Part I

Chapter 1

Becoming a Competent Marriage and Family Therapist

Introduction

This book is designed to help you make the transition from the classroom to the consulting room. In the classroom you have developed verbal and theoretical knowledge of how to do therapy. In the consulting room you will begin to change your verbal-theoretical knowledge into experiential knowledge. In the classroom you learned to respond to verbal descriptions of client behaviors. In the consulting room you will learn to respond to actual client behaviors in real time. You will begin to feel the responsibility of attempting to help clients deal with the complexities of their lives. Meeting clients for the first time is both exciting and frightening. In this effort you will not be alone. You will have the support and guidance of your supervisor who is an experienced therapist. Therefore, this text is also for supervisors. It will help supervisors provide the support and guidance new therapists need as they work to become competent therapists.

As a new therapist your goal is to become a competent entry-level therapist. Wampold (2001) stated that competent therapists have successful client outcomes. Therefore, your goal should be to help clients achieve their therapy goals. Your supervisor's goals are to help you become a competent therapist while safeguarding the welfare of your clients. How can you help clients to have successful outcomes? Successful therapy appears to be a function of four factors that appear to be common to all models of therapy (Lambert & Barley, 2002).

The Role of Common Factors in Therapy Outcomes

Research over the past twenty years has found that about 80 percent of clients who undergo psychotherapy are better off than those who do not (Lambert & Barley, 2002). Research has also found that about 40–50 percent of couples and families who complete marital or family therapy have successful outcomes (Shadish & Baldwin, 2002). Why marital and family therapy should be found to be less successful than individual therapy is not known. One could speculate that the difficulty of building and maintaining multiple alliances in families may be a contributory factor (Blow, Sprenkle, & Davis, 2007).

When individual therapy models are compared with each other none of the models have been found to be more efficacious than any other (Lambert & Barley, 2002). The same is true for

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marriage and family therapy models. When they are compared head-to-head, no marriage or family therapy model is superior (Shadish & Baldwin, 2002, 2005).

There are a few noteworthy exceptions in which specific treatments have been found to be effective for specific classes of problems (Lambert & Barley, 2002). For example, exposure treatments for anxiety, avoidance, and rituals have been found to be superior to other forms of treatment (Lambert, 1992). Similarly, exposure techniques appear to play a significant role in the treatment of panic disorder with agoraphobia (Craske, 1999; Michelson & Marchione, 1991). Also there is considerable support for cognitive behavioral therapy (CBT) as an effective treatment for depression (Clark, Beck, & Alford, 1999). However, even in these specific treatments the common factors appear to play an important part.

Common factors contributions to successful client outcomes

According to the common factors literature there are four factors that make up the variance in therapy outcomes (Hubble, Duncan, & Miller, 1999; Sprenkle, Blow, & Dickey, 1999). The four factors are (1) the *alliance*, (2) what the *clients bring* to therapy, (3) the *placebo effect*, and (4) the *treatment techniques*. The *alliance* is the relationship between the clients and the therapist and makes up 30 percent of the therapy outcome variance. What the *clients bring* to therapy makes up approximately 40 percent of the variance (Lambert & Barley, 2002) and includes their presenting problems, their readiness to change, their social skills, and their support systems (Asay & Lambert, 1999). The third factor is the client's expectations for a successful outcome, what some call the *placebo effect* of coming to therapy and makes up 15 percent of the outcome variance (Lambert & Barley, 2002). The fourth factor *treatment techniques* employed by the therapist are embodied in the therapy model used by the therapist. Therapist techniques are used to maintain the therapeutic conversation between the therapist and the clients (Frank & Frank, 1991, 2004). Treatment techniques are believed to make up the final 15 percent of the outcome variance. These four factors appear to be common to all models of therapy and seem to account for successful client outcomes in both individual psychotherapy (Lambert & Barley, 2002) and in marriage and family therapy (Sprenkle et al., 1999).

Two of these factors, what the clients bring to therapy and the placebo effect, appear to be primarily client factors and not directly open to manipulation by you the therapist. The remaining two factors, the alliance and therapy techniques are factors that you can influence.

Here I will deal with each of the common factors independently although in practice they are difficult to differentiate. For example, the placebo effect may contribute initially to the client's trust in you thus facilitating the development of the alliance. Building and maintaining the alliance is related to how you employ the treatment techniques (Blow et al., 2007). It is difficult to differentiate the role of the treatment techniques from procedures that build the alliance. The alliance is said to consist of three elements, the clients' trust in the therapist, the clients' agreement with the therapist on the goals of therapy, and the clients' agreement about the techniques needed to achieve their goals (Bordin, 1979). So, at the same time that you are working collaboratively with the clients to clarify and establish their goals they will begin to trust you. As you communicate respect and empathy and exercise care concerning their safety in the sessions, the clients come to trust that you are on their side, both as individuals and as a couple or family. In this way two of the elements of the alliance are being forged, first, agreement on goals and second, trust in you as their therapist. Next you will propose a treatment plan tailored to fit the clients' needs and goals. If the clients agree that the treatment is appropriate to help them achieve their goals then the third element of the alliance is being constructed which is agreement on the treatment methods or therapy model. Finally, the treatment model serves as a structure for a continuing conversation about the clients' problems, needs, and goals while they formulate their solutions and change their behaviors and

relationships (Frank & Frank, 1991, 2004). Thus, while treatment techniques have been found to contribute only 15 percent to the outcome variance, that 15 percent is not trivial.

Although the factors labeled "what the clients bring to therapy" and "client expectations" do not appear to be open to direct manipulation by you as a therapist there are potentially several ways you can influence the clients' perceptions of the alliance. These will be discussed at length in this chapter. Perhaps what is more important is that the delivery of the therapy techniques and the skill with which they are delivered is directly under your control. It has been shown that therapist's vary in their therapy delivering skill (Luborsky et al., 1986) suggesting that therapists can learn how to deliver therapy more effectively. By improving your skills in delivering therapy, you will increase the probability that your clients will have successful outcomes (Blow et al., 2007).

The Therapeutic Alliance

As stated above, the therapy alliance has been found to account for approximately 30 percent of the total outcome variance (Asay & Lambert, 1999). The alliance consists of three factors: (a) the clients' trust in, or bonding with, the therapist; (b) agreement between clients and therapist on the therapy goals; and (c) the clients' agreement with the tasks in the treatment plan (Bordin, 1979; Heatherington & Freidlander, 1990; Johnson & Talitman, 1997; Pinsof & Catherall, 1986). As a therapist you make a positive contribution to the therapy alliance by: (a) communicating respect, caring, and empathy (see Chapter 2); (b) helping clients clarify and establish their goals (see Chapter 3); (c) establishing treatment plans tailored to those goals (Chapter 3); and (d) dealing effectively with breaches in the alliance.

In individual psychotherapy you only need to be concerned with the alliance the client makes with you as the therapist. In family therapy you must be concerned about the alliance each family member makes with you (Friedlander, Escudero, & Heatherington, 2006; Pinsof, 1995). Family members may vary in their goals for therapy. Therefore, each family member will form her or his own alliance with the therapist. When family members' differ in their alliance with the therapist, the alliance is said to be split (Beck, Friedlander, & Escudero, 2006; Thomas, Werner-Wilson, & Murphy; 2005). Pinsof and Catherall (1986) were the first to define a split alliance. Split alliances occur when one member of the family rates the alliance with the therapist high and another member of the family rates the alliance low. Split alliances may lead to clients deciding to withdraw from therapy before they have reached their goals.

The probable causes of split alliances

In family therapy there may be as many goals for coming to and for staying in therapy as there are family members in the room (Friedlander, Escudero, & Heatherington, 2006). Family members have already formed alliances between each other before they come to therapy. Alliances between family members are what Friedlander and colleagues (2006) call family allegiances and what Garfield (2004) calls family loyalty. Family members may vary in their sense of family unity from total enmeshment to wondering whether or not they intend to remain in the family. It should come as no surprise then that the alliances they form with the therapist vary (Friedlander Friedlander, Escudero, & Heatherington, 2006; Symonds & Horvath, 2004).

The causes of split alliances are not yet well understood. The family power structure may be one factor in split alliances. Differential power may be a function of differences in physical size and development or in role differences between partners and between parents and children. The power hierarchy in the family may make some members vulnerable to other members in terms

of psychological and physical aggression and even abuse (see Chapter 2). Therefore, some family members will be motivated to avoid family therapy and others may be motivated to come in self-defense. You will need to be sensitive to the power issues and be prepared to provide for the safety of each family member. Power differences may also occur between family members based on gender, race, education, and control of family finances.

There appears to be support for the idea that gender influences alliances however, the results are not consistent. Quinn, Dotson, and Jordon (1997) found that wives' scores on an alliance scale predicted outcome while the husbands' scores did not. On the other hand, Symonds and Horvath (2004) found that the relationship with the outcome was greater when the male's alliance was stronger. They also found that the relationship between alliance and outcome was greater when both partners agreed on the strength of the alliance and when the strength of the alliance increased over the course of treatment. Knobloch-Fedders, Pinsof, and Mann (2004) found that individual psychological symptoms in the couple did not predict alliance formation. Similarly Mamodhoussen, Wright, Tremblay, and Poitras-Wright (2005) found that psychiatric symptoms did not predict the alliance but marital adjustment did. In both studies husband's greater marital distress was a predictor of poor alliance. In the Knobloch-Fedders study women's marital distress at intake and reports of family-of-origin issues predicted the tendency for a split alliance. However, in the Mamodhoussen study the husband's marital adjustment and wife's psychiatric symptoms were associated with split alliances.

Family secrets are another source of alliance difficulties in family therapy (Friedlander et al., 2006). Some family members fear that the secrets will come out while others worry that they will not. In these circumstances the issue of safety in the therapy sessions is a serious issue for family members and therefore for the therapist. As a therapist you must address concerns about safety in the therapy system from the beginning of therapy starting with the initial phone call (See Chapter 3).

It is likely that the therapist will be working with split alliances when spouses or family members have mixed motives, are concerned about differential power, and are concerned about family secrets. Heatherington and Friedlander (1990) and others (Mamodhoussen et al., 2005; Symonds & Horvath, 2004) have empirically verified the existence of split alliances between family members and the therapist. Symonds and Horvath found strong correlations between alliance and outcome when the partners agreed on the strength of the alliance and when the strength of the alliance increased from Session 1 to Session 3. Similarly, Safran, Muran, Samstag, and Stevens (2002) found evidence in individual psychotherapy that alliance predicts positive outcomes if found to be about average, as measured by alliance assessment instruments, or if the scores increase over the course of treatment.

Johnson, Wright, and Ketring (2002) found that in family therapy the alliance scores for family members predicted changes in psychiatric symptom distress for mothers, fathers, and adolescents. Agreement with the therapist on the therapy tasks domain of the alliance was the greatest predictor of the outcome for both mothers and adolescents while agreement on the therapy goals domain was greatest for fathers. Beck et al. (2006) also looked at alliances in families in a qualitative study with four cases. Interestingly, they found direct measures of split alliances with the therapist in only two of the four cases. In the study Beck et al. (2006) found that most of the problems centered on the lack of agreement between family members on goals for being in therapy, rather than disagreeing with the therapist on therapy goals. In two of the cases, which included husbands and fathers, most of the conflict appeared to be between spouses.

It seems clear that as a therapist you will need to guard against forming reciprocal emotional triangles with either partner (Bowen, 1978; Rait, 1998; Thomas et al., 2005). Triangles that form between you and any family member or groups of family members – such as aligning with the parents against an adolescent – seems to have the potential to form rifts in the alliances. In

addition, negativity or defensiveness on your part in response to client negativity may be harmful to the client-therapist alliance.

Detecting rifts in the alliance

Client confrontation of the therapist and client withdrawal from the therapist or the treatment program often signal a rupture in the alliance (Safran & Muran,1996; Safran et al., 2002). Confrontation is observed when the client openly expresses hostility or anger toward you or the therapy process. The far more frequent signal of a rupture is client withdrawal. The client may withdraw from you, the therapy process, or from her or his own emotional processes. Examples of withdrawal include passivity or refusal to talk and coming late or missing sessions. There can be, of course, a mix of ways of expressing alliance rupture in which the client manifests angry or hostile withdrawal.

It would appear that a split alliance in couple or family therapy should be treated as a therapeutic rupture (Friedlander, Escudero, & Heatherington, 2006; Pinsof, 1995). In family therapy one family member may confront you or attack the therapy process while another family member may experience you or the process as positive and helpful. In a split alliance one family member may withdraw from the therapy process, from you, or from interaction with the other family members.

When there is a split alliance two factors are said to determine the strength of the split (Pinsof, 1994). The first is the intensity of the negative alliance of one family member balanced against the degree of positivity in another family member. The second factor is the power of the subsystem, such as the parental subsystem, to influence whether or not family members keep coming to therapy. For example, your strong positive alliance with an adolescent son may not be sufficient to balance a negative alliance with the parents. Pinsof (1994) suggests that you need to give careful attention to the alliance with the most powerful subsystem in an attempt to help the clients continue the therapy. However, this does not justify failure to attend to the alliance with the less powerful subsystems. Thomas et al. (2005) makes it clear that husbands and wives wield alliance power in different ways. Therefore, family therapists must be especially mindful of the alliance with each spouse and between the spouses.

Learning to detect split alliances

Alliance ruptures and split alliances occur frequently in therapy. It is therefore important that you become proficient at detecting and in repairing them (Safran et al., 2002). One way to learn to detect and repair split alliances is to assess the alliance at the end of each session. This is especially important in the first three sessions (Symonds & Horvath, 2004) although it remains important throughout the treatment as the alliance is constantly subject to change (Safran et al., 2002). Some therapists assess the alliance at the end of each session by asking something like, "Did I say or do anything in this session that offended you or bothered you in any way?" It takes a great deal of courage on your part to ask such questions and then to accept the feedback without defensiveness. Some therapists find it easier to use one of the many reliable and valid client self-report instruments such as the Session Rating Scale (SRS: Duncan et al., 2003), the System for Observing Family Therapy Alliances self-report form (SOFTA-s: Freidlander et al., 2006), and the Revised Helping Alliance Questionnaire-II (Haq-II: Luborsky et al., 1996). The SRS is recommended as it is short, just 4 items, takes only a minute or two to administer, and it is easily scored in session.[1]

The SRS (Duncan et al., 2003) is a forced choice instrument with the choices separated by a 10 cm line. For example, the first item, entitled "Relationship," states at the left end "I did not feel heard, understood, or respected." The opposite end the line (at the 10 cm point) states, "I felt heard, understood, and respected." Clients are asked to place a mark on the line close to the description that "best fits your experience." As clients tend to rate their alliance with the therapist high, any mark at 9 cm or less should elicit a therapist enquiry. For example, if a client marked the "relationship" item above at 9 cm or less you might ask, "What happened or didn't happen in this session that made you feel you were not heard, understood, or respected?" After listening carefully to the client's reply you should immediately begin attempting to repair the breach by first accepting responsibility for the oversight, second by validating the client's feelings and thoughts, and third by offering to make changes in subsequent sessions. For example, you might say something like, "I'm sorry I appeared to not be listening at times. You have every right to be offended by my behavior. I will make a greater effort to let you know that I really am listening in the next session. If I look like I'm not paying attention in the future will you tell me right when it happens? I really do want to make our time together as helpful as possible." The issue should be entered in your case notes to serve as a reminder to change your behavior in the next session. Continuous use of the SRS will make early detection of alliance ruptures easier and facilitate your immediate attempts to repair the alliance.

Another way for you to learn to detect alliance breaches is to use the SOFTA-o which was developed for observers to evaluate therapy alliances (Friedlander, Escudero, Horvath et al., 2006). Friedlander, Escudero, Horvath et al. recommend that you and your supervisor observe your digitally or videotaped recorded sessions and rate each family member's alliance. The SOFTA-o has a helpful training manual and an online support system to help you learn how to observe alliance breaches.[2] You will increase your ability to recognize breaches in the alliance by reviewing the recordings of your sessions and discussing the clients' alliance with your supervisor. You can greatly improve your skills as a therapist by frequently and consistently reviewing your videotapes just as athletes and performing artists benefit from reviewing videotapes of their performances.

Interventions to repair ruptured alliances

Safran and Muran (1996; Safran et al., 2002) found that therapists who are successful in repairing alliance ruptures recognized the clients' withdrawal or negative responses earlier than therapists who were not successful. As soon as you detect a breach focus the clients' attention on the behavior that indicated the rupture in the alliance. Recognize the clients' expressions of negative feelings, validate those feelings, and then help them express and clarify their feelings. According to Safran et al. (2002) repair attempts generally consist of the therapist: (a) commenting in a nondefensive, noncritical way on the here-and-now communication; (b) accepting responsibility for the therapist's cognitive, behavioral, and emotional responses to the communication; (c) expressing supporting and soothing behaviors toward the participants; and (d) making expressions of validation and appreciation. For example, if one family member expresses negative feelings toward you and the treatment program you should immediately stop and ask what happened in a noncritical, nonblaming way. You might say something like, "I'm sorry. Did I say or do something that offended you?" After the client explains you might say, "I can see how what I said may have sounded harsh. Let me say that again in a better way."

Pinsof (1994) derived several techniques from psychoanalytic theory for repairing ruptures to the alliance. Pinsof recommends focusing on the marital couples' individual and collective experiences of the therapist and the therapy experience. This recommendation fits with Safran and Muran's (2004) finding that immediate focus on the experience in the session led to alliance repair. Pinsof also recommended changing the therapy context by seeing the spouses individually.

Pinsof and Catherall (1986) recommend focusing on the client or subsystem alliance with the most power in the relationship. This may include giving the most powerful member of the dyad more individual time. Beck et al. (2006) in a qualitative study of four cases found some evidence in two of the cases that split alliances were more a function of the family members' differences in their family allegiance than in feelings about the therapist. These researchers divided the clients into family subunits for treatment as did Pinsof (1994). Beck et al. (2006) suggests that breaking the session down into subunits allows the therapist to provide a safe therapy context for everyone. However, one could equally well argue that the clients should be seen together to discuss their issues. Seeing the couple or family conjointly seems justified since the differences in the family members allegiance to each other may be the critical element in their split alliance. It seems plausible that family members will benefit from a conjoint conversation about their differing responses to (a) each other, (b) the therapist, (c) the therapy goals, and (d) the treatment interventions – even if this conversation is emotionally highly charged. In this conversation you may act as a coach, being careful not to reciprocate negativity and not to align with one family member or family subgroup against another.

Should you decide to divide the treatment into two or more separate units of the family be sure to review your policies for seeing individual family members in separate sessions before you divide them (see the extended discussion about seeing family members individually in Chapter 3). Important issues of confidentiality and triangulation should be carefully considered and discussed with the clients prior to entering into individual sessions.

Summary: Establishing and maintaining the therapeutic alliance

In summary, each family member's perception of the alliance with the therapist appears to be an important element of successful outcomes. You can facilitate the alliance by communicating respect, care, and empathy while collaborating with the clients to establish the therapy goals and the treatment methods. You will need to attend to the safety needs of each member of the family by avoiding taking sides with one family member or family subunit over another. As Alexander and colleagues (2000) put it, each family member should leave the session feeling that you are on their side (Alexander, Pugh, Parsons, & Sexton, 2000). You can also facilitate the alliance by not reciprocating client negativity. Negativity toward the therapist or the treatment may be the result of a breach in the alliance and should be addressed as soon as it is detected. Another mark of a rift in the alliance is client's avoidance or escape behavior, such as defensiveness, withdrawing from the therapy process during the session, and/or coming late to or missing sessions. You should confront – in a nondefensive, nonpunishing way – the behavior that is indicative of an alliance rupture as soon as it occurs in the session. Successful therapists make early detection and repair of alliance ruptures one of their hallmarks. Early detection of breaches in the alliance can be facilitated by administering an alliance rating instrument, such as the SRS (Duncan et al., 2003) at the end of each session.

Box 1.1 Supervision and Split Alliances

Supervisors should assist beginning therapists to recognize breaches in the therapy alliance and should support therapists' efforts to repair alliance ruptures. It takes a great deal of courage on the part of therapist-interns to ask clients about any negative feelings they may be having toward the therapy and toward them as therapists. Therefore, if you detect a

potential breach in the alliance you should encourage the therapist-intern to identify and repair it. When the therapist does this the supervisor should make a point to congratulate the therapist on this accomplishment. The administration of an alliance instrument, such as the SRS (Duncan et al., 2003) at the end of each session should be encouraged as that will make it easier for therapist-interns to enquire about possible breaches in the alliance.

To help therapist-interns increase their skill at detecting alliance splits you may wish to review a recorded therapy session together using SOFTA-o (Friedlander, Escudero, Horvath et al., 2006). In this supervision session compare your observations with those of your therapist-intern. The goal should be to strengthen the intern's skill in detecting alliance splits. By helping interns learn to detect and repair split alliances supervisors will be protecting the welfare of the clients while increasing the competence of the therapist-intern.

Marriage and Family Theories and Evidence-Based Marital and Family Therapy

Family therapists and counselors use therapy models as a vehicle to help clients to establish an alliance and to change from dysfunctional to more functional behavior. The question then becomes – which model should therapist-interns be taught? Individual psychotherapy has over 250 models (Lambert & Barley, 2002) and marriage and family therapy has generated nearly as many (Becvar, 2003). What criteria may be applied to facilitate the decision about which model to use?

The traditional theories of marriage and family therapy were developed by outstanding clinicians responding to specific classes of clients often with specific classes of needs (Becvar, 2003; Sprenkle & Blow, 2004). For example, Minuchin's structural model resulted from his treatment of blue-collar families with physically ill children (Minuchin, Montalvo, Guerney, Rosman, Schumer, 1967). Haley's (1987) strategic therapy was designed for use with resistant clients. Bowen's (1978) intergenerational model derived from his work with individuals struggling to overcome attachment issues with their families of origin. Feminist theory grew out of protest against gender oriented power differentials and domestic violence cases where the female victims were blamed (Avis, 1988). Collectively these models came to be known as systems models because they are based on the concept that families form an interpersonal relationship system. A system is a closed or semi-closed set of interacting relationships and the behavior of individual family member is said to be determined by circular causality and feedback within the system (Becvar, 2003). Systems theory has served the field well until recently.

Currently, however, health maintenance organizations, government agencies, and professional accrediting bodies are demanding that mental health services provide evidence of treatment efficacy, effectiveness, and efficiency (Crane, 1995; Hayes, Barlow, & Nelson-Gray, 1999). As a result there has been a turn toward evidence-based practice both in marriage and family therapy and in the mental health field in general (Margison et al., 2000; Patterson, Miller, Carnes, & Wilson, 2004; Weisz, Jensen-Doss, & Hawley, 2006).

Evidence-based models as an alternative to theory-based models

In contrast to the theory-based systems models of marital and family therapy discussed above there are a number of evidence-based models available. Evidence-based practice in mental health is reported to have started in the United Kingdom in the 1990s and has spread to other countries (Norcross, Beutler, & Levant, 2006a). The intent of evidence-based practice is to use the most

reliable and valid information to establish what works best for specific types of clients, with specific types of problems, and in specific conditions or settings. Norcross et al. point out that the American Psychological Association differentiates between practice guidelines and treatment guidelines (American Psychological Association, 2006). Practice guidelines are said to refer to how professionals conduct themselves. Treatment guidelines provide specific recommendations about which treatments work or are considered "best practice." In this text we are primarily focused on best practice treatment guidelines.

What evidence-based therapies are available to marriage and family therapists?

A number of evidence-based models for marriage and family counseling are available. For recent reviews of empirically-supported family therapy treatments see Carr (2000), Christophersen and Mortweet (2001), Fonagy, Target, Cottrell, Phillips, and Kurtz (2002), Miller, Johnson, Sandberg, Stringer-Seibold, and Gfeller-Strouts (2000), Sandberg et al. (1997), and Sprenkle (2002). Treatment guidelines or protocols for two of these evidence-based models are presented in Part II of this volume. Chapter 7 describes the Gottman Method Couples Therapy, which is based on his research into the causes of divorce (Gottman, 1999). Chapter 8 presents Johnson's emotionally-focused therapy, which was designed for couples with commitment and attachment problems (Johnson, 1996).

Selecting an Evidence-Based Model for Marriage and Family Therapy Interns

The decision about which theories, methods, and techniques to teach beginning therapists has not been resolved in mental health fields and this is especially true for marriage and family therapy (Liddle, 1991a; Liddle, Becker, & Diamond, 1997; Pinsof & Wynne, 1995a, 1995b). As stated earlier there seems to be general consensus that all therapists need to be taught the basic listening and observing skills that are required to establish and maintain a working relationship with each member of the family in treatment. Beyond that, the current debate appears to be focused on whether one of the many general theoretical models – such as Haley's (1987) problem-solving strategic model or Bowen's (1978) intergenerational model – should be taught as opposed to the one of the evidence-based models – such as Gottman's in *The Marriage Clinic* (1999). In theory MFT educators and supervisors need not be limited to either theory-based or empirically-based training approaches. Both could be taught. However, in terms of the practical demands upon the time of therapist-interns, their instructors, and their supervisors, selection of one of these approaches will severely limit the amount of time that may be devoted to any other model or method (Calhoun et al., 1998). This is especially true for trainees enrolled on a two-year clinical marriage and family therapy master's program.

The debate about theory-based models versus evidence-based models is already well discussed in clinical psychology (Beutler, 1998; Calhoun et al., 1998; Garfield, 1998; Nathan, 1998; Norcross et al., 2006a, 2006b; Persons & Silberschatz, 1998) but marriage and family therapists, while recognizing the issues (Pinsof & Wynne, 1995a, 1995b, 2000), appear to continue to focus primarily on epistemological arguments. It would appear that epistemological arguments cannot be resolved as long as they remain arguments based on words alone. Other disciplines have found that the best way to resolve these types of disputes is to submit the questions to empirical test (Liddle, 1991b; Norcross et al., 2006a). However, as Liddle (1991b) and others (Pinsof & Wynne, 1995a; Shields, 1986) point out, empirical research has not been an important part of the culture of marriage and family therapy. How much longer marriage and family therapy can maintain a credible position

in the mental health field sustained primarily by epistemological arguments is an open question (Shields, Wynne, McDaniel, & Gawinski, 1994).

A step in the direction of establishing empirically supported treatments for marriage and family therapy was taken in October 1995. At that time a special edition of the *Journal of Marital and Family Therapy* entitled "The effectiveness of marital and family therapy" was published under the direction of then editor Douglas H. Sprenkle and special editors William M. Pinsof and Lyman C. Wynne. Pinsof and Wynne (1995a) established guidelines that could be used to select marriage and family therapies that have been found to be efficacious and effective.[3]

As discussed above, evidence-based therapies offer us the most promise for providing our clients with the best treatments available at any one time. These therapies have limitations of which we need to make ourselves aware. However, even with their limitations it appears better to go with the strength provided by the empirical evidence rather than depend on theory and clinical lore. The lists of best treatment will change as new research is carried out and results published. As better methods are tested and become available they should be adopted into practice. It is incumbent upon all therapists and their supervisors to continue to seek out the most efficacious and effective therapies through continuing education. It takes great intellectual courage to change from a known treatment that we are comfortable with to a new treatment (Polya, 1971). However, delivering the "best" treatment to our clients demands that we change when there is sufficient empirical evidence to warrant such a change.

Some criteria for selecting an evidence-based therapy model

If the effect on client outcomes that results from the therapy model is only 15 percent and if no model is more efficacious than any other, then the choice of a treatment model to teach beginning therapists appears to be somewhat arbitrary. However, the decision is important. To help with the decision some rules for selection of a therapy model may be set out.

First criterion: Select a treatment model with demonstrated efficacy

When you select a model find one that has been found to be efficacious for treating the clients' assessed problems. As described above a wide range of models for treatment of marital and family distress have been subjected to random clinical trials (RCT) and established as efficacious. Therefore, it should be possible to select an evidenced-based therapy that will satisfy the clients' values, needs, and goals.

Second criterion: select a model with a helpful treatment manual

Most evidence-based treatments have a treatment manual that was used to train and supervise the therapists involved in the clinical trial. Treatment manuals are useful, especially for training, as they spell out the interventions to be followed in delivering the treatment (Addis & Cardemil, 2006; Calhoun et al., 1998). This is helpful as you and your supervisor seek for ways to improve your treatment delivery (Chapter 4) and your adherence to the treatment interventions spelled out in the manual (Chapter 5). However, as pointed out earlier, therapist competence is not a function of adherence to the manual alone. One of the most important things you must learn is how to tailor the treatment to the clients' needs.

Third criterion: Select a model that can be tailored to the needs of the clients

A client-focused approach to therapy requires tailoring the therapy to the clients' needs and goals (Chapter 4). You will need to help the clients see how the model fits their needs, values, and

beliefs in order to build and maintain a positive therapeutic alliance (Horvath & Bedi, 2002). Tailoring the therapy to the clients' needs starts with "Therapy Task 1: Assessment" (Chapter 3). In the assessment phase you will determine the clients' needs and goals. This is followed by "Therapy Task 2: Establishing a Treatment Plan". The treatment plan should be an evidence-based treatment, which best fits the clients' problems. If your assessment is accurate then the clients are likely to agree that the treatment plan "fits them," that is, is tailored to their needs. However, the tailoring does not stop there. As you deliver the treatment you will need to continually assess the "fit" by measuring both the alliance and the therapy outcomes (Duncan & Miller, 2006; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). If you encounter splits in the alliance then you will need to make adjustments to the way you are delivering the treatment (Safran & Muran, 1996; Safran et al., 2002). Learning to tailor the treatment to the clients' needs is an important therapist skill, which when mastered will generally lead to successful client outcomes.

Fourth criterion: Select a best-treatment model where the outcomes are measurable

The fourth rule for selection of a treatment model is that treatment outcomes should be measurable (Miller, Duncan, & Hubble, 2004). The assessment instruments need not be specific to the model but should be relevant to the class of problems that the model treats. For example, the Outcome Rating Scale (ORS: Miller & Duncan, 2004) and the Revised Dyadic Adjustment Scale (RDAS: Busby, Crane, D. R., Larson, J. H., & Christensen, 1995) work well to assess psychological symptoms and marital distress respectively. These outcome instruments are applicable for any of the evidence-based marital therapies such as Johnson's emotionally-focused therapy (Johnson, 2004), Gottman's couple therapy method (Gottman, 1999), or *Integrative Couple Therapy* by Jacobson and Christensen (1996). By assessing the therapy outcomes continuously you will be in a position to recognize trends and to make corrections to the treatment if needed. If the clients are not making progress in therapy, as determined by the outcome measures, then you should consider altering the treatment and should consult with your supervisor (see Chapter 5).

In summary

Selecting the first therapy model for use by marriage and family therapy trainees is an important decision. Select an evidence-based treatment with has a treatment manual. The choice may be made by the faculty as a whole, by a training center, or by the instructor teaching the first clinical-experience class. Once the treatment model has been selected it is recommended that beginning therapists be given sufficient time to practice with the model so that they may gain skill and confidence in its use. This may require up to one year and the opportunity to treat three or four cases employing the model (Calhoun et al., 1998).

Practicing Within Your Competence

Therapists are admonished not to practice beyond their competence and ethical and legal sanctions are often imposed on unwary therapists who stray beyond their limits (AAMFT, 1998; Knapp & VandeCreek, 1997). Most beginning therapists feel that they are practicing beyond their competence in their first clinical cases. However, therapist-interns who have studied the treatment carefully and are committed to it, who follow the treatment manual in a flexible manner, who regularly assess their clients' progress and the alliance, and who receive supervision regularly are acting within their sphere of competence. Clients who come for therapy at training clinics are made aware of the fact that they are being treated by therapist-interns under the guidance of licensed supervisors. None the less, if the clients believe that treatment can be helpful, and if

they are presented with a plausible treatment for their problem that will allow them to undergo a healing experience, then they have a reasonable chance at a successful outcome (Wampold, 2001).

The Remainder of the Book

Part I of this text is designed to help you learn the five therapy tasks needed to deliver most models of therapy. Part II will help you learn to deliver selected marriage and family therapies.

You will need to learn to build and maintain an alliance with clients, which will help your clients undergo the changes in their behavior needed for successful outcomes (Frank & Frank, 2004; Horvath & Bedi, 2002; Norcross, 2002). You have begun to learn to build and maintain a therapy alliance in this chapter. In Chapter 2 you will learn to apply some basic therapist communication skills and you will learn to use the basic therapy skills to help clients explore their issues, consider alternative behaviors, and begin to make changes in their lives. In addition, in Chapter 2 you will also learn crisis management for both suicidal ideation and for family violence.

In Chapters 3 to 6 you will learn to apply the five key tasks of therapy. The five therapy tasks are; (1) Assessing the problem; (2) Establishing the treatment plan; (3) Delivering the planned treatment; (4) Evaluating treatment delivery and treatment outcomes; and (5) Terminating treatment.

- Chapter 3 will provide you with the skills you need for Therapy Task 1, which includes making the initial phone contact, introducing your clients to therapy and making your initial assessment of their problem.
- In Chapter 4 you will learn the elements of Therapy Tasks 2 and 3. Task 2 is establishing the treatment plan and includes how to develop a treatment plan and how to share the treatment plan with the clients. Therapy Task 3 focuses on how to begin delivering the planned treatment. Therapy Task 3 is continued in Chapter 5.
- Chapter 5 introduces you to the skills needed for continuing Therapy Task 3 and for Therapy Task 4 – how to evaluate your treatment delivery and how to evaluate your clients' progress toward successful outcomes. Successful outcomes lead to treatment termination.
- Chapter 6 will discuss the termination processes.

That will conclude Part I of this text. Part II provides an introduction to two empirically supported marriage treatment programs. The treatment protocols introduced in Part II are the Gottman Method Couples Therapy (Gottman, 1999) and the Emotionally-Focused Therapy (Johnson, 2004). I have selected these treatment protocols to show how the protocols can be used to treat marital problems as encountered by family therapists and counselors. Once you have assessed your clients' problems you may match one of these treatment programs to your assessment. You will then present it to your clients as a treatment plan. However, these selected therapy models are not the only empirically-supported family therapy programs and you may choose others to fit the needs of your clients as determined by you and your supervisor.

What Should You Take Away from Chapter 1?

1 There appear to be four factors which all successful therapies have in common (Hubble et al., 1999; Sprenkle et al., 1999). These four factors are (1) the *alliance*, (2) what the *clients' bring* to therapy, (3) the *placebo effect*, and (4) the *treatment techniques*. The alliance explains 30 percent of the outcome variance, what the clients bring to therapy explains 40 percent of the

outcome variance, while the placebo effect and the therapy techniques each explain 15 percent of the outcome variance.

2 The most important factor in successful therapy outcomes may be the therapy alliance. The therapy alliance is composed of (a) the clients' trust in the therapist to help them achieve their goals and meet their needs, (b) the clients' agreement that the therapist understands their goals, and (c) the clients' belief that the treatment provided by the therapist will help them achieve their goals.

3 The alliance is built and maintained by your skill in communicating respect and empathy while delivering a treatment tailored to the clients' needs, values, and beliefs. The treatment needs to be of sufficient length for the therapist and client to have a conversation about the clients' goals and needs, which lead to clients changing dysfunctional behaviors and relationships to more functional behaviors and relationships. In the course of the conversation the clients find ways to accomplish their goals and satisfy their needs.

4 Since all models are about equally effective the choice of a model should fit the clients' needs and goals. The model selected should be an evidence-based treatment that you are competent to deliver under supervision.

5 Advantages of an evidence-based treatment. Evidence-based treatments have a manual that provides you with structure and guidance. This in turn gives you and your supervisor with the opportunity to discuss and develop your treatment delivery and your alliance building enabling you to develop the competence and confidence you need to be an effective therapist.