8

Avoiding Shame and Blame

Learning Objectives

- Recognise the implications of blame and shame as a potential barrier to families accessing services
- Critically assess the historical context that has shaped our understanding of parent blaming
- Identify the ways in which families may use language to manage blame and accountability
- Reflect on dichotomous accounting practices and establish a dialectic alternative

Introduction

The focus of this chapter is on blame and shame. There are many kinds of interactions that occur *between* family members and blaming others in the family for their difficulties may be one of those social actions. This may be the result of a range of different responses to the emotional reactivity that inevitably occurs between family members. As these responses often occur in quite patterned ways, some family therapists have found helpful ways to support family members to move from these predictable reactive patterns to mindful ways of responding (Tomm et al., 2014).

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However, our focus for this chapter is not so much an investigation of these kinds of problematic patterned blame and shame sequences of interactions between family members, but *towards* family members. We examine the ways in which family members, particularly parents, may find themselves being positioned as accountable for their children's difficulties by others in wider society, and potentially also by the mental health professionals supporting them.

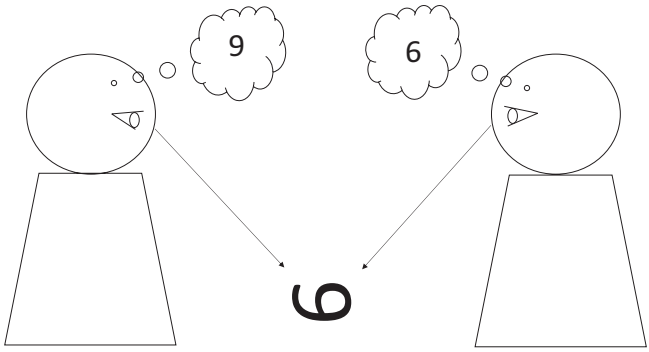
To contextualise that conversation, we begin by considering the social construction of polarised concepts, such as 'good' and 'bad', or 'sick' and 'well', or 'normal' and 'abnormal', 'moral' and 'immoral', 'nature' and 'nurture', or 'conformist' and 'deviant'. We have argued throughout this book that concepts such as these are not static or predetermined but socially constructed and therefore the meaning and boundaries of these concepts are fluid and temporal. The notion of blaming only makes sense within the context of constructs that position certain people as 'bad', 'abnormal', or 'deviant'. Therefore, we invite the reader to hold this in mind as we discuss some of the literature around blame and shame as they relate to family interaction in the context of mental health. The challenge of creating polarised social discourses that position some people as acceptable and others as unacceptable is that it creates a separation between the self and others, referred to as 'othering'. Arguably, from a psychodynamic perspective the so-called bad that we perceive in others, is a projection of the 'bad' that we cannot tolerate within ourselves.

In this chapter, we illustrate through our extracts of family therapy data that within the context of professional mental health conversations with families, there are several binary propositions that are either explicitly or implicitly revisited. We outline several of these below, with an explanatory description of how these discursive resources function:

- Good versus bad—this explanatory framework draws on a moral heuristic to position behaviours within a dichotomous construct.
- Sick versus well—narratives of health versus ill health are normative medicalised points of reference to distinguish those who need treatment.
- Normal versus abnormal—these are socially constructed boundaries of society and therefore culturally, historically, and politically mediated discourses.

- Moral versus immoral—these are socially constructed appraisals that legitimise the activity of making judgements to vindicate or condemn others.
- Nature versus nurture—aetiological explanations that contrast biological causal factors with environmental influences.
- Conformist versus deviant—unspoken social schemas dictate how people should behave, and when these are transgressed, it becomes legitimate to impose sanctions.

These polemic constructs are ubiquitously used in every family conversation, but because of their universality and the fact that they operate implicitly and subtly, they are not always immediately apparent. It may be helpful for practitioners to be mindful of how these discursive resources are drawn upon and articulated, particularly in contexts where blame and accountability are disputed. Supporting families to move away from mono-causal, black or white discourses about the causes of problems, involves helping them to consider the possibilities that both sides may have some truth in them. The illustration below demonstrates how this can be the case, where each person sees the number from their own perspective. Depending how you look at it, the number could be a six or a nine. Both are correct:



We suggest you think about your own practice context by engaging with the reflective activity in Box 8.1.

Box 8.1 Reflective Activity: Noticing Dichotomous Accounting Practices

Reflective activity

Accounting practices

Practitioners working in the field of mental health are likely familiar with the tendency for many clients to operate within a 'black and white' world view. The list of dichotomous discursive resources exemplifies ways in which this 'black and white' thinking might present itself in a family conversation. A therapeutic alternative to this polarisation of thinking is to adopt a dialectic approach. Dialectic means to consider that there is some truth in both ends of the spectrum. In other words, the phrase 'both/and' can be drawn upon rather than 'either/or'.

- Consider ways in which a dialectic approach may be valuable in working with families who have this polarising kind of discursive repertoire.

Identity Construction and the Role of the Good Parent

There is a growing literature that explores wider systemic influences on people and their health and behaviour, but the dominant discourses remain centred around individual or family accountability. Throughout this chapter, we use several interrelated terms, for clarity the ways in which we use these terms are, parents are *responsible*, but when child does something that is deemed to be socially inappropriate, parents become *accountable*, which then justifies the social action of *blame*.

There is a strong social ideology of what it means to be a 'good parent', with parents being treated as responsible for their child's behaviour (Liahaugen Flensburg et al., 2022). This model of 'parental determinism' purports that a child's future is determined by their parent's abilities (Lind et al., 2016). The action and choices that parents make are typically used as a reference point to account for their children's social problems, such as school failure, drug problems, or criminal activity (Barker & Hunt, 2004). Although parental determinism relates to both mothers and fathers, it has been suggested that parenting practices continue to be gendered and mothers retain greater levels of involvement in child

rearing (Fox, 2009). Social expectations about the role of women are influenced by cultural expectations and specifically what it means to be a 'good mother' (Collett, 2005). Cultural ideals of motherhood, therefore, affect not only how society perceives them, but also how they perceive themselves (Tabatabai, 2020).

It is fairly common when engaging with professionals working with families, for parents to feel that their parenting skills are being assessed (as often they in fact are). Against this backdrop of explicit or implicit evaluation, parents may seek to pro-actively demonstrate to professionals working with them, that they ought to be assessed as 'good' parents. The following two extracts from family therapy are examples of this. In the first extract, the father initiates a self-evaluation about himself and his partner about trying to be 'good parents'. In the second extract, the father evaluates his partner as 'good as a parent'. It is normal for people to compare and judge their parenting skills against the prevailing social norms about what constitutes a good parent (taken from O'Reilly & Lester, 2016, p. 499).

Niles family

```
Dad:  ↑Oh well >I mean< we try t' be good parents don't we >I
      mean< (1.2) I know he's not genetically mine but 'e gets
      (.) >I mean< I treat 'im like me own (.) >you know what
      I mean< he doesn't go without
FT:   You've been around for a long time Alex
```

Clamp family

```
FT:   Actually, Dan if I were t' ask Joanne where she rates
      herself as a parent (.) where do you think she would
      put herself
      (2.0)
Dad:  She's good as a parent
```

For parents who encounter criticisms for failure to meet societal expectations, they can experience significant stigmatisation and discrimination which can become internalised as parents worry about what others may

think (Wilkens & Foote, 2019). Concerns about how they are perceived by others can cause parents to worry about their own parenting competencies, meaning that they, as parents of children who deviate from social norms can be labelled by society and themselves as a 'bad parent' (Trigueros et al., 2022). The very categories of 'good' and 'bad' are moral constructs, and therefore when a parent is labelled as a bad parent, it is intrinsically a moral judgment that has been passed on them. There is considerable evidence that children with mental health needs are often stigmatised, and by association, parents and family members are affected by what Goffman referred to as 'courtesy stigma' (Goffman, 1963).

Courtesy Stigma

The prejudice and discrimination that a stigmatised person encounters are also experienced by their family members and others close to them.

When working with families, it is important that practitioners are mindful of this potential for courtesy stigma and how family members might be experiencing discrimination by association (see also Chap. 1 for discussion). For example, research shows that those experiencing courtesy stigma have a greater likelihood of increased emotional distress and social isolation (Green, 2001). Notably, this stigmatisation may come from within the extended family (Moses, 2010), some of whom may be present in the institutional interaction. It is therefore important to recognise that courtesy stigma is not the only challenge for families, as there are many kinds of stigma that might be encountered, and we outline these in Table 8.1.

For a family seeking help, they may have already encountered 'experienced stigma' prior to their referral both directly and via association, that is, 'courtesy stigma'. In accessing support, they may also have experienced 'treatment stigma' from others and additionally may expect a degree of stigmatisation from practitioners they are seeking help from, that is, 'anticipated stigma'. Therefore, as family practitioners working in the context of mental health, it may be helpful to bear in mind these psychological barriers to accessing services and the vulnerabilities that families

Table 8.1 Different kinds of stigma (Clement et al., 2015)

Stigma type	Description
Experienced stigma	Direct experience of stigmatisation for being deviant from social norms
Perceived stigma	Belief of experiencing stigmatisation
Stigma endorsement	Agreement with stigmatising perceptions of others
Anticipated stigma	The expectation of being treated unfairly due to stigma
Internalised stigma	Acceptance of others' prejudice and stigmatisation, and a belief that this is warranted
Treatment stigma	A stigma associated with seeking help or treatment

face in relation to their expectations of social views of bad parenting. Additionally, and more problematically, family members may also be experiencing 'internalised stigma', where they have actually taken on negative self-perceptions and may blame themselves for their child's difficulties.

Parent Blaming

The idea of positioning parents, particularly mothers, as blameworthy for their child's mental health and behaviour has a long history. In modern European history, psychoanalysis was the dominant practice for managing mental health and was highly influential at the turn of the twenty-first century (Porter, 1997). With this theorising, there was an emphasis on the individual, and mothers were spotlighted as being the most prominent figure in the child's development (Lafrance & McKenzie-Mohr, 2013). It was during 1935 that tensions started to emerge with the publication of the first child psychiatry textbook by Leo Kanner (Karim, 2015) bringing the idea that child mental health could be medicalised, and the post-second world war challenges with the rise of attachment theories (Bone & Marchant, 2016). This was politically useful to use the research on attachment to propagate the idea that women who had been out at work during the war, should return to homes to look after their children. Shortly after, with concern about growing divorce rates came

pressure on families to take responsibility for increases in what was positioned as juvenile delinquency, which was a precursor to family therapy (Dallos & Draper, 2010). We acknowledge that this is an extreme simplification, but for the purposes of introducing this chapter, we intend to demonstrate the socio-political influences that have shaped the ways that normality and deviance are constructed and the ways in which mental health services have adapted.

The legacy of those early conceptual frameworks about pathology being individualised and accountability for children's deviance being positioned within the family system is still evident today. Even in a modern society where gender equality is advocated, mothers are still positioned a primarily responsibility for the wellbeing of children (Jackson & Mannix, 2004), with a common expectation that the mother will put her child's needs before their own (Lind et al., 2016). Although fathers are becoming more visible, it is still mothers who typically take on much of the caring labour (Silverman, 2012). Thus, when children experience mental health difficulties, it is still culturally likely to blame the mother (Jackson, 2018), and mothers are often aware of this stigmatising practice, which can influence their help-seeking behaviour and service engagement (Jackson & Mannix, 2004).

Parents who anticipate blame and stigma for their children's mental or behavioural health difficulties, may be reluctant to seek professional support. It is therefore important for practitioners to understand the reasons for this barrier to help-seeking and consider ways to make services more accessible.

Indeed, research has highlighted that some mothers of children with mental health conditions had experienced negative comments and even felt that clinical practitioners had treated them negatively due to the child's difficulty (Blum, 2007). Thus, in clinical settings, it is common

for parents to try to discursively construct themselves as good parents (O'Reilly & Kiyimba, 2021), potentially due to their perception that they are being scrutinised by the clinical practitioners (Todd & Jones, 2003).

In addition to feeling stigmatised for being the parent of a child with a mental health difficulty or diagnosis, parents also face stigma when they have children who are struggling with addiction. As an example of this, a recent survey of 728 persons with a family member with addiction in New Zealand, reported that 45% felt embarrassed, 54% felt guilty, and 47% reported shame (Kiyimba & Scarlett, 2021). The authors of that study found that these are emotions that can inhibit help-seeking and accessing sources of support. In addition to feelings of guilt and shame, family members can also experience anxiety and depressive symptoms arising from the social judgements (Trigueros et al., 2022). These feelings of shame also extend to children and young people too as many tend to turn to peers for support rather than practitioners because of the stigma (Brophy & Holmstrom, 2006), and the feelings of embarrassment become a central barrier to their help seeking (Chandra & Minkovitz, 2006). We invite you to reflect on this challenge of blame and shame, by addressing the activity in Box 8.2.

Box 8.2 Reflective Activity: Overcoming Barriers to Help-Seeking

Reflective activity

Overcoming barriers

Although it is the child in the family identified as having the mental health condition, it is the parents who are the gatekeepers to access support for the child and there may be two significant barriers—one is their own challenges that arise from experiencing judgment and stigmatisation, and the other relates to fears of shame and blame from those they may be approaching for help.

- How can we as practitioners overcome these two barriers and facilitate family engagement with services?

Managing Responsibility and Blame

A well-established understanding of how children develop is the debate regarding biological causes (nature) combined with the influence of the environment (nurture). With regards to parents, they contribute both to the child's profile genetically and biologically, but also environmentally in terms of modelling learned behaviour. Whilst nature and nurture used to be positioned as binary concepts, an either/or causal explanation, it is now much more widely accepted that a child's development is influenced by a complex interplay of both. Nonetheless, in our data, we can see that parents draw upon this discursive repertoire of nature versus nurture as an explanatory resource for their child's problems.

In relation to the avoidance of blame, parents may explain their child's difficulties in terms of biological or genetic causes rather than environmental ones, thus working to absolve themselves from a blame position of poor parenting and mitigate any potential idea implication of them being poor parents. Thus, by constructing the child's behaviour and emotional challenges as related to an underlying health condition, and one that has a scientific or genetic foundation, parents can medicalise their child and move away from any potential consideration that this may be due to inappropriate nurturing and a lack of parental skills (O'Reilly & Kiyimba, 2021). The appeal to a scientific/biological discourse is one way of rhetorically managing their role in the child's health and absolving themselves of blame for their child's difficulties. A good example of this can be seen in the following extract where the parents are discussing their 16-year-old son who has been displaying inappropriate sexual behaviour toward his younger brother and others (taken from O'Reilly, 2014, p. 169).

Webber family

```
FT:    >I wuz gonna ask< (.) >you know< what kind of
       explanation::ns you have, fo::r (.) >you know< why it
       is that 'e's (.) he's ↑started doin' (.) <the:se things>
Mum:   <I don't know> (.) I ↑say it t' scho:ol (.) and >you
       know< there's this theory is it in the g::enes
```

LaFrance and McKenzie-Mohr (2013) suggest that drawing upon a biological explanatory framework is a way that people can manage and defend the way that others perceive their identity. In other words, a genetic account for a child's problem behaviour is proposed by the mother as preferred to the alternative. In the extract of data presented, the child's mother does two things. First, she positions the problem behaviour as '*in the genes*' and second, argues that the 'nature' explanation is one that was provided by an expert other, that is, the school. By reporting the expert opinion of another to support her own case, the mother adds weight to her proposal (see O'Reilly et al., 2023). In this way, a biological discursive construction of the child's mental health difficulties functions to absolve her from any potential assignation of blame for her inappropriate or deficient parenting skills as being the reason for the child's problem behaviour (Singh, 2002). We provide a second example of how parents draw on a discourse of a malfunction of the child's brain as an explanation, for their 14-year-old son's regular violent outbursts (as taken from O'Reilly, 2014, p. 169).

Niles family

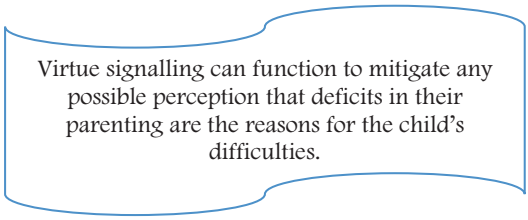
```
Dad:    It's (.) as if he's got 'e's got a little tiny
        >microchip< in 'is brain an' 'e's sayin' (.) every
        now and again 'e just goes flip
FT:     ↓Right
Dad:    switches off and he lo:ses it
FT:     So. (.) the::re's an idea that it's, inherited o::r
        ↑possibly somethin' >t' do< with >I dunno<
Mum:    >His dad<
FT:     chemistry of (.) Steve's ↑bra:in
```

Here, the stepfather uses a lay metaphor to provide a biological aetiology of the child's mental health difficulty as internal, physiological, and pre-determined. By positioning the behaviour as stemming from a pre-existing biological irregularity, the stepfather constructs his parenting as responsive to, rather than causal of, the child's behaviour. The family therapist further clarifies that what the stepfather is suggesting is that the predisposition is 'inherited'. The risk of using a concept like 'inherited' is that there is a subtle suggestion that indirectly parents carry some

responsibility. However, this is mitigated by the mother as she quickly interjects that any inherited behaviour is due to the biological, non-present father, not the stepfather who is present. A key aspect of identity construction that is at stake in this conversation relates to moral judgements. Social norms are inevitably interconnected with moral evaluations, and in an interaction like this, each of the parties involved is normatively involved in the process of attributing moral categories to people based on observed or reported behaviour (Roca-Cuberes, 2008).

Virtue Signalling and Identifying as a Good Parent

As discussed in the previous section, one of the ways of managing potential accountability and blame for the child's behaviour was to position it as biologically determined. By negotiating the child's difficulties as medical, parents negate other potential ascriptions that might imply the child's difficulties are because of their parenting practices. Another way that parents manage their parenting identity is to position themselves as virtuous. This is often done using examples of good parenting actions. The concept of virtue signalling is defined as deliberate statements constructed to highlight the virtuous or positive qualities of the speaker (Wallace et al., 2020).



The function of virtue signalling is to convince others of their moral respectability (Tosi & Warmke, 2016). What is often at stake for parents as they come into contact with professional services is that the practitioners working with them may attribute the child's difficulties to poor parenting. One way to guard against this judgement is for parents to find ways to present themselves as good parents, that is, stake inoculation. We present two examples from the mental health assessment data of parents

'doing a good parent identity' (taken from O'Reilly & Kiyimba, 2021, p. 6 of online version).

Family 11

```
Mum    [no he has ne]ver ↓crossed his the road on 'is own ↓you
       know I am [alw]ays with him
```

In this example, the mother describes her caution in keeping the child safe. Her use of the words 'never' and 'always' emphasise the point she is making that she takes her role as mother seriously and always looks after her child's best interests. These concepts are referred to as extreme case formulations (Pomerantz, 1986). In the following extract, a good parent identity is portrayed using the example of ensuring the child is adequately nourished despite the child's food refusal (taken from O'Reilly & Kiyimba, 2021, p. 6 of online version).

Family 26

```
Clin Psy   and if 'e is (.) if 'e won't eat somethin' how what
           would your re↓sponse to that?
Mum        I've always got a s[oup] in
Clin Psy                      [be]
Mum        (0.43)
           an:d soup is the standby really and [an']
Gran                                           [soup]
           an' cereal
Mum        soup and cereal yeah but most of the time he has:
           (I know) because I know what he likes and what he'll
           eat (0.57) and I'd rather him eat
```

In orienting to the child's food refusal, the clinical psychologist enquires of the mother how she manages the situation. The implication is that the question seeks clarification about the adequacy of her parental skills. In response, the mother acknowledges that a diet of soup is not ideal, but that she 'always' has some in the house as a 'standby'. By referring to this as a 'standby' indicates that this option is not her preferred choice, but her good parent identity is held intact by her diligence to ensure the child has something to eat.

Importantly, the efficacy of this strategy to present examples of good parenting actions relies on shared social norms of the kinds of behaviours that are expected of good parents. In the case of crossing the road and eating food, the virtue signalling of the mother in each case was successful because of these shared understandings. However, the following two extracts are examples of parents attempting to do virtue signalling through using examples of what they consider to be good parenting but fall short of wider societal social norms (taken from O'Reilly & Lester, 2016, p. 502).

Clamp family

```
Dad:    but we finished the course >what we did< on parenting
        but that was good (.) because we did lea:rn a lot on
        that it didn't help to smack children and
        ↑whatever ↓yeah
FT:     Yeah
Dad:    And we didn't we 'aven't smacked 'em for a long long
        time now >not unless< they've been really
        rea::lly bad
FT:     Hu::m
```

Clearly, a previous family professional had encouraged this couple to attend a parenting course to support their parenting skills, which the father refers to. In mentioning that they learned not to smack their children in this parenting course, the father reports that they have not used this punishment technique for a *'long long time'*. Ostensibly, this virtue signalling is effective in displaying improvement in their parenting skills. However, he adds the caveat '*unless they've been really really bad'*. In so doing, he undermines his presentation of self as a good parent because he potentially raises the question mark in the family therapist's mind about whether the children may at times be at risk (something we discuss in more detail in the next chapter).

When working with families, particularly in relation to child protection, there is a great deal at stake. Ultimately, there is the potential that the child may be removed from families if the practitioner believes that

the child is at risk. Our data demonstrate that parents work hard to present themselves in a positive light, but may have a distorted view on what constitutes safe and responsible care of their children. Practitioners reading this book are likely aware of the need to gather information from a range of sources, as well as evaluating the parental accounts to make an informed decision about requirements for additional professional services. In conducting this professional role with families, there is a difference between judgement and evaluation. Judgement is a potentially negative view of families, whereas evaluation is a sober professional assessment.

Final Thoughts

Throughout this chapter, we have used the language of shame and blame to discuss the responsibility of parents in their children's mental health and wellbeing. This terminology is a colloquial way of engaging with the topic and is familiar in everyday encounters that families may experience. Within wider society, notions of parental responsibility and therefore accountability permeate. As practitioners working with families, it is helpful to be aware of these wider social narratives and, at the same time, be cautious about reproducing them within the institutional setting. While there may be helpful guidance that parents can be informed about to enhance their capacity to parent their children successfully, we suggest that recommendations for such interventions come from a place of professional integrity rather than negative judgements or stigmatisation. In Box 8.3, Erin O'Neill talks about the guilt, stigma, and shame felt by parents of adult children struggling with addiction.

To close our chapter, we summarise the key messages from that we feel are important for you in Box 8.4.

Box 8.3 Practitioner Voice, Erin O'Neill

Practitioner voices
Erin O'Neill
Support network lead

Erin O'Neill understands the effects of addiction on family members: and was compelled to start Brave Hearts NZ—Manawa Kaha Aotearoa—a support network for whānau (the Māori word for extended family) and friends with a loved one in addiction. She felt families needed more peer support, education, and advocacy during this difficult time. Erin's tenacity has provided many with the help they've needed to get their family members into recovery and to move towards the ultimate goal of living addiction free.

PLEASE DON'T JUDGE ME

In the context of addiction, the family is an important institution. While it is the individual who has the issues, it is the whole network around them that needs the support for it to be a successful outcome for future generations. Families, therefore, are really asking themselves:

- "Is there something wrong with me?"
- "What did I do wrong in parenting the child?"
- "Where did I go wrong with consequences in adolescent years?"
- "Was I loving enough in my relationship with my partner, child, sibling?"

How can I support and love an addict—someone who is terrorising me, often a criminal, and being a drain on rather than contributing to society?

By showing that we are 'holding up really well', 'being a good member of society', this allows us to keep functioning but is really another layer of complexity thrown on top of what is already unbearable.

(*continued*)

Box 8.3 (continued)

Specialist help is often seen as patronising, so families present as being there to obtain help for the addict—nothing wrong with me—no stigma attached. Professionals who work with families need to be aware that we become so overburdened by what we can't talk about—feelings of guilt, feeling of being ostracised in society, being seen as weak or frail.

We are too scared of judgement to show our vulnerability. We need to know that you can break down these barriers and allow us to talk frankly and openly without fear of how the rest of the world sees us. Listening, understanding without pre-conceived judgement. These are important areas of reflection for the practitioner working with families.

Organisations are starting to employ people with lived experience as they recognise the importance of involving experts by experience. This peer support is invaluable in the sector—like helping with total empathy—and so important, to receive the essential *element* of Hope that comes from an individual with a successful outcome.

Organisations must have a responsibility to mitigate stigma in the delivery of their service. More awareness of how to do this would ensure earlier help seeking and ultimately save time and money. Continuous development and learning from each other. Identify what is working well. Those who have the essential tools to help them cope find this unbearable time is shortened, thereby ensuring that the effects on both the family and the addict are not as severe.

Box 8.4 Key Points

- Wider negative societal discourses of parenting may leak into professional mental health conversations.
- Parents have a stake and interest in presenting themselves in a positive way within those interactions.
- Anticipation of being blamed for the child's difficulties, and the potential for stigma, may inhibit help-seeking.
- Family practitioners benefit from being aware of these issues around blame and responsibility, to be proactive in avoiding re-stigmatisation in institutional settings.

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