Test Bank for Family Therapy Concepts and Methods 11th Edition by Nichols

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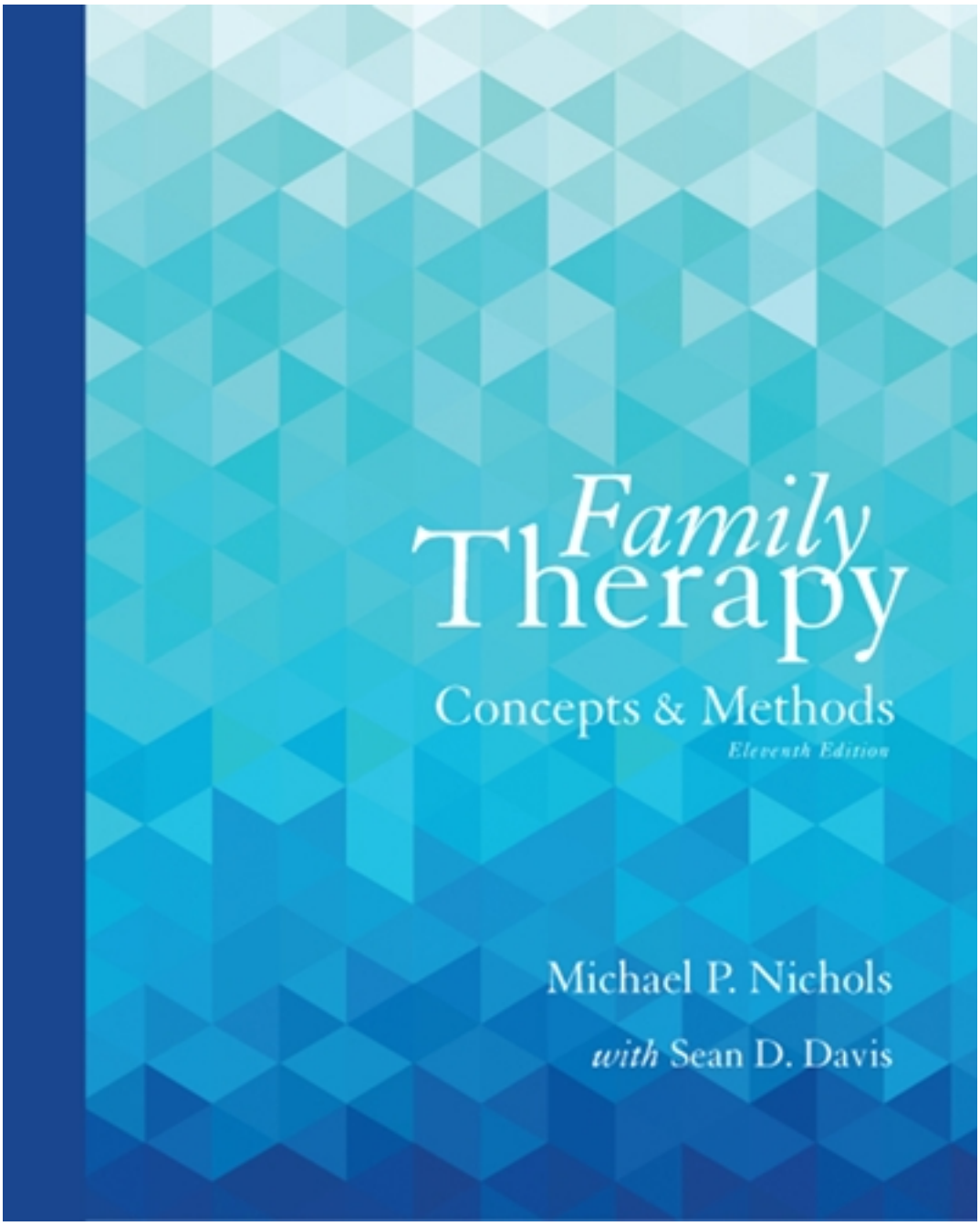

Test Bank

Chapter 2
Basic Techniques of Family Therapy

INTRODUCTION

This chapter offers guidelines for getting started in family therapy. The initial phone contact should be used to gather 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 its problems. In the first or second session, the family should be offered a *treatment contract*, which should define the conditions of treatment (time, place, fee, etc.) and offer the family hope that the therapist will be able to help them. Suggestions are offered 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 bring them up. Marital violence and sexual abuse are examples of clinical problems likely to require specialized approaches, and guidelines are offered for working with these difficult cases. Finally, suggestions are made for working collaboratively with the managed care industry and for establishing a fee-for-service private practice.

Leading Figures
Virginia Goldner, Michael Johnson, Marsha Sheinberg, Gillian Walker.

Important Terms
circular causality: the idea that actions are related through a series of recursive loops.
complementary: relationships based on differences that fit together, where qualities of one make up for lacks in the other.
empathy: the ability to put yourself in someone else's shoes and understand how that person feels.
family homeostasis: tendency of families to resist change in order to maintain a steady state.
family life cycle: stages of family life, from separation from parents to forming a couple, having children, growing older, retirement, and so on; each stage typically requires some structural modifications in the family.
family rules: a descriptive term for redundant behavioral patterns.
feedback: the return of a portion of the output of a system, especially when used to maintain the output within predetermined limits (negative feedback), or to signal a need to modify the system (positive feedback).
genogram: a schematic diagram of the family system, using squares to represent males, circles to represent females, horizontal lines to indicate marriage, and vertical lines for children.
homework: therapeutic tasks assigned for clients to carry out between sessions.
identified patient: the symptom bearer or official patient as identified by the family.
hypothesis: a formulation explaining why clients have a particular problem and what is keeping them from resolving it.

linear: simple explanations of cause and effect, where A causes B.
managed care: a system in which third party companies control health care costs by regulating the conditions of treatment.
medical model: the idea that psychological disorders reside in individuals, just like medical diseases.
presenting problem: the specific complaint clients come in with, phrased in their terms.
process/content: distinction between *how* members of a group (or family) relate and *what* they talk about.
reframing: relabeling a family's description of behavior to make it more amenable to therapeutic change; for example, describing someone as "discouraged" rather than depressed.
resistance: anything clients do to oppose or retard the progress of treatment, often for purposes of self-protection.
structure, family: the way a family is organized, involving closeness and distance, which defines and stabilizes the shape of relationships.
subsystems: smaller units in systems, in families these are determined by generation and function.
symmetrical: in relationships, equality or parallel form.
systemic context: the network of surrounding people, including family, friends, and important others.
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

GETTING STARTED

The goal of the **initial phone call** is to get an overview of the presenting problem and 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's generally not useful to imply "that everyone is part of the problem" or that the consultation is a prelude to "family therapy." Rather, simply saying that the clinician needs everyone to attend in order "to get as much information as possible" or "to get everyone's point of view" is usually sufficient to ensure the family's attendance. Finally, a reminder call before the first session may 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's 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 the family's immediate 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 useful to observe the *process* and *structure* of their interactions. Often it turns out that families have trouble solving their problems not because they lack ideas 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 such conditions of treatment 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 are 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 not affected by one another. Regardless of how the therapist might question assumptions or interactions, it's essential to respect and acknowledge clients' feelings and points of view. **Homework** assignments may be used to test a family's flexibility or 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** therapists take a less directive role and begin 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. Therapists should make certain that they haven't begun 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 the course of 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 author suggests that most family therapists spend too little time on this essential endeavor. 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 only one description but each family member's perspective. Pay attention both to the problems described and to how family members respond 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?

In systems oriented family therapy, it's important to help families shift from a *linear* perspective (the symptomatic family member is the only problem) and *medical model* thinking (he or she is his or her diagnosis) to an interactional perspective. To accomplish this shift, a therapist needs to

broaden the focus from the identified patient (IP) and his or her symptoms to the entire family and their interactions.

Other important considerations in the 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 any and 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 the use of 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 widely 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 drive up emotionality.

In cases where a child has been sexually abused, the first priority is to ensure 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 adult 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.

Working with Managed Care

Rather get fall into an adversarial (and self-defeating) relationship to managed care companies, therapists are advised to learn how the system works, find out how to get on provider panels, and develop cooperative relationships with case managers. Willingness to accept difficult cases, responding promptly, providing concrete goals and strategies, and writing well-defined treatment plans are among the steps recommended to help clinicians work effectively with the managed care industry.

Fee-for-Service Private Practice

Therapists who choose not to accept managed care insurance can compete in the marketplace if they have established reputations or unique skills. Advanced training is one way to attract fee-paying clients. Establishing an excellent reputation in the community is important in attracting clients willing to pay full cost for treatment. While they may not be everyone's cup of tea, marketing and networking are also important in building a private practice.

SUGGESTED LEARNING ACTIVITIES

Role Plays/Observations

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

2. 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 a 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?

3. Conduct a first interview with a role-play family. Ask students to role play a family with a rebellious adolescent who is failing the 10th 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 family members and develop some hypotheses about what family patterns are maintaining the problem. Break and discuss observations, reactions, and questions.

   N.B. Although an instructor can suggest a particular scenario, role plays often work best when students are left to invent their own scenarios.

4. Have students conduct a family observation. Be sure to have students obtain permission from the family to audio or videotape the session. Have students take extensive notes on their 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 that 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 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 tape 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 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 videotape and discussing students' observations.

Videotapes/Films

Paul Watzlawick: Mad or Bad? (American Association for Marriage and Family at http://www.aamft.org/resources/index.htm then select "AAMFT Tape Store." 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. VHS, approximately 136 min.

Jay Haley & Judge Clinton Deveaux, In the Maze: Families and the Legal System (American Association for Marriage and Family at http://www.aamft.org/resources/index.htm then select "AAMFT Tape Store." This videotape offers guidelines for effective compulsory therapy as an alternative to incarceration. VHS.

Virginia Satir: The Use of Self in Therapy #7953 (Menninger Video Productions, distributed by Altschul Group Corporation, 1560 Sherman Ave., Ste. 100, Evanston, IL 60201. 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. VHS, 30 minutes.

Virginia Satir: The Lost Boy (American Association for Marriage and Family Therapy at http://www.aamft.org/resources/index.htm then select "AAMFT Tape Store," or call 1-800-776-5454). 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. VHS, 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--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 individuals.

7. Propose (or have students generate) ethical practice dilemmas where traditional clinical values (neutrality, confidentiality, etc.) might conflict with legal or ethical principles or common sense.

Supplemental Readings

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Walsh, F. 1998. *Strengthening family resilience.* New York: Guilford Press.

TEST QUESTIONS

2.1 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?