Chapter 2. Basic Techniques of Family Therapy

Learning Outcomes

1. Describe how to arrange for and conduct a first interview with a family.
2. Explain how to move from a *linear* to a *systemic* perspective in a family assessment.
3. List questions to explore problem drinking.
4. Summarize the basic principles of ethical treatment.
5. Evaluate the two basic paradigms for treating domestic violence. What are the pros and cons of each?

INTRODUCTION

The first part of this chapter offers general guidelines for family therapy. The initial phone contact should be used to gather basic information and arrange for the whole family to come in for a consultation. In the first session it's important to establish an alliance with everyone present, to explore the presenting complaint and its interpersonal context, and to formulate a tentative hypothesis about what might be keeping the family from resolving their problems. In either the first or second session, the family should be offered a treatment contract, which can be relatively informal but should define the conditions of treatment (time, place, fee, etc.) and offer the family some hope that the therapist will be able to help them. Suggestions are presented for the remaining stages of treatment, through and including termination and follow-up.

The second section of this chapter is devoted to more extensive suggestions about assessment, emphasizing certain issues that should be explored even when families don't introduce them. Marital violence and sexual abuse are examples of problems likely to require special treatment approaches, and guidelines are offered for working with these difficult kinds of cases.

Important Terms

boundaries: emotional barriers that protect the autonomy and functioning of individuals and subsystems.

family life cycle: stages of family life, each of which typically requires some structural modifications in the family.

genogram: a schematic diagram of a family system, using squares to represent males, circles to represent females, horizontal lines to indicate marriage, and vertical lines for children.

homework: therapeutic tasks for clients to carry out between sessions.

hypothesis: a formulation explaining why clients have a particular problem and what is keeping them from resolving it.

linear vs. interactional: the idea that the presenting problem resides within one particular family member vs. that family members' interactions play a role in the problem.

managed care: a system in which third party companies control health care costs by regulating the conditions of treatment.

problem-determined system: those people directly involved with the presenting problem.

process/content: distinction between *how* members of a family relate and *what* they talk about.

resistance: anything clients do to oppose or retard the progress of treatment, often for purposes of self-protection.

structure, family: the functional organization, involving closeness and distance, which defines and stabilizes the shape of relationships.

therapeutic alliance: the working partnership between therapist and clients.

treatment contract: an explicit agreement between therapist and clients regarding the terms of treatment.

SUMMARY OF KEY POINTS AND ISSUES

The Stages of Family Therapy

The goal of the **initial phone call** is to get an overview of the presenting problem and to arrange for the family to come for a consultation. When clients resist the suggestion to bring in the whole family, the therapist should try to understand the reasons for their reluctance. It is generally not useful to imply "that everyone is part of the problem" or that the consultation is a prelude to "family therapy." Instead, simply saying that the clinician needs to see everyone in order "to get as much information as possible" or "to get everyone's point of view" is usually sufficient to ensure a family's attendance. Finally, a reminder call before the first session may help to cut down on the no-show rate.

The primary objectives of the **first interview** are to build an alliance with the family and gather information to formulate a hypothesis about what is maintaining the presenting problem. Because family members are often anxious or uncertain about the need for their participation, it's important to listen respectfully to everyone's perspective on the problems that brought the family to treatment and to acknowledge any reluctance to participate. Some therapists use *genograms* to diagram the extended family history, while others concentrate more on a family's current situation.

Two especially useful kinds of information are *solutions that don't work* and *transitions in the family life cycle*. Moreover, although most of the emphasis may be on a family's problems, it's important not to overlook their strengths and successes. In addition to exploring the content of a family's problems, it's important to observe the *process* and *structure* of their interactions. Often it turns out that families have trouble solving their problems not because they lack some necessary information but because they aren't working together effectively. By the end of the first or second session, the therapist and family should agree on a *treatment contract* specifying the family's goals and the conditions of treatment, such as meeting times, attendance, and fees.

The **early phase of treatment** is devoted to refining the therapist's hypothesis into a formulation of what is maintaining the presenting problem and beginning to work with the family to resolve it. While the therapeutic alliance must be maintained at all times, the emphasis now shifts from joining the family to challenging them to look at other options. While strategies and techniques vary, effective therapists share the ability to be forceful and persistent in their pursuit of change.

Among common strategies are challenging the idea that one person is the problem and that family members are isolated individuals. Regardless of how a therapist might question assumptions or interactions, it is essential to continue to respect and acknowledge clients' feelings and points of view. **Homework** assignments may be used to test a family's flexibility and to help them practice new coping strategies. Supervision can help therapists check the validity of their formulations and more effectively implement change strategies.

In the **middle phase of treatment** the therapist takes a less directive role and begins to encourage family members to rely more on their own resources. If change is initiated in the early phase, the middle phase is the time for consolidating those changes. During this phase therapists are advised to encourage family members to talk more among themselves and to increasingly test their own coping resources. The therapist should make certain that he or she has not come to assume responsibilities that render family members dependent.

For most family therapists **termination** comes when a family has resolved the presenting problem and begins to feel that they can now manage their lives without professional help. At this time, it's useful to review with the family what they've learned in therapy and to anticipate and plan for upcoming challenges. In many cases a therapist may wish to terminate with the implication that the family can return if they feel the need in the future.

Family Assessment

While clinicians vary in the extent to which they do formal assessments, the authors suggest that most therapists spend too little time on this essential activity. When exploring the **presenting problem**, it's important not to jump to conclusions. Listen carefully to the family's account of the problem and ask detailed questions to elicit not just one description but each family member's perspective. Pay attention both to the problems described and to how family members have responded to those problems. It's also important to understand the **referral route**. Who made the referral and why? What does this person or agency expect, and what expectations have they created in the client family?

Other important considerations in an assessment include the **systemic context** (important others, including people outside the family, relevant to the presenting problem), the **stage of the family life cycle** (which may provide a clue to the system's being stuck in transition), the **family's structure** (including the possibility of overinvolvement or neglect on the part of various family members), and **communication problems**. Any suspicion of **drug** or **alcohol abuse**, **domestic violence**, **sexual abuse**, or **extramarital affairs** should be explored carefully. In many cases, individual interviews may be indicated for exploring these toxic problems.

Finally, even though client families may not raise these issues themselves, therapists should be sensitive to **gender inequalities**, **cultural idiosyncrasies and strains**, as well as **ethical issues**, including the importance of confidentiality (and its limits in cases where outside agencies are involved), as well as the balance of fairness among family members.

Family Therapy with Specific Presenting Problems

Most therapists no longer believe that any one therapeutic model can effectively be applied to all clinical problems. Among the cases for which it may be particularly important to tailor the approach to the problem are marital violence and sexual abuse.

Even those (e.g., Virginia Goldner and Gillian Walker) who advocate couples therapy in cases where there has been physical violence, believe that the first priority should be that both partners take responsibility for ensuring that no further incidents of violence are tolerated. Once the batterer has accepted accountability for his actions and committed

himself not to repeat them, and his partner realizes that she must take steps to guarantee her own safety at the first hint of violence, it may then be possible to explore the couple's relationship dynamics. Planned time-outs are recommended to defuse arguments as soon as they begin to escalate, while inquiring into the specific details of conflict may help reduce the global judgments that provoke emotionality.

In cases where a child has been sexually abused, the first priority is to make certain that the abuse does not recur. Establishing support systems to break through the isolation that allows sexual abuse to take place is one of the goals with the family, as is taking steps to make sure that children and their caretakers maintain appropriate boundaries. A combination of individual and conjoint sessions may be useful to give children a forum to talk about their painful and embarrassing experiences, while ultimately supporting the parent(s) in their role as the child's caretakers.

SUGGESTED LEARNING ACTIVITIES

Role Plays/Observations

1. Have students break into groups of 2-3. One student (a client), should describe a problem (e.g., frequent fights with spouse or partner; difficulty getting along with co-workers; parent of an adolescent child who is acting out; workaholic, etc.) and the others should ask him or her questions about what he or she has done in response to the problem. The goal of the exercise is to discover the problem-maintaining behavior, and maybe to suggest trying something different to the client. Reverse roles until all students have played both client and interviewer.

2. Ask two students to play members of a couple and to choose an emotional topic for discussion, something on which they are likely to disagree (finances, housekeeping responsibilities, frequency of visits with parents, sex, communication problems). Instruct one or both members of the couple to talk about "you" and the way things "are" and "should be," rather than saying "I think," "I wish," and "I feel." Stop after 10 minutes -- observers should notice how destructive this habit is. Next instruct each member of "the couple" to speak in the first person singular (I feel..., I think..., My thought is that....); making personal statements about personal matters ("I would like to visit my family..." versus "You should want to visit with our family during the holidays."), and speaking directly to, not about, each other. Discuss the contrasting experiences of the students who were role-playing across the first and second role play. Discuss the observers' perceptions of these differences. Ask students to consider implications for treatment.

3. Divide the class into groups of 4 and have students conduct two types of role plays using communications family therapy techniques. Instruct two students to play a couple with relationship difficulties, one student to play the therapist, and one or two students to observe. In the first type of role play instruct the therapist to use a didactic approach in treating the couples' presenting difficulties, by making their rules of communication explicit and teaching them principles of clear communication (using the first person singular--I, me, mine--when referring to one's thoughts and feelings about an issue, making personal "I" statements, speaking directly to and not about the other).

   In the second role play, two students should role play a couple with relationship difficulties. This time instruct the therapist to use a more indirect strategy to treat the couple, by attempting a paradoxical intervention (prescribing the symptom, reframing the problem, creating a therapeutic double-bind, etc.). Encourage the therapist to call a time-

out during the role play session in order to confer with observers and design an effective paradoxical intervention. Following the role plays, instruct the groups to discuss the effectiveness of the direct, didactic vs. indirect, paradoxical styles of intervention. What were the couples' experiences as targets of the interventions? Which felt more effective? In each case, was the therapist able to induce change in the couples' styles of communicating, ways of thinking about the problem, etc.? Which intervention style fits best with students' own personality styles?

4. Have students break into groups of 3-4. Have two students role play a conversation in which each reacts with emotional responses to the other's statements--observers should take note of what happens. Next have them role-play a similar conversation but this time instruct them to first acknowledge what the other has said before they respond. Have the group discuss each role play. What impact did acknowledgment of the other's perspective have on the quality of the interaction? Discuss the implications for how one would conduct couples therapy.

5. Have students take turns role-playing therapists talking on the phone to clients requesting help for one family member in which the therapist's job is to listen sympathetically but convince the caller to bring the entire family for a consultation.

6. Generate a list of complaints that callers might request therapy for and have the class come up with hypotheses about what might be going on in the family that's maintaining these problems. Note the extent to which the class considers process dynamics, family structure, psychopathology, and psychodynamics. Do they avoid considering or over-rely on any of these important dimensions?

7. Conduct a first interview with a role-play family. Ask students who may know each other well to volunteer to play a family with a rebellious adolescent who is failing the 10^{th} grade. Father has recently been laid off from his job as a distribution manager and mother has had to return to work for a temping agency and is barely making minimum wage. Two other siblings are in the family, a 12-year-old daughter who is a model child, and a 10-year-old brother. Demonstrate to the class during a 15-20 minute role-play how a family therapist works to build an alliance with the family and develop some hypotheses about what family patterns are maintaining the problem. Break and discuss the class's observations, reactions, and questions.

8. Have students conduct a family observation. Be sure to have students obtain permission from family to audio or video record the session. Take extensive notes on your observations. One suggestion is to divide your note-taking paper into 3 sections—speaker, content, process observations. Be alert for expressions, body movements, note interruptions, topic changes, and times when one family member disconfirms another by ignoring, changing the topic, or speaking about another with a third family member. Who sits closest to whom? Who's furthest away from whom? Does this proximity and distance reflect the level of verbal involvement between members or not? Who talks to whom? How would you describe the climate of the family, what they talk about and the way they interact during periods of calm versus any periods of higher tension/anxiety? Try to track a few of the process dimensions during the observation and then review the video to conduct a more thorough analysis of the interactions. What evidence did you observe for the existence of homeostasis, negative feedback loops, complementarity, what family rules seemed to exist? and any paradoxical communications.

Students should apply their knowledge of family systems theory learned thus far to record and discuss their perceptions of the family interactions…e.g., parents with each child, husband and spouses with one another. Students can be instructed to submit a written report or prepare a presentation of their observations for class. Spend some time in class reviewing sections of video and discussing the class observations.

Videos/Films

Paul Watzlawick: Mad or Bad? American Association for Marriage and Family In his consultation with a family whose 25-year old son presents with chronic somatic symptoms, Watzlawick employs strategic use of Ericksonian-style questions. The systemic function of symptoms in protecting the family from other problems is highlighted. Approximately 136 min.

Jay Haley & Judge Clinton Deveaux, In the Maze: Families and the Legal System American Association for Marriage and Family This video offers guidelines for effective compulsory therapy as an alternative to incarceration.

Virginia Satir: The Use of Self in Therapy #7953 Menninger Video Productions Michele Baldwin, Ph.D., co-author with Satir of The Use of Self, draws on Satir's legacy of clinical recordings to demonstrate the tenets of her theory and practice. Therapy footage is interspersed with expert commentary. Explored are methods to empower family members, bolster self-esteem, reframe problems, and communicate with congruence. Approximately 30 minutes.

Virginia Satir: The Lost Boy (American Association for Marriage and Family Therapy Satir conducts an experiential session with a large intact family with ten children whose presenting problem is grief following the loss of one of the children who is still missing a year after his abduction. This session provides a good demonstration of Satir's open, directive, spatial style. Approximately 80 min.

Class Discussion

1. Ask the class to generate a list of suggestions for cutting down on the no-show and cancellation rates. Do students think it would be more effective for the therapist to place a reminder call before the first consultation session or ask the family to take the responsibility for calling to confirm their attendance?

   Have students role play talking on the phone to a client who has called to cancel, in which (a) the therapist politely accepts the client's excuses, and then (b) doesn't readily accept the client's explanation and instead acts as though it isn't okay not to show up. Sort of a polite skepticism.

2. Under what circumstances should a therapist refuse to meet with a family if not everyone shows up?

3. What are the pros and cons of taking a formal history, including a genogram?

4. When terminating with a family, what are the advantages and disadvantages of suggesting that they may wish to return for further sessions some time in the future?

5. What are some of the dangers of couples therapy with violent couples? What are the dangers of not seeing such couples together? Discuss the role of countertransference in the clinician's response to the issue of marital violence.

6. Is it possible to work effectively with clients if the therapist cannot empathize with them? What are some of the kinds of people that students have trouble empathizing with? What can be done to help a therapist increase his or her ability to empathize with such difficult clients as the hostile father, the controlling mother, the rebellious teenager, etc.?

   Have students role play families with hard-to-empathize-with members – and have the student who acknowledges trouble empathizing with certain types of people to be the one who plays those people.

Supplemental Readings

Anderson, C., and Stewart, S. 1983. *Mastering resistance: A practical guide to family therapy*. New York: Guilford Press.
Minuchin, S., and Fishman, H.C. 1981. *Family therapy techniques*. Cambridge, MA: Harvard University Press.
Minuchin, S., Nichols, M. P., and Lee, W-Y. 2007. *Assessing families and couples: From symptom to system.* Boston: Allyn & Bacon.
Nichols, M. P. 2009. *The lost art of listening,* 2nd ed. New York: Guilford Press.
Patterson, J. E., Williams, L., Grauf-Grounds, C., and Chamow, L. 1998. *Essential skills in family therapy*. New York: Guilford Press.
Sheinberg, M., True, F., & Fraenkel, P. 1994. Treating the sexually abused child: A recursive, multimodel program. *Family Process, 33*: 263-276.
Taibbi, R. 2007. *Doing family therapy: Craft and creativity in clinical practice* 2nd ed. New York: Guilford Press.
Trepper, T.S., & Barrett, M.J. 1989. *Systemic treatment of incest: A therapeutic handbook*. New York: Brunner/Mazel.
Walsh, F. 1998. *Strengthening family resilience*. New York: Guilford Press.

TEST QUESTIONS

Multiple Choice Questions

1. For initial interviews, the author recommends seeing:
   a. the "problem-determined system"
   b. the adults in the family
   c. the parents
   d. everyone in the household

2. A treatment contract typically includes:
   a. the therapist's strategies for solving the presenting problem
   b. the fee and how it should be paid
   c. the therapist's therapeutic model
   d. all of the above

3. What is the major presenting pitfall in listening to a family's perspective on the presenting problem?

a. accepting a linear perspective on the problem
b. hearing too many conflicting points of view
c. allowing children too much leverage in family decision making
d. challenging the family's perspective too soon

4. The goal of a first interview with a family is to develop an alliance with the family and:

A) To determine if medication is indicated
B) To get a detailed picture of the identified patient
C) To develop a tentative hypothesis about the what is maintaining the problem
D) To consider whether or not to take the case

5. Challenging linearity means:

A) Asking how others are involved in the presenting problem
B) Asking for a chronology of the presenting problem
C) Asking for a family history
D) Asking family members for a circular explanation of the presenting problem

6. According to the author, therapists should inquire about drug and alcohol consumption:

a. when there is suspicion that this may be a problem
b. in every case
c. in every case where the identified patient is a teenaged child
d. when there is a history of this being a problem

7. All but which of the following is not part of exploring a family's structure?

A) Subsystems
B) Boundaries
C) Family rules
D) Triangles

8. At termination a family therapist should___

A) Explore the therapeutic relationship
B) Challenge the therapeutic relationship
C) Review the therapeutic relationship
D) Focus on what the family has been doing

Short Answer

1. What are the pros and cons of insisting that the entire family attend the initial consultation?

2. What is the "problem-determined system"? Give a couple of examples.

3. What is essential to accomplish in the first session in order to establish a productive therapeutic alliance with a family?

4. How can a therapist effectively challenge linear attributions of blame? Give a couple of examples.

5. Why is it important for a clinician to develop a therapeutic hypothesis, and what are some of the elements that such a formulation should include?

6. What is the danger of a therapist taking too active and directive a role in the middle stages of a family's treatment?

7. Why is traditional couples considered potentially dangerous in the treatment of cases involving marital violence?

8. What are some of the arguments in favor of treating violent partners together in couples therapy?

9. What are the first priorities in treating cases involving child sexual abuse?

Chapter 2. The Evolution of Family Therapy
Answer Key

Multiple Choice Questions

1. D p23
2. B p25
3. A p29
4. C p24
5. A p26
6. A p31
7. C p30
8. D p28