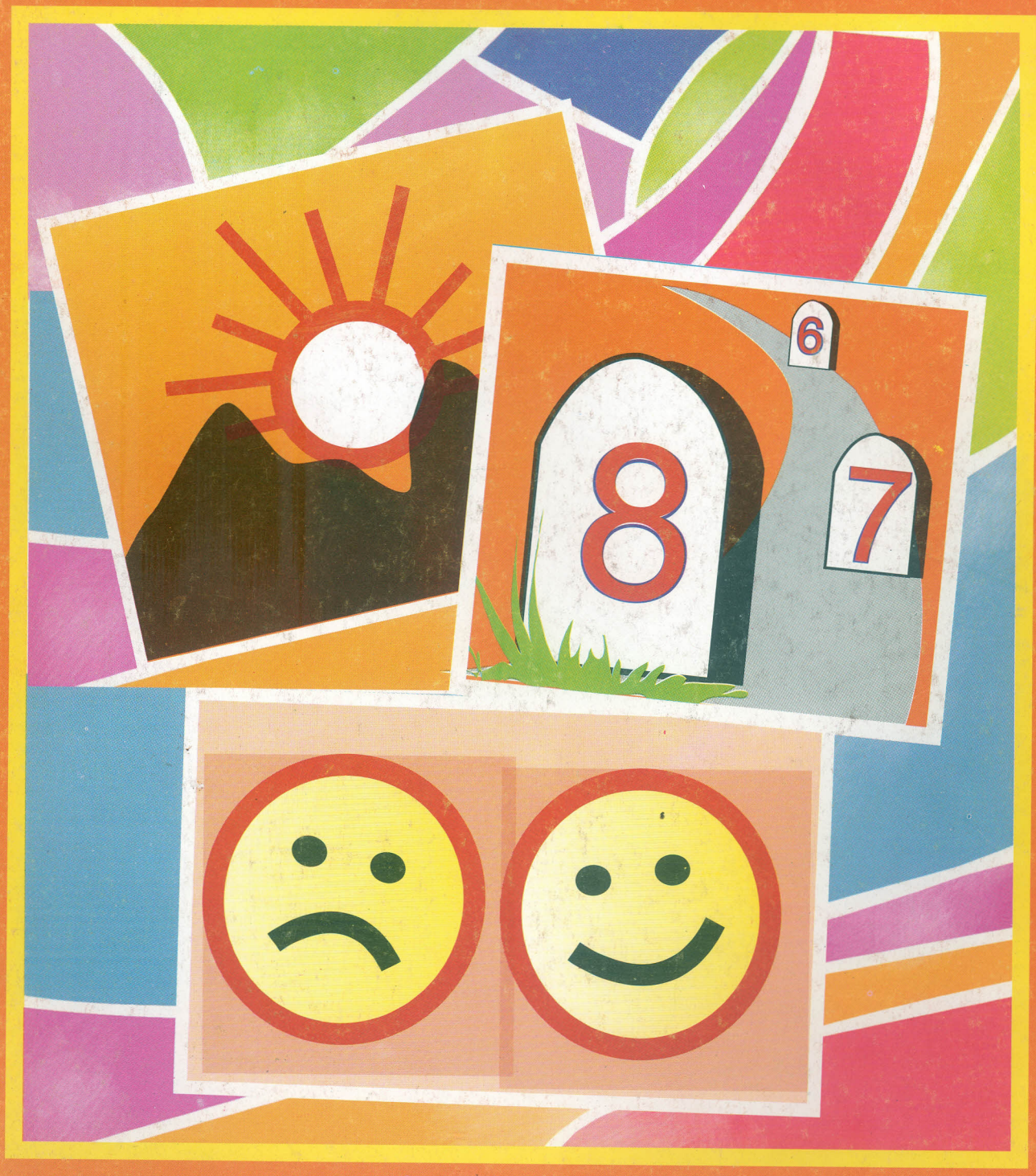
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# MCFT-003
## Counselling and Family Therapy: Basic Concepts and Theoretical Perspectives




## SCHOOLS OF FAMILY THERAPY 3

"Education is a liberating force, and in our age it is also a democratizing force, cutting across the barriers of caste and class, smoothing out inequalites imposed by birth and other circumstances."

— Indira Gandhi

"शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्तगत विषमताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।"

- इन्दिरा गांधी

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# MCFT-003
# Counselling and Family Therapy: Basic Concepts and Theoretical Perspectives

Block

# 3

## SCHOOLS OF FAMILY THERAPY

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# BLOCK 3 SCHOOLS OF FAMILY THERAPY

## Introduction

Block 3 "Schools of Family Therapy" will acquaint you with the various approaches to family therapy. The Block consists of five Units.

*Unit 9* is on *"Structural Family Therapy"*. The Unit deals with the primary assumptions of structural family therapy. It also describes the key concepts of structural family therapy like family structure, subsystems, power and alignments. Indications and contraindications for structural family therapy is explained in this Unit. The main goals of structural family therapy are also discussed. Techniques that are used in structural family therapy are discussed in detail, which include joining techniques, family mapping and structural diagnosis, and restructuring techniques. The efficacy and effectiveness of structural family therapy is discussed at the end of this Unit.

*Unit 10* is on *"Solution Focused and Strategic Family Therapy"*. Basically, this Unit is divided into two parts, The first part deals with the solution focused family therapy and the other part is concerned about strategic family therapy. In the first part of this Unit, we will study the historical perspectives of solution focused family therapy and its objectives and basic assumptions. Further, the principles of solution focused family therapy are discussed. The significant aspects of solution focused family therapy are the questions put to the client asked to silent during sessions. These questions may be goal-defining, problem-defining, exception questions, existing resources questions, miracle questions, scaling questions, advantage questions or coping questions. We will discuss the importance of these questions in this Unit. Various techniques are used in solution focused family therapy; we will study there in detail. Further, we will learn the process of solution focused family therapy including the role of family therapist in this therapy. The second part of the Unit deals with the strategic family therapy. The strategic family therapy are defined in this part along with its assumptions and main goals. The theoretical models in strategic family therapy are also discussed. Further, you will learn about the techniques used in strategic family therapy. At the end of this Unit you will study various stages of strategic family therapy.

*Unit 11* entitled *"Systemic Family Therapy"*, will provide you an insight of systemic approach to family therapy. The Unit begins with the introduction of systemic family therapy which also includes the target group of systemic family therapy and it redefines the term 'family'. Historical development of systemic family therapy is also explained in detail in this Unit. Further, you will understand the basic features of systemic family therapy and learn the concepts that help to understand family communication process. The Unit also discusses the process of change in systemic family therapy. The practice of systemic family therapy may include several steps such as convening the family, mapping the family through the genogram and the cultural genogram and identifying areas for investigation. Aspects such as hypothesising, circularity, neutrality, interview techniques and intervention have also been discussed in detail in this Unit. We will learn about the therapist's role in systemic couple and family therapy. The Unit will help you to identify the success and failure of systemic family therapy.

At the end of this Unit, you will become aware of various factors and contexts that lead to success and failure of systemic family therapy.

*Unit 12* is entitled *"Cognitive Behavioural Family Therapy"*. The Unit begins with the introduction of cognitive behavioural family therapy which includes the assumptions and key concepts of this form of family therapy. Further, the Unit deals with the processes in cognitive behavioural therapy, that are, clinical assessment, cognitive interventions and behavioural interventions. Cognitive interventions include educating couple or family about the cognitive behavioural model, identification and modification of automatic thoughts, identification of distorted cognition and cognitive restructing techniques, where as behavioural interventions include communication skills training, problem solving skills training and behavioural change agreements. At the end of this Unit, you will learn about the efficacy and effectiveness of cognitive behavioural family therapy.

*Unit 13* is on *"Integrated Approach to Family Therapy"*. The Unit deals with the historical evolution of family therapy in India and historical evolution of the integrated model. The Unit also acquaints you with the knowledge and consideration of special sociocultural issues in family therapy and major constraint factors in family therapy.

# UNIT 9 STRUCTURAL FAMILY THERAPY

## Structure


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9.2 What is Structural Family Therapy?

9.2.1 Assumptions of Structural Family Therapy

9.2.2 Key Concepts in Structural Family Therapy

9.3 Processes in Structural Family Therapy

9.3.1 Indications and Contraindications for Structural Family Therapy

9.3.2 Goals of Structural Family Therapy

9.4 Techniques in Structural Family Therapy

9.4.1 Joining Techniques

9.4.2 Family Mapping and the Structural Diagnosis

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9.5 Efficacy and Effectiveness of Structural Family Therapy

9.6 Let Us Sum Up

9.7 Glossary

9..8 Answers to Check Your Progress Exercises

9.9 Unit End Questions

9.10 Further Readings and References


## 9.1 INTRODUCTION

Salvador Minuchin is the founder of structural family therapy (SFT), which has been serving as a leading model in family therapy since its inception. Drawing from the systemic model, structural family therapy emerged in the 1960s and 1970s as a new model. The general systems model developed by Karl Ludwig von Bertalanffy, a Viennese biologist, looked at the world in terms of relationships and integration between the parts of the system that constitute the whole. Boundaries regulate the flow of information and energy required by a living system. Open systems are in dynamic interaction with the environment and maintain an equilibrium. Families are seen as living systems of interconnected and interdependent individuals, none of whom can be understood in isolation. A change in one member of the family has an impact on the others, which in turn influences the individual member. The tendency of the family system to function in a predictable way, even if this is maladaptive, is known as *homeostasis*. In all families there is an ongoing dynamic tension between trying to maintain stability and introducing change.

These basic principles have contributed to the development of the structural family therapy approach, which continues to be one of the most widely used models for family therapy.

**Objectives**

After studying this Unit, you will be able to:

- Define the primary assumptions and concepts of structural family therapy;
- Explain the goals of structural family therapy;
- Illustrate the indications and contraindications for structural family therapy;
- Elaborate on the therapeutic processes and techniques of structural family therapy; and
- Summarise the research evidence on the effectiveness of structural family therapy.

## 9.2 WHAT IS STRUCTURAL FAMILY THERAPY?

Let us examine the basic assumptions and key concepts of structural family therapy (SFT).

### 9.2.1 Assumptions of Structural Family Therapy

- Structural family therapy focuses upon the person within the family system, rather than solely on the individual (Colapinto. 1982; Minuchin, 1974). The structural family therapy approach moved away from the focus on individual pathology in the traditional mental health model. It recognised that individual symptoms and dysfunction are best understood in the context of family interactional patterns.
- The underlying philosophy of the structural family therapy approach is that "man is not an isolate" (Minuchin, 1974). The concept of *interrelationships of the whole system* implied that the individual, while a separate being, is also a part of the whole family. Thus, the influence of each person's behaviour within the family cannot be separated from other family members' behaviours. In other words, any behaviour is contingent on someone else's behaviour (Colapinto, 1982). For example; a husband who complains that his wife never listens to him also has a set of behaviours that reinforces his wife' not listening.
- Structural family therapy focuses on the present rather than on the past. The rationale behind this idea is that past dysfunctions are manifest in current functioning; hence a change in current functioning could alter embedded dysfunctional behaviour (Minuchin, 1974).
- Structural family therapy attributes problems to dysfunctional family structures. The solutions and changes also arise from the changes of the family structure. For example, a family may have a pattern in which the father and daughter are extremely close and frequently side against the mother. In order to change this pattern, the father and mother must make changes in their interpersonal transactions in order to re-establish their roles as a parental subsystem. Minuchin and Nichols (1993) described the family as being naturally inclined to continue with familiar patterns of interacting even though developmental changes have made these patterns less functional. The therapist must undermine this homeostasis, introduce crisis and instability and move the system towards better functioning.

- Structural family therapy assumes that family dysfunction arises out of difficulties in adapting to the changing demands of various developmental stages. Minuchin and Fishman (1981) identifed four main developmental stages: The first stage is *couple formation* where the two individuals form a new system and establish new roles and rules. The stage of *families with young children* entails a rearrangement of family relationships and developing specific functions for each spouse. The third stage of *families with school-age or adolescent children* is characterised by a need for the family to relate to other systems. The last stage of *families with grown children* is when children leave the nest (house), the family re-negotiates its roles, members learn to relate to each other as adults and the parents become a couple again.
- Structural family therapy also recognises the strengths and inner resources of the family to participate in the change process with the therapist's assistance. This approach also assumes that families generally act with good intentions and therefore, allocation of blame is unnecessary (Powell & Dosser, 1992).
- Structural family therapy is an approach with an active therapist role where families are directed and challenged to realign structural relationships and learn more effective conflict resolution.

**Check Your Progress Exercise 1**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Choose the correct answer

i) In family therapy, the therapist must attend to all of the following except:

a. Each member of the family as an isolated individual.

b. Each member of the family in interaction with other family members.

c. Subgroups within the family in interaction with each other.

d. The family as a whole.

ii) Structural family therapy originated in the work of :

a. Bowen.

b. Satir.

c. Haley.

d. Minuchin.

iii) Structural family therapy is most concerned with :

a. Improving family members' insight.

b. Rigid boundaries.

c. Identifying and changing the underlying organisation of the family.

d. Permanent, long-term change.

iv) The role of the structural family therapist is:

a. Involved, active and directive.

b. As a neutral observer.

c. Focus on the symptomatic family member.

d. Identify dysfunctional cognitions.

## 9.2.2 Key Concepts in Structural Family Therapy

Structural family therapy utilises many concepts to organise and understand the family. Of particular importance are structure, subsystems, boundaries, enmeshment, disengagement, alignment and coalition. Each of these concepts will be explored in the following section.

1. **Family structure:** As defined by Minuchin (1974), "family structure is the invisible set of functional demands that organises the ways in which family members interact. A family is a system that operates through transactional patterns. Repeated transactions establish patterns of how, when, and with whom to relate, and these patterns underpin the system".

Colapinto (1988) found that the family structure is governed by two principles. Firstly, families have a hierarchical structure in which parents have greater authority than children. Functional families are believed to have a clear hierarchy with "consistent rules about who is in charge of what" (Nelson & Utesch, 1990).

Secondly, every family is unique and each of its members develops ways of interacting with each other that are distinctive. All families contend with stress but those with a clear and organised structure will recover quicker and function better in the long term than those families that have dysfunctional structures.

2. **Subsystems:** Subsystems are the smaller units of the family system, for example, the spousal subsystem, parental subsystem, sibling subsystem and extended family subsystem. It is important that each of these subsystems is differentiated from each other so that all members feel both belonging and separateness which promotes a healthy environment for living. Relationships between subsystems are governed by spoken and unspoken rules.

The spousal subsystem works best when the spouses negotiate their roles and accept their interdependency. One of their most important tasks is to develop a boundary around their subsystem. Children learn about intimate relationships from the transactions in this subsystem.

As the couple has children, the parental subsystem is formed. In some families, the parental subsystem may consist of extended family or single parents. Adults are responsible for meeting the child's needs but also have rights in this position of authority. As children grow, the parental subsystem must change and grow as well.

The sibling subsystem contains family members who are of the same generation and forms the child's first peer group. Here children learn how to get along, how to negotiate and how to deal with conflict. The parental subsystem should allow the sibling subsystem to function without too much interference.

**3. Boundaries:** Boundaries are the invisible barriers that govern the contact that subsystems have with other subsystems and are necessary for a healthy family structure (Minuchin & Fishman. 1981). A functional organisation within the family must have appropriate boundaries between subsystems that are, the parental, the siblings, the family unit as a whole, and the individual. For example, the boundary that separates the nuclear family from the extended family or the boundary between parents and children in the family. In order to function well, boundaries must be clear and not too rigid. For instance, the spousal subsystem should be clear in that children and other members of the family not interfere when a husband and wife are focused on marital relations. Importantly, boundaries must go through developmentally appropriate changes as the family progresses through the family life cycle. For example, a father may intervene when his young children are fighting but would expect them to work out their differences when they became adults.

*Clear boundaries* allow for family members to feel connected while maintaining their individuality and autonomy. They can freely exchange information and give and receive corrective feedback. Sometimes families have boundaries that are too rigid or too diffuse.

*Enmeshment*: Families with boundaries that are diffuse are described as *enmeshed.* This is a state in which the boundaries are too permeable and thus autonomy is reduced in order to maintain the greater sense of belonging to the family system (Minuchin. 1974). Dependence is encouraged and family members tend to stay close to home, expecting to have all of their needs met by the family (Gladding, 1998a). These members are hesitant to form close relationships outside of the family. This system lacks the necessary resources to change under stressful conditions and is sensitive to even minor events within the family.

*Disengagement*: Disengagement occurs when families have boundaries that are overly rigid (Minuchin, 1974). Inflexible boundaries serve to keep people separated from each other. Members have significant independence but little interdependence exists within the family system and there is little communication between the subsystems (Minuchin, 1974). As a result, family members have inadequate relatedness with each other and become disconnected from other family members. Often, individual problems may not be perceived until very severe. The figure (Fig 9.1) below represents the enmeshed and disengaged families.

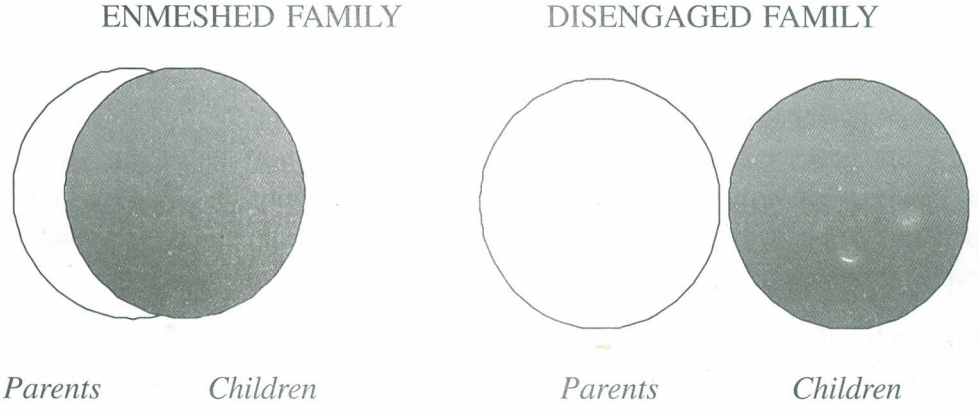



**Figure 9.1: Enmeshed and disengaged families**

**3. Power:** The concept of power refers to the level of influence that each family member has on the outcome of an activity. It is the ability to get something done.

The hierarchy of power in the family structure defines who makes the decisions in the family and also who controls the behaviours of family members. Power is generated by the way in which family members react. For example, a father's power may depend on the response from his wife and children, either reinforcing or negating his power.

The inversion of power hierarchies; for example 'father-as-homemaker and mother-as-breadwinner' in traditional cultures, children holding more power than the parents or mother and child functioning as the parental unit; can be extremely disabling.

4. **Alignment:** An alignment can include the joining of two people for a common interest (frequently called an *alliance*). Alliances within the family structure can be a healthy and positive influence on the system. For example, the father and children may share their love of sports and spend time together engaged in activities. However, alignments can also be pathological when they include the joining of two people actively excluding a third person.

5. **Coalition:** A coalition is an alignment between two people in a system which excludes a third person. There is a rigid boundary around the coalition. Minuchin's concept of *triangulation* describes arrangements of two family members pitted against a third. For example, where the parents disagree and they ask the child, "Is mother right or is father right?". Detouring and cross-generational coalitions are two types of triangulation described by Minuchin.

*Conflict-detouring:* There are two types of detouring triads. In the *detouring-attacking* the parents are unable to resolve problems between them and they identify the child as the problematic member of the family. They band together and focus negativity on the child. This serves to distract from the tension in the marital dyad and also reinforces maladaptive behaviour in the child. This type of triangulation also is sometimes referred to as *scapegoating* as the child's well-being is sacrificed in order that the marital conflict might be avoided (Minuchin 1974). In the *detouring-supportive* triad, the parents are able to mask their differences by providing enormous, overprotective concern towards a child who is defined as "sick".

*Cross-generational coalition* is defined as an "inappropriate family alliance that contains members of two different generations". For example, a cross-generational coalition could develop when one of the parents responds to the child's needs with excessive concern and devotion while the other parent withdraws and becomes less responsive. Husband and wife are unable to resolve their conflicts, so they continue to argue through the children. Both husband and wife are critical of each other's ways, but both perpetuate the other's behaviour with his or her own. For example, father says mother is too permissive; mother says he's too strict. He withdraws, she criticises; he withdraws further. An enmeshed relationship is perpetuated between mother and child, while father disengages, not responding even when a response is necessary.

Research indicates associations between cross-generational coalitions and the presence of psychosomatic illness (Minuchin, Rosman, and Baker 1978) and marital distress (Kerig 1995).

The table below depicts the symbols used to depict the structural relationships within the family system (see Table 9.1).

**Table 9.1: Symbols depicting structural relationships in the family system**

| Symbol | Description |
|---|---|
| ---------- | Open or clear boundary |
| ———— | Closed or rigid boundary |
| . . . . . | Diffuse boundary |
| ═══ | Clear alliance |
| ≡≡≡ | Over involved affiliation |
| ⊣ ⊢ | Conflicted affiliation |
| } | Coalition of several members against another member or group of members. For example, mother and two daughters against father and son. |
| | Mother, Daughter, Daughter } { Father, Son |
| ⇩ | Detouring conflict through a third family member. For example, father and mother detouring conflict between themselves by detouring conflict onto their child |
| | Father ═══ Mother ⇩ Child |

**Check Your Progress Exercise 2**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill in the blanks:

i) The way coalitions mask tensions by focusing on a third party as the problematic family member is called

ii) Families that have diffuse boundaries are called families.

iii) An inappropriate family alliance that contains members of two different generations is called a

iv) In disengaged families, the boundaries are found to be

v) The subsystem including the children in the family is called the subsystem.

vi) The symbol ≡ indicates an affiliation that is

## 9.3 PROCESSES IN STRUCTURAL FAMILY THERAPY

In this section, we will study the important indications and contraindications for structural family therapy. The primary therapeutic goals are outlined and followed by the description of therapeutic techniques and processes.

### 9.3.1 Indications and Contraindications for Structural Family Therapy

There are a number of factors that guide the selection of patients for structural family therapy. Most of the indications and contraindications are common across many forms of family intervention. The indications for structural family therapy include:

1. The clinical problem manifests in explicitly family terms, that is, family dysfunction. For example, a marital conflict dominates; or tension between parents and an adolescent child dislocates family life with everyone getting involved in the conflict. Here family therapy is the treatment of choice.
2. The family has experienced a major stressful or disruptive life event, which has led or is leading to dysfunction. These events are either predictable or accidental and include, for instance, accidental or suicidal death, diagnosis of a serious physical illness, or the unexpected departure of a child from the home. As such, the ensuing disequilibrium becomes associated with family dysfunction and/or the development of symptoms in one or more members.
3. Continuing demanding circumstances in a family are of such a magnitude as to lead to poor or inappropriate adjustment. The family's resources may be inadequate and external sources of support may be scanty or unavailable. Typical situations are chronic physical illness or a persistent or recurrent psychiatric illness.
4. An identified patient may have become symptomatic in the context of a poorly functioning family. Symptoms are an expression of that dysfunction. For example, depression in a mother, an eating problem in a daughter and alcohol use in a father may be judged to reflect underlying family difficulties.
5. A family member is diagnosed as having a psychiatric illness such as schizophrenia or depression. The complicating factors are the adverse effects in the family stemming from that diagnosis. For example, the son with schizophrenia taxes his parents in ways that exceed their problem-solving capacity; a recurrently depressed mother comes to rely solely on the support of her eldest daughter. In these circumstances, family members might begin to respond maladaptively towards the diagnosed relative, which paves the way for deterioration of his or her condition.

Following are the contraindications for structural family therapy :

1. Family members are unavailable because of geographical location or death.
2. There is no shared motivation for participation and change among family members.
3. The level of family disturbance is so severe or long-standing, or both, that a family approach seems futile. For example, a family that has fought bitterly

for years is unlikely to engage in the constructive purpose of exploring their patterns of functioning.

4. Family equilibrium is so precarious that the inevitable turbulence arising from family therapy is likely to lead to decompensation of one or more members.

5. The patient or family member is too incapacitated to withstand the demands of family therapy. For example, a person in the midst of a psychotic episode may be too affected by the illness to engage in family work.

### 9.3.2 Goals of Structural Family Therapy

The goals of structural family therapy cover a wide spectrum in order to bring about positive changes in the family's level of functioning. The primary objective is to help families change their structure and organizational makeup.

Friesen (1995) outlined five main goals of structural family therapy. These are as follows:

(1) Creating an effective hierarchical structure in the family,

(2) Helping parents to complement each other in their roles as parents in order to be an effective parental subsystem,

(3) Aiding the children to become a subsystem of peers,

(4) Increasing the frequency of interactions and nurturance, if the family is disengaged, and

(5) The differentiation of family members, if the family is enmeshed.

Since, the dysfunction in families reflects the organisational arrangement of the system, the structural family therapist also focuses on adjusting coalitions and alliances and promoting the acquisition and learning of new coping mechanisms, to alleviate maladaptive functioning. These changes are accomplished by making modifications to the current familial rules and developing healthier boundaries between each of the family's subsystems. The structural changes should result in the reduction of the initial "symptoms" that brought the family in for intervention.

**Check Your Progress Exercise 3**

***Note:*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Mark 'True' or 'False':

The following characteristics are considered as relative contraindications for structural family therapy;

i) History of psychiatric diagnosis in more than one family member. True/False

ii) Very severe and chronic family disturbance. True/False

iii) Lack of motivation for participation and change. True/False

iv) Prior exposure to other therapeutic modalities. True/False

v) Precarious family equilibrium and vulnerability for decompensation of individual family members. True/False

2. Describe the main goals of structural family therapy.

.....

.....

.....

.....

## 9.4 TECHNIQUES IN STRUCTURAL FAMILY THERAPY

Structural family therapists have developed and adapted a variety of therapeutic techniques. They can be classified into following categories:

1. Techniques that are primarily used in the formation of the therapeutic system,
2. Family mapping and making a structural diagnosis, and
3. Techniques that are directly aimed at provoking disequilibrium and change.

### 9.4.1 Joining Techniques

Joining is one of the main tenets of structural family therapy and a prerequisite to restructuring. The therapist must first form an empathetic collaborative relationship with the family to create a 'therapeutic system'. Part of the joining process requires the therapist to reflect back an understanding of the family's problems and highlight the strengths in the family Although the joining process is more evident during the initial phase of therapy, the maintenance of a working relationship with the family is important throughout the therapeutic process. Contrary to a rather common misunderstanding, joining is not just the process of being accepted by the family; it is being accepted as a therapist, with the authority to advocate changes.

*Accommodation* specifically refers to the adjustment process that each therapist undergoes when integrating herself or himself into the family structure. The therapist must be nonjudgemental and accommodate by adopting the family's organisation and communication style. However, the therapist must maintain some distance and not be enveloped by family rules.

There are three main phases of the joining process in family therapy; these are given below :

1. Maintenance,
2. Tracking, and
3. Mimesis.

1. **Maintenance:** The therapist lets himself be organised by the basic rules that regulate the transactional process in the specific family system. The therapist needs to analyse and accurately perceive the family structure or the characteristics of its individual members. For example, if a three-generation family has a rigid hierarchical structure, the therapist may find it advisable to approach the grandfather first and then to proceed downward. The therapist may stand a better chance to generate a therapeutic impact by respecting the rules of the family system. However, the therapist needs to use this technique

to point out the strengths and potential of family members while also retaining the power to challenge the system.

2. **Tracking:** While maintenance concentrates on process of interactions in the sessions, tracking consists of an accommodation of the therapist to the content of speech. In tracking, the therapist closely follows the subjects offered by family members. In tracking the content of the therapy session, the therapist clarifies and amplifies the verbal messages of the individual members to show approval and reinforce positive communication patterns in the family structure. A structural family therapist may use such statements as "um-hum" to show interest and promote the continuation of the interaction (Minuchin, 2003).

3. **Mimesis:** At times the therapist will find it necessary to establish a closer relation with a certain member. This may be done through verbal interventions or through *mimesis,* that is a nonverbal response where the therapist adopts the other person's mood, tone of voice or posture, or imitates her or his behaviour. For example, crosses her or his legs. In a jovial family, the therapist may adopt a jovial and expansive manner or slow her or his pace in tune with the family's communication style.

   The act of joining helps the therapist fit into the family system but is also an act of diagnosis. The therapist develops the family map and makes a tentative structural diagnosis in the initial sessions.

### 9.4.2 Family Mapping and the Structural Diagnosis

Family mapping is a vital and necessary tool as it gives therapists a broad picture of the dynamics and structure of each family that they are treating and formulate proposed structural changes and intervention plan. These maps are evaluated using two fundamental concepts; these are, family shape and family development. *Family shape* deals with the demographic makeup of the family (that is, two-parent, single-parent, extended family) whereas *family development* refers to the fact that each family has its own distinct cultural environment with standards for acceptable behaviours. The therapist must join the family and then disengage to take an observer role in order to diagram the most accurate map of the family structure (Minuchin, 2003).

For example, in Fig 9.2, the family map depicts a closed family unit boundary with an over involved mother and son making up the parental subsystem. There is a rigid boundary between them and the daughter. However, all members of the family are in a coalition against the father.

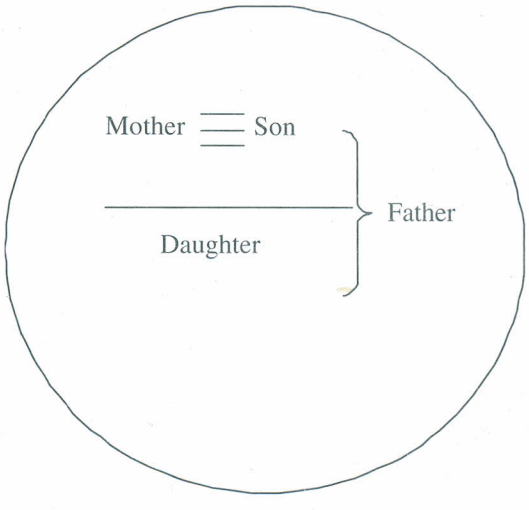



**Figure 9.2: An example of a family map**

The structural diagnosis is an important therapeutic task in the initial phase of therapy. This includes the therapist's reflections on a) the alliances, coalitions and splits among family members; b) hierarchical distribution of power; c) boundary problems; and d) the critical interactional sequences within the family. Thus, the structural diagnosis is a hypothesis about the systemic interaction between the family context and the symptomatic behaviours of the individual members. It illustrates the purpose that the symptomatic behaviour serves within the family system. For example, in a family, the child's anxiety symptoms, refusal to go to school and clinging to mother make him the identified patient. The structural reformulation may suggest that these symptoms serve to deflect from the marital difficulties and provide an opportunity for the couple to demonstrate that they are united as parents.

This reformulation of the presenting problem from a focus on the individual to the family system is a tentative hypothesis that is tested in subsequent sessions. The structural diagnosis is translated back to family members in an acceptable way so that they can participate in the therapeutic process. This also enables the therapist to plan the structural changes required, and who in the family needs to be involved at the different stages of the intervention.

### 9.4.3 Restructuring Techniques

The second, larger group of techniques encompasses all interventions aimed at changing the system. Some of them, like enactment and boundary-making, are primarily employed in the creation of a different sequence of events, while others like reframing, punctuation and unbalancing tend to foster a different perception of reality.

Let us discuss some of the restructuring techniques in detail. These are as follows:

a) **Reframing:** *Reframing* is putting the presenting problem in a perspective that is both different from what the family brings and more workable. Typically this involves changing the definition of the original complaint, from a problem of one person to a problem of the entire family within a structural perspective. For example, the problems of an "uncontrollable" child might be reframed in terms of the patterns of transactions between an ineffective mother, an undisciplined child, and an authoritarian father.

Reframing through *complementarity* involves the presentation of an individual's behaviour as contingent on somebody else's behaviour. In the earlier example, the child's uncontrollability could be related to the mother's ineffectiveness which is maintained by father's taking over; which, on the other hand, is triggered by mother's ineffectiveness in controlling the child. Thus, all family members can be described as mutually contributing to each other's difficulties.

Once the problem is reframed in terms of complementarity, all family members can participate in changing transactions within the family system.

2. **Enactment:** *Enactment* refers to the way in which the family therapist "constructs an interpersonal scenario in the session in which dysfunctional transactions among family members are played out" (Minuchin & Fishman, 1981). This can occur spontaneously or be contrived by the therapist. The rationale for using an enactment is that by making changes in the transactions between family members in the therapy session, changes will occur in their transactions outside the session.

One of the common enactments in Minuchin's work with anorexics was to join the family for a meal and observe the family's typical way of functioning. Nichols and Minuchin (1999) states that the way to begin an enactment is to have one family member respond to something that another family member has said. Enactments in the first few sessions are best used for assessment and should have very little interference by the therapist. Enactments can illustrate many things about the family's structure. For example, can the adults discuss an issue without bringing the children into the argument? Can two family members talk without being interrupted? Enactments allow the therapist to observe what roles each family member performs and demonstrate enmeshment or disengagement.

In the later stages of therapy the therapist might prescribe enactments, directing family members to behave differently in relation to each other. In this way, the therapist intervenes in the rules that regulate who should interact with whom, about what, when and for how long. For example, the therapist may say to a father who tends to talk to his son through his wife, "Talk to your son about your concerns, I don't know if he understands what you feel". Thus the therapist keeps the mother out of the transaction. This simple enactment can provide the family with a different experience of reality.

3. **Boundary making:** *Boundary making* aims at helping the family define, or change the boundaries within the family. It is a special case of enactment, in which the therapist defines which interactions are open to some members of the family but closed to others (Colapinto, 1982). It is a restructuring manoeuvre because it changes the rules by which family functions. With physical boundary making, the therapist may rearrange seating or use hand gestures to silence other family members. Verbal boundary making includes giving specific instructions to the family and giving verbal reminders to prohibit interruptions (Minuchin & Fishman, 1981). For example, if a therapist wants to block a son from making decisions that should be made by his father, this could be done verbally, by stating "I see you like making decisions for your father, what about if you let him make this one?" or physically by asking the son to sit in a chair on the other side of the room, away from his parents or through a combination of both. Another form of delineating boundaries and fostering individuation would be by seeing certain subsystems or individuals for separate sessions. The one-way mirror may be used where the therapist separates an enmeshed or unproductive family member to point out transactions happening within the family.

4. **Punctuation:** *Punctuation* is the selective description of a transaction in accordance with the therapist's goals. A variety of pu ctuation is *intensity,* a technique that consists of emphasisng the importance of a given event in the session. Usually, the therapist magnifies something that the family ignores or takes for granted, as another way of challenging the reality of the system. Intensity is achieved sometimes through repetition, for example, repeatedly asking a family member who had decided to move out of her or his parents' home and did not do so: "Why didn't you move?". Other times the therapist creates intensity through emotionally charged interventions or confrontation like "What your father did just now is very disrespectful". Importantly, structural family therapist needs to monitor the intensity of the therapeutic process, so that the level of stress imposed on the system does not become either unbearable or too comfortable.

5. **Unbalancing:** *Unbalancing* is a technique in which the therapist supports an individual or subsystem against the rest of the family. This should be viewed

as a challenge to the system rather than an attack on any member. For example, a therapist may sit next to a daughter who is being accused of not living up to the family's tradition. When this technique is used to support the underdog in the family system, a chance for change within the total hierarchical relationship is fostered. Therefore, if the therapist must enter into a coalition with certain members against others, the family must always understand that this temporary alignment is for the best of the entire familial system (Minuchin, 2003).

6. **Task assignments:** The structural family therapist may also allocate tasks to be completed by individual members or whole subsystems. Structural therapists use tasks to explore or highlight a particular area of the family's functioning. The main function of these tasks may be, for example, to promote proximity between particular members or to help parents learn effective parenting skills related to disciplining their children. The therapist can allot tasks in imagination, for example, "Just imagine shifting your chair to sit next to your mother"; propose action in the session, 'Please say that clearly to your wife right now."; or as a homework task, "Today you let your husband take your child out in the evening for an hour". The therapist needs to highlight and reinforce positive behaviours.

7. **Support, education and guidance:** Finally, one of the most important interventions that a structural therapist can give a family is support, education and guidance to help them with their particular problem. This part of the intervention process is similar to joining and has also aims at enabling the family to offer support, nurturance and healing to each of its members (Minuchin, 2003). Therapist's role is to provide encouragement to each member of the system with regard to what aspects of treatment are going well for them (Vetere, 2001).

Since, the symptoms of the identified patient is the primary reason for the family's seeking therapy, the structural therapist utilises the symptoms as a way to diagnose and change the family's maladaptive transactional patterns. The role that the identified patient's symptoms play in the overall interaction process is challenged by re-labelling, de-emphasising, as well as encouraging the progress of the identified patient. The interventions should result in a stage when retaining the symptom is no longer functional to the family system.

The techniques and the degree of therapist participation and involvement vary according to the unique needs of each family. Restructuring interventions should result in changes at the level of individuals, subsystems and the overall family system.

When doing structural family therapy it is especially important to recognise the fact that too much change can lead to prematurely ending therapy by the individual members. On the other hand, not enough movement in the family's structure can cause individuals to maintain the same maladaptive patterns that were originally the presenting problem in therapy (Vetere, 2001).

According to Salvador Minuchin, change during the therapeutic process occurs for three main reasons: a) the perception of the client's reality is challenged, b) alternative ways for acting within the family unit are presented and c) new relationships provide self-reinforcement to them once they have utilized alternative transactional patterns (Minuchin, 2003).

## Check Your Progress Exercise 4

***Note:*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Match the following:

| | | |
|---|---|---|
| i) | Adoption of the family members' mood, tone of voice, posture and behaviour by the therapist. | a) Tracking |
| ii) | The therapist's perception and adaptation to the family's hierarchical structure. | b) Maintenance |
| iii) | The therapist's close attention to the content of communication within the family system. | c) Mimesis |

2. Draw a family map depicting a family system with over involvement between mother and child, conflict between the parents and inadequate communication and relatedness between father and child.

.....

.....

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3. Choose the correct answer:

i) According to Minuchin, when the therapist deliberately supports one family member against the rest of the family, the technique used is called:

a) validation.

b) unbalancing.

c) joining.

d) enacting.

ii) A family is seeing a structural family therapist because there are huge arguments at home every time the topic of the daughter's career choices comes up. The therapist tells the family, "I want you to act out exactly what happens when this topic is raised by your daughter." The structural family technique being used is:

a) introjection.

b) restructuring.

c) joining.

d) enacting.

iii) The structural family therapist might try to alter boundaries by:

a) Focusing on the symptomatic family member.

b) altering dysfunctional cognitions.

c) changing the seating arrangement during sessions.

d) drawing a three-generation genogram.

iv) Which of the following techniques is not used in structural family therapy?

a) Reframing.

b) enactments.

c) asking the 'miracle question'.

d) unbalancing.

## 9.5 EFFICACY AND EFFECTIVENESS OF STRUCTURAL FAMILY THERAPY

Structural family therapy has been applied to many different populations. Although a large part of the research is based on case studies, there is increasing evidence about its effectiveness as a form of psychological treatment.

Initial evaluations by Minuchin and his collaborators demonstrated the effectiveness of structural family therapy in cases of labile diabetes, anorexia nervosa and intractable asthma (Rosman, Minuchin, Liebman & Baker, 1978).

Stanton and Todd (1 979) reported the effectiveness of structural family therapy in the treatment of drug addicts and their families. Specifically, these researchers found that post-treatment addict families displayed better boundaries between subsystems. In another study, Szapocznik and colleagues (1989) found that structural family therapy was superior to psychodynamic child therapy in improving family functioning. Both treatment conditions were essentially equivalent in reducing behavioural and emotional problems in boys with problem behaviour. Research indicates the usefulness of this approach with families of drug-abusing adolescents (Stanton & Shadish, 1997).

Many studies in this area have been done with children and adolescents and there is a paucity of research on adults and on applications in psychosomatic and medical disorders. The structural family therapy model appears to be an effective model for a variety of client issues. However, further systematic research is required to support the experiences of therapists working in the field.

Structural family therapy has faced criticism due to its primary focus on the family group that may ignore the influences of extended family, neighbourhood, schools and other social institutions. There is concern that this approach might reinforce traditional gender roles and may not adequately address the unequal power between couples due to gender differences. Critics point out that Minuchin expects women to fulfill expressive roles and men to fulfil executive roles, with the optimal family hierarchy of a two parent system with the male holding the position of power and authority (Gladding, 1988; McGoldrick, 1989). The structural focus on the present in the description and alleviation of problems, may limit the ability to explain and predict symptomatic behaviour. The structural view that the symptom serves a purpose within the family system has been challenged. Current clinical practice must understand and address the needs of the range of contemporary family structures; for example, single-parent families or couples who are not legally married. It is also important to define concepts like "enmeshment" differently in Western and Eastern cultures like India.

Structural family therapy offers therapists a model that is active and clearly defined, transforming an abstract concept like 'family' into concrete concepts like boundary and hierarchy. This teachable model retains a focus on the strengths of families and has had an undeniable impact on the field of family therapy.

## 9.6 LET US SUM UP

In this Unit, we have learnt about structural family therapy approaches in therapeutic intervention. The unit focused on:

- Outlining the basic assumptions of structural family therapy,
- Learning about the key concepts in structural family therapy,
- Delineating the primary goals of structural family therapy,
- Listing the indications and contraindications for structural family therapy,
- Describing the therapeutic processes and techniques in structural family therapy, and
- Summarising the research evidence on the effectiveness of structural family therapy and critically evaluating its strengths and limitations.

## 9.7 GLOSSARY

**Boundaries** : Invisible lines of demarcation in a family which may be defined, strengthened, loosened or changed as a result of structural family therapy. Boundaries range from enmeshed (extreme togetherness) to disengaged (extreme separateness). Ideally, boundaries are clear.

**Coalition** : A (usually) covert alliance between two family members against a third. For example, when one parent joins a child in a rigidly bounded cross-generational coalition against the other parent, this is called a stable coalition.

**Detouring** : A process by which stresses between a couple get redirected to the child so that the spouse subsystem gives the impression of harmony.

**Disengaged family** : An extreme pattern of family organisation in which members are so separate or psychologically isolated that they seem oblivious of the effects of their actions on each other. Boundaries among family members are typically impermeable.

**Enmeshed family** : An extreme pattern of family organisation in which members are so tightly locked that autonomy is impossible. Boundaries among family members are typically diffuse.

**Family mapping** : The diagrammatic representation of family's organisational structure, boundaries and patterns of interaction.

**Generational Boundaries** : Invisible lines of demarcation between generations. Healthy generational boundaries allow parents to maintain parental roles and children to maintain child roles.

**Hierarchy** : A boundary that demarcates the leader of an organisation from others. In a family, the parents are usually higher up in the hierarchy when compared to the children, meaning that they have a greater say in decisions regarding how the children should behave.

**Joining** : The therapist's efforts to be accepting and accommodating to families to win their confidence and circumvent resistance.

**Parental child** : An overly responsible child who has power and authority that more appropriately belongs to the parents.

**Reframing** : Relabeling a family's description of behaviour with more positive connotations to make it more amenable to therapeutic change. For example, describing some one as "discouraged" rather than "depressed".

**Subsystems** : Units within a family based on characteristics such as age, gender, or function.

**Triangulation** : A process in which two family members demand that a third (usually a child) side with each against the other.

## 9.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

### Check Your Progress Exercise 1

1. i) a , ii) d , iii) c , iv) a

### Check Your Progress Exercise 2

1. i) conflict-detouring
   ii) enmeshed
   iii) cross-generational coalition
   iv) rigid
   v) sibling
   vi) over involved

### Check Your Progress Exercise 3

1. i) False
   ii) True

iii) True

iv) False

v) True

2. The main goals of structural family therapy are described as follows:

i) Creating an effective hierarchical structure in the family,

ii) Restructuring an effective parental subsystem,

iii) Effective functioning of the sibling subsystem as peers,

iv) Increasing the frequency of interactions and nurturance, if the family is disengaged, and

v) The differentiation of family members, if the family is enmeshed.

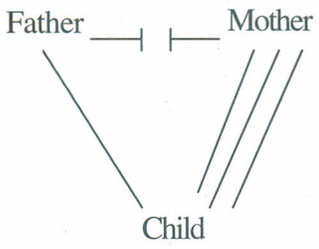
**Check your Progress Exercise 4**

1. i) c)

ii) b)

iii) a)

2. Following family map depicts a family system with over involvement between mother and child, conflict between the parents and inadequate communication and relatedness between father and child:




3. i) b)

ii) d)

iii) c)

iv) c)

## 9.9 UNIT END QUESTIONS

1. Discuss the key assumptions of structural family therapy.
2. Enumerate the characteristics of enmeshed and disengaged families.
3. What is triangulation? Illustrate 'conflict detouring' and 'cross-generational coalitions" by drawing structural diagrams.
4. Describe the initial "joining" stage in structural family therapy.
5. Discuss the processes of family mapping and making a structural diagnosis.
6. What are some of the restructuring techniques used in structural family therapy? Illustrate with examples.

## 9.10 FURTHER READINGS AND REFERENCES

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# UNIT 10 SOLUTION FOCUSED AND STRATEGIC FAMILY THERAPY

## Structure


10.1 Introduction

10.2 Solution Focused Family Therapy

10.2.1 Objective of Solution Foused Therapy

10.2.2 Assumptions of Solution Focused Therapy

10.3 Historical Perspective

10.4 Principles of Solution Focused Family Therapy

10.5 Questions in Solution Focused Family Therapy

10.6 Techniques Used in Solution Focused Family Therapy

10.7 Therapeutic Processes in Solution Focused Family Therapy

10.8 Strategic Family Therapy

10.8.1 Assumptions of Strategic Family Therapy

10.8.2 Goals of Strategic Family Therapy

10.9 Theoretical Models in Strategic Family Therapy

10.10 Techniques Used in Strategic Family Therapy

10.11 Stages of Strategic Family Therapy

10.12 Conditions for Change

10.13 Let Us Sum Up

10.14 Glossary

10.15 Answers to Check Your Progress Exercises

10.16 Unit End Questions

10.17 Further Readings and References


## 10.1 INTRODUTION

In this Unit, we will study about two important approaches for family therapy that are solution focused family therapy and strategic family therapy. In solution focused family therapy we will learn about its main objectives and important assumptions. Further, we will have a glimpse of historical perspective of this approach. Principles of solution focused family therapy are also discussed in this Unit.

The other part of the Unit deals with strategic family therapy. We will study the assumptions and main goals of strategic family therapy. Theoretical models given by Haley, Madanes and Milan group are also discussed in this part of the Unit.

At the end of this Unit, we will discuss some conditions necessary for change in strategic family therapy.

**Objectives**

After studying this Unit, you will be able to:

- Understand the solution focused and strategic family therapy;
- Explain the principles of these therapies;
- Describe various techniques used in solution focused and strategic family therapy; and
- Discuss the therapeutic process of solution focused family therapy and strategic family therapy.

## 10.2 SOLUTION FOCUSED FAMILY THERAPY

Solution focused family therapy (SFFT) is an approach to psychotherapy based on solution-building rather than problem-solving. It explores current resources and future hopes rather than present problems and past causes and typically involves only three to five sessions. Solution focused theory was a front runner in the adoption of the social constructivist thinking that became prominent in the late 1980's and early 1990's. Solution focused family therapy (SFFT) is pragmatic, cognitive and easy to both practice and teach. It emphasises brevity and a non-pathological view of people. It projects optimism, uses praise of people's strengths and accomplishments, and refers to the past only to search for exceptions (times when things had been progressing smoothly or past solutions tried by the client). Solution focussed family therapy is sometimes linked to general brief therapy, problem-focused therapy and possibility therapy. All these therapies share same common points of focus.

### 10.2.1 Objective of Solution Focused Family Therapy

The objective of this approach is to focus on the process of change rather than dissecting the problem. The aim in solution focused family therapy is to help clients transform troubling issues into specific goals and evolve an action plan for achieving them. Solution focused family therapy is an effective way of helping people solve many kinds of problems, including relationship problems, depression, substance abuse, eating disorders, and many other issues.

### 10.2.2 Assumptions of Solution Focused Therapy

The main assumption in solution focused family therapy is that creating a detailed picture of what it will be like when life is better, creates a feeling of hope, and this makes solutions seem possible. The therapist helps the client focus on the future and how it will be better when things change. The therapist also helps in developing a set of specific, detailed goals. These goals drive the therapy process and keep it focused and efficient.

## 10.3 HISTORICAL PERSPECTIVE

The roots of this therapy were developed at the Mental Research Institute (MRI) in Palo Alto and mutated from a problem solving focus to a solution focus. Most of the innovators of solution focused family therapy came from the Brief Family Therapy Centre (BFTC) in Milwaukee in the late 1970's. The initial partners of BFTC, Steve deShazer and Insoo Berg are credited with being the primary

developers of SFFT. Other members of this team were Eve Lipchik, Wallace Gingerich, Elam Nunnally, Alex Molnar and Michele Weiner Davis. All these names are important, not just as pioneers of a new way of doing therapy but also because their collaborative work and writings have brought about drastic changes in the conceptualization of social functioning, mental health and well being.

**Check Your Progress Exercise 1**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Fill in the blanks:

   i) Solution focused family therapy is _____ .

   ii) The roots of solution focused family therapy developed at _____ .

   iii) The main objective of SFFT is focus on the process of change rather than _____ the problem.

   iv) The main assumption of solution focussed family therapy is that creating a detailed picture of what it will be like when life is better, creates a feeling of _____ and makes the _____ seem possible.

## 10.4 PRINCIPLES OF SOLUTION FOCUSED FAMILY THERAPY

Let us discuss the important principles of solution focused family therapy. These are given as follows:

- **Clients have resources and strengths to resolve problems:** It is the therapist's task to access these abilities and help clients put them to use.
- **Change is constant:** Therapists can do a great deal to influence clients' perceptions regarding the inevitability of change and what is likely to happen during the therapy session.
- **Therapists' tasks are to identify and amplify change:** The therapist accomplishes this through choice of questions, topics focused on or ignored. The main focus is on what seems to be working, however small; to label it as worthwhile; and work toward amplifying it. If the change is in a crucial area, it can change the whole system.
- **It is usually unnecessary to know a great deal about the complaint in order to resolve it:** What is significant is to understand what the clients are doing that is working. It is also necessary to learn from clients what is different when the problem is not troublesome. This can be then used to help clients learn to function that way again to solve the problem.
- **It is not necessary to know the cause or function of a complaint to resolve it:** Even the most creative hypotheses about the possible function of a symptom will not offer therapists a clue about how people can change. It simply suggests how people's lives have become static. People would be happy if the problems are to disappear than to understand why it occurs.

- **A small change is all that is necessary:** A change in one part of the system can effect change in another part of the system. The introduction of positive changes is likely to continue and may even expand and have beneficial effects in other areas of the person's life.
- **Clients define the goal:** Do not assume that therapists are better equipped to decide how their clients should live their lives. Ask people to establish their own goals for treatment.
- **Rapid change or resolution of problems is possible:** We believe that, as a result of our interaction during the first session, our clients will gain a more productive and optimistic view of their situations. If this first session proceeds as planned and clients gain a new perspective, then it is highly probable that they would go home and do what is necessary to make their lives more satisfying. Average length of treatment is less than 10 sessions, usually 4 to 5 sessions and occasionally just a single session may suffice.
- **There is no one "right" way to view things:** Different views may be just as valid and may fit the facts just as well. Views that keep people stuck are simply not useful. Sometimes all that is necessary to initiate significant change is a shift in the person's perception of the situation.
- **Focus on what is possible and changeable rather than what is impossible and intractable:** Focus should be given on the aspects of a person's situation that seem most changeable. This imparts a sense of hope and power.

## 10.5 QUESTIONS IN SOLUTION FOCUSED FAMILY THERAPY

The significant aspects of solution focused family therapy are the questions put to the client during the interview session. The questions may be for goal identification or for solutions. The main types of questions employed are discussed below:

1. **Goal definition:** Clients usually start out by describing their problems and goals in broad terms and it takes careful and active listening and clarifying before a clear goal can be determined. If a client specifies several goals ask the client which one to start with. The initial goal also is to change the topic in the session from problem talk to solution talk. The examples of questions during goal identification can be:
    - What brings you here today?
    - How will you know coming here is worthwhile?
    - What will you be doing differently?
    - What will other people notice?
    - How will you know you don't have to come here anymore?
2. **Problem definition:** Solution-construction is easiest when the goal is focused down to a problem that can be described in specific behavioural terms. For example, the goal may be to be less depressed. The focused problem

description could be to have more energy to study, or to call up friends and more outings. The questions a therapist could ask to define problems are:

- How is (example: depression) a problem for you?
- Is that a problem for anyone else? How is it a problem for others?
- How does it effect you?
- How will things be different when the problem is solved — for you and for others?

3. **Exception questions:** Proponents of solution focused family therapy insist that there are always times when the problem is less severe or absent for the client. Exceptions are times when things had been progressing smoothly. The counsellor or therapist encourages the client to describe what different circumstances exist in that case, or what the client did differently. Here the therapist is looking for past solutions that clients have tried and that have worked or what client had done in the past which was successful. The goal for the client is to repeat what has worked in the past, and to help them gain confidence in making improvements for the future. Don't ask for exceptions until the therapist and the client are clear about what the problem and the goal is. You should be clear about the following questions during the process:

   - When don't you, or didn't you have this problem? . . . even a little bit?
   - What was different at those times?
   - What will make it possible for more of that to happen?
   - What small changes will you notice?
   - How will the small changes make a difference for you and for others?
   - What will you notice about yourself and others? What will they notice about you?

4. **Existing resource questions:** A key task in solution focused family therapy is to help clients in identifying and attending to their skills, abilities, and external resources (for example, social networks). This process not only helps to draw the client's attention to herself or himself as a competent individual, but also aims to help the client identify new ways of utilizing these resources to deal with the problem. Resources can be identified by the client and the therapist will achieve this by empowering the clients to identify their own resources through use of scaling questions, problem-free talk, or during exception-seeking. Many resources can be internal like the client's skills, strengths, qualities, beliefs that are useful to them and their capacities. These types of questions aim at identifying the strengths and resources in the clients which they can build on:

   - What have you tried to do to solve the problem? What helped even a little bit?
   - How have you dealt with similar problems in the past?
   - What have you learned from previous experiences like similar past situation that might be useful in this situation?

5. **Miracle question:** The 'miracle question' is a method of questioning that a coach, therapist, or counsellor uses to aid the client to envision how the future will be different when the problem is no longer present. This may also help to establish goals. This question or any question asking about a hypothetical solution is usually asked when the client cannot think of any exceptions or when she or he is having difficulties in defining a goal. In 'The Miracle Method', authors Scott D. Miller and Insoo Kim Berg described how to create solutions with these steps:

1. State your desire for something in your life to be different,
2. Envision that a miracle happens and your life is different,
3. Make sure the miracle is important to you,
4. Keep the miracle small,
5. Define the change with language that is positive, specific, concrete, and behavioural,
6. State how you will start your journey rather than how you will end it, and
7. Be clear about who, where, and when, but not why.

The question may be formed in the following way:

- If a miracle happened tonight and you woke up tomorrow morning and your problem was solved, how would things be different? Describe the differences from your point of view and what others would be doing and experiencing.

In response to clients' answers ask:

- Does some of that happen already at times? . . . even a little bit?
- What will allow more of that to happen?
- What will you and others have to do to make it possible?

6. **Scaling questions:** Scaling questions are tools that are used to identify useful differences for the client and may help to establish goals as well. The client is asked to rate their current position on the scale, and related questions are then used to help the client to identify resources, exceptions and to describe a preferred future. These questions are usually asked to help clients get a better perspective about how severe a problem is. This question is also asked to track progress from session to session:

- On a scale from 0 to 10, with 0 being totally unacceptable and 10 as good as you can imagine, where would you put your relationship at this point?

  *Or*

- On a scale from 0 to 100, with 0 being never and 100 being always, what percentage of the time would you say you feel those anxious feelings that make you afraid to leave the house?

Further, in response to answers ask:

- How many degrees would it have to change for you to feel better?
- What would a small step (For example, from 3 to 3.5) look like? What will you be doing differently?

- What will others be doing differently?

7. **Advantage questions:** This type of question is asked when clients keep giving negative answers. For example:

   - This may seem like a strange question, and I don't want you to think that I am not concerned about how serious this problem is for you, but is there an advantage to your having this problem? . . . Is there anything positive about this negative situation?

   In response to answers ask:

   - How can you have the advantage without having to maintain this problem? What can you do instead?

8. **Coping questions:** Coping questions are designed to elicit information about client resources that will have gone unnoticed by them. Even the most hopeless story has within it examples of coping that can be drawn out: For example, *I can understand that things have been really difficult for you, yet I am very impressed by the fact that, inspite of these difficulties, you manage to get up each morning and do whatever is required to get the kids ready for school. How do you do that?"* Genuine curiosity and admiration can help to highlight strengths without appearing to contradict the client's view of reality. The initial summary, *"I can understand that things have been really difficult for you"* is true for them and validates their story. The second part *"you manage to get up each morning etc."* is also a truism. Undeniably, they cope and coping questions start to gently and supportively challenge the problem-focused narrative:

   - How come things aren't worse? What have you done to keep them from being worse?

   If the client still does not answer with exceptions or positives ask:

   - Do you think things can get worse? What will that be like for you? For others?

   - What is the smallest thing you can imagine that will make a difference?

**Check Your Progress Exercise 2**

***Note:*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the main principles of solution focused family therapy?

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2. List the types of questions usually asked in solution focused family therapy.

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## 10.6 TECHNIQUES USED IN SOLUTION FOCUSED FAMILY THERAPY

The family therapist uses different techniques in helping clients to achieve the goal. Some of them are discussed below:

1. **Introducing uncertainty:** The therapist can introduce some uncertainty into the problem definition by asking "What gives you the impression that things seem difficult to handle?" Or she or he can imply that there are days when the problem is nonexistent by asking "What is different about the days when things seem manageable?"

2. **Framing questions:** Certain questions can elicit information about strengths, abilities and resources. Perceptions of problems then change significantly in this context. They are mainly the Exception question and Miracle question ( Explained in section 10.5)

3. **Reframing problem definitions:** Therapists offer new, and more workable problem definitions that are within the power of the client and therapist to solve. They usually help the client to reframe the problem definition to a more positive one or enable the therapist to listen for a hint of something in the client's complaint that can be solved. This co-creates the experience that the problem is solvable and the client has some ability to solve it.

4. **Problem solving techniques:** Some of the problem solving techiques dispel the idea that there is a problem by helping clients to see their situations in new ways. Negotiate a solvable problem by reducing the size of the problem in the client's eyes. (Get specific about the problem; focus on stage when it is not so serious a problem). Foster the idea that clients have all the abilities and resources to solve the problem by creating an atmosphere that facilitates the realisation of strengths and abilities.

5. **Matching the client's language:** Use the exact words the client uses to describe the problem, in asking questions about what they have done before, when it is not so serious a problem, etc. Also, attend to client's metaphors and utilise them to extend observations, learn about clients' interests or hobbies.

6. **Channeling the client's language:** Make a conscious effort to move away from jargon into action descriptions used in every day language. This has the effect of de-pathologising or normalising clients' situations. Gradually change your terminology to less serious, more positive words. (Example: Use the words, 'transitional period' as this gives the client the opportunity to take solace in hearing that a problem is temporary, and helps shape their expectations for the future). Use verb forms by creating a reality where the problem is in the past and possibilities exist for the present and in the future. "When you had this problem before, you used to . . . you were having difficulty . . . how did the old you . . ." Help clients make distinctions that are helpful (feeling like or thinking about . . . rather than doing it).

7. **Normalizing and de-pathologising:** Tell clients that their problems are "understandable" and put the situation in an everyday frame of reference. Say such things as "naturally", "of course", "welcome to the club", "so what else is new", "that sounds familiar", or "yeah, me too."

8. **Goal setting:** Start with small goals like, "What will be the first sign that things are moving in the right direction?" Goals must be concrete.

9. **Fast-forwarding questions:** Fast forwarding questions are useful when clients cannot identify exceptions or past solutions. Clients are asked to envision a future without the problem and describe what that looks like. For example, The miracle question or a magic wand question). "What *will"* not "what *would* be different?"

## 10.7 THERAPEUTIC PROCESSES IN SOLUTION FOCUSED FAMILY THERAPY

1. **Find out about the client's life:** Therapist should study the client's life with special attention to interests, motivations, competencies and beliefs. This is accomplished in a social, conversational manner by "chatting" with the client about their work, hobbies, vocations and commitments. This is an on-going process in that the therapist is always learning about the client, but a short time, usually 5-10 minutes, should be given in the first session to get the sequence started.

2. **Gathering a brief description of the problem behaviours:** After the solution-focused family therapist is acquainted with the client's life history, she or he proceeds to gather a problem description from the client by asking questions such as "What would make you know that it was worth your time to come and see me today?". The client will usually volunteer to provide information about the presenting problem. The therapist asks follow-up questions to gain a sense of the problem, context of the problem, duration, severity, situations in which problems occur, the people involved, past attempts to solve those problems and similar and related questions.

3. **Asking relationship questions to help the client define the socially constructed nature of the problem:** Relationship questions are used throughout the sessions at different points to help the client gain a meta-perspective about the problem, and to assess the individual cognitive constructions and social constructions, concerning the problem definition and resolution. Relationship questions can be used to help clients to discuss their problems from a third person's perspective, making the problems less threatening.

4. **Tracking solution behaviours or exceptions to the problem:** The therapist proceeds to identify stage or times when the problem did not occur, when there were effective coping responses and the contexts for the absence of the problem. The therapist gathers as many exceptions to the problem pattern as possible by repeatedly asking the client 'what else'..., 'what other times'...?

5. **Scaling the problem:** The therapist uses scaling questions to anchor the problem and to track the progress toward problem resolutions. The client is asked questions about where the client is on the scale in relationship to solve the problem; or the level client is affected by the problem. Solution behaviours described by the client, through the use of the scaling technique, are often used in constructing specific tasks or homework assignments that are prescribed and discussed in future sessions.

6. **Using coping and motivation questions to assess how the client perceives they are coping and to determine their motivation for change:** This is a variation on the scaling questions that helps the therapist to assess the client's motivation for solving the problem as well as to judge that the client's perception of how well they are coping with the problem.

7. **Asking the miracle question to develop solutions:** Through the miracle question, an extreme amount of detail is elicited to help develop a set of solution behaviours that are concrete and behaviourally specific, through envisioning the future.

8. **Negotiating the goal for change:** From the problem descriptions and the miracle question, the therapist negotiates with the client small, concrete behavioural goals that the client would like to work towards. The goals should comprise the miracle picture of the client. The goal should be important to the client. Goals should be small and attainable. Goals should be concrete, specific and behaviourally defined so that clients are motivated to accomplish them. The client should say they are committed to working toward the goal. Clients should have clearly stated that this is something that they want for their lives. Goals should include the presence rather than absence of a behaviour. Goals should be represented to the client as a beginning to behaviour change rather than an end to the process. The therapist may use phrases like, "this is a step" or "this is a beginning".

9. **Taking a session break for reflection, development of compliments, and formulation of a set of behavioural tasks:** Near the end of the session the therapist takes a 5 to 10 minutes break for reflection and to have time to construct the information gained into a behavioural task or homework assignment. It is not absolutely necessary for the therapist to give a homework assignment. He or she may simply offer a set of reflections for the client to think about, but in most instances such an assignment is given. Part of the work of the therapist is to formulate as many genuine compliments as possible to deliver to the client when they return to the session.

10. **Delivering compliments and tasks:** The therapist delivers the compliments and behavioural tasks. The session is ended by setting another appointment. To complete this sequence in a successful manner the therapist should have given 4 to 5 genuine compliments to the client, developed a set of meaningful reflections or a concrete behavioural task for the client to work on in-between sessions, obtain a commitment from the client to do the task, communicate that they will follow-up on their successes in the next session and set another appointment.

11. **Summation message:** The summing up message should contain what the therapist heard in terms of the complaint, the goals, any progress that has already been made, client's delineation about how the situation is affecting her or him (including emotionally), therapist's reaction to the situation, reinforcement of positives and changes, normalisation, reframes or new information, acknowledgement of clients' feelings, and the tasks set.

### Role of Family Therapist

A solution-focused family therapist is likely to do the following. Instead of going over past events and focusing on problems, the therapist helps to envision a future without today's problems and discover solutions, identifies and encourages more

of what is already working, guides the client to identify what does not work and to focus on doing less of it.

**Check Your Progress Exercise 3**

***Note:*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the various techniques that are used in solution focused family therapy.

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2. What are the various steps of therapeutic process in solution focused family therapy?

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**Case Illustration**

*Therapist :* So John, what are your hopes for this session?

*John :* I don't know.

*Therapist :* What do you think?

*John :* I suppose it will be useful.

*Therapist :* In what way do you hope it will be useful?

*John :* I don't know.

*Therapist :* What do you think?

*John :* Stop me drinking.

*Therapist :* So if this meeting helps you stop drinking it will have been worth your while?

*John :* Yes.

*Therapist :* So can I ask you some unusual questions?

*John :* Sure – I have seen so many doctors and people, I am used to it!

*Therapist :* Okay, here's an unusual one: let's imagine that tonight while you are asleep a miracle happens and your drink problem is resolved. But because you are asleep you don't know. What will you notice different in the morning that begins to tell you that drink is no longer an issue for you?

| | |
|---|---|
| *John :* | I don't know, I can not imagine that. |
| *Therapist :* | Have a go! |
| *John :* | I don't believe in miracles. |
| *Therapist :* | No, neither do I but it's very helpful for me to have an idea about how you want your life to be so we can move in the right direction. So what time would you wake up? |
| *John :* | About nine. |
| *Therapist :* | And what is the first thing you will notice yourself doing differently that begins to tell you a miracle has happened? |
| *John :* | Nothing will be different. I will get up, take some stuff to clear my head, have a coffee and go out. |
| *Therapist :* | Stuff ? |
| *John :* | I will take anything, anything I can get hold of, pills, the lot. It helps clear the head. |
| *Therapist :* | So let's say the miracle stops you needing stuff as well as drink. What will be different when you go out? |
| *John :* | Look, what you have to realize is that 90 per cent of my friends drink, so what do you expect me to do? |
| *Therapist :* | No, it is certainly not easy. So what might you do if drink and drugs are no longer a problem? |
| *John :* | I do not know, there are all sorts of things. |
| *Therapist :* | So what might one of them be? |
| *John :* | The thing is, it is impossible to concentrate on anything because I am always worrying about money. |
| *Therapist :* | So what would you notice about the way you worried about money if drink and drugs were no longer a problem? |
| *John :* | Well, then I would have to do something about it, would not I? |
| *Therapist :* | So what might you be thinking of doing? |
| *John :* | Well, I can get work if I need it. I do gardens. |

The therapist makes no attempt to advise or encourage John to 'perform' any of his described activities and simply ends the session by complimenting John on his honesty, his continuing interest in fighting his problem, his loyalty to his drinking friends and his courage in continuing to live such a hard life.

## 10.8 STRATEGIC FAMILY THERAPY

Strategic family therapy is based on strategy. The therapist devises and initiates interventions for solving the families' presenting problems. Strategic therapists are

concerned with dysfunctional hierarchies and repetitive sequences of behaviour between family members and other systems that help in maintaing the presenting problem. They all suggest that emotional problems and symptoms of family members result from hierarchical structures in which the boundaries are unclear or inappropriate for healthy family functioning. Problems are believed to be maintained through attempted solutions of the problem at the wrong hierarchic level, denying the presence of the problem or inventing a problem when there is none. The strategic thought was expounded by Jay Haley, Chloe Madanes, Mental Research Institute (MRI) and the Milan Group. Although each theorist explains somewhat different motivations for the problems that surface, they all see the repetitive sequences of behaviours as the process that maintains them. Each utilises strategic methods designed to correct hierarchical distortions and improve more age and role appropriate interactions. Strategic therapists work toward solving the presenting problem.

### 10.8.1 Assumptions of Strategic Family Therapy

Let us discuss some important assumptions of strategic family therapy:

1. All families are viewed as being functional from their unique perspectives.
2. The social context is emphasised and problems involve at least two or three people.
3. Functional families have an appropriate hierarchy of power with parents having more power than children.
4. Therapy is symptom oriented. Symptoms are tactics used by one person to deal with another.
5. Presented problems serve some function within the family.
6. Therapist assumes responsibility for determining the structure of the therapy. Change occurs not through insight but through the family carrying out the directives of the therapist.
7. Process is emphasized over content.
8. Family life cycle is considered important in understanding family dysfunction. Families get stuck at a particular stage.
9. Families are rule governed systems.
10. Emphasis is given on the here and now and not to the past history. Emotional expression is not encouraged. A brief therapy model is usually followed.

### 10.8.2 Goals of Strategic Family Therapy

Main goals of strategic family therapy are given below:

1. Dealing with the current problem and intervening on other existing problems if family asks for help. Strategic family therapists help the family by making them form clear, straight forward, immediate, behavioural goals and sticking to them.
2. Another goal of strategic family therapy is for structural re-organisation in the family similar to what is attempted by the structural therapists, but that

would be the secondary goal. They are more concerned with the immediate problem and deemphasise the importance of insight.

3. Another goal may be to bring harmony and balance into people's lives, to love and be loved, to find fulfillment in work, to play and enjoy.

4. To create new patterns of behaviour, along with new beliefs, that are supportive of the creation of new patterns.

**Check Your Progress Exercise 4**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. State 'true' or 'false' :

   i) Strategic family therapy is not based on strategy. _____

   ii) In strategic family therapy all families are viewed as functional for their unique perspective. _____

   iii) Structural reorganisation is primary goal of strategic family therapy. _____

   iv) Exphasis is given on here and now rather than past history. _____

## 10.9 THEORETICAL MODELS IN STRATEGIC FAMILY THERAPY

Haley's theories evolved through his diverse background. Although systemic in his thinking about family reciprocal interactions, he believes strongly in the importance of a hierarchical structure with parents in charge. He describes triads as the family unit that maintains its stability. Another focus is on the sequences of behaviour which refers to the communication patterns in the here and now. Paradoxical directives are the hallmark of strategic therapy. They are not ploys to outsmart families but thoughtful suggestions derived from long experience. In his view the struggle for power and control is central to family patterns. According to him, the symptoms result from repetitive, unproductive, attempts to control or influence other family members. Madanes is of the view that all problems brought to therapy can be thought of as stemming from the dilemma between love and violence. According to her, the family problems may be because of the intention to dominate and control or to be loved or to love and protect others or to repent and forgive.

The Milan group also believes that power games are unacknowledged patterns used by the family to control each other's behaviour. These patterns maintain the family as a self regulating system that controls itself according to rules formed over time. They used a systemic search for differences in behaviour, relationships and beliefs among family member to uncover the connections that keep the family system in homeostatic balance. They also hypothesize that the symptoms a person develops are to protect one or more other family members so as to maintain the delicate network of family alliances. The Milan model stresses on neutrality and curiosity and generates hypothesis through circular questioning. *Neutrality* is described as the avoidance of taking side or being partial to family members and

maintaining a neutral position. Curiosity and concern for patterns generates a respect for all participants, even as respect generates a sense of curiosity. The therapist needs to deal with a system with the understanding that the system is simply doing what it does and with no right or wrong label attached to what it does. Curiosity encourages all participants to look for different descriptions and explanations even when one cannot immediately imagine the possibility of any other way of thinking about the problem. *Hypothesization* refers to the definition of the problem or provides a tentative explanation about what functions the symptoms are serving in the family context. Another important element in strategic family therapy is the *circular questioning*. It is the technique nurtured by neutrality and curiosity. This questioning undermines the family's belief system that says an individual is the problem. Circular questioning is used to understand the relationships, subsystems and alliances, the degree of concern between family members, to note changes over time, to learn about a person's sense of control over another's actions, to help people recognise how one's reactions behaviours and feelings link with other family members or to help in looking for new insights. For example, a therapist could ask "if your mother decided to stop worrying about you, what would your father do?" Such questions create opportunities for new stories. There are three basic models for problem development in the family, these are: i) *cybernetic* (positive feedback loops), ii) *structural* (flawed family hierarchies) and ii) *functional* (one member develops symptoms to control others).

**Check Your Progress Exercise 5**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Define the following terms :

   i) Sequence of behaviour

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   ii) Neutrality

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   iii) Hypothesization

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## 10.10 TECHNIQUES USED IN STRATEGIC FAMILY THERAPY

The strategic approach focuses mostly on strategies adapted to the specific situation of a person and the problem. Each of the three models is somewhat different. Now let us discuss various techniques that are used in strategic family therapy.

These are as given below :

1. **Reframing:** Reframing is providing the family with a rationale for treatment. The Mental Research Institute (MRI) therapist may not believe what they tell the family, but that is unimportant as long as it is a rational explanation. The point of using this technique is not to bring insight, but to induce compliance.

2. **Out-positioning:** Out-positioning means one family member taking the role and place of other family members, to the extreme or enacting it in a highly exaggerated manner.

3. **Paradoxical interventions:** Paradoxical interventions are of two forms; compliance based, to simply get the family to change their behaviour by complying with a directive, or defiance based, in the hope that the family will defy the directive and improve. The therapist may tell the family, "Although we as therapists are change agents, we think you should *not change* because it is a good thing that Rohit has tantrums and that mother feels hopeless, as this pulls father in to help her". This statement creates a therapeutic double bind. If the family obeys, they disobey the therapist. If they don't change, they maintain the status quo and the pain that comes with it. The therapist is saying '*Don't change*' and is specifying how the symptom behaviour is serving a useful purpose that might not continue if the symptom is stopped.

4. **Symptom prescription:** It is an exposure based paradox used to expose the family's hidden relationships.

5. **Restraining techniques:** Restraining techniques are telling the family that they can not move very fast because they are not ready.

6. **Positive connotation:** It is to reframe the problem but in a way that the family members are not blamed or labeled as bad.

7. **Rituals:** Rituals are directives to engage the whole family in some behaviour that exaggerated or broke rules and family myths. They are the ceremonial acts proposed as tentative suggestions, as an experiment for the family to try out. Rituals promote new ways of doing things, which may alter the family's thoughts, beliefs, and relationship options.

## 10.11 STAGES OF STRATEGIC FAMILY THERAPY

In this section, we will study the stages of strategic family therapy. In general, we can say the strategic family therapy follows the following stages:

1. A structural initial interview,
2. Mutual definition of goal of therapy,
3. Observation of interactions by therapist as family members discuss problems,
4. Tasks and directives in the sessions and at home, and
5. Termination when symptom relief is achieved.

Milan group has described the stages of therapy in the following order:

1. **Pre-session**: In pre-session tentative hypotheses are made.
2. **Session**: The hypotheses are tested and refined in the session stage.

3. **Inter-session**: The team would meet with the therapist while the family waited outside.

4. **Intervention**: The therapist would return to deliver the intervention. There are several interventions that are used usually.

5. **Post-session**: The team would analyse the family's reaction and plan for the next session.

Madanes has given the stages in the following order:

1. **Social stage**: In social stage, everyone is greeted and spoken to in order to make everyone feel more relaxed and less defensive.

2. **Problem stage**: In problem stage, therapist introduce herself or himself and repeats what she or he knows about the problem, then speaks to each person and gets their opinions and ideas about the problem. Haley engages the father first, and observes all the family members' interactions to uncover hidden triangles.

3. **Interaction stage**: This is a stage wherein members talk about different perspectives on the problem. Therapist observes the family interactions around the problem. By asking what they have tried before, therapist gains information and also underscores the family's need for her or his help. Therapist can end the first session with a simple directive and no advice.

## 10.12 CONDITIONS FOR CHANGE

By attempting first order change or change in the behaviour, second order change or change in the system's structure can be achieved. They do not need insight as to why they have problems, nor do they need to understand why the change in behaviour is needed. They simply need to act differently and see for themselves that the family's rules for problem-solving can be more flexible. They try to keep resistance low and motivation high.

Strategic family therapists believe insight to be of little use, try to keep resistance low, and focus on behavioural change, arguing that before the family can think or feel differently, they must act differently. They also believe that since one person can change a system, she or he may be the most successful level to use in producing change.

**Check Your Progress Exercise 6**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the techniques used in strategic family therapy.

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2. What are the stages of strategic family therapy, according to Milan group?

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*Case situation analysis*

**Situation:** *Rahul is 16 and has recently refused to go out of the house.*

**MRI** would focus on getting Rahul out, believing the parents attempted solutions kept him home.

**Haley and Madanes** would focus on the triadic relationship between Rahul and both of his parents. Haley would wonder about the parents unresolved conflicts and marital struggles while Madanes would wonder about how Rahul staying home helped one or both of his parents.

**Milan** group would focus on the family's history and hidden power struggles, or family games, in which Rahul is embedded and has to stay home to help a family member "win."

## 10.13 LET US SUM UP

Since its origin in the mid-1980s, solution-focused family therapy has proved to be an effective intervention across the whole range of problem presentations, that is, in working with women and children, adult mental health issues, work in schools, in counselling and group work. The two key therapeutic issues which need to be kept in mind are; (1) how the client wants his or her life to be different, and (2) what it will take to make it happen. Solution focused approach is now in constant demand. Its efficacy is well established and supported by a solid and ever increasing body of research. Solution-focused thinking has earned its place and is widely accepted in the fields of therapy, social care, education and business.

Strategic family therapy been highly influential among all other approaches in family therapy. This approach has been used with families with psychiatric disorders, widely used in dealing with children or adolescents' problems, and also in couples with relationship issues. The attitude of curiosity and prompting of circular questions, have come to serve as the base of investigation for many family therapists. These techniques have been used by family therapists in helping the family develop a harmonious relationship.

## 10.14 GLOSSARY

**BFTC** : Brief family therapy centre

**Hypothesization** : Defining the problem or giving tentative explanation about what purpose or function the symptoms are serving in the family context

| | | |
|---|---|---|
| **MRI** | : | Mental Research Institute |
| **Neutrality** | : | To avoid side taking or being partial to members and maintain a neutral position |
| **SFFT** | : | Solution focused family therapy |
| **SFT** | : | Strategic family therapy |

## 10.15 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

### Check Your Progress Exercise 1

1 i) pragmatic

ii) Mental Research Institute (MRI)

iii) dissecting

iv) hope, solutions

### Check Your Progress Exercise 2

1. Following are the main principles of solution focused family therapy:

i) Clients have resources and strengths to resolve complaints,

ii) Change is constant,

iii) The therapist's job is to identify and amplify change,

iv) It is usually unnecessary to know a great deal about the complaint to in order to resolve it,

v) It is not necessary to know the cause or function of a complaint change to resolve it,

vi) A small change is all that is necessary,

vii) Clients define the goal,

viii) Rapid change or resolution of problems is possible,

ix) There is no one "right" way to view things, and

x) Focus on what is possible and changeable rather what is impossible and intractable.

2. The various types of questions asked in solution focussed family therapy are given below:

i) Goal defining questions,

ii) Problem definition,

iii) Exception questions,

iv) Existing resource questions,

v) Miracle questions,

vi) Scaling questions,

vii) Advantage questions, and

viii) Coping questions.

## Check Your Progress Exercise 3

1. Following are the various techniques that are used in solution focused family therapy:

   i) Introducing uncertainty,

   ii) Framing questions,

   iii) Reframing problem definitions,

   iv) Problem solving techniques,

   v) Matching the client's language,

   vi) Channeling the client's language,

   vii) Normalising and depathologising,

   viii) Goal setting, and

   ix) Fast-forwarding questions

2. Therapeutic process in solution focused family therapy follows following steps:

   i) Finding out about the client's life,

   ii) Gathering a brief description of the problem behaviours,

   iii) Asking relationship questions to help the client define socially constructed nature of the problem,

   iv) Tracking solution behaviour or exceptions to the problem,

   v) Scaling the problems,

   vi) Using coping and motivation questions to assess how the client perceives they are coping and to determine their motivation for change,

   vii) Asking the miracle question to develop solutions,

   viii) Negotiating the goal for change,

   ix) Taking a session break for reflection, development of compliments and formulation of a set of behavioural tasks,

   x) Delivering compliments and tasks, and

   xi) Summation message.

## Check Your Progress Exercise 4

1. i) False

   ii) True

   iii) False

   iv) True

**Check Your Progress Exercise 5**

1. i) Sequence of behaviour: Sequence of behaviour can be defined as the communication patterns in the family in present situation.

   ii) Neutrality: Neutrality can be defined as avoiding side taking or being partial to family members and maintaing neutral position.

   iii) Hypothesization: Hypothesization means defining the problem or giving a tentative explanation about what function the symptoms are serving in the family context.

**Check Your Progress Exercise 6**

1. Following are the various techniques used in strategic family therapy:
   i) Reframing,
   ii) Out-positioning,
   iii) Paradoxical interventions,
   iv) Symptom prescription,
   v) Restraining techniques,
   vi) Positive connotation, and
   vii) Rituals.
2. According to Milan group, strategic family therapy has following stages:
   i) Pre-session,
   ii) Session,
   iii) Intersession,
   iv) Intervention, and
   v) Post-session.

## 10.16 UNIT END QUESTIONS

1. How will you differentiate between solution focused family therapy and strategic family therapy?
2. How are the techniques used in solution focused family therapy different from the techniques used in strategic family therapy?
3. Write a note on assumptions of solution focused family therapy and strategic family therapy.
4. Explain theoretical models in strategic family therapy.

## 10.17 FURTHER READINGS AND REFERENCES

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# UNIT 11 SYSTEMIC FAMILY THERAPY

## Structure


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## 11.1 INTRODUCTION

This Unit explains the theory of systemic family therapy. This is important because therapists who work with families need to thoroughly understand, and be rooted in a conceptual framework, without which they are at risk of viewing the family and its problems exactly as the family does. This Unit also explains the shift from individual to a contextual focus, which is at the heart of systemic thinking. Since systemic ideas offer us a way to work with families and is a theory that is culture fair, giving culture a great deal of importance, it is ideally suited to working with Indian families.

**Objectives**

After studying this Unit, you will be able to:

- Define systemic family therapy;
- Explain historical development and key features of systemic family therapy;
- Understand the process of systemic family therapy;
- Describe the role of therapist in systemic family therapy; and
- Recognise the success or failure of therapy.

## 11.2 WHAT IS SYSTEMIC FAMILY THERAPY?

Systemic family therapy is a model of family therapy and shares concepts and ways of working with other family therapy models. The commonalities that it shares with other family therapy models are:

- The unit of treatment is the family; no one family member is singled out as a patient;
- The person whom the family identifies as the patient is considered as the person reflecting the family disturbances;
- The family members are seen together for the session;
- Traditional concepts and theories that describe personality types to explain individual behaviour are not useful in family therapy;
- Therapeutic goals and methods are family centered, and the whole family's welfare is of concern; and
- Circular causality rather than linear thinking is a central concept in family therapy.

Now, we will discuss what is systemic family therapy. The term systemic family therapy was used to refer to the Milan model of family therapy but the term now has a much wider meaning. It is used interchangeably with 'systems therapy' and refers to therapy in which systems principles are applied to the work. All systemic family therapists are systems thinkers. The systemic therapist is primarily interested in the relationships between individuals and

the system. Further, systems theory which is the basis for systemic family therapy (Rivett & Street, 2003) states that :

- a family is a *system* of interrelated parts in which relationships develop through a process of *feedback*;
- each family member's behaviour is determined by a *pattern* of interactions, and every action is a response at a point in a system;
- these patterns are repetitious and conform to *rules* that develop over time;
- the rules that govern actions have *meaning* for the system, and it is the meaning that reinforces the rules of behaviour, but change in behaviour can bring about change in meanings and thereby, also a change in rules;
- these patterns demonstrate to us the *circularity* of interactions;
- some of these patterns happen in *contexts* that promote change while others hinder change, so attention to the context is very important;
- *feedback* to the system determines which patterns are continued and which are modified; and
- when the system is unable to adapt to change it develops a *symptom.*

You will be reading about these points in detail in further sections.

### 11.2.1 Who would Benefit from Systemic Family Therapy?

Systemic family therapy beneficiaries have been discussed below:

- Families of all types, from all cultural, racial, ethnic, religious, class and caste backgrounds would benefit because of the attention paid to issues of power and being 'different' in systemic family therapy. It is recognised in systems work that a family who is a minority (e.g., ethnic, immigrant) may have more problems in contexts where they are disadvantaged by the majority viewpoint of what is considered normal or good. Systemic therapists also are very open and respectful of cultural differences in beliefs and practices (e.g., child rearing practices). In the session, systemic family therapist gives power back to the family to create alternatives and make choices.
- Families at every stage in the family life cycle, particularly when making transitions from one stage to another. It is commonly seen that families facing a developmental crisis of the addition of a member (as in birth or through marriage), or a loss (death or divorce, children leaving home for studies or employment) may have difficulty adapting to the change and one or more family members may develop symptoms. Family therapy offers a framework for diagnosing and treating families through the developmental tasks required in various life cycle stages. Since systemic work is oriented towards families, it is also child-focused and research shows that children greatly benefit from family therapy, from being able to listen and talk in the sessions with family members.
- Families in which one member has a diagnosis for a minor or major mental illness, for example, depression, anorexia, schizophrenia, anxiety

disorders, conduct disorders, school related problems, truancy, etc. Systemic family therapy helps the family to increase the options of the roles and responsibilities of people and to establish boundaries between wellness and illness as well as to blur these boundaries as required. For example, in a couple with a depressed wife, the husband had increasingly become more the responsible 'care-taker' and the wife sank more onto being the ill 'patient' doing less than she was able to do earlier. The systems therapist intervened by expressing worry about the husband's health due to the overload of work, and prescribed a day-off for the husband every other day. It was seen that the wife became more active in attending to her responsibilities and was more able to take turns in being the 'care-taker' with the husband as he gave up his rigid holding of his role as the functional one in the relationship.

- Inter-generation families which have children, either young, adolescent or adult, systems work with cross-generations in the same room allows for the most effective way of working as proven by outcome research.
- Individuals whose families cannot or will not attend family therapy, benefit from systems therapy.

### 11.2.2 What is a Family?

For some people this question may seem odd, because everyone knows that a family is, at its core, a husband-wife unit, married to each other and living together, with the children born to them. There may be values associated with a family such as good child-rearing or taking care of elders. This basic form of the family is considered the norm against which all other family forms are judged as being 'not normal' or deviant. For others, say in parts of India, the norm for a family is several generations living in the same house as a joint family. Any division into smaller units is seen as a 'partition' that is a disruptive fissure in family life that arouses a great deal of distress.

But for other people it may be more difficult to say what a family should be like (Silva & Smart 1999). They see that people are in intimate relationships with each other in many different ways. Some such examples are:

- married couples living in different places;
- unmarried heterosexuals living together;
- a family of friends, or a 'family' of choice;
- an orphan having relationships with people not related by blood;
- close relationship with someone not related by blood;
- a person in a loving relationship with a same sex partner;
- a divorced couple who are parenting their children and spend significant time together including, birthdays, festivals etc.;
- divorced couple who have married other people and are in relationship with ex-spouses, ex-inlaws, and stepchildren;
- as stepfamilies in which divorced people live together with their children conceived in their earlier relationships;

- older woman in significant relationship with a man 20 years younger and she is the primary earner;
- man with two spouses and their children who may live together or in separate households; and
- single parent family, where often a single mother will head the household.

There are many people who live in these and other forms of 'family'. Instead of seeing it as a sign of breakdown of society or of a moral and social decline, it can be seen as evolution of family practices. These forms of family have developed over time as a response to culture, history, and socio-economic circumstances (response to new employment practices, gender relationships or increasing acceptance of sexual orientations). One way to define family could be to call it a context for intimate relationship for the fulfillment of emotional and material needs of all members.

Systemic family therapy takes a very broad definition of 'family' in which co-residence, heterosexuality or even two adults are not a pre-requisite, in keeping with its value base of being respecting all views and cultural practices.

**Check Your Progress Exercise 1**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. State 'true' or 'false':
   i) In systemic family therapy, the unit of treatment is one family member who has a problem, instead of the whole family. _____
   ii) Families of all types, from all cultural, religious, ethnic, social, class and caste background would benefit from systemic family therapy. _____
   iii) Systemic family therapy adopts a very broad definition of family and respects variations. _____
2. Describe any three common featuers of systemic family therapy and other models of family therapy.

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## 11.3 HISTORICAL DEVELOPMENT OF SYSTEMIC FAMILY THERAPY

Family therapy developed out of the application of cybernetic theory to human relationships. The term *cybernetics* referred originally to the science of feedback mechanisms in machines, and later to communication in human systems. Gregory Bateson (1972), a pioneer in this new 'epistemology' said that the organisation of events (psychological, social, behavioural) could only

be understood in terms of pattern and information. He studied schizophrenia as an interactional phenomena rather than an intrapsychic one. Family therapy models including the Milan model developed out of the influence of Bateson's work as well as communication theory based on the work of Watzlawick and associates (1974). Later, the Milan model evolved into the current form of systemic family therapy which also incorporates narrative therapy within it. Given below is a brief description of the conceptual framework of the three forms *viz.* (i) Systemic family therapy; (ii) Milan systemic model; and (iii) Narrative therapy.

(i) **Systemic family therapy:** It evolved through innovations in earlier approaches of family therapy like the structural, strategic and experiential models. These developments grew out of the experience of working with families, and one of the important ones that shaped systems thinking came to be called the *Milan group work* because it evolved at a family clinic in Italy; and another one came to be called *narrative therapy* based on work done by Michael White in Australia. Both these family therapy practitioners are social constructionists or constructivists, who assume that a given situation can have several interpretations or versions, all being valid. There is no 'correct' view. According to their view it is more important to ask which view is most helpful to the family. They also say that the family's own view is the most important to take into consideration because it is the factor that will hinder or help the family in finding solutions to its problems. They emphasise Gregory Bateson's view that when information different to the family's dominant mode of thinking is presented to the family, it begins the change process.

(ii) **Milan Systemic Model:** The group of Mara Selvini Palazzoli, Luigi Boscolo, Guiliana Prata, and Gianfranco Cecchin worked together to develop systemic ideas with families with anorexia, encopretic and emotionally disturbed children. They developed circular questioning, hypothesising, and neutrality as systemic practices. They also emphasised changes in thinking as an important therapeutic goal. They looked for openings to provide families with a positive way of looking at problematic behaviours, called *positive connotation.*

(iii) **Narrative Therapy:** Michael White has incorporated social construction ideas through playful ideas that address the dominant negative view of the family, society and mental health field which is seen as oppressing the family. He suggests that the family needs to be liberated from these negative, oppressive frameworks by using their own expert knowledge. He encourages families to notice when their problems do not oppress them, when they do not have problems and small exceptions to their negative experience. He calls these moments '*unique outcomes*'. He uses this new heightened awareness of positive experiences as bringing forth a story or self definition of success that had been marginalised earlier but now can be re-claimed as theirs.

### 11.3.1 Contribution of Feminist Critique

Feminists have critiqued several early family therapy ideas in structural and strategic family therapy models and contributed significantly to the development of a gender-fair therapy (Burck & Speed,1995). Early family therapy theory stated that all participants in an interaction contribute equally

to its maintenance. This pathologised women caught in abusive sexual and physical abuse from their male partners. The challenge to this has encouraged thinking about other situations where power is unequal, in maintaining destructive and unhealthy patterns. Feminist thinking has also challenged 'mother-blaming' where women are held unfairly responsible for a number of family problems. Women are blamed for their own and other people's difficulties and this discourse in society is not only unfair to women but also to men because it has prevented any real discussion on masculinity and men's experience.

Systemic family therapy has incorporated in its theory and practice a focus on addressing issues of unequal power in relationships, not only in gendered relationships, but in other relationships in the family, in the relationship of the individual and family with practices of abusive power in the larger society, and even in therapy.

### 11.3.2 Influence of Social Construction and Post-Modernism

**Social construction:** The influence of social construction has been significant. In this viewpoint, all knowledge of the world is the result of our own constructing, ordering, creating and not the result of the discovery of some objective reality. In therapy this means that there is no one reality, the therapist and clients co-create new meaning of experience. This is the position taken by systemic therapists.

**Post-modernism:** This is a philosophical system that emerged in the 1970's and 1980's that focuses on elaboration, eclecticism, and inclusiveness. Modernism as seen in earlier models of family therapy ignored issues such as gender, ethnicity, and the impact of larger systems such as political and economic forces. Modernism also promoted the following of a single model of therapy. Post-modernism ideas have been incorporated into systemic ideas of working such as eclecticism and integration of theories.

## 11.4 KEY FEATURES OF SYSTEMIC FAMILY THERAPY

Let us discuss important features of systemic family therapy. These are given below:

### 11.4.1 The Family or Organization as a 'System'

A *system* is any set of interrelated parts that is structured on feedback. In systemic family therapy the family is seen as a 'system', made up of people who are part of that family. These family members can be called *parts of the system*. Each of these separate parts has a function for the whole system. Each part interacts and impacts every other part, like a stone thrown into a still pool of water will set off waves in every direction. The focus is on the relationship between the parts rather than on the parts themselves. Parts of a system interact, co-vary and evolve through feedback loops. Systemic theory gives a great deal of importance to the creation and observation of feedback processes.

### 11.4.2 Components of a 'System'

The parts of the system include the individuals who are in relationship with each other, the extended, inter-generational family members they are connected to, other groups to whom the family claims affiliation such as class, caste, racial, ethnic, religious, professional, cultural, political, social etc. The system also includes organisations and institutions that impact the family and are in turn impacted upon by families, educational institutions, the judiciary and legal system, social welfare system etc.

The relationship of the family to the world of ideas is also part of the system. Families live in different systems of belief which affect their thinking and their choices, for instance, the different belief systems about gender relationships in any community will impact what is considered appropriate behaviour for girls and boys. Each person, family, and community behaviours will in turn impact belief systems over time.

In systemic therapy the therapist is part of the therapeutic system with the family. The therapist is not an objective outsider but is a participant-observer of the system.

### 11.4.3 Systemic Theoretical Concepts

Following are some of the key theoretical concepts in systemic family therapy, as enunciated by Campbell *et al.* (1988):

1. Feedback over time creates patterns, that is, the rules that the system follows. Feedback defines and regulates the system.

2. Patterns develop in context. Let us study the following case vignette to understand this concept better.

**Case Vignette**

At dinner time, the eldest daughter, Tina (15 yrs.) starts by talking about something that happened at school. Mother listens carefully while Father starts watching Raman (5 yrs.), the youngest son who plays with his food. Father tries to feed him while the middle child Anita (9 yrs.) eats quietly looking down at her plate. Father asks Mother to feed Raman and Tina gets upset that Father only cares for Raman. Mother fusses over Raman and asks Father to listen to Tina. But Tina gets upset and walks away from the table. Father gets angry at Tina. No-one notices that Anita is silent. This interactional sequence is repeated over and over again. Several patterns of interaction can be identified.

Now, let us answer some of these questions:

Ques 1. In the given case what behaviours are manifested by each family member during dinner-time? If this family continues to interact in this way, which behaviours may get reinforced into patterns in each of the family members?

Ans 1: For the example given above, it is the father's pattern of behaviour that has got reinforced over time. Father believes that he has to be incharge of teaching the children correct behaviour, since his wife is unable to do it. He continues to teach Raman how to eat and later to study and what sport to play, and

continues to direct his wife to be a proper mother to Raman and the girls.

Ques 2: Suggest a few sentences for the rest of the family members regarding their behaviour patterns; Mother, Tina, Anita, and Raman.

Ans 2: *There is no correct answer, given below are suggestions:*

*Mother* believes that she has to be the peace keeper between people especially between Tina and her husband. In trying to be a good wife and good mother, she feels less and less able to intervene to resolve conflicts.

*Tina* believes that her father favours Raman because he is a boy. Her behaviour becomes more confrontational, and she sees that is the only way that she can get her father to notice her, even though it is negative attention. For her, Mother's attention is not as important as Father's. She has learnt to follow the family rule that males are more important than females, even though she fights against it.

*Anita* believes that as the middle child she is not as important as the eldest or the youngest sibling. The meaning she draws from being ignored at family time is that she cannot compete with her siblings be 'seen' or 'heard' and so she becomes self-reliant and does well at school. She appears self-confident and able but does not feel that anyone understands her.

*Raman* sees that he has to do little to get both his parents interested in him. He does not like the fighting at dinner time and cannot understand why Tina will not play with him. He sees that his father and mother argue about him and his mother is often scolded by father. He starts spending more time on the computer or out with his friends.

3. Context gives meaning for the events and behaviours of a family system. For example in the above family, the relevant contexts could be:

   i) Family belongs to middle class and there are cultural rules about proper behaviour for a father, mother, eldest child, middle child and youngest child;

   ii) Cultural beliefs about gender and desirability of a male child;

   iii) Extended family experience and meaning of having two girls and a boy with gaps of several years;

   iv) Parental and marital context for the couple;

   v) Family coming together at the end of the day; and

   vi) Argument at dinnertime.

**Definition of context**: Context is the frame in which behaviour, verbal and non-verbal messages become meaningful. Just as the meaning of a sentence comes from the text in which it is placed, so must behaviour be understood as being influenced by its context. Different rules for

behaviour are present in different contexts according to certain rules and functions. For example, rules for a sibling relationship are different from rules for a friendship, and the rules are again different for the same sibling relationship depending on whether the siblings are married or single. The symptoms of the individual/couple/family must be seen in the context of its meaning for the family and the wider social system. Each individual is embedded in a 'transactional field' and each family is also embedded in its 'transactional field' whose frame of reference is unique. Therapy always means a change in the individual context as well as in the collective family context.

4. A system develops patterns creating meanings and beliefs which then influence behaviours that reinforce existing systems in a recursive or circular loop.

5. Meanings can come from contexts that can be arranged in a hierarchical structure (Pierce and Cronen, 1985). Some contexts at higher levels are abstract, derive from nationality or culture and can apply to many families, while others are more personal and can apply to relationships such as a husband-wife relationship from a particular local culture.

In the case vignette of the family above, the contexts are placed hierarchically from the highest level to the lowest level as below:

i) Family's middle class and cultural rules about proper behaviour for a father, mother, eldest child, middle child and youngest child,

ii) Intergeneration patterns of interaction between genders,

iii) Marital quality of the parents,

iv) Rules of conflict between the members of this family (who can argue? Who can't?), and

v) Argument at dinner-time today.

Each level impacts and gives meaning to all other levels.

6. There are forces for change and forces for no-change or stability (homeostasis) in the system and the family's problems are seen as a struggle between these forces.

7. Disturbance in one part will affect all other parts and change in one part will affect other parts.

8. Change can come from any part of the system. Systemic therapists work towards creating the context for change, primarily in the family's thinking about the problem behaviour differently.

9. Therapists help bring about change in the family's thinking about the problem by listening carefully and posing questions which generate new ideas.

10. The therapist is part of the system, not an objective outsider and can get stuck with a limited view of the system, hence many views are presented in the therapeutic session.

### 11.4.4 Definition of a Problem in Systemic Therapy

Difficulties are considered as arising from relationships and not from individual people. Unlike psychodynamic therapies, family therapists do not locate problems in the individual's internal states, emotional, cognitive or behavioural, or in their personalities or individual history.

For instance, in the above case vignette, the family with 3 children, the family came in saying that they are worried that their 15 year old is an angry person and that this would affect her future life. The systems therapist would be interested in their construction of their daughter as an 'angry person' and would use circular questioning to get a behavioural description of what behaviours they call 'angry' and 'not-angry', and what it means to be either. The therapist asks 'who else in the family likes to fight and who likes to be peaceful?' 'In what situations, and with which persons, does daughter show more interest in being peaceful?'

This shift away from individual guilt and individual pathology to looking into how the parts of the system interact, is an important aspect of freeing the family from being stuck with a problem definition that is pathologising and hinders problem solving. Rather the focus is on the parts of the system from where problems have emerged. In the above case, the focus shifts from a labeling to an interactive description. The therapist asks, 'how do you explain her many friends at school and her good interactions with them and the wish to fight at home?'. It emerged that the daughter felt discriminated against at home in comparison to her brother who was favoured by father and grandparents. Overtime she had only become confrontational with the family. The family had a cultural bias favouring male children, even though daughters were cared for and loved. When the family saw that unintentionally they had sent out mixed signals they talked to elders in the family and made significant changes in their interaction with the children to correct the imbalance between boys and girls at home.

Problem development happens when the family is stuck and unable to respond to emerging situations appropriately. Overtime patterns develop that leave families with a limited range of options. The rules governing behaviour become fixed and make it difficult for the family to change. Dominant voices and views have subjugated other discourses so that this creates problems for the system.

Wider systems may also create problems for the family and the individual members. Attention must be paid to power relationships in immigrant families as well as to ethnicity, race, gender and all relationships where abuse may exist because of some people holding greater power because of being a majority, or of higher status or holding more resources.

Systemic therapists formulate as many hypotheses as they can of what the problem in the system may be. They are not bogged down by any one explanation because they believe that there is no one truth, instead they believe in multi-versions. Each version may be valid from the standpoint of the people who see it from their vantage point. But all problems are formulated in terms of relationships that are recursive. This means that people impact each other in a circular causality, rather than a linear one.

### 11.4.5 Function of the Symptom

The problem or symptom is seen as serving a function for the system. The symptom bearer is usually the person who is showing some difficulties and is brought in by the family to be 'cured'. The family therapist thinks of this person as the 'identified patient', the symptom bearer for the family system. The symptom is viewed as a communication about the context of the family. For example, sadness in one member may be a communication that the family is mourning the loss of someone, or failing in school leaving exams may be a communication that the family is not ready to enter the next phase of the family life cycle. The family therapist becomes very curious about the family relationships and the purpose of the symptom that the identified patient is showing. Through talking to the family and exploring the relationships around the presenting problem, the therapist actively seeks different explanations for the symptom development. Exploring the context of the family's life and the meaning they give their present difficulties will lead to a reformulation of the problem in an interactive form as existing within the domain of relationships.

**Check Your Progress Exercise 2**

***Note:*** a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the three forms of systemic family therapy.

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2. What are the key featuers of systemic family therapy?

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## 11.5 CONCEPTS THAT HELP TO UNDERSTAND FAMILY COMMUNICATION PROCESS

Communication theory has developed 5 principles (Watzlawick et al., 1967) that can help you to understand complicated communication processes, in particular the rules governing family interaction. These are discussed below:

- Human communication is a complex process. Verbal and non verbalV bodily communication is an example of such process. Analogue and digital is another way of describing human communication process. In *digital communication* there is no similarity between the expressed sign and its meaning—for example the word 'cry' in itself does not have anything 'crying' about it. Words and language, are digital in

communication. They are complex and open to wide interpretation. In *analogue communication*, there is similarity between what is expressed and the manner in which it is expressed, for example tears are a form of analogue communication. The information can still be ambiguous for example, tears can be for joy, sadness, anger, relief or other emotions. As a person acquires language, communication becomes increasingly 'digitalised'. A young child uses the word '*ma*' as an analogue communication to express need for food, love, other sensations and situations associated with mother. Later, the word is used in a narrower definition of a person called 'mother'.

- When people are in any kind of relationship with each other, all behaviour in interpersonal situations contains communication messages. One cannot not communicate. A person who is not attempting to communicate, who has withdrawn from an interaction, is paradoxically still communicating because non-communicating is a form of communication too.

- Every interpersonal communication is not only exchange of information about some topic, but also contains a message regarding the relationship between the people interacting.

  For example: Two people A and B are discussing what to cook for dinner. They discuss what vegetables are available (content or subject talk). During the talk, person A agrees with the opinion of person B (communication message about the relationship between the two people). Family therapists are more interested in the latter, which is talk about the process. Did person A show agreement because person B is higher in hierarchy ( older, higher in the family constellation, employer, teacher or more experienced) than person A?

  If both persons recognise the relationship (student–pupil, employer-employee, or as husband–wife who are equal partners in decision making) and agree with it, the communication will be clear. However, if the definition of the relationship is unresolved between them (person A and person B are rivals for a dominant position) the conversation will lead to conflict.

- The nature of a relationship between people is determined by the way they punctuate the communication between them. For example, a husband and wife each have their own perception of their interaction as having happened in a particular sequence, and each of them also have their own version of cause and effect. The husband says he withdraws because of his wife's nagging, while the wife says that she nags him because he withdraws from her. This is one way of punctuating the sequence of interaction, and it influences the meaning that is given to it. Each of them blames the other. Their own behaviour is then seen merely as a reaction and therefore 'innocent'. This type of thinking will lead to repetition of this interactional pattern. Change can happen when a different way of punctuation is facilitated by the family therapist. The therapist and the family have to be able to see the process between people, 'the process which connects them'. Rather than seeing the individuals and their individual viewpoints, and debating on who is to blame, or who is at fault, we have to accept each punctuation as a point of view. We have

to understand the process of interaction and be able to have multiple punctuations of any interaction. This is the crux of the systemic 'circular' view. It can be challenging for a novice because we are used to thinking in terms of either/or. Either good or bad, either in the wrong or in the right, either this version of events or that version of events, either responsible or irresponsible, or other dichotomies. Holding different punctuations or views of an interaction is something that you can start doing anywhere—at home, in the office, at the market. Just try to see things from different viewpoints and then try to understand the whole sequence of responses.

- Communication between people is either symmetrical or complementary depending on whether it is based on equality or difference. Bateson (1972) introduced the idea that there is a dynamic equilibrium in relationships based on these two types of patterns of relating. Examples of complementary relationship are doctor-patient, mother-child, aggressive-submissive, that is they are different but 'fit' together based on hierarchical positions of dominant or inferior. Haley (1963) elaborated on this by distinguishing two positions of complementary behaviour; these are:

  - One-up (being in control or leader) and one-down (being taken care of or follower).

  - Over-adequate—under-adequate functioning relationship in which one person does the work of the other, for example when a mother does the parenting work in order to compensate for the father's absence from home.

Examples of symmetrical relationships are siblings competing for parent's attention, that is in similar position in relation to a third party (in the example, the third party is the parent or the parental subsystem), but different in themselves. Most long term relationships are reciprocal, that is they alternate between symmetrical and complimentary.

## 11.6 SYSTEMIC IDEAS ABOUT CHANGE

When unexpected change occurs, in order to survive, a system can:

- Try to stay the same by pretending that nothing has changed, or by reinforcing its rules rigidly, thus causing symptoms to develop,

- Remove itself from the new environment, which is not possible in most cases,

- Adapt by making small changes, and

- Change its own internal structure of rules, patterns and meanings in a way that it is authentic and coherent for itself.

Thus, a system has the capacity for both, maintaining stability (homeostasis) and change (morphogenesis) and both are properties of a family system. Now, we will discuss these processes in detail.

**Homeostasis:** Homeostasis is the tendency to stability or protects the system from disorganisation or chaos and is as necessary as the capacity for change.

A system will be consistent with its belief and interaction patterns even when they cause pain, create problems or are otherwise apparently dysfunctional. This is because these patterns serve the purpose of consistency or retaining something that is known. Family members can predict what will happen and how others will behave. This helps them to reassuringly define themselves like 'this is who we are, and this is how we do things'. Even the most painful repetitions of behaviour offer comfort because they are dependably reliable. In any family the forces of homeostasis can vary from a limited number of rules about behaviour to a wide range. The system will correct itself when there are small changes to be made in order to remain stable, like in a see-saw where small adjustments are made in order that the see-saw retains its position.

**Morphogenesis:** Morphogenesis or the forces for change or are also a property of a system and is seen as a necessity for survival. The capacity to change causes new behaviours and beliefs to be created. Systems switch between times when the forces of change are stronger than the forces of stability and the family feels sufficiently drawn to giving up its familiar and reliable rules and patterns to venture into new and unexplored ways of relating.

## Change Process

A system is able to change in several ways. Some of the ways are discussed below:

- **Some parts of a system can change but the system itself does not change:** These changes are corrective and maintain the stability of the system The system does not learn anything new, and therefore does not increase its options for problem solving for the future. Cause and effect are still only linked in a linear way. This is called *first-order change*. The system responds to pain and corrects itself because of the negative feedback, and thus the system is kept at a constant level.

- **The system changes qualitatively:** It means, the rules that govern the system change. This is called *second order-change*. The system's ability to learn is enhanced and future adaptability is increased. Second-order change is evident when small therapeutic interventions produce large changes in families. Change is based on feedback in which small deviations are encouraged by positive feedback so that new structures of behaviour, rules, meanings and beliefs are developed.

  The goals of therapy largely determine which type of change is being consciously or unconsciously sought by the family. The preference of the family will make itself known in many ways, stated clearly as well as shown through behaviour, use of language and repeated phrases, and it is for the therapist to follow the feedback and to hypothesise what meaning and repercussion that change will have for the family. Some families want a return to *status quo*, that is, the condition that existed in the family prior to the appearance of the symptom. If one wants new patterns of behaviour and improved problem solving abilities then second-order change is the aim of therapy. In practice it is seen that different members may want different types of change or families themselves will

want different outcomes at different times. When there is more difference between people about the direction and amount of change there are more difficulties and symptoms become entrenched.

- **Change happens through new information:** In second–order change there is a small or big change but always a fundamental change in relationships through positive feedback to the system. Bateson (1979) calls such changes *'a difference that makes a difference'*. Systemic family therapists conceptualise new information somewhat differently than the normal definition of information. Information is only information when it is recognised and responded to as being different from earlier manifestations. For example, when a son who is known in his family for his aloofness, sits together with the family and talks to them, it is different behaviour. The family responds to this by talking with warmth and openness. When the family reflects about what was different today, it emerges that the son had not been criticized today for being a failure in his board exams by his parents, instead he had been encouraged by them and consequently had joined in the pleasant talking. If no-one had noticed this new way of relating it would have been forgotten and the more dominant narrative of 'aloofness' would have continued. Instead, there is a new narrative of mutual respect and participation in the family.

  *'News of a difference makes a difference'* Bateson's words guide a systemic therapist to search for and highlight new information or exceptions to a taken-for-granted way of behaving.

- **Change either/or frame to both/and:** When we attempt to expand our frame of reference from either/or to something more inclusive of all viewpoints or punctuations it is useful to think in terms of a frame of 'both' (either this or that) dichotomous viewpoints plus add some more viewpoints ('and'). This resulting frame of 'both/and' represents the systemic idea of there being no one right version but there are multi versions of any event. This post-modern frame encourages circular thinking.

- **Change from focus on content to process:** Most families come in describing 'what' (content) happened and as pointed out earlier the narrative is punctuated by individuals from their individual frame of reference. Such talking, no matter how thorough it is, can not lead to change with couples or families unless we include talking about 'how' (process). This switch can lead to punctuation that shows us the patterns of interactions. The meanings that interactions have for the participants can only emerge in talk about process of communication. When families are observed by the therapist as they talk about the content, therapists can observe the areas where the family is stuck in redundant patterns. When the therapist intervenes by focusing on process, new information will emerge about the process of the family's communications, which is amplified by the therapist to facilitate change for the family.

Systemic therapists also are cautious about content talk when it is focused on symptomatic behaviour that pathologises one or more members of a

family. This kind of talk may be harmful because the more the therapist asks questions about it, the more it is described, and as the therapist listens it appears as if the description is being accepted. The power to define the 'problem' is handed over to the person or persons who are describing it. It is important that the focus shift to the process of how the problem came to be defined, and who were the people involved in this description and who were not. The therapist thus feels free not to accept the dominant pathologizing explanations and descriptions, and instead can show respect and create room for new descriptions. Another area where it is important to move in and out of talk about content is when content talk is too dominant about any one area of the family's life or relationships. At any one time there are many areas that can be usefully explored and it is important for the systemic therapist to keep moving between them rather than getting stuck with one aspect of it and drawing too many conclusions or meanings from it. All hypotheses must be explored. A family session may go like this — move into content, stop short, move into process, stop short, omitting any conclusion or further exploration. This way content or process are part of a recursive rhythm that reveals 'many threads that can be woven into a fabric of meaning for the family' (Inger & Inger 1992).

**Check Your Progress Exercise 3**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Match the following:

| | |
|---|---|
| i) Digital communication | a) The tendency to stability |
| ii) Morphogenesis | b) Condition that existed in the family prior to the appearance of the symptom |
| iii) Analogue communication | c) No similarity between the expressed sign and its meaning |
| iv) Homeostasis | d) The forces for change |
| v) Status quo | e) Similarity between expressed emotion and its meaning |

2. Enlist some ways in which system is able to change.

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## 11.7 PRACTICE OF SYSTEMIC FAMILY THERAPY

In this Section, we will discuss practice of systemic family therapy.

### 11.7.1 Convening the Family

Convening the family can be easy or it can be the most difficult part of the whole therapeutic process (Burnham,1986) depending on therapist's skill, the nature of the problem, family factors, the institution's intake procedure, and the referring person. While it is possible to work with parts of the family system it is important to convene the whole family or any significant others for the following reasons:

i) The systemic nature of the problem is clearer to all, including the family,

ii) If people don't attend in the beginning it is more difficult to bring them in later, which is also true in couples work,

iii) The interactional nature of the problem and it's solution is revealed with all present, and

iv) The therapist is less likely to be influenced by the people present about the people who are absent.

**Convening skills**: The more the convening is done in a routine matter-of-fact way by everybody concerned, including the telephone operator or receptionist, the more compliant the family. However, some skills are required for successful convening. Clients may ask why should everybody come when the problem is only with Zaheer and the other children are fine? The therapist should answer in a way that does not blame anyone and also emphasises how useful she or he has found this way of working. To answer, 'This maybe a problem in the family' is to blame the family and will discourage the family. A better response is, 'It is the best way to solve problems and results are quicker' or, 'In my experience, it helps to use the family's strengths to work effectively' or, 'We have seen that the family has useful information that helps us in our work' or 'Right now we need the views of everybody to help us with our work'. Avoid using the word family therapy or systemic family therapy unless directly asked the name of your approach or technique. Technical jargon is unnecessary, calling a session a meeting, or discussion or 'talking together' is more democratic language in which you and the family are equals.

***Whose responsibility is it to bring in reluctant family members?***

It is better if one or several people in the family take responsibility for bringing in reluctant members who are significant for family therapy. The following steps may be followed:

- Listen to the account of the person who has asked for the therapy,
- Re-state how important and useful it is for you to hear from all the family members how you can help them,

- Say that you really need to know how this problem affects them and others,
- Work out a meeting time that is suitable to the availability of all the family members. This takes some time and needs patience, and
- Coach the person present on how to ask the reluctant member to join the next session.

For a session in which the couple was to attend, if only the wife turns up, the therapist should follow the above steps, and reduce the time for the session by 15 to 20 minutes in order to not penalise the person attending but also to keep to one's way of working which is to see the family members together. Persistence gives results. In certain circumstances you can offer to make contact with the reluctant member by telephone, letter or email if the person will not object. It is better to ask the person attending whether it would be alright for you to do so. The message conveys 'no blame' and is an invitation to present their viewpoint on the difficulties. It also should convey that changes may be happening in the sessions that the absentee may want to contribute to or know about. For example the therapist could write/or say to a reluctant father — "I know that as a father you would have some good ideas about your son's growing up and would want to be a part of anything involving him, so I am calling you to find out when we could possibly meet?".

### Who to Invite

Convention varies, with some therapists insisting that the family therapy can only happen when all the members are present, to other therapists who will work with whoever from the family is interested in attending the sessions. Clarify your own ideas about this prior to the session and then present them confidently. Generally, you should invite all family members to attend, or any other significant persons. The composition depends on who is significant to the problem. Children benefit greatly by talking together with the family and should be included in family therapy sessions.

### Where to Meet

It is best to meet at your work place, meeting in the family's home is more complicated and the family tends to not value it as much. If you have to meet at their home because significant members are handicapped or physically unable to come, then set out formal rules like:

- Ask all members to be present in the room undisturbed for 45 minutes,
- Ask them to switch off phones/TV/radio,
- Ask for chairs to be placed so that all members can see everyone, in a circle,
- Ask household staff not to disturb the meeting, and
- Children should only have quiet toys or drawing material to play with.

### When to Meet

There needs to be structure, as well as flexibility in fixing the time for sessions. To be too vague and leave session time too open conveys a non-seriousness of your intentions, while being too rigid does not work when

arranging for the whole family as well as the worker to be available. Leave some days with fixed timings for family sessions, say, Tuesday and Thursday afternoon between 10 a.m. and 2 p.m. Thus, you can offer choice to the family as well as have structure. Say that the session will take an hour to hour and a half in all, once a week, once a fortnight and later once a month, and that every family needs a different number of sessions but that you will try to keep the sessions to a minimum.

### 11.7.2 Mapping the Family Through the Genogram and the Cultural Genogram

Genograms are diagrams of the family relationship system, usually involving several generations. It shows the names, ages, dates of marriages, deaths, divorces, births, illnesses, the emotional closeness or distance, or conflict between family members. It can be used to map other pertinent information such as violence in the family, or decision-making dyads in each sub-unit of the family. The genogram is an important tool when used with a family because it can provide a transitional map of the family as it traces each members and the family as a whole in their various transitions, namely, life stages, cultural origins, family form, etc. Thus the genogram provides new information to the therapist and family to support or discard hypothesis. It is also useful in mapping different rates of change in family subsystems and can present the family with a view of itself and its functioning. The cultural genogram is a variation of the genogram in that it maps the influence of the family's culture on their behaviour, rituals, meanings and transition points. Both genograms are part of the systemic therapist's tool kit to help the family to change as it needs to.

### 11.7.3 Identifying Transition Stage: The Family Life Cycle

Most families experience some difficulties when they are in a transitional phase in family life. The family life cycle is an important tool to understand their difficulties. This framework or model outlines different stages that families pass through. There are cultural variations as well as different life stages for different family forms but all families change during their span of existence. At each stage the family has to negotiate various changes in structure, composition, roles, hierarchy, position in social status etc. Each stage has its own tasks that have to be accomplished these are emotional, psychological behavioural, symbolic, rituals, economic tasks etc. The triggers for change are generally exit and entry of people in the family and formation of bonds among various members. People may exit through death, divorce, migration, cut-off, marriage, desertion etc. People enter through birth, marriage, friendship, work, romance, bond formation, or extra-marital relationship. For example, an Indian family may experience transition points at many stages as in the example given below which starts with the marriage of young Mr. and Mrs. Jain, who live in a three generation family.

1. ***Their marriage–stage tasks:*** It includes joining of couple formation, integration of new member in Mr. Jain's household and loss of member in Mrs. Jain's household and entrance of son-in-law.

2. ***Birth of first child–stage tasks:*** It includes change of couple relationship to include parenting, involvement of other family members in child-rearing, rise in status for couple, role change to mother, father, etc.

3. ***Family with adolescent children—stage tasks:*** It includes negotiating relationship with between parents and children as they grow older, preparing children to be responsible as they grow older, negotiating entry of friends in adolescents' life, negotiating autonomy and cooperation between different generations of the family, particularly grandchildren.

4. ***Illness/grandparent's death—stage tasks:*** It includes taking care of elders in the family, mourning loss, assumption of more roles for Mr. Jain, re-negotiating power hierarchy with his siblings, assumption of seniority role by Mrs. Jain, their children's involvement with careers and new relationships.

5. ***Split with household of father's male siblings—stage tasks:*** It may include parents' grieving loss and also relief, re-negotiating relationships with joint family, loss of old family identity and creation of new one, changed economic circumstances and responses to that, new dwelling, new ways of staying connected, maintenance of old rituals in new ways.

Most of the above transitions are culture specific. There will be variations for families from different places, ethnicities, cultures and religious backgrounds (Carter & McGoldrick, 1988). The family life cycle for different family forms will also be different. For example, if the eldest child of Mrs. and Mr. Jain were to be of a homosexual orientation, the Jains' expected life-cycle would change in an unforeseen manner and may include task stages such as coming out, disorganisation of family, conflict and hopefully integration of the life choices of this family member. Divorce may be another unexpected life event in any family that requires many small and big changes.

### 11.7.4 Areas for Investigation

***At the initial intake*** it is useful to ask for information about:

1. The referral source and relationship with family,
2. Clinical information: It may include brief description of the problem and how it affects every family member,
3. Experiences in previous therapy or other informal help,
4. Family information about all the people who are affected by, or have an impact on the problem,
5. Expectations from family therapy, and
6. Scheduling information: It means who should attend, timing and frequency of the sessions.

***The first interview*** should also start the process of therapist and family joining to create a therapeutic relationship. The therapist should focus on following things:

1. Identifying family strengths,
2. Addressing issues of race, gender, age, culture between the family and the therapist,
3. Starting to track interactional sequences (who says what to whom and when), and

4. Developing therapeutic contracts by addressing client expectations, negotiating own role, providing rationale for goals (for example, why it is important to involve children) and roles (for example, the parents are responsible for supervising children in the session), exploring motivation, and addressing issues of confidentiality.

There are ***many areas that the therapist explores*** such as gender issues, race and culture, life cycle stages, nuclear or joint family experience, and other areas that impact the particular family. Given below is a sample list of questions to explore an intergenerational family as an example.

In ***assessing intergenerational dynamics*** the therapist may ask questions regarding family issues from the past, current extended family relationships, and future hopes for these relationships. Examples of such questions are:

- What stories from your family history have an influence on the thinking and behaviour of family members?,
- Does your current situation remind you of any other similar situation in your family of origin?,
- With which extended family member are you most comfortable with? With which least comfortable?, and
- Do couples relate differently to each other in this generation than in the previous generation? How will the next generation relate to their spouses?

### 11.7.5 Hypothesizing, Circularity and Neutrality

There are three guidelines for the therapeutic session (Selvini, *et al.,* 1980) and these are:

**Neutrality:** This is a desired trait for the family therapist. No family member is given the opportunity to feel that she or he has a special relationship with the therapist. The same degree of emotional closeness or distance is maintained to each family member. It helps in preventing the therapist from being drawn into family strategies that reduce the effectiveness of the therapist in the face of stormy or disturbing family events. The family therapist has empathy in relating to the distress and pain and uses circular questions to talk with the family rather than just reacting emotionally to one member's account.

**Hypothesizing:** It is the formulation by the therapist of a hypothesis based on the information that is known about the family which is being interviewed. It marks the starting point for the ideas that the therapist has and for the validation or discarding of these ideas. If the hypothesis are incorrect then new ones are made based on the information acquired during the testing of the earlier ones.

**Circularity:** It is the conducting of the session based on feedback received from the family in response to the information that is asked about relationships, differences and change. The term circularity or recursiveness or circular causality are used interchangeably to denote a sequence of cause and effect that loops back to the cause and according to the feedback loop can impact it to change. Cause and effect can be reversed in their impact on the individual or family (in memory, family rituals) if not in time (time cannot be reversed). For example, a family rule that was established in the past, is applied to the

present, and can be continued or modified in the future, according to the feedback that the family system receives. The therapist asks circular questions to elicit information that can be used as:

i) Feedback to the therapist to formulate hypothesis, and

ii) Feedback to the family to remain the same, or change.

### 11.7.6 Interviewing Techniques

Let us discuss two important interview techniques, that are as follows:

**Circular questioning:** It is a technique for asking questions about relationships, specifically about differences and similarities in viewpoints of family members, about context and meaning. Patterns of behaviour are revealed as recursive through circular questioning. Questions are based on hypothesis and help in confirming or discarding of the hypothesis. The purpose is to gather new information and to create possibilities for change. Circular questions are of many types.

**Reflexive questioning:** This type of questioning is designed to challenge the couples or families construction of reality, that is, their fixed and limiting explanations and descriptions of a relationship or an event. Karl Tomm (1988) has classified them into three categories called as hypothetical questions, questions about the future and triadic questioning.

### 11.7.7 Interventions as Part of Therapeutic Process

A *therapeutic intervention* is the process of entering an ongoing system of relationships for the purpose of initiating a change in the system. The therapist intervenes in many ways, verbal as well as nonverbal. Interventions can be direct or indirect, spontaneous or planned, and are chosen according to the therapist's experience and the family's requirements.

Family therapy is known for a wide range of interventions, however most of them involve the following steps:

i) Understanding thoroughly the family and its problems through talking to them and observing them. The family's dilemmas must be framed in clear terms of behaviour and belief,

ii) A respectful acknowledgement of the pain caused to them by their difficulties and sincere appreciation of their efforts to seek solutions, and

iii) Selection of intervention for each unique family.

In systemic therapy the interview process is itself an intervention. It uses following strategies for intervention.

- **Questions as interventions :** In family therapy the primary interventions are the questions that the therapists poses to the family thus opening up the conversation for the family members to examine their situation from all viewpoints. In the grammatical form of questions there is something that invites reflection and this creates possibilities for change, for something new to happen. Even small changes in people's thinking or behaviour can have profound change because it frees people from their habitual, stuck and rigid ways. The therapist's questions are directed to help family members generate

greater flexibility and increased choices for themselves.

Everything that a therapist does is an intervention, so questions are not randomly asked. All interventions have to be based on a systemic hypothesis about the family and the symptom like, Is the symptom a temporary response to a perceived crisis, or does the symptom serve a function to keep the family the same, or to bring about desired change? The criterion for the therapist in selecting questions is to choose those that enhance the family's own ability to find suitable solutions for their difficulties.

- **Reframing:** This is an intervention used by systemic therapists and has eveolved out of the positive connotation technique used by strategic family therapists. It can also be called *positive connotation*. The difference appears to be that the term reframing is more consistent with systemic therapy's stance on neutrality towards outcome and being respectful of not manipulating the client's experience.

In reframing, a concept or event or opinion is re-labeled or redefined to a slightly different and more constructive perspective.

For example, a boy called lazy by his parents, is referred to as a 'boy who likes to do things in his own time scale'.

A couple's complaint everyone fights a lot in their house at dinner-time, is reframed by the therapist as having lively and passionate discussions at dinner-time.

This process by which we label feelings, thoughts, attitudes, behaviours and events has been recognised as having a very significant influence on the way we perceive reality. It appears that we construct our own reality on the basis of our views that we impose on our experiences. Reframing effects an alteration in the family's internal model of the world. Thus, from a systemic perspective, not only the symptom bearer's behaviour is reframed, all the family members' behaviour is reframed too. The reframing is based on a hypothesis about the circular cause of a family's interaction patterns. This ensures therapist neutrality and avoids linear ideas of causality.

**Check Your Progress Exercise 4**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Answer the following questions in your own words as a systemic family therapist trying to convene a family.

   i) The problem is only with Samuel, the rest are normal. Why do you need all of us to come?

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ii) My husband's schedule is so tight, he is traveling all of next week, and again he will miss the session. Also he says that he does not think that Sanskritika has any problem, its all in my head. So, should I just come with Sanskritika?

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2. For the next two life stages of Mr. & Mrs. Jain's family given in subsection 11.7.3 write the stage tasks that the family has to do.

i) Marriage of first child

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ii) Birth of first grandchild

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3) Reframe each of the following in a few words of your own

i) She gets hysterical.

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ii) He is a miser, stingy about money.

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iii) The children never do as they are told.

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## 11.8 THERAPIST'S ROLE IN SYSTEMIC COUPLE/FAMILY THERAPY

The therapist's role and function is crucial to the successful outcome of systemic family therapy. The therapist takes a 'not knowing' stance, acknowledging that the therapist is not the expert on the family or on what

exactly would solve the family's difficulties. The family knows much more about itself and each of its members and the history of their life. They know their strengths as well as their problems, and the reasons for each, more than the therapist does. Sometimes families are too dis-empowered by society and their traumatic experiences; and the professional helping system can dis-empower them more by taking decisions on their behalf. Hence, it is important that therapists adopt a stance to give power back to the family.

The therapeutic relationship between the therapist and the family is 'decentred' (Flaskas, 1996) and the relationship of the clients to their significant others is central. The therapist's engagement with the family in systemic therapy requires the therapist to make and hold connections with them that are based on respect and compassion. Circular questioning and reframing of their problems creates a therapeutic bond. It may appear that the systemic therapist is detached, clinical and uninvolved because of the neutral stance and the hypothesising and circular questioning that the therapist, of necessity undertakes. In fact, all of this requires a high degree of empathy. The neutrality of the therapist does not mean disinterest about the family's distress or the damaging situations they are experiencing. The therapist's empathy is a source for the hypothesis and questions that the therapist employs. The therapist uses her or his empathy to pick up on the possibility of suicide, illness, violence, or abuse and to accordingly adjust their role to being an advocate or social controller or doctor. The therapist has to constantly attend to and adjust her or his relationship with the family and with the wider contexts of the family.

### 11.8.1 Key Competency Skills

The important skills that a therapist should have are discussed as follows:

- Acknowledge difference and uniqueness,
- Acknowledge positive efforts from the family and its members. The therapist appears to take a pro-family stance, giving a feeling of caring, or sincerely attempting to understand in a non-judgemental way. This is best done by recognising the desire of families for living in affectionate and caring relationships,
- Focus on family process rather than on content of talk, including adeptness at reading non-verbal communication and questioning of what experiences underlies it,
- Constant reflection on one's actions and intentions, by switching between taking the role of the other, viewing the world as she or he sees it, and one's own thoughts and feelings,
- Constant soliciting of feedback from clients of the effect of one's actions as therapist, the ideas that one brings to bear on therapy and interventions so that the client voices have equal say in the therapy context,
- Creating a safe context for talking where all members and all views can find expression, that is, patterns of abusive power relationships are not repeated in the therapy room, and are blocked by the therapist,
- Constructing new and alternative plans and their consequences, and
- Exploring meaning, determining significance, and making tentative interpretations.

### 11.8.2 Working with Co-Therapist, Reflecting Team and Other Professionals

Working with co-therapists, reflecting teams and other professionals in the therapy room are activities that embody the post-modern ideals of openness and reflectivity.

**Co-therapy:** Co-therapy refers to therapy in which two therapists work together in the same room with the same couple or family. Either both are listening and talking, or one talks with the couple or family while the other one observes silently until such time that the 'lead' therapist asks the silent therapist to share her or his observations. Sometimes the two therapists, after talking with the clients, will turn to each other and have a conversation with each other for a few minutes reflecting aloud about what they have heard the clients speak. Then they will ask the clients to reflect aloud or comment if they wish to, on what they the therapists spoke.

**Reflecting team**: This is the method that Tom Anderson (1987) developed. A team of family therapists observe a live session either on video tape or in the next room or behind a one-way mirror, and give suggestions to the therapist conducting the session while the therapy is occurring. They also deliver the end-of-session message to the family through the therapist.

There are many reasons why teamwork has proven to be particularly effective in family therapy. Some of them are explained below:

- In family therapy sessions, it is difficult for one person to observe and process the flood of information that emerges,
- The co-therapist or reflecting team ensures that the therapist is not getting involved and drawn into the family dynamics or taking sides with any one member or subgroup,
- The main reason for using team work is to ensure that the family hears a variety of ideas rather than only one interpretation or hypothesis. This is the systemic post-modern stance of doing therapy collaboratively with the family. No one view is seen to be better than others, all views are valid and therefore the search for many explanations and many descriptions is part of therapy,
- Working with co-therapists or the reflecting team is an attempt to share the power base of being the 'expert' therapist with other people,
- Encouragement to families to see their problems in a new light by creating new perspectives from the team about the subjugated narratives of the family through reframing,
- Using 'I' statements, the reflecting team members talk about the position of the family members, often pushing the differences in their position to extreme poles and debate on the dilemmas facing the family, thus clarifying and opening possibilities for change,
- Observation for training and supervision of the interaction between therapist and family is easier when the reflecting team can observe behind the one-way mirror, and
- Heterosexual co-therapy is recommended to minimise triangulation in therapy with conflicted, divorcing, or divorced couples.

The multi-perspective may be introduced by the co-therapist or team members near the middle or end of the session, in the presence of the therapist who remains silent till the co-therapist or team has finished. The reflecting team takes on the position of different family members or subsystems and then, having experienced the family from different viewpoints, has a discussion in front of the family. After the reflecting team finishes, the therapist asks the couple or family members whether they agreed or disagreed and how would they respond to what was said.

Sometimes other professionals such as the family doctor or a special educator, religious or spiritual guide, may be invited to the sessions to help with the therapeutic work. Their experience and advice may be sought by the therapist in knowing the family dynamics better.

**Check Your Progress Exercise 5**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. In your own words, explain why working with co-therapists and a team is useful for families.

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## 11.9 RECOGNISING SUCCESS AND FAILURE

The framing of success or failure in systemic family therapy is dependant on the definition of success and failure. Unrealistic and undefined goals to measure success will lead to a definition of failure either by the family or by the therapist. Failure or impasse in systemic therapy should be seen by a systemic therapist as an opportunity to re-think and re-hypothesise about the reason for the deadlock. It is a challenge for the therapist to reframe the failure. An impasse or no–change situation can be seen as:

- The family system communicating that it is not ready yet for change,
- The need to be slow and cautious to change is valuable for the family,
- The therapist-family system is at cross purposes with each other, working towards different goals,
- Feedback to the family system from other contexts is increasing resistance to change as the therapy is unsupported by other significant people or institutions, and

- The therapist or therapeutic system is not suitable for a particular family, and other experts need to be consultants to the therapy (cultural, language, special educators etc.).

### 11.9.1 Indications that Therapy is Failing

Let us discuss some of the indications that show therapy is failing:

- Goals for recognising success or failure by the family and therapist are different,vague or not discussed,
- Talk in sessions is repetitious,
- No new information is emerging,
- The therapist is no longer asking interesting questions,
- The family and therapist appear disheartened,
- The family report that there is no change at all, or things get worse,
- Feedback from others significant to the family is negative,
- Talk in the sessions is very general, and unfocused,
- Conflicts develop between therapist and a family member, and a tussle for dominance happens repeatedly,
- One or more members talk all the time and others do not speak,
- Sessions are forgotten or missed, and
- Sessions are led by therapist and the family takes an increasingly passive role.

### 11.9.2 Indications that Therapy is Successful

There are some indications through which one can judge that therapy is successful. These are as follows:

- Symptoms decrease and the distress caused by symptoms is less,
- Feedback from the family system and context is positive,
- Talk in sessions is focused and pertinent,
- New information emerges in the talking,
- There are shifts and changes in what people say and do in the session and outside sessions,
- More complexity and other contexts are brought into the conversation,
- There is a shared responsibility about participation and finding solutions between therapist and family,
- All members participate and contribute to the session, and
- Family is attending sessions regularly as scheduled.

### 11.9.3 Therapist Factors and Therapist Context that Contribute to Success or Failure

There are various therapist factors and therapist context that may contribute to success or failure of therapy. Let us study some of these factors and context in detail.

- The systemic model works best in a team or co-therapists working together. A lone therapist, particularly a beginner may find it harder to see a number of people together, since there are so many people to observe and attend to,

- Lack of training, supervision and support from the professions in the mental health field (due to unfamiliarity) is a common reason for the under-confidence displayed by therapists,

- Lack of fit between therapist and family regarding race, ethnic background, social class, experience, and value system can cause misunderstanding. Some theorists believe that a greater fit between therapist and family is desirable. Certainly the therapist has to work hard to prepare for working with people who are from different backgrounds. In doing cross-cultural work, the therapist should do considerable research on the family's historical and cultural roots,

- The therapist who adapts to the language and pace of change in any particular family is likely to have a greater chance of success than one who does not. This adaptation is part of the 'joining' process with a family,

- The therapist who can regulate the emotional closeness or distance from the family according to the messages that the family sends has a greater chance of success. The therapist may not be as neutral with all members as desired. If the therapist finds that some members of the family are becoming alienated while others are being sided with by the therapist, they must 're-punctuate' the relationship by asking themselves what is the circular nature of these relationships and in which way the family system has drawn the therapist into its patterns of relationships. Self-reflexivity of the therapist and feedback from supervisor or co-therapist or team are important aids to therapist neutrality, and

- Lack of support for family therapy in the institution or workplace may be a reason for the failure of family therapy. The lack of support could vary from the lack of a meeting room which is not large enough to accommodate a family, or to questioning the validity of family work.

The most important advantage is that this method frees the therapist from upholding a 'normative' or ideal view of family form and functioning. It reduces the chances of therapist's negative judgement and blaming of family. It also encourages therapists to include other professionals and institutions (including themselves and the context of therapy) in their systemic formulations thus freeing the therapist to be creative in increasing options for interventions.

### 11.9.4 Family Factors and Family Context

Similarly there are some family factors and family context that leads to failure or success of family therapy. These are discussed below:

⇒ **Resistance:** Resistance by the family to outside help is but natural. Families who are 'sent' for therapy resist the idea that it may help, and they feel angry that someone is pointing out that there is something wrong with them. Hypothesising about the resistance can help in addressing the issue and thus, some families stay on in therapy. However, some families may be too attached to their resistance stance in which case the therapist has no option but to reframe it positively and encourage the family to attend when they wish. The other type of resistance that can sabotage family therapy is resistance to change. This often happens because change has been a negative experience for the family; sometimes several generations have suffered due to change. For example, a Sikh family that had lost all their possessions due to partition in 1947, again lost their house and several relatives during the riots of 1984. They could not bear the pain of expressing hope about a better future. In this situation the systemic therapist has to formulate a hypothesis that for this family change has been a terrible experience. After mourning the losses, the therapist begins to explore exceptions to the rule; that is when change has been positive.

⇒ **Disagreement about the nature of the problem:** The disagreement may be between family members or between family members and professionals involved with some aspect of the problem. Examples of disagreements are; Is the problem due to one member's behaviour or is it caused by the family? Does the problem need medicines or therapy? Professionals tend to take sides on such issues and the systemic therapist needs to accept the various viewpoints and suggest that the family wants so much to solve their problems that it is worthwhile to try all options before rejecting any of them.

⇒ **Family members want different outcomes from therapy:** This is a common problem in couples and family work. For example, a husband wanted to continue his extra-marital relationship and his goal for couples therapy was that his wife stop being hysterical and accept the situation while the wife wanted to come to therapy to make him realise his mistake and give up the affair. In such a situation, the systemic therapist has to attend to both and to carefully question the couple to find out a common goal as a starting point. In this case the common goal agreed to by both partners was to reduce the conflict between them for the children's sake.

⇒ **The context of the family:** When work with a family is not progressing, it is important to hypothesise about other sources for problems, for example, neighbourhood, extended family, workplace, other people involved with one or several family members etc. and to include that in the therapy work. For instance, therapy had not reduced the school fear that an 8 year old boy was exhibiting until the family and therapist convened a meeting with his class teacher in the school and it emerged

that there was a communication gap between parents and teacher due to language difficulties, about homework tasks. It could also be hypothesised that the intervention of a professional on behalf of an immigrant family aided the creation of a cooperative stance from the school.

**Check Your Progress Exercise 6**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List atleast four indicators of success of systemic family therapy.

.....

.....

.....

2. What are the indications of failure of systemic family therapy.

.....

.....

.....

## 11.10 LET US SUM UP

In this Unit, you have studied about the concepts that are used in systemic family therapy. This method allows the family to be seen together by the therapist, which is useful in observing and intervening to help the families resolve their difficulties. The shift in focus from linear to circular thinking is the most challenging for a beginner. This method is non-judgemental as it does not have a 'normal family' model. It can be used with families from different cultural practices and family forms. Theories of communication and pattern formation feedback loop allows you to understand how problems develop and also how change can happen. The idea that 'new information' about the family can be useful to the family to initiate change is a simpleery and very effective way that systemic therapists can use to help the family.

## 11.11 GLOSSARY

**Analogue communication** : There is similarity between what is expressed and the manner in which it is expressed.

**Digital communication** : There is no similarity between the expressed sign and its meaning.

**Positive connotation** : Provide families with a positive way of looking at problematic behaviours.

| | | |
|---|---|---|
| **System** | : | Any set of interrelated parts that is structured on feedback. |
| **Status quo** | : | The condition that existed is the family prior to the appearance of the symptom. |
| **Therapeutic intervention** | : | The process of entering an ongoing system of relationship for the purpose of initiating a change in the system. |

## 11.12 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

### Check Your Progress Exercise 1

1. i) False

   ii) True

   iii) True

2. Three common features of systemic family therapy and other models of family therapy are given below:

   i) The unit of treatment is the family; no one family member is singled out as a patient;

   ii) The family members are seen together for the session; and

   iii) Therapeutic goals and methods are family centered, and the whole family's welfare is of concern.

### Check Your Progress Exercise 2

1. Following are the three forms of systemic family therapy:

   i) Systemic family therapy,

   ii) Milan systemic model, and

   iii) Narrative therapy.

2. Following are the key features of systemic family therapy:

   i) The family or organisation is a system,

   ii) Components of a system,

   iii) Systemic theoretical concepts,

   iv) Definitions of problem in systemic therapy, and

   v) Function of the symptom.

### Check Your Progress Exercise 3

1. i)-c), ii)-d), iii)-e), iv)-a), v)-b)

2. Following are the various ways in which system is able to change:

   i) Some parts of a system can change but the system itself does not change,

ii) The system changes qualitatively,

iii) Change happens through new information,

iv) Change either/or frame to both/and, or

v) Change from focus on content to process.

**Check Your Progress Exercise 4**

1. i) It is my experience that many heads help in solving problems better. Your family has information and views that would help me a lot and I would really value their involvement to help Samuel.

   ii) I am sorry your husband is so busy with his work and we have missed having his contribution in today's session. I would really like to know his opinion, whatever it is, because as a father he has some special understanding of the relationships in the family and of the people in it. Perhaps he could spare some time to tell me about it. Could you convey this to him from me? Do you think you could do that? I could adjust my time according to his timings as I am sure that he would like to be involve in any developments regarding Sanskritika. I would prefer to wait to start our work in order to give him the chance to attend.

2. (i) **Marriage of first child:** Mr. and Mrs. Jain becoming in-laws, assimilation of new member and another family, supporting couple formation, re-adjustment of all other family relationships, more freedom and more responsibilities for married couple, success/failure in fulfilling social and cultural obligations.

   (ii) **Birth of first grandchild:** New roles again for parents, grandparents, and siblings, the household is expanding, resources of space, time, etc. may be stretched. Members who are not married yet need new roles in family.

3. i) She shows her worry or she shows she cares desperately.

   ii) He is careful to preserve family resources or he has a habit of saving.

   iii) You have raised your children to have independent minds or the children show that they are strong individuals already and that they are not easily afraid of anything.

**Check Your Progress Exercise 5**

1. Families benefit from working with two therapists or a team of therapists because they have the benefit of having more than one person thinking about their difficulties and how to understand and help them. They get many more new ideas and viewpoints which can open up more avenues for positive change. They are not restricted by the views of only one person. The team can also think in detail from the position of each person in the family and this helps in making differences and similarities clearer.

**Check Your Progress Exercise 6**

1. Following are the indications of success of systemic family therapy:
   i) Symptoms decrease and the distress caused by symptoms is less,
   ii) Feedback from the family system and context is positive,
   iii) Talk in sessions is focused and pertinent, and
   iv) New information emerges in the taking.
2. Following are the indications of failure of systemic family therapy:
   i) Talk in session is repetitious,
   ii) No new information is emerging,
   iii) Sessions are forgotten or missed, and
   iv) The family and therapist appear disheartened.

## 11.13 UNIT END QUESTIONS

1. What do you understand by the term systemic family therapy?
2. What are the key features of systemic family therapy?
3. Explain the process of systemic family therapy with the help of an example.

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# UNIT 12 COGNITIVE BEHAVIOURAL FAMILY THERAPY

## Structure


12.1 Introduction

12.2 Historical Roots of Cognitive Behavioural Family Therapy

12.3 What is Cognitive Behavioural Family Therapy?

- 12.3.1 Assumptions of Cognitive Behavioural Family Therapy Approaches
- 12.3.2 Key Concepts of Cognitive Behavioural Family Therapy

12.4 Processes in Cognitive Behavioural Family Therapy

- 12.4.1 Clinical Assessment in Cognitive Behavioural Family Therapy
- 12.4.2 Cognitive Interventions
- 12.4.3 Behavioural Interventions

12.5 Efficacy and Effectiveness of Cognitive Behavioural Family Therapy

12.6 Let Us Sum Up

12.7 Glossary

12.8 Answers to Check Your Progress Exercises

12.9 Unit End Questions

12.10 Further Readings and References


## 12.1 INTRODUCTION

The cognitive behavioural perspective has made significant contributions to understanding and treating psychopathology in individuals, couples and families. The cognitive model was put forward by Beck in the 1960's. It proposed that peoples' perceptions or spontaneous thoughts about situations influence their emotional and behavioural reactions. Distressed individuals often have perceptions about themselves, others and the world that might be incorrect and dysfunctional. Cognitive interventions focus on teaching them to identify and evaluate their cognitions and view reality more clearly.

The tenets of this perspective are now being used in therapeutic interventions with couples and families. This Unit focuses on cognitive behavioural family therapy approaches.

### Objectives

After studying this Unit, you will be able to:

- Trace the historical development of the cognitive behavioural perspective in interventions with couple and family dysfunction;
- Explain the primary assumptions and key concepts of cognitive behavioural family therapy approaches;
- Elaborate on the therapeutic processes and techniques used in cognitive behavioural family therapy; and
- Critically evaluate the theory and practice in this field.

## 12.2 HISTORICAL ROOTS OF COGNITIVE BEHAVIOURAL FAMILY THERAPY

Early foundations of the cognitive behavioural approach to interventions with couples and families can be traced to the work of Albert Ellis (1977). The rational-emotive behaviour therapy approach (REBT) to family work placed emphasis on each individual's perception and interpretation of the events that occur in the family environment. Ellis and his colleagues proposed that relationship dysfunction among couples occurs when an individual;

a) holds irrational or unrealistic beliefs about her or his partner and relationship, and

b) makes extreme negative evaluations when the partner and relationship do not live up to such extreme expectations.

These illogical beliefs and distortions serve as the foundation for emotional distress and lead the individual to behave in negative ways toward the partner. The A-B-C framework proposed that family members tend to blame their problems on certain activating events in the family environment (A). They are taught to probe for irrational beliefs (B) which have emotional and behavioural consequences (C). These are then to be logically challenged by each family member and finally debated and disputed (see Fig. 12.1).

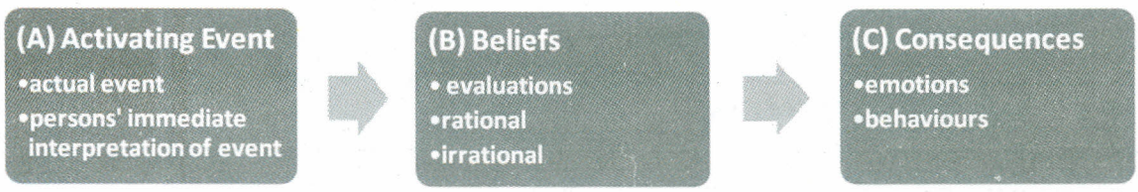



**Fig. 12.1: A-B-C Theory in Rational Emotive Behaviour Therapy**

The therapist uses an active and directive approach to modify beliefs and expectations to fit a more rational basis and thereby improve the quality of family relationships (Ellis, 1978). However, the 1960's and 1970's were dominated by the family systems theory and the REBT approach with problems in intimate relationships did not gain much popularity and acceptance.

Around four decades ago, behavioural interventions with children and adolescents began to include the reinforcement strategies, contracting and negotiation, communication skills and problem-solving strategies with family members as well (Patterson, McNeal, Hawkins & Phelps, 1967; Patterson, 1971; Jacobson & Margolin, 1979; Liberman, 1970). Gradually, behavioural principles and techniques that proved their effectiveness with individuals were applied to distressed couples and families. This behavioural approach too was viewed as simplistic, and as one which did not account for all the complex interactions within a family system.

Around the late 1970s and 1980's cognitions were included as an important component of behavioural therapists who worked with individuals, couples and families (Margolin & Weiss, 1978; Baucom, 1987; Dattilio, 1989). Family member's thought processes became a central focus and was addressed

systematically. Tracing the historical roots reveals that cognitive behavioural couples and family therapy grew out of the behavioural approach, initially as an additional component and later as a more comprehensive system of intervention which included various aspects of the family's interpersonal and physical environment.

**Check Your Progress Exercise 1**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Describe the A-B-C theory proposed by Albert Ellis as part of Rational Emotive Behaviour Therapy.

.....

.....

.....

.....

## 12.3 WHAT IS COGNITIVE BEHAVIOURAL FAMILY THERAPY?

Cognitive behavioural family therapy approaches are characterised by certain underlying assumptions and intervention methods. These distinguish cognitive behavioural approaches from other forms of interventions with families.

Kendall & Hammen (1988) highlighted four basic assumptions underlying cognitive behavioural therapy. These are as follows:

1. Patients respond to their interpretation of events, not the reality,
2. Thoughts, behaviour, and feelings are interrelated and therefore influence each other,
3. Successful therapy depends on changing the way patients think about themselves and the world, and
4. It is important to change both behaviour and thinking.

Cognitive behavioural family therapy is a time–limited and structured approach with sessions usually held once to twice weekly. Interpersonal factors important in any form of therapy are also important in cognitive behavioural family therapy. It emphasises a collaborative approach, fostering a strong therapeutic alliance, in which the therapist and family members function as a team. The therapist engages with clients in a process of "collaborative empiricism" to investigate the validity of their thoughts and beliefs. Within this goal oriented framework, the therapist helps clients to specify their treatment goals clearly and teaches them to use skills (cognitive and behavioural) to practise in sessions and through homework assignments. This educative problem-oriented process is a hallmark of the cognitive behavioural stance.

### 12.3.1 Assumptions of Cognitive Behavioural Family Therapy Approaches

Cognitive behavioural family therapy assumes that an individual's emotional and behavioural reactions to life events are shaped by her or his interpretations, rather than solely by objective aspects of the events (Beck, 1976; Ellis, 1978). Behaviours of family members are seen as constant life events which are interpreted and evaluated by other family members (Epstein & Schlesinger, 1996).

This framework explains the development of family conflict as arising from the mutual influence of family relationships, cognitions, emotions, and behaviours on each other. This includes the premise that family members simultaneously influence and are influenced by each other. Consequently, the behaviour of one family member leads to behaviours, cognitions, and emotions in other members, which, in turn, elicit cognitions, behaviours, and emotions in response in the former member (Dattilio, Epstein, & Baucom, 1998). The cycle can escalate the dysfunctional family dynamics and conflicts. As the number of family members involved increases, the complexity of interaction also increases and the conflict can spiral.

Epstein and Schlesinger (1991, 1996) described four ways in which family members' cognitions, behaviours, and emotions may interact and build to a crisis and crystallise into family patterns and permanent styles of interaction. These are outlined below:

1. The individual's own cognitions, behaviours, and emotion regarding family interaction (for example, the person who notices himself or herself withdrawing from the rest of the family).
2. The actions of individual family members toward the individual.
3. The combined (and not always consistent) reactions that several members have toward the individual.
4. The characteristics of the relationships among other family members (for example, noticing that two other family members usually are supportive of each other's opinion).

The cognitive behavioural perspective is based on assumptions regarding a variety of cognitive variables that influence the quality of family relationships (Baucom & Epstein, 1990; Dattilio, 2005, Epstein & Baucom, 2002). Although, cognitive processes do not cause all emotions and behaviours, they play a significant role in the interactions between emotions, behaviours, cognitions and events.

### 12.3.2 Key Concepts of Cognitive Behavioural Family Therapy

Let us discuss some important concepts of cognitive behavioural family therapy. These are given below :

1. **Family schemata:** Core beliefs or schema occupy a central position in cognitive therapy as proposed by Beck (1976). Epstein and associates (1988) propose that these schemata are "the longstanding and relatively stable basic assumptions that she or he holds about how the world

works and her or his place in it". For example, if a child is given love and attention from parents only in response to specific desired behaviours, then the child might develop a schema that "love and attention are conditional". While individuals have basic schema related to themselves, others, their world and future, families also have jointly held cognitive beliefs or assumptions formed through the years of interactions together.

Family schemas have strong influences on how individuals think, feel and behave in the family context. Schwebel and Fine (1994) described family schemata as: "All of the cognitions that individuals hold about their own family life and about family life in general. Included in this set of cognitions are an individual's schema about family life, attributions about why events occur in the family, beliefs about why events occur in the family, and beliefs about what should exist within the family unit. The family schema also contains ideas about how spousal relationships should work, what different types of problems should be expected in marriage and how they should be handled, what is involved in building and maintaining a healthy family, what responsibilities each family member should have, what consequences should be associated with failure to meet responsibilities or to fulfill roles, and what costs and benefits each individual should expect to have as a consequence of being in a marriage".

The unconscious and conscious beliefs associated with two types of family schemata influence childrearing patterns and family interactions (Dattilio, 2005). One schemata is related to the experiences, perceptions and interactions in the parents' families of origin and the other related to families in general. The family schemata are not static and can change over time, particularly as a response to major life events like major illness, death of a family member or divorce.

2. **Attributions:** These are causal and responsibility explanations for relationship events or behaviours that have already occurred. Family members make attributions about both positive and negative characteristics in each other. For example, "My mother does not listen to what I have to say because she loves my sister more" or "My parents usually ask me my opinion because they value what I have to say". Attributions stem from the underlying beliefs or schemas that family members hold about themselves or about others.

3. **Expectancies:** These are predictions of what will occur in the relationship in the future. These can influence the emotional reactions and behaviours of an individual and the other family members. For example, a woman who believes that her husband does not enjoy spending time with her, may predict that he will refuse any request she makes and therefore withdraws from communication with him. This may further reduce the couple's interaction, thus reinforcing the wife's initial negative belief.

   Expectancies and attributions are closely related. For example, when couples make negative attributions about their partner's behaviour as being unlikely to change, it most often leads to emotions like anger and depression and negative predictions about the future of the relationship.

4. **Assumptions:** These are beliefs that each family member holds about other family members and of the relationships. These set of rules are used to guide and make attributions about the causes of their own and

others' behaviours. For example, "My worth depends on what others think of me".

5. **Standards:** These involve individual's beliefs about what people and relationships should be like. For example, how close parents should be to their children or the manner in which forgiveness is granted.

   Schwebel & Fine (1992) described various standards about family life which forms part of a "family constitution". These include the following:

   (i) Standards for interrelationships between family members,

   (ii) Standards for division of labour,

   (iii) Standards for dealing with conflict,

   (iv) Standards for boundaries and privacy, and

   (v) Standards for individuals outside of the family unit.

   The standards held by individual family members might be unrealistic. At other times, they might create difficulties because although they are realistic, family members hold different standards.

   **Automatic thoughts:** These are spontaneous cognitions that often occur in a fleeting manner and are mostly conscious and easily accessible (Beck, 1976). These may be positive or negative but tend to be negative in conflict situations. For example, after an argument, a wife might think "It is too late to save this marriage". Or a husband might think "My wife is late again – she does not care about me." Individuals might accept these negative automatic thoughts without questioning their validity. Often schemas or bore beliefs might be revealed through an individual's automatic thoughts.

   **Cognitive distortions:** These are defined as irrational ways of reasoning or errors of logic that lead to misconceptions or faulty assumptions. Table 12.1 describes some common cognitive distortions.

**Table 12.1 : Some common cognitive distortions**

| Cognitive distortions | Explanation |
|---|---|
| **Arbitrary inference** | Conclusions are made in the absence of supporting substantiating evidence. For example, a man whose wife comes home from work 30 minutes late concludes, "*She must be having an affair*". |
| **Selective abstractions** | Information is taken out of context and certain details are highlighted while other important information is ignored. For example, a woman whose husband fails to answer her greeting the first thing in the morning concludes, "*He must be angry at me again*". |
| **Overgeneralisation** | An isolated incident or two is allowed to serve as a representation of similar situations everywhere, related or |

| | |
|---|---|
| | unrelated. For example, after her husband forgets to pay the electricity bill once, the wife concludes, "*He is totally unreliable*". |
| **Magnification and minimisation** | A case or circumstance is perceived as having greater or lesser significance than is appropriate. For example, after finding out that the husband has paid more than planned for a new car, the wife concludes, "*We are financially ruined*". |
| **Personalisation** | External events are attributed to oneself when insufficient evidence exists to come to this conclusion. For example, when the husband does not eat dinner after returning late from work one day, the wife concludes, "*He must be dissatisfied with my cooking*". |
| **Dichotomous thinking** | Experiences are seen as either black or white, a complete success or total failure. This is otherwise known as "*polarised thinking*". |
| **Labeling and mislabeling** | One's identity if portrayed on the basis of imperfections and mistakes made in the past, and these are allowed to define oneself. For example, subsequent to continual mistakes while learning to drive a car, a spouse states, "*I am worthless*", as opposed to recognizing her error as being human. |
| **Tunnel vision** | People only see what they want to see or what fits their current state of mind. For example, if mother believes that the son has no respect for parents, she may judge all his behaviour in that light. |
| **Mind reading** | This occurs when an individual believes that she or he knows what another person is feeling or thinking without communicating directly with the person. For example, "*I know what Ashok will say when he hears that I will be working late tomorrow*". |

The conceptual foundations of cognitive behavioural family therapy have been integrated to explain the interactions between negative automatic thoughts, cognitive distortions, various individual and family schemata, life events and experiences and related emotional and behavioural responses (see Fig.12.2).

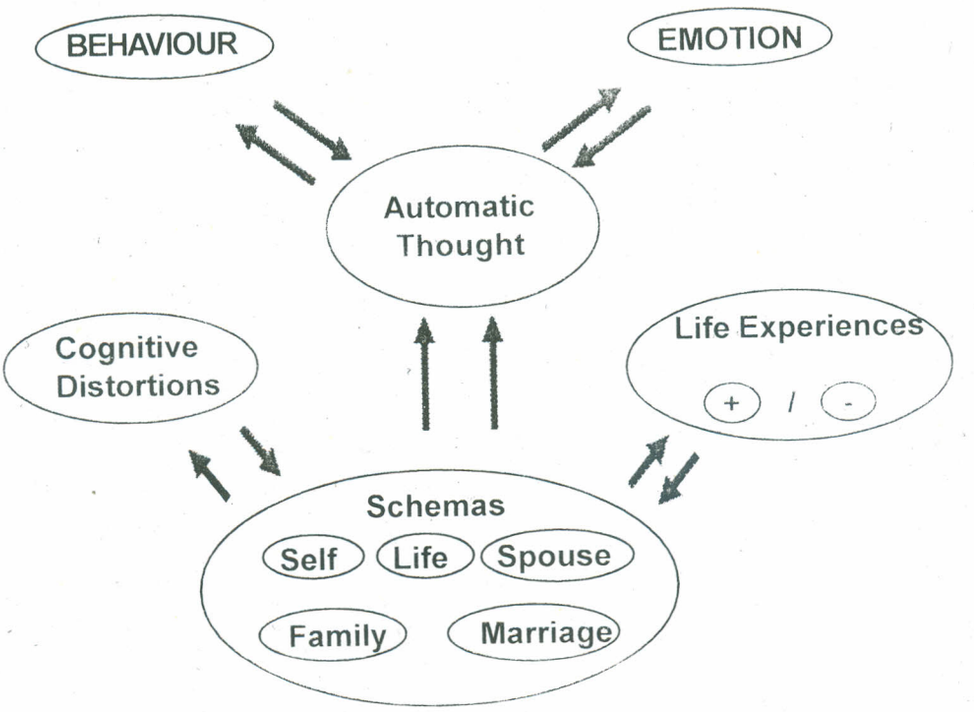



Fig 12.2: Interrelationships between cognitive factors (Dattilio, 1993)

**Check Your Progress Exercise 2**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Match the following:

| | |
|---|---|
| i) All or none thinking | a) Longstanding, stable assumptions about family life. |
| ii) Automatic thoughts | b) Beliefs about what people and relationships should be like. |
| iii) Arbitrary inference | c) Experiences are seen as either black or white, a complete success or total failure. |
| iv) Family schema | d) Causal and responsibility explanations for relationship events or behaviours that have already occurred. |
| v) Standards | e) Conclusions are made in the absence of supporting substantiating evidence. |
| vi) Attributions | f) Spontaneous cognitions that often occur in a fleeting manner and are mostly conscious and easily accessible. |

## 12.4 PROCESSES IN COGNITIVE BEHAVIOURAL FAMILY THERAPY

In this section, we focus on the processes in cognitive behavioural family therapy. The areas examined are: the first phase of clinical assessment, followed by the distinct cognitive and behavioural therapeutic techniques and processes.

### 12.4.1 Clinical Assessment in Cognitive Behavioural Family Therapy

The stage of detailed clinical assessment is essential before commencing therapeutic intervention with distressed couples or families. Dattilio (2005) listed the aims of the comprehensive clinical assessment as follows:

i) Identify the strengths and the areas of difficulty in individual family members, in the couple and other family relationships as well as in the environment,

ii) Place each family member's current functioning in the context of their developmental life stage and any recent changes or transitions, and

iii) Identify specific intervention targets in the areas of cognitive, behavioural and affective functioning.

Similar to other family intervention models, here too the emphasis is on seeing the family members together for the initial interview. The therapist is able to make keen observations about the individual members' cognitions, behaviours and emotional reactions towards each other and formulate hypotheses about the patterns in their problematic interactions. The assessment specifically focuses on the negative cognitions associated with conflicts in family interactions. It is an opportunity to assess each member's reason for seeking treatment and their specific expectations of change. The assessment spans information across the family of origins, interactions and relationships (for example, significant marital discord and violence in the father's parents), individual vulnerabilities (for example, chronic physical illness in one partner), both current and historical relationship dynamics (like longstanding differences in the couple's expectations of intimacy and autonomy), influences of environmental changes and life events (for example, loss of job), available resources and patterns of help seeking.

The therapist might choose to see family members individually as well, during the assessment phase. This can serve multiple purposes; allowing individuals to express their personal difficulties or to assess the need for additional individual therapy for any member. However, the therapist clearly indicates that information that affects the wellbeing of another family member cannot be kept confidential. This ensures that the therapist remains neutral and does not appear to be taking sides with any family member.

Observations of the family member's verbal and nonverbal communication and interactions during sessions can yield valuable information. The therapist might also assign the couple a task during the session; for example to discuss

regarding their child's request for pocket money; and then observe their communication and problem solving styles. Additionally, the therapist may use questionnaires or other self-assessment tools to obtain further information during this assessment phase.

The clinical assessment ends with a collaborative discussion between the therapist and family members. The therapist provides a feedback regarding the assessment and moves towards a consensus on the priorities for change. The therapist then works with the family members to use a series of cognitive and behavioural strategies to restructure the core beliefs of the family and altering and modifying behavioural patterns.

### 12.4.2 Cognitive Interventions

In this sub-section we will discuss some of the cognitive intervention. These are given below:

1. **Educating couples or families about the cognitive behavioural model:** The initial step discusses the basic concepts and structure of the planned intervention. Family members are made aware that home work assignments focusing on thoughts and behaviours will form an essential part of the treatment. Ground rules for the therapy are laid out – for example, that individuals should not tell the therapist secrets that cannot be shared with other family members, and that verbally and physically abusive behaviour is not allowed. The planning of explicit agendas for each session is also discussed at the initial stage.

2. **Identification and modification of automatic thoughts:** Firstly, the therapist introduces the concept of automatic thoughts and the need to monitor those associated with negative emotional and behavioural responses. Family members are encouraged to keep a systematic record of automatic thoughts linked with relationship distress or conflict. This homework assignment helps them to identify the links between these thoughts and negative emotions and behaviour in their interactions. The therapist coaches them to recognise that change is possible though exploration of alternative cognitions that can lead to different emotional and behavioural responses in those conflictual situations.

3. **Identification of distorted cognitions:** The therapist helps family members to identify the distorted cognitions involved in their automatic thoughts and label them in their daily record of dysfunctional thoughts. The therapist directs family members to use the dysfunctional thought record and ask themselves "What's going on through my mind now?" (see Fig.12.3).

| Date<br><br>Time | SITUATION DESCRIBE: | AUTOMATIC THOUGHTS | EMOTIONS DESCRIBE: | COGNITIVE DISTORTIONS | ALTERNATE RESPONSE | RESPONSE OUTCOME |
|---|---|---|---|---|---|---|
| | 1. Actual event leading to unpleasant emotion, *or* 2. Stream of thoughts, day dreams, *or* recollection, leading to an unpleasant emotion, *or* Any other thought, feeling that is felt. | 1. Write automatic thought(s) that preceded emotion(s).<br><br>2. Rate belief in automatic thought(s) 0-100% | 1. Specify sad, anxious/ angry, etc.<br><br>2. Rate degree 0-100% | For example Magnification, Personalisation etc. | 1. Write rational response to automatic thought(s).<br><br>2. Rate belief in alternative response 0-100% | 1. Re-rate belief in automatic thought(s) 0-100%<br><br>2. Specify and rate subsequent emotions 0-100% |

Questions to help formulate the ALTERNATIVE RESPONSE: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What should I do about it? (5) What's the effect of my believing the automatic thought? What could be the effect of changing my thinking? (6) If _____ (person's name) was in this situation and had this thought, what would I tell him/her?

**Figure 12.3: Dysfunctional thought record (Dattilio; 1993)**

4. **Cognitive restructuring techniques:** A range of cognitive restructuring intervention strategies can be used to examine evidence to evaluate the validity of automatic thoughts and cognitive distortions.

   i) **Socratic Questioning:** This technique is the hallmark of the cognitive-behavioural approach and involves a method of questioning in a nonjudgemental manner that does not requiring a 'correct' answer. By definition, leading questions cannot be asked. This dialogue helps family members to clarify and define problems, assess the consequences of specific thoughts and behaviours, re-evaluate previous conclusions and develop new ideas. The aim is for family members to learn to use this questioning approach themselves. Some examples of Socratic questions are:

   What is the evidence that supports this idea? What is the evidence against this idea? Is there an alternative explanation for my family member's behaviour? How can I get additional information that will help me judge if my thoughts are logical and appropriate? What is the worst thing that could happen? Could I live through it? What is the best thing that could happen? What is the most realistic outcome? What shall I do about it? What is the effect of believing the thought? If I changed my thinking—what would be the effect? What would you tell a friend in the same situation? (Epstein & Baucom, 2002).

For example, let us consider a situation in which the wife is upset that the husband spoke to her in a gruff tone. The therapist might guide the wife to ask herself questions like these:

- Does it follow that because my spouse spoke sharply that he was angry with me?
- Are there alternative explanations for my spouse's tone of voice (for example, he could have a cold or be stressed about something at work)?
- Even if my spouse was angry, does it follow that:
  i) My spouse doesn't love me?
  ii) My spouse is always unfriendly?
  iii) My spouse will make life miserable for me?
  iv) I did something wrong?

Behavioural experiments can be used to challenge expectancies. Here one family member acts in a particular way and then observes if the other family member(s) behave in the predicted manner or not.

ii) **Downward arrow technique:** One of the most critical and powerful techniques in the cognitive behavioural approach is the inductive "downward arrow" method. This includes a series of questions to tap underlying meanings of family members' reactions. The technique was initially used by cognitive theorists in individual therapy settings, (Beck, et al, 1979) but has been effectively extended to therapeutic work with couples and families.

An initial thought associated with an emotional reaction might be extremely upsetting due to its association with other significant questions. The therapist may clarify these by asking a series of questions such as; "And if that happens, what will it mean to you?" or "What will that lead to next?" Such questions can help uncover the individual's real concerns and core beliefs or might uncover a catastrophic expectancy that, in reality, might be unlikely to occur. Dattilio (1993) discussed a chain of questions using the 'Downward arrow technique' to uncover the schema underlying a woman's behaviour of screaming during disagreements with her husband. By starting with the initial thought and then asking, "If he doesn't listen, what does that mean to you?" followed by a series of questions about subsequent thoughts; the underlying schema of vulnerable and helpless was uncovered (see Fig. 12.4).

**DOWNWARD ARROW TECHNIQUE**

"I need to scream because Harry doesn't always listen to me".

↓

"If I don't scream, I'll never be heard".

↓

"If I am not heard, I am nobody".

↓

"If I am nobody, I am helpless".

↓

"If I am helpless, people will run over me".

↓

"Harry will run over me and this will give him complete control."

**Figure 12.4: Downward Arrow Technique (Dattilio, 1993)**

Dattilio (2005) proposed a series of steps to facilitate the process of schema analysis and restructuring:

(i) Uncover and identify shared family schemas and highlight the areas of conflict and dysfunction that are fuelled by the schema. These are uncovered by probing automatic thoughts and using techniques such as the downward arrow technique.

(ii) Trace the origin of the family schemas and how they have evolved to become a pattern within the family. This can be done by exploring the couple's or parents' backgrounds and upbringing and comparing this with their individual schemas.

(iii) Point out the need for change, indicating how the restructuring of a schema can reduce conflict and promote more harmonious and adaptive functioning.

(iv) Elicit acknowledgment and encourage cooperation from the entire family for a need to change the dysfunctional schema.

(v) Assess the family's ability to make changes in their basic beliefs and plan appropriate strategies as well as assess the degree of resistance to change.

(vi) Implement change through collaborative brainstorming for ideas to modify belief. It is also critical to consider how family interactions and specific behaviours would change if they live according to the modified schema.

(vii) Enacting new behaviours by using family exercises and homework assignments to assess the impact of alternative behaviours and ways of thinking.

(viii) Solidifying the changes involves establishing the changes through repeated practice and also being open to future modifications as required.

Dattilio (2005) cautions that, at times, it may be necessary to focus on areas of an individual family member's schemas that may be causing the greatest amount of family conflict. Reworking both individual and family schemas may be very challenging as they are often rigid and families may be reluctant to make changes that can disrupt the family balance.

### 12.4.3 Behavioural Interventions

The behavioural interventions in cognitive behavioural family therapy focus on various aspects of family members' actions. These include (1) excess negative interaction and deficits in pleasing behaviours exchanged by family members; (2) expressive and listening skills used in communication; (3) problem solving skills; and (4) negotiation and behaviour change skills.

Various clinicians have described the different interventions that are used (Dattilio & Padesky, 1990; Jacobson & Christensen, 1996; Baucom & Epstein, 2002). Some of these are discused below:

- **Communication skills training:** Cognitive behavioural approaches include an important focus on each family member's non-verbal and verbal communication with each other. The therapist provides guidance in both expressive and listening skills. Some examples of expressive skills are: pointing out positives as well as problems, talking in specific rather than in global terms, describing one's emotions as well as thoughts. Examples of listening skills include nonverbal aspects like eye contact, attempting to understand and empathise with the other's perspective. These may be practised initially within the sessions, followed by homework assignments involving communication on increasingly conflictual topics.

- **Problem-solving skills training:** The major steps in problem-solving include: i) a clear definition of the problem in terms of difficult or absent behaviours, ii) generating possible behavioural solutions without evaluating either own or family members' responses, iii) weighing the advantages and disadvantages of each solution, iv) selecting the solution that seems to be feasible and acceptable to all members, and v) agreeing on a time frame to implement and then evaluate the effectiveness of the solution.

- **Behavioural change agreements:** These are an important component of intervention where the therapist negotiates a verbal or written agreement with family members to facilitate behaviour change. The essential focus is for each family member to make a commitment for change without waiting for others to take the initiative and demonstrate change. These contracts may include specific agreements to decrease certain negative behaviours while simultaneously increasing positive behaviours or shared activities in the family, for a specified time, on specified days of the week. Contracts can also include contingency plans if conflict arises during the shared times. Behavioural rehearsal during the sessions can help prepare family members for the homework assignments.

**Check Your Progress Exercise 3**

*Note:* a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Mark 'True' or 'False':

   i) Cognitive-behavioural family therapy focuses on thoughts, feelings and behaviours that have unconscious roots. True/False

   ii) Individual family members are seen in separate sessions throughout the assessment phase of cognitive behavioural family therapy.

   True/False

   iii) Identification of negative cognitions is the hallmark of the assessment phase in cognitive behavioural family therapy. True/False

   iv) Information about interactions and relationships in the families of origin is an important part of the initial assessment. True/False

2. Choose the correct answer:

   i) In cognitive behavioural family therapy, the _____ is the method by which the therapist teaches the client to identify and document thoughts and cognitions.

      a) free association

      b) dysfunctional thought record

      c) dreams

      d) transference

   ii) All of the following are components of cognitive behavioural family therapy except for:

      a) downward arrow technique

      b) working through

      c) socratic questioning

      d) cognitive restructuring

   iii) A chain of questions using the _____ can be used by therapists to uncover core beliefs or schema.

      a) empty chair technique

      b) free association method

      c) downward arrow technique

      d) dysfunctional thought record

   iv) In cognitive behavioural family therapy, _____ analysis uncovers shared patterns of beliefs held by families.

      a) conflict

      b) transference

      c) schema

      d) defense

3. Choose the correct answer:

   i) Weighing the advantages and disadvantages of each solution is the _____ step in problem solving skills training. (third, fourth)

   ii) Communication skills training includes guidance in listening and _____ skills. (expressive, cognitive appraisal)

## 12.5 EFFICACY AND EFFECTIVENESS OF COGNITIVE BEHAVIOURAL FAMILY THERAPY

There is increasing research evidence suggesting that cognitive behavioural family therapy is an effective psychological treatment for couples and families in distress.

Research has indicated the effectiveness of cognitive behavioural interventions in reducing couples' relationship distress (Baucom, Shoham, Mueser, Daiuto,

& Stickle, 1998). Some studies combined cognitive restructuring techniques with behavioural interventions and found that cognitively focused interventions resulted in more cognitive changes while the behavioural techniques influenced behavioural interactions.

Strengths of the cognitive behavioural perspective include collaborative therapeutic relationship, problem-solving and skill-building approach and its inclusion of cognitive, affective, and behaviour realms. Some criticisms of the cognitive behavioural approach include the directive role of the therapist, its relative neglect of underlying dynamics of family conflicts and emotional and affective aspects. Dattilio (2001) has attempted to address some of these criticisms and clarify the strengths and limitations of the cognitive behavioural approach in family therapy.

There has been considerable research supporting the role of cognitive behavioural interventions in individual therapy. Further research is needed on the effectiveness of cognitive behavioural interventions with distressed couples and families, specific indications and contraindications, and comparisons with different therapeutic and other family therapy models.

## 12.6 LET US SUM UP

In this Unit, we have learnt about cognitive behavioural approaches in therapeutic intervention. The unit focused on:

- Tracing the historical contributors to the development of cognitive behavioural family therapy approaches;
- Outlining the basic assumptions of cognitive behavioural family therapy;
- Describing the therapeutic processes and techniques in cognitive behavioural family therapy; and
- Summarising the research evidence on the effectiveness of cognitive behavioural family therapy approaches.

## 12.7 GLOSSARY

**Automatic thoughts:** Spontaneous cognitions that often occur in a fleeting manner and are mostly conscious and easily accessible.

**Cognitive distortions:** Inaccurate or illogical thoughts which maintain negative thinking and help to maintain negative emotions.

**Cognitive restructuring:** The process of learning to refute cognitive distortions or "faulty thinking," with the goal of replacing irrational, illogical beliefs with more accurate and beneficial ones.

**Downward arrow technique:** The use of a series of questions used by the therapist to tap underlying meanings of an individual's reactions. It's purpose

is to elicit the chain of inferences which lead the individual to a given conclusion from a specific fact.

**Family schemata:** The set of cognitions that individuals hold about their own family life and about family life in general.

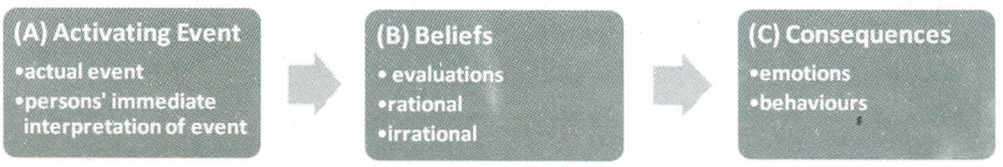
**Socratic questioning:** A series of connected open-ended questions that lead to a more logical conclusion about an individual's inner experiences.

**Schemas:** Cognitive structures that organise thought and perception and have an integral influence on emotion and behaviour. Epstein *et al.* (1988) define an individual's schemas as "the longstanding and relatively stable basic assumptions that she or he holds about how the world works and her or his place in it".

## 12.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

### Check Your Progress Exercise 1

1. The core of Rational Emotive Behaviour Therapy is the A-B-C theory. 'A' stands for Activating Event which is an environmental situation or event; 'B' represents the irrational and/or rational belief arising from the person's evaluations of the event and 'C' is the emotional and behavioural consequences following the belief.




### Check Your Progress Exercise 2

1. i) -c)
   ii) -f)
   iii) -e)
   iv) -a)
   v) -b)
   vi) -d)

**Check Your Progress Exercise 3**

1. i) False
   ii) False
   iii) True
   iv) True
2. i) -b)
   ii) -b)
   iii) -c)
   iv) -c)
3. i) third
   ii) expressive

## 12.9 UNIT END QUESTIONS

1. What are cognitive distortions? Illustrate the important cognitive distortions that are assessed in cognitive behavioural family therapy.
2. Elaborate on the concept of family schemas. Outline the steps involved in modifying schemas during cognitive behavioural family therapy.
3. Describe the use of the dysfunctional thought record as a cognitive restructuring technique.
4. Illustrate the use of socratic questioning and the downward arrow technique.
5. Briefly discuss the use of communication skills training and problem-solving skills training in sessions with distressed couples and families.

## 12.10 FURTHER READINGS AND REFERENCES

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# UNIT 13 INTEGRATED APPROACH TO FAMILY THERAPY

## Structure


13.1 Introduction

13.3 Historical Evolution of Family Therapy in India

13.3 Family Therapy – Integrative Sytemic Model

- 13.3.1 The Initial Phase of Family Therapy
- 13.3.2 Middle Phase of Family Therapy
- 13.3.3 Termination Phase of Family Therapy
- 13.3.4 Special Sociocultural Issues in Family Therapy
- 13.3.5 Constraint Factors in Family Therapy

13.4 Let Us Sum Up

13.5 Glossary

13.6 Answers to Check Your Progress Exercises

13.7 Unit End Questions

13.8 Further Readings and References


## 13.1 INTRODUCTION

In the previous Units, you have learnt the different schools or models of family therapy. The main schools are the behavioural and psychodynamic schools and the structural and strategic schools. The proponents of these schools would necessarily teach and train in the pure forms of these techniques that they described. In actual practice of family therapy though, the therapist must decide on the school that best suits the family for therapy. For example, behavioural therapy techniques require the clients to be extremely cooperative in doing home work assignments and also role plays of sessions which may not be possible with the rural and socio-economically backward families. Psychodynamic therapy requires the clients to introspect quite a lot and talk about influences and emotions from the past. This would require a certain degree of psychological mindedness and sophistication. On the contrary, we must also look at the comfort and knowledge of the therapist in doing the different techniques. Novice therapists may find it difficult to understand or actually carry out strategic interventions like paradoxical interventions and they may rather be more comfortable with behavioural exercises that are more concrete and structured. Hence in real day to day practice the therapist must choose the therapy depending on the client, therapist and therapy fit. This particular model would really be eclectic in its theory and would integrate techniques from the different schools you have learnt so far about.

**Objectives**

After studying this Unit, you will be able to :

- Know the historical evolution of family therapy in India;
- Understand an integrated model of family therapy; and
- Identify the constraint factors in family therapy.

## 13.2 HISTORICAL EVOLUTION OF FAMILY THERAPY IN INDIA

Mental health professionals in India have always involved families in therapy. But formal involvement of families occurred about one to two decades after this therapeutic modality was started in the West by Ackerman.

Vidyasagar is credited to be the father of Family Therapy in India though he wrote sparingly of his work involving families at the Amritsar Mental Hospital (Vidyasagar, 1971). Bell (1971) brought out a small volume based on this seminal work. The therapy carried out by Vidyasagar focused mainly on the index patient and involved families in the care of these patients. Families of the patients supported each other though group participation. Subsequent to Vidyasagar's pioneering work, two centres in India took up work with families.

The first such work was an unique experiment at the Mental Health Centre at Vellore (Verghese et al. 1971) where all psychiatric patients were (and are still) admitted with families to unit family rooms. The experiment is unique because of the obligatory nature of admission with families. Over the years, the work at this centre has focused on family education and counselling about how to manage the index patient. Description of this work is available in other references (Verghese, 2002 & Cherian, 2002).

The second experiment was the experience of dealing with families at the psychiatric services at NIMHANS, Bangalore (Narayana et al, 1977). Descriptions of this early work carried out at NIMHANS showed that families were taught to cope with their burdens through education, counselling and group support. Subsequent work with these families was elaborated by Bhatti & Channabasavanna (1979), Bhatti et al., (1980), and Geeta et al., (1980). These studies showed the usefulness of involving families in the management of a variety of psychiatric disorders.

**Box 13.1 Historical Evolution of the Model of Family Therapy at Family Psychiatric Centre, NIMHANS**

The Family Psychiatry Centre at NIMHANS was formally opened in 1977 though family work had been going on at the Institute since the 1960's. The Family Psychiatry Centre is essentially a referral centre with patients being referred from adult psychiatry units, child guidance centres and neurological services from all over India but mainly from Southern states. NIMHANS also takes self referrals and referrals from outside agencies like Family Counselling Centres and Family Courts.

The development of family therapy may be arbitrarily divided into 3 phases, the first phase in the 1970's, second phase in the 1980's and the third phase 1990's. In the first phase, the work carried out involved the studies of families with different problems and experiments in therapy. This phase witnessed the development of different tools, like the Family

Interaction patterns Scale and the Family Typology Scale (Bhatti et al., 1985 & 1986). The family work at this time involved education, counselling and coping skills with families of different psychiatric disorders like hysteria, schizophrenia and bipolar disorders.

In the second phase, during 1980's the postgraduate students were posted to the Centre and formal training was started. At the same time various package programmes were started for different disorders like schizophrenia, hysteria, epilepsy, and marital enrichment programme. These programmes essentially used a behavioural framework and interventions with families of the index patients. Some authors call this family psychiatry to indicate that one of the members has a psychiatric disorder as opposed to family therapy where family therapists predominantly deal with family discord.

The third phase (1990's) saw the Centre handling patients and families with more difficult and intractable problems like poor prognosis schizophrenia, conduct disorders in adolescents and personality disorders in young adults and chronic neurotic conditions. With a simple behavioural model of therapy, the clients stayed in therapy longer, got more dependent and caught up with the therapy team and their problems took much time to change. This caused dissatisfaction and frustration with the model that was practised. This, together with systemic training and inputs received from experienced systemic therapists, caused the team to shift to a more systemic family therapy model. To match this change, the training curriculum was also changed to more emphasis on looking at families with a general systems perspective as a base, bringing in the concept of "circularity" and more emphasis on the structural and strategic schools and also from the psychodynamic and behavioural schools. This Unit will describe this integrative systemic model of family therapy. We will discuss the stages of therapy, the process and techniques used.

**Check Your Progress Exercise 1**

*Note:* a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Fill in the blanks:

i) _____ is credited to be the father of family therapy in India.

ii) _____ is the place where family therapy started in India.

## 13.3 FAMILY THERAPY – INTEGRATIVE SYSTEMIC MODEL

Most family therapists use an eclectic model to conduct sessions in family counselling and therapy. As you have seen from the other Units there are many schools and theoretical models for family therapy. Whichever school is used the underlying principle and understanding of families is based on our understanding of the family system. For this we have to be familiar with

systems theory that you have read in earlier Units. Remember that the things that happen in a family are never simply based on simple linear cause and effect. For example, the mother may beat a child because he was having a tantrum. However, we must remember that the child's tantrum and the mother's strictness to the child may be determined by each of their relationships with the father. The father could be lenient and over indulgent to the boy and hence, the child shows tantrum. Also, the marital relationship may be strained and that makes the mother more angry and frustrated with the child's tantrum.

So, we can see that we need to be "circular" to understand family interaction patters and there is a need to handle all the sub-systems in therapy. The interventions also have to account for all the persons involved in the family. In the example given above it is not just enough to do therapy with the child with tantrums and to help the mother with parent-child training; it is also important to work with the couple on their marital relationship so that their interactions and messages to the child are uniform. With this background let us now look at a systemic integrated model of therapy in the Indian context. You will see how all the schools of therapy have a basis in the family systems theoretical model.

### 13.3.1 The Initial Phase of Family Therapy

The initial phase of therapy can be divided into different stages, like:

- The referral intake,
- Family assessment,
- Family formulation and treatment plan, and
- Formal contract for therapy.

- **The Referral Intake**

Patients and their families are generally referred. They are usually referred as some family problem has been identified by the mental health professional who saw them. At the time of the intake the therapist reviews all the available information in the family from the case file and the referring clinicians. This intake session lasts for 20 to 30 minutes and is held with all the available family members. The tasks of the intake session is to briefly understand the families' perception of their problem, their motivation and need to undergo family intervention and the therapist assessments of suitability for family therapy. Once this is determined, the nature and modality of the therapy is explained to the family and an informal contract is made about modalities and roles of therapist and the family members.

- **The Family Assessment**

The assessment of different aspects of family functioning and interactions takes about 3 to 4 sessions with the whole family, each session lasting approximately 1 to 1 ½ hours. Different therapists take assessments in different ways depending on their style. Hence, given below are a few tasks which the therapist needs to perform. Usually, it is recommended that the naive therapist starts with a 3 generation genogram and then follows up with the different life cycle stages and family functions. Let us discuss some of methods of family assessment

which are given below:

i) **Genogram:** The three generation genogram is constructed diagrammatically listing out the index patient's generation and two more related generations, for example parents and grandparents in an adolescent client, or parents and children in a middle aged client. The ages and composition of the members are recorded and the transgenerational family patterns and interactions are looked at to understand the family from a longitudinal and epigenetic perspective.

ii) **Family life cycle:** The life cycle of the index family is explored next. The functions of the family and specific roles of different members are delineated in each of the stages of the family life cycle (Duval, 1967). The index family is seen from a developmental perspective and the therapist gets a longitudinal and temporal perspective of the family. Care is taken to see how the family has coped with problems and the process of transition from one stage to another.

iii) **Problem solving:** Many therapists look at this aspect of the family to see how cohesive or adaptable the family has been. Usually, the family members are asked to describe some stress that the family has faced, that is some life events, environmental stressors or illness in a family member. The therapist then proceeds to get a description of how the family coped with this problem. Here "circular questions" are employed and therapist focuses on antecedent events, the crisis and the consequent events to look for patterns that emerge. The family function (or dysfunction) is heightened when there is crisis situation and the therapist looks at patterns rather than the content described. Thus, the therapist gets an "as if I was there" view of the family. The same enquiry is possible using the technique of enactment (Umbarger, 1983).

iv) **The structural map:** Once the enquiry is over, the therapist draws the structural map, which is a diagrammatic representation of the family system, showing the different subsystems, its boundaries, power structure and relationships between people. Diagrammatic notions used in structural therapy or Bowenian therapy are used to denote relationships (normal, conflictual, or distant) and subsystem boundaries, in different triadic relationships. This can also be done on a timeline to show changes in relationships in different life cycle stages and influences from different life events.

- **Family Formulation and Treatment Plan**

A systemic family hypothesis is now postulated by looking at the function of symptoms for both the client and her or his family. It is known as *circular hypothesis* Answers to the following two questions provide the circular hypothesis:

1) What the client is trying to convey through her or his symptoms?; and

2) What is the role of the family in maintaining these symptoms?

This circular hypothesis can be confirmed on further enquiry with the family to see how the "dysfunctional equilibrium" is maintained. The family formulation is discussed by all the therapists and supervisors ("the reflecting team") in a

session lasting about one hour. This leads to a comprehensive systemic formulation involving three generations. This formulation will determine which family members we need to see in a therapy, what interventional techniques we should use and what changes in relationships we should effect. The therapist and their team will also discuss the minimum, most effective treatment plan which emerges considering the most feasible changes the family can make.

- **Formal Contract for Therapy**

A brief understanding of the family homeostasis is presented to the family. Sometimes the full hypothesis may be given to the family in a non-critical and positive way ("Positive connotation") appreciating the way in which the system is functioning. The therapist presents the treatment plan to the family and negotiates with the members the plan and action they would like to take up at the present time. The time frame and modality of therapy is contracted with the family and the therapy is put into force. The frequency and intensity of sessions is determined by the degree of distress felt by the family and the geographical distance from the centre, that is, families may be seen as inpatients at the centre if they are in crisis or if they live far away.

## 13.2.2 Middle Phase of Family Therapy

This phase of therapy is the major work that is carried out with the family. Depending on the school of therapy that is used, these sessions may number from a few (strategic) to many sessions lasting many months (psychodynamic). This depends on the understanding of the family during the assessment as much as the family therapist fit. For example, the degree of psychological sophistication of the clients will determine the use of psychodynamic and behavioural techniques. Similarly a therapist who is comfortable with structural or strategic methods would put these therapies to maximum use. The nature of the disorder and the degree of pathology may also determine the choice of therapy, that is, behavioural techniques may be used more in chronic psychotic conditions while the more difficult or resistant families may get brief strategic therapies. We will now describe some of the important techniques used with different kinds of problems. These are as follows:

- **Psychodynamic therapy :** This school was one of the first to be described by people like Ackerman and Bowen. Recently, this method has been made more contextual and briefer by therapists like Nagy (1984) and Framo (1985). Essentially the therapist understands the dynamics employed by different members of the family and the inter-relationships of these members. These family ego defenses are interpreted to the members and the goal of therapy is to effect emotional insight and working through of new defense patterns. Family transferences may become evident and may need interpretation. Therapy usually lasts from 15-30 sessions and this method may be employed in persons who are psychologically sophisticated, and able to understand dynamics and interpretations. Sustained and high motivation is necessary for such a therapy. This method is found useful in couples with marital discord from upper middle class backgrounds. Time required is a major constraint.

- **Behavioural methods :** Behavioural techniques are used in many types of therapies and conditions. It has been extensively used in chronic psychotic illnesses by workers like, Falloon et al., (1986) and Anderson

et al., (1986). Psychoeducation and skills training in communication and problem solving are found very useful with families which don't have very serious dysfunction. Techniques like modeling or role plays are useful in improving communication styles and to teach parenting skills with disturbed children. Obviously, motivation for therapy is a major requisite and hence techniques like contracting, homework assignments are used in couples with marital discord. Behavioural techniques used in sexual dysfunction are also possible when adapted for out clients.

- **Structural family therapy :** Structural family therapy was described by Minuchin (1974); Fishman et al., (1988) and Umbarger (1983). Indian families are available with their manifold subsystems of parents, children, grand parents and structure is easily discerned and changed. Additionally in recent years a majority of our clients present with conduct and personality disorders in adolescence and early adulthood. So techniques like unbalancing, boundary making are quite useful as the common problems involve adolescents who are wielding power with poor marital adjustments between parents. These techniques are useful for a large number of our clients.

- **Strategic technique :** It is found that these brief techniques can be very powerfully used with families which are difficult and highly resistant to change. A family therapist usually employs them when other methods have failed and the therapist needs to take a U-turn in therapy. Techniques employed by the Milan school (Palazzoli, 1980 and Tomm, 1984); reframing, positive connotation, paradoxical (symptom) prescription have been used effectively. Other techniques like prescription in brief methods advocated by Erickson (1971) and Watzlawick et al., (1974) have also been useful. Familiarity and competence with these techniques is a must and therapy is usually brief and quickly terminated with prescriptions.

### 13.3.3 Termination Phase of Family Therapy

This last phase of therapy is finished in a couple of sessions. The initial goals of therapy are reviewed with the family. The family and the therapist review together the goals which were achieved and the therapist reminds the family the new patterns or changes which have emerged. The need to continue these new patterns is emphasised. At the same time, the family is cautioned that these new patterns will occur when all members make a concerted effort to see this happen. Family members are reminded that it is easy to fall back to the old patterns of functioning which had produced the unstable equilibrium necessitating consultation.

At termination, the therapist usually negotiates new goals, new tasks or new interactions with the family that they will carry out for the next few months in the follow up period. The family is told that they need to review these new patterns after a couple of months so as to determine how things have gone and how conflicts have been addressed by the family. This way the family has a better chance of sustaining the change created. Sometimes booster sessions are also advised after six to twelve months especially for outstation families who cannot come regularly for follow-ups. These booster sessions will review the progress and negotiate further changes with the family over a couple of sessions. This follow up period, after therapy is terminated is crucial for working through process and ensures that the client-therapist bond is not

severed too quickly. It is easy to deal with the clients' and therapist's anxieties if this transition phase is smooth.

### 13.3.4 Special Sociocultural Issues in Family Therapy

Most Indian families are functionally joint families though they may have a nuclear family structure. Also unlike the Western world more than two generations do readily come for therapy. So it becomes necessary to deal with two to three generations in therapy and also with transgenerational issues. Indian families also foster dependency and interdependency rather than autonomy. This issue must also be kept in mind when dealing with parent-child issues. Indians have a varied cultural and religious diversity depending on the region from which the family comes. The therapist has to be familiar with the regional customs, practices, beliefs and rituals. The Indian family therapist has to also be wary of being too directive in therapy as families may give the mantle of omnipotence to the therapist and it may be more difficult for us to adopt a one-down or non-directive approach. Hence, while systemic family therapy is eminently possible in India, one has to keep in mind these sociocultural factors so as to get a good "family-therapist fit".

### 13.3.5 Constraint Factors in Family Therapy

The economic backwardness of the majority of the families makes therapy feasible and affordable, in terms of time and money spent, only to the middle and upper classes of out society. The poorer families usually drop out of therapy as they have other more pressing priorities. The lack of tertiary social support and welfare or social security makes it less possible to network with other systems. We are also woefully inadequate in terms of trained family therapists to cater to our large population. In our country distances seem rather daunting and modes of transport and communication are poor for families to readily seek out a therapist. We work with these constraint factors and so the "family-therapy" fit is an important factor for families that are seeking and staying in family therapy.

**Check Your Progress Exercise 2**

***Note:*** a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. State 'True' or 'False' :

   i) Patients and their families are referred by doctors only. _____

   ii) The three generation genogram is constructed diagrammatically listing out the therapist's information. _____

   iii) Hypothesis that is based on the function of symptoms of the clients and their family is known as circular hypothesis. _____

## 13.4 LET US SUM UP

Family interventions and therapy have been carried out in India for the last five decades. Over the last few years a clear model has evolved for service

and for training. The model uses a predominantly systemic framework for understanding families and the techniques for therapy are drawn from different schools namely the structural, strategic, behavioural psychodynamic therapies. The therapist integrates different therapy techniques so as to get a therapy, client/family and therapist fit. The socioeconomic status of the family place of residence(rural or urban) and the psychological sophistication of the family would determine the eclectic mixture of different therapy techniques.

## 13.5 GLOSSARY

**Circular hypothesis** : Hypothesis based the function of symptoms of both the client and her or his family.

**Reflecting team** : All the therapists and supervisors participating in family therapy.

**Termination phase** : Last phase of family therapy.

## 13.6 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress Exercise 1**

1. i) Vidyasagar

   ii) Amritsar Mental Hospital

**Check Your Progress Exercise 2**

1. i) False

   ii) False

   iii) True

## 13.7 UNIT END QUESTIONS

1. What do you understand by the integrated approach to family therapy? Illustrate with the help of an example.
2. What are the phases of family therapy? Explain them with special referrence to Indian families.

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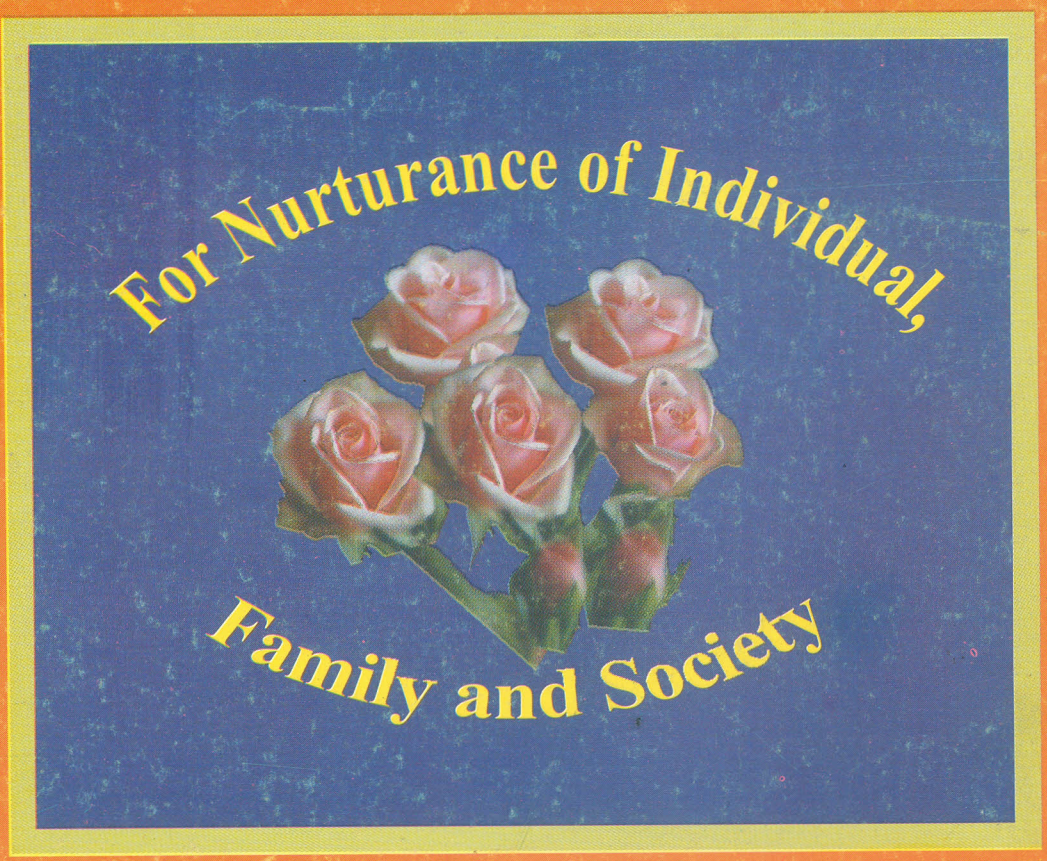
# MCFT-003

# COUNSELLING AND FAMILY THERAPY: BASIC CONCEPTS AND THEORETICAL PERSPECTIVES


| | | |
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**MANUAL FOR SUPERVISED PRACTICUM (MCFTL-003)**

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