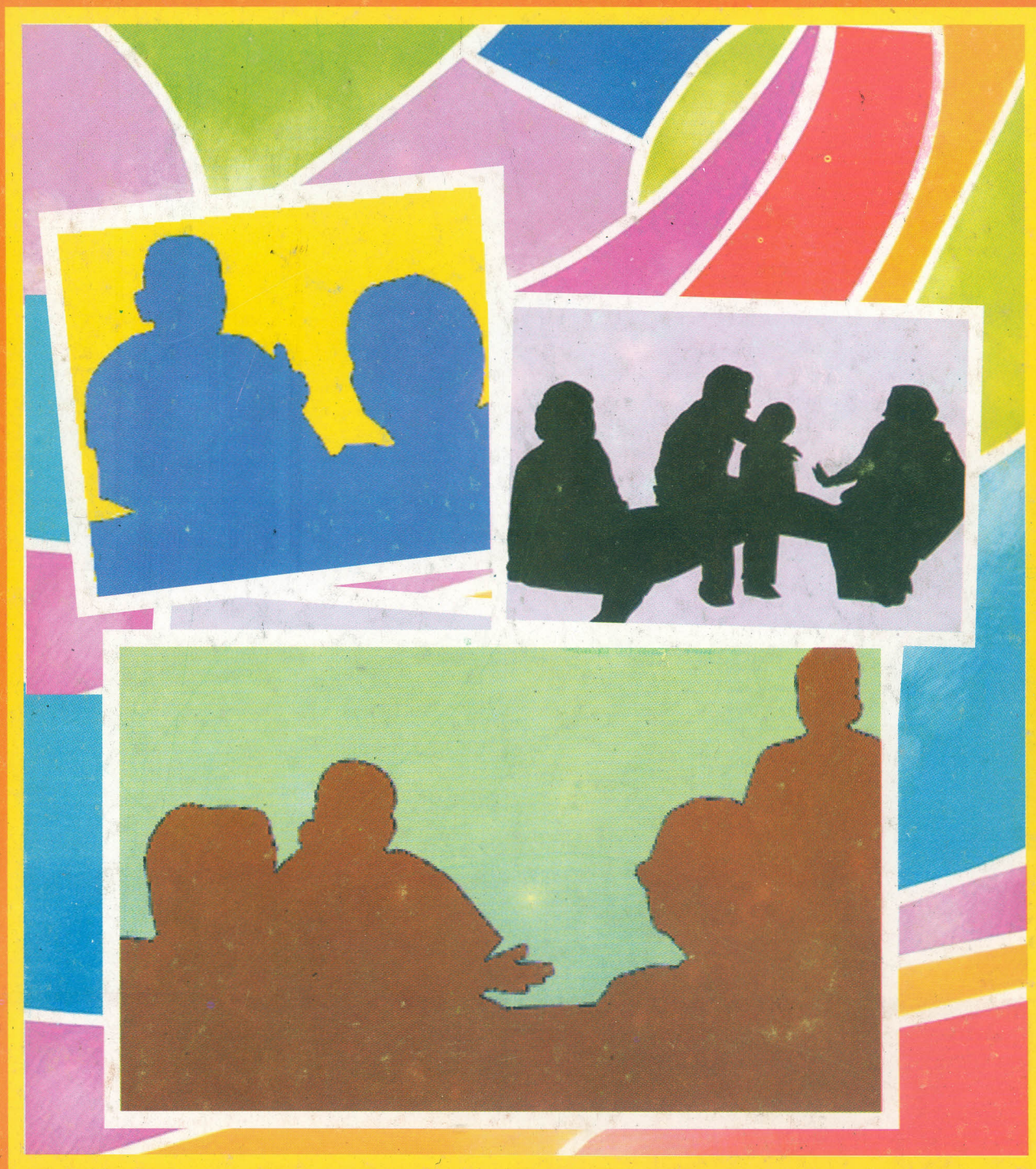




Indira Gandhi  
National Open University  
National Centre of Disability Studies

**MCFT-004**  
**Counselling and Family Therapy:**  
**Applied Aspects**



**PROCESSES OF COUNSELLING AND  
FAMILY THERAPY**

**4**

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

- इन्दिरा गांधी

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*“Education is a liberating force, and in our age it is also a democratising force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances.”*

- Indira Gandhi

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**Block**

# **4**

## **PROCESSES OF COUNSELLING AND FAMILY THERAPY**

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**UNIT 15**

**Referral and Intake** **5**

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**UNIT 16**

**Initial Phase** **20**

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**UNIT 17**

**Middle Phase** **31**

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**UNIT 18**

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## **BLOCK 4 PROCESSES OF COUNSELLING AND FAMILY THERAPY**

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### **Introduction**

The Block 4 “Processes of Counselling and Family Therapy” will acquaint you with the knowledge of various phases of counselling and family therapy. The Block consists of four units.

The Unit 15 is entitled “Referral and Intake”. As the name suggests the Unit describes the referral and intake process in counselling and family therapy. The Unit is divided into two parts. The first part of the Unit explains the referral process which includes the meaning of referral, who refers and to whom. This part helps, you to understand how referral helps in family therapy and also describes the various reasons of non-attendance of session. The later part of the Unit deals with the intake process. It includes various resistance to the family concept, environmental settings, observations and therapeutic planning and the contact. Further, the Unit also explains the important things to remember while conducting intake. In the end of this Unit, the role of the counsellor and family therapist in referral and intake process is described.

The Unit 16 is on “Initial Phase”. The Unit begins with the main theme of initial phase and important assumptions of initial phase. Further, the Unit acquaints you with the knowledge of assessment process in initial phase, which includes, initial contact, defining the goals for the initial phase and family history and genograms. In the end of this Unit, structural family system rating scale is explained in detail. The main aspects included in this scale are family structure, resonance, flexibility, developmental stage of family, identified patienthood, conflict resolution, common techniques, developing a family formulation, feedback and recommendations to the family and arranging the next step.

Unit 17 is “Middle Phase”. The Unit acquaints you with the knowledge of middle phase of family therapy. It begins with the main goals of middle phase of counselling and family therapy. The family therapy goals should have joint creation and agreement on goals. Clarity of goals to family members as well as family therapist is very important. There are two types of goals, that are, short-term and long-term goals. Further, the Unit discusses the various challenges to establishing goals in family therapy. The Unit illustrates the middle phase processes with the help of a case. In the end of the Unit, various challenges to family therapy are explained, with particular focus on therapist neutrality and family resistance.

Unit 18 is entitled “Termination Phase: End Processes”. Termination phase is the last phase of family therapy and this Unit acquaints you with the processes involved in this phase. The Unit begins with the introduction of termination phase and its types. Further, the Unit highlights the indicators for planned termination. The various steps included in termination process like, information regarding planning of termination, summarise hypothesis, goals and what happened in therapy, examine changes, anticipate problems, reinforcement and hope building and plans for follow-up are explained. The two important issues – termination anxiety and resurgence of problem are also discussed. While going through the Unit, you can understand various therapist and client related factors that lead to unplanned termination. In the end of this Unit, you will learn to deal with termination both planned and unplanned.

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# UNIT 15 REFERRAL AND INTAKE

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## Structure

- 15.1 Introduction
- 15.2 Meaning of Referral
- 15.3 Who Refers?
- 15.4 Referral to Other Centres
- 15.5 How Referral Helps?
- 15.6 Non-attendance
- 15.7 Meaning of Intake
- 15.8 Process of Intake
  - 15.8.1 Resistances to the Family Concept
  - 15.8.2 Environmental Setting
  - 15.8.3 Observations
  - 15.8.4 Therapeutic Planning and the Contract
- 15.9 Important Things to Remember while Conducting Intake
- 15.10 Aspects to be kept in Mind by the Family Therapist or Counsellor
- 15.11 Let Us Sum Up
- 15.12 Glossary
- 15.13 Answers to Check Your Progress Exercises
- 15.14 Unit End Questions
- 15.15 Further Readings and References

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## 15.1 INTRODUCTION

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The present Unit deals with the referral and intake processes in Counselling and Family Therapy. The Unit begins with introduction of referral. Further, it states the persons who normally refer (send) the client or patient to the counsellor or therapist. You will understand the reason of referring client or patient to other related professionals and how this process takes place. The second part of this Unit deals with intake process. It describes the meaning and process of intake. There are some important points that a counsellor or therapist should keep in mind with regard to the intake process. We will discuss these points in detail in this Unit.

### Objectives

After studying this Unit, you will be able to:

- Define referral and intake process;
- Understand importance and procedure of referral and intake process;  
and
- Understand the role of therapist or counsellor in intake process.

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## 15.2 MEANING OF REFERRAL

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*Referral* usually is the process in which a client is sent for seeking a higher level intervention or opinion. In general, a lot of patients are sent from primary care centres to tertiary care centres for availing services. In the same way, couples or families who seek help in harmonising the relationship or bringing change in their life are sent to specialists who are experts in handling relationship issues.

The client's first contact with the counsellor will be either by sending a letter or calling up through telephone to seek an appointment or by face to face contact, if there is a drop-in service or crisis service. So, *therapists* need to be appropriately prepared and monitor how the clients experience this first communication. This may be a crisis intervention. Along with dealing with the presenting problems, arrangements can be made for further counselling appointments also.

### 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. Define referral.

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## 15.3 WHO REFERS?

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Usually, the families or couples will be referred by practising psychologists, psychiatric social workers, teachers, doctors, friends or by self. It is important to understand why they are referred to you and their expectation from you as therapist. You may thank the person for referring and also report to her or him about what happened later. You may also contact the person who refers for further details in helping the couple or family. You need to be discretionary about what and how much feedback you will give about the family matter. You may discuss the interaction pattern or a few dynamics to a therapist, but not to the friend. Taking the permission of the couple or the family for the same is more important.

Sometimes referrals will be made to you by another counsellor or therapist. It may be that the therapist has no vacancies, or that you have an expertise in a certain area or that the other therapist is moving to another part of the country. Ideally the other therapist will contact you first in order to ask you whether you are willing to accept this referral and possibly she or he will give you some information about the client (with client's permission). If you receive a referral from another counsellor or therapist it is important to spend as much time as is needed on the client's feelings about the referral. While it may appear a sensible option to the practitioner involved to refer the client to

another counsellor but, it may appear differently to the client. The family or the client may feel rejected or may understand that her or his problem is so bad that no one can deal with it or there may be anger on client's part. If these feelings are not explored there may be resistance from the client in the new counselling situation.

### 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. State 'True' or 'False' for each of the following statements:

- i. Referrals can not be made by another counsellor. \_\_\_\_\_
- ii. If the feelings of client are not explored there may be resistance in new counselling situation. \_\_\_\_\_
- iii. It is not important to understand the expectations of client from a counsellor/therapist. \_\_\_\_\_

## 15.4 REFERRAL TO OTHER CENTRES

It is important for a counsellor to refer the family in the case when he or she is not able to meet the needs of the client. Not only during the first counselling or therapy session, especially, but also throughout the whole counselling contract, we need to be alert to the possibility of the advisability of referring to a medical expert for mental health problems. Some forms of fatigue, emotional problems, anxiety and depressive stages may result from a physiological or hormonal imbalance that could be cured by investigations and treatment from a medical practitioner. It is helpful to be aware of the complementary therapies available that could be used in conjunction with counselling. As you practice, it is exceedingly useful to have the name and phone number of the client's doctor or psychiatrist, to explore the family's or couple's resources and terms of available family members or friends. A referral in the middle phase of therapy is advised if there is transference and counter transference and the therapy is stuck.

### 15.4.1 Referral for Psychiatric Assessment

The bottom line is "Can counselling help this client?" Warning signs may be where there is a history of suicidal or extreme aggressive impulses, serious alcohol abuse, obsessive compulsive disorder, personality disorder, severe depression or psychosis. It may be that you have a special training or ability or experience in dealing with these kinds of problems, but it is always useful to have a second opinion and back up. There are also some people who need psychotropic drugs as psychiatric intervention alongwith you (that would require involvement of a medical expert) in order to control their problematic thoughts, feelings or behaviour.

The counsellor should be aware and be able to judge the point at which the individual, family or couple needs to be sent for another opinion. Therapist should have a list of professionals working in the locality to refer. Send the

client to the exact place and concerned person. A referral note containing a brief introduction about the individual or couple or family and its problems should be sent to the professional whom you are referring, along with request to give you feedback.

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## 15.5 HOW REFERRAL HELPS?

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A call or a letter from a source helps therapist to form an initial hypothesis. It also helps to start probing as there is already some information available about them. A referral also helps in finding out a therapist.

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## 15.6 NON ATTENDANCE

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If the client or the family doesn't attend the first appointment, it is usual to offer another appointment either by telephone or through any messaging source. Some clients may not wish to be phoned at home or work. It's essential for the counsellor to get the contact details of the individual, family or couples whom they are counselling and counsellor should give her or his contact, so that they can contact if there is any change in the session. Make it open to them that, informing you on certain changes in appointments will be appreciated. Also, the counsellor should find out the reasons for missing the appointment.

### 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. Fill up the blanks:

- (i) It is helpful to be aware of the \_\_\_\_\_ therapies available, that could be used in conjunction with counselling.
- (ii) Some clients need \_\_\_\_\_ drugs through psychiatric intervention in order to control their problematic thoughts, feelings or behaviours.
- (iii) A call or a letter from a source helps therapist to form \_\_\_\_\_.
- (iv) It is essential for the counsellor to have the \_\_\_\_\_ details of the family whom they are counselling.

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## 15.7 MEANING OF INTAKE

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A family systems interviewing format is particularly useful in mental health consultation. It can serve effectively as a diagnostic tool and for planning and initiating psychotherapy of any variety. Information is developed rapidly and in appropriate multi-dimensional complexity; scapegoating of the identified patient is reduced, family systems' resistances are made visible, and strategies for coping with them are initiated from the outset. While it is not always practical or psychologically feasible to arrange for such family consultations, substantial

benefits can accrue to the patient, family and the therapeutic enterprise when this standard structure is used.

The psychotherapist accustomed to one-to-one dyadic interviewing is apt to feel bewildered by the rate and volume of information obtained. In this Unit, an attempt is made to provide a simple guide to considering such consultation. 'Intake session' means initial family interviewing; it would be presumptuous to suggest there is 'one' correct way to carry out such a consultation. Some regularisation of interviewing techniques is possible and major training centres tend to teach in fairly standard ways. There is obviously much difference in these ways as well. The most obvious sources of it are the family itself and the personal style, training and theoretical persuasion of the therapist.

An initial family systems consultation would certainly include all of those evaluation that are conventionally associated with mental health; such as assessment of an individual family member's psychic functioning, principle conflictual areas, adaptive and coping capabilities, biologic endowment, skill level and so on.

### Goal

The main goal of intake process is mapping the aspects of systems of the present complaint. This is limited to defining those aspects of the systems which are relevant to the immediate presenting difficulty and to the immediate family.

#### 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. Write short note on intake.

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## 15.8 PROCESS OF INTAKE

The initial interview is full of excitement, uncertainty, newness and difficulty of understanding. In this, parties come together by previous arrangement, and they meet for the first time in the knowledge that they will need to find a way to work and live together.

During the intake process, the tentative establishment of an emotional contact between the family therapist and the various members of the family takes place. They appraise the family therapist and her or his skill, as well as her or his capacity to understand them and to relate to the client's distress. In turn the therapist appraises the client-family as well as its various members. The therapist evaluates the pathology as well as the healthy aspects of their

relationships. She or he listens to them and evaluates the issues. After a tentative hypothesis is established, the therapist identifies some of the outstanding conflicts and shares her or his observations with the individual or family. This leads to the beginning of the therapeutic contact. Tentative treatment goals and prognosis need to be set by the end of the intake. Intake also determines if counselling/family therapy is required or not and further referral to other helping sources.

Intake is basically the first meeting, the individual, family or couple has with therapist. It is very important in many ways in the therapy. The individual, family or couple may come for therapy as referred by somebody or by self or after getting an appointment with the therapist or just walk-in for the meeting. In any case, therapist meets them. Intake is the initial session with them to understand their concerns and reasons for the visit, in brief. You may not see all significant persons during the intake. You may get a person who seeks help for others too. In any case, it becomes the responsibility of therapist to enquire about their problems.

### **15.8.1 Resistances to the Family Concept**

Sometimes, the client refuses to involve one or more of the family members. In such instances, it is often useful for the therapist to review her or his own doubts and anxieties such as whether she or he is convinced that the whole family needs to be present at the session. Therapists often have a fear of dealing beginning with so many people or of exposing the children to the affairs of their parents or of handling an explosive marital situation in front of both the partners etc. If the therapist has such resistance, then it is most likely that it will reinforce resistance in the family.

Initiation of family sessions with few members of the family is risky. Many experienced therapists have come to regard the willingness of the entire family to participate as an important prognostic sign. Should the therapist ally herself or himself with that member of the family, it undoubtedly threatens the rest of the members. Resistances can be seen in terms of other family members objection to sessions. So, in the initial session itself, the therapist can enquire whether the other family members are aware of the visit and how they feel about it.

### **15.8.2 Environmental Setting**

The therapy room should be large enough to hold the family group and allow for free movement. There may be more chairs than the number of people expected so as to permit the family to represent their structural relationship by the seating arrangements. Allowing family members to arrange the seating in the room is a valuable guide to family splits, and to the position the therapist is intended to occupy. Therapist should be seated in the position which is visible to every member and, therapist can also look at all of them easily.

### **15.8.3 Observations**

Visual data collection about the family begins as soon as the therapist sets eyes on them. The common observations are 'How are they dressed?', 'How do they hold themselves?', 'Who is alone and who clings to whom?'. The therapist should particularly notice differences in the family interaction in the waiting room in contrast with their presentation of themselves (family) in the consultation room, for example, 'Do they talk naturally to each other while

waiting for the session to begin or are they frightened, fragmented or subdued?'. The family's way of greeting the therapist can be quite important. Who stands up first, speaks first, dresses, scolds or cuddles with the children, all can be observed and added to the hypothesis.

#### 15.8.4 Therapeutic Planning and the Contract

Most families come into the therapeutic situation with a knowledge of their symptoms, but they have no idea of what the underlying causes of their distress are. The therapist should be in a position to share her or his tentative formulations with the family and plan about the interventions. It is inappropriate attempt to review here the wide range of considerations entering into treatment planning. However, it is desirable for the treatment contract to be clearly spelled out and reviewed in sufficient detail, so that, family members and the therapist understand what is being proposed and how this would grow out of the experience they have had in the initial consultation with each other.

##### 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. Briefly describe the process of intake.

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### 15.9 IMPORTANT THINGS TO REMEMBER WHILE CONDUCTING INTAKE

The following are the important issues in intake session:

1. **Establishing rapport:** Greeting the couple or clients and to offer them seats is foremost. Make them feel comfortable. Family therapist or counsellor needs to introduce herself or himself. Make sure the information you share with the clients is necessary in a therapeutic relationship. The clients would show interest in knowing more about the therapist. Therapist or counsellor can be discretionary about details to disclose. You also ask them to introduce themselves and get to know about each of the family members. Developing a rapport is possible by asking their whereabouts, the place they come from, what they do etc. instead of directly jumping into their problems.
2. **Understanding reason for the session:** Ask them about the reason for meeting family therapist or counsellor, which helps in understanding their difficulties. As far as possible try to avoid using the words like '*problem*' and '*why*'. Family therapist or counsellor needs to enquire about what each member thinks, and what the problem is. It is essential to get perception of each member.

3. **Understanding the expectations:** It is important to understand individual's/family's expectations from the therapy and reason for seeking help at this point of time. This is in order to understand how serious they are with their help seeking behaviour and also to understand what steps they had taken in the past to handle those issues. The family should be explained about the role of dialogues in family therapy. Sometimes, they may also expect miracles to happen. Therapist needs to discuss with them about their various unrealistic and realistic expectations.
4. **Appointment:** After understanding the preliminary concerns, its important to give the family a time and date for the session. Make sure that you are available for the therapy session on the given time and date. It is important to inform them, if there is a change. It helps in building up of trust and rapport with the client(s).
5. **Duration of intake:** The intake session should not go on for a long time as this is intended to be brief, to understand their primary concerns. The session should take maximum 20 to 30 minutes. During this time the therapist needs to understand the presenting complaint in systemic perspective.
6. **Payment norms:** Payment for the session depends on the agency with which the family therapist or counsellor is working. The agency will have its policies on charging the session. Usually, in the intake session, family therapist or counsellor is expected to explain to the family or couple about the payment aspects, so that the family can be prepared for the payment or they have the choice to opt out.
7. **Members to be present:** Sometimes family therapist or counsellor cannot decide who are the members to be presented for the intake session. It may be any family member or members that will be present for the intake session. But once the intake is done, the therapist should know who are the significant members to be present in the coming sessions, and the individual or the family should be informed about the same.
8. **Motivating the family for therapy:** The intake session is not only deciding minutes to screen the family for assessment, but there may be some other family members who are not fully willing for family therapy. The family therapist or counsellor needs to motivate all the members for family therapy; in particular to work on their relationship or presenting problems.
9. **Duration of therapy:** Most of the clients or families will have their doubts on how long the session will go on and how many sessions they need to bring about change. This is a tough question for a new family therapist or counsellor to answer. The family therapist or counsellor needs to gain the confidence and can learn it through supervision and experience.

**Check Your Progress Exercise 6**

*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. List down the important points that should be kept in mind while conducting intake.

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## 15.10 ASPECTS TO BE KEPT IN MIND BY THE FAMILY THERAPIST OR COUNSELLOR

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Following are the key aspects that need to be borne in mind by any family therapist or counsellor:

1. **Confidentiality:** Family therapist or counsellor has greater role and responsibility in the first meeting with the family. First and foremost, it is essential to communicate with the family about the confidential nature of the information they share. Confidentiality is essential in all the helping professions. Family therapist or counsellor must not reveal details of the therapeutic relationship without the client's permission. Family therapists are often seeing more than one persons in a session; in that case, the release of any information must be agreed to by all parties. The stated exception is when the family therapist or counsellor fears the client will do any harm to herself or himself, or to another person. It is good practice to discuss the diagnosis being given and the expected treatment, such as number of sessions and type of approach, with the client(s) and to ask them to sign an understanding of that information. This process, of informed consent, allows the client to decide whether and how they are willing to proceed and protects the family therapist or counsellor who may otherwise be questioned or charged with breach of the client's confidentiality. The family therapist or counsellor will have to make efforts for ensuring confidentiality; for instance, ensuring that others do not get access to therapist's therapy notes, privacy being maintained and so on.
2. **Informed consent:** Clients have the freedom to choose whether to enter into or remain in a counselling relationship and need adequate information about the counselling process and the family therapist or counsellor. Family therapists or counsellors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the family therapist or counsellor and the client. Informed consent is an ongoing part of the counselling process. The family therapist or counsellor should appropriately document the discussions of informed consent throughout the counselling relationship.

3. **Being neutral:** Family therapist or counsellor who tries to understand the family will have to take a neutral position. In simple words, she or he should not be taking sides with any of the members. It is obvious to see in family therapy that family therapists or counsellors get attracted more to the sufferer or the underdog. Or sometimes spend a little more time with one family member than another. Family therapist or counsellor taking such a stand in favour of a single family member, can cause differences in the rapport of the family therapist or counsellor and the other family member and Family therapist or counsellor should ask questions to each family member, give equal time for each member and avoid meeting single members unless and until she or he can give equal time for each member.
4. **Understanding the emotional aspects:** At any point of the session, family therapist or counsellor is expected to have skills in handling the emotional issues during the session. The clients can be found sad, angry, happy or in any other emotion. Family therapist or counsellor needs to express appropriately with the situation.
5. **Gender issues:** Family therapist or counsellor needs to be gender sensitive. You may get a male or female client and sometimes a predominance of family members may belong to one gender. It is better that the family is comfortable with the gender of the family therapist or counsellor, and family therapist or counsellor also can find herself or himself comfortable. It is also apt to take a co-therapist of other gender if there are issues expected from a gender perspective in the therapy like in sex therapy.
6. **Ethical issues:** The American Association of Marital and Family Therapy Code of Ethics, addresses the confidentiality, financial, research, advertising, and other business and professional concerns that protect the legitimacy of the therapeutic profession and shows consideration for clients. It is the responsibility of therapists to know and to adhere to the code of ethics of the professional organisation with which they affiliate. It is their responsibility to know about and utilise social services and other resources that could be helpful to client families. When therapists make referrals, they need to make sure clients understand and agree that referral will be helpful for them. In a nutshell, therapists have to act responsibly, be non-exploitative, protect client confidentiality and in general be respectful and do no harm.
7. **Responding to life threatening behaviours:** There are times when the client is endangering herself or himself or others, that a family therapist or counsellor must intervene to protect both the client and the potential victim. The decision to react to those situations is always difficult, usually as painful to the therapist as to the client. A family therapist or counsellor should utilise her or his professional support system, supervisors, and colleagues to help implement these reactions and for support after having taken the necessary action. In general, calling on supportive professionals helps to reduce stress and burn out.
8. **Supervision and continuing education:** It is not ethical to allow biases to interfere with providing appropriate services to clients, but how open should one be? These issues should be addressed in supervision. When the family therapist or counsellor becomes aware of being uncomfortable

with clients around bias issues or any others, she or he should process those concerns with a supervisor or colleague. It is in the therapist's as well as the client's best interest for the therapist to participate in a supervision group, or at least have a colleague available for support and consultation. This is true as long as a family therapist or counsellor is in practice. If the therapist finds herself or himself unable to overcome those feelings of discomfort regarding particular clients, she or he must find a positive way to refer them to some one who will be able to work more successfully with them. It is also better to participate in continuing education programmes which includes, attending conferences offered by professional associations, workshops, seminars, reading professional books and journals, and holding case conferences with colleagues.

9. **Record keeping:** Good record keeping is an important part of a professional's task. Records should be in clear straight forward language. They should be concise and accurate. Record keeping is a key element of how a service is delivered, assisting practitioners in planning, assessment and decision making processes and in monitoring the progress of plans. They should clearly differentiate between facts, opinion, judgements and hypothesis. Case recording can give a structure so that work is focused. The case record ensures that staff can account for and evident the work undertaken, and provides a wider source of information necessary to that work, including user views, resource allocation and financial management. The record can also place the work with users in the context of agency policy, procedures and criteria for service provision.

The important points that should be kept in mind while keeping records are:

- i) Therapist should know 'HOW AND WHAT TO RECORD'.
- ii) Keep your record up to date, that is, entries should be made not later than five working days from the contact, correspondence or meeting.
- iii) Make your record easy to read and understand. Use plain jargon-free English, avoiding slang or colloquialisms.
- iv) Recording should be purposeful. State wherever possible the purpose of visits, contact or meetings.
- v) Recording must contain information that is essential to the purpose of your contact.
- vi) Recording must be accurate. Ensure that names are spelled correctly and consistently throughout.
- vii) The record must not be used to record or justify time spent, resource or funding difficulties relating to the service, or personal feelings and comments.
- viii) Keep the recording as concise as possible and relevant to the current intervention.
- ix) Separate fact from opinion. Indicate in your recording what is fact and what is a judgement or opinion. Always state whose opinion is it.
- x) Case files must contain a chronology of significant events at the front.
- xi) Every individual case must have its own case file.
- xii) All recording must be dated and legibly signed.

- xiii) Spring clean periodically like, shift through the case file, discarding duplicate papers and checking that everything is in the correct place. Update front sheets and key information regularly.
- xiv) Family therapists or counsellors create records and to the extent the records are under their control. They maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work. It is done in order to:
- (1) facilitate provision of services later by them or by other professionals,
  - (2) allow for replication of research design and analyses,
  - (3) meet institutional requirements,
  - (4) ensure accuracy of billing and payments, and
  - (5) ensure compliance with law. Family therapists or counsellors, maintain confidentiality in creating, storing, accessing, transferring and disposing of records under their control, whether these are written, automated or in any other medium. Documentation should protect clients' privacy to the extent that is possible and appropriate, and should include only information that is directly relevant to the delivery of services. They store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

**Case illustration**

*Therapist: Good afternoon.*

*Rahul: Good afternoon.*

*Therapist: I am Mr. Chetan, could you introduce yourself?*

*Rahul: I am Rahul and she is my wife Priya. We are basically working in software company in this city.*

*Therapist: Could you tell me what brings you here?*

*Rahul: Well, we have been married for the last five months and we find it difficult to live together.*

*Therapist: Could you explain about it?*

*Rahul: Its very difficult to adjust with her. She has her complaints about me that I don't come home early from office. And I don't find her also coming early for home.*

*Therapist: Priya, what do you say about it?*

*Priya: He said right. We don't get to see each other very often.*

*Therapist: What makes you say so?*

*Priya: Well, I think we both are very much interested in our work than family life. We should have married somebody in the office than each other. Nowadays we talk only when we need to shout at each other. And hardly go out.*

*Therapist: What do you think Rahul is the reason of such happenings?*

*Rahul: Well, I think, we haven't realised the importance of spending*

*time with each other. And above all, the job is too hectic for both of us. I think if we take some time out to talk to each other, we may solve most of our issues.*

*Therapist: Good, you could identify some reasons for your difficulties. Well, Priya, what do you say about it?*

*Priya: Of course. I feel the same and rest of the reason we need your help to find out and help ourselves.*

*Therapist: That's really nice. I think, I need to understand both of you in detail to comment about what is happening to you and how to intervene. So are you both willing to work on your relationship?*

*Rahul: That's the reason I am here.*

*Therapist: What do you say Priya?*

*Priya: Yes, of course!*

*Therapist: So, we will meet again tomorrow at 2:00 P.M. Is that ok with you?*

*Rahul and Priya: Yes.*

*Therapist: The information you give me will be kept confidential. The session is for 45 minutes to one hour, and each session will be charged as per the rules of the agency about which I think you are already aware.*

*Rahul: Yes. We are aware and we agree to it. We will meet you tomorrow.*

*Therapist: See you.*

*Rahul: Thank you so much.*

*Priya: Thank you.*

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## 15.11 LET US SUM UP

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In this Unit, we have learnt about referral and intake process. The Unit began with the introduction of referral process. It also described who refers and how referral helps the family. The later part of the Unit deal. with intake process. The intake procedure is brief in terms of the time but the things to be taken care of during the session are too many. Family therapist or counsellor, as he or she progresses with learning and experience, will master the skills in understanding and managing the client and family.

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## 15.12 GLOSSARY

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**Intake Session** : Initial family interviewing; it would be presumptuous to suggest there is 'one' correct way to carry out such a consultation.

**Referral** : A client is sent for seeking a higher level intervention or opinion.

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## 15.13 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

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### Check Your Progress Exercise 1

1. Referral can be defined as the process in which a client is sent for seeking a higher level intervention or opinion.

### Check Your Progress Exercise 2

1.
  - i. False
  - ii. True
  - iii. False

### Check Your Progress Exercise 3

1.
  - i. complementary
  - ii. psychotropic
  - iii. an initial hypothesis
  - iv. contact

### Check Your Progress Exercise 4

1. Intake session is an initial family interviewing. It would be presumptuous to suggest there is 'one' correct way to carry out such a consultation. The main goal of intake process is to map the aspects of systems of the present complaint. This will be limited to defining those aspects of the systems which are relevant to the immediate present difficulty and to the immediate family.

### Check Your Progress Exercise 5

1. Process of intake: The initial interview is full of excitement, uncertainty, newness and difficulty of understanding. In process of intake, two parties come together by previous arrangement and they meet for the first time in the knowledge that the family will need to find a way to work and live together. The tentative establishment of an emotional contact between the family and therapist takes place. Intake process also determines if family therapy is required or not and further referral to other helping source.

### Check Your Progress Exercise 6

1. Important things to remember while conducting intake:
  - i. Establishing rapport,
  - ii. Understanding reason for the session,
  - iii. Understanding the exceptions,
  - iv. Appointment,
  - v. Duration of intake,
  - vi. Payment norms,
  - vii. Members to be present,
  - viii. Motivating the family for family therapy, and
  - ix. Duration of family therapy.

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## 15.14 UNIT END QUESTIONS

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1. What do you mean by referral? Explain with the help of an example.
2. How can referral help the family and the family therapist?
3. Explain the process of intake.
4. What are the aspects that a family therapist or counsellor needs to bear in mind?

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## 15.15 FURTHER READINGS AND REFERENCES

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## UNIT 16 INITIAL PHASE

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- 16.1 Introduction
- 16.2 Main Theme of Initial Phase
- 16.3 Assessment Process in Initial Phase
  - 16.3.1 Initial Contact
  - 16.3.2 Defining the Goals for the Initial Phase
  - 16.3.3 Family History and Genograms
- 16.4 Structural Family Systems Rating Scale (SFSR)
- 16.5 Common Techniques Used in the Initial Phase
- 16.6 Developing a Family Formulation
- 16.7 Let Us Sum Up
- 16.8 Glossary
- 16.9 Answers to Check Your Progress Exercises
- 16.10 Unit End Questions
- 16.11 Further Readings and References

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### 16.1 INTRODUCTION

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The family systems perspective holds that individuals are best understood in the context of relationships and a “client’s” problem might be an indication of how the system functions and is not just a symptom of the individual’s maladjustment, history and psychosocial development. To focus on just the individual dynamics without considering the interpersonal dynamics yields an incomplete picture. Therefore, a treatment plan that addresses both the ‘client’ and the larger context is necessary.

Most commonly families seeking family therapy are the following :

- Concerns about children or adolescents;
- Families reporting that members have problems in relating to each other;
- Families in which one of the family members has a chronic illness and the family members want to understand how to cope with it better; and
- Families that appear to be having difficulty making the changes required to pass from one developmental stage to the next – for example when adolescents start to become more autonomous.
- Family therapy in such cases is an effective way of dealing with concerns which are set in a troubled family system. It may often be suitably combined with treatment of individual family members.

#### Objectives

After studying this Unit, you will be able to:

- Understand the assumptions of systems theory;
- Learn the process of assessment in family therapy; and
- Make family formulation.

## 16.2 MAIN THEME OF INITIAL PHASE

The initial stage is a very crucial stage in any form of therapy. It's the stage where a working relationship is established with the family. It also involves motivating the family to accept treatment and clarifying any misconceptions the family might have about therapy. The therapist right from the initial meeting tries to alter the individual/family's perspective of the problem. An effort is made to weaken the idea that the presenting problem associated with the index patient is encased within that person; instead the problem is perceived to be a by-product of the situation that individual is in. In other words, therapy involves understanding what the individual/family wants, how they see the problem, and how well the therapist can help each family member take up responsibility for it. Then, the initial phase also involves defining tentative goals for therapy which can either be modified or more precisely defined during the course of therapy.

### 16.2.1 Assumptions

The family perspective is grounded on the assumptions that the presenting concern of the family may:

1. Serve a function or purpose for the corrective maladaptive/deficient family pattern,
2. Maintain homeostatis in the family,
3. Be a function of the family's inability to operate productively especially during developmental transitions, and
4. Be a symptom of dysfunctional patterns handed down across generations.

#### 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. List the common contexts in which a family therapist sees clients.

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2. Name the important things to be covered during the initial phase of therapy.

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3. List the basic assumptions of systems theory regarding presenting concerns of families.

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## 16.3 ASSESSMENT PROCESS IN INITIAL PHASE

Assessment reflects the theoretical basis of the therapists. But, regardless of the theoretical background, a careful and thorough assessment is very important for successful therapy. A psychoanalytic therapist emphasises interactional themes including presenting complaints. Systems theorists centre assessments around certain core themes or dimensions for all the family members. Behaviourists focus on the stimulus–response contingencies in interactions. The presenting complaints may be taken at face value in systems perspective or behavioural perspective but not in psychoanalytic perspective. However, the aim of the assessment process is to understand the current functioning of the family. There are two ways of achieving this; these are given below:

1. Observe the family members' interaction, and
2. Ask relevant questions and study carefully the responses of the family members, that is, both verbal and non verbal.

### 16.3.1 Initial Contact

This is where the stage for the formal assessment of the family is set. During this phase, the emphasis is upon 'joining' the family and establishing a rapport with the entire family. The therapist should demonstrate control over the session while being relaxed, confident, conversational, indicating warmth through eye contact, body language, and allowing all the members of the family to talk.

The therapist should explain to the family that the sessions would be once or twice a week, and each session for about an hour.

The therapist should stress on the need for the entire family to attend the sessions and elaborate on the same. To help the family members understand the importance of this, the therapist may point out that:

- The problems of the individual may be best understood in the context of that person's family,
- The behaviour of one person is always affected by the behavior of the other family members,
- The other members of the family might be a part of the solution and may be able to help in the improvement of the problem behaviour.

Even when the family members are reluctant to attend, the therapist will be able to gather information regarding the system's functioning and resistances.

The therapist begins the process by obtaining details about various family events and observing the interaction between the members of the family and uses this to gradually understand the past and the present of the family life and the family history gradually emerges over the course of therapy.

The therapist at this stage has to deal with the expectations that the family has regarding therapy. They have to be helped to understand that the change will happen gradually in the family and cannot be brought about at the end of every session.

Most family therapy is conducted by a solo therapist though therapist pairs and multiple observer-consultant teams are common in some training centres.

### 16.3.2 Defining the Goals for the Initial Phase

Both the therapist and the members of the family are involved in defining the goals for the initial phase. These goals can initially be tentative but can be modified as the therapy progresses.

Most family, and couple-oriented therapists endorse many or most of the following goals, regardless of the particular nature of the presenting problem:

1. Reduction of presenting problem behaviour or experience
2. Improving the family or couple relationship, for example, enhanced communication, problem-solving and conflict resolution skill and better coping skills
3. Helping the family members improve autonomy and individuation
4. Improving the ability of the family to interact effectively with important larger social systems, and
5. Increasing the awareness and understanding of how couples' and families' patterns of interaction influence the everyday effectiveness in living.

There are goals which are short term and help the family in the process of achieving their own or the therapist's objectives. These are sometimes referred to as *process goals*. Common forms of such mediating or process goals are achievement of insight, the teaching of various interpersonal skills, for example, communication and problem-solving, and the disruption of problem-maintaining patterns of behaviour to allow family members to learn more adaptive responses. Mediating goals may also be more abstract and are not necessarily discussed with the families by the therapist.

### 16.3.3 Family History and Genograms

A genogram, also referred to as '*family map*', is a useful tool both in the assessment phase as well as the intervention phase of therapy. Information about the family can be gathered from the family using the genogram and the duration or timeline as an aid. A useful point to start would be to gather information regarding the dates of life events like marriage, birth of a child, and death of a parent. This provides a reference point and the other information can be gathered around it. It provides information regarding the relationship of individual family members, their age, gender, health issues, strengths, weaknesses and other relevant details. It is useful to construct the genogram in the family members' presence during the sessions since this makes it easier for them to remember the relevant details.

It is important to include all the members of the family in the construction of the genogram unless they are very young to participate. This further continues rapport building and also helps therapist understand their perspectives about family functioning.

**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 common goals of family therapy?

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2. What are process goals?

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**16.4 STRUCTURAL FAMILY SYSTEMS RATING SCALE (SFSR)**

This scale, developed by Szapocznik et al., helps the therapist understand the family along the following six dimensions of family functioning. The therapist should be able to make observations regarding most of these by the end of the first session itself. Information on these aspects can help the therapist draw hypotheses regarding the family functioning.

- 1. Structure:** Structure can be defined as the invisible set of functional demands that organises the way the family interacts, or the consistent and repetitive modes of behaviour of the family members. The observation of patterns of interaction gives clues about how the family is organised.
- 2. Resonance:** Resonance is the extent to which the family members are enmeshed or disengaged with each other.
- 3. Flexibility:** Flexibility can be defined as the capacity of the members of the family to tolerate change.
- 4. Developmental stage:** Many families' presenting concerns would be related to the difficulties in making the transition from one developmental stage to the next. It then becomes important for the therapist to understand the developmental stage and the successful or difficult transitions the family has made. This would also guide the process of goal setting in the therapy.

The developmental stages according to the Duvall are :

1. Married couples without children,
2. Child bearing families (oldest child 0 to 30 months),
3. Families with pre-school children (oldest child 2½ to 6 years),
4. Families with school going children (oldest child 6 years to 13 years),
5. Families with teenagers (oldest child 13 years to 20 years),

6. Families launching young adults (from first child to last child leaving home),
  7. Middle aged parents (empty nest to retirement), and
  8. Aging family members (retirement to death of both parents).
5. **Identified patienthood:** There is usually one person who would be seen as the focus of the concern in the family. The relationships that the identified patient (IP) has with others may reflect other relationships in the family, even the relationships that do not involve the IP directly.
6. **Conflict resolution:** This gives information regarding the communication within the family, the family's approach to solving a problem, its strengths and weaknesses. Families who are able to handle conflicts constructively move from focusing on people to focusing on issues. They attempt to meet everybody's needs instead of demanding their own.

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## 16.5 COMMON TECHNIQUES USED IN THE INITIAL PHASE

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The following are some of the techniques to be practised by the therapist during the initial phase itself and these techniques would be useful throughout the process of therapy.

- **Neutrality**

When asking questions to each family member, the therapist may seem allied with the person being questioned while the question is occurring, but the alliance shifts when the therapist questions the next family member. The end result is that the therapist has successive alliances with every member and is allied to everyone and no one at the same time. The therapist also has to be careful to declare no judgement about any family member whether implicitly or explicitly since this would lead to ruptures in the alliance.

- **Circularity**

This is the ability of the therapist to ask questions based on the feedback given by the family members in response to her or his own questions about the family. This is done to help the family to understand the systemic view and also to provide new information about their own concerns. This also helps the therapist confirm or negate her or his own hypotheses about the functioning of the family. This method also helps the therapist raise the neglected issues in the family indirectly. For example, expressing appreciation for each other or modeling a desired behaviour for the child.

When asking circular questions, it is important to:

- Ask about specific behaviours, family events or interaction,
- Attempt to discover the full sequence of the members' behaviours which may occur repeatedly with the problem behaviour thereby maintaining it,
- Ask only in terms of relationships between family members,
- Engage each member of the family, never spending more than 5 to 7 minutes with each person, and
- Ask those questions which are relevant to the hypotheses, not questions which are random and without purpose.

Some examples of circular questions are given below:

1. What does he do to show you that he is angry?
2. When does he show this behaviour?
3. How does your sister respond?
4. How is it different from what was happening when papa was alive?
5. What would be the problem in the family if the things continued to be as they are?
6. What do you think your brother will do if mummy starts working full time?

● **Reframing**

Reframing refers to changing the perspective of the family members about an issue such that, the meanings of the behaviours associated with that issue are viewed in a different way so that modifying the behaviour becomes easier for the person or family.

The member's intent behind the actions can be positively viewed, not necessarily the actions themselves. The parents, for instance, may be using inappropriate methods to discipline the child, may be using physical or verbal abuse. But, the intent of disciplining the child is commendable if not the 'means'. This feedback might help the parents think of other 'means' to achieve the same goal namely, disciplining the child.

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## **16.6 DEVELOPING A FAMILY FORMULATION**

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This involves considering how the family functions and if the presenting problems are related to how the family functions, if so, how so and to what extent? The formulation should summarise the therapist's understanding of the family. It should involve:

- A brief description of the presenting concern that has led the family to seek help, and of the expectations they have from therapy,
- Family members' ages, relationships, occupations, and the family's developmental stage (genogram),
- The therapist's understanding of the family, it's current functioning and how the problem behaviours are being maintained, using any theoretical model that the therapist finds helpful,
- The family's strengths, assets and motivation to change, and
- Information about the family's relationship with the supra-systems and how this is affecting the family.

The formulation also should logically lead to the treatment plan and the prognosis – with and without treatment.

**Feedback and Recommendations to the Family:** The feedback depends on the theoretical orientation of the therapist as well as the nature of the family's concerns. The feedback should always include any recommendations the therapist has regarding the further investigation or assessment of the family and it should state whether further treatment is recommended and if so, what

type. At this stage, the family members are given more choices, alternatives, and more effective options.

**Arranging the Next Step:** Following are the signs of successful completion of initial phase and preparation for middle phase:

- Increased dependency on therapist, for example, family may ask therapist, "Tell us what we can do?",
- Weakening of rigid family patterns,
- Spontaneous recognition of dysfunctional aspects of interactional styles,
- One or more than one member spontaneously identifies that she or he needs to change in specific behaviours, and
- Family members are helped to remain hopeful.

It is important that the family knows what is to happen next when they leave the initial interview.

**11. Feedback to Referring Professional and Others:** Feedback to the referral source should include the referrers' involvement in the ongoing treatment process for the family. Sometimes more active participation might be necessary like joint treatment planning with teachers, special educators, physicians or social workers.

**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. Name the six dimensions assessed in the Structural Family Systems Rating Scale.

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2. What is circularity?

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3. What is neutrality?

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4. What is reframing?

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5. What are the main aspects of a family formulation?

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## 16.7 LET US SUM UP

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- Family therapy involves understanding the presenting problems of the individual in the context of his/ her relationships.
- During the initial phase itself, the therapist helps the family understand that the presenting problem associated with one person is not only due to that person; instead it is seen in the context of the interpersonal relationships in the family.
- The assessment phase begins with the therapist joining the family and establishing a relationship based on trust and respect with all the members of the family.
- The family and the therapist are jointly responsible for discussing the goals of therapy.
- The therapist tries to understand the functioning of the family by observing the interaction of the family to understand about the past and its relevance to the present.
- Some of the techniques that would be useful to keep in mind through out the process of therapy are neutrality, reframing and the method of circular questioning. This would help in building and strengthening alliance with the members and also enhance their motivation to change.
- This would lead to a family formulation which explains if the presenting problems are related to how the family functions, if so, how so and to what extent?
- Feedback is given to the family and the recommendations regarding further investigations and treatment are given.
- The referral sources are also involved in the treatment process if and when necessary.

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## 16.8 GLOSSARY

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- Circularity** : Ability of the therapist to ask questions based on the feedback of the family members on therapist's earlier asked questions about the family.
- Flexibility** : The capacity of the members of the family to tolerate change.
- Genogram** : A pictorial display of a person's family relationships and medical history.

- Process goals** : Short term goals that help the family in the process of achieving their own or therapist's objectives.
- Reframing** : Changing the perspective of the family members about an issue such that, the meaning of the behaviours associated with that issue are viewed in a different way so modifying the behaviour becomes easier for the person or family.
- Resonance** : The extent to which the family members are enmeshed or disengaged with each other.
- Structure** : The invisible set of functional demands that organises the way the family interacts, or the consistent and repetitive modes of behaviour of the family members.

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## 16.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

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### Check Your Progress Exercise 1

1. The common contexts in which a family therapist sees clients are families with concerns about children or adolescents, families reporting that members have problems in relating to each other, one of the family members has a chronic illness and the family members want to understand how to cope with it better, and families with difficulty in transition from one stage to the next.
2. The important things to be covered during the initial phase of therapy are establishing rapport, alteration of problem perception, motivating the family for change and setting of tentative goals.
3. The basic assumptions of systems theory regarding presenting concerns of families are to serve a function or purpose for the corrective maladaptive/deficient family pattern; maintain homeostasis in the family, be a function of the family's inability to operate productively especially during developmental transitions and be a symptom of dysfunctional patterns handed down across generations.

### Check Your Progress Exercise 2

1. The common goals of family therapy are: reduction of presenting problem behaviour, improving the family or couple relationship, helping the family members improve autonomy and individuation, improving the ability of the family to interact effectively with important larger social systems, increasing the awareness and understanding of how couples' and families' patterns of interaction influence the everyday effectiveness in living.
2. Process goals can be defined as short term goals that help the family in the process of achieving their own or the therapist's objectives.

### Check Your Progress Exercise 3

1. The six dimensions assessed in the Structural Family Systems Rating Scale are structure, resonance, flexibility, developmental stage, identified patienthood and conflict resolution.
2. Circularity is the ability of the therapist to ask questions based on the feedback given by the family members in response to her or his own questions about the family.
3. Neutrality can be defined as the technique where the therapist has successive alliances with every member of the family and is allied to everyone and no one at the same time.
4. Reframing is changing the family's perspective of a problem such that the meanings of behaviours associated with the problem are viewed in a way that modifying the behaviours becomes easier for the family.
5. The main aspects of a family formulation are brief description of presenting concern and expectations from therapy; genogram; therapist's understanding of current family functioning; family's strengths and weaknesses and family's relationship with the supra-system.

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## 16.10 UNIT END QUESTIONS

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1. What is the main theme and assumptions of Initial stage of family therapy.
2. Describe the various processes used in assessment in your words.
3. What do you mean by SFRS? Explain the common techniques used in this.
4. Discuss the main signs of successful completion of initial phase.

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## 16.11 FURTHER READINGS AND REFERENCES

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# UNIT 17 MIDDLE PHASE

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## Structure

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## 17.1 INTRODUCTION

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The middle phase of therapy marks the beginning of the intervention phase. Through the assessment, the therapist obtains information on the problem areas, the structure and functioning of the family and its strengths. Most importantly, assessment contributes to the development of the family hypothesis. An important, initial task of the middle phase is the formulation of therapy goals. The second task of the middle phase is to address the therapy goals by employing various family therapy techniques. Some techniques employed are common across the different schools of family therapy, while others are more specific to a particular school. Usually, techniques are integrated from different schools to best achieve the goals of therapy. The middle phase of therapy usually incorporates an average of fifteen sessions. The number of sessions may vary across families. Some individuals/families that present with more complex issues require more number of sessions. The usual frequency of sessions is once or twice a week. In this Unit, we will study about the middle phase of counselling/family therapy.

## Objectives

After studying the Unit, you will be able to:

- Understand the middle phase of family therapy;
- Explain the goals for middle phase of therapy; and
- Discuss the challenges in family therapy.

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## 17.2 GOALS OF THERAPY

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Let us now get familiarised with the goals of family therapy.

### 17.2.1 What are Goals?

Family therapy goals refer to the objectives of therapy. Everything the therapist does help the family to achieve these goals. Goals are the answer to the questions, like “what do I want to achieve at the end of this therapy?”; and “what are the changes that need to be brought about in the family to improve its functioning?”. Goals often represent the ‘desired state’ at which families coming for therapy wish to reach (Barker, 1992). Many families and couples come to family therapy with negative goals. Parents want their children to stop fighting with each other, a spouse may want her or his partner to stop arguing; a couple may want their child to stop spending so much time with friends. Though these are valid reasons for seeking therapy, it is helpful if the family therapist can help the family reframe their objectives in positive terms. For example, it is useful to ask if the children are not to fight, how they should deal with disagreements. This gives some direction to the goals. The family may then define the goal as children should learn how to talk peacefully and solve disagreements.

### 17.2.2 Joint Creation and Agreement on Goals

In family therapy goals are always created jointly by the family and the family therapist. When a family comes for therapy, the family members have their own agenda of what they would like to see changing. At times, what the family wants may not be in their best interest. At other times, the family therapist may identify some areas that are important to be addressed for healthier functioning of the family, but the family may not identify that as a goal of therapy. For example, the family may identify change in the behaviour of the children (fighting) as a goal of therapy. However, as a family therapist one may identify that for the behaviour of the children to improve the parents need to function better as a unit and their communication and disciplining styles need to improve. The therapist then puts this across as the goal of therapy and helps the couple see the importance of achieving this goal for themselves and/or their family. The therapist does not force her or his own agenda, rather, helps the family accept it as valid. Consensus between the therapist and the family on what the goal of therapy is important. Absence of this consensus often becomes a reason of poor outcome and drop-out from therapy.

### 17.2.3 Clarity of Goals

Many a times even when goals are stated in positive terms, they are often vague and ill-defined (Barker, 1992). A family may define the goal of therapy

as 'to be a happy family'; to 'get along with each other better' or 'be closer as a couple'. These are desirable goals for a family and for family therapy; however, these are still vague. The therapist does not have an idea of what will make a family closer or help them get along better. It is helpful to ask the family to elaborate or describe in detail what will make them happy. Some questions that can be used to gain clarity can be "what would make you happy as a family; what needs to change to make things happier; how should things be in the family now; what does each member need to do differently to make it a happy family?" Answer to these questions will help both, the therapist and the family to gain clarity on what they expect out of therapy and their family members.

#### 17.2.4 Short and Long-Term Goals

As the name suggests goals can be either short-term or long-term. *Short term goals* refer to the goals that are more immediate and need to be achieved in order to address the larger goals. These, at times, are not even explicit to the family but are a step towards achieving the desired goals. Some of the short-term goals include: (a) ensuring that both partners participate equally in the session; (b) help discussions on their emotional experiences (for example, hurt or shame); (c) altering communication between members to reduce conflicts and increase positive communication; (d) increasing their problem solving capacity; (e) ensuring the well-being of the family members and reducing the stress experienced; and (f) avoid blaming and decrease escalation of fights in the family.

Long-term goals reflect the domains of the family functioning that need to be improved. These may include: (a) increasing intimacy between couple; (b) increasing cohesiveness; (c) making the hierarchies more age appropriate; (d) encouraging forgiveness in the relationship; (e) building trust between family members; (f) creating healthier subsystem boundaries; and (g) creating healthier external boundaries to make families self-reliant for negotiating future events.

#### 17.2.5 Challenges to Establishing Goals in Family Therapy

There exist numerous challenges to establishing goals in family therapy. These challenges can present in different ways. For example, while obtaining clarity on goals, one member's criteria for happiness can be quite different from the opinion of the other family member. One partner may define happiness in form of greater closeness between the couple while the other may define it in terms of partners sharing a better relationship with her or his family of origin. Parents may want that the family can become cohesive if the children (adolescents) spend more time with them, while the adolescents may demand their own space and privacy. At other times, the goals may be completely opposite where one partner may want to stay in the marriage while the other may want to separate. Thus, in these situations though the members have clarity on goals, there exists a disparity and disagreement on the goals of therapy. It is at these times that one of the primary task of the family therapist is to help in arriving at a common agenda in therapy, where all the family members are willing to work towards achieving it. Reaching a consensus on goals then becomes an important short-term goal of therapy. This arriving at a consensus on goals itself may require a few sessions. It is often achieved through use of present and future oriented circular questions.

At times, though diverse, agendas of all family members can be adopted. For example, the quality of time that the adolescents and parents share can be enhanced to increase closeness; simultaneously the importance of individuation can be explained and encouraged in the parents, where they respect their child's right to privacy. On the other hand, there are times when the goals are opposite and a middle path needs to be found. For example, a couple may decide that they are going to give their marriage one more try, and then decide if they can not be in a relationship together and separate. Establishment of a common agenda is essential for the therapy to have a direction, achieve its goals and be successful.

**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. What are short-term goals? Give examples.

.....  
.....  
.....

2. State a few long-term goals of family therapy.

.....  
.....  
.....

**17.3 CASE ILLUSTRATION**

**17.3.1 Reason for seeking therapy and background information**

Mr. B and Mrs. P had been married for nine years and had a daughter M aged seven years. Mr. B was aged 36 years, a postgraduate and a manager in a private firm. Mrs. P was aged 32, a postgraduate and a homemaker for last five years. The family presented for consultation as they wanted to know how to deal with their daughter. M's teacher had found her beginning to get angry with her classmates and occasionally hitting them, and thought it best to inform parents about this emerging problem. Both parents felt that something was not fine with M as she had become clingy and demanding at home also. P also consulted as she felt helpless at not being able to do anything for M and felt sad most of the time.

**17.3.2 Family Life Cycle Assessment**

To understand the problem, we have to first assess the family information.

**1. Family of origin of Mr. B**

B was youngest of three siblings and described his family as being a distant family. His father was a strict disciplinarian and frequently used punitive

measures. He was often afraid of his father and switchboard communication was present through the mother. Father was the nominal and functional head and his leadership was accepted by the family. Decision making style was autocratic. Roles were gender specific. B admired his mother for her patient, selfless way of looking after the family, but resented her for not being able to stand up for him in front of the father. Over time he accepted this behaviour of mother. His style of coping was to avoid fights; he would often agree with his father on the face, but did what he pleased to do. His family would only come to know about it later and if they got angry, he would tune himself out or just bear with what they said. Communication was more instrumental. Family rituals were present. The noise level in the family was high.

### **Family of origin of Ms. P**

P was second of four siblings and reported her family to be conflictual. There were frequent fights between parents about how things needed to be done at home. Father was the nominal and functional head, though his leadership was challenged by her mother. Decision making was chaotic, though most of the time mother had to do what the father said. P felt that the parents were often so involved in their fights that she felt left out. She learnt the habit of asserting herself as she wanted her needs met. Comparatively close relationship was present between the siblings. P was often the person who was good at things but at times felt that her family favoured her brothers. She often took responsibility for her siblings and advised them, but felt unappreciated. Communication was instrumental and emotional. Roles were gender specific. Family rituals were present.

### **Courtship**

The couple had an arranged marriage with the courtship lasting four months. Both families liked the proposal on account of the family background, partners being well educated and financially independent. Communication was minimal during the courtship and at times initiated on wife's insistence. Husband wanted a wife who could be his companion and who would be able to get along with his family such that there would not be any fights. Wife wanted a partner who would be able to appreciate her for who she was; who loved, supported and cared for her.

### **Married Couple Without Children**

The couple lived as a joint family after marriage. Fights usually revolved around wife feeling unsupported by the husband. P experienced role strain on account of continuing with her job and looking after the family. She felt family was unappreciative and un-cooperative as she put in her level best to fulfill her responsibilities. She often felt B was unable to take a stand or a decision; often she had to push him to do something. Husband felt that P was often dominating; telling him what to do. He felt incompetent and began to feel less confident about his ability to handle his family. During fights B would often withdraw, angering P more. P thought that B kept quiet as he did not understand what she meant and would often continue to explain things to him for a long time. B at that point would tune himself out, superficially agree with P and then not do it. This angered P more and she felt that B did not listen to her or respect her.

### **Married Couple with Child 0-3 Years**

Couple planned a child within a year of marriage. Over a period of time the above mentioned pattern of interaction was further established. P experienced a greater role strain with the birth of M. Though she had some help from B's parents in bringing up the child, she felt his parents were indulging M. This increased fights at home and increased the occasions where P expected B to take a stand, make a decision or support her in front of his parents. B felt that P was always angry with him and kept demanding more from him. B felt that P's behaviour of confronting his parents was leading to a tense atmosphere at home.

### **Married Couple with Child 3-6 Years**

Couple decided to separate from B's parents when M was three years. P decided to quit her job and become a homemaker. B felt that separation was a way of decreasing fights at home. Though role strain felt by P was marginally reduced and B was supportive in childcare, the other pattern of interaction continued. P felt that every thing at home was her responsibility. B had to be continuously reminded of things like bills, or maintenance work at home. B gradually felt less and less need to remind himself of it as he felt that anyway P would tell him about it. P felt she was the only one thinking about their family and their relationship and felt tired of being the responsible one. Parenting roles were shared by the couple and M shared a close relationship with both parents. M also shared a good relationship with her grandparents; however, P felt that times when M was with her paternal grandparents they indulged her and often put P down in front of M or challenged her disciplining style. She found B unsupportive in trying to establish a boundary with his parents.

### **Married Couple with Child 6-12 Years**

With the same pattern of interaction fights continued to increase with B beginning to avoid time spent with P. P felt increasingly unloved, unsupported and sad. B often came back late from work as he felt uncomfortable in the tensed atmosphere at home. Fights increased with M often witnessing these. For the last few weeks parents reported that M would start crying or getting angry if the couple had any fights. This ended the fights as the couple paid attention to M. At times M became more clingy and demanding and parents would have a difficulty disciplining her or understanding her behaviour. Both felt alarmed when the teacher also noticed changes in M's behaviour.

By the end of assessment, information was obtained about the life cycle stages, maladaptive interaction cycles, and behaviour of each of the family members and their feelings about the situation and each other.

Therapists need to gather information across all three areas: behaviour, thoughts and feelings. Even across the family therapy, continuous information is obtained across these areas. For this family, more information was available about behaviour; thoughts and feelings about each other need to be explored more.

At the end of assessment some of the areas of intervention that can be visualised include, addressing M's insecurities, parenting skills, communication, conflict resolution styles, decreasing role strain in wife, creation of positive interactions, addressing external boundaries and identifying and meeting emotional needs.

### 17.3.3 Family Hypothesis

In his family of origin, B learnt the conflict resolution style that the best way to deal with conflict is to avoid it. He avoided conflict with dominating people (father) and became passive aggressive. He saw mother agreeing to everything father had to say and appreciated her being selfless. In her family of origin, P was always the responsible one, but felt unappreciated for her strengths. She saw that mother could oppose the father but, there was no point as he did what he wanted. She learnt that asserting herself was important.

After marriage B's expectation of having a companion and no fights in the family was not fulfilled. P found herself again being the one taking responsibility of the relationships and not being supported or appreciated by B. B began to view P as dominating and reacted to her in the same way as he would to his father. P became more adamant about asserting herself as B often would not do what she asked and neither would he independently take responsibility for things. Both felt disappointed in each other and their relationship. The more P asserted herself or made B sit down and listen to her the more he tuned out and did what he pleased and lost confidence in himself. He felt that P was constantly undermining him. B was unable to get a feeling of companionship and P felt uncared for. The disappointment and fights increased over the years. The couple started to drift apart. Further, their style of conflict resolution (B withdrawing P becoming aggressive) continues to feed relationship anxiety. Thus, a mutually dissatisfying cycle of interactions is perpetuated. M's getting aggressive, clingy or demanding was a reaction to fights at home. M was feeling emotionally insecure. Often her crying and aggression made the parents stop the fights and this reinforced her behaviour. Further, disagreements over how to discipline M between P and B's parents was increasing the disciplining problems they faced with M.

### 17.3.4 Creating Treatment Goals

The assessment was completed and the couple was given a feedback of hypothesis. Both accepted that their behaviour was having a negative impact on the child and that they needed to make the child feel more secure. Here we can see that the child's behaviour was bringing the parents closer together so as to work on their problems. This is the role played by the symptom. Both accepted the hypothesis partially; they accepted that their style of resolving conflicts was making them distant from each other. Both agreed to make this a goal of family therapy.

Though both accepted the hypothesis, they had difficulty understanding the systemic view. They blamed each other for their fights. P felt that B deliberately did not want to listen to her and took pleasure in making her angry. B felt that P was dominating, thought he was incompetent and incapable of anything and he felt tensed with her. Each felt the other should change. These *negative attributions* that they had about each other were *reframed* – couple was helped to see them not as inherent faults in each other but as the outcome of their interaction pattern where each was arousing these feelings and thoughts in the other. This helped the couple shift their stance from individual to systemic, *decrease blame* and made them willing to explore it further as a goal of family therapy.

Not all issues identified during assessment are addressed in family therapy. Family therapists need to identify those areas, where change will lead to

maximum positive impact on the relationship. The couple was helped identify the following goals:

### Short-Term Goals

- Helping deal with M's feelings of insecurity,
- Improving parenting skills,
- Improving communication skills,
- Identifying a different way of handling conflicts,
- Addressing wife's anger and feeling that the family was only her responsibility, and
- Increasing participation from husband (family therapist objective – not visible to couple).

### Long-term goals

- Clarity on expectations from relationship
- Fulfillment of emotional needs

### 17.3.5 Intervention

Intervention began simultaneously across the different goals set in therapy. Primarily the interventions described here can be understood as: doing systemic work, changing dysfunctional thoughts and feelings; and skill building (communication, conflict resolution and problem solving). It is discussed here in the order of intervention techniques and not in the order in which it occurred across sessions.

Right at the beginning of therapy one rule was set for the couple, that is, there would be no fighting in front of M. Consent and cooperation was elicited from both spouses. They were helped to understand the negative psychological impact of M being a witness to their fights. Both agreed to make efforts to do the same.

The interaction pattern identified was repeated in the session, with P automatically assuming responsibility for the discussion and B not participating much. Efforts made by P to elicit an opinion from B were met by silence; this increased her giving explanations to him about what they should be doing as parents. B response to this was saying yes to P that he would do what she asked him to do. P interpreted this as a again putting responsibility on her, which led to increased anger in P. At this point the family therapist needs to create space and support the partner who usually speaks less in order to encourage them. Setting up *communication rules* of the session like each partner will get their own time to talk; respecting each other's time to talk; emphasising on the importance of listening to each other; importance of respecting diverse views of the partner even if they are different from your own; and making them understand that both are likely to have different perspective on things and this does not make either person a 'liar', are often helpful in making the partners slow down and listen to each other.

Interactions can be broken down and the couple can be helped to *reflect on their feelings and verbalise them*. Asking both partners about 'how the

interaction went, how would they like it to be different and what made P angry and B withdraw' helps elicit both feelings and thoughts about their interaction. This lays the foundation of *systemic intervention* with the family. Often the therapist can assist this process by breaking down the sequence of the interaction and encouraging reflections from partners on each aspect. Family therapists can also add their own reflections in order to prompt reflections from clients. This process helped B identify that he was not just tensed when with P, but felt scared of her. His fear of her prevented him from voicing any ideas and he put the responsibility of the decision on P (*connecting feeling with behaviour*). B realised that his assumption that 'P will take care of everything anyway' had kept him from paying attention to P's needs (*connecting thoughts with emotions and behaviour*). B made *negative attributions* that P was aggressive and critical of him. This made his behaviour towards P passive aggressive and dismissive of her feelings. P's aggressiveness was *reframed* as her clarity of thought and desire to do the best for her family.

P identified that it was important for her to do the right thing for her family. This *implicit expectation of herself* became stronger when she felt that she could not rely on B to think for their family. She was able to reflect that it was this expectation that increased the pressure she put on herself and on B. Further, P was encouraged to *reflect on B's disclosure of his feelings* (he felt scared of her). P initially felt angry at how could B think of her like that. Questions like; "What did you feel when he shared this with you? Is he usually withdrawn with all people? How are his interactions different with other people? What could be the reason for this difference?" helped P reflect on her behaviour. Here the *positive aspect of B's feeling was emphasized*; it was important for B what P thought of him. P was able to state that her anger was not because of B's inability to take responsibility, rather because he could not be open with her about his thoughts and feelings. This made her feel insecure. Encouraging B to reflect on this helped him understand P's fears. This identification of underlying feelings, fears, insecurities and needs in a relationship is an important technique of *emotion focused* school of therapy. This school assumes that expressing underlying emotions encourages bonding between partners.

These *insights* into what caused and maintained their dysfunctional patterns were *translated into goals* for change. Couple was helped to discuss about what they would like their relationship to be like in the future. This *solution focused technique* was used to help the couple identify what they would like to see changing in their relationship to make it better. This also helped clarify expectations from the relationship. B identified increased participation in family decision making, and spending more time with wife and increased comfort in being himself in the relationship as his therapy goals. P identified working on her anger, directly asking for B's involvement and being open to B's ideas as goals for herself. Family therapist also *interpreted* P's actively pursuing any decision and trying to gain control as a way of achieving security in the marriage.

While it was encouraged that B become more open about his thoughts and feelings, P's style of communication often prevented an open discussion from taking place. P's frequent and uncontrolled expressions of anger came in the way of B feeling safe with her. B's lack of assertive skills prevented him from opening up with P. For instance, while discussing how they would make M

feel more secure and how they can address her behavioural problems, P made statements like 'You are ridiculous, you don't know how to handle her'. B withdrew initially and then hesitantly said that 'She always thought that she knew what was the best, if that was so then things would not have gone wrong'.

These negative interactions are characterised by blame and often have a tendency to escalate such that they then lead to fights. It is the task of the therapist to change dysfunctional communication styles. Spouses here were taught *communication skills*. Communication skills work is not done independently in therapy. It is usually contextualised in discussions about issues in therapy. In communication skills training both *verbal and nonverbal aspects of communication* were addressed.

While communicating it was found that P's tone of voice was sarcastic; she would get loud and start raising her voice when angry – these were related to B withdrawing from the interaction. B's silence and using a blaming or dismissive stance caused P to get angry. Often B would not pay attention to P as a result when P asked him something he would not respond appropriately. Communication skills taught to them included active listening skills like: maintaining eye contact; not interrupting a partner, rather waiting for them to finish; listening to partner, asking a question, clarifying or confirming if they have understood it correct and then giving a response; listening to what the partner is saying now, and not responding on the assumption that she or he is going to always say the same thing, and; understanding partner's point of view were taught. P was also encouraged to modulate her tone of voice, especially when angry.

Couple was encouraged to use "I" statements instead of "You" statements. P was then able to articulate that "I will sit down and talk to M about how she is feeling. I don't know if she is feeling scared. I know that you worry about her also, so I would like us both to talk to her together". B responded by saying "I agree with you. I think we both should talk to her. I think my spending more time with her, and you, will also help her see that we are together". Here the couple was not only able to find a solution to how they would address the goal of M's feelings of insecurity, they were also able to talk about what they think, express their own ideas about how they can solve the situation and affirm each other's point of view. It is important that couples learn these skills. Teaching couples to express ideas of resolving a situation instead of blaming each other, making requests instead of demands and each assuming responsibility for the well-being of their family is vital. Parenting skills were addressed in the same context.

Couple was explained regarding not using derogatory labels for each other. P often had a habit of telling B, "How can you be so stupid". This was discouraged and more respectful communication style of making requests, giving positive feedback and not using any threats or ultimatums was taught. They were helped to understand that when communication breaks, both people are responsible for its failure and blaming the other does not help.

Importance of having a common and consistent style of *parenting* was emphasized. The couple was explained that it was important that M received the same message from both parents. It was vital that P and B share a common view of what is acceptable form of behaviour. P was encouraged not

to put down B's efforts in front of M. P was helped to understand that even if she did not agree with how B was handling a situation, it was important they do not challenge or disagree with each other in front of M. Having a discussion in private to sort out and reach an agreement on how to discipline M was encouraged.

*Boundary issues* with B's parents were addressed in the end. This was done so as the family of origin is a sensitive subject and more importantly the marital subsystem needs to be strong enough to negotiate with it. Both were asked to discuss what did M being close to her paternal grandparents mean. P was able to clarify that she wanted M to be close to both sets of grandparents but felt hurt when the paternal grandparents put P down; she felt hurt and felt that they did not consider her a part of the family. P wanted to share a positive relationship with them but did not know how to begin. Clarification of this helped soften B's stand regarding the issue. Both were encouraged to *problem solve* regarding how would they like to communicate the same, who will do it, how would they like to encourage a more positive relationship, and what behaviours could make it happen.

Solutions to any problem need to emerge from the couple and are not provided ready made by the therapist. The therapist can guide the partners in reaching a solution by facilitating the process. It is only when the family members come up with a solution will they be motivated to work towards it.

### 17.3.6 General Principles in Family Therapy

One of the important initial tasks of the family therapist is to help *build hope* in the family. Often asking the family members to identify their strengths, positive moments or aspects of their relationship helps build hope. Therapists should however refrain from making blanket statements like "everything will be fine". Therapist may often have to act as the role model and help family members *identify positive changes*. *Positive reinforcement* from the family therapist *validates* the efforts put by the family and builds hope. Therapist helps the family members learn the importance of positive feedback as an important motivator of change. Additionally, if the therapist finds that only one aspect is being discussed predominantly in the sessions (behaviour, thoughts and attitudes or feelings), it is the task of the family therapist to find out more about the neglected areas. Usually couples find it easier to talk about behaviours and these are first to change in therapy. Finally, it is vital that family members understand that responsibility for change lies with all members of the family.

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## 17.4 CHALLENGES IN FAMILY THERAPY

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### 17.4.1 Therapist Neutrality

In family therapy, neutrality is one of the biggest challenges in therapy. Since both partners are likely to feel that they are right, family therapists are often put in the uncomfortable role of 'judging who is right' by the family. Family therapists need to be aware of it such that they do not get pulled into the position of taking sides. They need to encourage the family members to clarify their positions with each other and come up with answers. Therapists can step in with a solution only when they find that the solutions that the family members have come up with are unacceptable, unrealistic or damaging to the well-being of the family.

## 17.4.2 Resistance to Change

Resistance in therapy can be visible in different forms. It may present as one family member disrupting the sessions process, a member not being able to move ahead in family therapy (for example, remaining stuck with a belief), and at other times it may be the inability of the family to carry out the tasks discussed in therapy. In either case, it is important that the family therapists do not lose patience with the family or feel disappointed and angry at them. It is crucial that the reason for resistance be identified and addressed. For instance, at times the task set may be difficult for the family such that they are either not ready for it or do not have the necessary skills to execute it.

### 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. State 'True' or 'False' :

- i) Therapist neutrality is one of the biggest challenges to family therapy.  
\_\_\_\_\_
- ii) Resistance to family therapy does not affect the family therapy process.  
\_\_\_\_\_
- iii) The identification of underlying fears, emotions, feelings, insecurities and needs in a relationship is an important technique of emotion focused school of therapy. \_\_\_\_\_

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## 17.5 LET US SUM UP

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In this Unit, you have studied that;

- Middle phase marks the beginning of the intervention stage,
- Tasks of the middle phase include : setting of therapy goals and employing various therapy techniques to address them,
- Goals refer to the objectives of therapy,
- Goals are created jointly by the family and the family therapist – consensus between the family members and the therapist is important,
- Clarity is essential in formulation of goals,
- Goals can be short term or long term,
- Goals link the family assessment with the therapy plan,
- Middle phase involves feedback of hypotheses to family. This helps them understand the problem better,
- Techniques from various schools are integrated to address the goals of therapy,
- Change needs to be brought about in three areas there are, positive behaviour, feelings and thoughts,

- Responsibility of change lies with both partners, and
- Therapist neutrality and resistance to change pose challenges to the therapy.

## 17.6 GLOSSARY

- Short-term goals** : The goals that are more immediate and need to be achieved in order to address the larger goals.
- Resistance** : The factors that restrict the family members from participating in family therapy.
- Neutrality** : Therapeutic quality to be observed towards the various participants in a family group equally.

## 17.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

### Check Your Progress Exercise 1

1. Short term goals refer to the goals that are more immediate and need to be achieved in order to address the larger goals. Some of the short-term goals include:
  - i) Ensuring that both partners participate equally in the session,
  - ii) Help discussions on their emotional experiences,
  - iii) Altering communication between members to reduce conflicts and increase positive communication,
  - iv) Increasing their problem solving capacity,
  - v) Ensuring the well-being of the family members and reducing the stress experienced, and
  - vi) Avoid blaming and decrease escalation of fights in the family.
2. Long-term goals of family therapy may include :
  - i) Increasing intimacy between couple,
  - ii) Increasing cohesiveness,
  - iii) Making the hierarchies more age appropriate,
  - iv) Encouraging forgiveness in the relationship,
  - v) Building trust between family members,
  - vi) Creating healthier subsystem boundaries, and
  - vii) Creating healthier external boundaries, making families self reliant for negotiating future events.

### Check Your Progress Exercise 2

1. i) True
- ii) False
- iii) True

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## 17.8 UNIT END QUESTIONS

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1. What are the tasks of the middle phase?
2. What are the types of goals for middle phase?
3. What are the principles of communication skills training?
4. List some of the techniques that can be used to bring about a change in maladaptive emotions.

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## 17.9 FURTHER READINGS AND REFERENCES

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Ables, B.S. (1977). *Therapy for couples*. San Francisco: Josey-Bass.

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Green, J.B. (2003). *Introduction to family theory and therapy: Exploring an evolving field*. Canada: Thompson Learning.

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# UNIT 18 TERMINATION PHASE: END PROCESSES

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## Structure

- 18.1 Introduction
- 18.2 Types of Termination
- 18.3 Indicators for Planned Termination
- 18.4 Steps of Termination
- 18.5 Issues in Termination
  - 18.5.1 Termination Anxiety
  - 18.5.2 Resurgence of Problems
- 18.6 What can Cause Unplanned Termination?
  - 18.6.1 Client Related Factors
  - 18.6.2 Therapist Related Factors
- 18.7 Dealing with Unplanned Termination
- 18.8 Let Us Sum Up
- 18.9 Glossary
- 18.10 Answers to Check Your Progress Exercises
- 18.11 Unit End Questions
- 18.12 Further Readings and References

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## 18.1 INTRODUCTION

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Termination is often a topic that although important, is comparatively less emphasised in literature. Much of the literature focus on how to initiate and continue the therapy rather than how to end it (Barker, 1992). Nevertheless, the way the therapist handles the therapy termination is important. Termination of a therapy session and the therapeutic relationship are significant for the client. Termination is a process and usually not carried out in a single session. The termination phase may last up to three sessions. Sessions are gradually tapered with longer gaps such that both the therapist and the family feel confident of their ability to handle things on their own.

Family therapists usually begin by sharing with the families in the initial session that the family therapy process is a time-limited relationship established for achieving certain goals in family therapy. Even if the duration of family therapy is not specified, clients know that it is a time-bound and session-bound relationship. This helps prepare the families for the termination right from the beginning. We will learn about the termination phase of family therapy in this Unit.

## Objectives

After studying this Unit, you will be able to:

- Understand termination and its types;
- Explain indicators and steps in planned termination process;
- Discuss the issues in termination process; and
- Identify the causes of unplanned termination.

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## 18.2 TYPES OF TERMINATION

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Therapy terminations are of two types: (a) planned termination and (b) unplanned termination. Planned terminations, as the name suggests, are designed and considered. These are initiated by the therapist and on some occasions by the family. For example, when the family therapist feels that the family has been able to achieve the goals of family therapy. Unplanned terminations are usually sudden and leave the family therapy tasks and goals unfinished. These are initiated by the families themselves. For example, when the family has a session appointment and does not turn up for the session and does not make any efforts to continue with the family therapy.

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## 18.3 INDICATORS FOR PLANNED TERMINATIONS

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Termination by the family therapist may be indicated in any of the following circumstances:

- When objectives of the treatment are met. A review by both the therapist and the family regarding whether the desired changes have taken place helps clarify if the family is ready for termination. Asking the family to examine what has changed is helpful. Termination is better accomplished when the family members are able to see the extent of the changes that have occurred, and when they realize their problem solving skills have improved.
- At times the family therapist may decide to terminate the therapy if the family's functioning has changed positively such that now they have the resources needed to deal with any of the remaining problems. Here, even though all the goals set are not met, if the family has the resources to achieve them on their own, termination is planned. There may be structural and functional changes in the family which enables the family members to cope with problems that they could not have been able to solve earlier.
- Confidence of the family members in the changes they have been able to bring about is another essential condition. Their confidence that they can maintain these changes achieved in therapy indicates to the family therapist that a termination can be planned. Also, certain techniques can be used in termination to help them develop this confidence for immediate future interactions and events the family will encounter after termination.
- The family therapist may decide to terminate therapy if it has been ineffective despite giving it a good trial. At times a family may not respond

to a particular style of therapy. The therapist explains to the family the reasons for termination. If the family is willing for therapy, a referral is arranged for them with another professional such that the therapy process can continue. It is important to do this in a manner such that the family does not lose hope for change. At times, explaining that a different therapist or a style of therapy may benefit them more is useful in maintaining the hope and motivation for change.

- At times a family therapist may plan termination as individual therapy may be more indicated than family therapy. For example, in cases of domestic violence, where one family member is scared that the other family member is not going to take responsibility and stop the aggression; where a member talking about the aggressor's behaviour is likely to make her or him more aggressive, is where participation in the family therapy is discouraged. Here individual therapy may be indicated and encouraged.
- Evidence of generalisation of skills learnt to many similar family problems.

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## 18.4 STEPS OF TERMINATION

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The termination phase of therapy incorporates the following steps:

1. **Inform regarding planning of termination:** Though the tapering of the sessions is an indicator of termination, the family therapist explains to the family that they can consider termination. The reasons for why the family therapist thinks so are shared with the family. Family therapist can inform the family either that their goals are more or less complete or that there has been little or no progress, and that is why termination is being planned.
2. **Summarize hypothesis, goals and what happened in therapy:** The entire therapy process is summarised, right from the problems that the family presented with, the goals established, what occurred, was addressed or was learnt in therapy is recapitulated and gains consolidated. Each member's understanding of their family relationships is focused on.
3. **Examine changes:** What has changed for each member and for their family relationships is reviewed. Changes in beliefs, behaviours, feelings and family structure and functioning are examined by asking all members in therapy to reflect on them. Each family member's confidence in those changes and their ability to maintain those changes is explored as well as corrected from therapist's point of view. This is a good way for the family to identify changes made, such that they feel motivated and hopeful.
4. **Identify Issues left out:** Allow members to reflect on issues left out of the sessions that they would like to address on their own. These can either be goals that were established which the therapist feels the family is capable of addressing, or these can be areas that have not been explicitly addressed. Even asking the family what is it that they would like to work on can identify left out issues.
5. **Anticipated problems:** Helping the family identify challenges it may face in the future and how they can use their strengths and resources to meet these challenges is useful. This prepares the family for what is likely to happen. It helps build their confidence in their skills and also gives the family therapist an idea of whether the family is ready for termination.

6. **Reinforcement and hope building:** The family therapist can also provide a recap of what changes she or he has seen the family members make during the course of therapy. Recognition of strengths of the family and individual members is useful. Positive reinforcement of the family members' efforts builds hope and belief in their own ability to solve problems. This also motivates them to maintain their efforts to improve as a family.
7. **Plans for follow-up:** The family therapist also makes plans for follow-up. When the follow-up session can be scheduled and the purpose of the follow-up session is explained to the family. Family is informed of the availability of the family therapist if required; termination of sessions does not imply that they cannot consult the family therapist ever again. Contact numbers of the family therapist are made available. Family is informed regarding coming for more sessions (booster sessions) if new issues emerge.

### *Case illustration*

The termination phase of the couple discussed in Unit 17 on 'middle phase' is discussed here. The middle phase of therapy with B and P lasted for 14 sessions. Initially the sessions were held weekly. After session six the sessions were made bi-monthly and then gradually tapered.

The termination phase with the family comprised of two sessions. Couple was explained that the therapist felt that the family was ready to terminate therapy. Both spouses felt that they too were ready to think of termination. This phase focused on each partner's understanding of their relationship and their family since the start of therapy. The presenting problems were reviewed. Each partner was encouraged to verbalize their new understanding of what had been happening in their family; each was able to reflect on their own behaviour that was dysfunctional. The family therapist reviewed the goals of the therapy with the couple. Both felt that they were able to achieve most of the goals set at the beginning of therapy. They were able to make M feel more secure and were able to discipline her better. M was better adjusted at home and at school. Each felt the other was supportive as a parent.

They were able to review the new understanding they had gained about their own behaviour, needs and expectations from each other and the relationship. Each member's confidence in the changes made was explored. Both felt more confident about their style of interacting. B felt he was more comfortable with P and was gaining confidence in his ability to make decisions. P reported a better control over her anger and an increased ability to involve B in discussions with her. Both were able to jointly take decisions; though B felt that he himself would like to increase his participation in the process by giving more ideas by himself rather than P prompting him. New ideas about themselves and the relationship were reviewed and where appropriate were readjusted by the family therapist.

Both also reported an increased emotional fulfillment as B was able to respect P and be supportive of her. P felt more secure in the relationship. B felt that he was able to build a sense of companionship in the relationship. Quality time spent with the family had increased. Commitment of each partner to the changes made was ensured. Both were hopeful and were motivated to maintain the changes made.

Couple was also given space to freely reflect on issues left out of sessions and what they would like to do about it on their own. P identified further

increasing their intimacy as a goal. B was also able to acknowledge that. Both discussed ideas to enhance it further. P felt a more direct expression of her needs would perhaps make it easier for B to recognize them. B felt that whenever he was aware of P's needs, he would try and address them. Here the family therapist made the expectations realistic that B may not always be able to do so; this was not a sign of failure. Rather, both spouses can acknowledge when they will not be able to address each other's needs immediately.

Any problems that they could anticipate were also discussed. Changes made by the couple like improved parenting, softening their stance towards each other, greater understanding of each one's motivation, commitment to new forms of communication and behaviours etc. were highlighted both as hope building and as a review of gains achieved. This helped address the anxieties regarding termination.

Couple was explained regarding a follow-up after 4 to 6 months. Contact numbers were given and the couple was assured of family therapist's availability if need arose. The idea and availability of booster sessions was explained.

### 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) Planned terminations are designed, considered and usually initiated by the family therapist. \_\_\_\_\_
- ii) Termination cannot be planned even when the goals of the therapy has been met. \_\_\_\_\_
- iii) Confidence of family regarding handling the problems can be one of the indicators of termination. \_\_\_\_\_

2. What are steps of termination process?

.....  
.....  
.....  
.....

## 18.5 ISSUES IN TERMINATION

### 18.5.1 Termination Anxiety

It has been observed that at times when the termination sessions are being conducted the family may express anxiety about their ability to handle things on their own. They may doubt their ability to retain the changes made and their confidence in their ability to employ the skills learnt may decrease. Space is given to the couple or family to voice what problems they can anticipate so that these can also be addressed. Often helping the family reflect on

changes made, their strengths and the family therapist's confidence in their abilities helps the family overcome this anxiety. At other times, addressing anticipated problems helps the family gain a sense of control.

### **18.5.2 Resurgence of Problems**

Occasionally, the termination anxiety may present itself in the form of resurgence of problems. The therapist can then adopt some of the techniques discussed above to address it. If the problems that emerge at this stage are new it means that there are still issues that need to be addressed and that individual or family is not ready for termination. The duration of sessions is extended to address the newly emerged problem areas.

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## **18.6 WHAT CAN CAUSE UNPLANNED TERMINATION?**

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There are numerous reasons for unplanned terminations. Some of the reasons are client based while at other times some therapist related variables may result in unplanned terminations.

### **18.6.1 Client Related Factors**

Individuals come from different view points and this affects whether they continue with family therapy or not. Some families may discontinue or dropout from therapy after the single session itself. Others may terminate after two or three sessions.

Some client related factors, that are related to unplanned terminations are:

- Some families may decide to terminate if they are not really interested in improving their family functioning.
- At times, families may get referred to the family therapist and when they come for therapy they may not have any idea of what family therapy is all about. They come just because they have been referred. At times like these, when the therapist explains to them what family therapy involves, they may not feel the necessity to work on their family.
- At times when the family therapist is unable to help the family understand the systemic view despite all efforts, and the family continues to see only one individual in the family as problem, then the family is likely to drop out of family therapy.
- Some families that have lived with their problems or dysfunctional patterns for a long time may not engage in therapy.
- Lack of patience with the therapy process and lack of energy that is required to be invested to bring about a change may also lead to abrupt terminations.
- At times, families may expect that a single session will solve their problems. The fact that there are no magical solutions may disillusion them.
- Some individual factors have been identified, that are related to individuals or families dropping out of treatment. Some of these are: individuals with

poor coping skills, with minimal frustration tolerance, poor ego strength, and those whose relations with other significant people in their infancy and childhood were so bad that they expect only bad things from the family therapist (Ables, 1977).

- At times, family therapy may be discontinued when one core family member who is needed for the therapy decides not to come for therapy.
- Lack of motivation for change.
- Conflictual goals that affect therapy outcome and unwillingness to arrive at common goals.
- Unwillingness to take responsibility for change and family despite efforts made by the therapist to encourage the same may lead to terminations.

### 18.6.2 Family Therapist Related Factors

Some of the family therapist related factors that are related to terminations are as follows:

- Failure to establish rapport with the family.
- Family therapists pushing their own agenda in family therapy and dismissing family's agenda entirely.
- Times where the family therapist is unable to control the session process such that it allows all the family members to feel safe in the session may lead to drop-out of a family member and thus the family.
- If one family member feels guarded or threatened in the therapy and/or by the therapist, it is important that therapists identify and address this. At times, despite all efforts whatever interventions the family therapist may try, she or he may fail to engage the clients in family therapy.
- Aligning only with one family member alienates the others leading to termination.
- Sometimes a spouse may refuse to come for family therapy as they feel that the therapist had already seen their partner earlier. It is helpful that when the couple is seen together, therapists maintain neutrality and not align only with the partner who sought therapy. Address the agenda of the relationship and not the partner who came first for consultation.
- Difficulties in helping the family make some constructive use of the session, especially, if they are not ready to work, or when little is accomplished in therapy sessions may lead to terminations.
- Inadequate assessment of the problem.
- Setting unrealistic goals.
- Family therapist losing patience with the family and holding them responsible for not changing.

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## 18.7 DEALING WITH UNPLANNED TERMINATIONS

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At times when unplanned terminations occur and where other family members are left who still want to come for therapy, then the therapy is usually continued with willing family members. The systemic view is retained and the members are helped to achieve their goals for their family as best as they can. Efforts to get the absent family member can still be made. Family therapists also need to reflect if there was anything in the therapy process itself that may have led to a family member dropping out of therapy. At times, family may approach the family therapist after some time and want to resume therapy. This is encouraged and their abrupt termination is not held against them.

### 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 up the blanks:

- i) Some families may decide to terminate if they are \_\_\_\_\_ in improving their \_\_\_\_\_.
- ii) Lack of \_\_\_\_\_ to change may lead to unplanned termination.
- iii) Family therapist's \_\_\_\_\_ to establish rapport with family can become the cause of unplanned termination.
- iv) Setting \_\_\_\_\_ goals is one of the therapist related factors for unplanned termination.

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## 18.8 LET US SUM UP

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In this Unit, we have studied that:

- There are two types of terminations – planned and unplanned.
- Unplanned terminations can occur for both client and therapist related reasons.
- The family therapists need to learn to deal with unplanned terminations.
- Achievement of goals of therapy, confidence in the changes made and generalisation of these changes are indicators of readiness for therapy termination.
- Informing the family of termination, summarising, examining changes and issues left out, addressing anticipated problems, hope building and making plans for follow-up are the steps of therapy termination.
- Termination anxiety and resurgence of problems can complicate termination.
- At times a family may not be ready for termination and family therapy needs to be continued for more sessions.

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## 18.9 GLOSSARY

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- Planned Termination** : Termination that is designed, considered and initiated by the family therapist.
- Unplanned Termination** : Sudden termination in which tasks and goals of family therapy are left unfinished.
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## 18.10 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

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### Check Your Progress Exercise 1

1.
  - i) True
  - ii) False
  - iii) True
2. Following are the steps of termination process:
  - i) Inform regarding planning of termination
  - ii) Summarise hypothesis, goals and what happened in therapy,
  - iii) Examine changes,
  - iv) Identify issues left out,
  - v) Anticipate problems,
  - vi) Reinforcement and hope building, and
  - vii) Plans for follow-up.

### Check Your Progress Exercise 2

1.
  - i) not interested, family functioning
  - ii) motivation
  - iii) failure
  - iv) unrealistic

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## 18.11 UNIT END QUESTIONS

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- 1) What are the types of terminations?
- 2) What are the therapist related factors in unplanned terminations?
- 3) What are the indicators of a planned termination?
- 4) What are the steps of termination?

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## 18.12 FURTHER READINGS AND REFERENCES

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- Ables, B.S. (1977). *Therapy for couples*. San Francisco: Josey-Bass.
- Barker, P. (1992). *Basic family therapy*. Oxford: Blackwell Scientific Publications.

# Notes



## MCFT-004

### COUNSELLING AND FAMILY THERAPY: APPLIED ASPECTS

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**BLOCK 1 : PROFESSIONAL ISSUES IN COUNSELLING AND FAMILY THERAPY**

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- Unit 1 : Essentials for a Counsellor and Family Therapist  
Unit 2 : Self of the Counsellor/Therapist  
Unit 3 : Therapist/Counsellor and Client Relationship  
Unit 4 : Professional Approach and Ethical Issues

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**BLOCK 2 : PRACTICAL ASPECTS OF COUNSELLING & FAMILY THERAPY-I**

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- Unit 5 : Creating a Therapeutic Climate  
Unit 6 : Developing Communication Skills for Counselling  
Unit 7 : Mediation in Counselling and Family Therapy  
Unit 8 : Mediation in Family Disputes  
Unit 9 : Life Skills Education

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**BLOCK 3 : PRACTICAL ASPECTS OF COUNSELLING & FAMILY THERAPY-II**

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- Unit 10 : Reflective Relationship Techniques  
Unit 11 : Relationship Building Strategies  
Unit 12 : Strategies for Facilitating and Evaluating Change  
Unit 13 : Barriers to Actualizing Therapeutic Relationships  
Unit 14 : Coping with Difficult Situations in Counselling and Family Therapy

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**BLOCK 4 : PROCESSES OF COUNSELLING AND FAMILY THERAPY**

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- Unit 15 : Referral and Intake  
Unit 16 : Initial Phase  
Unit 17 : Middle Phase  
Unit 18 : Termination Phase: End Processes

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**MANUAL FOR SUPERVISED PRACTICUM (MCFTL-004)**

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