Austin Journal of Psychiatry and Behavioral Sciences

Open Access

Austin Publishing Group

Research Article

Supporting Parental Self-Efficacy in Family Therapy

Aada Ahola, MA; Heidi Stenberg, MA; Aarno Laitila, PhD*; Kirsti Kumpulainen, MD
Department of Psychology, University of Jyväskylä, Finland

***Corresponding author: Laitila A**
Department of Psychology, University of Jyväskylä, Finland.
Email: aarno.a.laitila@jyu.fi

Received: November 21, 2023
Accepted: December 20, 2023
Published: December 27, 2023

Abstract

Parental self-efficacy is a significant factor that influences parenthood. It is important to pay attention to this factor when treating children with conduct problems. This study examined the ways how parental self-efficacy is supported in family therapy, where family has come due to children`s conduct problems. Also, the way how supporting parental self-efficacy changes during therapy was studied. The material consists of one family`s therapy process, that was carried out in an outpatient clinic. Parents' self-efficacy was supported by various means that were focused on supporting parental self-efficacy indirectly through two processes mediating self-efficacy. In addition, it was found that supporting parents' self-efficacy changed as the therapy progressed. In the light of these results supporting parental self-efficacy seems to form a significant part of the treatment of children with conduct problems. This study provides new information about practical means that can be used in supporting parental self-efficacy in family therapy.

Keywords: Family therapy; Conduct problems; Interaction; Self-efficacy; Parental self-efficacy; Change

Introduction

Children's conduct problems are external disruptive behaviours that, if prolonged, cause problems in the child's interactions [2]. Conduct problems are seen as a broader umbrella term for a variety of behavioural disorders, including conduct disorder and defiant disorder [2]. Conduct disorder is defined as repeated and persistent behaviour that violates social guidelines or age-related norms and rules. In contrast, conduct disorder is defined as a long-term angry or irritable mood lasting six months or more, accompanied by defiant or vindictive behaviour.

Child development takes place in a continuous interaction between the child and his or her social environment, such as the family [25]. While parents influence the child through their actions, the child reciprocally influences the parents through his/her actions [5]. The interaction between parent and child lays the foundation for the child's overall development. Problems in this interaction contribute to the challenges in the child's development. For example, a negative family atmosphere and interactional challenges can be significant risk factors for the development of problem behaviour [27]. Among family factors, parenting practices in particular are associated with child behaviour problems [23], with negative parenting practices contributing to the severity of the child's behaviour problems and increasing the child's external problem behaviour [3,10], In turn, children's problem behaviour adversely affects parents' well-being and parenting in general, for example by causing increased levels of stress [4] and mental and physical exhaustion [15]. Children's problem behaviour also affects parents' beliefs about their child's behaviour. Parents of children with problem behaviour are more likely to believe that their child's positive behaviour is temporary and due to factors beyond the child's control [8].

Family therapy is often based on a systemic approach to problems [11]. From a systems perspective, the family is seen as a system of interactions between its members, in which each member influences the others through their actions and is influenced by the actions of others [20]. The aim of family therapy is to bring about a change in the spheres of influence that sustain psychopathology in family interactions (Anonymous for peer review), and to find new ways of dealing with situations that are problematic for family functioning [2]. This is done primarily by identifying positive resources in family interactions [1]. Parenting support can be seen as an important part of treating children's behavioural problems. One of the major factors underlying parenting has been identified as the self-efficacy of parents.

Bandura et al., [5] defines *self-efficacy* as an individual's beliefs about his or her own ability to act and behave appropriately and to cope with situational challenges. An individual's self-efficacy beliefs are also understood to be one of the most important determinants of agency [6]. However, self-efficacy is not seen as a stable personality trait, but as an ever-changing process. Bandura et al., [7] sees self-efficacy as being constructed mainly through four factors: experiences of success, vicarious experiences provided by social models, feedback from the social environment, and the physiological and emotional states

Citation: Laitila A. Supporting Parental Self-Efficacy in Family Therapy. Austin J Psychiatry Behav Sci. 2023; 9(2): 1096.

of the individual. According to Bandura et al., [7], success experiences are the most important source of self-efficacy, as they provide concrete evidence of an individual's ability to act in a particular way. The vicarious experiences provided by social models, on the other hand, enable the construction of self-efficacy, especially in situations where it is difficult to assess one's ability to act in a certain way. In these situations, observing and monitoring the actions of others can provide individuals with an experience of their own ability to perform those actions. Feedback and support from the social environment, in turn, reinforce the individual's experience of self-efficacy, especially when the individual doubts his or her own abilities. An individual's physiological and emotional states also influence whether he or she feels able to perform as required by the situation; in a positive state of mind, an individual is more likely to believe that he or she can succeed [7]. It manifests itself in the individual's functioning through cognitive, motivational, emotional and behavioural processes [6].

Parental Self-Efficacy (PSE) is a concept derived from self-efficacy [21], broadly defined as a parent's beliefs about his or her ability to perform the tasks of parenting [16]. Parental self-efficacy is also understood as the parent's perceived ability to influence his or her child's development and behaviour in a favourable way [8]. Parental self-efficacy has a significant impact on parenting. It is related to family interaction, a variety of parenting skills, child behaviour problems and parent's emotional states, among other things [9,17]. Parental self-efficacy affects parents' beliefs and images of their parenting and their child's behaviour, motivation to face difficulties and endure failures, emotional states and stress, and behaviour through, for example, parenting practices. For example, parents who perceive their self-efficacy as high have been thought to view their child's problems as challenges requiring effort and creativity, while parents who perceive their self-efficacy as low see their child's problems as a threat beyond their parenting coping abilities [9]. Parents who rate their self-efficacy high also use effective parenting practices even when their child behaves in challenging ways [16]. Parents' experience of their inability to influence their child's behaviour may also lead parents to think of their child's negative behaviour and problems as permanent characteristics of the child [9].

Research Questions

Parents' capacity for self-efficacy is an important foundation for parenting and thus for the development of the child. Therefore, supporting parental self-efficacy becomes an important factor in the treatment of children's behavioural problems. However, directly supporting parental self-efficacy is challenging, if not impossible [9], as self-efficacy is complex and affects the individual in a holistic way. In the present study, we were interested in how to support parents' self-efficacy in family therapy, where they had come to for help with their children's behavioural problems. In addition, it was examined whether there is a change in the support of parents' self-efficacy as the therapy process progresses. The research questions are:

1. How to support parents' self-efficacy in family therapy?

2. Is there a change in the support for parents' self-efficacy as the therapy process progresses?

Method

Survey Data and Participants

Family-centred treatment and systematic patient feedback in the prevention of social exclusion of children diagnosed with Oppositional Defiant Disorder, (ODD) is a collaborative project between the University of Jyväskylä, the Department of Child Psychiatry at Kuopio University Hospital and the Department of Child Psychiatry at the University of Eastern Finland, which started in 2015. The aim of the research project is to study the effectiveness of psychotherapy and to support the involvement of children and their families in the treatment process to prevent social exclusion. The research project involved children aged 6-12 years diagnosed with defiance or conduct disorder and their families (N=14). The research material consists of audio and video recordings of family therapy sessions conducted at the outpatient clinic of child psychiatry and at the families' homes at Kuopio University Hospital, as well as background information forms and patient feedback questionnaires. Before the study started, families were sent home by letter with information about the study and how to participate, and were then given the opportunity to participate in the study if they wished to do so by giving their written consent. Written consent was obtained from both parents and children.

For this study, the therapy process of one family was selected from the original data. This family was selected for the study because both parents of the family attended almost every therapy session together, which allowed for a broader examination of the phenomenon under study. The family's therapy process also consisted of several sessions (15), thus allowing for a longitudinal analysis of change. A total of six sessions were selected for the family therapy process: two consecutive sessions from the beginning (sessions 1 and 2), the middle (sessions 7 and 8) and the end (sessions 14 and 15) of the therapy process. The choice is based on the fact that the phenomenon is clearly identifiable in the temporally distinct phases of the study, so that any change in the phenomenon during the therapy process is more clearly visible. The analysis of two consecutive sessions also reduces the risk of random situational factors influencing the phenomenon under study. All 15 sessions of the family were conducted in the outpatient clinic and lasted approximately one hour. The overall therapy process lasted just under a year, with sessions ranging from one week to almost three months apart. In addition, a follow-up interview was conducted one year after the last therapy session. Two family therapists were involved in the family therapy process, hereafter referred to as T1 and T2.

Family members are referred to by pseudonyms to hide their identities. The family consists of mother (M), father (F), younger sister Liisa (L) and older brother Jesse (J), who was 7 years old at the start of the study. Jesse had been diagnosed with an obsessive-compulsive disorder. At the start of the study, the parents reported Jesse's behavioural problems as severe and assessed the behavioural problems as affecting, among other things, family life and Jesse's friendships. According to the parents, Jesse's behaviour was characterised in particular by lying and irritability. They described Jesse's behaviour as unchanging and beyond their control. The family atmosphere was also seen as partly negative. In particular, communication between mother and Jesse was often negative, with limited positive expressions.

Analysis of the Data

Conversation analysis is a qualitative research method that examines conversations between two or more people in detail [18]. In this study, the analysis was conducted using a datadriven approach, using therapy sessions conducted in an outpatient clinic as data. Bandura's self-efficacy theory and the research

literature provided a framework for the findings and guided the examination of relevant aspects of the phenomenon under study. The aim was to examine the conversations between the family and the therapists in detail and to look for sequences of interactions relevant to the phenomenon under study. Sequence structuring is seen as one of the building blocks of interaction [24], through which the aim is to examine what can be produced and achieved through the discussions [14]. The therapy sessions of the family selected for the study were therefore examined in terms of sequences of successive speeches, sequences in which the parents' self-efficacy was supported in some way. Attention was paid to the type of interventions that led to the production of a speech that supported the parents' sense of self, and to the type of means of supporting self that emerged from the situation. The focus of the study was on the interventions that strongly followed each other in the discussions, i.e. the adjacency pairs [24], which formed episodes in the discussion. Although the researchers had a special interest in the speech produced by the therapists, they were not examined in isolation from the rest of the discussion. Nothing that occurred in the discussion was considered to be random, but in line with discourse analysis, the discussion and the interaction of the speakers involved were seen as an organised and structured activity [14]. In addition to speech, the analysis took into account even the smallest sounds, such as coughs, pauses and laughs, as they also play a role in interaction [22].

The first two authors watched the video recordings of all six therapy sessions together twice. During the first viewing session, the relevant interactional episodes in which the therapists supported the parents' self-efficacy were observed and recorded. The therapists' interventions had to be linked to the theoretical background of self-efficacy, thus excluding therapeutic means that were irrelevant to the phenomenon under study. The purpose of the second round of observation was twofold: to ensure that all the points in the data where the therapists supported the parents' self-efficacy had been identified, and to observe whether there was a change in the support for self-efficacy as the therapy process progressed. The means found were grouped under four core categories to facilitate the structuring and outlining of the data. Finally, the means found and the core categories were named.

Results

The first research question looked at how parents' self-efficacy is supported in family therapy. Eleven means of interaction were used to support parents' self-efficacy: giving positive feedback, supporting views on the activity, activating the activity, giving advice, reinforcing positive speech, filtering negative speech, presenting the positive side, praising the child, opening up the reasons behind the activity, presenting the child's perspective and normalising.

The means identified were grouped into four core categories: supporting parental action, supporting parents' linguistic expression of the child, supporting parents' positive thinking and challenging parents' established views. For each core category, one mean is illustrated with a sample of data and colour coding is used to illustrate a key part of the interaction sequence.

Supporting Parental Action

Parents were supported in four different ways: giving positive feedback, supporting their views on the activities, activating the activities and providing advice. Through these means, therapists reinforced parents' belief in the approaches they already had in place and provided them with new methods and tools for parenting.

The therapists supported the parents' activities *by giving positive feedback* (extract 1) to the parents on their activities. Therapists gave positive feedback when parents reported acting in a way that could be interpreted as constructive and in the best interests of the child. By providing positive feedback, therapists reinforced parents' sense of having effective coping strategies to deal with challenging situations, thus encouraging parents to have confidence in their own abilities. Positive feedback was often addressed directly to parents and included expressive adjectives such as 'important' and 'good'. Expression was also reinforced by non-verbal gestures such as hand gestures and nods.

Extract 1 from Session 8 (53:40-54:23) "The Importance of Paying Attention after Conflict Situations"

Earlier, the father expressed concerns about the impact of the home situation on Liisa, which had been raised by the school. Earlier in the hearing, the parents also said that they often went to calm Liisa down after conflict situations between Jesse and her mother. T2 and Jesse are not present at the meeting.

1. M: (looks at his feet as he speaks) I don't think it's anything like that.
2. not traumatised, but that's what I'm thinking (1.5) so I'm sure you're wondering about them.
3. situations [that] how=
4. T1: [mm]
5. M: =of course it's something like that, but then again, of course it's taking a leaf out of that book.
6. how Jesse
7. T1: mm
8. M: behaves [well it's not] like this=
9. F: [but not-]
10. F: =no, but it's something like this, of course, and maybe something like normal
11. behaviour if now not (wait for it) then a kind of mentality that. hhh really so
12. the crowd wants something like this=
13. T1: mm
14. I: =conflict situations so yes, it's quite a bit like that (gestures with his hands) actually quite a bit
15. quick normal [that's what] that's what
16. T1: [**(-)] and then I think it's important ((T1) gestures with his hand to the mother)) that you go like this - or have gone afterwards... or one or the other ((T1 points to both father and mother)) goes like this to show Liisa that there's nothing to worry about and>**

Extract 1 begins with the mother's view that she does not believe that Liisa is traumatised by her home situation (lines 1 and 2). However, the mother expresses concern that Liisa would

start to model Jesse's behaviour (lines 5, 6 and 8). The father expresses his view that Liisa's behaviour is also a normal reaction to conflict situations (lines 10, 11, 12, 14 and 15). T1 then returns to the parents' earlier talk about how parents often go to calm Liisa down after conflict situations at home, and gives the parents positive feedback on this. T1 addresses first the mother and then both parents (line 16). T1 reinforces his feedback by using the stress word 'important' and gesturing towards both parents (line 16).

The support for the views related to the intervention occurred in situations where parents expressed a view that the therapists went out of their way to support. The parents' views were related to Jesse and included the parents' own ideas about how to act in situations. Therapists often supported the parents' views either by using paraphrase or by verbally expressing their agreement with the parents. By supporting parents' views, therapists also encouraged parents to trust and act on their own abilities.

Activating action was done with questions designed to get parents to take action or become active in solving problematic situations. Parental activation occurred in situations where parents reported situations and issues that they found challenging. In these situations, the therapists asked parents about the solutions they had adopted to resolve the situations. Parental activation always occurred through the therapist's questions, which were often phrased in conditional terms.

The giving of advice was seen in the data as subtle attempts by therapists to advise parents in their activities. The advice given by the therapists was informative psychoeducation on parenting and child-rearing with new information. The advice was often either related to problems reported by the parents or were suggestions for action. By giving advice to parents, therapists indirectly imparted information to parents and, in doing so, provided parents with methods and tools for parenting. Therapists did not give advice directly, but expressed it indirectly. Therapists often softened the expression of advice by, for example, pausing their speech, using words that emphasised uncertainty and giving advice in the passive voice. The expression of advice was also softened by non-verbal means such as gestures and facial expressions.

Supporting Parents' Linguistic Expression of Their Child

Means of supporting parents' linguistic expression included reinforcing positive speech and filtering negative speech. Through these means, the therapists supported the parents' linguistic expression concerning Jesse in a more constructive way, thus facilitating communication and interaction between the parents and Jesse.

Although the content of the parents' speeches and the way they expressed themselves about Jesse was negative in some places, there were also constructive and positive interactional patterns in their speech. Such speech was evident, for example, when parents praised Jesse and communicated with Jesse in a constructive way. In these situations, the therapists *reinforced the parents' positive talk* (extract 2) by asking further questions, using exclamations of interest or interjections, and communicating their interest through facial expressions and gestures such as smiling. The therapists themselves could also take the initiative to stimulate positive talk.

Extract 2 from Session 2 (27:11-27:50) "Discussion on puzzle books"

Therapists, parents and Jesse discussed earlier about Jesse's own money and how to spend it.

1. M: you made a purchase remember=
2. J: =e: =e? I had lollipops yesterday.
3. (0.9)
4. M: ((mom looks at the ceiling)) @Well yesterday you bought lollipops that you weren't really allowed to buy @ but from the recycling center.
5. (1.6)
6. J: well it was a puzzle book°
7. M: [mmm.] [[@puzzletaskbook@] Hmm?
8. T1: **[@puzzletaskbook@]**
9. T2: **umm?**
10. M: how many tasks were there?
11. J: six hundred and fifty-four ((mother smiles))
12. T1: **ohhoh**
13. T2: **[huhhuh what a number]**
14. T1: **[well it was] a pretty thick one then = ((shows her fingers in the book thickness))**
15. M: =he wanted to go to the recycling centre with me and [I thought] now there's 19 books in the world messed up I'll take [money] with me that's all right?
16. T2: oh yes
17. T2: **uhumh ((smiles))**
18. M: well, he had sometimes stalked #more recently ((T2 laughs)) them there puzzle books and# (0.7) ((therapists nod enthusiastically to mother simultaneously))
19. °never mind [had to buy]°
20. T2: **[so those were] in his mind=**
21. M: =°mm°.

Extract 2 begins with the mother directing Jesse to tell her about his latest purchase (lines 1, 4 and 5). Jesse joins the conversation and says he bought a puzzle book (line 5), which his mother confirms (line 7). T1 repeats Jesse's answer in an excited and curious voice (line 8) and T2 also shows interest (line 9). The mother takes the conversation further on her own initiative by asking Jesse a question (line 10). Jesse answers the mother (line 11), and the therapists show their interest in Jesse's answer by using interjections and by verbalizing their surprise at the number of tasks (lines 12, 13 and 14). The mother follows up with more spontaneous information about her shopping trip with Jesse (lines 15, 18 and 21). T2 picks up the mother's speech with short words of surprise (lines 19 and 20), which T2 uses to encourage the mother to continue. T2 reinforces his expression by smiling (line 17). In addition, the therapists nodded to the mother while she was speaking (line 18), thus signalling their interest to the mother. In this interaction sequence, Jesse was also an active participant, which may have been facilitated by the mother's encouraging and interactive talk.

The therapists also supported the parents' linguistic expres-

sion about the child *by filtering the parents' negative talk about* Jesse. This filtering was done in such a way that the therapists created an experience of being heard for the parents, but did not continue with the issue raised by the parents. Therapists influenced the end of parents' negative speech by pausing between their speech and the parent's speech, giving minimal feedback in a quieter voice than the surrounding speech, and looking away from the speaker.

Supporting Parents' Positive Thinking

The parents' positive thinking was supported both by pointing out the positive aspects of things and by praising Jesse. By emphasising and highlighting what is already good and working in the family and in Jesse's behaviour, the therapists broke down negative thinking patterns in the family and guided parents to see the positive side of things. In doing so, the therapists also challenged parents' perceptions of themselves as parents.

The therapists often highlighted the *positive aspects* (extract 3) of the issues raised in the discussion, directing parents to pay attention to the good things that are already evident in Jesse's behaviour, for example. These therapists' interventions always included some new positive content on the previously discussed topic. The therapists often highlighted the positive aspects of things when the parents described something as negative, but sometimes also without the parents' negative description. Therapists often phrased their interventions as conditional statements or questions.

Extract 3 from Session 14 (27:13-28:01) "Some good things have started to happen"

Earlier, T1 asked parents how Jesse had been doing in after-school club. Parents said that there were no major problems now, just a little bit now and then. Jesse is not present at the meeting as he is working in the next room with the worker pointed to him.

1. M: but I'm sure that they have a slightly different attitude and (.) we'll get down to business because they with Anne a bit (.) ((mom nods her head in the direction of therapists))
2. T1: mm.
3. M: discussed
4. T1: yes (1.0) they have learned to work with Jesse now
5. T2: m
6. T1: that sounds nice (0.6) yes, even there [has] not come home to you [such] concern[messages]
7. T2: uhumm, yes
8. M: [mm]
9. M: but as such, as a mother, I'm not in the least bit convinced that ((mother begins smile))) °everything is here now°
10. T1: €mmm?€ ((mother laughs while scratching her neck))
11. T2 **so: there is a lot but there is also maybe a lot of good things that have happened. thinking about Jesse in the ((dad moves his hands behind his neck)) lobby now that it was quite nice. discussion**
12. M: [ye:s]
13. M: mm
14. **T2: and he wanted to show that painting to €you and€**
15. M: mm
16. **(1.2) you didn't start in any (1.0) resistance position(s). but was happy to go [to visit]**
17. T2:
18. M: [mm]
19. [mm]
20. T2: yes

Extract 3 begins with the mother's account of possible changes in the after-school club's policy towards Jesse (lines 1 and 3). T1 summarises the mother's contribution by saying that the staff at the after-school club have learned to work better with Jesse (line 4). T1 states that the situation sounds nice (lines 6), which the mother accepts with minimal feedback (line 8). However, the mother then laughs and says that she is not totally convinced about the changed situation (lines 9 and 10). T2 responds by highlighting the positive side of the situation, saying that a lot of good things have already happened in Jesse's behaviour (line 11), and gives the example of the encounter with Jesse in the lobby before the meeting started (lines 14 and 16). T2 formulates his view as conditional by using the words "maybe" (line 11) and "now that it was quite nice" (line 11). The mother accepts this (lines 12 and 13), and T2 goes on to elaborate on her positive observations of her encounter with Jesse, sometimes smiling and laughing (lines 14, and 16).

The therapists' *praise of the child* was reflected in the positive aspects of Jesse. In this way, the therapists made Jesse's positive aspects visible to the parents. In addition, Jesse's praise can also be seen as implicit praise of parents, as hearing praise about their own child sends a message to parents about their success as parents. The praise was either based on the speech produced by the parents or Jesse, or on Jesse's activities in the therapy room. The therapists showed their praise of Jesse either to the parents or directly to Jesse through the direction of their gaze and gestures. Therapists phrased their praise in direct and declarative terms, and often used word choices to emphasise their message.

Challenging Parents' Established Views

The therapists challenged the parents' established views by opening up the reasons behind the behaviour, bringing out Jesse's perspective on things and normalising Jesse's behaviour. In doing so, the therapists brought out new alternative ways of thinking about things and created space for Jesse's views and experiences to be shared in the discussion. Through the contributions of new perspectives, new knowledge and understanding of the topic was provided.

Parents had views of Jesse's behaviour as an unchanging and permanent way of acting, and did not describe the reasons behind Jesse's actions and behaviour. In these situations, the therapists took initiatives *to open up the reasons behind the behaviour* (extract 4). In this way, the new perspective suggested made the behaviour of a person more understandable by opening up the reasons behind the behaviour. The opening up of the reasons behind the action always started with the therapists' initiative, but occurred either when the therapists themselves suggested reasons or when they activated either Jesse or the

parents to reflect on them. In opening up the reasons behind the activity, the therapists used different means of expression, which was particularly pronounced when the therapists themselves suggested the reasons. Expression was softened by pausing speech, framing suggestions as implicit, and by non-verbal means such as gestures and changes in posture and gaze direction.

Extract 4 from Session 2 (18:17-18:50) "The Blind Spot of Enthusiasm"

Parents, therapists and Jesse discussed the rules of the adventure park earlier and how Jesse has disobeyed them. T1 asked Jesse if he was aware of the rules before going to the adventure park. Jesse did not answer the question, and when asked by his mother to answer, Jesse started joking around.

1. M: ((Mum looks at Jesse)) but the problem is that if you know really well what you're doing.

2. what you can and can't do (0.8) but you still do those ((T2 looks at Jesse)) things

3. which are not the good ◦things◦ ((T1 looks at Jesse))

4. J: hhh

5. (2.6)

6. T2: **how about (1.1) what is the word that would describe that it is so (0.9) nice ((T2 looks at parents)) that it becomes a kind of is it the enthusiasm ((T2 changes position on the chair)) kind of thing that the enthusiasm comes so strong in the process of doing it, that then maybe I forget the (1.8) I**

7. I think ((T2 waves his hand and looks at T1)) over there to the adventure park and they ((T2 turns to Jesse)) [can be a really nice thing]

8. M: [applies to what] [any]

9. T2: [hmmh] yeah

At the beginning of Excerpt 4, the mother says that Jesse does forbidden things, despite knowing what he can and cannot do (lines 1, 2 and 3). T2 considers the reasons behind Jesse's disobedience and suggests whether the intense excitement of the situation might cause Jesse to forget to follow the rules (Lines 6 and 7). T2 softens his message by pausing his speech (lines 6, 7 and 9), changing the direction of his gaze (lines 6 and 7) and changing his posture (line 7). In addition, T2 reinforces his message by emphasising the possible reasons behind Jesse's behaviour, namely "nice" (line 6) and "enthusiasm" (line 6). The mother counters T2's suggestion by stating that noncompliance applies to any situation (line 8). T2 accepts the mother's contribution with minimal feedback (line 9).

At the therapists' initiative, the parents also started to think about things from Jesse's point of view. *By bringing up the child's perspective,* the therapists showed the possibility of Jesse's experience having been different from that of the parents. In this way, the therapists created an image of the child as an individual separate from the parents. The presentation of the child's perspective was always initiated by the therapists, either by bringing up the child's perspective themselves or by asking Jesse or the parents to think about the issue from Jesse's perspective. When the therapists did bring up the child's perspective, they phrased it in a declarative way, but softened their expression with vocal inflections and by lowering their voices. The therapists could also verbalise the issue on Jesse's behalf, putting themselves in Jesse's shoes and speaking their message as if through the child's mouth.

In addition, therapists *normalised* Jesse's behaviour by explaining its prevalence and normality in boys of his age. In this way, the therapists increased parental understanding and challenged parents' perceptions of Jesse's behaviour as simply the result of ODD. The therapists normalised Jesse's behaviour in situations where parents reported Jesse's problematic behaviour in a situation. The therapists often punctuated their normalising remarks by pausing their speech and by framing their expressions in conditional terms. However, when normalising, therapists often reinforced their message by using generalisations such as 'everyone' and 'everybody'.

The second research question aimed to find out whether there is a change in the support of parents' self-efficacy as the therapy process progresses. Change was found in the ways therapists used to support parents' self-efficacy, both in their emphasis on the different stages of the therapy process and in their expression.

There were three changes in the emphasis on means. The use of some tools decreased as the therapy process progressed, while the use of some tools increased as the therapy process progressed towards the end. In addition, more than half of the identified and named tools were used more frequently in the middle of the therapy process compared to the beginning and end of the therapy process. The change in the expression of the means was in turn noticeable in the verbal expression of the therapists. This change was most evident when comparing the early and late stages of the therapy process, and it was therefore decided to examine the change between the two stages. At the beginning of the therapeutic process, therapists tightened up the expression of the means, for example by using a lot of word choices that emphasised the uncertainty of their expression. In contrast, towards the end of the therapy process, therapists used less word choices that emphasised the uncertainty of their expression and expressed their means more directly. However, the expression of means was always characterized by some form of produced conditionality. Another change in the expression of means was observed in the way the therapists reacted to the disagreement, defence or avoidance expressed by the parents. At the beginning of the therapeutic process, therapists were more likely to back off if parents expressed disagreement with the therapist's proposal. In contrast, at the end of the therapy process, when parents made disagreeing, defensive or evasive comments about therapists' proposals, therapists were nevertheless more likely to repeat the method they had used.

Conclusion

This study examined the support of parents' self-efficacy, a phenomenon defined in terms of individual psychology, in family therapy and the possible change in support as the therapy process progressed. Eleven tools were used to support parental self-efficacy. In addition, there was a change in the support for parents' self-efficacy as the therapy process progressed, with different means being emphasised at different stages of the therapy process and a change in their expression. As previous research literature has shown, self-efficacy cannot be supported directly [9], which was also evident in this study. The tools found were found to support parents' self-efficacy by targeting two processes that mediate self-efficacy, which were parents' behavioural and cognitive processes. In the present data, par-

ents' self-efficacy, identified as impaired, was mediated at the behavioural level by dysfunctional parenting practices and interactions. In addition, parents' self-efficacy was mediated at the level of their cognitive processes as beliefs and perceptions related to both Jesse's problematic behaviour and the limits of parents' own influence in the current situation. Since parental self-efficacy in this data was mediated at the level of parental behaviours and beliefs, it was found that therapists targeted their self-efficacy support to these self-efficacy mediating processes.

Through the tools contained in the core categories of supporting parental functioning and supporting parents' linguistic expression of their child, the therapists promoted more constructive parenting behaviours and interactions with Jesse. At the beginning of the therapeutic process, the parents' self-efficacy was mediated in their actions by passivity and negative parent-child communication. Supporting parental behaviour is an important part of supporting parents' self-efficacy, which is supported by previous research on the relationship between parental self-efficacy and behaviour [16].

Through the tools, the therapists provided parents with methods and tools for parenting, and reinforced parents' belief that they have the skills and effective methods to deal with challenging situations. Parental self-efficacy requires parents to be confident in their own abilities and to have sufficient knowledge of effective parenting methods [9]. When parents have effective tools and methods for dealing with a child who is behaving in a challenging way, this increases parents' sense of self-efficacy [28]. Having tools to support parenting can also enable successful experiences of parent-child interactions. When parents have effective tools and methods to interact with their child, this can result in successful interaction situations, which in turn create successful experiences for parents. Successful experiences are one of the most important factors that build self-efficacy [7].

By supporting positive thinking and using the core categories of supporting established beliefs, the therapists strengthened parents' belief in their own abilities and their ability to influence Jesse's behaviour. At the beginning of the therapy process, parents' self-efficacy was conveyed not only in their actions but also in their beliefs and understanding. The parents saw Jesse's behaviour largely through the prism of his defiant disorder, and thus Jesse's problematic behaviour appeared to them as a permanent and unchanging feature of Jesse.

Parents also perceived their own influence as limited. Through the tools, the therapists provided parents with alternative perspectives on the situation and made visible what was already working and what was good in Jesse's behaviour. Identifying and making visible the positive resources within the family is therefore an essential part of working in family therapy [1]. In addition, by highlighting the family's resources, i.e. what is already working in the family, the family is given tools to solve problems that arise in family interactions. Through the tools, the therapists also strengthened the parents' belief in their own empowerment in challenging situations with Jesse. It is therefore important that parents believe in themselves and feel that they can influence things through their own actions. When parents' belief in their own empowerment is strengthened, their motivation to confront and intervene in their child's problematic behaviour increases [9].

The second research question aimed to examine whether there is a change in the support of parents' self-efficacy as the therapy process progresses. The support for parents' self-reliance changed as the therapy process progressed, and this change was reflected in the methods used by the therapists.

The change in means was reflected in their emphasis on the different stages of the therapy process and in the way therapists expressed their means. The therapists used most of the tools most frequently in the middle of the therapy process. This high use of tools in the middle of the therapy may be due to the fact that at this stage of the therapy process, the challenges and problems faced by the family had already become more clearly defined. The middle phase of therapy can also be seen as the most active phase of working through the problems. In addition, the fact that there had already been several therapy sessions may have enabled the family and the therapists to strengthen their working relationship and develop trust. As a result, parents may have been more receptive to therapists' suggestions. The quality of the working relationship therefore influences clients' ability to receive and respond to therapists' suggestions [12].

There was also a change in the expression of the means used by the therapists, which was reflected in the reduction of words that emphasised the uncertainty of the expression and the repetition of the means despite the parents' disagreement, defence or avoidance. Here too, the development of the therapeutic relationship may have enabled the change observed. When the working relationship becomes trusting, it becomes more open and direct. The development of a cooperative relationship may therefore explain why, at the end of the therapy process, the therapists had the courage to repeat the methods they had used more boldly, despite the parents expressing their disagreement. The change in parents' reactions may also have influenced how courageous therapists were in repeating methods. Indeed, parents were less likely to express disagreement, defensiveness and avoidance of therapists' methods at the end of the therapy process. The change in the expression of the means may also have been made possible by the parents' increased self-confidence. As parents' self-efficacy is strengthened, they may find it easier to accept the therapist's means, which contribute to challenging their views and practices as parents.

In this data, supporting the parents' self-efficacy proved to be an important part of dealing with the child's behaviour problem. In line with the systemic perspective typical of family therapy work, dysfunctional family structures and interactions were also seen as a perpetuating factor in Jesse's behavioural problems in this family. Thus, the intervention focused on the whole family system. Moreover, the support for parents' self-efficacy was seen as typically resource-centred in family therapies, as several of the interventions focused on highlighting and making visible the patterns and practices that were already working in the family.

Self-efficacy is an abstract and complex phenomenon, which makes it challenging to study. This study aims to make this abstract phenomenon easier to grasp and understand. In addition, the study sheds light on how self-care is seen in practical therapy work. The study offers new insights and knowledge on the practical means to support parents' self-efficacy in family therapy. The practicality of the methods makes them easily adaptable and transferable to clinical therapy work. In the light of current knowledge, no previous research has been carried out to identify specific ways of supporting parents' capacity for self-efficacy.

A limitation of the study is that it was not possible to assess the level of self-efficacy of the parents. Information on the level of parents' self-efficacy before and after the intervention would have allowed for an examination of the change in self-efficacy. Another limitation of the study can be seen in the fact that it only covered the active phases of the work during the therapy sessions, but not what happened outside the sessions. The key to change is therefore what happens between sessions and how the issues discussed in the sessions are transferred into the family's everyday life. In addition, although the analysis of the study was data-driven, the theory of individual self-efficacy served as a guiding framework for the observations. Therefore, the possibility that the theoretical background may have influenced the analysis of the data to a greater extent than was realised cannot be completely excluded.

This study shows that family therapy supports parents' self-efficacy in a variety of ways and that support is seen as an important part of the treatment of a child's behavioural problem. It would be important to have more research on the different ways in which parents' self-efficacy can be supported. As this study only used one family's therapeutic process as data, it is not possible to know whether the same results would be obtained for other families. The means to support self-efficacy that were found emerged for this particular family, but different means might emerge for another family. Further research could help to find new ways of supporting parents' self-efficacy. In addition, this study was not able to assess the level of parents' self-efficacy, which would be important for further research to take into account. As parental self-efficacy lays the foundation for parenting and thus has a significant impact on child development, it would be important to gain more insight into how best to support parental self-efficacy.

References

1. Aaltonen J, Laitila A. Perheterapia (Family therapy, in Finnish). In: Huttunen M, Kalska H. editors. Psykoterapiat. 4th Renewed Ed. Duodecim. 2020; 243-261.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, DSM-V. 5th ed. American Psychiatric Association Publishing. 2013.
3. Bailey JA, Hill KG, Oesterle S, Hawkins JD. Parenting practices and problem behaviour across three generations: monitoring, harsh discipline, and drug use in the intergenerational transmission of externalizing behavior. Dev Psychol. 2009; 45: 1214-26.
4. Baker BL, Blacher J, Crnic KA, Edelbrock C. Behavior problems and parenting stress in families of three-year-old children with and without developmental delays. Am J Ment Retard. 2002; 107: 433-44.
5. Bandura A. Self-efficacy. In: Ramachandran VS, editor. Encyclopedia of human behavior. Academic Press. 1994.
6. Bandura A. Self-efficacy in changing societies. Cambridge University Press. 1995.
7. Bandura A. Self-efficacy: the exercise of control. Freeman. 1997.
8. Bussanich P, Hartley SL, Bolt D. Parental attributions for positive behaviors in children with autism spectrum disorder. J Intellect Disabil Res. 2017; 61: 643-55.
9. Coleman PK, Karraker KH. Self-efficacy and parenting quality: findings and future applications. Dev Rev. 1998; 18: 47-85.
10. Crum KI, Waschbusch DA, Bagner DM, Coxe S. Effects of callous-unemotional traits on the association between parenting and child conduct problems. Child Psychiatry Hum Dev. 2015; 46: 967-80.
11. Goldenberg I, Stanton M, Goldenberg H. Family therapy: an overview. 9th ed. Brooks: Cole. 2017.
12. Goldfried MR, Davila J. The role of relationship and technique in therapeutic change. Psychother Theor Res Pract Train. 2005; 42: 421-30.
13. Graham H, Senior R, Lazarus M, Mayer R, Asen K. Family therapy in general practice: views of referrers and clients. Br J Gen Pract. 1992; 42: 25-8.
14. Hakulinen A. Fundamentals of conversation analysis (1317). In: Tainio L, editor. Vastapaino; 1998.
15. Hodgetts S, Nicholas D, Zwaigenbaum L. Home Sweet Home? Families' Experiences With Aggression in Children With Autism Spectrum Disorders. Home Sweet Home. Focus Autism Dev Disabil. 2013; 28: 166-74.
16. Jones TL, Prinz RJ. Potential roles of parental self-efficacy in parent and child adjustment: a review. Clin Psychol Rev. 2005; 25: 341-63.
17. Korja R, Piha J, Otava R, Lavanchy Scaiola C, Ahlqvist-Björkroth S, Junttila N, et al. Parents' psychological well-being and parental self-efficacy in relation to the family's triadic interaction. Infant Ment Health J. 2015; 36: 298-307.
18. Lindholm C, Stevanovic M, Peräkylä A. In: Stevanovic M, Lindholm C, editors. Conversation analysis: how to study social action and interaction. 2016; 9-30.
19. Matthys W, Lochman JE. Oppositional defiant disorder and conduct disorder in childhood. 2nd ed. Wiley-Blackwell. 2017.
20. Minuchin P. Families and individual development: provocations from the field of family therapy. [de Montigny F]. & Lacharite C.. Perceived parental self-efficacy: concept analysis. Child Dev. 1985; 56: 289-302.
21. de Montigny F, Lacharite C. Perceived parental self-efficacy: concept analysis. Journal of Advanced Nursing. 2005; 49: 387–396.
22. Peräkylä A, Antaki C, Vehviläinen S, Leudar I. Analysing psychotherapy in practice. In: Peräkylä A, Antaki C, Vehviläinen S, Leudar I, editors. Conversation analysis and psychotherapy Cambridge University Press. 2008; 5-25.
23. Powell NR, Lochman JE, Boxmeyer CL. The prevention of conduct problems. Int Rev Psychiatry. 2007; 19: 597-605.
24. Tainai L, Sameroff AJ, Mackenzie MJ, Raevaara L. Guest pairs – A question and answer example. In: Tainio L, editor. Fundamentals of conversation analysis. 1998; 75-92.
25. Sameroff AJ, Mackezie M. Research strategies for capturing transactional models of development: The limits of the possible. Development and Psychopathology. 2003; 15: 613- 640.
26. Shadish WR, Montgomery LM, Wilson P, Wilson MR, Bright I, Okwumabua T. Effects of family and marital psychotherapies: A meta-analysis. J Consult Clin Psychol. 1993; 61: 992-1002.
27. Siegel AW, Scovill LC. Problem behavior: the double symptom of adolescence. Dev Psychopathol. 2000; 12: 763-93.
28. Sofronoff K, Farbotko M. The effectiveness of parent management training to increase self-efficacy in parents of children with Asperger syndrome. Autism. 2002; 6: 271-86.