Responsibility inoculation: Constructing ‘good parent’ accounts when accessing child mental health services

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Abstract
With the prevalence of child mental health conditions rising, the role of the initial mental health assessment is crucial in determining need. Utilising a critical discursive analytic framework, we explored the ways in which parents during these mental health assessments constructed the child’s difficulties as medicalised and doctorable as opposed to systemic and familial. Through this discursive positioning, we examined the ways in which parents mitigated blame and accounted for the child’s behaviours and emotions. Parents engaged in three accounting practices to construct the child’s problems as dispositional and to mitigate against an alternative familial system interpretation. First, they drew upon normative cultural repertoires of parenting. Second, they mediated ways whereby normative practices were deviated from in the best interest of the child. Third, they rhetorically positioned overcoming systemic difficulties by illustrating cooperative parenting in separated families. Our findings have implications for how parents build a case for the need for medical intervention in assessment settings.

Keywords
Systemic, parenting, discourse, families, mental health, assessment

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1. Introduction

Child and adolescent mental health is increasingly highlighted as an international priority. Estimates suggest a global mental health condition prevalence of 10–20% in children and young people (Keiling et al., 2011), with 12.8% of 5–19-year olds in the United Kingdom having a diagnosable condition (NHS Digital, 2018). A focus on identification, prevention and early intervention has been prioritised by the UK multi-agency initiative (Department of Health, 2017). Typically, the responsibility for identification and categorisation of ‘disorders’ falls under the specific disciplinary activities of psychiatry and psychology. Such professions usually base decision-making on standardised criteria provided through formal psychiatric classification systems: the DSM-5 or ICD-11. Arguably, however, this categorisation is predominantly informed by a biomedical understanding of children’s behaviour or emotions as symptomatic of underlying cognitive or affective deficit. We argue for an alternative perspective that what constitutes ‘normal’ behaviour in relation to developmental expectations is better thought of as culturally, socially and historically situated. From this position, what constitutes ‘normality/abnormality’ are constructs that are created via professional practices as opposed to being revealed by them (Burman, 2008).

Taking a wider perspective to understanding mental health conditions, the bio-psycho-social-spiritual framework offers a heuristic for conceptualising presenting ‘difficulties’ within a systems approach. Attempting to make sense of mental health involves accounting for the complexity of the intersection of several interrelated social, familial, cultural and educational systems around the child (Weare, 2000) and how these are negotiated and oriented to by the people within them. Such systemic thinking can facilitate researchers in their investigations of mental health by promoting a mapping of connections between behaviours and perspectives (Dixon, 2007). At the heart of this thinking are theoretical ideas of intersecting systems around an individual child. One particularly influential theory has been the five interconnected systems identified by Bronfenbrenner (1979) that demonstrate the multidimensional layers of social influence on children and young people. These were (1) micro-system, for example, family and school; (2) meso-system, for example, interaction between different components of the micro-system; (3) exo-system, for example, school policies; (4) macro-system, for example, cultural norms and government policies; and (5) chrono-system, for example, democracy.

Within the context of the macro-and chrono-systems, the identification of the aetiology of the child’s mental health difficulties typically occurs within a child and adolescent mental health assessment framework informed by mental health policies. The task of these multidisciplinary assessments is to tease out explanations for a child’s difficulties in a way that identifies the need for either specialist professional intervention or whether other factors like parenting skills require attention. The pervasive Western cultural rhetoric about children’s behaviour often positions blame for anti-social or non-normative behaviour with the parents. In such discourses, women typically carry the societal burden due to the perspective of failure to fit the idealised view of motherhood (Blum, 2007; Jackson and Mannix, 2004).

Thus, as a possible counter to this pervasive societal perspective, it is common for parents presenting their children at a mental health clinic to position the child’s problem as
dispositional and medical (Berg and Steiner, 2003), rather than arising due to difficulties in the family system. The institutional task of the mental health professionals is to undertake an initial assessment, which is designed to screen for symptoms consistent with a diagnosable condition, identify risks and create an initial formulation (Mash and Hunsley, 2005). From the perspective of a parent, there needs to be an alignment between the presenting issue and institutional business which is evidenced in the way that parents present their child’s difficulties. In other words, parents work to present a ‘doctorable reason’ (Heritage and Robinson, 2006) for their attendance at the assessment.

Consequently, presenting a ‘doctorable reason’ in the context of child mental health assessments is a complex endeavour in which parents may anticipate and rebut interpretations that a dysfunctional familial system is a viable alternative explanation. Parents may therefore present their accounts to resist potential allocation of blame in ways that exonerate them (Patrika and Tseliou, 2016). It is recognised that parents often need to be quite persistent in seeking out professional mental health support for their children. For example, one study illustrated that families typically wait an average of 3.1 years from initial parental concern to diagnosis (Shanley et al., 2008). Their persistence in seeking specialist professional input is indicative of parents’ conviction that the strategies and resources they have utilised in the family context are insufficient to meet the needs of the child and that additional mental health intervention is required. Therefore, problem presentation is an essential focus for both families and mental health professionals (O’Reilly et al., 2015).

The aims of this article are to investigate the ways in which parents position their child’s difficulties as individual and doctorable as opposed to (micro)systemic and familial, in the context of mental health assessments. To ascertain how parents position themselves as ‘not-to-be-blamed’ and position their children as medically mentally unwell in this institutional setting, we examine the social actions, discursive resources and accountability practices they use.

2. Method

2.1. Context

The study was undertaken in a UK Child and Adolescent Mental Health Service (CAMHS), from which a purposeful sample of all consenting first assessment appointments were included (urgent referrals were excluded). These were video recorded to capture the whole assessment. These initial mental health assessments were multidisciplinary. Children and young people were usually assessed by two mental health practitioners and all 29 practitioners participated consisting of consultant, staff-grade and trainee psychiatrists, clinical and assistant psychologists, community psychiatric nurses, psychotherapists and occupational therapists. On average, each assessment was 90 min and 28 families participated, consisting of 64% boys and 36% girls. The referred children and young people attended with one or both parents and sometimes with siblings, grandparents and/or others.

To spotlight and understand real world practice, we collected naturally occurring data for the study. This involves recording natural events to capture what happens in practice.
rather than retrospective reports via interviews or focus groups (Kiyimba et al., 2019). Data were transcribed using the conventional method of Jefferson, to illustrate both what was said and how it was said (Hepburn and Bolden, 2017). This is a collection of symbols that represent exactly how the words were said, including paralinguistic features and lengths of silences. See Table 1 for a summary.

2.2. Analytic approach

Critical Discursive Psychology was undertaken to analyse the data corpus. This approach is considered a synthesis of Foucauldian discourse analysis and conversation analysis, utilising the core conceptual framework of discourse analysis (Wetherell, 1998). This approach maintains the integrity of the earlier form of discourse analysis that draws upon the notions of subject positions, interpretive repertoires (Wetherell and Potter, 1988) and ideological dilemmas (Billig et al., 1988). While founded in discursive psychology, critical DP accounts for the wider sociopolitical ideologies and institutional frameworks within which they are produced (Willig, 2013). This is valuable for the research question as it takes the position that discourse is ‘a basic medium of action’ (Potter, 2012: 104), so it is a useful way of looking at how parents in an assessment perform the social action of positioning themselves as ‘good’ or ‘virtuous’ as a rhetorical means of stake inoculation against other possible inferences about their parenting. In other words, the speaker uses language in such a way as to ward off any potential accusation of having a vested interest in the outcome.

2.3. Ethics

The research study was subject to the National Health Service ethical governance procedure and approved. All members of the assessment provided informed consent/assent before and after completion of the assessment. Pseudonyms are used for anonymity, and safeguarding was the responsibility of the clinical team.

| Symbol | Description |
|-----------------|-----------------|
| () | A period (full stop) inside parentheses denotes a micro-pause |
| (0.2) | A number inside brackets denotes a timed pause |
| [ ] | Square brackets indicate the start and end of overlapping speech |
| >talk< | Inward-facing arrows either side show the pace of the speech has speeded up |
| <talk> | Outward-facing arrows show that the pace has slowed down |
| Underlined | This underlining indicates a raise in volume or emphasis |
| ↑ | An upward arrow means a rise in intonation |
| ↓ | A downward arrow means a lowering of intonation |
| → | An arrow like this denotes a sentence of interest to the analyst |
| CAPITALS | Indicate something was said loudly or shouted |
| :::: | Colons represent elongated speech, a stretched sound |
3. Analysis

The institutional task of the CAMHS multidisciplinary assessment team is to determine the presence or absence of a diagnosable mental health condition for which the service can offer an intervention. Their obligation is to appropriately allocate resources to children and families who would benefit from the service. Purportedly, the task for the parents and family members is to persuade the professionals that the child’s behaviour ought to be understood a symptom of an underlying mental health condition rather than being the consequence of poor parenting skills. In other words, the child’s deviation from social norms is due to an internal, medical, dispositional deficit, rather than due to parental mismanagement. The difference between the two explanations has implications not only for service provision but also for how responsibility, accountability and blame might be drawn upon as resources to discursively position self and others. What is at stake for families in this context is access to mental health resources and support, but the risk is that they will be unable to gain access and instead be signposted to alternative services such as parenting classes. The following examples are indicative of the ways in which families oriented to this institutional business and the possible outcomes.

Extract one: Family#4 (Child = 9 years [M])

Mum  I just wanted to try and get him assessed (0.50) cos I’m just sick of ‘im being classed as a naughty child

Extract two: Family#6 (Child = 9 years [F])

Doctor  The message I’d give to her today (0.43) is that I think she’s got lots of positives but she has to take responsibility for her behaviour ... and she has to understand that when you say no it means no
Lines omitted
and then >I think CBII is gonna reinforce that we- we-what we would have is (0.82) assessment of our (letter) I would go to them

Early in the assessment (extract one), the mother orients to her previous experience of the child being conceptualised as ‘a naughty child’, which is contrasted with the need for him to have a mental health assessment. In doing so, she constructs the assessment as a necessary solution for warding off a potential evaluation of the child’s behaviour as being attributable to poor discipline practices. What is at stake (Edwards and Potter, 1992) is a possible failure to position the child’s behaviour as warranting medical intervention. The second extract demonstrates that this alternative reading of a child’s behaviour is a very real possibility, when the doctor at the end of the assessment recommends parenting classes (i.e. CBII). In both extracts, the child is positioned against normative markers of behaviour, with extract one positioning the child as deviating from the norm due to mental health need, and in the second extract, the child is
positioned as deviating from the norm due to a lack of enforcement of parental boundaries (e.g. when you say no it means no).

The analysis of this article focuses on parents’ work to mitigate against a potential outcome of redirection to parental support. The stake management of families within these mental health assessments occurs from a wider sociocultural rhetoric of parental blaming and child mental health (e.g. Dallos, 2019; O’Reilly and Lester, 2016; Singh, 2004). Thus, one of the recurrent features of child mental health assessments is the demonstration of parents accounting for their child’s behaviour. Our analysis demonstrates three types of accounting practices whereby they position themselves as parenting appropriately within the familial context: (1) they draw upon normative child-rearing repertoires, (2) they justify deviations from normative child-rearing practices and (3) they mitigate familial systemic disruption.

3.1. **Engaging in normative child-rearing repertoires**

The first way of accounting used by parents in this context was to draw upon examples of normative child-rearing practices and illustrating the parallels between their own ways of ‘doing parenting’ and its alignment with socioculturally accepted strategies. As such, they highlight the virtues of their own parenting skills and simultaneously imply that the child’s behaviour or difficulties need to be understood through a medical paradigm lens. The following group of extracts illustrate a range of normative child-rearing practices that were oriented to by parents including going to bed at an appropriate time (extract 3), holding a child’s hand as they cross the road (extract 4) and ensuring the child eats (extract 5).

Extract three: Family#3 (Child = 13 years [M])

Doctor  
when do you go to bed?  
Child  
half ten  
Doctor  
half ten  
Mum  
I send him up at ten ((laugh))

Extract four: Family#11 (Child = 9 years [M])

Mum  
[no he has ne]ver crossed his the road on 'is own do you know I am [al]ways with him

Extract five: Family#26 (Child = 8 years [M])

Clin Psy  
and if 'e is (.) if 'e won’t eat somethin’ how would your response to that?  
Mum  
I’ve always got a s[oup] in  
Clin Psy  
[be]
In each of these three extracts, the mothers positioned themselves as being a responsible parent by attending to the primary needs of their children: food, sleep and safety. In extract three, the mother treated the doctor’s question about the child’s bedtime as at least partially her responsibility and corrected the child’s answer of ten-thirty to state that she tells him to go to bed at ten. This functions as a display of attempting to do good parenting by taking an appropriate course of action, whether or not the child actually complies. The laughter at the end of her turn orients to this potential tension between what she tells him to do and what he does. In extract four, the use of extreme case formulations (ECFs) such as ‘never’ (Pomerantz, 1984) bolsters the mother’s claim to being attentive to her child’s safety and even at the age of 9 years, still holding his hand as he crosses the road. Again, accountability to be a responsible parent is managed by positioning herself as engaging in appropriate parenting behaviour. In extract five, the child’s refusal to eat was constructed as problematic by the doctor, and the mother was in effect called to account for how she manages this behaviour. Her response was a display of knowing what her child likes to eat and taking responsibility for ensuring she always has that kind of food available, that is, ‘good mother’ activities.

Notably, while the parents orient to these normative practices, by looking at the sequential design of the conversation, it becomes visible that there are shared norms between families and mental health practitioners, as seen in the way the practitioners respond to these appeals of ‘good parenting’. In the following extract, the mother described her decisions about her working life in terms of prioritising availability for the children before and after school.

Extract six: Family#13 (Child = 8 years [M])
The underlying social rhetoric about working mothers as potentially detrimental to their child’s well-being is implicitly addressed when the mother reports that she drops her children ‘off at school’ and balances her work commitments to only do ‘six hours’. The collaborative accomplishment between the mother and Registrar is that this means that she can pick them up from school as well. Her use of the phrase ‘rush back’ indicates that it is difficult for her to manage this which emphasises her ‘good mothering’ as she does something difficult for the sake of her children. The two turns interjected in this narrative by the doctor confirm the social norm that being at home when the children are at home is ‘ideal’. The collaborative nature of this sequence between the mother, Registrar and Doctor works to corroborate the mother’s narrative within which she offers a subject position of her good mothering, as acting in the best interests of her children. In so doing and by the Doctor’s use of a strong agreement marker (‘ideal’), there is an emphatic endorsement of the subject position proposed. The underlying repertoire that is drawn upon by the mother is consistently that of being a good parent, which acts as a way of inoculating against any possible inference that the child’s problem is a matter of poor parenting. Later in the assessment, the conversation turns to more specific examples of the child’s behaviour as illustrated below.

Extract seven: Family#13 (Child = 8 years [M])

Mum you know he’s bitten me
Registrar um
Mum er throws things around (0.34) shouts screams
Registrar [um] how do you deal with that when that happens? (. >what do you do?<
Mum I tried the (0.82) ignoring it to start with you know (. I thought oh okay (. we’ve tried that we’ve tried
Registrar [um]
Mum (0.45) send him to his room
Registrar °umhm°
Mum shouting at him
(1.20) smacking him
Registrar °um°
Mum >um there doesn’t seem to be anything that (1.39) really (0.34) calms him down

In this example, the mother constructed the child’s actions through extreme terms by listing a range of challenging behaviours including ‘bitten me… throws things… shouts… screams’. The way in which the child’s behaviour was constructed through the continuous present tense argues a case for an ongoing problem. The rhetorical function of this kind of listing of behaviours combined with the specificity of the reported actions builds a case
that the behaviours are reflective of the disposition of the child. What is at stake is the ideological dilemma (Billig et al., 1988) of whether the child’s behaviour is symptomatic of poor parenting or an underlying mental health condition. The question in response by the Registrar potentially can be heard as either a risk assessment question if her response raised safeguarding concerns or as a way of establishing the appropriateness of her parenting skills in behaviour management. The mother’s three-part list (Jefferson, 1990) illustrates traditional parenting responses to bad behaviour of ‘ignoring it’, sending the child ‘to his room’ and ‘shouting at him’. This point in the conversation is what is known in CA as a Transition Relevance Place (Sacks et al., 1974) which is an obvious point in the interaction where another speaker might come in and take their turn. Following this three-part list, there is a significant pause of 1.2 s, and the mother resumed the conversational floor by adding an additional (and potentially more controversial) mode of discipline ‘smacking him’. The risk of adding smacking to the list is that her parenting may be called into question; however, the behaviour was positioned as so extreme that this is implied as a last resort discipline. This statement was followed by the social action of a complaint that nothing works, ‘there doesn’t seem to be anything that calms him down’. By using the term ‘anything’, the mother positioned herself as having tried every other appropriate parenting strategy to manage the child’s problem behaviour. Importantly, her presentation of the objective of trying to calm the child down constructs her motivation as being in the child’s best interest rather than a punishment for the behaviour. Additionally, it positions her presence in the assessment as a request for some other intervention that will calm the child down. By implication, this could be medication or at least service provision.

3.2. Justifying deviations from normative child-rearing practices

An important dilemma for the parents relates to demonstrating that the child has a doctorable problem, rather than a parental discipline challenge. One way in which this was accomplished was to present a case for the extremity of the lengths they have already gone to from a behavioural management point of view to illustrate that despite those strong efforts, this had not been successful in reducing the child’s problematic behaviours. One of the risks for parents in describing their use of behaviour management strategies that are outside normative expectations of what would be appropriate may be that these are construed by the practitioners as countering sociocultural child-rearing practices. This could present an ideological dilemma for parents working to build a case for the pathology of their children’s behaviour while managing their ‘good’ parenting identity. The following extracts are examples where parents disclosed rather more extreme techniques for trying to calm their children down, while justifying the necessity of those.

Extract eight: Family#4 (Child = 9 years [M])

Mum ↓ cuz Jason ↓ sleeps with me

Doctor ↓ alright (. ) ok ↓ is there any particular ↑ reason for that is there ↓ or-

Mum Yeah (0.53) because:: (0.86) me sixteen year ↓ old’ s been studying ↓ obviously for his GCSE: ’ s
In this extract, the mother disclosed that her son, nine-year-old Jason (the child referred for the assessment), sleeps in her bedroom with her rather than with his brother James. This may be interpreted as contravening sociocultural norms risking positioning the mother as making an inappropriate parenting decision. In British culture, it is expected that children sleep separately from their parents by school age at least. However, she manages what is at stake for her parental identity by positioning this decision as protecting Jason from James’ violent attacks, ‘it’s not safe for him to be in the same room as James’. In doing so, she simultaneously treated the disclosure as accountable and open to interpretation as poor parenting, and yet mitigated against this possible reading of it by evoking a protective parent narrative which would supersede the prior infringement. The following extract is a similar example of what ostensibly may seem an example of inappropriate parenting, but when the parental justification is accounted for, can be interpreted differently.

Extract nine: Family#6 (Child = 9 years [F])

The extract opens with the mother’s complaint that she has ‘tried everything’ by which she means that she has engaged in the usual parenting discipline strategies to ensure compliance with childhood bedtime routines. Through her narrative, the mother incrementally built a version that positioned her daughter as being uncooperative and
defiant. The culmination of the narrative was that the mother disclosed that she had locked her daughter out of her bedroom. Again, this could be perceived as being an inappropriate and potentially unsafe parenting practice. However, the justification provided more contextual information that the child’s violent behaviour ‘kicks and punches me’ warranted this extreme reaction. The use of the phrase ‘I have to’ indicates that the mother did not have any other option. In presenting this account of her own parenting, she managed to build a case of the child’s extreme behaviour and thus invoke the notion that there was a mental health reason for the violence of the child. In so doing, the mother oriented to the institutional business of the assessment while managing her stake in the outcome. The ambiguity of the non-committal acknowledgement token from the doctor ‘uhum’ precipitated an extension to the mother’s narrative, which portrays her as maintaining connection with her daughter by sitting behind the door, and also points to the success of the strategy in ultimately resulting in the child being able to ‘calm down’. The third example in this category relates to the mother providing cigarettes to her 13-year old daughter. Ostensibly, this would clearly be considered inappropriate parenting behaviour, but it is argued by the parent to be the lesser of two evils.

Extract ten: Family#14 (Child = 13 years [F])

MHN and do you smoke cigarettes?
Child Ye:ah
MHN How many?
Child ↓I don’t know
(0.65)
I don’t really[(know)]
Mum [she normally goes] mental if she don’t have a (1.78) cigarette in the morn’ ↓or:
Child or[( )]
Mum (you know I have t (.) keep mine in me pocket an’ (0.68) sleep wi’ me purse and) (0.89) shouldn’t be like that but =
Child <but sometimes you let me have one> (0.45) *(it depe[nds though])*°
Mum sometimes I ave to li:ke let her ↓have one an’ you know just calm her ↓do:wn an’
MHN °um (.) ok°
Mum I don’t agree to (i:t) but either that or she’ll (0.52) go out an’ steal (0.95) or (0.24) I don’t know
MHN umhm

The ideological dilemma navigated by the mother was to decide between two risky behaviours. The first by allowing her daughter to be distraught ‘go mental’ and not doing anything to help her; the daughter would ‘go out and steal’ which could result in a criminal
record. The second was to position a parenting strategy as something that she does not agree with ‘I don’t agree to it’, but was less risky, which was to allow her daughter to have a cigarette ‘let her have one’. By using the construct ‘have to’, the mother indicated that there was a lack of alternatives in this situation. Within the context of the mental health nurse’s question about how many cigarettes are smoked, the mother’s statement with a specific orientation to only providing her daughter with ‘one’ cigarette indicates the minimal concession possible in a bad situation. This rationale works to accomplish positioning the mother as a ‘good parent’ as the outcome was that daughter calmed down and was not engaged in criminal activity.

3.3. Mitigating familial systemic disruption

Normatively, the rhetoric associated with separated families tends to be negative in tone. Arguably, while there is evidence that there can be poorer outcomes for children from separated families (Hanson, 1999; Rodgers and Pryor, 1998), there is more of a need to present the case that the child’s problems are grounded in medicalised reasons and not familial ones. For some parents in the data corpus, the construction of their parental identity as a good parent was located within the wider family system. The following extracts represent examples of parents during the mental health assessment of their child, acknowledging but rejecting the societal rhetoric of a negative impact of their separation by demonstrating their continuing commitment to prioritising the child’s welfare.

Extract eleven: Family#1 (Child = 13 years [F])

Clin Psy  How’s your relationship with him?
Mum  Yeah we get on we’ve got on for years I mean obviously since I’ve [split up we’ve got on]
Clin Psy  [um]
Mum  for Deborah’s sake yeah

In the institutional context of a child mental health assessment, the question from the clinical psychologist about the quality of the mother’s relationship with the child’s father can be heard as potentially accountable. The mother’s response that she ‘gets on’ and has continued to ‘get on for years’ with her ex-husband is a display of ongoing and consistent co-parenting. Importantly, the reason is reported to be for the well-being of the child ‘for Deborah’s sake’. This was thus constructed as a deliberate intentional continued effort on the part of both parents to maintain an amiable relationship to facilitate cohesion in the family system.

Extract twelve: Family#16 (Child = 8 years [M])

Mum  like I say the relationship between him and his father’s always been consistent right from day one you [know] there’s never been any breaks for
Nan  [Yeah]
Doctor  So has he always had contact?}
The potential criticism that was implicitly attended to by the mother in extract twelve was that there may be deleterious effects on a young boy who is not able to maintain regular contact with his father. The institutional business is to establish the possible aetiological development of the child’s current difficulties as well as the anticipated prognosis and intervention. Her narrative builds a very strong case for her intentional prioritisation of the value of the wider family system on the child’s well-being. Thus, mitigating any interpretation that the child’s difficulties were due to an absent father. The strength of the mother’s case is largely determined by her use of ECFs (Pomerantz, 1984) in her narrative. For example, she emphasised that the child had contact with his father from the outset of their separation, ‘from day one’, and that there were ‘never’ breaks in that contact, that he ‘always has him in the holidays’, and that the phone calls were regular to the point of being almost ‘every day’. Thus, the use of these ECFs ‘cuts off the basis for the search for an account’ (Sacks, 1995: 23). In this way, she positioned herself as a good mother for fostering this kind of relationship, but simultaneously positioned the father as a good father for taking care of his son and maintaining such regular contact.

Extract thirteen: Family#13 (Child = 8 years [M])

Notably, in this example, both parents were present in the assessment, and although the father was speaking, he was doing so on behalf of himself and the child’s mother through the inclusive pronoun ‘we’. In the previous two extracts, one present parent was reporting on a non-present parent and appraising their involvement in the child’s life. However, in this example, the mother and father cooperatively build a case that they work collaboratively and are ‘consistent’ in their approach to the child, with the father verbally articulating the consistency and the mother providing non-verbal
agreement. Through his articulation, the father worked to counter the negative rhetoric associated with separated couples and directly reported that they do not ‘bicker’ or ‘say bad things about each other’ and emphatically stated the absence of any ‘violence’ between them or towards the children. Thus, the father positioned other separated couples as possibly hostile towards each other, and yet contrary to that he positioned himself as part of a separated couple but still effectively engaged in co-parenting with his former wife. In this, there was an orientation that good parents not only treat their children well but are also considerate towards each other. This is an acknowledgement that child rearing is a systemic practice and not just an individual parenting activity. Likewise, in the following extract, the parents were both together in the session and collaboratively work to separate their positions as parents from their position as a couple to illustrate their view that their parenting was not compromised by the separation.

Extract fourteen: Family#19 (Child = 14 years [F])

Doctor

Okay so,

Dad

No and we still work together [as (. ) as parents]

Mum

>[still see each other every day]<

Doctor

Okay

Dad

>[d’ you know] what I mean so we do:(0.24) it’s not like (0.44) those relationship where (. ) they jus’ (0.23) go an’ (. ) like I’m not talkin’ to ‘er an’

Doctor

Ye:ah

Dad

things like that we do work very close together <like on all aspects of >

Mum

"of the children"

In a similar way to the previous extract, the articulation of the fact that the cultural norm of separated couples is that there may be some antagonism between them, the father worked in this extract to make this explicit point via a contrast structure. He contrasted the relationship he has with his former wife with generic cultural relationships ‘it’s not like those relationships’. Through this rhetorical device, this functions to anticipate and address a potential counter reading of their parenting. Specifically, the mother states that she and the child’s father see each other ‘every day’. Although this is positioned as a positive co-parenting strategy, arguably from a therapeutic point of view, this may be perceived as confusing for the child. Thus, although they draw upon a repertoire of the cooperative family system, this is not necessarily undertaken in a reflective way. Nonetheless, what such discursive work does is construct their position that they recognise some separated couples are adversaries, and in doing so demonstrate anticipation that they may be perceived by the doctor in the same way. It takes effort to do something counter culturally normative, and thus he constructed their cooperation as ‘working together’ which was for the benefit of the children. The implication is that it is a virtuous action to put effort into their relationship as a couple for the benefit of the children. In the literature,
this is referred to as virtue signalling, a concept that refers to behaviour being intentionally public, and deliberately constructed to signal the virtue of the individual (Wallace et al., 2020). Virtue signalling is a form of moral grandstanding, whereby a speaker contributes to moral discourse in ways that function to convince others of the moral respectability of the person (Tosi and Warmke, 2016). At stake for the parents here, was that if their parenting was questioned by the assessors, the outcome was more likely to be a recommendation of parenting intervention and skills, rather than that of a medicalised intervention. Thus, the parents worked to build a case together to discount that reading of their child’s behaviour.

4. Discussion

Within society, there is a broad social discourse that parents are responsible for their children’s behaviour and are therefore accountable for any misbehaviour. Misbehaviour is a social construct whereby people’s behaviour is perceived to be outside the range of what is socially acceptable. This is typically attributed to parental mismanagement if there is not a bio-psychological explanation. Parents operate within this social framework and demonstrate an awareness of the potential for being blamed for their children’s deviance from norms. Therefore, they tend to act in ways that construct their accounts of their children’s difficulties in ways that absolve them from blame (Patrika and Tseliou, 2016).

The focus for analysis of this article was to explore the ways in which parents in mental health assessments positioned their children’s difficulties as ‘doctorable’. In doing so, they inoculated against an alternative interpretation, that is, that the issue was systemic and familial rather than medical.

In the data corpus examined, three accounting practices were identified. We illustrated that parents frequently referred to specific examples of child-rearing practices that would normatively be considered characteristic of good parenting such as holding the child’s hand across the road, making sure they eat healthily and making sure the child has adequate sleep. When parents gave examples of parenting approaches that may be interpreted as outside of these ideal practices, they gave logical justifications that positioned themselves as acting in the child’s best interests. Such approaches included providing the child with cigarettes to prevent the likelihood of theft and to calm her down, allowing the child to sleep in with the mother to avoid the risk of the child being harmed by a sibling and locking the child outside of the parental bedroom to minimise the child’s violent behaviour and help her calm down.

Where parents were separated, they presented an argument that they retained a functional co-parenting relationship that supported the child’s well-being. Arguably, this systemic thinking is important in the context of mental health assessments, particularly as evidence suggests that children sit at the centre of multiple systems (Bronfenbrenner, 1979), with the family system being especially influential on childhood outcomes. Thus, any threat or break in the familial system has potential to negatively impact on the child, and parents worked rhetorically and discursively to counter this possibility. They accomplished this through narratives that illustrated their co-parenting, consistent and communicative approaches and focussing on the best interest of their child. Parents
constructed their argument that their children were a priority despite their separation from each other.

In developing a dispositional account that individualised the child’s difficulties, parents worked to move away from potentially blaming aspects of family system explanations to bio-psychological explanations. In this way, it is proposed that irrespective of the micro- and meso-systems close to the child, their behaviour and emotional need would remain endemic. In designing their accounts in this way, parents demonstrated an awareness of the relevance of the family system in the child’s development but resisted this as a potential explanation for the child’s difficulties. Any interpretation within that systemic framing could be viewed by professionals in the immediate institutional context and the wider community as the fault of parenting practices.

There is a wider macro-system expectation that the UK government provides health services for every member of society which is free at the point of access (in the form of the National Health Service). The macro-system thus orients to the idea that the parents in the micro-system are not alone in taking responsibility for the welfare of their children, but that this responsibility is shared between parents and government-provided services. Health policies dictate that children should function in a mentally healthy way to achieve academic attainment to become productive adult members of society. In the immediate interaction between families and healthcare providers within this meso-system space is a negotiation of who will take responsibility for meeting the child’s immediate needs, a government-provided mental health service or the parents themselves. One of the limitations to this negotiation is the availability of support systems for parents, for example, the availability of family therapy tends to be regionally variable with long waiting lists. Thus, although parents appealed to mental health services that there was a need for intervention from what the macro-system has put in place, there may be acknowledgement the availability of family-based interventions might be limited. If the child’s difficulty was successfully positioned as being dispositional and therefore ‘doctorable’ and individual to the child, then the responsibility for intervention would lie with the medical profession which is a micro-system set up by the government macro-system of health policy and cultural beliefs that the State has a duty of care to the child.

Through our data, we illustrated the discursive techniques used by parents to persuade professionals that it was not the familial micro-system that required further support to discharge their responsibility for the child’s well-being, but rather than an additional micro-system that of the medical profession needed to be co-opted for the child to return to a state of wellness. In practice, the parents and the State share responsibility (and authority for making decisions in the child’s best interest, as well as the financial burden) for raising and socialising children to grow into healthy well-adjusted adults. This is a dynamic process, and largely the parents are the primary distributors of care, but parents can appeal to the State for additional support for the child if they perceive the child to have a specialist care need within the domain of State jurisdiction (like health). However, this appeal can be resisted, and the institutional business of the child mental health assessment requires case building by the parent that State intervention is necessary (O’Reilly et al., 2019). In the context of possible alternative outcomes, where professionals may determine that a child’s
needs do not require medical intervention but should be met within the familial system, discourses of stake and accountability are rife. It is within this contested environment that responsibility inoculation was found to be a discursive resource that parents drew upon to contend for their child’s need for State-governed mental health service provision.

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