Chapter 1
Foundation Ideas

Introduction

This chapter presents some of the foundation ideas upon which the systems approach rests. It is divided into two parts: Part 1 is **Concepts** and Part 2 is **Procedures and Processes.** It is a potpourri of theory and guidelines, with a heavy sprinkling of practical tips and suggestions.

I like to think that theory develops as much from the feet up as it does from the head down. Theory and practice is a two-way exchange: theory provides a framework for thinking, a direction to go and what to look for, while face-to-face experience with families builds up our own personal knowledge about what works and what doesn't. Theoretical constructs are the most helpful in the early stages of learning family work, a period when we need guidance. Over time, however, our practice experience becomes primary and is likely to guide our actions more than textbook theory.

I've always believed that it is the application of our ideas that determines our effectiveness in helping families through their difficult periods. What we know—our body of knowledge, theoretical and otherwise—does not help families. The most knowledgeable person on the methods and theory of all the schools of family therapy will not necessarily be an effective family therapist. How the knowledge is *applied* in face-to-face interactions with families is the critical test.

The content described in this section gives us a place to start—how to convene a family for counseling and have an organized first session, the systems orientation, the assumptions and rationales behind the systems approach, various uses of family work, and a few guiding suggestions and tips about how to apply these ideas in interactions with families. Other ideas and issues in this section are included because they need a prominent place in our thinking about family counseling. Included in this category are ethics and cultural sensitivity, both of which can be overlooked in the myriad details of managing a particular case. Recent research on family therapy is presented for students and professionals who want to dig deeper into the empirical and evidenced-based underpinnings of the family approach to helping.

My suggestion to the reader is to peruse these foundation ideas to see which of them might appeal to you. Then read these topics more thoroughly. The next step is to try them out in family sessions. Some ideas may be selected and become part of your ongoing work while others will simply fade out. Applying them in your practice makes this selection possible.

Part 1: Concepts
Learning Family Counseling

In my training and supervision with colleagues, the most frequent question I am asked is, "What do I do with *this* family?" It's a good and important question, and I try to give my best suggestions. It conceals, however, an even more important question: "How do I acquire the knowledge and skills to do counseling with *any* family? I wish my colleagues would ask this second question more often.

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1. Why should I learn to do counseling with families?
   Because significant human relationships are a central part of most people's problems. Our longing for love, our hopes, frustrations, sense of security, fears, and happiness are closely linked to our relationships with our families and significant others.
2. What should I do to learn family counseling?
   Get supervision from a colleague who is more experienced in family work, use video- or audiotaped sessions of yourself, watch other counselors do it, go to workshops, get lots of experience working with families, and find a colleague with whom you can process your sessions. At appropriate times, share with your colleagues what you are learning.
3. How long does it take to learn?
   The learning never stops. To start, you need a setting in which you can acquire experience. You can expect one to two years of practice before you begin to feel competent doing this type of counseling. As a foundation, you need 50–100 hours of supervised experience with families, 20–30 hours of watching a more experienced counselor do his or her thing with families, and 4–6 days of workshop training. Read at least three books on the subject.
4. What do I read?
   That depends on what model of family counseling you want to learn. I started with the Structural-Strategic model, which gave me the foundation concepts and skills to learn on my own. I read *Family Therapy Techniques* by Minuchin and Fishman and *Foundations of Family Therapy* by Lynn Hoffman and studied *Problem Solving Therapy* and *Leaving Home* by Jay Haley (see Recommended Readings at the end of this book) plus many articles and handouts.
5. What is some basic information I need to know before starting?
   How to view a family as a system, how to get the family members to come for a meeting, how to conduct a first interview with them, and how to initiate family change while resolving the presenting problem. You can get the foundation knowledge from this book.
6. Should I choose parts from various approaches and put them together?
   Trying to integrate different approaches too early in your learning can create confusion and result in mishmash, scattered therapy. It's like a mechanic taking parts from different automobile models and putting them together to make one car. The thing will run poorly, if at all. Each model has components designed to function together. If you become eclectic too early, taking a little from each ''school'' of family therapy, you will not learn one model well enough to understand it. Stick with one model until you know how its rationale, procedures, and techniques form a unified whole, until you learn its integrity. Then you can select pieces from other approaches and make informed decisions about how they fit into the one you have learned. With experience, you can determine an approach that works well for you. Develop your own model.

Why Family Work?

I suspect that most professionals who work conjointly with families have their list of reasons for choosing this therapeutic mode. Here is my list.

1. With a symptomatic member (the ‘‘identified patient’’), everyone in the family is affected. All must accommodate to the problem of one member, whether that member is a child or adult. If the problem is long-standing, the members can develop habitual and unhealthy ways of responding to the problem, causing the problem to intensify, leading to more family dysfunction.*
2. By the time a family reaches the treatment stage, the whole family has been emotionally damaged by the ordeal. All members need support, validation, and a new look at the problem on a family level.
3. How the family members react to the symptomatic member can determine whether the symptoms get worse, stay the same, or get better. In one sense, the family is part of the treatment team for the identified patient.
4. The family’s reaction to the problem could be helping to maintain it. This phenomenon, known as ‘‘enabling,’’ is the family’s unwitting protection of a member from the consequences of his or her behavior. It was brought into focus and named by counselors working with chemically dependent families, but it also happens with problems other than substance abuse. A teenager’s irresponsible behavior at home and at school, for example, can be enabled by parents who react to it ineffectively.
5. Family work helps the family view the problem in a different way. The all-important mind-set toward the symptomatic member, or toward the nature of the problem, can be altered with exploration and understanding. A different mind-set, in itself, can lead to family change.
6. Family counseling can have prevention benefits. If current problems are managed more effectively, it can prevent other problems from cropping up in the future. Or if they do appear, the family in counseling has learned better coping strategies to deal with them.
7. Paradoxically, when symptoms subside, the family needs to learn how to live without the problems. Removal of the problems may leave a void to be filled since the symptoms could be serving an important function in the family.
8. Having the family meet together around a problem can be a new and unbalancing experience in itself. Counseling provides a structure for the family to sit down and focus, something they are not always able to do at home. Once they cross the threshold into ‘‘treatment,’’ family members cannot deal with their problem in quite the same way. Examples: the ‘‘family secret’’ is out; shame and guilt may diminish; new understanding points to new behaviors.

* **dysfunctional:** This is an often-misused word as it applies to families. It doesn’t mean ‘‘not functional’’; it means impaired, incomplete, or painful functioning, but functioning nonetheless. The confusion lies in the prefix ‘‘dys-,’’ meaning ‘‘bad, ill, or difficult,’’ which sounds identical to ‘‘dis-,’’ meaning ‘‘not.’’

Assumptions of a Family Systems Model

The systemic approaches to family counseling in this book rest on these assumptions.

1. Individual problems express themselves in the person's family and social relationships, which, in turn, make the individual's problems better or worse. Most problems are the individual's attempt to adapt to his or her social world and are expressed in relationships with other people.
2. A family is an interacting system.
   a. Family members are *inter*dependent in their behavior. What one member does depends on what others do. Members react as much as they act.
   b. Cause and effect are circular: person A acts; person B responds, which affects A's next move and B's next response, etc. More than two people can be involved in repetitive patterns.
   c. To some degree, what happens within an individual or in part of a family affects the whole family.
   d. A family household is part of a larger system: extended family, friends, work, school, church, neighborhood, community, culture.
3. A well-functioning family has a structure in place, a hierarchy. The parenting adults have more power, influence, and responsibility than the children; older children have more influence than younger children. Different degrees of closeness and conflict exist between different members.
4. The *family* is the unit of change: family relationships, patterns, and structure are the primary focus. The feelings and behavior of each individual are important to the degree they affect family functioning. Family functioning, in turn, affects the way individuals feel and behave.
5. Brief interventions (5–10 contacts) are enough to begin a positive change process. Additional sessions may occur weeks or months later if the need arises.

The Systems Orientation in Theory

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Families are complex, and to work with them requires an organizing orientation. The systems orientation is the most universally accepted framework.

A system is a group of elements that interact to form a unified whole. Examples of systems include a tree, an automobile, a nation, a family. In each of these systems, the parts interact in ways that maintain an integrity and balance. The actions of one part affect the actions of the other parts, which, in turn, may change the first part; the components of a system are *inter*dependent. In families, you can see members reacting to each other in this circular, interdependent fashion, as in the following:

1. The more a parent questions the teenager about his whereabouts and activities, the briefer and less informative the teenager becomes, which prompts more questions, etc.
2. To the degree the father is strict with the daughter, the mother protects her.
3. To the extent the grandmother spoils the grandchildren, the mother becomes more accommodating with them in order to win back their affections. The father reacts with more authority toward the children, displacing onto them his anger at the permissiveness of his wife and mother-in-law.

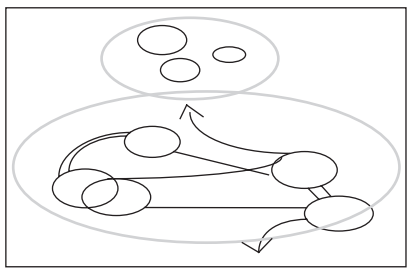
Families have the characteristics of social systems, including

- **a structure and hierarchy.** Different roles are defined for different members, and power is not distributed evenly.
- **powerful rules of conduct,** many of which are unspoken and unacknowledged.
- **a set of politics.** Particular members are closer to some members than to others; two members will support each other against a third; one member may temporarily defer to another out of self-interest. The politics may change, depending on the situation.
- **habitual patterns.** The content of the interaction between members changes, but *how* they deal with the content tends to be repetitive.
- **a history.** Anyone who becomes involved in a family steps into its history.
- **influences from the outside**—from the extended family, from the neighborhood, from the work and school community, from the environment.
- **a tendency to resist change.** A family, like an individual, has a sense of self and will resist a challenge to its self-definition.

The systems-oriented counselor will

1. Treat the *family*, rather than individuals, as the primary unit of change. Individual change is assumed to be created within relationships in the family. ***Mapping*** is a technique that brings family relationships into focus.
2. Use a broad definition of ‘‘family’’ to include anyone who may be enabling the problem to continue or who may be a resource for solving it.
3. Be aware that change in one relationship may produce change in another. When the parents begin to work more effectively together, the siblings may get along better.
4. Take a wide-angled view of the physical and social context of the problem—the home, extended family, neighborhood, community, and culture. A systems orientation urges the practitioner toward a broad network focus.

The Systems Orientation in Practice



The counselor works more with the reciprocal relationships between the family members than with the individual dynamics of each member. Even while talking to individual members, the systems counselor is exploring family patterns and repetitive sequences of actions and reactions between members. The family functioning is the target for change.

The following examples—which contrast the individual and systems orientations—assume a teenage son is the identified patient; his mother calls for an appointment. Also in the home are father and sister.

Individual Orientation	**Systems Orientation**
The Counselor:	The Counselor:
Invites the son and mother in for counseling.	Invites everyone living in the home.
Stays central—the "switchboard" for communication in the room.	Is sometimes central but also encourages members to talk to each other.
(To mother): "How do you feel when your son does that?"	"How do you and your husband react together when your son does that?"
Elicits feelings from a member while the family listens.	Does this but also gently directs the talking member to "tell him/her how you feel."
Focuses on individual members, one at a time.	Comments on relationships between members.
Attends only to the person speaking.	Notices all members when one is speaking.
Sees a talkative, dominant wife and a silent husband.	Sees a couple who has co-created a pattern where she talks and acts more than he does.
Assumes that the four people present are the only players in the drama.	Inquires about others who may play a role in maintaining (and solving) the problem.

The systems-oriented counselor is the manager and director of the session—sometimes focusing on individuals, sometimes spotlighting the interaction between two or more members, sometimes stepping back to see the family as a whole. To understand the family dance, the counselor is working with sets of relationships, not individuals acting independently.

Other examples of systemic questions and comments by the counselor:

- To father, while mother and son are talking: ''Where are you in this conversation?''
- (To son): ''I notice that when you are silent, you may be sending a message to your parents. Could you find out what message they are getting?''
- (To daughter): ''How does your mother react when your father and brother have a disagreement?''
- (To mother and father): ''Each time the two of you disagree, your daughter interrupts your conversation. Could you find out from her what that's about?''
- ''Who outside the home is concerned about the problem?''

Learning to work interactionally and systemically takes some adjustment, since most counselor education and training in graduate school is individually oriented.

The Systems Orientation in Concepts

The person who said, "There's nothing so practical as a good theory" must have been thinking about systems theory. This orientation to family work certainly has practical benefits.

An **Organizing Concept**—Any system, social or biological, consists of various elements and the way they function together. The four characteristics of a system are

1. **Organization:** Elements have specified functions to serve the whole.
2. **Interaction:** The elements act on each other, reciprocally.
3. **Interdependence:** Each element changes, and is changed by, the other elements.
4. **Stability:** A system adjusts to maintain itself over time.

Understanding—Systems thinking aids our understanding of why people act the way they do; it's a good explanatory model. Example: Taken out of the family context, a young person's self-defeating behaviors or low self-esteem make no sense, but they might make sense when seen in the family environment.

Resistance—Systems thinking helps us understand resistance and denial and therefore tolerate them better. Resistance and denial is a system's normal, natural tendency toward stability and survival. Like any other system, a family resists change, even positive change.

Blame—Thinking systemically erases the notion of blame (at least intellectually). Example: Mother is too strict with the child because the father is too lenient, but father is too lenient because mother is too strict. Who is to blame? (There are, however, individual strengths and weaknesses in parenting.)

Interdependence—Thinking systemically reminds us that change in one part of the system affects other parts. Example: When the conflict between father and his daughter eases, the relationship between the mother and son improves.

Complementarity—Systems work teaches the counselor to think in self-perpetuating and overlapping circles. Complementarity is expressed by ''to the degree'' statements. Examples: To the degree he pursues, she distances; to the degree the son is aggressive, the parents retreat; to the degree that mother and son are close, father and son are distant.

Context—Systems thinking reminds us to place problem behavior in a broader context (family, extended family, friends, neighborhood, culture, other professionals). An individual and a family are only subsets of a larger context.

Note: Be patient with yourself. Systems thinking is awkward at first. In our American culture, the perspective on human behavior is individually oriented. We understand human activity more in terms of what's inside the individual person—self-determination, free will, personal responsibility, accountability, etc.—rather than in terms of the interaction with the social and physical environment.

Levels of Systems Interventions

Here is a way to conceptualize systems interventions. Levels 1–5 define the scope of our interventions in a client's "people world." Level 1 is the most restricted intervention, and Level 5 is the broadest. Each level incorporates the levels below it: If we are working on Level 3, we're also working on Levels 1 and 2.

Explanation

Most clients (child or adult) have connections to significant others who influence, and are influenced by, the client (Figure 1.1). These could be mother of the client, father, grandparents, siblings, spouse, children, friends, aunts, uncles, teachers, co-workers, dating relationships, etc. The systems orientation urges us to consider these people in our view of the client's world, even though all of them will seldom be involved in counseling sessions together.

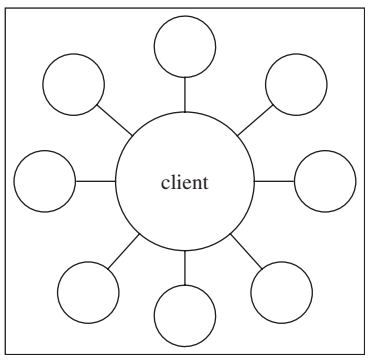


Figure 1.1 Significant Others

The significant others surrounding the client have relationships with *each other* (Figure 1.2), which can also influence and be influenced by their relationship with the client. The mother-father relationship, for example, influences how the child client is parented. For an adult client, conflict between his or her spouse and family of origin can affect the client's marriage.

If we are working exclusively with the individual client, we are working on Level 1. If we are working with the client plus his or her relationships with one or more significant others, we are on Level 2. If we are working with the client, his or her primary relationships, plus the relationships *between* the primary relationships (mother/father relationship with a child, for example), we are on Level 3.

The ''people world'' of the client doesn't stop there, however. The intimate social group is embedded in a larger system—neighborhood, school, church, community, courts, agencies, etc.—and is being affected by these outsiders (Figure 1.3). If we are working with the influences these outsiders have with the intimate social group, we are working on Level 4; and, as before, if we are considering the relationship *between* the outside people or agencies, we are on Level 5.

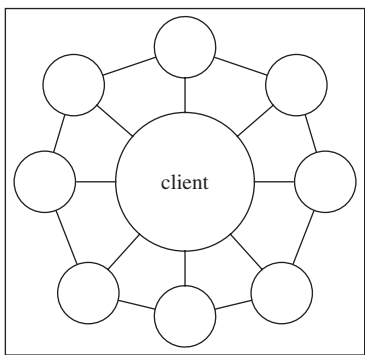


Figure 1.2 Relationships Between Significant Others

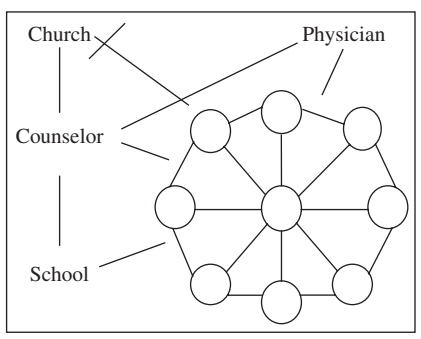


Figure 1.3 Outside Influences

Tanya's Case

Tanya, a 22-year-old single female, presents with depression. She dropped out of college in another state and is now living with her mother, grandmother, and a teenage brother and sister while attending the local community college. She has a steady boyfriend (grandmother doesn't approve of him, but mother does), and they have talked about marriage. She also has a close girlfriend, attends church with her family, and has been strongly influenced by one of her teachers at the community college, who is urging her toward a career in practical nursing. This client is conflicted about her decisions on marriage, her career, and living at home (a busy, argumentative place at times).

How can we characterize this young woman's depression? Is it mostly a reaction to the circumstances in her life, or does it have an organic basis? In this case, it seems reasonable to rule out the organicity (no prior history, no family history). To help her, we need to consider her current life circumstances as the major contributors to her depression: her living arrangements, career decisions, marriage decisions, and how her relationships with others affect and are affected by these decisions.

Some of the work with this client could be individual counseling, offering her a private, impartial sounding board for the changes she needs to make. But at some point, I would want the other people in her life to be a part of the work, since they affect her decisions and are affected by them. Certainly the family who lives in her home and the relationships they have with each other are affected by her depression and are also affected by whether or not she marries and leaves home. I would want to have these people in at least one session to build my own picture of Tanya's family relationships. I could also talk with Tanya about inviting her boyfriend to a session in order to explore that relationship. Her best friend, who is probably her close confidante, may be included in a session or invited just with Tanya. I would also arrange an appointment with a physician to talk about the temporary use of antidepressants. Tanya would be seeing both myself and the physician, requiring us to coordinate and communicate.

In Tanya's case, I have incorporated all five systems levels:

Level 1: Individual counseling with Tanya.

Level 2: Tanya's relationships with several other people in her life, especially her mother, boyfriend, and best friend.

Level 3: The relationships *between* some of these people in her life (mother and grandmother, mother and boyfriend, for example).

Level 4: I've considered the influences coming from outside the intimate group (teacher at school, church, counselor, physician).

Level 5: I've considered the relationships *between* the professional ''outsiders'' (me and the physician, for example).

Most agency professionals are content to stay on Level 1 for adults and Levels 1 and 2 for children. Aligning closely with the medical model, these counselors prefer to focus on the individual patient. This can provide relief, support during crises, new insights for the client, and even new behaviors. For the most part, individual counseling is good.

In many cases, especially with children, I wonder if it's good enough. The best we can do one-on-one for a symptomatic child is to provide nurturance and guidance and sometimes therapeutic drugs. But if the child goes back to a home filled with anxiety, violence, insecurity, and inadequate parental supervision, his or her symptoms will persist and frequently get worse with age. These all-important home conditions are under the control of the adults and parents, not the child client.

To understand a case (adult or child identified patient), I rarely drop below Level 3.

Cause and Effect in Systems

Causation is a tricky subject, even in the physical sciences, where conditions can be carefully measured and controlled. In the social sciences, with minimal control and precision, causation is so complex that sorting out precise cause and effect can turn into theoretical, almost metaphysical, mumbo jumbo. I just try to remember three points.

Point 1. Counselors are not held to the scientific standards distinguishing correlation from causation.

I have a working definition of causality: If A, then B; if not A, then not B; therefore A is the cause of B. I know—this is correlation, not causation. But they often look the same. The substance abuse of a single mother, for example, may not *cause* the abuse and neglect of her children. Rather, the mother's absence; inadequate food, clothing, and shelter; money and legal problems; inconsistency; domestic violence, etc., are the direct causes of the abuse and neglect. If the substance use was removed, however, these problems could be much less serious and may not lead to harm to the children. From my practical, unscientific viewpoint, the substance addiction is a cause of the abuse and neglect.

Point 2. An outcome usually has multiple causes, acting together or in sequence. As counselors, we don't have to help our clients change all the causes for the problem to change or disappear.

To illustrate this at workshops, I hold a pencil over a chair and let it go. The pencil drops to the chair seat. I ask, ''What caused the pencil to hit the chair?'' ''Gravity'' is the usual first response from the audience, but then two more causes pop up: ''Because you let it go'' and ''Because you were holding it over the chair.'' I agree with their answers and make the point that it took *all three* causes to produce the result. If any one of the causes was eliminated, that specific outcome would not have occurred.

Point 3. In human interaction, cause and effect are circular, not linear.

Systems thinking assumes that the cause-effect cycle is circular: He does something, she yells at him, he then becomes quiet, she feels guilty, he acts hurt, she apologizes, he accepts her apology, she feels better, and he feels better—so much better that he might try the ''something'' again later, and the cycle repeats. In this sequence, an action caused a reaction, which changed the next action, causing another reaction, and so on, in a circular fashion. The acts in the chain are dynamically linked and interdependent; each is a cause *and* a result. A similar thing happens within an individual: Does the person's emotional state (depression, anxiety, etc.) cause the drug abuse, or does the drug abuse cause the emotional state? It's best to assume it's both.

The Thing in the Bushes

We see the bushes rustling but can't get a clear picture of what's causing the stir. The amorphous creature stays just beyond our clear view, and even when it's finally spotted, different viewers describe it differently, depending on their perspective. I usually handle the thing in the bushes by avoiding the word ''cause'' altogether and by asking, ''What is happening in this family that results in this problem?'' *Something* is feeding the problem. What we're liable to spot in those rustling bushes is not one entity but a gaggle of the fluffy little things.

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The Systems-Oriented Program Assessment

The systems orientation can be integrated into any program that offers human services. Here are a few of the characteristics of the ideal systems-oriented helping agency (the "Program"). If you want a rough gauge of the degree of systems orientation of your agency, circle a number for each statement and put a total score at the bottom. (In my opinion, a score above 20 indicates a systems-oriented program.)

1. The Program knows that real progress for their clients occurs in the client's social community, work, school, and home life, not in an agency. The Program's role is to help the client function better within the real-life context of his or her problems.	Rarely 1	Some 2	Often 3
2. The Program has flexible hours for the staff and stays open in the evenings at least twice a week to accommodate working people and families.	Rarely 1	Some 2	Often 3
3. Where appropriate, the client's family and significant others are invited with the client to the intake interview, or at least to the second session. Families are not just an afterthought, brought in later to give information about the individual client.	Rarely 1	Some 2	Often 3
4. The Program has working connections with other helping agencies, groups, and activities in the community and refers clients to them when appropriate. The Program sees itself as part of a larger helping network.	Rarely 1	Some 2	Often 3
5. The clinical staff members of the Program do more together than just discuss clients at case conferences. They also occasionally sit in on each other's sessions for a second opinion, video- and audiotape sessions for use at staff conferences and training, and occasionally observe each other from behind a one-way mirror. They work as a team.	Rarely 1	Some 2	Often 3
6. The Program learns how to get around the individualistic, medical model to how sessions are counted for insurance, payment, and data purposes.	Rarely 1	Some 2	Often 3
7. The Program is not afraid to call a meeting of everyone involved—family, extended family, and relevant staff from its own and other agencies—to identify and solve problems preventing real progress in the case (see ***Brief Network Intervention***). The Program knows that helping systems can be just as stuck as client systems.	Rarely 1	Some 2	Often 3
8. The Program opens its doors to other professionals and offers training in the specifics of Program design, systems-based clinical skills, and innovative management ideas.	Rarely 1	Some 2	Often 3
9. The Program contributes to community awareness and education in its area of expertise through presentations and workshops.	Rarely 1	Some 2	Often 3

Code of Ethics

The American Association for Marriage and Family Therapy (aamft.org) sets the ethical standards for family professionals. The current Code of Ethics (July 2001) is published by AAMFT, 112 South Alfred St., Alexandria, VA 22314. The code contains 67 statements of ethical conduct, listed under 8 principles. Only the principles are listed here, but the entire code should be reviewed annually by professionals and their supervisors who work with couples and families.

I. Responsibility to Clients
Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance and make reasonable efforts to ensure that their services are used appropriately.

II. Confidentiality
Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

III. Professional Competence and Integrity
Marriage and family therapists maintain high standards of professional competence and integrity.

IV. Responsibility to Students and Supervisees
Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

V. Responsibility to Research Participants
Investigators respect the dignity and protect the welfare of research participants and are aware of applicable laws and regulations and professional standards governing the conduct of research.

VI. Responsibility to the Profession
Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

VII. Financial Arrangements
Marriage and family therapists make financial arrangements with client, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

VIII. Advertising
Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

Cultural Sensitivity

In one sense, every family is a different culture, with its own worldview, values, rituals, organization, and ways of conducting its business. With every family, counselors are like anthropologists, sitting in the midst of a new culture to learn what it is like.

Culture includes so many characteristics that classifying families by cultural variables is a form of broad stereotyping and should be accompanied by all the caution this implies. In this respect, *all* family counseling is multicultural—every family has identification with some aspects of culture.

Hays (2001) has suggested the acronym ADDRESSING to remind us of the many variables that compose cultural diversity:

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Age and generational influences
Developmental and acquired
Disabilities
Religious and spiritual orientation
Ethnicity
Socioeconomic status
Sexual orientation
Indigenous heritage
National origin
Gender

Some of these cultural characteristics may present challenges for counselors. The following discussion suggests ways to manage cultural diversity issues in counseling.

Approaching Cultural Diversity

1. When the counselor is culturally or ethnically different from the family, in most cases, an acknowledgment by the counselor of this difference conveys cultural sensitivity and is appropriate in the first or second session. For example, when I, a white person, work with a non-white family, at some point early on I will say something like, ‘‘I notice that we represent different ethnic backgrounds. I’m wondering if there is anything you want to tell me that would help me understand your family better.’’
2. If appropriate, we can make our cultural assumptions explicit and check them out. For example, with a Latino family, I might say, ‘‘I am told that in many families from your ethnic origin, the father has the last word. Does it work that way in your family, or does it work some other way.’’ This fairly provocative question is one that not only reveals information about the family but also conveys the counselor’s sensitivity to important cultural details.
3. We need to keep in mind the important differences between families with the same or similar cultural influences. For example, it is easy (but incorrect) to assume that working with all Vietnamese families will be the same. While I may see two Vietnamese families in the same day who live in the same geographic region, there are likely to be some important differences between the two families simply because of varying acculturation levels and the unique personalities of the family members. Moreover, it can be stereotypical and misleading to assume that what I know about Asian-American families automatically applies. Not all Vietnamese families are alike, and a cultural description of ‘‘Asian families’’ may or may not apply to the family in front of me.

4. As stereotypes go, this one holds up well concerning role differences of parents in families of any ethnic origin: Fathers have a ‘‘special authority’’ with the children, and mothers have a ‘‘special knowledge.’’ This stereotype is so universal and generally acceptable, I can even use the phrases with parents at appropriate times. If, for example, I want to include the father more in conversations in the session, I could say to him, ‘‘You have a special authority with your children. What do you think about this?’’ Or to the mother, ‘‘With your special knowledge of your child, what do you see?’’
5. If English is not the first language of the parents, and the counselor does not speak their native language, I favor using a translator. This is preferable to putting the children in the ‘‘translator’’ role, thereby reversing the hierarchy and possibly demeaning the parents in front of their children.

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At times, dimensions of cultural diversity may challenge counselors' worldviews and values. For example, some counselors may feel uncomfortable working with a family of a different race, ethnic background, or socioeconomic level. Other counselors may feel uneasy with families who have very different religious beliefs from them or who are much younger or older in age. Still other counselors may be challenged in working with families with two lesbian or two gay parents. Some of this discomfort may be from lack of experience, some from differences in deep-seated beliefs and attitudes. None of us will see clients exactly like ourselves. When we commit to being counselors, we also commit to working with clients who represent many different groups, lifestyles, and values. We also commit to being respectful of diversity and of being as nonjudgmental and accepting of clients as possible, regardless of our own backgrounds. Fortunately, in most instances, our training enables us to be accepting of individual differences.

Occasionally, however, counselors find themselves at continuing odds with the worldviews and lifestyles of a particular family. Often, clients are able to sense this judgment from the counselor; family members could feel more marginalized than they did prior to entering the counseling relationship. When this happens, we are presented with a dilemma: refusing to work with a family because of cultural differences can be harmful to the family, yet to continue to see a family in an atmosphere that lacks acceptance can also be harmful.

In these instances, we turn initially to our supervisors and colleagues, seeking consultation surrounding the obstacles in our path so that more damage to the family does not result. To complicate matters, however, our personal blind spots in the area of cultural diversity may prevent us from being aware of our prejudice or bias. This requires that supervisors be vigilant to the warning signs of cultural friction: the counselor's uncharacteristic low interest in the case, humorous references to the clients' behavior and cultural values, body language (especially facial) when talking about the case, and more than usual frustration with the client or family's unwillingness to change. In many cases, consultation and supervision will increase our self-awareness and enable us to work more effectively with the family. If we continue to have differences with a family such that rapport and joining are impeded, referral to another counselor or bringing in one's supervisor or colleague for one or more sessions is appropriate.

In all such cases, the counselor has an opportunity for growth and new learning and may emerge from the episode with increased self-awareness and a little more wisdom.
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Uses of Family Counseling

Family counseling is well suited to the trend toward time-limited, more effective therapies. It is suitable for a wide variety of family, couples, and individual problems. This model is a brief, goal-directed, problem-solving approach with a systems orientation.

- **Brief:** This model is designed to accomplish worthwhile goals in 5–10 one-hour sessions with the family. More sessions may add effectiveness to the treatment.
- **Goal-Directed:** The counselor and family set goals together, usually arising from the presenting problems.
- **Problem-Solving:** This approach helps family members solve their current problems and gives them tools for continued improvement, especially with communication, closeness-distance, and parental management of the family. It is not an in-depth, insight-oriented model.
- **Systems Orientation:** Each of us has an intimate social group that affects, and is affected by, our behavior and mental health. The family-as-system assumes that family members affect each other interdependently, in a circular, repetitious pattern, sometimes leading to symptoms for one or more members. The systems approach also casts a broad net, looking at how the family interacts with its social, cultural, and physical surroundings.

Family counseling can be used

1. As the main therapy. Everyone living in the home, including the identified patient, is seen every session. Generally, family counseling requires fewer sessions than individual therapy.
2. As a supplement to individual therapy, to gain information about the client's family situation and symptoms.
3. During a client crisis or relapse. As treatment becomes more short term, families take on more responsibility for crisis management and caretaking.
4. During a *family* crisis that affects a client's progress.
5. To prevent a client crisis. This is accomplished through the ***Brief Network Intervention*** technique, which convenes the family members and others in a client's life (including professionals) to prevent a particular crisis from developing.
6. To avoid or shorten inpatient treatment or to help the family manage during and after hospitalization.

Treatment recommendations

1. If the client is a child or adolescent, family work is the treatment of choice.
2. If the client is an adult with marital or partner issues, most sessions should be with the couple together.
3. If the individual client is an adult who has relationship problems with parents, other family members, a friend, or a lover, at least one or two sessions should include these people. Relationships are easier to understand when they are observed firsthand by the counselor.

Forms of Family Work

Family work can be used in a variety of forms. The guidelines and techniques in this book will be helpful regardless of the setting or the type of family work you practice.

Couples and Family Therapy

Family therapy consists of face-to-face meetings with families, or portions of families, for the purpose of resolving problems brought to the therapist. It can take different forms, depending on the practice setting in which it is done and the theoretical orientation of the practitioner. The six major schools of family therapy currently practiced are Behavioral, Structural, Strategic, Communications, Psychoanalytic, and Experiential. Therapy meetings usually last about an hour, occur weekly, and span from a few sessions to several months or longer. In some theoretical schools, the systems orientation is used; in others, it is not.

Family Counseling

Counseling is distinguished from therapy by the length of time and depth of treatment. Counseling is briefer and is usually (but not always) applied to less serious and long-standing family problems. Most family counselors subscribe to one of the previously mentioned six theoretical schools. The approach in this book has a combination of the Structural and Strategic schools as a foundation. Family counseling (including marriage and couples work) can be practiced in most settings in which individual and group therapy are conducted. The terms ‘‘counseling’’ and ‘‘therapy’’ are used interchangeably in this book.

Family Interviewing/Clarifying

Interviewing and clarifying usually take place during one or two sessions with a family in order to gather information or explore family issues. Collateral information about the primary client is needed mostly in schools, hospitals, inpatient or outpatient treatment centers, and hospices. Family interviewing and clarifying by themselves are not intended to resolve family problems.

Informal Contact

Informal contact is any social contact with a family for the purpose of involving them in the agency’s activities or to keep them involved with the client or student. It is used in such places as schools, hospitals, churches, residential child care, and inpatient centers. The primary purpose is to obtain information and to build rapport and trust between the agency and the family members.

Family Work in Different Settings

For each setting, I've listed how family work is used, along with a few of the obstacles to its use—some procedural, some attitudinal—that I have observed.

Mental Health Agencies

Uses of family work

1. For treatment of a variety of children and adult presenting problems.
2. To better understand the family and social situation of the individual client.
3. To manage a family crisis or family dynamics affecting the individual client.

Obstacles to overcome

1. The medical model (one-on-one treatment) is deeply embedded, beginning with the charting and billing procedures and extending into the clinical methods.
2. Accordingly, paperwork and reporting procedures discourage family work.
3. Most of the staff's training and education have been in individual and group counseling; few are trained to work with the family as the unit of treatment.

Department of Social Services (DSS)

Uses of family work

1. For Child Protective Services investigations.
2. To work through family problems to keep the family together.
3. To prepare a child and family for the child's return home from out-of-home placement.

Obstacles to overcome

1. Child protection is the primary goal, which often leads to excluding the child's family.
2. Many workers are reluctant to convene the family or network during in-home visits, preferring to see whoever is present during the visit.
3. DSS is overwhelmed with so many cases that its criteria for child abuse and neglect are extreme.
4. The chemical dependency of parents is too often seen as a collateral rather than a causative factor in child abuse and neglect.

Residential Child Care

Uses of family work

1. To keep the family engaged as a resource for the child.
2. To work with family problems that resulted in the child's placement.
3. To prepare the family for the child's return home.

Obstacles to overcome

1. Historically, residential facilities grew out of the concept of removing the child from the family and offering alternative ''parenting.''
2. Most group homes and residential campuses are child-centered, preferring to protect the child rather than engage his or her significant family. This is slowly changing to a more child-in-family approach.
3. Agency policies work against engaging the family, with little or no informal family involvement in the cottage life or campus activities.

Schools

Uses of family work

1. Parent conferences, to solicit parents' help for a student's school problems.
2. Family interviews, when a more in-depth look or a referral is needed.
3. Social work assistance to the student and family.
4. Brief family counseling for family disruptions and crises.

Obstacles to overcome

1. Some parents are difficult to get to conferences.
2. Parents often see the school, not themselves, as responsible for their child's behavior.
3. Schools are reluctant to become involved in family affairs.
4. Schools are not staffed to do family counseling.

Hospitals

Uses of family work

1. To help the family understand and manage the patient's illness.
2. To help correct family habits that may contribute to the illness.
3. To prepare the family for the patient's return home.

Obstacles to overcome

1. The medical model is narrowly focused on the patient's body parts.
2. Family relationships are often seen as complicating the medical treatment.
3. Hospitals are not trained or staffed to handle the psychosocial and emotional factors in the patient's healing.

In-Home Services

Uses of family work

1. To prevent expensive out-of-home child placement.
2. To help change family patterns that threaten to dismember the family.
3. To work on problems that contribute to family abuse, neglect, and violence.

Obstacles to overcome

1. In-home services have become too brief, except for family stabilization.
2. Workers usually lack a holistic, systemic view of the family.
3. Workers are reluctant to structure the interviews (who attends, etc.) in the family's home.

Private Practice

Uses of family work

1. To assist individuals who present with family or interpersonal problems.
2. To bolster the individual's social network by including others in the sessions.
3. For briefer resolution of individual problems.

Obstacles to overcome

1. Therapists are quick to accept the paying client's preferences about how the work should proceed; excluding significant others may be the client's, not the therapist's, preference.
2. The practitioner may become inducted (sucked in) by the client's negative view of his or her family.
3. Managed care is cutting into the profitability of private practice.
4. Many insurance companies do not reimburse for family counseling.

Suggestions for Family Work in Different Settings

Public Social Workers (DSS, In-Home Services, etc.)

The multi-problem families in these settings have environmental and economic pressures that put stress on family relationships. Another characteristic is that family roles may be defined loosely—for example, a cousin may be treated like a sibling. Family bonds can be strong.

1. To define the relevant family system, cast a broad net. Work with the family living in the home, plus (where appropriate) extended family, neighbors, friends, and the social network.
2. Support the parent(s) or adults in the home acting as parents. If the parental stress is lessened, the relief will flow down to the children. Find adult support for the single parent.
3. Stay problem-centered. For many of these families, the primary concerns are being safe, surviving, and easing a hard life, not enriching family relationships.
4. Chemical dependency is rampant and is often a direct (not collateral) cause for abuse, neglect, and parental incompetence (see chapter 6).
5. Home visits are essential, and the safety of the worker must always be considered. Once rapport and trust with the family are established, begin to put the adults in charge of the home, with your coaching and support.
6. Don't do for them what they can do for themselves. Helping too much is seductive, since they need so much.
7. Find close colleagues and supervisory support. Working with these families can be stressful; the helper needs the relief of talking to colleagues about his or her cases.

Residential Child Care Professionals

Where possible, a functional family is the best permanency plan for most children in placement. After a round of ''group home drift,'' most children return home anyway.

1. Because you develop close ties with the child in placement, you have a natural and normal bias. This can lead to taking too much responsibility for parenting the child, overprotection of the child, and overidentifying with the child's anger at the family.
2. If DSS has custody of the child, it has the ultimate authority. Work with the agency closely and carefully.
3. Family reunification should be ruled out before any other placement is considered. Parents are often ambivalent about parenting their child. They don't set out to harm their children, but they're not sure they want the responsibility of parenting. I believe that, except in the worst cases, the residential facility should address and resolve the parental ambivalence in 90 days or less and determine whether reunification with the family is an option. (If it is an option, it will often, of course, take more than 90 days to return the child home.)
4. Treat the parents as the experts on their children. To the degree you overfunction by taking the expert role and the responsibility for ''fixing'' the child, the parents underfunction.
5. Watch the six-month time frame: After the child has been about six months out of home, you sometimes have to ''sell'' the child back to the family.
6. Because of physical and emotional danger to the child, some children cannot be returned home to their families. If the child's family is not available, find ways to help the child deal

with his or her feelings about family relationships. You can take the child out of the family, but you can't take the family out of the child.

7. Start with family sessions early in the child's placement. When the family is engaged at the outset and made a full partner in the care of the child, family reunification is more possible.

Public Mental Health Staff

1. Most mental health centers were created around the individual, medical model of treatment. The charting, billing, and record-keeping functions encourage individual, not family, treatment. Separate, individual treatment of a child is helpful, but whether it is helpful enough is another question. Returning an improved child to an unimproved family holds little promise.
2. Family counseling often consists of the problem person and one other family member: for example, the identified patient child and the most available parent, without the other parent (if applicable), siblings, others living in the home, or influential extended family members. The identified patient could be a depressed adult in an unhappy marriage or partnership, without the partner being included. Returning an improved partner to an unimproved partnership also holds little promise.
3. Most of the mental health staff members have the experience and ability, but not the confidence, to do marital and family counseling. The lack of confidence comes from inadequate supervision in family work, insufficient training, and lack of encouragement and support by management.
4. Effective family work requires a slight shift in working hours. Centers should provide evening hours 2–3 days per week.

Private Practitioners

There is a built-in ethical problem in private practice: The clinician may believe that couples and/or family therapy is the preferred mode of treatment in a given case but fail to insist on it because the paying client is resistant to the idea.

1. Even though private practice contains some of the most talented and experienced professionals in the helping field, many have had no formal training in systems therapy and fail to use this model when indicated.
2. Many private practitioners work alone, even though they are in a practice with other professionals. Everyone's time is valuable, so they don't take adequate time to talk to each other about their cases. As a result, private practitioners often drive home after work talking to themselves.
3. When couples therapy is used, children are frequently omitted from all sessions. This can make the couples work less effective for several reasons:
   a. The conflicts are often the result of the couple's parenting functions.
   b. Children in the home are affected by, and affect, the parents' relationship problems.
   c. Children are often valuable assets in couples therapy because the parents (and therapist) need to hear the children's side of the story.
   d. The presence of children in one or more of the sessions is a reminder to the couple to do the hard work of change for the sake of their children.

Rationales for This Approach

Rationales are reasons for what we do with families. Like hypotheses, they may be wrong in a given case, but we need them anyway. Sometimes our rationales are based on our theoretical orientation, sometimes on our experiences, sometimes both. Here are some of the rationales for my approaches.

1. **Seeing the whole family together (at least everyone living together).**
   You can't understand the nature of a family by talking to one or two of its members. In a family, realities are based on individual truths, and each member will have a slightly (or radically) different one. To be valuable to families, counselors need their own ''truth,'' which can only be developed by seeing the family function together.
   Assuming a four-person household (two parents, two children), too often ''family'' counseling consists of seeing the mother and the problem child. This is not *family* counseling and is as confusing as watching a play with half the characters missing. The mother-child subset of the family provides more questions than answers and keeps the counselor at least four steps away from understanding what's happening in the family:
   1. What's the father's role with the child?
   2. What's going on between the parents?
   3. How do they parent the non-problem children?
   4. How does the family function together as a unit?
2. **Keeping parents in charge of their children.**
   I do this more than most family counselors. My reasons:
   1. Parents care about their children and want the best for them.
   2. The parents must cooperate with plans for their child if the plans are to work.
   3. Parents know their children and their family situation better than we do.
   4. If the professional takes the one-up, knowledgeable, expert role regarding what is best for the child, the counselor will also be handed the responsibility for ''fixing'' the child.
   5. Children want their parents to succeed as parents.
   6. This approach confirms and supports the parents, which is good for children to see.
   7. The counselor's relationship with the child and family is brief. The parents' relationship with the child is for a lifetime.
3. **Paying special attention to the adult relationships in the family, especially the primary parents.**
   The parent-parent relationship is, in my opinion, the most important relationship in the family. If this bond is solid and supportive, the children get consistent messages from both parents, the children cannot ''split'' and manipulate the parents, and they learn what a loving, cooperative relationship is all about. This assumes, of course, that the parents have decent parenting skills and are making decisions in the best interest of the children.
4. **Attending to all children in the home, regardless of who the identified patient is.**
   The welfare of their children motivates most parents, and strong motivation is needed for the changes the adults have to make. Having all children in the home at most sessions reminds parents (and counselor) that the children are being affected, directly or indirectly, by everything the parents do or don't do. Also, *all* children in the home need to be looked at, not just the identified patient child. In a troubled family, the ''good'' child is also suffering.

Bedrock Beliefs About Families

I have several bedrock beliefs about families. They grew from my experiences, both professional and personal, and so far they have not let me down.

Parents care about the welfare of their children.

No matter how angry, withdrawn, or abusive the parents are, they will choose what they believe is good as opposed to what they believe is bad for their child. Their intentions are usually honorable. The problem, of course, comes when the parents behave inadequately as parents, coming mostly, I suspect, from the poor parenting they received in their families of origin. Also, most parents have been dealt a difficult hand since they have had no real preparation or education to take on one of the most difficult things human beings do. I have much admiration for parents who manage to do it well.

Children want their parents to succeed as parents.

No matter how angry and resentful the children are at their parents, and despite runaways, severe conflicts, and emotional cutoffs, children want the security of nurturing, limit-setting parents. The problem, of course, comes when the children engage in a struggle for their freedom (starting at about age two) and later when they try to differentiate from their parents and become their own person. This adolescent struggle is often a conflict-ridden time and can last from months to a lifetime.

Family members want the same things: security, love, to get along.

No matter how much conflict exists over how these needs should be met. In the family journey, members are different travelers, seeing the landscape from different windows, all trying to get to the same place. Their common emotion—longing to belong—is usually just below the surface and can often be reached in family sessions.

Children are a major reason why families exist.

In the family ‘‘body,’’ if parents are the brains and muscles, children are the heartbeat; they keep it alive with new blood. If children are in the family picture, I use the parent-child bond to motivate parents, and I have found no stronger motivation for family change than the love (and guilt) of parents toward their children.

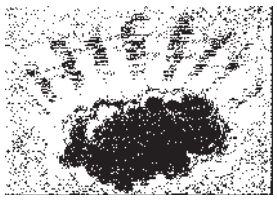
The family is always partially right.

No matter how poorly the family is functioning, any outsider looking in is viewing only a snapshot in the dynamic history that led to the current situation. Given the set of conditions family members are working with—their circumstances and backgrounds—many of us would act in similar ways. They’re doing the best they can.

Families have much strength and resilience.

They have survived a long time without us. The family bonds are sturdy and can endure much testing and crises. In most families, it takes a shakeup or crisis to bring about change, a natural process in all systems.

A Theory of Change



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A theory of change is useful for family work. It guides our actions and gives meaning to our experiences with families.

I believe we all have a personal theory of sorts, a set of beliefs and assumptions about families and what helps them change. Whatever our theory, we should be congruent—our *beliefs* about change and our *actions* to promote change should match. Here is my own theory about what conditions help families change.

1. **Discomfort**

   Without some level of discomfort, people have no reason to do things differently. Feelings such as anger and fear are disturbing, and they energize us to take action.

   If I believe this, I should not ignore, minimize, or try to take away the family discomfort. Since counselors would rather help people get rid of their pain; it's easy to allow the family members to avoid what hurts. To help people stop running, turn around, and face the thing they're running from is not easy and requires all the courage and patience we can muster.

2. **New Experiences**

   Experiences are anything we perceive through our senses, plus our emotions and thoughts. Experiences are primary; they are the raw material for change.

   If I believe this, I should create opportunities for new experiences during sessions. One way is to set up conversations between members that they don't usually have or help them have the same conversations in new ways or not have a conversation at all, as with the techniques of ***Sculpting*** or ***Drawings.*** To do this, members need prompting, encouragement, support, feedback, and sometimes here-and-now coaching.

3. **New Understandings**

   New understandings (insights) can come before behavior change, but just as often they happen after. They are promoted by honesty between the members, by new expressions of feelings, by new information, and by observations from the counselor.

   If I believe this, I should take full advantage of my position outside the family and offer my (relatively) objective feedback at the appropriate time, without attempting to interpret, label, or change. Sometimes, just getting a firm grip on the obvious and holding a mirror up to the family is valuable:

   1. ''The two of you seem to have differences on how to approach the problem.''
   2. To wife: ''Your husband has been silent on that topic.''
   3. ''In the past few minutes everyone has been talking at once. Is this the way it is at home?''

4. **Hope**

   People need to believe there's a way out of the problem, that it's possible for them to overcome their difficulty. Hope gives energy.

   If I believe this, I should stay in touch with my own hope that families can change, and I should use this energy to generate hope in the session—by finding the family strengths, showing realistic optimism, normalizing members' behavior and feelings, and using appropriate humor. If I don't have hope that the family can change, can I expect them to?

Children Raise Adults

I've never known exactly what the phrase from Wordsworth's poem—''The child is father of the Man''—means, but it sounds important. Of several possible interpretations, I choose this one: Children raise adults. This is not as crazy as it sounds, especially if you consider the strong maturing influence children have on parents. I've seen children get parents to be more responsible, move out of a dangerous neighborhood, quit smoking, change their exercise and diet habits, have a better relationship with their parents, and recover from drinking and drugs. Children, especially young ones, are little change agents, and their power is in opposite proportion to their size.

We all know that children are important in families, but how do we make this idea work in family sessions? One way is to mention every child in the home every session, whether or not the children are present. This keeps the family unit as the level of focus, since everything that happens between the parents will sooner or later affect their children. In couples therapy, for example, Jennifer, age 6, and Brian, age 8, may not be brought to the sessions by the couple, but their absence doesn't make them irrelevant. Ask questions like, ''Where were Jennifer and Brian when that happened? How much do they know about what is going on? How much do you want them to know? Do you think the problems you are having affect them?''

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If young children are in the family session, another way to make them important is to let them contribute through techniques such as ***Drawings***, ***Sculpting***, or other movement and games rather than just through verbal expression. The main language of children is metaphor and play. If children do the ***Circle Method***, for example, show the drawing to the parents: ''What do you suppose Brian meant by putting his dad partly outside the circle?''

Everyone who is partnered and has children wears two hats: partner/spouse and parent. When dealing with spouse issues, it is sometimes easier to find agreements and successes of the couple in the parent arena, since regardless of their differences and conflicts, the welfare of the children provides a strong common concern. Get the couple (where appropriate) to put on their parent hats: ''How have you worked out the disciplining of your children?''

During a session, give parents a chance to be parents. Instead of you correcting their child, comment on what you see, and let the parents correct the child's behavior. If Jennifer, for example, is in the corner writing on your office wall, make a profound comment to the parents: ''Jennifer appears to be writing on the wall.'' If Brian keeps interrupting one or both parents while you are talking to them, say, ''Brian is interrupting as we talk.'' Let the parents decide what to do, and watch them be parents. If parental support and coaching are required, provide them.

If you are unclear whether the children should be hearing a particular topic of conversation between you and the parents, ask the parents for guidance: ''Are you okay with Jennifer and Brian hearing this?'' If you are uneasy about the children hearing a conversation (argument, etc.), say to the parents, ''I would prefer that we discuss this without the children. Can I take them over there and give them some drawings (toys, etc.) to keep them occupied?''

I have much respect for the integrity of the parent-child bond, and I rarely do anything with children in a family session without going through their parents, either by encouraging the parents to attend to the child's behavior or by getting their permission before I do something. Keep parents in charge of their children.

Neglected Relationships in Family Counseling

If a child is the identified patient, we usually focus mostly on the parent-child relationship in family work. This is important, but other relationships are also important as a resource for helping the family.

Parent-Parent

In two-parent households, this is perhaps the most important relationship in the family:

1. It influences virtually all significant parenting decisions.
2. When parents are divided on one or more parenting issues, their children are likely to ''split'' them, that is, take advantage of their disagreements for the child's own purposes, or even play one parent against the other.
3. If parents are having relationship problems, they may detour their conflict through one or more children by fighting about the child rather than dealing directly with their issues with each other.
4. When parents are divided, the children may get conflicting messages (''I don't care what your father said, I want you to do it this way!''). If one parent says ''yes'' and the other says ''no,'' either way the child moves will disappoint one parent. It's a lose-lose proposition for children, and it makes them anxious.

I always work with the parent-parent relationship, urging the parents to speak with one voice and to present a consistent, team-like message to their children. When parents act together, it increases the parental leadership tremendously. And when they don't, problems are likely to arise.

Grandparent-Grandchild

Today, many households with children are being held together by grandparents, especially single-parent households. Whether grandparents and grandchildren live together or not, however, the bond between them is special. For grandparents, it's a chance to enjoy their grandchildren without having daily responsibility for them, and for grandchildren, it's a chance to experience the grandparents' love and ''spoiling.'' This relationship also adds depth to the child's three-generation family experience and sense of belonging.

I have a bias—I believe that children should have a relationship with their grandparents, even if one or both parents are in conflict with the grandparents. This adult conflict may have a deep history, but it can rob a child and punish a grandparent. If the parent has legal custody, however, he or she must be kept in the controlling role around grandparent-grandchild contact. I let my bias be known, when appropriate, and offer to help with the adult conflicts to avoid penalizing the child.

Sibling-Sibling

Siblings are a child's first peers. Sometimes a sibling will be more influential on a child than the parents are, especially if the siblings are teenagers. An older sibling is a role model; a younger sibling is someone for the older one to protect and teach. Also, during their lifetime, children will know their siblings longer than they will know their parents. The ***Sibling Talk*** technique is one way to put a light on this special relationship.

Getting a Grip on the Obvious

1. Family members *feel* their family but they can't *see* their family. Client families are often blind to their own structure, patterns, and repetitive interactions, which result in symptoms for one or more members. They don't see their interdependent behavior.
2. Except to give us factual information, family members are not talking to us, even though they appear to be. They are using us to talk to each other.
3. You can't help children by trying to take their parents' place. Keep the parents in the parental role in a family session (unless you plan to go home with the family and do it for them).
4. Regardless of how parents act, they care about what happens to their children.
5. Regardless of how angry or disruptive children act, they care about their parents. They also want them to succeed as parents.
6. Parents and children are not peers. During parent-child dialogues and negotiations, give the parents more authority (and responsibility).
7. You can't solve all the problems in the family. In fact, *you* can't solve any of them.
8. It's better to ask one question at a time, keep it brief, and not answer it for them.
9. Don't always talk directly to the person(s) who you want to receive the message. If you say it to someone else, the target person listens better.
10. Rule of 20/20: If you lean forward in your chair by 20 degrees or more for a total of 20 minutes or more in a one-hour session, you're probably inducted (sucked in, too close).
11. When you can't think of what to do in a specific moment, just make an observation, without interpreting (''I notice that when you two [parents] disagree, your son interrupts a lot''). Sometimes, just hold a mirror up to the family.
12. Observations and impressions that we keep to ourselves are of no use to the family. Be careful about when and how you say something, but don't be too secretive.
13. Some of our uneasiness in family sessions comes from a belief that we aren't supposed to meddle in another family's business. We aren't sure we have permission to be there. Work with respect and sensitivity, and you will have all the permission you need.

Experience Is Primary

We learn to do things through our experiences, and everything else—reading, discussions, watching others do it, workshops, etc.—is just preparation for learning, not the learning itself. We benefit from these inputs, but we learn primarily from our own experiences, not someone else's. Before trying family work, if you read all the family therapy books, listened to all the audiotapes, watched all the videos of master therapists, and studied all the various and conflicting theories, you would emerge a little smarter, but no wiser, and too confused to stir a muscle. Learning a complex skill requires personal trial and error.

I should have known. My dad used to say, ''I don't care how many times you're told something, you have to experience it for yourself.'' My family trainer was fond of repeating, ''You've got to put in your hours'' (in the therapy room with families). Another saying goes, ''The map is not the territory,'' meaning, I suppose, the talk is not the walk, the theory is not the practice. All this advice was warning me that experience is primary, and that you learn through doing, bit by bit, over considerable time. No one becomes Virginia Satir overnight, not even Virginia Satir.

The American Association for Marriage and Family Therapy (AAMFT) recognizes the importance of putting in your hours and requires 1,500 hours of face-to-face experience in some form of family work (plus 200 hours of training) before the organization will certify a family therapist. Fifteen-hundred hours is an hour every workday for over *six years*.

Our experiences gradually change us. Here is my opinion about the stages counselors go through in learning family work through their supervised experiences:

1. **Wide-Eyed Wonder:** ''I'm open to anything.''
2. **Experimentation:** ''This is harder than it looks.''
3. **Familiarity:** ''I've seen this before.''
4. **Confidence Building:** ''I think this might work.''
5. **Adolescence:** ''Don't tell me; I've got it.''
6. **Journeyman:** ''I'm sometimes inept, and that's OK.''
7. **Maturity:** ''I've learned a lot, and have a lot to learn.''
8. **Wide-Eyed Wonder:** ''I'm open to anything.''

As T. S. Eliot said, ''[t]he end of all our exploring [w]ill be to arrive where we started. And know the place for the first time.''

Traditional education seems to favor a certain sequence—theory first, then experience. We studied butterflies in the classroom and then went outdoors to see butterflies. We study counseling theories in graduate school to prepare for doing counseling when we get to the real world; students are lucky to get any supervised experience at all. In contrast, my trainer had me in the room with a family within three hours of our ''education'' about family work, and every time she arrived for training, we had an observed family session. I, of course, had no idea what to do, but after those first sessions, I was all ears. Aside from motivating us, our experiences gave us good reality testing for the ideas we were hearing in our education.

Of course, in actual practice, learning goes back and forth between the preparation and the actual learning—between learning *about* it and *doing* it. Education and experience inform each other in a constant interplay. In the skills arena, experience without supervision and education is an inefficient way to learn, and education without experience is nearly useless.

Too Many Variables

A variable, in scientific jargon, is any condition that can vary.

Recently, I sat with a father, stepmother, and their 15-year-old daughter, who was classified as mentally retarded and who had recently been harming herself and threatening others. The parents were seeking help for her at a mental health center. Of the dozens of conditions that can vary from one family to the next in a case like this, I chose to focus on

1. The people who live in the girl's home (father, stepmother, two younger siblings)
2. How long the problem has existed
3. The parents' clues about when her behavior is deteriorating
4. The parents' agreements/disagreements on how to manage the child
5. The action plan by the parents if the daughter threatens self or others
6. The way the parents talk to the child, and who initiates the conversation
7. The strength of the conflict between stepmother and patient
8. The agreements (often unspoken) between the parents regarding who takes the parenting lead with the daughter
9. How the two younger siblings in the home react to the daughter
10. The influence of the biological mother
11. And so on

Considering the above variables, notice

1. They are too numerous to list completely.
2. The family has more control over the variables than the treatment provider does.
3. The information we collect will largely depend on what variables we explore. I chose to focus mostly on the relationship variables in the case and how the relationships affected the way the family handled the girl's problems.

Also note that most of my exploration of the variables is hypothesis testing. I'm exploring certain areas and ignoring others because I have an opinion or bias to check out. I wanted to know, as I do in every blended family, if the biological parent or the stepparent took the lead in parenting the identified patient. In my experience, if the biological parent withdraws and turns over the primary parenting to the stepparent, the child often acts out his or her anger.

I am fond of saying that every intervention in a family is an experiment. We try a particular input to see how it affects the variables. But unlike a scientific experiment, we have limited power to manipulate and control the variables, and we therefore have minimal control of the outcome. The input side, where we do have some control, is our main responsibility.

And that is responsibility enough. We have been given a difficult job—changing human behavior—and few of us will do it as quickly or as well as we're expected to by the lay public, the law, and the insurance companies. We are responsible for caring about what we do and doing the best we know how; for consulting with supervisors and colleagues; for keeping up our skills and knowledge base; for maintaining professional ethics, standards, certifications, and licensures; for sometimes working with clients we don't especially like; for doing stacks of paperwork; for being held accountable to our clients, supervisors, and administrators; and for working with impossible cases. We have our own set of variables to look after.

Too-Brief Family Counseling

This is an efficient, one-session model that should appeal to busy counselors. Use any two of the tenets of this model, and your goal of one interview will probably be achieved. Use all 12, and your goal is assured. (If your intention is to have more than one session, this approach is not recommended.)

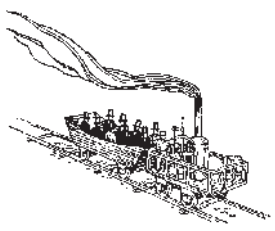
1. Encourage everyone to express all their feelings about each other. Quickly get everything out in the open, no holds barred.
2. Do not tolerate boring stories, details, anecdotes, and crises situations you have heard many times before from other families.
3. Dispel their superficial views about what's wrong in the family. Explain the underlying dynamics of the problem.
4. Find out who's right, and help them defend their position against the others.
5. Ignore their strengths and successes. The family is here because of their weaknesses and failures.
6. Disregard the power structure in the family. It's probably not working anyway.
7. Aggressively defend a scapegoated family member.
8. Go directly to the underlying parental conflict that is feeding the family problem.
9. Explain to them the systemic underpinnings of their behavior: their circular causality, negative feedback loops, and cybernetic epistemology.
10. Be an expert, full of ready answers. Also be an expert on *their* family.
11. Assign a homework task that they have been unable to do in the past. If the presenting problem is communication, for example, say, ''During the coming week, I want you to spend one hour a day together examining your areas of mutual conflict.''
12. After the interview, follow them out of the counseling room, into the halls, and out to the parking lot. Use this extra time to explain how you have helped them in spite of themselves. As they drive off, wave a final good-bye.

Traveling Pairs of Concepts

Some pairs of ideas about parenting sit side by side and travel well together; others don't belong on the same train.

Control/Nurturance

These two travel well together. Parents need to establish control before they can nurture. This is obvious to anyone who has tried to nurture a young child who is having a tantrum, but it also applies to out-of-control teenagers who do whatever they want without regard for others or themselves. Unless parents establish some limits and control the teenager's behavior, giving the child what he or she needs—love, attention, guidance, consistency, protection, limits—is difficult at best. Establish control and limits (hopefully in a loving way), then nurture.



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Love/Objectivity

These two don't go together. Love, by its nature, is subjective. Objectivity, by its nature, is dispassionate, rational, detached. Love explains why parents can't stand aside and see what is happening with their child or distort the truth or enmesh their child and smother their autonomy. ''Parental objectivity'' is an oxymoron. As counselors, we need to allow parents the normality of being irrational about their children.

Parent/Friend

These two don't go together. I hear parents—often single parents—proudly say that they're their child's best friend. With good intentions, these parents try to mesh these incompatible roles. Friends don't tell you to clean your room or fuss at you for a bad report card or provide food, clothing, and shelter. Trying to be both parent and friend is confusing to children and weakens the parent's authority. If a single parent is the child's best friend, the child has lost both parents.

Responsibility/Authority

These two go together. It's frustrating, even crazy-making, to have the responsibility for doing a job but not the authority to do it. Many parents of problem children are in this dilemma. They have the responsibility to raise their children, but their authority has been eroded by trying to be their child's friend, by guilt, by inconsistent or mixed messages, or by another adult who has a strong influence on the child, among others.

Parenting/Guilt

These seem to go together. A warning should be placed on the child's birth certificate: ''The parents of this child will feel intermittently guilty during the child's lifetime.'' Parental guilt is so common that I consider it normal and easy to understand. The world's most difficult job is too difficult to be done without mistakes, and sometimes the child will pay for these parenting mistakes. Managing guilt is part of the parents' job description, and if it isn't managed, it can control the parents, making them too lenient, too inconsistent, too accommodating, too apologetic, or too something.

Research on Marital and Family Therapy*

Does family counseling work? This question is too general to answer—it depends. For what specific problems? With what populations? Using what methods? Conducted how and by whom? With what outcome criteria, measured by what means? When it comes to research, the details are critical. Fortunately, we have decades of research studies (along with their details) to guide our practice.

The next few pages contain a summary of the empirical evidence on family-based interventions with a number of common clinical and medical conditions. (References are found in the Research References at the end of the book.) Overall, research suggests that utilizing family-based treatments, especially with children, enhances or extends positive outcomes (Dowell & Ogles, 2010). Moreover, including family-based interventions does not drastically increase the costs of services (Crane, 2008).

Two valuable sources used extensively for this research summary are Alan Carr's reviews of the effectiveness of family therapy and systemic interventions, including family therapy in conjunction with other family-based approaches (e.g., parent education/training), for both child and adult problems (Carr, 2009). Carr utilized meta-analyses, systematic literature reviews, and controlled research trials in his reviews of the literature. With child problems, he found evidence that supports the effectiveness of systemic interventions, either alone or as part of multimodal programs, for childhood sleep disturbances, feeding and attachment problems in infancy, child abuse and neglect, conduct problems, emotional problems, eating disorders, and somatic problems. For adults, he found that couples and family therapy are effective ''either alone or as part of multimodal programs'' for relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol and drug abuse, schizophrenia, and adjustment to chronic physical illness (Carr, 2009, p. 46). Carr's findings, along with other research, are summarized in the following pages.

Research Findings on Specific Disorders

1. Problems of Infancy and Early Childhood
   a. Attachment Problems

      Brief (15 sessions or fewer over 3–4 months), highly focused, family-based interventions (that involve fathers and mothers) specifically aimed at enhancing maternal sensitivity to infants' cues are ''effective in improving maternal sensitivity and reducing infant attachment insecurity'' (Carr, 2009, p. 6).

   b. Feeding Problems

      Family-based behavioral modification programs are effective in ameliorating severe feeding problems and in improving weight gain in infants and children, including children with developmental disabilities (Carr, 2009).

   c. Sleep Problems

      Family-based behavioral modification programs and pharmacological interventions are effective in the treatment of children's sleep problems; however, only systemic interventions (that include family therapy, parent training, and/or multisystemic therapy that engages extended family or wider family networks in efforts to ameliorate familial problems) have long-term positive effects on children's sleep problems (Carr, 2009).

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* Credit goes to Daphne Cain, PhD, LCSW, Chair, Department of Social Work, Louisiana State University, for this section on research and for the Research References at the end of the book.

2. Childhood Disorders
   a. Attention Deficit Hyperactivity Disorder (ADHD)

      A multimodal approach that consists of family, school, and psychopharmacological interventions is the most effective (Abikoff et al., 2004; Carr, 2009; Hinshaw, Klein, & Abikoff, 2007; Jensen et al., 2007).

   b. Conduct Problems

      Behavioral parent training is effective at ameliorating childhood behavior problems and can be maintained for over one year with periodic follow-up sessions (Carr, 2009). Teaching parents cognitive behavioral techniques to increase children's prosocial behaviors (attending and positive reinforcement) while also reducing antisocial behaviors (ignoring, time-out, and contingency contracts) is critical to this process (Carr, 2009, citing Patterson, 1976). Moreover, behavioral parent training may be enhanced by including child-focused therapy to improve child self-regulation, problem solving, and emotional coping (Carr, 2009). Behavioral parent training is less effective with parents coping with mental health problems, for parents who have limited social supports, and among parents with high levels of poverty-related stress (Carr, 2009, citing Reyno & McGrath, 2006). When such factors are present, concurrent parent-focused interventions aimed at ameliorating the effects of these factors should be considered (Carr, 2009).

   c. Delinquency

      Functional Family Therapy (Alexander, Sexton, & Robbins, 2000) in combination with prenatal care, home visitation, bullying prevention, drug and alcohol prevention, mentoring, life skills training, and reward systems for graduation and work are effective at ameliorating the risks for delinquency (Zagar, Busch, & Hughes, 2009).

   d. Separation Anxiety Disorder (SAD) and School Refusal

      Structural Family Therapy is effective in the treatment of SAD (Mousavi, Moradi, & Mahdavi, 2008). Moreover, school refusal, which is frequently due to SAD, can be effectively treated with behavioral family therapy (Carr, 2009; Heyne & King, 2004).

   e. Obsessive Compulsive Disorder (OCD)

      Family-based exposure/response cognitive behavioral strategies are effective in the treatment of OCD among young people (Barrett, Farrell, Dadds, & Boutler, 2005; Carr, 2009; Storch et al., 2007).

   f. Adolescent Anorexia Nervosa

      There is ''growing evidence that family-based treatment models are indicated for recent onset child and adolescent anorexia nervosa and that specific forms of family therapy are more effective and user-friendly with certain types of patients and families. Family therapy models that are initially symptom-focused and resource-oriented bring about more positive results than deficit-based models that do not consider the individual symptom'' (Cook-Darzens, Doyen, & Mouren, 2008, p. 168). For a review of the research on family interventions with adolescents with anorexia nervosa, see Le Grange and Eisler (2008).

   g. Adolescent Bulimia Nervosa

      Family therapy is as effective as cognitive behavioral therapy and is more effective than supportive therapy for adolescents with bulimia nervosa (Carr, 2009; Le Grange, Crosby, Rathouz, & Leventhal, 2007; Schmidt et al., 2007).

   h. Juvenile Obesity

      Family-based behavioral intervention is more effective than dietary educational programs in promoting weight reduction among obese juveniles (Carr, 2009; Jelalian & Saelens, 1999).

i. Juvenile Sexual Offenders

Community-based multisystemic therapy (MST) adapted for juvenile sexual offenders evidenced significant reductions in sexual behavior problems, delinquency, substance use, externalizing symptoms, and the need for out-of-home placement (Letourneau et al., 2009).

j. Depression

The combination of family therapy with group-based parent and child psychoeducational sessions is effective in the treatment of major depression among children (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Carr, 2009; Lewinsohn, Clarke, Hops, & Andrews, 1990; Sanford et al., 2006; Trowell et al., 2007; Weersing & Brent, 2003).

k. Grief and Bereavement

A combination of family and individual treatment is effective in the treatment of grief/bereavement reactions, including grief reactions associated with parental loss (Carr, 2009; Cohen, Mannarino, & Deblinger, 2006; Kissane & Bloch, 2002).

l. Bipolar Disorder in Adolescents/Early Adulthood

While psychopharmacological treatment is the primary treatment for bipolar disorder, conjoint psychoeducational family therapy is an effective intervention to prevent relapse (Carr, 2009; Fristad, Goldberg-Arnold, & Gavazzi, 2002).

m. Alcoholism and Other Drug Addiction in Adolescents/Early Adulthood

Deas and Clark (2009) conducted an analysis of published research (from 1990 to 2005) on the current state of treatment interventions for alcohol and other drug (AOD) use among adolescents. Overall, they found that the majority of current treatment options utilize ''family-based interventions and multisystemic therapy, motivational enhancement therapy, behavioral therapy, and cognitive-behavioral therapy'' (Deas & Clark, 2009, p. 76). Moreover, these interventions have evidence to suggest effectiveness. Additionally, Multidimensional Family Therapy (MDFT) (Liddle, 2002) in combination with a peer group intervention with young teens demonstrate effectiveness in reducing substance use, substance use problems, delinquency, and internalized distress (Liddle, Rowe, Dakof, & Henderson, 2009).

3. Child Abuse and Neglect

a. Physical Abuse and Neglect

Effective treatments to reduce the risk of physical abuse and neglect of children include therapy that is ''family-based, structured, extends over periods of at least six months, and addresses specific problems in relevant subsystems and includes children's post-traumatic adjustment problems, parenting skills deficits, and the overall supportiveness of the family and social network'' (Carr, 2009, p. 7). Specific manualized approaches that demonstrate effectiveness in reducing the risk of subsequent physical child abuse include cognitive behavioral family therapy, multisystemic therapy, and parent-child interaction therapy (Carr, 2009).

b. Sexual Abuse

''Trauma-focused cognitive behavior therapy for both abused young people and their non-abusing parents has been shown to reduce symptoms of post-traumatic stress disorder and improve overall adjustment'' (Carr, 2009, p. 8, citing Deblinger & Heflinger, 1996). It is recommended that therapists working with sexual abuse survivors carry small case loads (fewer than 10), that services be provided to families for at least 6 months, and that along with regular family therapy sessions, the non-offending parent receive parent-focused intervention along with child-focused interventions (Carr, 2009). Furthermore, a thorough assessment of the child's environmental needs is

recommended, and a separate living environment for the offending party is necessary, at least until he or she has completed treatment and is deemed to be at low risk to re-offend (Carr, 2009).

4. Mood Disorders in Adults
   a. Depression

      Evidence on the efficacy of couples therapy as a treatment for depression is inconclusive (Barbato & D'Avanzo, 2008). Barbato and D'Avanzo conducted a meta-analysis using 8 controlled trials (567 subjects) on the efficacy of couples therapy as a treatment for depression. There were no statistically significant differences found between couples therapy and individual psychotherapy on depressive symptom levels. However, results reveal that ''relationship distress was significantly reduced in the couple therapy group'' (Barbato & D'Avanzo, 2008, p. 121).

   b. Bipolar Disorder

      The primary treatment for bipolar disorder is pharmacological (Carr, 2009); however, concurrent family therapy is effective in reducing relapse (Carr, 2009).

5. Anxiety Disorders in Adults
   a. Panic Disorder

      Partner-assisted, cognitive behavioral exposure therapy is as effective as individual cognitive behavioral treatment for panic disorder with agoraphobia (Byrne, Carr, & Clarke, 2004; Carr, 2009).

   b. Obsessive Compulsive Disorder (OCD)

      Systemic couples or family-based approaches are at least as effective as individual cognitive behavioral therapy (Carr, 2009; Renshaw, Steketee, & Chambless, 2005).

6. Marital Problems
   a. Marital Dissatisfaction and Conflict

      Wood, Crane, Schaalje, and Law (2005) conducted a meta-analysis of 23 studies on marital and couples therapy and determined that both behavioral and emotionally focused couples therapy are effective but that emotionally focused couples therapy is more effective with more highly distressed couples (Carr, 2009). Moreover, Snyder, Wills, and Grady-Fletcher (1991) found insight-oriented marital therapy to be more effective over the long term (4 years post-treatment) at preventing divorce than behavioral marital therapy (Carr, 2009).

   b. Spouse Abuse

      Based on a small body of empirical evidence (6 experimental studies), it appears that ''carefully conceptualized and delivered couples treatment appears to be at least as effective as traditional treatment for domestic violence, and preliminary data suggests that it does not place women at greater risk for injury'' (Stith, Rosen, & McCollum, 2003, p. 407).

7. Sexual Disorders

   Sensate focus exercises (Masters & Johnson, 1970) in combination with directed masturbation are effective treatment in most cases of female orgasmic disorder (Carr, 2009; Meston, 2006). The combined use of medications (such as Viagra) and cognitive behavioral sex therapy is more effective than the use of medications alone for cases of male erectile disorder (Banner & Anderson, 2007; Carr, 2009).

8. Alcohol Abuse in Adults

   Community Reinforcement and Family Training (Smith & Meyers, 2004) and behavioral couples therapy (O'Farrell & Fals-Stewart, 2003) are among the most effective treatment approaches for alcohol abuse (Carr, 2009; Miller, Wilbourne, & Hettema, 2003).

9. Physical Illness
   a. Juvenile Asthma
      Psychoeducational family-based interventions are more effective than individual therapy in treating poorly controlled asthma in children (Brinkley, Cullen, & Carr, 2002; Carr, 2009).
   b. Type 1 Juvenile Diabetes
      Family-based interventions that are appropriate for age and life cycle stage are effective at helping juveniles control their diabetes (Carr, 2009; Farrell, Cullen, & Carr, 2002).
   c. Chronic Illness
      Systemic interventions for people with chronic illnesses such as dementia, heart disease, cancer, chronic pain, stroke, arthritis, and traumatic brain injury are more effective than standard care (Carr, 2009; Martire, Lustig, Schultz, Miller, & Helgeson, 2004). Systemic interventions may include family therapy and psychoeducational groups for caregivers. Additionally, it appears that couples therapy is particularly effective at alleviating depression among chronically ill patients (Carr, 2009).
10. Schizophrenic Disorders
   a. Systemic Family Therapy (SFT) appears to be effective in the treatment of schizophrenia. Patients treated with the Milan School model of SFT had an improved clinical course and better medication compliance at the end of treatment (12 months) than patients treated with routine psychiatric treatment (Bressi, Manenti, Frongia, Porcellana, & Invernizzi, 2008).
   b. A meta-analytic study of 25 interventions revealed that psychoeducational family interventions are effective at reducing patient relapse as measured by rehospitalization or a significant worsening of patient symptoms (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). Best outcomes were found with longer-term family interventions (longer than 3 months).
   c. In a large study combining four meta-analyses, Pfammatter, Junghan, & Brenner (2006) found that ''compared with medication alone, multi-modal programs which included psychoeducational family therapy and anti-psychotic medication led to lower relapse and rehospitalization rates, and improved medication adherence'' (Carr, 2009, p. 62).

Part 2: Procedures and Processes

Recruiting Families for Counseling

Who decides who attends the first session? If the family (or one member) decides, the counselor may be playing into some of the splits, conflicts, and coalitions that are part of the problem. Family counseling goes better when the counselor decides who needs to be present (initially, everyone in the home). The following are several working guidelines that will improve the chances of getting families in.

Make Recruitment an Agency-Wide Issue

Recruiting families for counseling is not a contest between the counselor and one or more family members, although at times it seems that way. Getting families in also involves the agency management, the receptionist staff, and the record-keeping procedures.

Agency management controls the important resources: space, time, policies, and money. A different space may be needed because many counselors' offices are not large enough for a family; the working hours may need to include more evening appointments; the treatment policies determine the amount of firmness counselors can use in recruiting families; when required, time and money are needed for training.

The receptionist staff who receive phone calls for referrals are a vital—and frequently overlooked—component in a treatment system. If they do not understand the rationale for working with family units, they are not likely to convince a client to bring everyone in the home for the first interview. These initial contact people should be included in at least some family case conferences, clinical meetings, and training workshops.

In public mental health organizations, record keeping is individually oriented and may require opening a new chart on each person who attends family sessions. This extra paperwork discourages counselors from recruiting families. Someday, the *family*, not the individuals, will be allowed as a treatment unit. In the meantime, an expedient answer to this problem is to keep an individual chart for the identified patient and to include the family members as collateral contacts.

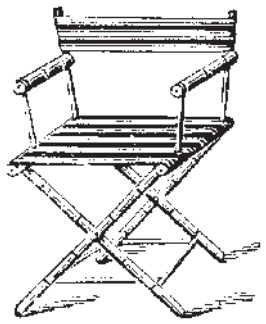
Get Administrative Support

Marriage and family therapy (MFT) is an important supplement to a clinical program. Here are some ideas to use when talking to your administrators about increasing the use of MFT in your program:

1. MFT is evidenced based and well researched for a wide variety of problems. For a recent research survey, see pages 32–36.
2. The average time spent with clients can be calculated for each counselor or agency. I suspect that MFT is 25–40% briefer than individual counseling. This faster turnover means more clients served per year but not more clients on the rolls at any given time.
3. Shorter treatment and higher client turnover result in lower cost per client served.
4. More people receive treatment at the same expenditure of staff time. A session with a family of four takes about the same time as a session with an individual.
5. MFT has prevention benefits. If a family with a problem adolescent, for example, can make progress in counseling, the likelihood that problems will develop later in younger siblings or in other members can be decreased.
6. Since MFT is more of a team effort than individual therapy, it produces positive change in how the staff members work together.

Recruit Missing Members

A family will often present itself for counseling in fragments: an individual with marital or partnership problems, a mother with an acting-out teenager, a young adult who lives with his or her parents. The counselor may want to involve the missing members if the work is to be effective.



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1. During the initial phone call, ask the caller for the names and ages (of children) of everyone living in the home. Say to the caller, ‘‘The way we work (or ‘‘Our policy . . . ’’) is to see everyone living in the home at least once to get a clearer picture of your situation.’’ Ask the caller to invite the other members to the first interview.
2. If the above effort to recruit everyone living in the home fails, agree to see whomever the caller wants to bring. Example: A mother who wants to bring only her problem son; also in the home is the mother’s spouse/partner and daughter.
   a. At the first session, put empty chairs in the circle to represent the missing spouse and daughter.
   b. During the interview, join with the persons present and in need. But also talk about the missing members: ‘‘What does spouse and daughter think the problem is? What would (your spouse) say about that? How does the situation affect your daughter?’’
   c. Ask, ‘‘Who can get your spouse and daughter to come to the next session?’’
   d. The father’s attendance at family counseling is sometimes a problem, perhaps due to his work schedule or because he disagrees with the mother’s approach to the problem. Since you want to promote parental teamwork in reaction to the problem child, his presence is important.
   e. If other attempts fail to include the father, write down some questions for father (‘‘What is your major concern in the family?’’ ‘‘How do you see your son’s problem?’’ etc.). Give them to the mother to take to the father and have her bring his answers to the next session.
3. If you get the family’s permission to phone the missing member directly, include some of these ideas and statements:
   a. Hear their story and viewpoint.
   b. Emphasize the importance of that member to the family and to the problem solution.
   c. ‘‘I am trying to be impartial, which is difficult when I have only one side of the story.’’
   d. ‘‘All I know about you is what I hear from your _____ (wife, son, etc.).’’
   e. If he refuses to attend with his family, ask to see him for an individual session ‘‘to get his view of the situation.’’ During the individual interview, emphasize his importance in helping his son by attending family sessions.
   f. If he still refuses, ask his opinion about what should be talked about in the sessions and about his views of the problem and the solution.
4. Other recruitment suggestions:
   a. In the first session with a partial or a complete family, join well. Support their strengths and successes without minimizing the problem. Go with the problem they bring you, even though you believe it’s a surface issue. The overriding goal of the first session is to have a second session.
   b. Don’t be afraid to gently use leverage (DSS, legal, etc.) when necessary and available.
   c. If the identified patient is a child or young person living at home, it is especially important to get both parents, if available, to come to counseling. You can get their written

permission to work with their child, including an agreement by the parents to participate in the treatment when requested.

d. If other methods fail to engage the missing member(s), place a tape recorder in the empty chair and make a recording of the session (with the adult family member's permission). At the end of the session, give the tape to the client to take to the missing member(s). (''They will cooperate better if they know what's going on.'').

e. If the family members don't return after the first interview, call them. If they reveal that something you did (or didn't do) decreased their motivation for counseling, apologize, if appropriate, and ask to be given a chance to correct your misunderstanding at another session.

Conducting the Initial Family Interview

The ReSPECT Sequence

ReSPECT is an acronym that helps us remember the sequence in the initial interview:

Re: Recruitment
S: Social
P: Problem
E: Exploration
C: Closing
T: Talk to colleagues

1. **Recruitment**—Recruitment is included in the sequence of steps in the first interview because without effective recruitment, there won't be a first interview, at least not with the right family members. During the first contact (usually by phone), collect certain information (the presenting problem, who lives in the home) and set the appointment for the first session.
2. **Social**—When the family members arrive, greet them and ask them to be seated in a prearranged circle of chairs. Ask each member about themselves in a polite, ''small-talk'' fashion, gathering information about school, work, hobbies, etc.
   a. Begin with one of the parents. If both parents are present, begin with the one who did not make the initial call; this balances the information sharing and draws in the (presumably) less involved parent/spouse. Proceed from parents to oldest child to youngest child. This sequence of addressing members of the family supports the natural hierarchy of the family unit.
   b. Discourage discussion about the presenting problem until a social response is obtained from each member.
   c. Find out about the extended family (grandparents, aunts/uncles, etc.). Depending on the amount of contact with the family and their availability, these members may be asked to attend one or more future sessions.
   d. Usually, about 3–5 minutes is enough time to complete the social stage. The purposes of this stage are to
      1. Begin the counseling in a friendly, non-threatening way.
      2. Give the family a chance to adjust to space, place, and person.
      3. Show that everyone in the family will be considered important and attended to by the counselor.
      4. Collect information about each family member and about others who may be involved with the immediate family.
3. **Problem**—After the social exchange between you and family members, ask each member how he or she sees the problem.
   a. The sequence is the same as that in the social stage: begin with the parents and proceed from oldest to youngest child.
   b. Ways to ask about the problem:

      ''What is your major concern in your family right now?''
      ''How can I be of help to you?''
      ''How do you see the family situation now?''

c. Hear each person's view of the problem. If you like, summarize to the speaker your understanding of what he or she said. Make no attempt at this point to help the speaker see the problem differently or to offer solutions.

d. Ask questions of a person to clarify an unclear statement of the problem; however, don't urge the person to reveal information or feelings that he or she may not want to disclose this early.

e. Gentle control of the session is important; do not allow extensive discussion between the members until everyone has been given a chance to express the presenting problem.

f. The Problem stage clarifies the family's motivation for counseling, establishes the therapeutic contract, and gives permission to explore certain areas of the family's functioning.

4. **Exploration**—This is the stage to explore the presenting problem in more detail (who, what, where, when) and to observe how the family functions. The Exploration stage is the main part of the first interview, taking most of the time.

   a. Ask any question that will clarify the family situation for you. It's best, however, to avoid certain topics or questions if the members have too much difficulty with them. Save such topics for later, when you have developed more of a relationship with the family.

   b. At some point in this stage, you want a shift from the members *describing* the problem (in Stage 3) to *interacting* with each other around the problem. This usually occurs spontaneously, since they often have different, and often conflicting, ideas about the problem. If the interaction between the members doesn't occur spontaneously, encourage two or more members to talk together concerning some aspect of the problem.

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   c. If appropriate, ask non-participating members to join the conversation between two other members (''Where are you in this conversation?''). This will reveal everyone's involvement in the topic and give information about each person's relationship to the others (who sides with whom, who is most active and inactive, who has the apparent power, etc.).

   d. The Exploration stage gives valuable information about family patterns. It also prepares the family members for future sessions when you will sometimes become less active to allow them, with your support, to do their work directly with each other.

5. **Closing**—The counselor wraps up the session.

   a. Create motivation for the family members to return, pointing out their strengths and their current efforts to improve the family. Present the hope that in these meetings, they will find relief from their problem.

   b. Set the appointment for the next interview.

6. **Talk with colleagues**—As written elsewhere in this book, I believe it's important to discuss our cases with colleagues and supervisors (see Colleague Consultation in Chapter 2). Simply telling another person about your session or your case will often trigger an idea about a direction to go with the family. It's not necessary to discuss every session with colleagues to get this benefit.

Initial Interview Summary

Date: _____

Counselor: _____

Living in the Home: (names and relationships; ages of children)

Follow this sequence (ReSPECT):

1. **Recruitment:** Ask for everyone living in the home to attend the first session.
2. **Social:** Gather social information from each person (work, school, hobbies, etc.). Also, get information about the broader family system and who else might be involved. (Family Data below).
3. **Problem:** Ask each person to define the problem the way he or she sees it.
4. **Exploration:** Learn more about the problem, and allow family members to talk to each other on a relevant topic. Listen and observe all members, and support their efforts.
5. **Closing:**
   a. Support strengths and positives in the family; give them hope.
   b. If appropriate, explain your treatment program and policies.
   c. Set an appointment for the next session.
6. **Talk to colleagues:** Discuss your case with a supervisor and/or colleague.

Family Data: List others with whom the family has contact, including parents, grandparents, in-laws, aunts, uncles, friends of the family, and other helping professionals.

Tips for the First Family Interview

The first interview with a family is usually not the most interesting session, but it's one of the most important. For one thing, it can determine if there will be a second session. It also sets the stage for later interviews by showing the family what to expect and what is expected.

First Session

1. The purpose of the first session is to understand, not change, the family.
2. Avoid getting wrapped up in paper.
3. Have a plan or sequence of steps to ensure that everything gets covered. The **ReSPECT** sequence (previous page) does that.
4. Be a good listener. Just ask questions and ''soak in'' what they tell you without challenging their perceptions or trying to change their minds.
5. Check out everyone's viewpoints, and don't let the talkative member take all the time. All members need to feel their input is valued.
6. However, give more attention to the parent(s). They are the architects of the family.
7. If a non-parent member (child, adult child, or grandparent, for example) is obviously influential and has the ability to bring the family back, you must join carefully with him or her.
8. Notice who is apparently aligned with whom around the problem situation. Against whom?
9. Ask, ''Who else knows about the problem?'' This gives information about who is involved.
10. Gently maintain control of the session so you can gather your information while letting the family members feel a guiding hand.

Bodyspeak

As counselors, we know that the client's body language and meta-communication (*how* something is said) is as important, if not more so, than what they say. Usually, I find it's best to just take this in as information. If we point out a client's body language immediately, it can make him or her uneasy and suspicious. Besides, sometimes a twitch is just a twitch.

Here are a few nonverbal communications to look for in the first, and later, sessions:

1. Who is missing?
2. In a two-parent household, do the parents look at each other when one is talking? If they don't, it may (or may not) mean parental splits and conflicts.
3. Communication is often expressed by our bodies before the words are shaped by our mouths. If someone moves noticeably, they often want to speak.
4. Who shifts in their chair? Around what topics?
5. Who moves their chair slightly and in what direction?
6. Facial expressions are telling: smiles, frowns, confused looks, grimaces, squints. A subtle eye roll by the wife while the husband is talking could speak volumes.
7. Do the children look scared and speak only when spoken to? If so, it could mean unhealthy secrecy in the family.

Four Basic Tools for Family Counseling

1. **Enactment:** An in-the-room transaction between two or more family members around one of their real-life issues. The counselor sets up the conversation (or allows it to happen).
   Purposes and examples:
   a. To establish parental authority and parenting teamwork. Example: ‘‘To be clear with your son, decide together now what the two of you will do if he comes home late again. I will listen while you talk together.’’
   b. To help the child negotiate with parents. Example: ‘‘Find out from your parents what it will take for them to get off your back.’’
   c. To include a silent, detached member. Example: ‘‘Your husband hasn’t expressed an opinion about that. Would you find out from him what he thinks?’’

   During enactments, several things are happening simultaneously:
   a. The counselor, as observer, is receiving information about relationships, communication styles, strengths, weaknesses, and problem-solving ability.
   b. Family members are practicing more direct communication with each other and learning firsthand about how each other thinks and feels.
   c. The counselor, from a non-central position, is communicating to the family members that they must work together to change their relationships. The counselor cannot do it for them.

   Comments:
   a. Be directive in creating enactments. Tell them (politely) what you want them to do.
   b. Keep enactments relevant (a topic they consider important).
   c. If necessary, physically shift yourself in the room to keep the participants from talking directly to you.
   d. During enactments, monitor the interaction, support, clarify, challenge, and help them stay on the topic.
2. **Segmenting:** Working with a portion of the family at a time.
   Purposes and examples:
   a. To draw boundaries around subsystems. Example: Get the parents’ permission for the children to leave the room while the parents work out agreements together about the children’s activities or so the parents can discuss spouse issues.
   b. To remove distractions. Example: Young children may be placed in the care of a colleague and removed from the room (with parents’ permission) if they are distracting the parents from important issues.
   c. To discover a ‘‘family secret’’ or pattern of communication that is blocking progress. Examples: Spouses may speak more freely when seen individually; children interviewed without parents may give information they would not reveal in front of parents.

   Comments:
   a. Get both parents’ permission before doing anything with their children.
   b. Give a reason for the segmenting. To parents: ‘‘I would like to talk with you about how you make decisions together about your children. Can your children wait for us in the waiting room?’’
3. **Task:** Between-session homework for the family.
   Purposes and examples:
   a. To start a new process between members. Example: Father and daughter plan to do something together without mother (go to a movie, etc.).

b. To clarify boundaries around subsystems. Example: Mother and father ''have a date,'' leaving the children at home.
c. To reestablish role modeling of parents. Example: Father teaches the son about cooking by fixing a meal with him for the family.

Comments:

a. Tailor the task to each family: members' activity preferences, their schedules, etc.
b. Keep it simple and easy, to encourage a success.
c. Make a specific plan with the family for the task (who, what, where, when).
d. Assign everyone a role in the task, to make it a family commitment.
e. Inquire about the task at the beginning of the next session. If the task wasn't completed (or only partially), discuss it thoroughly. This lets family members know that the tasks are important. Talking about an uncompleted task also gives information about how the family functions.

4. **Unbalancing:** Interrupting habitual interactions in a family by creating alternative interactions in the room.

Purposes and examples:

a. To test the flexibility of the family. Example: Encourage the parent who talks least about the children to talk more about them.
b. To interrupt enmeshment. Example: Ask a father who is overinvolved with his son to sit aside (with the counselor) and listen to his wife and son discuss a particular topic.
c. To interrupt a severe power imbalance. Example: The husband is overtalkative and domineering, the wife is silent and submissive. The counselor gently and temporarily sides with the silent wife. Alternatively, the counselor can join with the husband, gently pushing him to change his wife's behavior by changing the way he acts toward her.

Comments:

a. When making an unbalancing move, be sure to note everybody's reaction, not just the members who are directly involved.
b. If it is too difficult for the family, back off. Two tries are enough, unless you have a strategic reason to continue.

General Guidelines

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The physical setting for counseling is important.

a. The way family members arrange themselves in the room will influence their interaction together. (It's difficult to get a detached father or sullen teenager to be involved in the session if he or she is hiding in an overstuffed chair in the corner.)
b. If possible, the chairs should be of the same height, moveable, and placed in a circle.
c. The room should be large enough to allow the counselor to get up and move around, or to get out of family members' way when they are productively engaged with each other.
d. If your office is not suitable, find another space for family work: the group room, conference room, reception area after hours, etc.

Work with the relevant family system.

a. Everyone in the home should attend the first session: ''*The way we work* is to meet with everyone in the home to get a clear idea of how we can help.''
b. During the first interview, inquire about extended family (siblings, grandparents, aunts, uncles, etc.) and significant others (friends, professionals, etc.). A good question for this is, ''Who else knows about the problem?'' Obtain enough family information to allow you to view the family's problem in a larger social context. You may also want to include some of these people in a later interview.

Include the family as early as possible.

a. If the problem is initially presented for individual counseling and you believe that family or marital treatment is more appropriate, no more than 2–3 individual sessions should be held before getting the family/spouse in. If you have a long-standing counseling relationship with the individual member, the family may resist attending because they assume that you are biased toward the individual member's viewpoint. They could be right.
b. If you have more than three sessions with the individual member, refer the family—including the identified patient—to a colleague for conjoint family counseling. You may or may not choose to continue the individual sessions with the identified patient.

Get the family in.

a. It's best to start counseling with the family rather than with an individual. If the identified patient comes alone, get his or her permission (release form) for you to contact family members by phone to invite them to the second session.
b. During the initial phone contact, try to avoid letting the caller determine who comes to the first session. You want to see everyone living in the home. Exception: If the presenting problem is in the spouse relationship and the parents insist on leaving the children out, comply with their wishes. However, the children should be present in a later interview to give a broader view of the relationship patterns in the family.
c. During or immediately after a crisis is the best time to get family members into treatment. They are the most receptive for help at this time and the most susceptible to change.

Recruit missing members.

a. Always discuss a member's absence at the beginning of the interview (empty chair in circle): ''I thought Janet was coming today. What happened?''

b. You may want to try to let the family get the missing member in (‘‘Who can get Janet to join us?’’). If this doesn’t work, get permission for you to contact the missing member by phone to invite him or her to the next session.

c. When phoning the missing member, emphasize the importance of that person to the counseling (‘‘Your family needs your help.’’). Also, let them know that you are striving to be impartial, which is made very difficult when you have only one side of the story (‘‘All I know about you is what I hear from your wife, husband, children, etc.’’).

d. It may be necessary to offer the missing member an individual interview to get his or her private opinions of the situation. One or two of these interviews may be required to get the resistant member to the family sessions.

Keep the presenting problem in focus.

a. Stay with the problem presented for treatment. Switching problems (for example, from a child’s school problem to parental conflict) can quickly lead to confusion, denial, anger, and leaving counseling. You can usually find a way to work with the relationships in the family by staying with the problem presented for treatment.

b. Later, when the presenting problem improves, you can ask about focusing on a different problem.

Join with the family.

a. ***Joining*** is the activity of making a connection between the counselor and family members; establishing rapport and trust; seeing their reality, individually and collectively. It is the same counselor-client process that must occur in any form of counseling. However, its importance in family work is even greater because of the need to gain everyone’s cooperation in spite of multiple and often conflicting viewpoints within the family.

b. Joining includes
   - listening well
   - pointing out positives
   - matching their mood (at least initially)
   - using their words and metaphors
   - accommodating (in a variety of ways)
   - communicating understanding
   - expressing genuine concern
   - gently challenging
   - giving hope

c. The most hostile or uncooperative member must be joined with carefully, especially if that member is one who has the power to stop the family counseling.

Get the family members to talk to each other.

a. Families tend to talk directly to you rather than to each other, keeping you in the center of conversations. This centrality of the counselor is appropriate most of the time, but there also needs to be some interaction *between* members around their important issues. It may take some kind of directive and physical shift by the counselor for this to happen: ‘‘Decide together now about _____. I’ll get out of your way while you talk.’’

b. While they are talking to each other, you can—from a more detached position—monitor the interaction and
   - observe relationship patterns, strengths, flexibility, etc.
   - help them stay on the subject

- support their efforts
- clarify
- question and challenge
- bring others into the conversation (if appropriate)
- protect the conversation from intrusion by others (if appropriate)
- move toward problem solving and resolution

c. Don't answer a question that could or should be answered by someone else in the session (Member to counselor: ''Why do you think he does that?'' Counselor: ''That's a good question. Ask him.'').

d. Be cautious about encouraging ''emotionally divorced'' parents to talk to each other about sensitive issues. This may be difficult for them at first, and pushing for it too early could create resistance to the counseling.

Search for strengths.

a. All families who come for counseling have strengths and positive attributes—they do many things right. Families without competence would not have survived as a family unit and certainly would not have enough cohesion to be in counseling together.

b. To focus entirely on problems and weaknesses in a family is a therapeutic error. Families are likely to change, not because they believe something they are doing is wrong, but because they feel supported in their efforts to change.

c. Set up ***Enactments*** between members, then find and report out positives and strengths in their interaction (''You have differences on that issue, but it's obvious you have the ability to stay with something important even when it's uncomfortable.'').

d. Use ***Positive Reframing.*** This is a technique based on the assumption that for every negative behavior, thought, or statement, there is a positive intention or characteristic of the person being expressed. For example, an argument could be reframed as strong desire to communicate with each other. An angry ''He's never at home!'' could be reframed by the counselor as, ''I can see that having more time with him is important to you.''

e. It's better not to be long-winded with positive reframing and praise. Be brief and sincere.

If the Presenting Problem Is a Child or Young Person

General Approach

a. In a two-parent family, some behavior problems in young people are the family's way of denying or diffusing conflict between two other members, often the parents. The guiding direction for you is to push, with benevolent and patient skill, to get the parents to *work together* to take charge of the young person's problem behavior. In this way, you are working on the parents' relationship while focusing on the problem of the young person. If this focus is maintained, it will often bring the parental conflicts and disagreements to the surface so they can be resolved. If the parenting relationship improves, the child may be free to give up his or her symptoms. (The variations on this approach for single-parent, blended, and separated/divorced families are discussed under **''Therapeutic Themes by Family Type''** on p. 60.

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b. When the parenting adults begin to work together to set limits on the young person, expect the child to temporarily get worse (''testing the limits''). *Be sure to warn the parents that this will happen.* Explain that this is normal; their child's behavior will become worse before it gets better: ''This is your child's way of testing you to see if you are serious about the change.''

Join thoroughly with the parents.

a. In this approach, it is essential that the parents feel supported by the counselor in their struggle to change the problem behavior of their son or daughter. The counselor must join well with the parents; if their cooperation is lost, helping the family or the child becomes unlikely.

b. Do not join the young person against the parents, even if you believe the child is right. The question is not who is ''right'' but what helps.

If the identified patient is a teenager:

a. Keep the parents in a responsible parenting role with their adolescent. They, not the counselor, are the experts on their teenager. If you accept the responsibility for changing the adolescent, parents tend to remove themselves and turn over the treatment to professionals (''fix my kid''). Reframe the problem behavior of the child in a way that enlists the parents' involvement **(*Strategic Child Assessment*; *Problem Reframing*).**

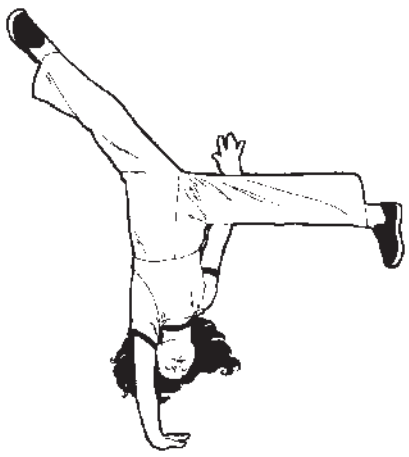
b. Repetitiously support the teenager as becoming an adult who is learning, with the parent's help, to be more self-directing and responsible.

- If the identified patient is an adolescent substance abuser with a driver's license, ask, ''Do you allow your son/daughter to drive an automobile?'' If the answer is yes, discuss it at some length. This is the number one cause of death among teenagers; do not let the parents dismiss it as an unimportant detail.
- The parents must stop the driving until everyone, including the counselor, is sure that the young person is not driving while impaired.

Do not allow a child or adolescent to be openly disrespectful to parents during a session.

a. Give your support to the parents to get them to stop tolerating the child's disrespectful behavior (open defiance, name-calling).

b. If that doesn't work, announce to the parents the rule that ''During family sessions, I do not allow young people to do that. What you do in your own home is your business, but here that kind of behavior is not acceptable.''
c. If that doesn't work, ask the parents to have the young person leave the room and wait in the reception area. Whenever a young person is asked to leave the room, especially if he or she is agitated or upset, an available colleague should check on the young person or, better, invite him or her to talk with the colleague in private (to get his or her side of the story, find out what happens at home, etc.).
d. Notice that in the above interventions, the counselor always goes through the parents to deal with the young person's behavior. This is consistent with the direction of keeping the parents in charge of their children.



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Parents are not to blame.

a. Parenting is an impossibly difficult job, and for parents to entirely escape feelings of guilt is rare.
b. I assume that parents feel some guilt, whether they admit it or not. Guilt is often the driving emotion behind the behavior of many parents.
c. Address the parental guilt by statements such as
   - ''You are not responsible *for* your son's behavior, but you are responsible *to* your son.''
   - ''You're not the problem, but hopefully you will be part of the solution.''
   - ''We want to help you use a different way to help your son.''

If the Presenting Problem Is a Marital or Couples Issue

Define the problem.

a. In defining the problem, allow each person to be somewhat general in the beginning, to protect them from having to reveal information or feelings they are not ready to talk about. The problem should, however, be specific enough to allow the counseling to proceed. For example, ''We have problems communicating'' is too general. Counselor: ''How will you know when you are communicating well together?''

b. Encourage the couple to stay on current issues rather than have extended and detailed arguments about past events.

Keep the broader system in mind.

a. In a couples conflict, there are sometimes others (in-laws, extended family, friends, etc.) who are, in some way, playing a part in the struggle. Find out who else is involved. If appropriate, and with the couple's permission, you may want to include one or more of the others in a later session.

b. Examples of questions:
   1. ''Who else knows about this problem?''
   2. ''When you want to talk to someone besides each other about this, who do you go to?''
   3. ''Do you believe this problem has an effect on anyone else? If so, who?''

Meet their children.

a. If the couple has children, get the parents' permission to include them in at least one session. Make it clear that you will respect the parents' wishes for the children not to be included in certain conversations; the parents will control what their children hear.

b. Including the children in one or more sessions has advantages. It allows the counselor to
   1. Reveal the effects of the problem on the children
   2. Motivate the couple to solve their relationship problems for the benefit of the children
   3. Get the children's input and opinions
   4. Show the children that the family's problems are being worked on

"Take sides" carefully.

a. You need to strive for a position of impartial involvement with the couple.

b. If you take sides with one, have a therapeutic purpose for doing so, and make the temporary coalition explicit: ''On that point I will have to agree with your _____ (wife, husband, partner, etc.).''

c. If you temporarily take sides, find something in the opposing viewpoint to join with, if not immediately, then later in the same session.

Ask about sex.

a. The couple's sexual relationship should be discussed, even if they have not included it in the presenting problem. It's best to wait until some rapport and trust have been established (3+ sessions) before introducing the topic.

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b. Suggested opening: ‘‘One important part of an adult relationship is how you function together sexually. Even though you did not present this as a problem, it is too important not to mention. How is your sex life together? Do either of you have any concerns you want to talk about?’’

c. If one or both partners admit to a sexual dissatisfaction, determine if the problem can be resolved within the context of the couples counseling or if specific sex therapy is needed. Examples of questions:
   1. ‘‘Has the problem you brought to counseling affected your sex life?’’
   2. ‘‘Have either of you noticed any change in your desire to have sex together?’’
   3. ‘‘Do you talk together about your sexual relationship?’’
   4. ‘‘How often do you have sexual relations? Is this frequency satisfactory to you both?’’
   5. ‘‘Who usually initiates sexual activity?’’

d. If either partner shows reluctance to continue on this topic, suggest separate interviews to obtain more information. This would be accomplished with the help of an opposite-sex colleague: A male counselor interviews the man, a female interviews the woman. Assure the couple that nothing will be revealed to the other partner without explicit permission.

e. During the separate interviews, determine if referral to a qualified sex therapist is needed and desired. If the couple is referred, you may want to continue the couples counseling concurrent with the sex therapy or resume couples counseling after the sex therapy is completed.

General Clinical Suggestions

Use repetition.

a. Important therapeutic messages need to be repeated. Repetition of a therapeutic theme (for example, overinvolvement of one or both parents with their children) is necessary when they are too caught up in a process to see what's happening.

b. Repetition can be done with different words and in different contexts. It can become the ''melody'' of a song that is recognizable even though played with different keys, instruments, and arrangements.

c. Example: Parent-child interactions in the sessions can occur in ways that discourage the child's autonomous behavior, like when a parent speaks for a silent child, when a child always seems to get his or her way with the parents, when a parent consistently sits closer to a child than to his or her spouse, or when parents repeatedly and ineffectively lecture their child during the session. All these transactions may indicate some form of parent-child overinvolvement. The counselor can intervene in each of these seemingly different incidents and still be addressing only one theme: parent-child enmeshment. Usually, it is not necessary to make this theme explicit (''You're overinvolved with your children.''). Your repetitive process with the family speaks the message.

Good questions to ask:

a. ''What have you tried to solve the problem? How did that work?''

b. ''What is likely to happen if the problem isn't solved?''

c. ''What makes the problem work?''

d. ''What will you do the next time he/she does that?''

e. Instead of the question, ''How do you *feel* about . . . ?'' try ''What do you *do* when . . . ?'' This maintains an action focus and gives information about how the members react to each other—the actual behaviors that maintain the problems.

Segmenting the family: Working with a portion at a time.

a. Segmenting helps to draw boundaries around subsystems in a family (parental, spouse, or sibling subsystems). Examples:

   1. Asking the parents' permission to have the children leave the room while the parents work on appropriate rules for the children to follow. After decisions are made, the children return to the room and the parents (together) inform them of their decisions.
   2. Asking only the parents to attend a particular session, leaving the children out.
   3. Arranging individual interviews with conflicted spouses. This may enhance the joining process and reveal important information.

b. If you are taken aside by one member before or after a session or are called on the phone between sessions, keep the conversation brief and

   1. Encourage the member to deal with his or her concerns during the next family session or
   2. Get the member's permission for you to bring up his or her concerns during the next session: ''Is there anything you told me today that you do not want discussed with your family the next time we meet?''

Don't try to "win" an argument you can afford to lose.

a. Avoid having an argument with a member unless there is a strategic purpose for doing it. Your strong disagreements show the family member(s) that either you do not understand their situation or you are a stubborn person, or both.

b. If you believe it is necessary to express an opposing belief, gently do so, but later find something to join with the member(s) about. This protects the counseling from a ‘‘I’m right, you’re wrong’’ power struggle.
c. Join more thoroughly with the most resistant member, especially if that person is a parent or spouse who has been pressured into coming for counseling.

If the counseling gets stuck:

a. Redefine the problem. If the counseling has no definite direction, it could be because everyone has forgotten where it’s supposed to be going.
b. If two or more members reach a block in their communication, become more central yourself, drawing the attention to you and away from each other.
c. Get up and move around or leave the room for 3–4 minutes. Sometimes a fresh perspective helps.
d. An effective way to change interactions between people is to add or subtract. For the next session, you can add family members (or relevant others) or can reduce the number attending. A different mixture of people will usually change what happens in the session.

Use the team approach.

a. Even though I believe that co-therapy (two counselors in the room in each family session) is usually unnecessary, it is important for counselors to work together. I do not recommend doing family counseling without colleague support.
b. Ideally, this is accomplished by a colleague(s) observing the session through a one-way mirror and processing with the counselor afterwards.
c. If observation of live interviews is not possible, try ***Colleague Teamwork*:**
    1. Video- or audiotape the sessions (with the family’s permission) for later review by the counselor, colleagues, or supervisor.
    2. Invite a colleague to sit in for one session. The reason for this, of course, would be explained to the family (‘‘We frequently work as a team in improving our help to families.’’). This would be necessary only when the counselor wants a second opinion.

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Discuss mistakes.

a. Our therapeutic mistakes can be viewed as the family’s way of teaching us something about them.
b. While working with something as complex as a family, counselors will usually make mistakes. The real mistake, however, is not that a mistake is made but that nothing is learned from it.
c. The vast majority of therapeutic errors are correctable. The one that may not be correctable is when the family leaves treatment prematurely. In all such cases, ask yourself, ‘‘Could I have done something to prevent that?’’ A discussion with colleagues can facilitate this learning.
d. Frequently, therapeutic mistakes are not recognized as such by the counselor. What he or she did made perfectly good sense to that person. This is where our colleagues can help, when we are willing to listen.

Termination

a. In many cases, it is appropriate to terminate the counseling by lengthening the interval between sessions: ‘‘Together you are doing some nice work on this problem. I don’t believe

it's necessary to meet next week, so let's make our next appointment two (three) weeks from now.''

b. When family members return in two or three weeks, and if they're still doing well, give them your phone number at the end of the session and ask them to call if they need to return.

c. If the family members decide to terminate and you believe it's too early, try to keep them in counseling. If they are reluctant, it's best to point out the positive changes they have made and let them go. Reason: If you make it reasonably easy for them to leave, they are more likely to return if necessary.

d. After successful (or unsuccessful) termination, the family will usually appreciate the counselor calling after 3–4 weeks to see how things are going. This also gives you information and feedback and accelerates your learning.

Session-by-Session Guidelines

The First Interview

1. Understanding the family, not changing it, is the purpose. Having a *second* interview is the goal.
2. Follow the **ReSPECT** sequence or some other guide to an orderly first session.
3. Define the family system. Who else may be part of the problem (or solution)?
4. Ask about missing members (who live in the home but are not present). What do they think?
5. Keep parents or caretakers in the central role by getting their permission before doing or saying anything significant with their child or children.
6. Report out strengths and successes as a family. If children act well, compliment the parents.
7. Be ready to stop a line of questioning or a topic if it's a struggle for them. Accommodation to their moods, views, attitudes, and behaviors is greatest in the first session.
8. Contract for 3 sessions (2 more). ''At that time, we will decide about continuing.''
9. Build a bridge to the next session: ''Next time, I want to find out more about . . . ''

The Second Interview

1. Make a brief social contact with each person before starting.
2. If they don't start, you can begin with an open-ended question. Examples: ''What's important to you today? How did it go last week? Who wants to start today?''
3. If a member who was not at the first session attends, do a brief social talk with that member (asking about job, school, etc.) and find out his or her view of the problem.
4. Milder basic tools and techniques are appropriate in this session: ***Enactments***, ***Segmenting***, ***Sculpting***, ***New Talk***, ***Circular Questions***, and others. (After this second session, all techniques in this book are appropriate.)
5. During this session, begin pursuing a direction based on your understanding of the family structure and functioning. Is one parent closer and more protective with the teenager than the other parent? Does this cause conflict between the parents? If you suspect a particular family pattern, check it out without trying to change it. But be ready to let go if your inquiries are too difficult for them.
6. In general, give parents (or other adults) more talking time than children, even if the parents are not talkative and the children are. Parents need to have more authority and responsibility than their children.
7. Allow family members to talk to each other. If necessary, use ***Enactments***.

The Third Interview and Beyond

1. Often, the third session is different: A small crisis has happened, members show more emotion, a quiet member gets more expressive, a hidden conflict pops to the surface, or some other shift occurs. Family sessions are more familiar, the members feel safer, and they let their guard down.
2. The process from the third session and beyond is circular: Learn about the family; develop hunches about what part of the family functioning may be contributing to the presenting problem; check out your hunches with exploration and techniques; gradually focus more and more on the hunches that are confirmed; develop new hunches, etc. While doing all this, never stray too far from the family's expressed concerns (the presenting problems). Most families come to counseling to solve a problem, not for random exploration or to achieve self-actualization as a family.

Session Checklist for Family Counseling

After a session, you can use this checklist to monitor yourself. You can also use it while observing a colleague's session (live or videotaped) and refer to it in your post-interview discussions together. If you use this form for several interviews, you will have a good idea of your strengths and the areas you need to work on.

- ☐ Made a brief introductory statement about the purpose of the interview (first session).
- ☐ Helped the family members define their needs and concerns.
- ☐ Defined the relevant family system.
- ☐ Collected detailed information about the nature and history of the identified problem.
- ☐ Interrupted chaotic interchanges.
- ☐ Shifted approach when one way of gathering information was not working.
- ☐ Used short, clear communications.
- ☐ Stayed relevant to their concerns.
- ☐ Structured or directed interaction between family members.
- ☐ Engendered hope.
- ☐ Used appropriate self-disclosure.
- ☐ Demonstrated warmth and empathy.
- ☐ Conveyed sensitivity to their feelings.
- ☐ Spoke at a comfortable pace.
- ☐ Concentrated more on the interaction of the family than on individual dynamics.
- ☐ Used ***Positive Reframing*****,** and reported out strengths.
- ☐ Rearranged (when appropriate) the physical seating of family members.
- ☐ Helped the family establish appropriate boundaries.
- ☐ Encouraged the family to find its own solutions.
- ☐ Explored current feelings and reactions to each other in the room.
- ☐ Focused more on process (how) than content (what).
- ☐ Used own affect to elicit affect in family members.