	'Breaking the 'culture of silence': exploring therapist perspectives of culturally sensitive systemic psychotherapy in contested sociopolitical contexts- a Northern Ireland case study'. Young & Mooney, 2024 Northern Ireland (NI), UK	To explore the practice of cultural sensitivity via qualitative interviews with systemic psychotherapists.	Five systemic psychotherapists in community services.	Inductive thematic analysis of semi-structured interviews.	Themes: • The 'culture of silence' • Whiteness as an invisible norm • Theoretical paradoxes influencing therapist reticence • Perceived benefits of exploring cultural differences and lived experience of racism The authors call for contemporary therapist practice to go beyond concepts such as cultural sensitivity and move toward a third order change approach in which therapists are accountable for how their practice replicates or helps transform social inequities.	**+** Pioneering research in a region (NI) often ignored with the UK. **+** Recognition of an overlooked increasing portion of the NI population (Black and ethnic minoritised communities) **+** Calls for experiential learning grounded in trainee systemic therapists' local socio-demographic context. **-** Researcher identities may have biased findings/analysis **-** Small sample size **-** Sample comprised of senior therapists' rather than more mixed sample including junior/ more recently qualified therapists.

2	'Immigrant family members negotiating preferred cultural identities in family therapy conversations: a discursive analysis'. Sametband & Strong, 2018 Canada	To better understand how preferred cultural identities are negotiated discursively among immigrant family members during family therapy sessions.	Nine families and their family therapists in a community family therapy clinic.	Discursive Analysis of family therapy sessions and follow up semi-structured qualitative interviews with each family member.	Preferred cultural identities were negotiated by: 1. Foregrounding cultural identity ascriptions 2. Resisting misrecognition 3. Recognising preferred cultural identities Therapist reflexive questions or offering understandings, can elicit family members to position preferred cultural identities and how family members can conversationally misrecognise cultural identities.	**+** Draws attention to the taken for granted micro-interactions of therapeutic interactions around cultural identity **+** Offers insights into how therapists can support families in appreciating each other's preferred identities. **-** Due to the nature of discursive analysis, the same data may be interpreted differently by another researcher.
3	'Cultural reflexivity and the referral problem: A discourse analysis of three initial sessions of intercultural couple therapy'. Cadenhead et al., 2022 UK	To analyse the strategies of power used by therapy participants to promote their preferred construction of the referral problem, focusing on the intersections of gender, psychopathology and culture.	One therapist-client dyad: systemic psychotherapist and inter-cultural couple in a community family therapy clinic.	Discourse analysis of a single case study.	"Themes of talk": 1. Cultural misunderstanding 2. Cultural continuity versus individual agency 3. Cultural difference/similarity 4. Tolerance and compromise The construction of the referral problem is situated in wider gendered and cultural systems of meaning making and normative therapeutic ideas and can be reproduced through language.	**+** Provides an in-depth exploration of discursive processes. **+** Highlights how discursive patterns play out in wider sociocultural discourses. **-** Did not include same sex or non-binary couples. **-** 'Intercultural' was narrowly defined as one Western. partner and one non-Western partner.

4	'Joining revisited in family therapy: discourse analysis of cross-cultural encounters between a therapist and an immigrant family' Lee et al., 2018 Canada	To critically reflect on how the joining process in family therapy is3 navigated discursively through the cultural notions and subjective positions of the therapist and the family.	One family therapist and one mother-daughter dyad in an outpatient family therapy clinic.	Discourse analysis of family therapy session transcripts.	The same discursive joining techniques were found to both facilitate joining with the family and to preclude further exploration of the families' cultural views.	**+** Detailed and rich analysis of therapeutic dialogue **+** Analysis was cross-checked by both authors to reduce sociocultural biases **+** Multiple methods of analysis and theoretical lenses allowed for triangulation of the data. **-** Analysis of transcripts only therefore missing nuances in speech and non-verbal cues.
5	'Social GRRRAAACCCEEESSS in intercultural couple therapy: A semantic analysis' Kalaydjian et al., 2024 UK	To explore how intercultural couples negotiate meanings using the Social Grrraaaccceeesss Model and the concept of semantic polarities.	Two Intercultural couples and two systemic psychotherapists.	Semantic analysis and Thematic analysis of therapy transcripts.	The dominant semantic polarities in both couples were *belonging* and *freedom*. Thematic analysis identified themes of gender, culture and religion (couple 1) and racism, (couple 2) when relating the semantic analysis to the Social GGRRAAACCEEESSS. Each therapist played different roles in giving voice to issues around diversity, holding responsibility to facilitate these conversations.	Strengths not stated in the paper. **-** Cases presented were 'primed' with the expectation of talking about difference.
6	'Addressing White privilege in family therapy: A discourse analysis' Cotrell-Boyce, 2021. UK	To explore clinicians' thinking in relation to White privilege and to question how this lens might impact their therapeutic practice.	Four systemic family therapists.	Foucauldian Discourse Analysis (FDA) of four semi-structured interviews.	Participants described White privilege as: a product of colonialism; constructed opposing discourse of White Privilege; expressed 'race-anxiety'.	Strengths and limitations not stated in the paper.

7	'Gendered patterns of interaction: A Foucauldian discourse analysis of couple therapy' Sutherland et al., 2016 Canada	To examine how gendered power is produced and reproduced through repeated patterns in couple therapy.	Three sets of couples and their therapists.	Foucauldian Discourse Analysis of audio recorded systemic couple therapy sessions.	Gendered discourses supported subordinating patterns of interaction and maintained patriarchal power norms within couples. Call for a feminist/ discursive lens to identify how gendered inequalities are produced in couples' interactions.	Strengths and limitations not stated in the paper.
8	'Windows of Cultural Opportunity: A Thematic Analysis of How Conversations Occur in Psychotherapy' Trevino et al., 2021 USA	To examine the ways in which cultural conversations emerge (drawing on the Multicultural Orientation Framework, MCO) during the first psychotherapy session, and how clients and therapists engage in these cultural conversations.	Twenty-two therapist client dyads at a University Counselling Centre.	Reflexive thematic analysis of individual psychotherapy transcripts.	Therapeutic conversations included several "windows of opportunity" through which clients and therapists approached cultural opportunities Therapists varied in how they engaged in cultural opportunities – attending or not attending to cultural opportunities.	**+** Examples of how cultural factors can emerge and be engaged with in practice. **+** Statement of researcher positionality. **-** Cultural values impacted by the sample's strong influence from the Christian church. **-** Limited inclusion of intersecting identities **-** Access to transcript data only. **-** Potential for researcher biases to influence the data.
9	'A discourse analysis of cultural humility within counselling dyads' Zhu, Isawi & Luke, 2023 USA	To (1) identify discursive techniques and strategies associated with the enactment of Cultural Humility (CH) within counselling sessions. (2) explore how the identified linguistic features used to enact	Six therapist-client dyads at university clinic.	Interactional sociolinguistic discourse analysis (IS-DA) of individual counselling sessions and follow up interview transcripts	Therapists used a range of socio-linguistic strategies (positioning, reinforcement and repetition and use of pronouns) that corresponded to cultural humility dimensions.	**+** Collaborative researcher-participant research design. **+** Analytic triangulation through use of an external IS-DA auditor. **-** Small sample size. **-** Trainee counsellor. participants may not have a developed CH understanding.

		CH impact the counselling process				
10	'Sociocultural Attunement to Vulnerability in Couple Therapy: Fulcrum for Changing Power Processes in Heterosexual Relationships' Knudson-Martin et al., 2021 USA	To clarify the clinical processes involved when therapists seek to facilitate a more equitable power balance in couples therapy.	Nine couples and 12 therapists at an Education and Counselling training clinic.	Qualitative Constructivist grounded theory of video recorded Socio-emotional Relationship Therapy (SERT) sessions.	Sociocultural attunement (SCA) to vulnerability was the key clinical process in enacted by therapists and bring voice to client lived experiences around the connections between vulnerability and power.	**+** Contributes to the evidence base around expressions of vulnerability within intimate partner relationships. **-** Did not study long term outcomes or client perceptions of their clinical experiences. **-** Limited diversity of sample
11	'The role of cultural factors in engagement and change in Multisystemic Therapy Fox et al., 2017 UK	To explore the experiences of Multisystemic Therapy among ethnic minority carers in relation to presenting issues, engagement and change in therapy.	Seven caregivers who had completed Multisystemic Therapy (MST) in a community MST service.	Qualitative Grounded theory of individual semi-structured interviews.	Carers' engagement was supported by therapists adopting a culturally sensitive approach and feeling culturally understood by their therapist.	**+** First published qualitative study on MST **+** First published study on ethnic minority users' experiences of MST. **-** Excluded ethnic minority carers born in the UK and non-English speaking carers. **-** Did not include accounts of those that refused / did not complete intervention **-** Voice of young person missing

12	'Challenging core cultural beliefs and maintaining the therapeutic alliance: a qualitative study' Yon et al., 2018 UK	To look at how therapists explored a family's cultural belief system alongside developing a strong therapeutic relationship.	One family and two systemic family therapists at a Child and Adolescent Mental Health Service (CAMHS).	Thematic analysis of semi-structured interviews.	Cultural sensitivity and awareness of cultural differences/ similarities was facilitated through therapist authenticity and 'cultural reflexivity' and supported engagement with the family.	**+** First known study to investigate alliances with families from minoritised backgrounds and addressing both therapist and client perspective. **+** Multifaceted account of experiences by combining qualitative methods. **+** Diverse cultural backgrounds of families, therapists and researchers. **-** Small sample meant 'data saturation' was not met. **-** Findings focus on therapists' strengths as opposed to areas for change or improvement.

Quality Assessment of the Studies

The quality of the studies included in the review was assessed using Tracy's 'big tent' criteria (Tracy, 2010), offering a framework that conceptualises different qualitative methodological paradigms (Tracy and Hinrich, 2017). While there are several quality appraisal tools available (e.g., CASP, 2018; Madill et al, 2000), Tracy's (2010) criteria were felt to be the best fit given all the studies included in the systematic review adopted different qualitative methodologies. In this model, high quality research is marked by eight criteria: worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics and meaningful coherence (Tracy & Hinrich, 2017). Studies which met six or more of the eight criteria were rated 'high'. Table 7 details the quality scorings of each study.

Table 7

Quality Appraisal of the SLR using Tracy's 'Big Tent' Criteria

#	Author(s) / Year	Worthy Topic	Rich Rigor	Sincerity	Credibility	Resonance	Significant Contribution	Ethical	Meaningful Coherence	Overall Quality rating
1	Young & Mooney 2024	✓	✓	✓	✓	✓	✓	✓	✓	High
2	Sametband & Strong 2018	✓	✓	✓	✓	✓	✓	✓	✓	High
3	Cadenhead et al. 2022	✓	✓	✓	✓	✓	✓	✓	✓	High
4	Lee et al. 2018	✓	✓	✓	✓	✓	✓	✓	✓	High
5	Kalaydjian et al. 2024	✓	✓	✓	✓	✓	✓	✓	✓	High
6	Cotrell-Boyce 2021	✓	✓	✓	✓	✓	✓	✓	✓	High
7	Sutherland et al. 2016	✓	✓	✓	✓	✓	✓	✓	✓	High
8	Trevino et al. 2021	✓	✓	✓	✓	✓	✓	✓	✓	High
9	Zhu, Isawi & Luke 2023	✓	✓	✓	✓	✓	✓	✓	✓	High
10	Knudson-Martin et al. 2021	✓	✓	✓	✓	✓	✓	✓	✓	High
11	Fox et al. 2017	✓	✓	X	✓	✓	✓	X	✓	High
12	Yon et al. 2018	✓	✓	✓	✓	✓	✓	✓	✓	High

Worthy Topic. Worthy topics are regarded as relevant, timely, significant, interesting or evocative. All studies were considered to meet these criteria in differing ways: focusing on methodology, study motivation and perspective. Considering methodology first, several studies used observational data (rather than self-report) coupled with discursive approaches to analysis, providing new thinking about how sociocultural discourses operate linguistically in therapy (Cadenhead et al., 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sametband & Strong, 2018; Sutherland et al., 2016; Zhu et al., 2023;). Kalaydjia et al., (2024) provided a novel and interesting analysis of the Social GRRRAAACCCEEESSS and intersectionality through a psychodynamic lens, while Knudson-Martin et al., (2021) provided empirical evidence for the concept of 'sociocultural attunement' (Knudson-Martin, McDowell & Bermudez, 2019) that previously had only been considered theoretically. In regard to study motivation and perspectives, specific social and political landscapes influenced studies of Fox, Yon, Cotrell-Boyce (2021) and Young and Mooney (2024) including: barriers in access to, and underrepresentation of ethnic minority groups in, mental health services (Fox et al., 2017 and Yon et al., (2018); political movements e.g., Black Lives Matter (Cotrell-Boyce, 2021); and contested socio-political contexts (Young & Mooney, 2024). These studies offered fresh perspectives on debated social and political issues such as 'hard to engage' populations, naming race and racism, and structural inequalities.

Rich Rigor. This criterion is demonstrated through methodological thoroughness, referring to; sufficient, abundant, appropriate and complex description of research design, sample, context; the theoretical constructs drawn upon; and accounts of the data collection and analysis processes. All studies broadly met these

criteria, however some demonstrated more methodological thoroughness than others. Seven studies did not explicitly state the sampling method employed, a further two studies did not state the research design, and only half of the studies stated their epistemological stance. Several studies offered further elaboration on their choice of design, for example, Zhu et al. (2023) chose interactional sociolinguistic discourse analysis (IS-DA) due to a core feature of this approach being to capture culture and value diversity between speakers. Cadenhead & Fellin (2023) and Lee et al. (2018) chose a single a case-study design (from a large body of collected data) as this maximised suitability of the data for the topics under investigation. Nearly all studies provided detailed descriptions of the research context, including the type of therapy service from which the data was derived, the specific therapy approach(s) offered and associated geographical and demographic information. Descriptions of theoretical constructs and frameworks that informed the studies' motivation, design and analysis were detailed across all studies. The theoretical concepts described offered a variety of conceptual lenses, including discursive (feminist, Foucauldian sociolinguistic), psychodynamic, systemic and multicultural and sociocultural frameworks. Finally, analysis processes were sufficiently described across all studies. Studies by Cottrell Boyce (2021) and Cadenhead & Fellin (2023) stated following Willig's (2003) six stages of discourse analysis but did not detail these stages or how they were applied to the data. Yon et al. (2018) used Braun and Clarke's (2006) Thematic Analysis guidelines but did not detail the process involved beyond identification of initial codes, followed by identification of themes.

Sincerity. Sincerity relates to transparency around the research process (including challenges and mistakes) and evidence of self-reflexivity of the researchers.

All but one paper (Fox et al. 2017) attempted to offer elements of sincerity, with some demonstrating more comprehensive consideration than others. Three papers (Knudson-Martin et al., 2021; Yon et al., 2018; Young & Mooney, 2024) shared the study motivation, self-reflexive processes and limitations of the research study. In regard to self-reflexivity in these three papers, Young & Mooney (2024) and Yon et al. (2018) offered insights into how their biases may have impacted on the research process and analysis, while Knudson-Martin et al. (2021) provided useful information on researcher positionality, however, none commented on how this impacted the research process. Three studies detailed self-reflexive processes, the implications of these on the research process, and limitations of the research study (Cadenhead & Fellin, 2023; Trevino et al., 2021; Zhu et al., 2023). Lee et al. (2018) considered several limitations of the study and stated that self-reflexivity was enacted through a reflexive research log, however no details of these reflections or how they impacted the research process were provided. Two studies shared details of self-reflexivity only (Cottrell-Boyce, 2021; Sutherland et al., 2016). None of the studies stated challenges or mistakes that occurred during the research process.

Credibility. Credibility of qualitative research is achieved through the trustworthiness, plausibility and consistency of the research findings and are marked by thick description, triangulation or crystallisation, multivocality and member reflections. All studies were deemed credible, particularly in terms of including detailed excerpts and quotations, or 'thick descriptions' (Geertz, 1973) from data in the findings or results section of the papers. This allowed for the findings of the studies to be shown to the reader, rather than told to the reader (Tracy & Hinrich, 2017). Several studies achieved triangulation through combining methods, for example

Kalaydjian et al. (2024) used both semantic analysis and thematic analysis while Yon et al. (2018) used thematic analysis and incorporated the Interpersonal Process Recall (IPR) into the interviews. Cadenhead & Fellin (2023) and Sutherland et al. (2016) approached the analysis of discourse at both the micro and macro analytical level, adding depth and breadth to their findings. Multivocality was achieved in different ways; theoretically, by drawing on multiple theories and approaches to inform analysis (Lee et al, 2018; Kalaydjian et al., 2024; Cottell-Boyce, 2021; Sutherland et al., 2016); including participants in the research process such as in Zhu et al. (2023) where the researchers offered participants the opportunity to react and refine research interpretations of the data; and including the voice of multiple stakeholders such as in studies where data from both therapy clients and therapists were analysed. Finally, trustworthiness was referred to through use of supervision or co-author meetings to reflect on research process and analysis (in attempts to control for biases), transcribing audio or video data into written form and practices of triangulation and multivocality.

Resonance. Resonance refers to how the research resonates with the reader and meaningfully impacts the audience. All findings were deemed to resonate with a wider audience, largely due to practical applications that can be made from the research findings to clinical practice. All studies demonstrated the importance of interpreting the findings in their context, rather than generalising findings to all contexts or groups.

Significant contribution. This refers to the influence the research has from a variety of perspectives: methodological, conceptual, theoretical, heuristic, moral or practical level. Several studies brought heuristic contributions: Young and Mooney (2024) and Sametband & Strong (2018) on the complexities of navigating cultural

identity in therapy in previously unexplored (Northern Ireland) and minimally explored (immigrant) populations. Fox et al. (2017) expanded knowledge on Multisystemic Therapy in interventions with ethnic minority carers and Trevino et al. (2021) in the application of the Multicultural Orientation framework to observational data (rather than self-reported data). Considering conceptual contributions, Sutherland et al. (2016) complicated existing ideas around the role of family therapists in how they navigate gender in therapy while also proposing the need for a feminist discursive lens alongside a systemic lens when working with gender in systemic psychotherapy. Lee et al. (2018) extends the systemic concept of 'joining' in family therapy to a "culturally saturated" (p. 174) construct and Kalaydjian et al. (2024) offers an interpretation of the Social GGRRAAACCEEESSS (Burnham, 1992, 2012) through a psychodynamic lens. Finally, some studies brought practical contributions: Cadenhead & Fellin (2023), through application of the findings to practice, proposes discourse analysis as a practice development tool within the field of systemic psychotherapy, with particular relevance for developing self-reflexivity. Cottrell-Boyce's (2021) examination of White privilege in a sample of family therapists highlighted the implications of White privilege in therapy and the need for White therapists to practice 'relational risk taking' to avoid complicity and maintenance of White privilege.

Ethics*.* This criterion ensures that the research has been conducted in an ethical manner throughout. Two studies did not state that they underwent ethical review and approval (Fox et al., 2017 and Knudson-Martin et al., 2021) however Knudson-Martin et al. (2021) does state that consent to participate was gained and Fox et al. (2017) acknowledges that pseudonyms were used to protect anonymity of the participants. All others stated that their studies gained ethical approval from an

ethical board. In addition to stating ethical approval for the research, four studies also stated gaining consent from participants, while two studies stated approval, consent and processes for maintaining participant anonymity. Kalaydjian et al. (2024) refers to participant awareness that their data would be used for research purposes and cites a larger study where more information on sampling and data processing can be found. Similarly, Lee et al. (2018) and Knudson-Martin et al. (2021) cites larger studies from which the current study is a part of, but do not explicitly guide the reader toward those studies for more information on ethical procedures. Studies by Zhu et al. (2023) and Yon et al. (2018) offered further considerations regarding relational ethics, specifically how the possibility of coercion in recruitment process was managed (Zhu et al., 2023) and how the status and power of the therapist participant may have biased the feedback that client participants provided (Yon et al., 2018). No study included in the SLR commented on ethical considerations relating to exiting the research.

Meaningful coherence. This criterion refers to whether the research achieves what it is set out to achieve, and whether the methods and procedures used fit the stated goals. All studies appeared to meet the research aims they stated, in an appropriate manner where aims, findings and interpretations fit meaningfully together and contribute to the evidence base.

Data Synthesis

Thematic synthesis was used to synthesise the papers. This approach uses thematic analysis to analyse and synthesise qualitative studies and it is deemed an appropriate method to analyse data in primary qualitative research (Thomas & Harden's, 2008). Guidelines for using thematic analysis as a qualitative methodology were applied predominantly to the findings or results section of the twelve papers, and in some cases the discussions section, adopting the flexibility of Thomas and Harden's approach where they noted that sometimes 'findings' appear in other sections which were not always reported the same way in the text. When familiarisation with the findings of each paper was achieved following several readings, Thomas and Harden (2008) three step process was applied to synthesise the studies' findings: coding text line-by-line; developing descriptive themes; generating analytic themes. The coding process enabled the translation of concepts from one study to another or if necessary, developed new codes (Thomas & Harden, 2008). An example of the text coded from two studies under the code "theory versus practice" were:

"Getting it wrong I think is a constraint and the fear of getting it wrong" (Cottrell-Boyce, 2021, p.150)

"Despite the ostensible acknowledgement of the critical importance of culture and ethnicity to a person's lived experience and worldview, paradoxically four of the five participants expressed reluctance to raise the issue of cultural, racial, or ethnic experience or beliefs with families, seeing this as exercising power over clients and determining the therapeutic agenda" (Young & Mooney, 2024, p. 16).

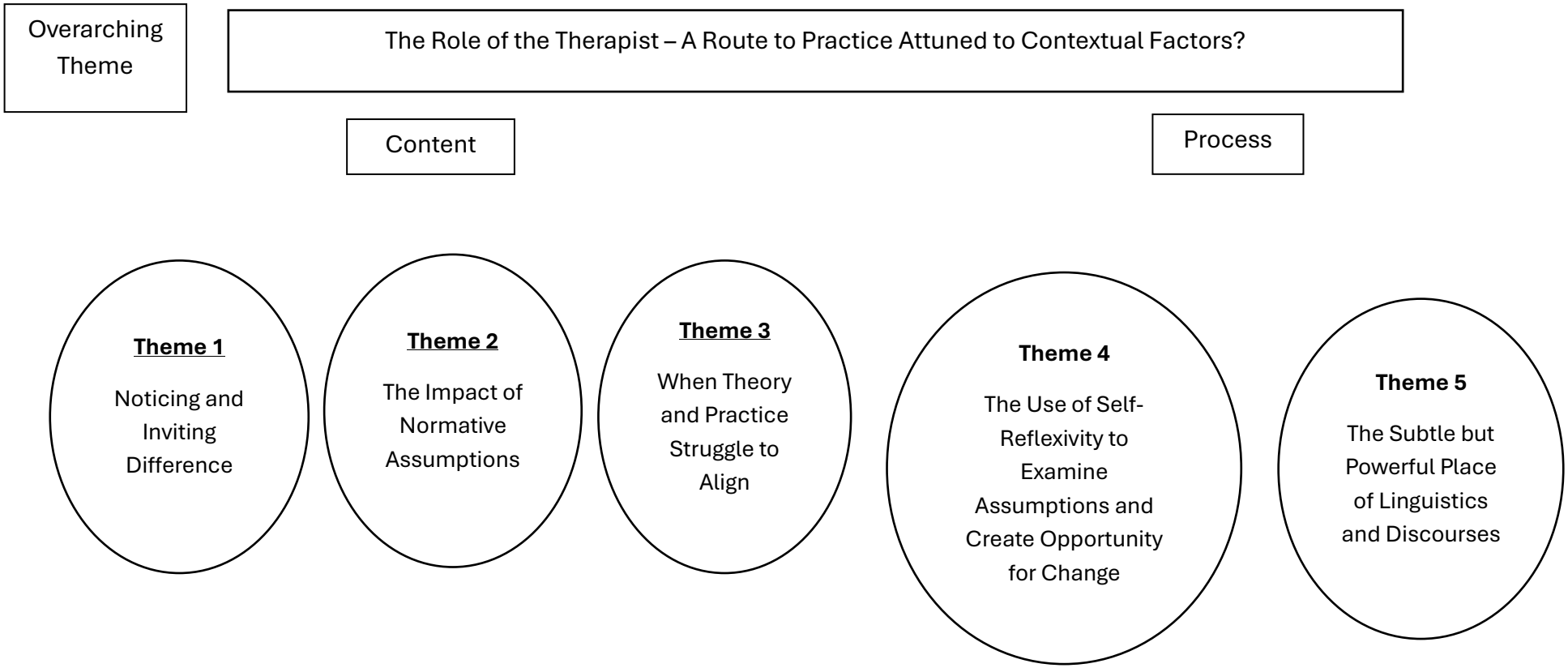
The generation of analytic themes involved 'going beyond' the content of the original studies (Thomas et al., 2004; Thomas & Harden, 2008) until the analytical themes generated offered an interpretation based on all the studies' findings being considered together rather than apart. Discussion with my supervisor supported this process by highlighting how descriptive themes relate, and facilitating reflections considering the studies together, rather than apart. A map of the interrelated descriptive themes can be seen in Appendix C.

Thematic Synthesis

One overarching theme was developed to provide organisation and thematic structure: **The Role of the Therapist- a Route to Practice Attuned to Contextual Factors?** This theme captures the analysis overall by suggesting that addressing the social context in psychotherapy research is determined by the therapist, and in some cases can lead to practice that is attuned to these aspects, whereas in others it may not. Five key themes relating to this overarching theme were generated. Themes one, two and three were associated with content (*what* was addressed) and themes four and five were associated with process (*how* it was addressed). Figure 3 outlines the themes in the form of a thematic map.

Figure 2

Thematic map of the thematic synthesis of the SLR studies



Noticing and Inviting Difference. Eight studies highlighted the role of therapists in inviting, noticing and accepting difference in psychotherapy conversations (Fox et al., 2017; Kalaydjian et al., 2024; Knudson-Martin et al., 2021; Lee et al., 2021; Sametband & Strong, 2016; Trevino et al., 2021; Yon et al., 2018; Young & Mooney, 2024). 'Difference' related to cultural (views, values, understandings) differences and gender (Kalaydjian et al., 2024; Knudson-Martin et al., 2021; Trevino et al., 2021, Sutherland et al., 2016) predominantly, with religion (Kalaydjian et al., 2024) and power (Kalaydjian et al., 2024; Knudson-Martin et al., 2021) also considered specifically.

Therapists' attention to aspects of cultural difference supported therapeutic engagement and alliance, as well as facilitating reflection, perspective taking and change (Fox et al., 2017; Kalaydjian et al, 2024; Trevino et al., 2021; Yon et al., 2018). In Yon et al.'s (2018) study, clients described how the therapists' pointing out of the differing views between British and Pakistani cultures helped the family to "know where the balance is, where the balance isn't" (p.190). In Fox et al. (2017), the therapist's facilitative role in negotiating cultural difference between family members was described by caregivers as a way to share perspectives and support a shift in relationships: "it was helpful for my daughter to know that I have a background, and it's as important to me as her background, you know, she probably has to start thinking about how do I feel about my background, just as I feel about hers" (p. 254).

There were examples of where such noticing, attuning and inviting difference did not occur, missing opportunities for socio-attuned practice. Lee et al.'s (2018) study

provides an example of where the therapist's choice of content to *track* (facilitating joining moments with the family) results in a missed opportunity to attune to the social and cultural context and experience of the Pakistani immigrant family settled in Canada. The therapist doesn't pursue the client's frustration around the cultural context of her daughter not engaging in education (i.e., following wisdom of parents and pursuing upward mobility for the family) and instead discloses her own view on the situation. The authors argue that this serves to highlight the mother and daughter's "different and often conflicting views, while positioning them apart rather than fostering connection" (p. 166). Kalaydjian et al.'s (2024) study in a couple's therapy context highlighted how religion remained an "invisible story" (p. 396) despite it being stated as central to the male partner in the couple pair. The authors suggest that the gender alliance of the therapist with the female partner who did not want to speak about religion, perpetuated her un-acknowledgement of the need for it to be explored, leaving questions unanswered relating to cultural and religious differences between the couple and how this impacted upon the couple's relationship.

The Impact of Normative Assumptions. Several studies demonstrated the therapists' alignment with normative assumptions which subsequently, and often unknowingly, constrained to what extent the socio-contextual aspects of clients' experiences were addressed. Cadenhead & Fellin's (2023) couple's therapy study highlights how the therapist aligns with normative (Western) neoliberalist ideas around gaining employment (e.g., offering advice, finding solutions and drawing on inner resourcefulness). After a lengthy explanation from the client around her

experience of employment difficulties as primarily relating to cultural differences and the structural injustices navigating recruitment as an immigrant, the therapist does not attune to this and instead asks, “how do you think you can make use of your strengths and skills to get a job?” (p. 367). This results in a minimal response from the client, which the authors suggest is an indication of interactional trouble and the client’s lived experience not being validated. Lee et al.’s (2018) family therapy study similarly demonstrates how the therapist’s normative assumptions about the term ‘culture’ being something binary and exclusive, leads her to assume the families’ experience of living across cultures is fraught or in conflict. She continues to suggest this idea despite the family never describing their experience in this way and thereby misses an opportunity to fully understand and address the families’ cross-cultural experience throughout the therapeutic exchange. The authors argue: “Once Jennifer [therapist] refers to culture in Pakistan as ‘different’ from Aisha’s (probably because it is different from Jennifer’s), it forecloses the creation of space to explore how Aisha may have developed her subjective position as a complex multicultural being” (p. 173). The authors suggest that that therapist’s enactment of her idea of culture serves to disconnect mother-daughter as the daughter, unknowingly, begins to adopt the therapists view “leaving no common shared space to join interpersonally with her mother and the extended family” (p173).

Young & Mooney’s (2024) interviews with family therapists identify how the “invisible norm” (p. 15) of whiteness and White privilege was perceived to limit their reflection and therefore consideration of issues of racial, ethnic, and cultural

difference. One therapist participant described how they had failed to reflect on their whiteness until they were confronted with diversity: “it’s only recently I’ve taken stock of that… because being in a monoculture, you don’t really have to think about yourself in those terms. It’s wherever you’re… interacting with people from different cultures, that you begin to reflect…” (p. 16). The authors highlight the vital importance of Northern Irish context, in which the therapists lack of interactions with people of colour and from different cultural backgrounds contributed to a “culture of silence in naming and exploring cultural and ethnic identities per se” (p. 19).

When Theory and Practice Struggle to Align. Five studies identified how therapists demonstrated a tension between wanting to engage in socio-attuned practice based on theoretical, intellectual and moral recognition of its benefits, and taking the steps to action this in the therapy room. For some therapists, moving from the ‘knowing’ to the ‘doing’ felt more difficult (Knudson-Martin et al., 2021). For example, Cottrell- Boyce’s (2021) study with family therapists identified a tendency toward ‘White fragility’ where therapists’ discomfort and shame around their white privilege resulted in avoidance of conversations around whiteness or race. As one therapist commented: “The shame that we feel when we get caught out, or what it’s like to be monitoring yourself all the time for your privilege? Yeah; how uncomfortable that is” (p. 150). Cottrell-Boyce described how the contradicting discourses adopted by White therapists such as ‘colour blindness’, alongside an agreed narrative among therapists of the importance of acknowledging race, racism and privilege as a vital context in therapy, are “compelling but fundamentally opposing” and “they can

potentially paralyse" (p.152). In Young & Mooney's (2024) interviews, family therapist participants acknowledged the benefits of considering issues around racial, ethical or cultural experiences for strengthening the therapeutic alliance, while also expressing a fear that raising issues around racial, ethnic or cultural experiences or beliefs, could be experienced as discriminatory, and resulting in therapist reticence. Drawing on Singh (2014), the authors suggest how this may represent a discourse of "political correctness" which they identify "as constraining White practitioners raising issues of 'race' in the therapeutic domain due to feelings of 'race anxiety' and self-policing" (p. 17). Zhu et al.'s (2023) interviews with psychotherapists identified a similar reticence: "we did not have the same interests and background… So that was another thing that made me less likely to be genuine, because I didn't want to offend" (p. 175). The authors suggest how "these comments highlighted [the therapists] internal tension involving wanting to enact cultural sensitivity and broaching while feeling nervous about the potential therapeutic rupture resulting from confrontation" (p. 175).

There were also examples of therapists recognising this tension but taking action to move past it. For example, in Yon et al.'s (2018) study, therapists challenged core cultural beliefs of their family clients through a process of both validating a cultural belief but also offering an alternative perspective. The authors argued that this allowed for "true dialogue" to take place and a "less colonising" approach (p. 194). Knudson-Martin et al.'s (2021) study with couples working toward more equitable power relations highlighted the role of the therapist in taking action and being persistent through voicing client's lived experiences and "to move from an abstract

understanding of societal context to being able to voice clients' personal lived experienced around the connections between vulnerability and power" (p. 1165).

The Subtle but Powerful Place of Linguistics and Discourses. Moving toward process issues, six studies were associated with this theme. Considering the place of language first, the creative potential of language to open up conversations around social contextual factors was demonstrated through therapists' use of specific discursive techniques. Sametband & Strong's (2018) discursive micro-level analysis of family therapy sessions demonstrated how the therapist employed reflexive questioning, position calls and candidate understandings, allowing "family members to publicly position themselves according to preferred cultural memberships more explicitly acknowledged and validated by their relatives" (p. 216). Zhu et al.'s (2023) study identified the importance of the therapists' discursive positioning in the therapeutic exchange, as both expert/ helper: 'it seems like you have two different sides of your brain fighting with each other on this"; and learner: "so I'm curious, and you can say no to this." (p. 171). The authors argue that this flexible positioning between expert and curious learner enriched the therapists understanding of the client's cultural experience. Trevino et al.'s (2021) analysis of how cultural conversations occur in individual psychotherapy described how cultural opportunities emerged out of the therapist's use of the same language as their clients, which they conceptualised as "looking out the same window" (p. 269) when responding to cultural material, noticing cultural references and gathering information on these. This contrasted with times when the therapist engaged only in a "glance out the window"

in which cultural topics were only briefly touched on and "were typically carried and led by the client as the therapist provided limited encouragers" (p. 269). Interestingly, the authors also highlight times when the therapist does ask further questions about what has been shared but it does not deepen understanding of lived experience of cultural identities. Knudson-Martin et al.'s (2021) study demonstrates how therapists can use the action of therapy, in which clients and therapists implicitly or explicitly position themselves in relation to dominant discourses. They described this action as "sociocultural attunement', a clinical stance in which therapists 'get' client affect and understand its meaning within the larger sociocultural context" (p1158). In an excerpt from the study the therapist explores societal prescriptions about what it means to be a man, addressing the male partner in a couple therapy session: "where did you get messages that men are required to do that?" (p. 1158) which opened up further reflection on societal messages and normative discourses around men needing to provide for their families. The authors highlight how sociocultural attunement differs to simply reflecting client feelings because it requires attuning to wider cultural meanings, socialised expectations and power contexts.

The place of language was also considered at the macro level across studies (Cadenhead & Fellin 2023; Cottrell-Boyce, 2021; Sutherland et al., 2016) with particular attention given to the way in which more culturally and socially dominant discourses can be foregrounded through therapeutic encounters which serves to marginalise others. For example, the construction of the referral problem in Cadenhead and Fellin's (2023) couples therapy study, is argued to be situated in a discourse of individual

psychopathology and a patriarchal construction of female distress as a psychological problem. In one excerpt, despite the female partner's attempts to resist being positioned as psychologically unwell by drawing on the discourse of gendered male violence as a culturally universal phenomenon, the therapist privileges the need for individual specific treatment. The authors suggest that "the repeated pathologising of Leila [female partner] is made possible through the restraints of dominant Western discourse, which puts the burden of responsibility onto women to keep themselves safe and maintains the invisibility of male perpetrators, as they are never mentioned" (p. 364). Sutherland et al.'s (2016) analysis of couples therapy sessions locate gendered interactions in segments of talk highlighting how the couple interactions are circular but also politically structured whereby dominant gender order and division of labour is reproduced. In an excerpt in which a couple are negotiating issues about sharing domestic tasks and caring for children, the father accounts for his absence in childcare by referring to the baby's age of one month old stating "she [baby] is sleeping all the time Emma [mother], like 18 hours a day" (p. 21). The authors suggest how this "offers a range of cultural inferences not only about developmental needs of newborns but also about what caregiving at this early age entails... indirectly presenting any caregiver's involvement with a newborn as largely unnecessary" (p. 21). However, the child's age does not excuse the mother from caregiving. The authors argue that because of the taken for granted nature of these gendered and social patterns of interaction, systemic therapists need a discursive lens, particularly one that addresses power and resistance (i.e. Foucauldian) to recognize when language and wider

discourse is positioning clients in specific ways and may be contributing to how couples understand their relational difficulties.

Using Self-Reflexivity to Examine Assumptions and Create Opportunity for Change. Self- reflexivity or 'use of self' was described as an essential component of the therapist role when addressing the social context in therapy in eight studies. Yon et al.'s (2018) analysis of family therapy sessions highlighted the importance of therapists' self-reflexivity which they associated with feeling secure in their cultural identity and how these impact the therapist's relating to the client and progressing therapeutic goals: "to respectfully challenge core beliefs required confidence on the therapists' part and security in their own sense of identity in relation to the areas where their own cultural beliefs matched and differed from the family" (p. 192). Cottrell-Boyce's (2021) findings suggest how within systemic psychotherapy practice, White privilege creates "conflicts and contradictions" and how these "can be translated into questions to prompt clinicians to incorporate race into the practice of self-and-relational reflexivity" (p. 153). Kalaydjian et al. (2024) findings suggested that the onus was on therapists to give voice to issues around diversity and the centrality of self-reflexivity in this process: "therapists need to use self-reflexivity to investigate whether their own sociocultural backgrounds are a resource or a hindrance to the therapy" (p. 399). Cadenhead and Fellin (2023) call for the use of relational reflexivity particularly when socially dominant discourses contribute to a therapist's conformity to normative values (e.g., othering discourses on race and migration within the UK post-Brexit context). They suggest that this could allow for "further opportunities to negotiate issues of alignment and

misalignment" (p. 372) and reduce the further marginalisation of non-dominant or normative discourses and values. Lee et al. (2018) highlights the value of discourse analysis of therapy transcripts in developing therapist reflexivity as it can examine the sociocultural positions occupied by therapists and "may better reflect the doxic nature of our own assumptions and subjective positions, enhance our presence and joining moments in sessions, and consequently increase our effectiveness" (p.174).

Discussion

Critical Evaluation

The aim of this SLR was to understand what is currently known about how the social context has been considered in psychotherapy research and practice, by synthesising existing qualitative research. It has brought together 12 studies and used thematic synthesis of the findings of these studies. All papers were assessed for their quality across eight criteria, and the overall quality of papers was deemed high. Overall, the SLR highlighted how the social context has been addressed largely in terms of culture and gender, with a more limited consideration of race and racism, and religion. The SLR showed how some of the research reviewed has addressed the social context in terms of *content* and *process*, with all these studies recognising the role of the therapist as paramount in both. It is important to acknowledge however that a considerable amount of research has not addressed the social context suggesting that that social contextual factors may be considered as separate from much of psychotherapy practice and possibly indicative of more individualised understandings and approaches within the field. The need for the therapist to take responsibility and accountability to sensitively incorporate social contextual factors into the therapy encounter was clearly agreed upon across studies. The emphasis on how the therapist enacts this in practice varied across studies: drawing on process issues such as self-reflexivity and discursive strategies (Cadenhead & Fellin, 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sametband & Strong, 2018; Zhu et al., 2023) and the content of therapy discussions, such as what the therapist attends to or does not attend to during

the therapeutic conversation (Fox et al., 2017; Trevino et al., 2021; Yon et al., 2017;). The studies were grounded in the theoretical frameworks of discursive feminist, systemic, multicultural orientation and sociocultural attunement frameworks.

The SLR drew attention to the subtle yet powerful role of normative assumptions and how this impacts the way and the extent to which social contextual issues are addressed in therapy at both the micro discursive level and the macro discursive level (Cadenhead & Fellin, 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sametband & Strong, 2016; Young & Mooney, 2024). This offered new thinking about how sociocultural discourses operate linguistically in therapy and a unique insight into the creative and oppressive potential of language. The SLR brought to light a contradiction between therapist ideology and therapist action in which despite a therapist *knowing* the importance of addressing social contextual issues, such as race or cultural differences, there can be a lack of *doing* this in practice (Cottrell-Boyce, 2021; Kalydijian et al., 2024; Trevino et al, 2021; Young & Mooney 2024). In the studies that reported this finding, there was agreement that this lack of action was associated with feelings that prompted discomfort (such as fear or shame) in the therapist and to move beyond this discomfort required the process of self-reflexivity. Finally, a more limited number of studies offered the perspectives of clients providing helpful insights into how sensitive consideration of socio-contextual factors supported engagement, the therapeutic relationship, and therapeutic change (Fox et al., 2016; Yon et al., 2017).

Implications for Practice

The studies reviewed had several implications for practice. The findings suggested that therapist intention does not always match outcome, and this resonates with the third order approach proposed in the study by Knudson-Martin et al. (2021) that calls for moving from 'knowing' about sociocontextual issues to 'doing' socio-attuned practices. Several studies' findings highlighted the crucial role of therapist self-reflexivity (or cultural reflexivity or critical reflexivity) (Cadenhead & Fellin, 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sametband & Strong, 2017; Sutherland et al, 2016; Young & Mooney, 2024) in this process and suggest that the development and practice of therapist 'use of self' that notices contradictions, assumptions and biases, can lead to therapeutic actions that are more attuned to the sociocultural and political contexts of clients' lived experiences and their identities embedded within this. The benefits of observational 'naturally occurring' material in demonstrating what unfolds in the therapeutic exchange in relation to self-reflexivity (Cadenhead & Fellin, 2023; Lee et al., 2018; Trevino et al., 2021; Zhu et al., 2023) point toward the incorporation of such material into training and supervisory processes as professional practice development tools (Cadenhead & Fellin, 2023; Zhu et al., 2023). The use of discursive analysis and discursive strategies (Lee et al., 2018, Sametband & Strong, 2018) appeared a particularly insightful means of contributing to what Cadenhead and Fellin (2023) call "discursive vigilance" (p. 370), allowing heightened awareness of when therapists unknowingly impose their norms, values and assumptions upon clients, and

highlight the creative and oppressive potentialities of language (Cadenhead & Fellin, 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sametband & Strong et al, 2018).

Beyond the individual therapist, the findings of the SLR suggest action is required at the level of training institutions and bodies, and the development of self-reflexivity and relational reflectivity through experiential training, grounded in the trainee's local context, including current and past political and historical contexts (Cadenhead & Fellin, 2023; Young & Mooney, 2024). The pervasiveness of White privilege must also be addressed at an individual and institutional level and the findings call for training institutions and practitioners to have conversations that make Whiteness visible which could be supported through the tools of discursive analysis (Cottrell-Boyce, 2021; Young & Mooney, 2024).

Based on the reviewed studies, socio-contextual factors such as class, race, sexuality, religion, ability, education and employment were not at all or minimally addressed. This raises interesting questions around whether certain aspects of identity and context are 'easier' to address than others or are privileged more than others. Finally, most studies came from the field of systemic psychotherapy, with no studies coming from the clinical psychology field.

Strengths and Limitations

In considering strengths, this is believed to be the first SLR that has brought together research on how the social context has been addressed across psychotherapy disciplines. The search strategy process was thorough, involving use of search tools to support organisation and transparency, liaison with the University librarian and

contacting authors in the field for suggestions around search terms. The use of two independent reviewers at both title/abstract review stage minimised study selection bias. Any discrepancies were discussed and a resolution collaboratively reached. Through this dual review approach the reliability of the synthesis was increased. Another strength was the application of the quality appraisal tool. It is important to acknowledge that the synthesis process has been influenced by my White-Irish lens (residing in the UK), which in turn has impacted all aspects of the SLR. Finally, the Critical Appraisal Skills Programme (CASP) systematic review checklist to critically appraise the SLR was applied and can be reviewed in Appendix D.

In terms of limitations, the review included 12 studies only and it is possible that other relevant studies were missed due to the search strategy and the inclusion and exclusion criteria applied. Studies not published in English were excluded and thereby possibly valuable and relevant research published in other languages was not captured. All 12 studies included were carried out in Western, industrialised societies which will constrain the findings and interpretations shared. Furthermore, I chose not to include grey literature (information not produced by commercial publishers) in this SLR and therefore it has not captured research that falls into this category. This choice does not imply a belief that such literature is less important or of less weight than peer-reviewed papers, but rather due to the databases yielding a sufficient number of papers which were relevant to the review question.

The SLR was over-represented by studies pertaining to therapist experiences, thereby the voices and experiences of service users were under-represented. However,

it is important to note that the intention of some studies was not to access therapist or client experiences, but rather to examine the role of language and its function in the therapeutic exchange. This SLR has identified that culture and gender have been most addressed when it comes to consideration of the social context with psychotherapy practice. Additionally, all couples therapy studies incorporated heterosexual couples only and therefore the findings are limited by heteronormative experiences and assumptions.

Rationale for the Current Study

The findings of this SLR suggests that studying how the social context is addressed in psychotherapy requires attention to both therapist and client contributions to the conversational exchange. The review has highlighted how the field of psychotherapy is increasingly recognising considerations of social context, however, systemic psychotherapy as a relational therapy concerned with the relationships between people and the wider context of their lives, dominated. The studies from the systemic field included in this review have highlighted the drive for systemic therapists to address the role of culture and collective meaning making, societal systems and power dynamics more intentionally within the field (Cadenhead & Fellin, 2023; Cottrell-Boyce, 2021; Lee et al., 2018; Sutherland et al., 2016; Young & Mooney, 2024). While self-report designs offered insight into the experience of therapists and clients in addressing these factors, discursive methods combined with observational designs in which the data was ‘naturally occurring’ offered an opportunity to examine the micro-aspects of spoken communication in therapy and make connections between these

and wider macro-sociocultural discourses. This latter approach appeared particularly beneficial given the finding that therapist intention does not always match outcome and given that assumptions and biases are often out of awareness, and therefore not always noticed when enacted. Discursive analytic approaches that combine micro-macro levels of analysis were limited within the studies reviewed and none took place within a UK Child and Adolescent Mental Health Service context. This therefore highlights a gap in the literature and the need for a discursive analysis of naturally occurring therapeutic dialogue within this context. As such, developing a study to address how this naturally occurs in systemic family practice appears pertinent. This current research therefore aims to answer the following research questions:

1. How are aspects of identity that are shaped by sociocultural and political contexts (such as gender, culture, age, socioeconomic status) talked about in family therapy sessions?
2. When these aspects are talked about in therapy, in what ways do service users respond, and does the therapy seem to be helped or hindered?

In highlighting how certain discourses around these aspects of identity and context can shape the experiences and practices of therapy, this research could allow for taken for granted assumptions to be deconstructed and the reflexivity of therapists increased, with application to systemic and clinical psychology practice and training.

Methodology

This chapter outlines the methodological approach to answering the research questions:

1. How are aspects of identity that are shaped by sociocultural and political contexts (such as gender, culture, age, socioeconomic status) talked about in family therapy sessions?
2. When these aspects are talked about in therapy, in what ways do service users respond, and does the therapy seem to be helped or hindered?

I explain my rationale for choosing qualitative research methods: observational 'naturally occurring' data, and discourse analysis. I describe my recruitment strategy, the participants who took part, and the ethical considerations I enacted throughout the research. The chapter concludes by detailing my data collection and analysis process in the context of my own positionality, reflexivity and epistemological stance.

Qualitative approach

Research within the discipline of psychology has been dominated by positivism, where experimental and quantitative methods are privileged (Gough & Lyons, 2016) and realist, universalist claims are made about the world (Burr, 2015). Qualitative methods that consider reflexivity and subjectivity however are increasingly gaining legitimisation and are now included in methods textbooks and several scientific and academic journals (Harper & Thompson, 2012). It has been argued that qualitative approaches to research enable understanding of experience, process and sense

making in a person's subjective world that itself is embedded in a wider cultural and social context (Miller & Glassner, 2011). Given that the focus of this current study is on how language and discourse relating to aspects of identity and social context are used in therapy, adopting a qualitative method will more fully, and arguably more validly, capture the complexity of these phenomena.

As discussed in the introductory chapter, in adopting a social constructionist research epistemology, my understanding is that conversation and dialogue construct and maintain reality and that these conversations do not exist outside of a social and cultural context (Puig, Koro & Echevarria, 2008). It is therefore my understanding that families and family therapists within the therapy room socially construct their worlds, including their identities, beliefs and experiences, through language. My research approach is designed to give attention to these constructions.

Research Design

Discourse Analysis

Discourse analysis is a qualitative approach to studying psychological phenomenon, grounded in social constructionism (Georgaca & Avdi, 2012). Discourse analysis involves examining language in use and it considers language as constitutive rather than descriptive, examining how language is used to perform certain functions or achieve interpersonal interests (Harper, 1995). Discourse analysis views knowledge as historically, socially and culturally specific and sustained by social processes rather than empirical validity (Harper, 2006). It is compatible with systemic psychotherapy, the focus of the current study, due to its primarily interactional, language based

therapeutic approach and its critical stance towards taken-for-granted knowledge (Avdi, 2005). For these reasons, along with my aforementioned epistemological stance, this method was deemed to most effectively answer the research questions of the current study by facilitating examination of both language in use, and the wider influence of sociocultural discourses within the therapeutic exchange.

There is no wide agreement on the process of doing discourse analysis (Georgaca & Avdi, 2012). Researchers applying discourse analysis to therapy dialogues have taken a Foucauldian, or 'macro-level' perspective, examining the ways discourses construct objects and subjects, versions of reality, and maintain certain practices and institutional agendas (Willig, 2008). Other researchers have taken a 'micro-level' perspective with a focus on discursive practices or rhetorical devices used by speakers in everyday interactions, drawing on the principles of conversation analysis and commonly associated with discursive psychology (Edwards & Potter, 1992). In the current study, the analysis will adopt an integrative approach (Wetherell, 1998) where micro-macro approaches will be combined. Following others who have used this both/and approach (Cadenhead & Fellin, 2023; Lee at al., 2017; Pakes & Roy-Chowdhury, 2007) it is hoped that this will allow for the examination of the complexities of family therapy interactions and how historically, socially and institutionally constituted macro-level discourses play out in the micro-level context of participants' discursive exchanges.

Observational 'Naturally Occurring' Data

The use of naturally occurring material offers a way to see what words do in a therapeutic conversational exchange and how this shapes the relational dynamics. This can shed light on biases, assumptions and prejudices and enable a different approach to practice (Helps, 2021) in a way that self-report data (e.g., interview account) cannot.

The Challenges of Discourse Analysis

Antaki et al. (2003) helpfully highlight some 'methodological troubles' (p. 1) that can occur when performing discourse analysis. Some such 'troubles' include summarising, taking sides, over-quotation, leaving the data to 'speak for itself' (p. 5) or 'spotting' features in the talk alone (p. 6). The authors argue how these result in either under-analysis, or no analysis, but warn how easy it can be to slip into these actions, and thus the challenge for the discourse analyst is to draw attention back to the specific features of the talk (e.g., what particular discursive moves are coming from the speaker and how are discursive features and conversational manoeuvres being used to manage the interactional exchange).

It has been argued that discourse analysis can be seen as attributing personal criticism due to its analysis of the speakers' positions and taken for granted assumptions (Marks, 1993). In the context of this study in which therapists' and clients' talk is analysed, it was important to ensure that this did not occur through consistently highlighting that individuals do not *intentionally* use discourses in particular ways (Harper, 2006). Potter (1998) highlighted another challenge of discourse analysis in the danger of searching through transcripts to illustrate predetermined ideas. To avoid this, the analysis process was thorough, detailed and not rushed (Antaki et el. 2003). Finally, Billig (2009) warns of discourse analysis not sufficiently addressing the speaker's subjectivity, agency and choice. Throughout the analysis process I held this in mind by not overlooking the agency and active choices of the speakers in terms of what was spoken about and when.

Ethical considerations

Ethical approval

Ethical approval was granted by the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) in September 2024 (Appendix E). The Health Research Authority Reference number is 24/PR/0856. Sponsorship for the research was granted by the University of Hertfordshire in November 2024. The University of Hertfordshire Ethics Protocol number is LMS/PGR/NHS/02318 (Appendix F).

Informed consent

A therapist participant information sheet (Therapist PIS; Appendix G) and a family participant information sheet (Family PIS; Appendix H) were provided to potential participants to support them in making an informed decision about their participation. The information sheet explained the aims, requirements, confidentiality and anonymity, data protection, cost and benefits, and withdrawal processes. Potential participants were provided with time to consider whether they would like to participate and to ask any questions. Those who decided to participate were asked to sign a consent form (Appendix I and J) and thereby providing their consent to be included in the research, for their therapy session to be audio-recorded, and for their data used in analysis and write up. The consent form was countersigned by me as the lead researcher and stored electronically in a password protected file on the University secure share drive.

Transparency

The participant information sheets clearly detailed the aims, goals, advantages and disadvantages of taking part in the research. It was clearly stated that participants do not need to do any additional tasks to participate in the research – they simply attend (families) or facilitate (therapists) the therapy session – and thereby risk of harm or deception was deemed low. That there were no direct benefits in taking part in the research was stated, while also acknowledging the indirect benefits that the research is hoped to contribute to improved family therapy and clinical psychology training and provision. As lead researcher, my contact information was clearly included on all paperwork should participants wish to contact me with any potential questions and concerns. The contact details of the Chief Investigator were also included. Finally, the ethical approving body was stated in all paperwork, as well as the research sponsor.

Confidentiality

All participant information was collected in a strictly confidential manner. All identifiable information was removed or changed (for example, the service name, setting and location, and participants' names), and participants were asked to choose their own pseudonyms. Participants were informed that their data would be kept confidential and how this would be done (see below).

Data Protection

Data was collected in line with the Data Protection Act (UK Government Legislation, 2018) and stored securely in line with Health Research Authority (HRA) and

University guidelines. Audio recordings of the therapy sessions were encrypted (via a participant identification number) and stored securely on the university share drive through two factor authentication only accessible to me. The audio files were then permanently deleted from the recording device. Audio recordings were transcribed and anonymised and stored securely on the university share drive as described above. At the end of the study, the audio recordings of the therapy sessions were permanently deleted.

Risk of Distress

The nature of the therapeutic process may result in participants experiencing some distress due to the problems or difficulties that are discussed. The therapist participants were highly trained and experienced psychotherapists with the skills to manage any family participant distress that may have arisen during the therapeutic process. As part of their standard practice, therapist participants had access to clinical supervision should they have experienced any distress resulting from the therapeutic interaction.

Risk of Harm

Therapist participants conducted a risk assessment prior to family participants being approached about the research participation. The therapists used their clinical judgement to assess whether a family's participation in the study would be appropriate or not, and approached families based on this. Participation was voluntary and all approached families were informed that their choice to participate or decline would have no impact on their ongoing therapy.

Remuneration

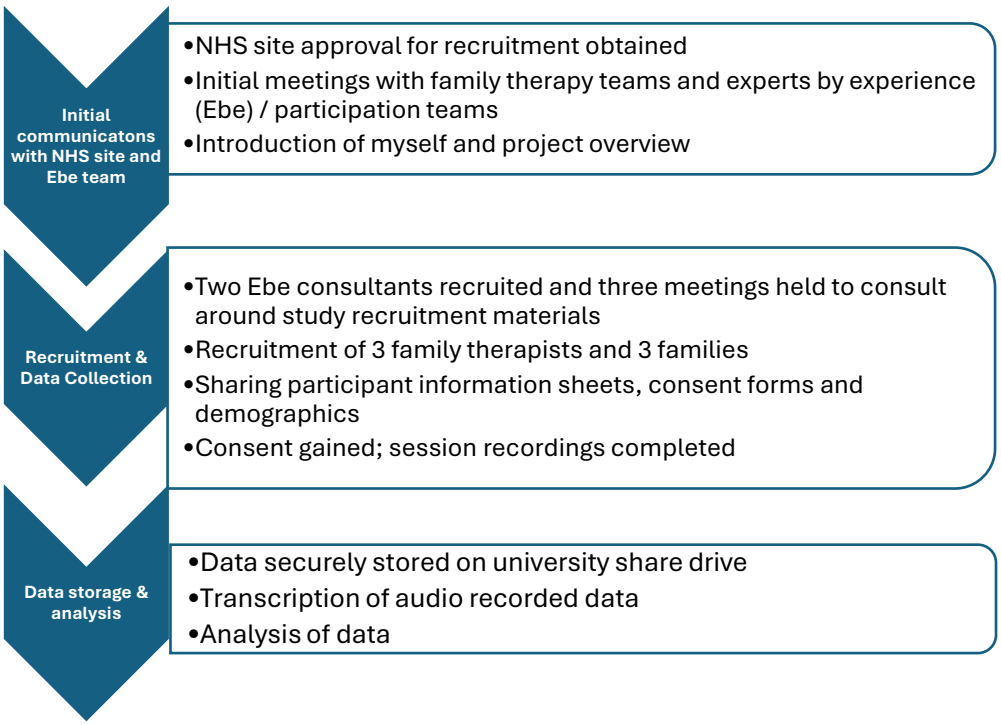
Family participants were remunerated for their time participating in the research in line with guidance from the Health Research Authority and the UK Research Ethics Development Group (UKREDG). Each family received a £20 Love2shop voucher.

Procedure

The research procedure is outlined in Figure 2 and further discussed below.

Figure 3

Procedure Flow Chart



Participants

Participant Recruitment

Recruitment occurred through one family therapy service, within a Child and Adolescent Mental Health (CAMHS) setting. A purposive sampling approach was used initially to recruit participants. Due to preexisting professional relationships, the family therapists were contacted directly via email and invited to participate in the research. The initial email included a research advertisement (Appendix K) that outlined further details of the study. A snowballing sampling method was also used by asking the family therapists who had agreed to participate in the study to share the recruitment advertisement with other family therapist colleagues who may also be interested in participating. Two family therapists were recruited via purposive sampling, and one family therapist was recruited via snowball sampling. All family therapists recruited were qualified family therapists having completed a UK accredited Systemic Psychotherapy professional postgraduate training.

The family participants were selected by the recruited family therapists, from their caseloads, based on informed consent being given and following an assessment made by the family therapist that the request to participate in research would not exert a disruptive effect upon the therapy. Therefore, each family was already accessing therapy, and the therapist had an established relationship with the family. A total of three families were recruited. The number was deemed acceptable and appropriate due to the nature of discourse analysis as a time and labour-intensive method.

Table 8

Participant Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Family participants already accessing family therapy • Assessment made by family therapist that the families' participation will not have a disruptive effect on the therapy • Have capacity to provide informed consent • Proficient in the English language and not require an interpreter • Young person family member aged 16 or 17	• Families not currently accessing family therapy • Assessment made by family therapist that the families' participation will have a disruptive effect on the therapy • Do not have capacity to provide informed consent • Not proficient in the English language and require an interpreter • Young person family member aged under 16

Challenges to Participant Recruitment

Despite participation in this research requiring minimal additional activities for participants to engage with due to the 'naturally occurring' research design, there were still some challenges to recruitment. Several therapists approached to participate in

the research declined due to working in very busy and demanding service contexts where they felt unable to take on a further responsibility of reviewing caseloads for appropriate families to participate. For other therapists that were approached, recruitment was not possible due to families on their caseloads being considered inappropriate due to the difficulties that they were experiencing, including, high risk of self-harm and therefore the focus of the work was on managing this risk. Several family participants who were considered appropriate to participate and approached by their therapists declined due to feeling uncomfortable with their session being recorded. This was sometimes related to not liking change to their usual therapy set up (sessions not recorded), and in other instances related to concerns over someone who is not their therapist (the researcher) hearing about their personal issues. While this did result in a slower recruitment process, and associated stresses with the tight deadlines for the research, these reasons for declining participation were respectfully understood. A reflective journal was kept throughout the process (Appendix L).

Participant Characteristics

All participants self-identified as White British or White European. To preserve anonymity only brief details of the three families involved in the study are given and all identifying information are omitted or disguised.

Family 1. This was a parent session with mother, Mel. Mel has three children, Oscar, Lauren and Lydia. Oscar is the young person currently open to CAMHS, referred for depression. The family are in the middle of their therapeutic intervention. The therapist was Liz.

Family 2. This was a parent/ carer session with mother, Diane, and grandmother, Jasmine. Martha is the young person in this family and was referred to CAMHS for self-harm and anxiety. The family are in the middle of the therapeutic intervention. The therapist was Sofia. The co-therapist was Alison.

Family 3. This session was with mother, Maggie and daughter, Alice. Alice was referred to CAMHS for anxiety and suicidal ideation. The family are in the middle of their therapeutic intervention. The therapist was Sofia. The co-therapist was Alison.

Service setting

The family therapy service is part of a CAMHS setting in England, UK. Referrals for family therapy mostly come via other mental health professionals working in the CAMHS setting, including psychiatry, social work, clinical psychology or creative therapy. Occasionally, referrals can come directly from the GP.

Experts by Experience consultation

I consulted with two Experts by Experience, accessed via the participation team at the CAMHS service from which participants were recruited. They reviewed the information sheet and consent form. They recommended amendments to the layout of the participant information sheet (using text boxes to separate the information rather than paragraphs) but had no amendments to the content. These recommendations were incorporated into a revised information sheet that was then used and shared with the participants. A family therapist reviewed the therapist research advertisement, recommending no further amendments. Due to the

interpretative nature of discourse analysis, it is not commonplace to involve service users in the research analysis process (Georgaca & Avdi, 2012). Furthermore, the aim of this study was not to produce a 'truth' or a 'finished version' of analysis, but rather to present an analysis of the data from the choices I made as the researcher-analyst, within a particular context and with particular aims in mind.

Data Collection

Each therapist was responsible for taking the audio recording device into their therapy session. The therapy sessions lasted between fifty and sixty minutes each and were recorded in full. The audio recordings were then transcribed (see data analysis). The original research design included a brief follow up semi-structured interview with the therapists with the aim of eliciting additional accounts (e.g., internal process and reflection) on the sessions and how aspects of identity and social context featured, how they were addressed (or not) and how their own backgrounds and context impacted the therapeutic interaction. These interviews were unable to be carried out due to therapists' unavailability. All research documentation (e.g., participant information sheet, research advertisement) includes the therapists' involvement in both the therapy session and the follow up interview. The therapist participants consented to both of these parts when initially recruited however when the time came to carry out the follow up interview, the therapists were unavailable. The implications of this are discussed in the discussion chapter, specifically in relation to limitations of the study and in recommendations for future research.

Data Analysis

Procedure

A discourse analysis of three audio-recorded therapy sessions with three families and their therapist was undertaken. Analysis started with listening to the recordings several times to allow immersion in the data. The recordings were transcribed following commonly used (e.g., Billig, 1997) transcription notation (Appendix M). Following transcription, several close readings of the text and initial coding were performed through identifying and marking sections of the transcript where lexical items were associated with identity or social context (such as culture, gender, age, socioeconomic status, occupation, (dis)ability, religion) asking questions of the data (e.g., 'what is happening and why?') and looking for discursive features and patterns (Appendix N). The functions of the text began to be developed through this process and was supported by the selection of extracts deemed relevant to the research question.

Analysis of the interactional micro-processes was informed by some of the basic principles of Conversation Analysis (Sacks, Schegloff & Jefferson, 1974). In adopting this Conversation Analysis informed approach, I adopted a selection of Conversation Analysis concepts in the analysis of the interactional micro-linguistic features of the speakers. I attended to *turn taking* where the speaker and recipient adapt and manage their turns and how this impacts the reality constructed between them. Specifically, *adjacency pairs*, where one utterance follows the other (e.g., question/ answer, suggestion/rejection), were examined. It is suggested that a delay,

pause or absence between the first and the second pair may be an indication of a power struggle, subjugation or 'interactional trouble' (Juhila et al., 2014). *Expansion* refers to several sequences of adjacency pairs (Schegloff, 2007) and was examined in relation to how talk about identity and social context were constructed and challenged and *expanded* across adjacency pairs. Finally *lexical choices*, or the speaker's selection of words, were examined in terms of how these may open up or close down turns, indicate particular stances or institutional agendas, or serve a function (e.g., dominance, collaboration). Together, these conversation analysis concepts were used to inform the interactional micro-processes of the analysis. Coming to the macro-level analysis, an overall critical Foucauldian perspective was adopted and involved several inter-related levels as described by Willig (2013) and detailed below:

Level 1: Language as Constructive*.* This level involved looking at how aspects of identity shaped by sociocultural and political contexts (or the 'object' of investigation) are constructed in the text and how it varies.

Level 2: Language as Functional: Discourses. This second level of analysis involves examining the dynamic of interaction. How the participants use language to organise the interaction was examined, such as what was similar or different in the constructions among families and therapists and how these were situated in wider discourses.

Level 3: Language as functional: Rhetorical strategies. This level explored what was gained from constructing the object in this way at this time, specifically the interpersonal functions of the language and the rhetorical strategies used.

Level 4: Positioning. Level four involved analysing how participants position themselves or are positioned by specific ways of talking. For example, attention was given to who is speaking and who are they addressing and how this endows different functions (e.g., authority as therapist, accountability as parent). The discourses that participants draw upon and how these discourses position themselves or others were noted.

Level 5: Practices, Institutions and Power. The relationship with discourses and practices was the focus of the fifth level and considered the role of specific discourses apparent in the data in maintaining or challenging dominant institutions and practices. Extracts analysed in relation to this theme examined the effects of dominant discourses in how family and therapist participants navigated conversations around identity and social contextual factors, as well as considerations of power, resistance and counter discourses.

Level 6: Subjectivity. Finally, analysis focused on how discourses positioned participants and the effects of this, such as how participants experience themselves as thinking, feeling individuals.

Reflexivity

Engaging in reflexivity in the research process involved attempting to highlight the motivations, interests and attitudes that I both imported into, and impacted upon, each stage of the research (Gough, 2003). Aligned with my social constructionist epistemology, it must be acknowledged that my interpretation and analysis did not occur in a vacuum but rather reflects my subjective, cultural and theoretical positions.

Contradictorily, social constructionist thinking presents the idea of the impossibility of 'knowing oneself' and requires more than simply listing one's social locations (Harper, 2003). Supervisory meetings helped me to notice assumption, biases and blind spots, for example encouraging me to notice when a discourse was coming from the data itself, or from me and my identities, context and assumptions. It also supported me to develop awareness of when I was falling into criticism of the speakers and how to manage this through focusing on the *talk* and its *effects*, regardless of what the motivations of the speaker might have been (Harper, 2003). To support me to develop a critical and non-judgemental gaze during analysis I found it helpful to try to suspend my normative beliefs about therapy (Stancombe & White, 1997) by focusing on the rhetorical work taking place. In this way I was better able to centre how the speakers present, respond and position themselves in the moment-to-moment talk and what this achieves in the talk (Gale, 2010). Furthermore, reflective discussions occurred during methodology workshops as organised by the University. These spaces encouraged me to further immerse myself in the data through, for example, revisiting why I was curious about a particular utterance in the first place and to embrace the multiplicity of ways of talking about a topic.

Another helpful means I found to support this process of reflexivity was to repeatedly read though the transcripts asking myself several analytic questions (Harper, 2003), including: what kind of positions are being set up or taken? (Davies & Harré, 1990); what is the aim of the speaker in saying this and what is the speaker hoping to achieve? (Roy-Chowdhury, 2003); What is responded to and what is not, how

are utterances responded to, and what effect does this have on the construction of meaning? (Kogan, 1997). Finally, I used a reflective journal throughout the analysis process to make sense of the shift in attitude and perspective that discourse analysis requires, for example, rather than responding to taken-for-granted understandings of psychological constructs relating to identity, I shifted my attention to how these constructs are relationally achieved, the knowledge bases drawn upon and how dominant discourses come into play (Gale, 2010).

Findings

This chapter presents an interpretive reading of excerpts from three family therapy sessions, purposely selected to illustrate the key elements outlined below with the aim of answering the research questions: "*How are aspects of identity that are shaped by sociocultural and political contexts talked about in family therapy sessions? When these aspects are talked about in therapy, in what ways do service users respond, and does the therapy seem helped or hindered?".* Following other discursive researchers that adopt a mixed-method or both/and approach to discourse analysis (e.g., Cadenhead & Fellin, 2023; Lee et al., 2018; Pakes & Roy-Chowdhury, 2007; Roy-Chowdhury, 2006; Sametband & Strong, 2018), the analysis combines micro (how the therapist and families manage turn-taking, adjacency pairs and expansions) and macro (the influence of socially situated subjective positions of the therapist and the family and their associated power) analytical approaches to therapy interactions.

In the elaboration of findings detailed below, Willig's (2013) six stages of Foucauldian Discourse Analysis (FDA) will be moved between flexibly, but attention specifically given to: (1) identifying the different ways the topic or object is constructed (e.g., constructs of identity and social context such as gender, parenthood, the construct of mental health 'problems'); (2) differences and similarities in the constructs among the therapists and families and situating them in wider discourses (e.g., professional expertise/ knowledge or gender roles); (3) exploring what is gained from constructing the object in this way at this time, or its *function* (e.g., legitimising,

persuading, silencing etc.); (4) how discourses position speakers as objects or subjects; (5) what opportunities or constraints for action are made possible by the available discourses and positions (e.g., inviting exploration of identity and/ or context or permitting topic change; and (6) how discourses influence the experience of participants (e.g., their social and psychological realities). The analysis highlighted three 'topics of talk' around which aspects of identity and social context were talked about (summarised in table 9). Within each discursive area, the families and therapists drew upon several discourses, as detailed below.

Table 9

Summary of findings

Topic of Talk
Gender Roles and Expectations *Gender-based Violence* *Men Protect Women*
Constructions of the Problem *Individualising Distress* *Professional Formulations* *Normalising versus Pathologizing*
Inviting 'restorying'

Gender Roles and Expectations

Gender-based Violence

The following excerpts illustrate the speakers' negotiation around the issue of male violence against women and how the speakers co-create meaning around this through constructions of responsibility and blame, and how dominant discourses come into play in this process, shaping discursive constructions of identity.

Family 1: Mum, Mel. Therapist, Liz. Excerpt 1 lines 60-78.

60 *Liz*: How is it for you that your Mum recognized this?
61 *Mel*: Umm, it was like umm (0.3) I was like umm (.) happy that she has finally recognized
62 and believed me that, because, you know she had mixed feeling before, she, even told
63 me that, in some ways she understands him. Because he had a very difficult childhood
64 and family history and she can understand him and ehhh (.) his reactions even if (.) if she
65 was, em, present when he had an anger outburst in front of her and the girls, and it wa-
66 *Liz*: Was he violent toward your Mum as well?
67 *Mel*: Emm, verbally, but he was kicking Lauren's bag that was packed for staying over at
68 his and, you know it was dramatic (0.2). I wasn't there but my Mum told me after how it
69 looked like and the girls were crying and they didn't stay, and actually he even, he
70 cannot control himself. He (.) he told them, to my Mum, but the girls were standing
71 next to her, "ok you take those fucking kids back" and sometimes she will say, explaining
72 him, that he cannot hold his anger but for me (.) there is no explanation and that is why I
73 was telling him via email that he should stop those behaviours because the children will
74 be [
75 *Liz*: Terrified.
76 *Mel*: Yeah, and that happened.

77 *Liz*: Yeah?

78 *Mel*: Yeah.

Prior to this excerpt, Mel had shared with Liz that her mother has recently recognised the impact that her ex-partner's historical violence continues to have on her children. In this excerpt Liz responds by asking Mel how this recognition is for her (line 60). In lines 62- 65, Mel's lexical choices ("in some ways"), extended sounds ("ehhh", "umm"), hesitations and pauses may imply some difficulty around sharing this perspective that her mother had around her ex-partner's violence as something that is explainable or understandable. In Lines 67-72, Mel's account of an incident of verbal and physical aggression that her mother witnessed is vivid and detailed (e.g., "he was kicking Lauren's bag", "it was dramatic", "the girls were crying", "he cannot control himself") suggests an attempt to discursively legitimise her resistance to her mother's perspective that she introduces in lines 71-72 ("and sometimes she will say, explaining him, that he cannot hold his anger") ahead of providing her own perspective in lines 72-73 ("but for me (.) there is no explanation"). Through these lexical choices, Mel discursively performs her resistance to the cultural narrative that male violence against women can be explained or justified (e.g., because a woman 'asked for it') (Towns, Adams & Gavey, 2008). In line 74 Mel's lexical choices ("and that is why I was telling him via email") may be a further discursive attempt to demonstrate her resistance. While Liz's interruption in line 76 is not challenged or resisted by Mel, only the children's experience of their father's violence ("terrified") is attended to, and it has the effect of closing further talk around the discursive resistance performed by Mel in this excerpt, before moving on to a different focus of discussion in the turn that follows.

It is important to note however that the therapist's managing of turns and conversation in the therapeutic exchange is a general phenomenon in psychotherapy (Anderson & Goolishian, 1992).

Family 1: Mum, Mel. Therapist, Liz. Excerpt 2 lines 140-145.

140 *Liz*: Can you say a bit more about that?
141 *Mel*: I feel guilty because I let him to treat the children like that, that long, emm. I feel
142 guilt because I know I should have stopped it earlier. But I wasn't prepared? To do that(.)
143 emm-
144 *Liz*: Can you tell me about that? That feels quite important, that you weren't prepared.
145 What was happening for you?
146 *Mel*: I was alone because I couldn't contact my parents and ehh, I was financially
147 dependent from him, so I thought, what can I do? I can report him (.) to the authorities
148 of course but I was frightened that he is going to (0.3) pay me back?
149 *Liz*: Like retaliate?
150 *Mel*: Yeah, and that happened, obviously, but I was more independent then. I had contact
151 with my Mum, my Dad, and I had work, so (0.2) then I was thinking that now is the best
152 moment, I have to go.

Prior to this excerpt, Liz has asked Mel about the difficult emotions she has in relation to her ex-partner and Mel's response describes how she feels guilt. In lines 141 and 142, Mel's lexical choices "I let him", "I should have stopped that earlier" and "I wasn't prepared?" seem to position herself as responsible for the violence perpetrated against her. Liz's responses in lines 144-145 ("can you tell me more about that?" and "what was happening for you?") indicates a discursive uncertainty, a technique that

discounts the importance of what the therapist thinks and implies that the therapee's account is more important. This linguistic device enables a discursive expansion from Mel in lines 147-149 in which her lexical choices (e.g., "I was alone [….] I was financially dependent from him […] I was frightened") construct herself rhetorically in a situation of lacking agency and power. Her rhetorical question in line 147 ("what can I do?") and the lexical choice in line 148 ("of course") may imply an unspoken and undisputed shared understanding (Billig, 1988) with Liz, as another woman, of this powerlessness experienced by women in the situation of a violent abusive relationship. Mel's lexical choices appear to reflect the wider societal discourse that places the burden of responsibility on women to keep themselves safe from male violence (Cadenhead & Fellin, 2023) while paradoxically highlighting the systemic barriers that women face in upholding this 'responsibility' – that even in reporting to the police, women do not necessarily feel safe or protected (line 147-148). The adjacency pairs that follow in line 149 and 150 between Liz and Mel, and Mel's lexical choice in line 150 ("obviously"), seem to reaffirm a shared understanding and suggest the discursive normalisation of male violence against women through both speakers' lexical choices. This excerpt illustrates Liz's skilful use of the 'not knowing' position which has the effect of *expansion* across several sequences of adjacency pairs in which the social and contextual experiences of Mel's life are elaborated. It also highlights how wider discourses can unknowingly play out in the moment-to-moment talk of the speakers and how this can limit the versions of reality that are talked into being.

Men Protect Women

The extracts included in this next section are used to illustrate the claim that the family are drawing on cultural discourses around gender roles that subsequently ascribe constructions of their behaviour, relationships and their own subjectivity.

Family 3: Alice, daughter; Maggie, mother; Sofia, therapist. Excerpt 1: lines 197-200.

197 *Maggie*: She said, “what happens if he is outside?”.
198 And I say “no, you are with your boyfriend, you are safe”. And after I share with
199 her the doorbell app, so even she, someone who is ringing the doorbell, can see using
200 the camera who it is.

In the conversation leading up to this extract, Maggie described an incident in which her ex-partner (and Alice’s father) showed up to her home without the family realising he was outside, and how he had dangerously blocked the front door with a tree trunk that had been left in the garden after Christmas. There is a history of domestic violence, and the family do not have contact with him. As a result of this incident, Alice was scared to leave the house. In lines 198, through Maggie’s lexical choices (“no, you are with your boyfriend, you are safe”), Alice is positioned to be safe via the presence of her boyfriend. As the discussion continues around this incident, the next excerpt indicates that there is a common discourse that both Maggie and Alice draw from regarding men protecting women:

Family 3: Alice, daughter; Maggie, mother; Sofia, therapist. Excerpt 2: lines 220- 225

220 *Sofia*: Do you see a link between what you have been feeling recently and your
221 reaction to your mum when you felt she was shouting? Do you feel there is any link,
222 maybe that that episode left you more vulnerable in a way?
223 *Alice*: No. Cos, I talked it through with my boyfriend when it happened.
224 Because I was scared obviously to go out. And he was like, don't be scared, because if
225 anything, I'd be here. So, I wasn't worried.

In response to Sofia's question (line 220-22), Alice's lexical choices resist being positioned as vulnerable ("no" in line 223) but at the same time attributes her safety to her boyfriend being there in lines 224 ("And he was like, don't be scared, because if anything, I'd be here"). This commonality in how Maggie and Alice position Alice's safety in relation to the presence of her boyfriend is interesting in the wider context of gendered based violence in the family, where Alice's father was abusing the women in his family, rather than protecting them. While the therapists do not invite further exploration about how these subject positions may have developed, in the next sequence of turns they relationally re-frame the argument between mother and daughter around the incident with Maggie's ex-partner and Alice's father, which at this time in the conversation might have been aimed at facilitating joining between mother and daughter.

Constructions of the 'problem'

Individualising distress

This next excerpt was selected to illustrate the claim that distress can be constructed as separate to the social context and the effects of this on how the family may conceive of themselves and their experiences.

Family 1: Mum, Mel. Therapist, Liz. Excerpt 3: Lines 233-281 (This is an edited excerpt due to length. The full excerpt is available in Appendix O)

233 *Liz*: Was it nice for him to have her?

234 *Mel*: Yes, he was very happy, because my Mum, she is very happy and very talkative and,
235 they all like her, they love her, they were very happy. I think Oscar was the most happy
236 she was with us, and he asked me when is she going to come back and I told him probably
237 autumn half term, he said "ohhh" he got really sad.

238 *Liz*: I think the work that we can do here in the context of Oscar, because he is the one that has been referred here, is to look at the impact the trauma has had on you. [……].

243 I think it will have a positive impact on you in general. I know we spoke about EMDR
244 last time, it is a technique. EMDR stands for Eye Movement Desensitization
245 Reprocessing. You don't have to speak or account a story per se, but we focus on an
246 image or a particular sensation, for example, the road, [……]

249 And then we would process the negative memory and feelings by asking you to look at
250 my hands, follow my fingers, and you are fully conscious for this, and what that does is it
251 helps your brain to process the memory. […..]

257 And so, by hhh (.) kickstarting this eye movement, and you can do it also, you don't have
258 to do it with eyes if that is difficult. You can do it with tapping yourself, we can try different
259 things [

260 *Mel*: Mhm [

261 *Liz*: But what that does is that it kickstarts that neurological process that the brain
262 automatically does when we sleep. So, when we go to sleep our brain automatically
263 processes all these different things that have happened to us during the day (.) and
264 have you ever heard about REM sleep?

265 *Mel*: Mhm

266 *Liz*: So, REM sleep is a stage of our sleep when our eyes naturally move right left.

267 *Mel*: Ah, okaaay

268 *Liz*: And that is the process our brain automatically uses to process memories, and [

269 *Mel*: Oh, right.

270 *Liz*: And we would do this when awake obviously.

271 *Mel*: That's interesting.

272 *Liz*: But the technique is the same (.) you use the hand movement to kickstart this
273 neurological process and then it allows the memory to go back and (.) kind of, close the
274 drawer kind of thing.

275 Mel: Mhm

276 Liz: It might take a while, it doesn't happen automatically but it allows it to have a
277 different mean- it doesn't erase the memory of course but the way that you will feel
278 in relation to that memory is different.

279 Mel: Mhmm.

280 Liz: And you can use this technique also with children, so adults and children.

281 Mel: Mhm.

Prior to this excerpt, Mel had been describing some of the difficulties her daughters are experiencing in attending school, and her son's upset when their grandmother left following her recent visit. Liz's then changes the topic to a

therapeutic intervention (EMDR – Eye Movement Desensitisation Reprocessing) commonly used for people experiencing flashbacks of traumatic events. The function of this topic transition may be Liz's attempt to offer a solution to the families' difficulties and her lexical choices appear to construct this intervention as helpful and valuable (e.g., line 243 "I think it will have a positive impact on you in general") coupled with the length and detail of the turn (lines 238-259) that may be an attempt to further strengthen this stance (Gayle, 2010) or give her account greater rhetorical force (Edwards & Potter, 1992). Through Liz's lexical choices (e.g., "there is a technique" in line 247, "it helps your brain to process the memory" in line 251 and "kickstarting this eye movement" in line 257), Mel's distress appears to be internalised and constructed as separate to the social context. It is notable that Mel's contributions are minimal (e.g., "mhm") throughout this sequence of turns (260-281). It is Liz's turns in which *expansion* occurs, enabling her to continue to share her professional opinion and in terms of action orientation, emphasise her expertise and ability to offer a 'solution' for Mel and her family. While Mel's response in lines 269 ("oh right") and 271 ("that's interesting") do not indicate challenge, the rhetorical effect of Liz's talk in positioning herself as the professional and therefore talking into being her stance on what will be helpful for Mel and her family, may be that Mel, at the level of subjectivity, feels unable to question or challenge Liz's utterances. Liz's lexical choices do illustrate a couching of her constructions within everyday talk (e.g., line 273-274 "kind of close the drawer kind of thing") to bolster a relatable or understandable position, however in line 277, Liz's lexical choice "of course" suggests a shared understanding yet one that is not discursively confirmed by Mel.

It is important to highlight that this analysis is based on selected discursive exchanges and that Mel and Liz had met on several occasions prior to this session. Therefore, it may have been that the concerns Mel expressed before this excerpt had been explored and acknowledged previously by Liz, as well as her understanding of the techniques and approaches that are discussed in this excerpt.

Family 3: Alice, daughter; Maggie, mother; and Sofia, therapist. Excerpt 3: lines 243- 263

243 *Maggie*: I don't really know. Maybe. Because (.) these things have happened, and before
244 that things were fine. Like I say, the issue I have with my legs. I try really hard to hide, but
245 sometimes it is too much. On the Friday, it was after night shift. I was not sleeping. It was
246 12.30 and then I go to sleep, and then wake up after one hour someone calling me and I
247 need to go pick up my younger one. So, I call Alice and she jumps and goes immediately
248 to pick her up. So, she really helped me. She called me to say that they are getting the bus
249 back. And then she come and ask what they are saying about my legs. And I told her. They
250 are doing investigations. But I think that accident with ex-husband has happened. Plus
251 that issue that I have, I can't go to apply to sickness, because if I need surgery I will be off
252 work, so I need to keep going to work and handling this pain (0.2) plus (.) I know I'm not
253 supposed to feel frustrated about shoes, but I think it frustrates me so much because of
254 everything.

255 *Sofia*: And maybe you overreacted too because a lot is on your mind? [

256 *Maggie*: Maybe.

257 *Sofia*: Yes, it feels like it touched on something that we have been talking about tha –

258 [

259 *Maggie*: And I think maybe both of us, because I said that, but I have this pain. And I think
260 also Alice, when she saw that video, she was really affected, she was scared to go out. I

261 think because sometimes something can happen but you don't even know and its hurting
262 us.

263 *Sofia*: Yeah. Yeah.

Prior to this excerpt, Maggie has been describing the impact of her ex-partner's showing up at their home on her, and her children. Alison (co-therapist) has asked if she thinks the incident was a contributory factor in the argument over the shoes between her and Alice. In this turn Maggie's lexical choices appear to position her in conflicting ways: in physical pain ("the issue I have with my legs" in line 244) and reliant on Alice for support (e.g., "she jumps and goes immediately" and "she really helped me" in lines 247-248); while also needing to resist this position ("I try really hard to hide" in line 244 and "I need to keep going to work and handling this pain" in line 252). This turn from Maggie is lengthy and detailed and may be attempt to strengthen her construction of these conflicting positions. In line 255 Sofia's response attends to the latter part of Maggie's utterance and the situation with the shoes, while the context of Maggie's prior talk is not directly responded to. Kogan (1998) refers to 'exteriority', a discursive manoeuvre in which the content of an utterance is not responded to as a signifier of experience. He describes how responding to the *exterior* of an utterance can signify that the speakers' experience is malleable and may lead to the context of prior talk being erased. Maggie's response in line 256 suggests uncertainty toward Sofia's suggestion ("Maybe") and in lines 258 Maggie interrupts Sofia's turn, a rhetorical move which may suggest a keenness to reassert her position ("but I have this pain" in line 259) and talk into being the context of her and Alice's experience ("she

was really affected, she was scared to go out" in line 260), to which Sofia's affirmative and minimal response in line 263, appears to discursively accept.

Family 3: Alice, daughter; Maggie, mother; Sofia, therapist; Alison, co-therapist. Excerpt 4: lines 264- 279

264 *Alison*: Do you feel, I don't know. As you are talking, I am connecting with the theme of
265 helplessness. In a way, there is helplessness. You can't influence how your foot is working.
266 You can't influence how your ex- partner is behaving and (0.2) I don't know, helplessness
267 plays into, I don't know, or moves into frustration or anger about -

268 *Sofia:* About the shoes because that could be sorted?

269 *Alison*: Yes.

270 *Sofia*: And maybe, we hav – [

271 *Maggie*: Because even at work. Physically I am not lifting or whatever, but people see,
272 and they say you look so tired. I am not tired. It is only the pain it is killing me. I am not
273 saying yes, I am tired. But I am also holding the pain. It is really affecting me. People see
274 my face and ask, "are you ok?".

275 *Sofia*: Yes. And actually Alice, you are, you read your mum very well. Have you been more
276 worried lately for your mum?

277 *Alice*: Mm. No.

278 *Sofia*: I wonder if you have seen her suffering and unwell and then the thing with – [

279 *Alice*: Mm she's been like that for ages. Well, I can't remember since when but she has been like that since ages. So, it's not changes but it's just (.) you know she'll say, or telling herself, "oh I can barely walk", you know. Just that stuff, "oh it hurts so bad".

In the next sequence of turns, co-therapist, Alison, offers an interpretation of Maggie's experience as one of helplessness (line 264-265) that is then expanded upon by Sofia in line 268 ("and about the shoes because that could be sorted"). Both therapists' use of Maggie's language and direct reference to the experiences she has already shared demonstrates a flexible positioning and an attempt to discursively construct a collaborative understanding between family and therapists. In line 271 however Maggie interrupts Sofia, a rhetorical move that may indicate discursive resistance, and her lexical choices appear to contradict the therapists' formulation (e.g., "I am not tired. It is only the pain it is killing me. I am not saying yes, I am tired. But I am holding the pain" in lines 272-273). In this turn Maggie may be resisting being positioned as "helpless" and instead attempts to position herself as "holding the pain", despite its effects. In the adjacency pairs across lines 275 to 281, Sofia's lexical choices ("I wonder") indicates discursive uncertainty and has the effect of expansion from Alice in lines 279-281 in which she constructs her mother's physical difficulties as longstanding and unchanged (lines 279 and 280). In terms of action orientation, Alice's lexical choices have the effect of constructing her mother's physical pain, and its contextual implications, as part of her mother's identity and their day-to-day experience as a family.

In these excerpts then, we see how the family and therapists discursively negotiate the impacts of the father and ex-partner showing up at their home. In terms of wider discourses, it appears that Maggie's positioning of "holding the pain" and continuing to work, draws on a neoliberalist and capitalist agenda that prioritizes work

and material gain, over health and family (e.g., "I can't go to apply for sickness, because if I need surgery I will be off work", lines 251-252). The therapists' interpretative comments (e.g., that Maggie may have "overreacted" or is experiencing "helplessness") are discursively resisted by Maggie through her lexical choices that construct her experience in the context of her day-to-day physical pain, her responsibilities as a parent, and to her work.

Professional formulations

The excerpts below were selected to illustrate the negotiation of therapist power and professional expertise with the family's accounts and understandings of the 'problem'; how this unfolds discursively; and its effect on the subsequent discursive exchange between therapist and family.

Family 2: Mum, Diane; grandmother, Jasmine; therapist, Sofia and co-therapist, Alison. Extract 1: lines 114-131.

114 *Diane*: Yeah, but she says it is hard and (.) because she doesn't have anyone else. And she
115 feels bad for sort of, feeling like that, but she can't help feeling that way when she doesn't
116 have any other friends. We went though, I've (.) joined a group on Facebook for home
117 educated kids and I got talking to one of the mums and we met up this week, with her
118 and her daughter, the same age. So, we went bowling. And her daughter seems to have a
119 bit of anxiety as well and they got on really well. They talked for ages. She said that this
120 girl only has a couple of friends too. So, they are quite similar.

121 *Sofia*: Ok, it shows how much you are being proactive. And em (.) you said you've also

122 been up and down? Has it been difficult for you in the last few months?

123 *Diane*: Yeah. I've been. I haven't really been great with my mental health.

124 *Sofia*: Do you have any idea of what makes it better or worse?

125 *Diane*: (0.3) I don't know really. (0.6) When her weed had got quite bad that really got me

126 down. (0.5) But as I say, she's doing really well with that now.

127 *Sofia*: So you would you say that, you feel that, in a way (.) that there is a link between

128 Martha's ups and downs and your ups and downs?

129 *Diane*: Yeah. Probably yeah.

130 *Alison*: Do you think she is aware of that link as well?

131 *Diane*: Ehh, yeah.

Preceding this excerpt, Diane had described how Martha felt lonely due to not having friends aside from her boyfriend. Diane's description of meeting with a family in the community is a detailed account of how this came about (e.g., lines 116-117) and may be attempt to highlight the efforts she is making to support Martha. Her lexical choices in lines 118 and 119 ("her daughter seems to have a bit of anxiety as well and they got on really well. They talked for ages") and line 120 ("so they are quite similar") appear to position Martha as similar to other young people and having an ability to engage as might be expected. Sofia's response in line 121 appears to validate Diane's account ("it shows how much you are being proactive"). However, the content of Diane utterance is not responded to. This is followed by a change in topic with a question from Sofia about Diane's mental health in line 122. Sofia's discursive strategies of hesitations and pauses suggest a positioning of 'not-knowing', while also demonstrating her relative professional power in changing the topic and returning to a question-answer conversational format. While Diane responds affirmatively in line

123 and offers an explanation of what she thinks makes her mental health worse in lines 125 and 126, several pauses and hesitations may indicate 'interactional trouble' (Jefferson, 1986). Her lexical choice and use of the contrastive *but* in line 126 ("but as I say, she's doing really well") may be an attempt to renegotiate her positioning in relation to her own mental health and return the focus to that of her daughter. This attempt to redirect the conversation is not successful, as the therapists' return to questioning about the connection between Diane's and Martha's mental health in lines 124, 127 and 130. While Dianes responds affirmatively in lines 129 and 131, her lexical choices ("probably", "ehh") suggest a tentativeness toward this positioning.

Family 2: Mum, Diane; grandmother, Jasmine; therapist, Sofia and co-therapist, Alison. Excerpt 2: lines 144-162.

144 *Sofia*: So, is it almost like that you cannot tolerate that something would happen to
145 the relationship?
146 *Diane*: Ehhh.
147 *Sofia*: It looks like maybe she is trying to protect the relationship by doing that?
148 *Diane*: Maybe. I think she just doesn't like it when I get down. So. [
149 *Jasmine*: No.
150 *Sofia*: (0.2). And do you think there are similarities when you get down?
151 *Diane*: (0.3) What? Similar to?
152 *Sofia*: Similar to her, like do you feel what happens to you, is like her, when you get down?
153 *Diane*: Emmm.

154 *Jasmine*: I mean you're the same as her. When I say to you "what's wrong?' cause I know
155 she's down cause she's not getting up and doing anything. Not getting dressed
156 and things like that. And she says, "nothing". And I say "well there obviously is". But you
157 say, "I don't know".
158 *Diane:* ((laughs)).
159 *Jasmine*: You do know but you just don't want to tell me [
160 *Sofia*: Then it's the same? [
161 *Jasmine*: Martha says she doesn't know. She says there are days when she feels really
162 down and "I don't want to do things. But I don't know why".

Prior to this excerpt, Jasmine offers her perspective that Martha does realise that her behaviour impacts Diane and the efforts she goes to minimise any confrontation between them. Diane's lexical choices in lines 146 ("Ehhh") and 148 "(Maybe") indicate a continued uncertainty towards Sofia's formulations in lines 144 and 147. Diane's interpretation of what she thinks Martha's intention is (line 148) is not acknowledged by Sofia, and in line 149 she responds with the same question previously asked ("And do you think there are similarities when you get down"?) perhaps suggesting that Diane's previous response was insufficient (Sametband & Strong., 2018). An indication of interactional trouble appears in line 151 where Diane responds first with a pause and then with a question, perhaps an attempt from Diane to challenge or resist the understanding of the problem that Sofia is proposing through her questions. Sofia's response in line 152 does not attempt a repair (e.g., by perhaps asking Diane *does this question feel hard to consider or respond to right now?*) and rather repeats the question previously asked. The turn-taking between Jasmine and

Sofia that marks the end of this turn (lines 154-162) appears to function to co-produce an understanding of a link between Diane and Martha's mental health however without Diane's contribution.

In this excerpt then, it appears that while rhetorical devices used by the therapists to signify uncertainty and the sharing of power, paradoxically also seem to let the family know what they think is occurring. The context of what Diane had shared in relation to experiences with another family in the community are not responded or elaborated. Instead, a link between Diane and Martha's mental health is talked into being between Sofia and Jasmine and it is notable that Diane's responses are brief, minimal and characterised by hesitation, suggesting at the level of subjectivity that she may not have felt heard, or part of this meaning making process.

Normalising versus pathologizing

This excerpt was selected to illustrate the effects of the dominant medical discourses and professional expertise on the way the families construct their identities, and the minute discursive moves by which knowledge claims are warranted or resisted.

Family 2: Mum, Diane; grandmother, Jasmine; therapist, Sofia and co-therapist, Alison. Excerpt 3: lines 432-460.

432 *Diane*: The school didn't think she had ADHD. [

433 *Jasmine*: I think that she has ADHD.

434 *Sofia*: You do think?

435 *Jasmine*: But the doctor thinks that she hasn't.

436 *Sofia*: Well, the new theory now is that we are all neurodivergent, all of us. And it is a

437 spectrum and so.

438 *Jasmine*: Yeah.

439 *Sofia*: And so – [

440 *Diane*: The doctor also mentioned BPD.

441 *Alison*: Yes, Borderline Personality Disorder.

442 *Sofia*: That is different though because it is not neurological.

443 *Diane*: Yeh. The doctor said she shows lots of signs of that, but she said that she couldn't

444 diagnose her until she is 18. So.

445 *Alison*: How do you make sense of that sort of (.) comment?

446 *Diane*: Well. I think (.) that I don't understand why it can't be diagnosed now if they think

447 that's what she's got. Because now if they do think that's what she's got. Because to me

448 if they can't diagnose it now then they can't treat it now. So, she's gotta wait until she is

449 18 to be treated for it. If that's what it is. So that doesn't make sense to me but –

450 *Sofia*: But BPD, it is not a proper diagnosis. It is an emm, it's more a way of being. Yeah.

451 And if you think, it is a description of how people function. But apart from the diagnosis.

452 There is something, whatever the diagnosis, there is a way of being that becomes a bit of

453 limiting factor in the interactions with others. And it looks like you are getting to know,

454 how does she function. And more like, what does she need to function in a relationship,

455 that is what I wanted to say. You have made an effort in understanding and when like today

456 you don't feel pleased about the interaction, it is probably because in that moment you

457 <u>don't</u> feel pleased about the interaction, because in that moment you were not,

458 and it happens with children, that we don't tune in. But it would be nice, in a way, (to be able to

459 say) that this morning I reacted to my own feeling and your need didn't match mine. That

460 could be a very nice reparation.

461 *Jasmine:* She is easier to talk to once she has calmed down [….] When she is in that thing
462 there is no talking to her. She just gets angry and shouts. You just get angry and shout.
463 And it just ends up [

464 *Sofia:* Yeah [

465 Jasmine: With the two of you upset.

Prior to this excerpt, Diane has explained that the ADHD (Attention Deficit Hyperactivity Disorder) diagnosis that Martha received when she was aged 5 is not agreed upon by professionals today. The differing perspectives expressed between lines 432 -435 are followed up by Sofia's introducing of the idea that neurodiversity is a spectrum (lines 436-437) and suggests an attempt at normalising the diagnosis (e.g., "we all neurodivergent, all of us") and why there may be differing points of view ("well, the new theory is"). Sofia's possible further expansion on this in line 439 however is interrupted by Diane, suggesting her keenness to share the perspective of the doctor. Diane's lexical choices in line 443 ("lots of signs") may be an attempt to suggest the doctor's perspective as the 'true' and accurate version of reality and in lines 446-449 her lexical choices suggest that her construction of Martha's 'problem' is situated within a medical discourse (e.g., "if they can't diagnose it now then they can't treat it now"). In terms of action orientation this construction may enable Diane to attribute Martha's problems away from her own actions (and away from the formulation that

has been previously proposed by the therapist, Sofia) by adopting a medical- diagnostic discourse (Moore & Seu, 2010).

Sofia's response in lines 450-460 attempts to destabilise this diagnostic account of Borderline Personality Disorder or BPD (e.g., in lines 450 "it's more a way of being", and 451 "it's a description of how people function") and to attribute meaning to Martha's behaviour in lines 452-454 ("there is a way of being that becomes a bit of a limiting factor in the interactions with others"). Sofia lexical choices in line 453 ("it looks like you are getting to know), 454 ("and more like what does she need") and 455 ("you have made an effort in understanding") constructs Diane as knowing and understanding Martha's needs, perhaps in an effort to shift Diane's conceiving of managing Martha's difficulties through the 'treatment' offered by medical intervention, and in her ongoing effort to attach meaning to Martha's behaviours. Sofia's subtle changing of the subject pronouns from "you" (line 457) to "we" (line 458) indicates an attempt to reduce attaching any blame to her utterance in which she suggests that there may be occasions when she is not attuned to Martha's needs. It is notable however that Diane does not respond to this turn, perhaps an indication of 'interactional trouble'.

Family 1: Mum, Mel. Therapist, Liz. Excerpt 4: Lines 310-323

310 *Liz*: Okay, okay. So how do you manage his health concerns, because last time, he

311 looked so ill and skinny and scrawny. [

312 *Mel*: So, yes, I. [

313 *Liz*: I am concerned about his weight actually.

314 *Mel*: Yes. [

315 *Liz*: More than anything else, I was thinking he looks very skinny ((laughs)). [

316 *Mel*: Yes, yes. [

317 *Liz*: That does not look good. And also because his physical health has a huge effect

318 on his mental health and I am concerned about the interplay of that.

319 *Mel*: So, he let me to (.) weigh him and to (.) measure him and I check his BMI and its, its

320 normal but very close to underweight, but he was always like that, he's been like that

321 since primary school. So obviously for me he is skinny, when I look at him, or anyone looks

322 at him, but it's not abnormal, and his appetite at the moment is very good.

The topic of conversation has turned to Mel's eldest son, Oscar. Between lines 310 and 318 Liz shares her concerns about Oscar's weight. In line 311, Liz's lexical choices ("ill", "skinny", "scrawny") seem to emphasise her stance that there is a problem with Oscar's weight and positions Oscar in relation to his physical appearance and physical health. While Mel's responses ("yes") in lines 312, 314 and 316 do not indicate challenge, Liz interrupts each of these utterances which seems to organise the interaction such that her talk dominates. As Mel's minimal responses continue ("Yes, yes") in line 316, Liz's stance is repositioned somewhat in lines 317-318, from a focus on physical health only, to the relationship between physical and mental health ("his physical health has a huge effect on his mental health, and I am concerned about the interplay of that"). This possibly suggests an awareness of the effect of her utterances in minimising Mel's responses and an attempt to discursively repair this. Mel's subsequent response expands across lines 319-322 in which she both asserts her

proactiveness and responsiveness in line 319 (“he let me to (.) weight him and to (.) measure him and I check his BMI”) and renegotiates Oscar’s positioning through her lexical choices regarding his weight in line 320 (“its normal but very close to underweight”) and 322 (“but it’s not abnormal, and his appetite at the moment is very good”). These rhetorical moves may indicate her discursive resistance to her son’s positioning as “ill” and her attempt to construct her son’s identity (and her own) in the way that is meaningful to her.

Inviting ‘restorying’

The following extract was selected to illustrate the claim that the discursive strategies used by the therapist bring about a shift toward the consideration of a counter narrative among the family in which they construct their identities in terms of their resourcefulness (rather than their difficulties).

Family 3. Alice (daughter), Maggie (mother), Sofia (therapist). Excerpt 5: lines 479- 493

479 *Sofia*: Yeah. So, do you feel that seeing dad was a reminder of the horrible experience
480 you had with him? Because for a young girl to see him naked, it’s enormous. I have no
481 words to describe how awful it must have been to be in that situation. And, maybe it
482 has all come out, and maybe seeing your mum a bit stroppy because she was tired and
483 in pain –
484 *Alice*: There were a lot of times when I saw her crying because he pushed her or laid a
485 hand on her. There were so many things. She would always be in the house, and I wouldn’t

486 know what to do, I am only a child. And what's a child to do when your mum is getting
487 abused by your dad? There is nothing you can do except be there. And I feel like she felt
488 alone because from my point of view she literally had no one.
489 *Sofia*: Did she know you were there, do you think? Is that your impression at that time?
490 Were you feeling that your mum knew that you were thinking of her?
491 *Alice*: Yeah.
492 *Sofia*: Yeah.
493 *Alice*: Yeah, because I used to always hug her and she hugged me back.

Prior to this excerpt, Alice has described how her and her mum's relationship was much closer before her younger sibling was born, where she felt at the centre of her mother's attention and care. She compares this to the attention and care that she now gets from her boyfriend and her feeling that this has been a very positive factor in terms of her own mental health, while also supporting her relationship with her mum. In line 479, Sofia's question redirects the conversation back to the incident in which Alice's dad would be naked around her when she was young (a disclosure that was followed up by the therapist in subsequent sessions and additional support offered). Her lexical choices in line 480 and in 481 ("I have no words", "how awful") ("it's enormous") suggest her stance on how impactful this incident was for Alice and suggest an attempt to empathise and validate. In lines 482-483 her question seeks to associate this incident with her reaction to her mum telling her to tidy away her shoes and their subsequent argument. In doing so she seems to construct Alice's response as meaningful within the context of her previous experiences. Alice's interruption in line 483 does not appear to contradict Sofia's utterance but rather to communicate that

the extent of what she witnessed and experienced through her lexical choices in line 484 (“there were a lot times”) and 485 (“there were so many things”). In terms of action orientation, Alice’s repeated phrases in lines 486 and 487 (“I wouldn’t know what to do” and “what’s a child to do”) may enable her to relieve herself of any responsibility or guilt she feels for being unable to protect her mother from her abusive father and to construct her position of helplessness in line 487 (“there’s nothing you can do except be there”). Sofia’s response in lines 489-490 may be an attempt to ‘restory’ (Roy-Chowdhury, 2006) Alice’s account and construct an alternative subjective position for Alice to consider (e.g., line 489 “did she know you were there, do you think?). Sofia’s minimal response in line 492 (“yeah”) appears to act as a prompt for further elaboration from Alice in lines 493. In this excerpt Sofia navigates a ‘not knowing’ position while also attempting to discursively guide Alice toward a counter narrative of her experience that mobilises the resourcefulness of the family. In the turn that follows, Maggie shares how Alice’s hugs during that period did help her, further validating this ‘restorying’.

Reflexivity

In writing these findings, through my efforts to analyse families’ and therapists’ discursive constructions, I have made decisions to place their talk in particular socio-cultural-political contexts which are themselves constructed from a version of the world as I see it. I therefore acknowledge that there are assumptions, biases and blind spots tied up in these findings. I have endeavoured to analyse the *effects* of the talk and situate the analysis within the details of the text to ensure that the data is not left

to ‘speak for itself’ (Anataki, Potter & Billig, 2003), and through supervisory meetings, critically reflect on and be challenged in, my interpretive process.

Conclusion

This chapter has presented the three ‘topics of talk’ and associated discourses that emerged through a micro-macro discourse analysis of how aspects of identity and the social context talked were about in systemic family therapy, and the effects of this talk on the therapeutic exchange. In the discussion chapter that follows, situating these findings in wider discourses and institutional practices will be expanded upon, as well as the implications of these findings in clinical practice and training.

Discussion

The aim of this research study was to analyse how aspects of identity and social context are talked about in systemic family therapy. This final chapter will elaborate on the key findings, situating them in wider discourses and in relation to existing research in this area. I critically evaluate the study, consider future research recommendations and clinical and community implications.

I came to this topic through my belief that knowledge, embedded in the wider socio-cultural context, is constructed between people and in social interactions through language. Furthermore, I adopt the view that language is both productive and constructive, and when this idea is applied to therapy, language is not an "add-on" to the "real" work of therapy but as a topic of study itself in which therapeutic phenomena occur within (Smoliak et al., 2021, p.48). This study applied a micro-macro discourse analysis approach to the transcripts of family therapy sessions and aimed to answer the following research questions:

1. How are aspects of identity that are shaped by sociocultural and political contexts (such as gender, culture, age, socioeconomic status) talked about in family therapy sessions?
2. When these aspects are talked about in therapy, in what ways do service users respond, and does the therapy seem to be helped or hindered?

The findings illustrate how families, through the topics of talk in the therapeutic conversation, discursively construct and enact their identities at multiple levels of

social, cultural and political context. In this way, the therapeutic alliance is embedded in a larger ecological context and influenced by power, privilege and oppression (Bronfenbrenner's, 1981, 1997). When applied to the therapeutic setting, therapists' and families' identities and the meanings and power attached to these identities, affect both how families construct and understand their experiences, and how the therapists understand and respond to what families bring (LiVecchi & Obasaju, 2018).

Summary of the Findings

Three family therapy sessions were analysed for this discourse analysis study. The analysis presented three 'topics of talk'. *Gender roles and expectations* highlighted how gendered discourses, such as paternalism and victim-blaming, enter the therapeutic dialogue of both therapists and families. In drawing upon these discourses, the family and therapist participants talked into being subject positions in which women are dependent on men for their safety, while also vulnerable to men's violence. The analysis highlighted how gender hierarchies can enter the discursive space of the therapy room that position men as dominant and powerful and women as lacking agency and power. Through discursive strategies these subject positions were navigated in different ways, such as therapists adopting the 'not knowing' position and inviting expansion from family participants on the impact of these positionings, or where family participants discursively resisted certain discourses, specifically those that excused male violence against women.

The second topic of talk, *constructions of the problem* detailed the complex negotiations between families and therapists around the nature of the problem and

how families constructed their difficulties and identities in relation to their contextual experiences and wider discourses (e.g., being a single parent, managing health difficulties, medicalised discourses). The therapists' use of certain rhetorical strategies and relative positional power was highlighted at the micro-level of the talk in how they managed turns, topic changes and discursively enacted their expertise, and the different effects this had on the talk. In some examples we saw how family members contributions were short but not explicitly disagreeing, adopting a subject position of compliance. In other examples, family participants stopped contributing at all for several turns or their lexical choices indicated hesitancy and possible resistance to the subject positions that therapists talked into being (e.g., that their child's difficulties are better understood in terms of how they relate to others rather than within a medical/ diagnostic framework).

The third topic of talk *inviting restorying,* details how the discursive techniques of the therapist such as minimal responses, invited elaboration from the family participant in which their resourcefulness, rather than their difficulties, were collaboratively talked into being and thereby a new subject position adopted. The analysis captured how discourse analysis can be used to raise awareness of the ways in which language constructs different versions of social reality and experience. It was apparent that the families' and therapists' talk was situated in wider societal and cultural discourses and that aspects of identity and context featured throughout the discursive exchange.

Situating the Findings within Wider Literature

The value of using rich data transcribed from therapy sessions and applying a micro-macro discourse analysis approach in this study is highlighted in how wider societal discourses enter the discursive space of the therapy room but how they often go unnoticed, and what the implications of this are on how interactions are managed, and the subject positions that are talked into being. For example, in the topic of talk *gender norms and expectations,* the analysis illustrates how gendered discourses, or "a way of seeing the world as it relates to gender" (Baker, 2016, p. 138), enter the therapeutic conversation and in doing so construct and enact gender and gender relations. Specifically, the analysis highlighted how a conflicted positioning emerges for Mel (mother, family one) in which her lexical choices draw on the societal victim-blame and responsibility discourse (Wild, 2022) in which women, as the victims of domestic violence, are also blamed for it. In this excerpt, the discursive resistance that Mel has previously enacted through her lexical choices that reject her ex-partners violence as something that could be explained, becomes subsumed by a gendered societal discourse that positions women as primarily responsible for men's violence. This serves as an example of how the close analysis of talk can reveal that the same speakers' utterances can both reinforce power relations while also challenge them (Sutherland et al., 2016). Liz (therapist, family one) does not acknowledge that such wider discourses seem to have entered the therapeutic conversation, which may reflect how influential normative discourses can be, how they become privileged and how others (such as, that women have agency and do resist) are evaded (Killian, 2002). The

discursive moments when Liz enacted the 'not knowing' and non-expert stance that invited elaboration from Mel around aspects of her identity and context, could have also been an opportunity for Liz to connect the content of Mel's talk to the wider socio-political context, or the 'third order' perspective (McDowell et al., 2019), such as that of gender inequality and power disparities between men and women. In Knudson-Martin et al.'s (2021) study with couples, the therapist's identification in session with the couple of societal discourses around the gendered idea that women should carry more relational responsibility, and the hidden power this therefore provides men, was found to open space for the generation of a new conversation around mutual responsibility and power and thereby challenge dominant patriarchal systems and discourses. In Cadenhead and Fellin's (2023) study with couples, they suggest the use of externalisation techniques as tool for therapists to highlight the injustice or sociopolitical constraint that subjugate women. Through applying these perspectives and techniques, they suggest that the development of counter narratives such as, that men's violence against women represents social and political inequalities, rather than women's inability to leave or prevent the violence perpetrated against them, can emerge. In their study of gendered patterns of interactions, Sutherland et al. (2016) highlighted the value of discourse analysis as a tool to help therapists to recognise the ways in which structural forces enter family life and therapy (e.g., sexist and patriarchal gendered expectations and norms) but just as importantly, to notice when families are making efforts to challenge these norms and transform sociopolitical arrangements (Sutherland et al., 2016)

The analysis highlighted that another gendered discourse, that men protect women, appeared to enter the therapeutic space. Maggie's and Alice's (mother and daughter, family three) lexical choices construct men as subjects with the ability to protect, and women as objects to be protected by men ("you are with your boyfriend, you are safe" [Maggie], "he was like don't be scared, because if anything, I'd be here. So, I wasn't worried" [Alice]) and may be an attempt to construct a different version of the world in which they are safe, where men are protectors rather than abusers. At the level of subjectivity this may allow them to challenge previous experiences of fear in relationships, with a new experience of safety. The therapists do not invite further exploration about how these positions developed, or what they mean to Alice and Maggie at the level of subjectivity. This may demonstrate how socially dominant discourses can contribute to therapists' conformity to normative values (that women's safety is contingent on men) and further marginalise non-dominant or non-normative discourses and values (that women's safety requires systemic change) (Cadenhead & Fellin, 2023). Through the systemic technique of circularity, the therapists invite Maggie and Alice to connect to how the experience of Maggie's ex-partner and Alice's father showing up to their home may have been a factor in their recent argument and in this way facilitate joining between mother and daughter.

Sutherland et al.'s (2016) study highlighted how family interventions that elicit circularity but do so without considering gendered ideologies and disparities in opportunities and resources available, risk reinforcing women's subordinate status vis-à-vis men and disadvantage them in how they negotiate gender roles and expectations.

It is interesting to consider what would have happened if the therapists had acknowledged the wider societal processes and contexts and their connections to the felt experiences of Maggie and Alice. Would the conversations have played out differently where, for example, intersectionality (Crenshaw, 2013) was considered more explicitly by therapists? This perspective of intersectionality could have been practiced through inviting discussions around how subjective positions may have been situated in social and cultural norms, and stories about how men and women relate to each other, and how these may influence the stories about gender roles and expectations that the family have developed (Afuape, 2020). The value of discourse analysis is seen here in how its focus on the micro-details of talk can make visible how language reproduces and challenges normative gender and power. It is important to note that these points are not to suggest that the therapists in these excerpts lack sensitivity to gendered power relations and their impact at the societal level, but to highlight how we all can be unwittingly recruited into the reproduction of dominant gendered norms and power relations. In paying attention to language use we can attend to when this may be occurring.

In the second topic of talk, *constructions of the problem,* the analysis highlighted how the therapists' positional power can influence the construction of the families' difficulties in ways that privilege their formulations or therapeutic agendas. For example, in family one, Mel's (mother) description of some of the difficulties her children have been experiencing because of their father's and her ex-partner's abuse, prompts a solution focused response from Liz in which her lexical choices (e.g.,

"neurological" and "process the memory") construct an individualised explanation of Mel and her family's experience of abuse. These constructions are reflective of Western medical discourses which, notwithstanding good intentions to "treat" the trauma, the traumatic experiences themselves can become separated from their context. Cadenhead & Fellin (2023) highlighted in their study how solution-focused therapeutic utterances can contribute to the privileging of constructions of internalised understandings of distress at the expense of wider contextual considerations. Mel's minimal responses throughout this turn may suggest, at the level of subjectivity, feeling that her lived experiences are being minimised or discredited (Madsen, 2016). Winter (2019) helpfully highlights how our tendency as therapists to promote a solution that is within the person themselves comes from a well-intentioned placed because we emphasise the parts of the narrative that seem achievable to work on or influence in therapy. However, as Harper (2016) highlights, there is substantial (and growing) evidence of what David Smail termed the 'distal' causes of psychological distress (e.g., economic climate, political ideologies) and therefore the need for the social and contextual factors of people's everyday experiences to be recognised and acknowledged.

The analysis offered a unique way of attending to the micro-actions of the therapists' and families' talk and how strategies of power can play out in the therapeutic exchange as the speakers attempt to legitimise their interpretation of the problem, but how these can escape the notice of the therapist (Cadenhead & Fellin, 2023). For example, in family two, Sofia (therapist) enacts a topic change, moving to a

question about Diane's (mother) mental health immediately following an account Diane has given describing a connection made in the community and a positive experience the family had. The subsequent questioning from Sofia about similarities between Diane and Martha's mental health (e.g., "would you say [….] (.) that there is a link between Martha's ups and downs and your ups and downs?" and "do you feel what happens to you, is like her, when you get down?") appears to discursively construct the families experience as separate to the social context while guiding it toward a relational perspective of the problem. While a defining feature of the systemic approach, the effect this has on the unfolding talk is of interest, particularly Diane's minimal responses and dispreferred turn (or a question when an answer is normally expected in an adjacency pair) that may suggest interactional trouble. At the level of subjectivity, Diane may feel that her perspective is not being heard. Lee et al.'s (2018) study highlighted the importance of staying with the client's choice of topic rather than changing the topic as this risks a more likely inserting of the therapist's agenda and power, with impacts on the therapeutic relationship.

In this same topic of talk, *constructions of the problem*, the analysis highlighted the contrasting discourses that families and therapists can draw upon. Diane's (mother, family two) lexical choices suggest that the medical discourse offers her a system of meaning making for her daughter, Martha's difficulties and Martha's identity is constructed in relation to diagnostic categories (Borderline Personality Disorder, BPD and Attention Deficit Hyperactivity Disorder, ADHD). In contrast, Sofia's (therapist) lexical choices drew on an interpretive discourse which constructs Martha's way of

being as relational, impacted by Diane's own mental health struggles, and the interaction between these. While Sofia's use of lexical choices that soften her construction (e.g., "that could be") and suggest uncertainty and not knowing ("it is probably" and "it looks like"), Diane's lack of responses to Sofia's utterances suggests that there may not be a shared understanding being talked into being. Smoliak et al., (2021) drawing on de Shazer (1984) describes the benefits of a "resistance-informed discursive lens" (p. 46) in systemic practice where therapist's notice hesitation from clients, pause and become curious about this act itself. They propose that individuals and families can disagree in subtle ways and attending to these ways can lead to a valuing and respecting of these subtle but important offerings from therapees. Diane's diagnostic attribution of Martha's difficulties may also be a discursive strategy to locate blame and responsibility away from her and the relational patterns between her and Martha. Previous studies have suggested that family members can treat therapists' discursive moves, which although intended to represent a position of neutrality, as allocating blame and responsibilities for the difficulties reported (Patrika & Tseliou, 2016).

The excerpts in which Maggie (mother, family three) speaks about her leg pain and her inability to take sick leave from work highlights how the impact of societal systems and power operates in the lives of families. The therapists' interpretative comments that construct Maggie in a position of 'helplessness' may inadvertently reinforce a position in which wider societal agendas, such as neoliberalism and capitalism that individualise distress, are maintained. Theoretical frameworks such as

'third order thinking' (McDowell et al, 2019) and 'sociocultural attunement' (Knudson-Martin, McDowell & Bermudez, 2017) may be a helpful lens through which therapists can consider discourses they may unknowingly reinforce and their effects on the meaning making process that occurs between them and the family.

The value of a discourse analysis in these excerpts was to make visible the micro processes of talk and their effects, particularly the attributing meaning and normative valuing that can be taken for granted and viewed as a shared understanding (Gayle, 2010). As highlighted by several previous studies, (Cadenhead & Fellin, 2023, Kalaydjian et al., 2024; Lee et al., 2018; Zhu et al., 2023) the practice of therapist self-reflexivity appears particularly important here to support therapists to notice when their discursive strategies are enabling some narrative possibilities and disabling others (Kogan, 1998). As exemplified through this analysis, discourse analysis has value as an adjunct to the process of self-reflexivity through highlighting when, as therapists, our inner dialogue and assumed knowledge about a person's motivations and interpretations are being privileged (Gayle, 2010) and by highlighting how theory is applied in therapy practice.

The "location of self" process (Watts-Jones, 2010) whereby therapists explicitly name and explore with families the similarities and differences in their social identities is interesting to consider in relation to the families and therapists in this study, given that there were some similar aspects of identity, namely identifying as female and White (British or European). Specifically in relation to White identity, Mooney and Young's (2024) research interviews with systemic family therapists found that in a

context where there is a lack of visible racial diversity, Whiteness became an "invisible norm" – as conceptualised by Singh et al. (2009) – which constrained self-reflection in these terms. In this research, it is possible that this same invisible norm played out discursively and may have led to assumptions and missing nuances of cultural differences that exist despite a shared White identity. Watts-Jones (2010) suggests that "making identities transparent is an invitation to clients to participate with the therapist in being mindful of how our mix of experience may at times create tension, misunderstanding or frustration and to talk about it. It extends collaboration" (p. 413).

In the final topic of talk, *inviting restorying,* the analysis illustrated examples of the therapists' enacting flexible positioning (Roy-Chowdhury, 2003) through their discursive moves and its effects on the talk and subject positions that family members adopted. For example, in the excerpts from family three, Sofia's (therapist) utilizing of minimal responses ("yeah") had the effect of conveying understanding and inviting elaboration from Alice (daughter) where she expresses her thoughts and feelings ("there were a lot of times when I saw her crying [….]. There were so many things […..]I wouldn't know what to do […..] and I feel like she felt alone"). Sofia's questions use Alice's language, a strategy that seems to convey engagement with her lived experience. These strategies result in a restorying of Alice's utterance from one in which she constructs herself as a *helpless* child not able to protect her mother in the context of her father's violence, to a *helpful* child in how she was holding her mother in her thoughts. The effects of this restorying are that Maggie (mother) discursively supports this new narrative offering an account of how much power her children gave

her throughout the abuse. Zhu et al.'s (2023) study also highlighted the value of the therapist's flexible discursive positioning as both expert/ helper through reflecting back what the client had shared, offering an activity to try and the opportunity to decline participation in this activity. These strategies were suggested to neutralise the power imbalance between therapist and client, and to provide space for the client to elaborate on their cultural and contextual experience. The analysis of this excerpt highlights how systemic psychotherapy as a discursive practice can support the generation of new, less problem saturated, subject positions collaboratively between therapist and family (Avdi, 2005). At the wider contextual level, these moments of acknowledging and elaborating on families' resourcefulness can support the creation of more hopeful stories about the current lives and past experiences.

Limitations

In considering the study's limitations and strengths, Tracy's 'Big Tent' (2010) quality appraisal tool was applied (see Table 10 for a summary). This study has focused on only three sessions of family therapy and therefore only offers a snapshot of the therapeutic exchange on these three occasions. The analysis was limited to audio recordings of therapy sessions, and therefore non-verbal communication and cues were not captured. In apprising the *sincerity* (Tracy, 2010) of the research, I acknowledge that what I notice and describe of the world, and the claims I have made throughout this research, is from my own position. Furthermore, I acknowledge that many of the assumptions and biases I hold are implicit and out of my awareness, and so, while I endeavour to be aware of them, my reading, interpretations and claims will

always be limited. I consider reflexivity as an ongoing process, and therefore something that can always be improved upon through thorough examination and naming of how my own lens and assumptions impact the research process. It is also important to highlight that my research has been influenced by the institutional framing of a Doctorate in Clinical Psychology training programme informed itself by a social constructionist perspective and that takes a critical approach, however is itself a part of a profession and systems rooted in colonialism, White supremacy hetero and cisnormativity and ableism, and the inherent contradiction that this creates.

In terms of families' and therapists' demographics, all were White British or White European and identified as female. All family members self-identified as heterosexual. This therefore limited the aspects of identity (such as racial identity, non-binary gender identity, homosexuality, etc.) and social contextual intersections that could have been addressed during the sessions. Incorporating racially and culturally diverse participant backgrounds could have increased the *significant contribution* (Tracy, 2010) of the research and generated a greater "sense of insight and deepened understanding" (Tracy,2010, p.864). It could be argued that this research's focus on language or 'just' words (Taylor, 2013) is removed from the issues clinicians face in their day-today practice. However, the combination of the micro-macro approach has allowed for a helpful reading of the therapeutic encounter that is referring to social, cultural and political structures outside of the text (Willig, 2013). The *credibility* (Tracy, 2010) of the research was limited by not gaining the perspectives of the therapists through follow up interviews. Triangulation of the data would have been increased had

these interviews been carried out. Finally, I recognise that is it easier to analyse sessions post hoc and much more challenging in the moment to notice these subtle discursive moves and how pervasive norms can so easily and unwittingly enter the discursive space.

Strengths

This research contributes to the still small but growing area of discursive research within the field of psychotherapy rendering it a *worthy topic* (Tracy, 2010) that contributes something new and may evoke further critical discursive research. The value of analysing rich data transcribed from naturally occurring therapy sessions added to the *rigour* (Tracy, 2010) of the research and was highlighted throughout the findings in how the therapeutic exchange does not occur in a vacuum, but rather wider social cultural and political discourses enter the therapeutic space and influence the unfolding talk, such as constructions of women as without agency in relation to the violence perpetrated against them by men and how this is discursively normalised. The research also highlighted how normative values, assumptions and discourses are central in the construction and articulation of 'problems' that families bring to therapy while simultaneously capturing the ways therapists' talk is bound up with assumptions drawn from wider societal and therapeutic discourses and norms in relation to what families bring to therapy, which often go unnoticed. The implications of this not noticing can be highlighted in the micro-actions of speech of family members, such as minimal responses, lack of contribution to the talk, that may indicate subtle acts of discursive resistance. In this way, the value of the use of discourse analysis in this study

was to illustrate the subtle ways families can disagree or resist, without explicitly doing so, offering a unique insight into the therapy process the I believe adds *resonance* to this study. Specifically, we as therapists may therefore benefit from sensitizing ourselves to the possible manifestations of families' ways of responding (Smoliak et al., 2021). The findings also illustrated the nuanced interaction between the therapists' use of discursive techniques and their power in ways that, in some instances, supported discursive expansion from families and indicated the therapists' flexible positioning, and in other instances, seem to constrain expansion from families. In this way, the current research is an example of the value of discursive research as a resource for enhancing therapists' self-reflexivity. Finally, there are few studies that have used discourse analysis in family therapy sessions to specifically analyse how identity and social context are talked about, and therefore, the current study is contributing something new and different to the knowledge base.

Implications

Implications for Training, Supervision and Professional Development

The findings of the current study suggest that the micro-macro discursive analysis approach offers an alternative reading of therapeutic process that has implications for training. Clinical psychology and systemic training programs could consider using discourse analysis research as a teaching tool to highlight how therapists and families are drawing on wider discourses and institutional processes in their talk-in-interaction and offer a reading into how families construct their identities

in relation to the social context. In this way, discursive methods can bring contextual consciousness to what families bring to the therapy room.

Training programmes could also develop trainees' skills in discursive analyses, encouraging its use as additional method to be used to analyse therapeutic process which complements and supplements other methods. In individual supervision, discursive approaches could be applied to session recordings to bring attention to the micro-actions of talk that indicate interactional trouble which could then be applied to clinical practice to help identify these moments and work on repair and alliance building (Cadenhead and Fellin, 2023). Furthermore, the use of discursive methods in this research was helpful in highlighting times when as therapists we may be enacting our power to elaborate our own ideas rather than collaborate with families to create and negotiate shared and agreed understandings (Smoliack et al., 2021; Guilfoyle, 2003). In sum, adopting a discourse analysis framework can enable a more critical and reflexive stance on our practice.

Implications at the policy and community level

In considering policy and community implications from the research, the findings of this research could be applied in the developing and constructing of services in ways that support people in their broader social context, that may include issues relating to social factors such as housing, access to social welfare and cultural practices, through partnering with other agencies and support services and thereby offering more collaborative interventions that go beyond what can be offered in the therapy room alone. This may also involve mental health services more readily investing in

community and peer support strands in their service provision that can support greater recognition of the resourcefulness of service users, and a moving away from individualising peoples' difficulties as purely intrapsychic phenomenon. This could include developing psychological services that are designed in partnership with volunteers across community settings and therefore are familiar to community members. In this type of model, Roy-Chowdhury (2013) proposes that the service must adapt their practice to the norms of the community and involves negotiation of professional role and power and more meaningful engagement between services and community. Similarly, Afuape and Kerry-Oldham (2022), drawing on liberation psychology principles, argue that systemic psychotherapy training (and I would argue, clinical psychology training) should include macro-level intervention skills (e.g., advocacy, community action work) and calls for structural and systemic changes in the delivery of services, where therapy is constructed alongside and in partnership with local communities, rather than imposed. This can allow for constructions of mental health to move beyond essentialist premises and for psychological practice that is less individualised, less rigidly model based, and more responsive to service user's social context and needs to emerge (Roy-Chowdhury, 2013).

For the clinical populations in which we work, the findings of this study demonstrated how the application of discourse analysis can allow for more thoughtful engagement with what actually occurs in the micro-macro level of the therapeutic exchange. In this way the creation of a therapeutic position that prioritises the therapeutic relationship and where understandings are mutually negotiated and

agreed, and culturally dominant or singular perspectives that serve to oppress families can be challenged and their resources, strengths and resistance acknowledged.

Invitations for future research

This study focused on only three family therapy sessions. Each family was accessing ongoing therapeutic interventions where talk about aspects of identity and social context could have emerged at any stage and in different ways. Therefore, it could be beneficial to undertake an extended analysis of several sequential therapy sessions to explore how these conversations emerge and shift over the course of the therapy. Future studies could also be enriched by incorporating other perspectives such as interviews with the therapists and the clients who participated in the study which could add a means of triangulating the interpretations made through eliciting additional accounts (e.g., reflections on the process). The families and therapists in this study self-identified as White British or White European, and all self-identified as female. Future studies could include families and therapists from more diverse social groups, such as those who identify as from the global majority, LGBTQIA+ and from differing social class backgrounds, to explore how talk about identity and social context emerges across these different backgrounds and contexts.

Dissemination

To further the potential impact of this research, dissemination will form the next part of this research journey. First, I hope to present the research at the University of Hertfordshire Doctorate in Clinical Psychology research conference, an opportunity to share the findings with my peers and the teaching staff. Furthermore, I plan to liaise

with the research teaching staff on the programme to discuss the potential of offering teaching on discursive methodologies, with the aim of encouraging more trainees in upcoming cohorts to consider these methodologies for their major research projects. I aim to, in collaboration with my supervisor for this study, write up and publish the research findings in a peer-reviewed journal, such as the Journal of Family Therapy.

Concluding remarks

By closely paying attention to lexical choices, turn taking, adjacency pairs and expansions, and how these impact on the interactional management, the findings of this research allow us as therapists to step back and consider when families are unsure or hesitating toward something the therapists' have said, as well as offering a lens to attend to when dominant sociocultural ideas are informing families' and therapists' talk. The analysis highlights the importance of what Cadenhead and Fellin (2023) conceptualise as "discursive vigilance" or the sensitizing to the "creative but also oppressive potentialities of language" (p. 370). Such discursive vigilance as applied in this research highlighted how the families construct their identities in relation to the social context and that normative cultural assumptions and discourses are embedded in the therapeutic encounter and play a role in the discursive process of meaning making.

Final reflections

This project has been an exciting, albeit challenging, process of learning about how language is used in the therapeutic process. The challenge has felt strongest in shifting the focus from the subjectivity of the individual that so much of my psychology

training and career has prioritised, to the relational, discursive and constructive focus that is performed in interaction between people, in this case, the family and the therapist. I feel inspired by the discourse analytic approach in how it can make visible the nuances of discursive interaction, revealing its complex and messy nature, and the taken-for-granted features of talk, particularly the subtle ways that families construct their identities and experiences in relation to the social context. There were several challenges with regards my own reflexive process, particularly in taking a critical stance in my analysis of the therapists' use of their positional and discursive power. I was mindful of my positionality firstly as a trainee clinical psychologist and secondly as a researcher. I reflected on my position as a trainee outside of the field of systemic family practice and questioned what power I had to take a critical stance towards the practice of qualified systemic family practitioners. As a researcher, I attended to the power I held in this position to analyse and interpret the data, without input or feedback from the participants themselves. These complexities I felt were important to acknowledge as they highlight the inherent contradictions in my positionality and the limitations of my interpretative and critical process as a result. There were times when I found the discursive process exposing in terms of my own practice, for example, reflecting on the conflicted positioning of the "not knowing" stance within an inherently unequal power dynamic that (despite all efforts to mitigate) exists in the therapist and family/ service user relationship. I feel hopeful that the wider application of this approach in training and future research can help myself and my fellow therapists to attune to the "hows and the whats" (Smoliak & Strong, 2018) of therapeutic communication.

Quality Appraisal

I have used Tracy's 'Big Tent' criteria to evaluate the quality of the research. Since this was a qualitative study, the evaluation tool must be tailored to fit the methodology (Willig 2012) and Tracy's 'Big Tent' offers multifaceted appraisal criteria that is relevant to qualitative research practices such as resonance, sincerity and credibility, as opposed to the quantitative criteria of generalisability, objectivity and validity. For appraisal criteria where I feel there is room for improvement, I have rated ✓. For criteria which have been sufficiently met I have rated ✓✓.

Table 10 *Quality Appraisal of the study using Tracy's 'Big Tent' Criteria*

Criteria	Evaluation	Rating
Worthy Topic	I consider this research to be a relevant, timely and significant topic given the current social and political context in the UK and the research that suggests service users presenting difficulties are inextricably linked to their social context. Research that uses a discursive approach to analyse how these aspects of people's lives are discussed in the therapeutic exchange are limited and therefore this research offers a novel and evocative perspective.	✓✓
Rich Rigour	Rich rigour was demonstrated in several ways: through a consistent grounding of the research in the social constructionist epistemology throughout; detailed methodology including micro-level analysis of the talk; use of quotation to illustrate constructions and effects of the talk. Robust qualitative studies formed the basis of the literature review and theoretical frameworks and constructs were embedded throughout.	✓✓
Sincerity	Reflexivity formed an integral part of the research study and reflective statements are included at various points to support the reader in positioning my interpretations. My decision-making process as well as challenges I encountered were documented to support transparency for the reader. I do not consider self-reflexivity as something that is final or ever definitively 'achieved'. Rather I see it as an ongoing process. Therefore, self-reflexivity could have improved through more explicit naming of how my lens and assumptions impacted the research process.	✓
Credibility	Credibility was supported through thick description of the language at both the micro and macro level that provided a complex and expansive description of the data (Tracy, 2010). Diverse data sources and reflexive analysis also contributed to the criteria of trustworthiness. Triangulation could have been increased through gaining the perspectives of therapists through follow up interviews.	✓
Resonance	I am hopeful that the research will resonate with readers and can see it's potential to do so through the unique lens that discursive research offers, particularly the taken-for-granted aspects of language and discourse. I see potential for the findings to be valuable across systemic and clinical psychology contexts. The intention of this research was not to produce results that can be generalised but to encourage readers to be able to make choices about how they understand the research and how it may have implications for their own practice and context.	✓✓
Significant contribution	The study provides a notable contribution to how identity and social context can be addressed discursively in therapy and challenges taken-for-granted assumptions, practices and discourses that can enter the therapeutic encounter. In this way the research has practical significance in supporting readers to "see the world in another way" (Tracy, 2010, p. 846) and "generate a sense of insight and deepened understanding" (Tracy, 1995, p.5). Further research is required to build on these findings and offer alternative interpretations, contributing to the social constructionist idea of "multiple truths".	✓
Ethical	Ensuring ethical practice throughout the research was a priority. Ethical considerations were detailed in the methodology chapter relating predominantly to procedural ethics (e.g., informed consent, confidentiality). Relational ethics was also practiced throughout in enacting respect, compassion and care when recruiting participants and in analysing the data. Ethical practice will continue to be prioritised in the next stages of dissemination.	✓✓
Meaningful coherence	I have attempted to achieve meaningful coherence through connecting my research design, data collection and analysis within a theoretical and empirical framework that fits the research methodology. The findings have been conceptualised within the wider literature at both the micro and macro levels and the conclusions and implications of the research "hangs together" within the literature discussed.	✓✓

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Appendices

Appendix A - Search Planning Form

Question: *What do we know about how social context has been considered qualitatively in psychotherapy research and practice?*

Identify the main concepts of the question (use as many as you need)

Concept 1	**Concept 2**	**Concept 3**
Social Context	Psychotherapy	Qualitative

List alternative keywords, terms and phrases below

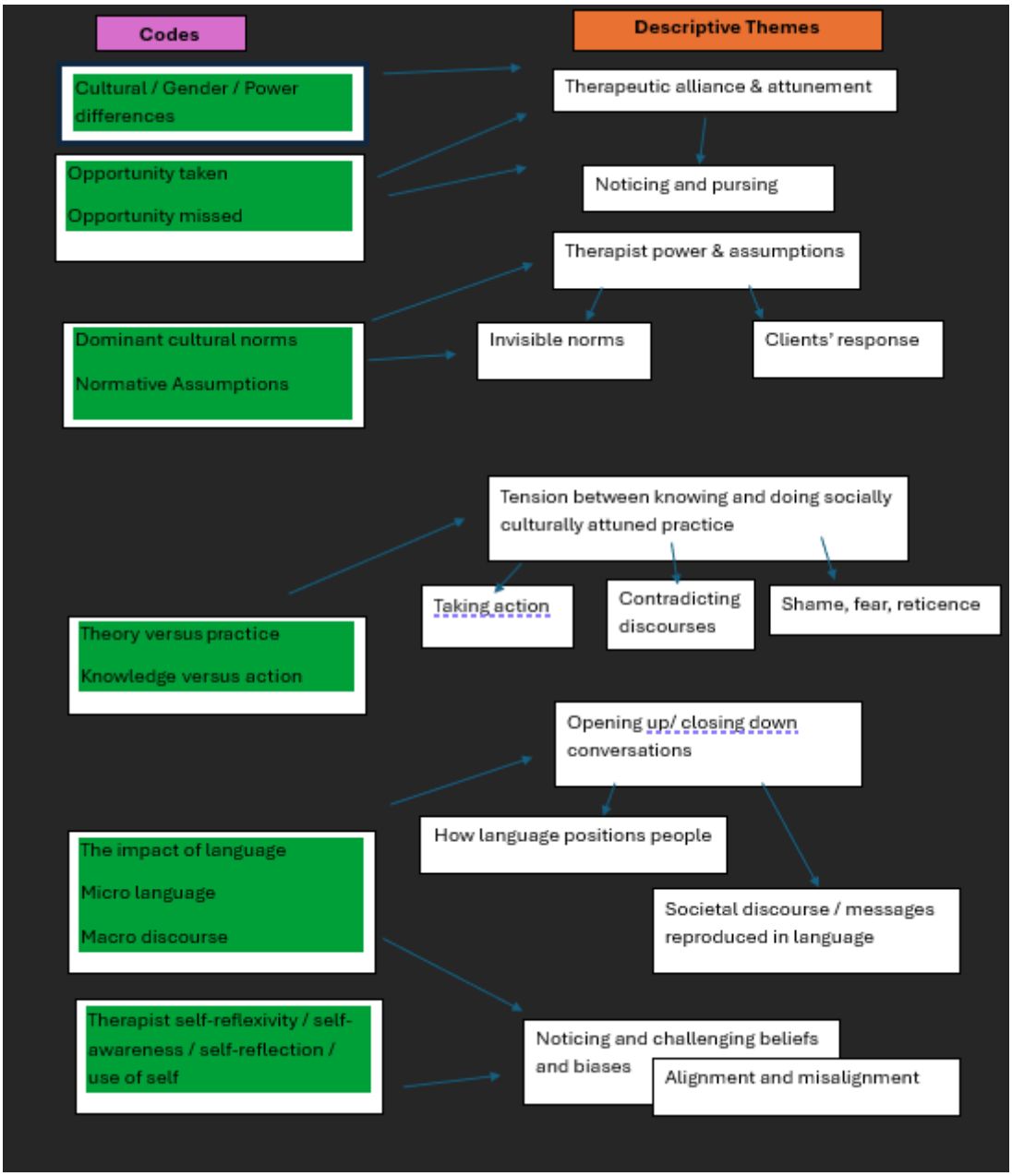
Concept 1	**Concept 2**	**Concept 3**
OR culture	OR family therapy	OR discourse analysis
OR social class	OR systemic psychotherapy	OR conversation analysis
OR class	OR couple therapy	OR discursive psychology
OR identity	OR clinical psychology	OR grounded theory
OR gender	OR counselling psychology	OR ethnography
OR race	OR counselling	OR thematic analysis
OR intersectionality		OR narrative analysis
OR cultural reflexivity		OR action research
OR reflexivity		OR case study
		OR interpretative phenomenological analysis

←AND → ← AND →

Appendix B - Database Searches

A	B	C	D	E	F
Date	**Database**	**Search Terms**	**Search Format**	**No. Results**	**Comment**
12.06.24	Scopus	"social* context*" OR cultur* OR identit* OR "cultural reflexivity" OR reflexivity OR class OR gender OR rac* AND "family therapy" OR "systemic family therapy" OR "systemic practice" OR "systemic psychotherapy" OR "couple* therapy" OR psychotherapy OR counselling OR "clinical psychology" OR "counselling psychology" AND qualitative OR "discourse analysis" OR "conversation analysis" OR "discursive psychology" OR "grounded theory" OR "interpretive phenomenological approach" OR "thematic analysis" OR "narrative analysis" OR "ethnography" OR "Action research" OR "case study"	title, abstract, keywords Filters: English & Human	3886	Too many! Not many looking relevant
21.06.24	Scopus	"social* context*" OR cultur* OR "social class" OR identit* OR "cultural reflexivity" OR reflexivity OR class OR gender OR intersectionality AND "family therapy" OR "systemic psychotherapy" OR "couple* therapy" OR psychotherapy OR "clinical psychology" OR "counselling psychology" AND qualitative OR "discourse analysis" OR "conversation analysis" OR "discursive psychology" OR "grounded theory" OR "interpretive phenomenological approach" OR "thematic analysis" OR "narrative analysis" OR "ethnography" OR "Action research" OR "case study"	Abstract Filters: English & Human Filters Include subject areas: Psychology Filters: 2014 - present	253	Filters helped reduce results and some relevant showing

Appendix C - SLR Synthesis: Descriptive Themes Map



Appendix D - Critical Appraisal Skills Programme (CASP)

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results of the review valid?

1. Did the review address a clearly focused question?

Yes ✓
Can't Tell
No

HINT: An issue can be 'focused' In terms of
- the population studied
- the intervention given
- the outcome considered

Comments: Population was focused on psychotherapy practitioners and service users. Through use of a systematic search strategy the psychotherapy disciplines included were clear.

2. Did the authors look for the right type of papers?

Yes ✓
Can't Tell
No

HINT: 'The best sort of studies' would
- address the review's question
- have an appropriate study design (usually RCTs for papers evaluating interventions)

Comments: All papers were published in relevant academic journals and spanned a range of psychotherapy disciplines. All papers had the appropriate study design (qualitative) and were assessed for their quality uses a quality appraisal tool.

Is it worth continuing?

3. Do you think all the important, relevant studies were included?

Yes ✓
Can't Tell
No

HINT: Look for
- which bibliographic databases were used
- follow up from reference lists
- personal contact with experts
- unpublished as well as published studies
- non-English language studies

Comments: The databases used were chosen for their relevance to the SLR topic (psychology, behavioural and life sciences, allied health, and being multidisciplinary spanning across the social sciences.) Snowballing from the reference list of papers was used to identify further relevant papers. Contact was made with authors around search terms and paper access. Unpublished studies and non-English language studies were not included however a clear rationale (limited resources of doctorate thesis).

4. Did the review's authors do enough to assess quality of the included studies?

Yes ☑
Can't Tell ☐
No ☐

HINT: The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies' results ("All that glisters is not gold" Merchant of Venice – Act II Scene 7)

Comments: All studies were appraised thoroughly using Tracy's Big Tent Criteria.

5. If the results of the review have been combined, was it reasonable to do so?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- results were similar from study to study
- results of all the included studies are clearly displayed
- results of different studies are similar
- reasons for any variations in results are discussed

Comments: Summary table of results included in the SLR. The synthesis of findings captures similarities (areas of agreemnt) and areas of contradiction discusses why this may be.

Section B: What are the results?

6. What are the overall results of the review?

HINT: Consider
- If you are clear about the review's 'bottom line' results
- what these are (numerically if appropriate)
- how were the results expressed (NNT, odds ratio etc.)

Comments: Results clearly explained and linked to rationale of the proprosed research questions.

7. How precise are the results?

HINT: Look at the confidence intervals, if given

Comments:	'Precision' is not relevant for this SLR due to all studies included being qualitative.

Section C: Will the results help locally?

8. Can the results be applied to the local population?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- the patients covered by the review could be sufficiently different to your population to cause concern
- your local setting is likely to differ much from that of the review

Comments:	The reviews offers several applications to clinical practice that clinicians can implement locally. There are also applications for training.

9. Were all important outcomes considered?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- there is other information you would like to have seen

Comments:	While it is possible that some studies were missed and therefore not all outcomes considered, limitations of the the doctorate thesis did not allow for extensive inclusion of studies.

10. Are the benefits worth the harms and costs?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- even if this is not addressed by the review, what do **you** think?

Comments:	Many of the studies inclued in the review were of naturally occuring data and therefore did not require pariticipants to engage in any additional research studies. The possible harm that studies may have cost participants is deemed low.

Appendix E - HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Sim Roy-Chowdhury
Hatfield
Hertfordshire
Al 10 9EUN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

04 September 2024

Dear Dr Roy-Chowdhury

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**How are aspects of identity and context talked about in family therapy? A discourse analysis.**
IRAS project ID:	**343957**
Protocol number:	**TBC**
REC reference:	**24/PR/0856**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

Appendix F - University Sponsorship

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Professor Wendy Wills
PhD, MSc, BSc, SFHEA, Reg Nutr (Public Health)
Professor of Food and Public Health
Pro Vice-Chancellor (Research and Enterprise)
Director, NIHR Applied Research Collaboration (ARC) East of England

Dr Sim Roy-Chowdhury
Aedín Kelly
Department of Psychology, Sports and Geography
School of Life and Medical Sciences

20 November 2024

Dear Dr Sim Roy-Chowdhury

Re: **UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:**
RESEARCH STUDY TITLE: How are aspects of identity and context talked about in family therapy? A discourse analysis.
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Sim Roy-Chowdhury
NAME OF INVESTIGATOR (Student): Aedín Kelly
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGR/NHS/02318
HEALTH RESEARCH AUTHORITY REFERENCE: 24/PR/0856

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission to the Health Research Authority (HRA) Research Ethics Committee (REC) and I must also be notified of the outcome. It is also essential that evidence of any further NHS Trust or other site permissions is sent as soon as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely,

Professor Wendy Wills
Pro Vice-Chancellor (Research and Enterprise)

Appendix G - Participant Information Sheet Therapist

IRAS ID 343957
IRAS Title *'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'*

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

PARTICIPANT INFORMATION SHEET (THERAPIST)

Research title: How are aspects of identity and context talked about in family therapy sessions? A Discourse Analysis.

Researcher: Aedín Kelly, Trainee Clinical Psychologist, University of Hertfordshire.

Supervised by: Dr Sim Roy-Chowdhury

Contact: a.kelly9@herts.ac.uk simroychowdhury@gmail.com

Why have I been given this information sheet?

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve.

If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who is the researcher?

My name is Aedín Kelly. I am a Trainee Clinical Psychologist at the University of Hertfordshire.

As part of my studies, I am conducting the research that you are being invited to participate in. The supervisor and Chief Investigator of this research is Dr Sim Roy-Chowdhury (University of Hertfordshire).

What are the aims of the research?

I am researching how aspects of individual/ family identity and context, such as culture, race, class, gender and sexuality are talked about in family therapy.

The study aims to explore how talk about these aspects of identity/ context occur in family therapy and how helpful it is. In doing so it hopes to further contribute to future family therapy practice, education, and training.

Why have I been invited to take part?

To address the study aims, I approached the X Family therapy service and asked family therapists and families accessing their services, to take part in my research.

It is entirely up to you whether you take part or not, participation is voluntary.

The study aims to recruit a total of three families and three therapists.

Are there any benefits to taking part?

There are no direct benefits in taking part, but we hope that the findings of this research will contribute to future family therapy practice, training and education, and thereby benefit families that have family therapy in the future.

Are there any disadvantages to taking part?

No disadvantages or risks are expected to occur from talking part in the research. There is no deception involved and you do not need to perform any tasks or activities that could pose risk to you. The therapy sessions that will be audio recorded and later analysed are not taking place specifically for the purpose of this study but would be happening anyway as you as a family therapist are already running family therapy sessions.

Version 3
03.09.24

IRAS ID 343957
IRAS Title *'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'*

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318 The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

What will I be asked to do if I agree to take part?

Part 1: If you agree to take part, you will be asked to review your caseload and identify families that meet the recruitment criteria and are reflective of the demographics of local community. An assessment will be made by you based on your knowledge of the family, and your experience and expertise, that participating in the research will not result in any adverse consequences for the family, or negatively impact upon the progression of therapy. Aedín, the lead researcher will provide you with Participant Information Sheets to give to the identified families. Following this, for families that wish to participate in the study, Aedín will provide you consent forms to give to the families.

Part 2: You will be asked to fill out a short demographic form and to facilitate the family therapy session as normal. The therapy session will be audio recorded. The session is audio recoded because it is then transcribed (into written text) for analysis later in the research. The transcribed data will be anonymised, removing any identifiable information. The recordings will be transcribed by the lead researcher, Aedín.

The topics discussed in the sessions do not need to be altered in any way for the purpose of the study. In fact, the aim is for the session to occur as naturalistically or normally as it would any other time.

Part 3: After the session, you will meet with me, Aedín, for a brief interview, to find out about your experience of incorporating talk about the aspects of identity and social context into the session, and how you did this. The interview will take place online using a secure platform. The interview will last approximately 20 minutes. It will be audio recorded.

You will sign a consent form that will also be countersigned by me, Aedín. You will be provided with a copy of this countersigned form for you to keep.

What will the researcher do with the information I give them?

We will keep all information about you safe and secure.

All information collected is strictly confidential. Information will be stored in a locked filing cabinet that is only accessible by Aedín. Encrypted documents and audio recordings will be stored in password protected folders on encrypted devices. Personal identifiable information will only be accessed by Aedín. Information that could identify you will be removed or changed. We will ask you to choose your own pseudonym so that your real name will not be used.

The transcriptions of the audio recorded sessions will be accessed by the lead researcher, Aedín, and Dr Sim Roy-Chowdhury (University of Hertfordshire), only. The written transcript will be kept in a secure location for five years. After this time, it will be destroyed securely.

Recordings of the sessions will be kept securely (saved as encrypted files, in password protected folders, on secure password protected device) until the end of the study (one year and four months), at which point they will be deleted.

How will the researcher use information about me?

We will need to use information about you for this research. This information will include your name and contact details. This information will be used to share consent forms, information sheets and later, the study results. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. The final report of the study will be written in a way that no one can work out that you took part in the study.

IRAS ID 343957
IRAS Title ***'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'***

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318 The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

What are my choices about how my information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

- at www.hra.nhs.uk/information-about-patients/
- or contacting the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk.
- by sending an email to the lead research, Aedín, on a.kelly9@herts.ac.uk

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on University of Hertfordshire's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all the material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

What happens if I agree to take part but then later change my mind?

You can change your mind at any time and withdraw at any point, including during the family therapy session that is being recorded and up to 14 days after. You can withdraw for any reason, and you do not need to provide an explanation.

You can choose to withdraw from the study even if the family choose not to withdraw. *Withdrawal from the study will have no impact on your job role*. If you would like to withdraw from the study, you can do so by directly contacting the lead researcher (Aedín) to withdraw your participation.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. **Aedín Kelly** a.kelly9@herts.ac.uk

Version 3
03.09.24

Appendix H - Participant Information Sheet Family

IRAS ID 343957
IRAS Title *'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'*

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

PARTICIPANT INFORMATION SHEET (FAMILY)

Research title: How are aspects of identity and context talked about in family therapy sessions? A Discourse Analysis.

Researcher: Aedín Kelly, Trainee Clinical Psychologist, University of Hertfordshire.

Supervised by: Dr Sim Roy-Chowdhury

Contact: a.kelly9@herts.ac.uk simroychowdhury@gmail.com

Why have I been given this information sheet?

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who is the researcher?

My name is Aedín Kelly. I am a Trainee Clinical Psychologist at the University of Hertfordshire. As part of my studies, I am conducting the research that you are being invited to participate in. The supervisor and Chief Investigator of this research is Dr Sim Roy-Chowdhury (University of Hertfordshire).

What are the aims of the research?

I am researching how aspects of individual/ family identity and context, such as culture, race, class, gender and sexuality are talked about in family therapy. The study aims to explore how talk about these aspects of identity/ context occur in family therapy. In doing so it hopes to further contribute to future family therapy practice, education, and training.

Why have I been invited to take part?

To address the study aims, I approached the Bedford Family therapy service and asked family therapists and families accessing their services, to take part in my research.

It is entirely up to you whether you take part or not, participation is voluntary.

All family members will need to agree to participate in order for the whole family to participate in the study.

The study aims to recruit a total of four families and four therapists.

Version 3
03.09.24

IRAS ID 343957
IRAS Title ***'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'***

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to fill out a short demographic form (asking for your age, ethnicity and gender) and attend your family therapy session as normal. Each family member will be asked to complete the demographics form. The family therapy session will be audio recorded. Your family therapist will bring the audio recorder to the session. Only ***one*** of your family therapy sessions will be audio recorded. The session is audio recoded because it is then transcribed (into written text) for analysis later in the research. The transcribed data will be anonymised, removing any identifiable information. The recordings will be transcribed by the lead researcher, Aedín.

The topics discussed in the sessions do not need to be altered in any way for the purpose of the study. In fact, the aim is for the session to occur as naturalistically or normally as it would any other time.

You will sign a consent form that will also be countersigned by the lead researcher, Aedín. Each family member will sign a consent form. You will be provided with a copy of this countersigned form for you to keep.

What will the researcher do with the information I give them?

We will keep all information about you safe and secure.

All information collected is strictly confidential. Information will be stored in a locked filing cabinet that is only accessible by Aedín. Encrypted documents and audio recordings will be stored in password protected folders on encrypted devices. Personal identifiable information will only be accessed by Aedín. Information that could identify you will be removed or changed. We will ask you to choose your own pseudonym so that your real name will not be used.

The transcriptions of the audio recorded sessions will be accessed by the lead researcher, Aedín, and Dr Sim Roy-Chowdhury (University of Hertfordshire), only. The written transcript will be kept in a secure location for five years. After this time, it will be destroyed securely.

Recordings of the sessions will be kept securely (saved as encrypted files, in password protected folders, on secure password protected device) until the end of the study (one year and four months), at which point they will be deleted.

What are my choices about how my information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

- at www.hra.nhs.uk/information-about-patients/
- or contacting the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk,
- by sending an email to the lead research, Aedín, on a.kelly9@herts.ac.uk

How will the researcher use information about me?

We will need to use information about you for this research. This information will include your name and contact details. This information will be used to share consent forms and information sheets. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. The final report of the study will be written in a way that no one can work out that you took part in the study.

Version 3
03.09.24

IRAS ID 343957
IRAS Title ***'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'***

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

Are there any benefits to taking part?

There are no direct benefits in taking part, but we hope that the findings of this research will contribute to future family therapy practice, training and education, and thereby benefit families that have family therapy in the future.

Are there any disadvantages to taking part?

No disadvantages or risks are expected to occur from talking part in the research. There is no deception involved and you do not need to perform any tasks or activities that could pose risk to you.

The therapy sessions that will be audio recorded and later analysed are not taking place specifically for the purpose of this study but would be happening anyway as you as a family are already accessing NHS therapy.

Do I receive any reimbursement for my participation in the research?

As a recognition of my thanks for your participation in the research, each family will receive a £20 voucher for the shopping outlet Argos.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on University of Hertfordshire's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all the material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

What happens if I agree to take part but then later change my mind?

You can change your mind at any time and withdraw at any point, including during the family therapy session that is being recorded and up to 14 days after. You can withdraw for any reason, and you do not need to provide an explanation.

You can choose to withdraw from the study even if your family members choose not to withdraw. *Withdrawal from the study will have no impact on your ongoing therapy*. If you would like to withdraw from the study, you can do so by telling your therapist or by directly contacting the lead researcher (Aedín) to withdraw your participation.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. **Aedín Kelly** a.kelly9@herts.ac.uk

Version 3
03.09.24

Appendix I - Consent Form Family

IRAS ID 343957
IRAS Title ***'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'***

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

CONSENT FORM (FAMILY)

How are aspects of identity and context talked about in family therapy sessions? A Discourse Analysis

PLEASE COMPLETE SECTIONS IN BLUE

	PLEASE TICK
1) I confirm that I have been given a Participant Information Sheet (*version 03.09.24)* for above study. I am aware that it states the aim, methods and design, the names and contact details of key people, the potential risks and potential benefits and how the information collected will be stored and for how long. I have had the opportunity to consider the information, ask questions and have these questions answered.	
2) I understand that my participation is voluntary and that I can withdraw at any time, without having to provide reason, and that my ongoing therapy sessions and my legal rights will not be affected. I understand that I can withdraw up to 14 days after the recorded session and my data will not be used in the study.	
3) I understand the family therapy session I am attending will be audio recorded.	
4) I understand that only ***one*** of my family therapy sessions will be audio recorded.	
5) I understand that when a report is written and published about the study, quotes/sentences from the therapy session may be used, but all identifying information will be removed or changed. I give permission for publication of these anonymised quotes.	
6) I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
7) I give my agreement to take part in the above study.	

PARTICIPANT:	**NAME:**	
	CHOSEN PSEUDONYM:	
	DATE:	
	SIGNATURE:	

Version 3
03.09.24
A signed copy of this consent form is provided to the research team
A signed copy of this consent form is provided to the participant
This research is sponsored by the University of Hertfordshire
Study Protocol Number: LMS/PGR/NHS/02318
Ethical Approving Committee: Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

IRAS ID 343957
IRAS Title ***'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'***

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

			Prefer not to say ∨
Participant demographic information	**My age is:**		
	The gender I identify with is:		
	The ethnicity I identify with is:		

Lead researcher sign off

LEAD RESEARCHER:	**NAME:**	
	DATE:	
	SIGNATURE:	
	CONTACT DETAILS:	a.kelly9@herts.ac.uk

Version 3
03.09.24
A signed copy of this consent form is provided to the research team
A signed copy of this consent form is provided to the participant
This research is sponsored by the University of Hertfordshire
Study Protocol Number: LMS/PGR/NHS/02318
Ethical Approving Committee: Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

Appendix J - Consent Form Therapist

ID 343957
IRAS Title *'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'*

This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

CONSENT FORM (THERAPIST)

ow are aspects of identity and context talked about in family therapy sessions? A Discourse Analysis.'

PLEASE COMPLETE SECTIONS IN BLUE

		PLEASE TICK
1) I confirm that I have been given a Participant Information Sheet (*version 3; 03.09.24)* for the above study. I am aware that it states the aim, methods and design, the names and contact details of key people, the potential risks and potential benefits and how the information collected will be stored and for how long. I have had the opportunity to consider the information, ask questions and have these questions answered.		
2) I understand that my participation is voluntary and that I can withdraw at any time, without having to provide reason, and that my job role and legal rights will not be affected. I also understand that I can withdraw up to 14 days after the recorded session and my data will not be used in the study.		
3) I understand ***one*** family therapy session I am facilitating will be audio recorded.		
4) I understand I will be interviewed by the lead researcher after the therapy session.		
5) I understand that when a report is written and published about the study, quotes/sentences from the therapy session and post session interview may be used, but all identifying information will be removed or changed. I give permission for publication of these anonymised quotes.		
PARTICIPANT:	**NAME:**	
	CHOSEN PSEUDONYM:	
	DATE:	
	SIGNATURE:	
Participant demographic information	**My age is:**	
	The gender I identify with is:	
	The ethnicity I identify with is:	

Version 3
03.09.24
A signed copy of this consent form is provided to the research team
A signed copy of this consent form is provided to the participant
This research is sponsored by the University of Hertfordshire
Study Protocol Number: LMS/PGR/NHS/02318
Ethical Approving Committee: Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

ID 343957
IRAS Title *'How are aspects of identity and context talked about in family therapy sessions? A discourse analysis.'*

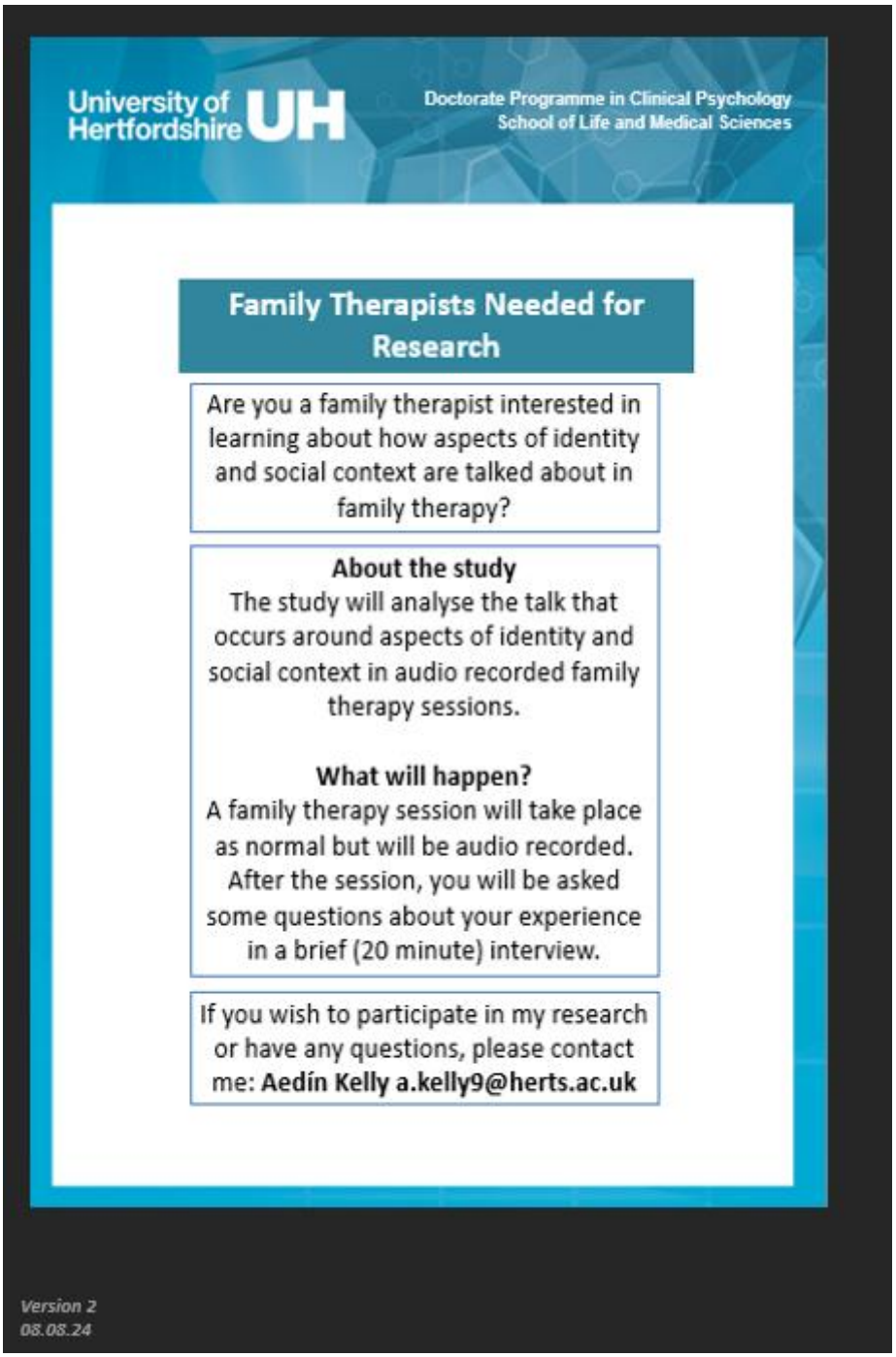
This research is sponsored by the University of Hertfordshire under protocol number: LMS/PGR/NHS/02318
The Ethical Approving Committee is Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

Lead researcher sign off:

LEAD RESEARCHER:	**NAME:**	
	DATE:	
	SIGNATURE:	
	CONTACT DETAILS:	a.kelly9@herts.ac.uk

Version 3
03.09.24
A signed copy of this consent form is provided to the research team
A signed copy of this consent form is provided to the participant
This research is sponsored by the University of Hertfordshire
Study Protocol Number: LMS/PGR/NHS/02318
Ethical Approving Committee: Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

Appendix K - Research Advertisement



Appendix L - Reflective Research Diary

November 2024: I have decided not to use grey literature in my systematic literature review. While I feel confident that the studies I have included in my SLR following database searching, I also feel somewhat conflicted about this decision particularly given my epistemological stance which assumes that no one type of knowledge is more 'real' or 'valid' than another and therefore whether this decision is going against this stance…. I think that the decision has been influenced mostly by the more practical constraints of this research (i.e. the time limitations of a doctorate thesis, the guidelines that we are encouraged to follow such as ensuring quality criteria can be applied etc.), which has left me feeling less adventurous (or maybe ambitious?) about how I want to approach the systemic review. I am mindful of the implications of this – that research that falls outside of commercial publishing interests and therefore could bring more varied, alternative perspectives is not captured. In hindsight, if I was to go back and start the SLR process again I would consider a scoping review that allows more nuance in approach incorporating empirical and non-empirical papers, as well as grey literature.

December 2024: As I continue to wait for participants to consent to my research, I am becoming more aware of the impact my 'outsider' position as a trainee clinical psychologist may be having on entering the systemic family therapy space. I realise that I had assumed that recruitment would be relatively straight forward and that the family therapists I approached would quickly consent and subsequently find consenting families on their caseloads. I see now how previous experiences of not having difficulty accessing experiences, opportunities and getting my professional needs met may have biased how I approached recruitment and maybe meant that I did not invest as much as I could have in making connections and forming relationships with possible participants. For future research that I carry out I will remember this learning.

January 2025: Several families approached to participate have declined, despite therapists expecting they would consent. I find myself feeling disappointed with this outcome, and my anxiety about meeting my deadlines increased. Rather than let this anxiety override, I have considered it an opportunity to think about what might be getting in the way. Is it that I am a researcher with no relationship with the families? Is it that I have not explained the research aims clearly with the therapists that approaching families, and therefore families are not understanding fully what the research is about? With this in mind, I have contacted the therapists who are attempting to recruit families to see whether a further meeting would be helpful, to talk through some of these barriers and whether there is something I can do. Separately, I have tried to place myself in the shoes of a family or young person accessing therapy. At the age of 16 would I have wanted my therapy session recorded? What would it feel like to read a participant information sheet about research when

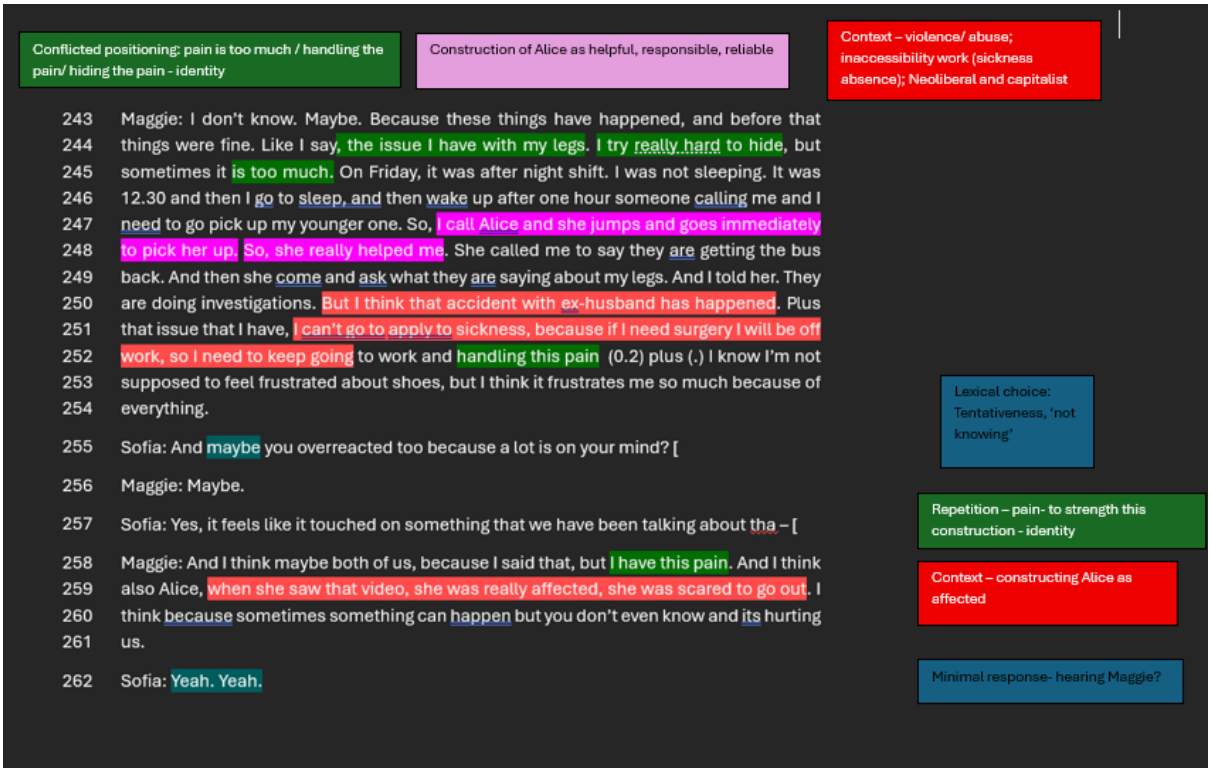
possibly feeling in a vulnerable position (accessing mental health services) and just wanting support?

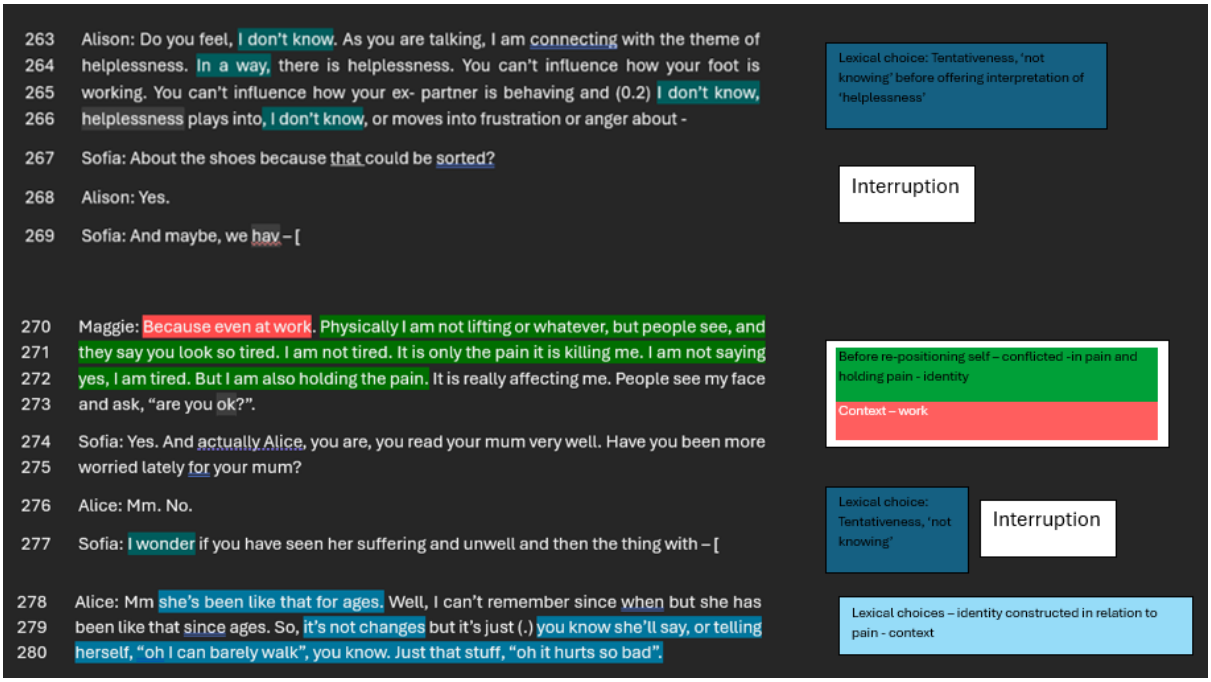
March/April 2025: The first theme I am seeing in the analysis of session one is around gender, specifically male/ female gender roles and the power differences inherent in that. I feel really engaged with this theme and I'm feeling motivated in continuing to analyse what the talk is doing in relation to this theme. I am also aware however of my sensitivity to this area based on my own positioning (a women, a feminist etc.) and whether this sensitivity is highlighting this theme to me more than it is actually occurring in the talk? While I accept that this is normal to a degree – what we have experiences of or interests in will heighten us to these things- but I want to ensure that I am keeping the language front and centre. I will go back over the transcript of this section to ensure that gender role/ expectations/ discourses are in really coming from the talk.

Appendix M - Transcription Notation

(.)	A pause, noticeable but to too short to measure
(0.2)	A pause, within and between speaker turns, in seconds
'Umm::'	Extended sounds: sound stretches shown by colons in proportion to the length of the stretch
CAPITAL	Words in capitals indicates a louder utterance
<u>Underline</u>	Words underlined indicates emphasis or stress
[	Overlap of talk
?	Indicates rising inflection
!	Indicates animated tone
'brok-'	A hyphen indicates a word/ sound is broken off
'hhhh'	Audible intakes of breath… (the number of h's is proportional to the length of the breath
(words…)	Parenthesis indicate uncertain transcription including transcriber's 'best guess'.
(( ))	Double parenthesis indicate clarificatory information e.g. ((stands up))

Appendix N - Transcript Coding Example





Appendix O - Transcript Extract

Family 1: Mum, Mel. Therapist, Liz. Excerpt 3: Lines 233-281

Mel: Yes, he was very happy, because my Mum, she is very happy and very talkative, and, they all like her, they love her, they were very happy. I think Oscar was the most happy she was with us, and he asked me when is she going to come back and I told him probably autumn half term, he said "ohhh" he got really sad.

Liz: I think the work that we can do here in the context of Oscar, because he is the one that has been referred here, is to look at the impact the trauma has had on you. As a parent, a person, parent and woman, you cannot separate obviously your identity as a women with your role a parent. So, I say as a parent, because this a child and adolescent service, but obviously thinking about trauma holistically is actually quite important. I think it will have a positive impact on you in general. I know we spoke about EMDR last time, it is a technique. EMDR stands for Eye Movement Desensitization Reprocessing. You don't have to speak or account a story per se, but we focus on an image or a particular sensation, for example, the road, and how triggering it is to drive through here. And then there is a technique that I will ask you, what is the negative belief you hold about that memory? What is it that you would like to think about instead of that? So, thinking about

a positive belief instead. And then we would process the negative memory and feelings by asking you to look at my hands, following my fingers, and you are fully conscious for this, and what that does is it helps your brain to process the memory. So, if you think about your brain as a big chest of drawers, so it has lots of drawers, and then when trauma happens it means that this drawer cannot close and so the memories that are in this drawer are constantly triggered, even though that happened maybe years ago (.) they are constantly triggered by things that are similar or maybe remind them of that, so similar to driving on that road. And what that does is it triggers that same sensation that happened maybe a long time ago (.). And so, by hhh (.) kickstarting this eye movement, and you can do it also, you don't have to do it with eyes if that is difficult. You can do it with tapping yourself, we can try different things [

Mel: Mhm [

Liz: But what that does is that it kickstarts that neurological process that the brain automatically does when we sleep. So, when we go to sleep our brain automatically processes all these different things that have happened to us during the day (.) and have you ever heard about REM sleep?

Mel: Mhm

Liz: So, REM sleep is a stage of our sleep when our eyes naturally move right and left.

Mel: Ah, okaaay

Liz: And that is the process our brain automatically uses to process memories, and so [

Mel: Oh, right.

Liz: And we would do this when awake obviously.

Mel: That's interesting.

Liz: But the technique is the same (.) you use the hand movement to kickstart this neurological process and then it allows the memory to go back and kind of close the drawer kind of thing.

Mel: Mhm

Liz: It might take a while, it doesn't happen automatically but it allows it to have a different mean- it doesn't erase the memory of course but the way that you will feel in relation to that memory is different.

Mel: Mhmm.

Liz: And you can use this technique also with children, so adults and children.

Mel: Mhm.