

Catalogue of Interventions for Systemic Family Therapy Assessment

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A Thesis presented to the Graduate Faculty  
of the College of William and Mary in Candidacy for the Degree of  
Master of Arts

Department of Psychology

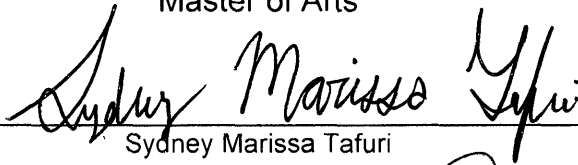
The College of William and Mary  
August 2013

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## APPROVAL PAGE

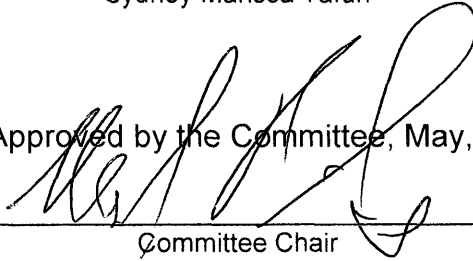
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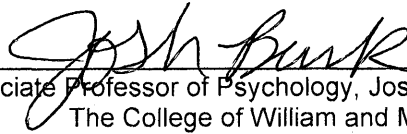
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Approved by the Committee, May, 2013

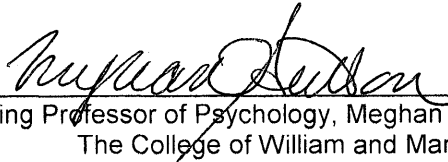
  
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Research approved by

The College of William and Mary's Protection of Human Rights Committee

Protocol number(s): PHSC-2011-10-31-7574-mpnich

PHSC-2012-10-30-8247-smtafuri

Date(s) of approval: 11/18/2011

11/10/2012

## ABSTRACT

In study 1, clinical raters set out to identify and define categories of therapist interventions that helped client families move from a linear perspective, in which problems are located in the identified patient, to an interactional perspective, in which problems are seen to also involve other members of the family. Raters observed 10 sessions with different families, conducted by three highly experienced systems-oriented family therapists. These sessions were used to compile a list of 25 categories of intervention as well as to track the frequencies of these interventions. Interventions were identified as being questions asked to gather information or various forms of challenge, designed to shift families' views from a linear to a systemic perspective. Judges were able to reliably categorize interventions that challenged family members. In study 2, the researchers examined the productivity of these interventions in helping clients understand and accept therapists' interventions and the extent to which these interventions help clients move from a linear, blaming perspective of their problems to a more systemic, organizational view of their conflict. The clinical importance of these findings is discussed.

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## ACKNOWLEDGEMENTS

I would like to thank Mike Nichols for guiding me throughout this project and for teaching me the most valuable tools in family therapy. I would also like to thank Lee Kirkpatrick, Meghan Sinton, Joshua Burk, Gillian Byles, Victoria Narine, and the undergraduate raters for seeing this project through with me. I appreciate all of your help and extend my deepest of gratitude.

This thesis is dedicated to my mother, Bonnie, and my sister, Sean for always supporting and believing in me and being my rocks.

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## CHAPTER I

### Introduction

The importance of viewing families as systems rather than as merely collections of individuals is the core theme in systems-oriented family therapy (Nichols, 2013). Systems-oriented family therapy goes beyond the behavior of isolated, individual family members, and instead, examines the family structure as a whole and how its organization contributes to a family's problems (Hoffman, 1981). Salvador Minuchin, a leading innovator of systems-oriented family therapy, defined the goal of structural family therapy as a progression leading families towards alternative and productive modes of interaction by changing the family organization (Minuchin, 1974).

When families seek therapy sessions, they usually have a linear understanding of their presenting problems. In other words, they see their problems as a direct result of one individual and believe that this person is the source of the family's difficulties (Minuchin, Nichols, & Lee, 2007). For example, if a mother called to complain that her teenage daughter was a compulsive liar, a traditional therapist might meet with the daughter alone to find out what was wrong. A systemic family therapist, however, would consider that something else might be going on in the family. Even in cases where the primary complaint is relational—"We have a communication problem"—there is usually an assumption that someone else needs to change. When you cut through all the fancy jargon, the essential systemic insight that clients need to achieve is not only that "Our interactions are part of the problem," but also that "*I* must change some aspect of what I'm doing to make things better."

Individual therapists recognize the importance of family life in shaping personality, but they assume that those influences are internalized in the individual patient (Freud, 1909; Schlesinger, 2003). Family therapists see individual family members as embedded in a network of relationships, or as part of an organized whole. The premise of systemic family therapy is that, by seeing families as structural units, rather than as collections of individuals, it is possible to bring about changes in organization that will affect the lives of every single family member (Nichols, 2008).

Although the systemic perspective—the understanding that families are systems with each family member being linked together—is not a difficult concept to understand in the abstract, it can be difficult to help individuals who come to therapy to change their fixed ways of viewing their family’s situation (Kerr & Bowen, 1988). What keeps family members stuck in their ways of thinking is that they often do not recognize their own contributions to problems. Thus, the fundamental challenge of a systemic family therapist is to move clients from a linear, medical model point of view of their problems towards a more systemic perspective with the understanding that problems arise when there is a dysfunction in the way a family system is interacting as a whole (Nichols, 2013).

A systems-oriented therapist’s task is two-fold: the therapist must listen to clients and let them know that they have been heard; then the therapist gradually helps families understand that their problems are systemic, originating in ways they are structured. This shift from a linear to systemic perspective changes the focus from one family member being seen as the sole problem and moves it towards how the family structure as a whole contributes to the presenting problems (Minuchin, Nichols, & Lee, 2007).

The point of systemic family therapy is *not* to establish that problems do not reside in individuals or even that they are not rooted in biological disorders. Instead, therapists focus on the influence of family interactions on their problems and emphasize family members' potential to help solve these problems (Hoffman, 1981).

#### *The role of research in family therapy*

An important distinction to make when pursuing research in any form of therapy is the one between *process* and *outcome* research. *Process research* refers to focusing on what happens within therapy sessions in order to establish what kinds of therapist interventions yield particular client responses (Greenberg, 1986). In a paper by Woolley, Butler, and Wampler (2000), the researchers described three different types of process research. One approach, *change-event analysis*, is a technique that requires researchers to identify key moments in therapy sessions in order to establish whether they lead to critical changes within sessions (Woolley et al., 2000).

The present study employed change-event analysis, which required close, moment-by-moment observations, aided by the use of audio and video recordings in order to pinpoint different interventions made by structural family therapists (Woolley et al., 2000). By honing in on therapist and client behaviors that surround meaningful moments within sessions, researchers can identify interventions that promote critical moments of change (Woolley et al., 2000). Therefore, in part one of the current study, we attempted to identify and categorize specific therapist interventions that challenged clients' linear views of their problems and encouraged them to see the complicating influence of family interactions on these problems. In part two of this study, we assessed

and rated levels of change within the therapy sessions to evaluate the effectiveness of the categories of intervention developed in part one.

Therapists typically strive to differentiate themselves from other therapists by defining their own unique approach to therapy (Friedlander et al., 1994). The beauty of process research studies is that these already-established professionals can adapt the findings of this type of research to their own practice in ways that suit their individual styles (Friedlander et al., 1994).

Conversely, *outcome research* examines what changes occur before and after therapy and evaluates patient improvement as a result of therapy (Greenberg, 1986). Outcome studies examine whether therapy is working or not, but not by what means. Unfortunately, it is difficult to capture how therapy is typically practiced in empirical research studies with experienced therapists (Greenberg, 1986). This difficulty is a result of therapists being instructed to practice therapy according to researchers' directions in experimental designs. Because experienced therapists are often reluctant to accept the use of extensive controls and measures involved in this type of research, most outcome studies employ using graduate students and relatively inexperienced therapists (Gurman & Kniskern, 1991). Outcome research is important to identify the value of different approaches to family therapy, but it does not evaluate how effective specific strategies and interventions are within sessions (Friedlander et al., 1994).

Previous process studies have examined an array of factors in systemic family therapy (Howe & Varga, 2010). In one such study, the researchers examined 48 videotaped family therapy sessions in order to identify the various steps that therapists use to initiate, maintain, and close enactments and, in doing such, developed the Family

Therapy Enactment Rating Scale (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001). Enactments are a technique used by therapists to engage clients in productive ways of communicating. An example of an enactment would be asking one family member to talk about a specific aspect of the problem with another family member (“John, can you talk with Mary about why you are upset with her?”) (Nichols, 2013).

The Family Therapy Enactment Rating Scale is used to track therapists’ use of interventions during the four phases of an enactment identified by Nichols and Fellenberg (2000). The researchers in this study examined the impact of enactments on change in families’ core dynamic problems and found that successful enactments were associated with overall change in the core problem dynamics (Nichols & Fellenberg, 2000).

Similarly, Burck, Frosh, Strickland-Clark, and Morgan (1998), analyzed a therapist’s “knowledge in use” to discover effective therapeutic techniques. This study examined one, five-member family over the course of 30 therapy sessions. The researchers analyzed the therapist’s specific language, which focused on themes surrounding the family’s conflict. The key technique used by the therapist was focusing on the family being in control over mitigating their problems rather than the therapist having control (Burck et al., 1998). The main challenge for the therapist was to constantly turn the control back to the family members whenever the therapist was praised for giving “useful” information. Burck et al. (1998) suggest that process research, although time-consuming and difficult, is a valuable way to discover important links between in-session events and success or failure outside of therapy sessions.

The researchers in the aforementioned studies developed reliable measures of tracking and organizing interventions, which serve as valuable tools for instruction. The

current study aimed to use a similar method and to develop an inventory of techniques that therapists' use, which can also serve as an important teaching tool for budding family therapists.

In addition, in an unpublished undergraduate honors thesis, Lisa Risely, a student at The College of William and Mary, examined therapists' attempts to increase fathers' involvement in family therapy. To accomplish this, Risely recruited undergraduate raters to rate fathers' participation in therapy sessions and their overall involvement by the end of the therapy sessions. Risely found that the increase in fathers' involvement was related to the number of interventions aimed directly at the fathers as well as related to interventions involving their children in the sessions. In addition, the repetition and frequencies of key interventions that addressed father-child interactions was strongly related to fathers' overall engagement.

*The challenge of shifting clients from a linear to systemic perspective.*

For a systems-oriented therapist, the art of assessment is to help families move from a linear to a systemic view of their problems. Minuchin, Nichols, and Lee (2007) developed a four-step model to describe the process of gradually moving a family from a linear to a systemic viewpoint of their problems: (1) opening up the presenting complaint, (2) highlighting problem-maintaining interactions, (3) a structurally focused exploration of the past, and (4) developing a shared vision of pathways to change (Minuchin, Nichols, & Lee, 2007).

When families come to therapy with problems to be solved, they expect that the therapist will accept their problems as defined by the family and will help them solve these problems. This is usually sufficient for medical problems, but the problems that

families bring to therapy are not usually medical and do not reside in an individual's disease processes, but rather involve the whole family and its members' interactions (Williams, Edwards, Patterson, & Chamow, 2011). Thus, the first challenge for a therapist is to explore the presenting complaint in a way that expands it and challenges a family's linear ("Johnny's the problem") and medical-model ("he's hyperactive") perspective on the problem to also include an interactional perspective (Minuchin & Fishman, 1981).

Therapists usually begin by asking questions to collect information. Therapists ask questions such as, "Why are you here today?" to get the clients' perspective on their problems. By the time they come to therapy, families have usually developed a coherent narrative about their problems, and these narratives usually focus on the identified patient as the primary source of problems. The therapist's challenge is to understand and empathize with the clients' point of view, but also to open up their fixed certainty about who is responsible for the family's problems (Minuchin, Nichols, & Lee, 2007). After gaining pertinent information about families' problems, therapists will ask questions meant to explore the interactional context of the problems families present. An example of this would be, "Which parent does she talk back to more?" A therapist's opening questions must give family members a chance to tell their stories and express their feelings in order to make them feel understood and to gain their trust. However, a therapist should not be quick to accept a family's description of the problem as residing in one person, but instead, to ask helpful questions to respect a family's concerns while remaining skeptical of accepting the identified patient as the sole problem (Minuchin, Nichols, & Lee, 2007).

The second step in a systemic assessment is to identify and focus on specific problem-maintaining interactions that might be perpetuating a family's conflict. This does not involve shifting blame from one family member to another, but rather shifting from linear to circular thinking in order to expand the focus from individual problems to patterns of interaction between family members (Minuchin, Nichols, & Lee, 2007). Circular thinking suggests that conflict is driven by a series of interactions and reactions, rather than by one particular family member. For example, in regard to a daughter who is described as a compulsive liar, a therapist might ask, "Who does she lie to most?" in order to gain insight into a family's interactions. If, for example, the daughter is said to lie most often to her mother, it might be that the mother and daughter are caught up in a control-rebel cycle (Minuchin, Nichols, & Lee, 2007).

By helping family members see how their actions may be inadvertently maintaining their problems, a therapist empowers a family to become its own agent of change (Burck et al., 1998). Talking with family members about how they may be contributing to the presenting problem involves overcoming a natural resistance to being blamed. Circular thinking is not designed to spread blame for causing problems, but instead to discover who is in a position to help resolve them (Minuchin, Nichols, & Lee, 2007).

The third step in this systemic assessment process involves a brief, focused exploration of the past in order to help family members understand how they came to their present points of view (Minuchin, Nichols, & Lee, 2007). Delving into the past is key to helping family members understand how their past experiences have come to influence their present behavior. This step is meant to help make clients' behavior

understandable in the context of their past experiences. It helps family members overcome resistance, because instead of emphasizing that they are doing wrong, it suggests that their behavior is related to experiences from their childhood (Minuchin, Nichols, & Lee, 2007).

The fourth step, exploring alternative ways of relating and identifying who needs to and is willing to change their behavior, is what makes assessments not just accurate, but useful. This step involves a therapist helping family members see how they have contributed to the problem and how they can change to help improve it (Minuchin, Nichols, & Lee, 2007).

In developing their four-stage model of assessment, Minuchin and his colleagues have provided a useful framework for the process of moving families from a linear to a systemic perspective. However, the question remains, how can the broad strokes of this conceptual model be translated into specific therapeutic interventions?

Interventions designed to help family members shift their thinking to include the systemic context of their concerns fall under the heading of *confrontation* in psychotherapy (Nichols & Paolino, 1986). Although the term, “confrontation” may suggest combativeness, in psychotherapy, confrontation is a technical term for pointing out things that clients may not have recognized as contributing to their problems and for bringing these behaviors or thoughts to light (Nichols & Paolino, 1986). Thus, in psychotherapy, confrontation need not be aggressive.

Confrontations are ways therapists can voice their opinions about the situation at hand and to express how therapists might view situations differently than the clients (Anderson, 1968). In other words, confrontation means pointing out things that clients

may not have thought about in order to help them expand their understanding of themselves and their problems.

Confrontations may be direct, or even blunt at times, with the intention of calling attention to client resistance (Nichols, 2013). Even when they are blunt, however, confrontations must not feel like attacks. Taken out of context, some confrontations may sound provocative, but previous research has show that when therapists have established an empathic working alliance with clients, the clients will accept direct criticism (Hammond, 2006). This is because they seem to feel it comes from someone who cares about them. For example, “Excuse me, but I’m talking to your wife right now,” or “You keep bringing the attention back to yourself, and it turns people off.”

In family therapy, the goal is to help clients see their family problems as resulting from various sources instead of from only one person or circumstance. Confrontations should produce in-session impacts or moments when the patients gain new insight into their problems or ways of behaving (Lambert, 2004). To move clients towards gaining insight, therapists should use different types of confrontation to bring to light associations between seemingly unrelated behaviors among family members that affect the overall problem dynamic (Stanton & Welsh, 2012). For example, a child’s acting out might be the result of an enmeshed mother-child relationship, which in turn may be a product of marital problems. The purpose of confrontation (or intervention) is to gradually bring these contributing factors to the surface and to foster client understanding and acceptance so that change in the family system can be achieved (Stanton & Welsh, 2012).

In 1968, Susan Anderson examined the effect of therapist confrontations on clients’ self-exploration, or the idea of examining themselves in the way the therapist points out

to them. The researcher looked at high and low levels of empathy, positive regard, genuineness, concreteness, and self-disclosure displayed by the therapists (Anderson, 1968). Fifty confrontations were scored, and confrontations that were rated high on the aforementioned elements were significantly associated with an increase in client self-exploration (Anderson, 1968).

Additionally, Berenson, Mitchell, and Laney (1968) conducted interviews with 56 therapists in order to examine each therapist's level of functioning, which was determined by high or low levels of four factors: empathy, positive regard, genuineness, and concreteness in conjunction with types of confrontation used. The authors observed five types of confrontation used by therapists in videotaped sessions: experiential (specific response to the patients' and therapists' differing views), didactic (clarification), strength (pointing out patients' potential resources), weakness (pointing out what patients needed to work on), and encouragement to action (telling patients to be active in treatment) (Berenson et al., 1968). The authors found that higher functioning therapists used more frequent interventions and used an experiential approach to therapy that involved the therapist directly addressing when the patient agreed or disagreed with his or her views. For example, "Why is it that you don't agree with me?" (Berenson et al., 1968).

In a more recent process study, Burck, Frock, Strickland-Clark, and Morgan (1998) set out to analyze therapist interventions using a single family's case as an example. The authors identified the main themes used in therapy. They identified "engagement with therapy," "attitude to change," "control," and "relationship of past to present" as frequently occurring themes in therapeutic practice (Burck et al., 1998). A step-by-step

process of how these themes unfold and are used by the therapists in the examples provided was discussed. The authors in this study focused on a handful of themes therapists seem to follow when conducting sessions in order to examine how these themes play out in therapy sessions (Burck et al., 1998). This method of process research is in line with what the current studies aim to accomplish in order to evaluate client responses to therapeutic interventions in systemic family therapy.

DiGiacomo (2011) examined the effect of confrontation on immediate client responses and within-session change. A significant positive correlation was found between the clarity of the interventions and the clients' responses. In addition, there was a significant positive correlation between clients' responses and within-session change, suggesting that confrontations that clients clearly understand are the most effective at producing client change within the therapy sessions and produce less resistance from clients to accept what the therapist says (DiGiacomo, 2011).

The current study aims to expand on the confrontation literature. The purpose of this two-part process study was to a) develop a catalogue of techniques that help to promote a shift from a linear, medical model perspective toward a systemic understanding of the problems that families present in therapy sessions, and b) to examine which interventions clients respond most productively to and that lead clients towards a systemic understanding of their problems.

## CHAPTER II

### Method

#### Study 1

##### *Data Pool*

The clinical sample consisted of ten videotapes of family therapy assessments drawn from the archives of the Minuchin Center for the Family in New York. The therapists conducting these sessions were experienced family therapists who have had at least 20 years of experience in the field.

All of the clients consented to the taping of their therapy sessions. The clients consented to be videotaped with the understanding that the tapes would be kept confidential and would be used only for teaching and research purposes.

The sample of 10 assessment sessions included six Caucasian families, three Hispanic families, and one African-American family. The sample included families of varying socioeconomic backgrounds as well as varying numbers of family members. The sample consisted of five two-parent families, three couples, and two blended families. The sessions were conducted by a total of three different family therapists: one of whom was a Hispanic male and two of whom were Caucasian males. Presenting complaints included child behavioral problems, post-traumatic stress disorder, marital problems, major depression, and heroin addiction.

##### *Clinical judges*

The team of clinical judges consisted of an experienced family therapist, a psychology master's student at the College of William and Mary, and an undergraduate

volunteer recruited from the College of William and Mary's psychology student population.

*Definition and categorization of interventions*

Interventions were categorized as either one of two kinds of interventions: simple questions designed to gather information, and challenging questions or statements that seemed to ask family members to consider the broader, systemic implications of their actions. Examples of the former were asking what the presenting complaint was and asking for details about the presenting complaint, "Why are you here today? What seems to be going on?" Examples of the latter were: "Where did you learn the worry that makes you interfere in your daughter's life?" and "Who is the boss in this family?" Families come to therapy with a one-sided view of their problems, and the goal of a therapist is to move clients away from a linear view of the problem towards a systemic view. This shift changes the focus away from one family member as the problem and towards the family structure as a whole and how it contributes to the presenting problem (Minuchin, Nichols, & Lee, 2007).

The three clinical judges recorded all interventions that seemed to challenge family members to consider the interactional influences on their problems. These interventions were not single sentences, but were complete thoughts. Descriptions of therapists' interventions were concrete and strictly behavioral in nature. An example of a challenging intervention would be the use of metaphor to describe the interactional dynamics between two people. An example of a metaphor given to a pursuer-distancer couple, for example, was: "Mary is like the North Wind that keeps blowing, which makes John want to bundle up his jacket and move farther and farther away from her." Dialogue

such as this was observed and recorded in the preliminary viewings to facilitate categorization of interventions.

#### *Data collection process*

The clinician judges used a category-based filtering method (Sollenborn & Funk, 2002) in which a log was kept of the developing new categories until it was determined whether those categories could be properly fit into already-existing categories or would remain categories in and of themselves. The research team viewed the therapy tapes, and whenever a therapist intervention occurred, the tapes were paused for discussion. We kept adding new categories of techniques until we viewed three sessions in which all interventions fit into the existing list of techniques. The criteria used for determining whether dialogue was a systemic intervention were that the dialogue must consist of questions or statements that challenged family members to see that their behaviors were interactive and organizational and that challenged them to see that their actions might be perpetuating their problems versus merely asking questions. For example, Therapist A asked a wife, “What will you do to give him more space to be involved?” Therapist B asked a husband, “Would you like to change your style enough so that this feels more like a give and take between the two of you?” Both of these statements were included in a technique category called *Therapist asks family member(s) how they will change to improve a problematic interaction*. Only those responses that at least two of the three clinical judges agreed either fit into a specific intervention or determined that a new category should be created were included in the final results. Undergraduate raters used these categories of intervention to rate the clients’ understanding of the systemic problem and their acceptance to change their unproductive behaviors in Study 2.

## CHAPTER III

### Results

#### Study 1

The clinical judges observed a total of 25 different categories of systemic interventions. In order to assess the reliability of our category system, the clinical judges watched three separate therapy sessions and independently assigned therapist interventions to the various categories. The percent agreement was then calculated to be 89.3%.

In addition to recording and defining categories of intervention, the clinical judges kept track of frequencies of these interventions across the 10 sessions. Among the most frequently observed interventions across all therapists were: *Therapist initiates an enactment*; *Therapist describes the structural problem in the family*; *Therapist describes family member's role in perpetuating an interactional problem*; and *Therapist describes problematic interactional pattern between family members*.

The most frequent interventions used by Therapist A were: *Therapist describes an organizational problem in the family* and *Therapist initiates an enactment—directs family to talk (or interact) with each other*. Therapist B used the following interventions most frequently: *Therapist describes a family member's role in perpetuating an interactional problem* and *Therapist initiates an enactment—directs family to talk (or interact) with each other*. Therapist C mainly used: *Therapist asks family member what other family member does to provoke a certain response from him or her*; *Therapist asks family member if he or she responds in a certain way to certain behaviors from other family*

*member(s); and Therapist describes a problematic, interactional pattern involving the roles of two family members.*

See Table 1 for a complete list of the categories of intervention, as well as the frequency of their occurrence.

<b>Intervention</b>	<b>Number of times observed</b>
Blocks third person from interrupting	5
Describes how enmeshed family member invites interference.	1
Describes an organizational problem in the family (i.e. a family structural problem involving more than two persons).	24
Describes a family member's role in perpetuating an interactional problem.	19
Asks for past history about how family member learned to respond in a problematic way.	3
Points out (to an enmeshed family member) that he or she has a resource (a disengaged member) who could be approached more.	2
Points out that the identified patient has behaved in the session more productively than the presenting complaint would have suggested.	5
Tells enmeshed family member that he or she should allow disengaged members to develop a relationship.	3
Praises family member(s) for behaving productively in the session.	11
Tells enmeshed family member that he or she should develop more outside relationships.	1
Tells family that they are doing something wrong that is perpetuating the presenting problem. (They are stuck in a rut.)	5
Asks family member what other family member does to provoke a certain response from him or her.	12
Asks family member if he or she responds in a certain way to certain behaviors from other family member(s).	11
Asks family member how he or she wants other family member(s) to behave differently toward him or her.	8
Describes a problematic interactional pattern involving the roles of two family members.	17
Asks family member how he or she tries to get a desired response from other family member(s).	3
Asks about the emotional feeling behind a family member's actions.	11
Tells disengaged family member that he or she needs to initiate contact with someone.	2
Asks family members what they are doing that might be contributing to a problem.	2
Describes how the presenting complaint is a function of interactional problems in the family.	3
Initiates an enactment—directs family to talk (or interact) with each other.	31
Asks family member(s) if they play specified roles in a problem dynamic.	2
Asks family member(s) what were the intentions that made them act a certain way.	4
Asks family member(s) how they will change to improve an interaction in the family.	9
Suggests how family members should behave differently to improve their interactions.	13

## CHAPTER IV

### Method

#### Study 2

In study 1, we developed a catalogue of techniques experienced family therapists use to help family members shift from a linear to a systemic view of their problems. In the second part of this study, we examined the impact of those techniques by evaluating family members' responses to the various interventions.

#### *Recruitment of Undergraduate Raters*

Undergraduate raters were recruited from the College of William & Mary's psychology classes. Individuals who showed interest were asked to attend one 90-minute orientation session in which the author and experienced family therapist described the level of commitment required for participation and gave a brief background on structural family therapy. The raters were shown a videotaped therapy session, and the clinical raters asked questions about the session to identify students who showed an understanding of this type of research. The aim of the orientation sessions was to acquaint the students with the purpose and method of the current study and to gauge the students' levels of availability and commitment. Volunteers were told to keep any information from the sessions confidential. Twelve raters were eventually selected for the study based on level of commitment and scheduling.

#### *Training of Undergraduate Raters*

The undergraduate raters were given two 90-minute training sessions, which were conducted by the author and the experienced family therapist. During these sessions, the raters were taught the principles and purpose of structural family therapy assessment. The

raters were given copies of instructions for rating interventions in addition to the two rating scales to be used in the study (See Appendices A, B, and C). The training sessions simulated data collection. The videotaped sessions were paused following interventions in order to give student raters supervised practice rating the interventions. The raters were asked questions about their observations and were taught how to use the measurement scales. The extent to which the clients understood and accepted the therapists' interventions, which was measured with The Client Intervention Rating Scale, as well as the extent to which each family member changed from a linear, blaming view of their problems to a more systemic viewpoint by the end of the session, which was measured with the Guidelines for Rating Change from Linear to Systemic Perspective.

#### *Measuring Instruments*

Two separate rating scales were designed to help raters quantify their observations, The Client Intervention Rating Scale (see Appendix B) and the Guidelines for Rating Change from Linear to Systemic Perspective (see Appendix C). Each scale was a Likert-like, seven-point scale with each numerical value paired with a description to represent the continuum of clients' understanding and acceptance rates of the 25 techniques and the extent to which each client shifted from a linear to systemic perspective by the end of the sessions. These behavioral descriptions were distributed to the raters, which served as the bases of their ratings.

#### *Rating of client understanding and acceptance of interventions*

In order for the undergraduate raters to quantify the extent to which clients accepted and understood the therapists' interventions, the clinical judges provided concrete descriptions and examples in the training sessions for what a high and low rating

would be on any given intervention. The Client Intervention Rating Scale ranged from “one,” meaning “No understanding and no acceptance,” to “seven,” meaning “Clear understanding and clear acceptance” of the intervention. For example, in a responsive client who would be rated highly, a therapist said, “I see you as a person who enters into competition very easily so that you enter into competition with your step-son as if you are his equal,” and the client responded, “Yeah, I totally agree with you.” In an example of a nonresponsive client who received a low rating, a therapist said, “You need to let your parents have their own relationship and find your own woman.” The client said, “Why do you keep saying that? You think I’m trying to break these two up? I’m not.”

The undergraduate raters were given a sheet with only the dialogue pertaining to the interventions being rated for each family assessment session in chronological order of intervention and were asked to independently rate each intervention as they occurred without discussing it with anyone. The raters were told that they were allowed to change their ratings only while the interventions were occurring should the clients have said something that warranted a change in their response ratings. After each rater was finished, the clinical judges led a brief discussion about the intervention at hand in which the raters stated their rating for that intervention followed by their justification for that rating. The raters were asked not to change any of their answers during this time. The clinical investigators monitored this carefully in order to ensure that ratings were not changed after each intervention discussion period.

#### *Rating of clients’ overall change in the session*

In addition to rating clients’ understanding and acceptance of each intervention, overall change from a linear to systemic perspective was rated for each family member at

the end of each session. Change was defined as by whether or not a client realized his or her role in perpetuating his or her family's problem and whether or not his or her initial views of blaming a particular family member ("It's Jason's fault we have problems") or circumstance ("We've always had issues") shifted to incorporate each person's role in the problem.

When family members enter therapy, they usually have a preconceived idea of whom or what they believe to be the sole cause of their family's problems. The blame tends to be on one person or circumstance (Nichols, 2013). The goal of structural family therapy is to open clients' eyes to the notion that one person or situation is not the only reason for a family's problems, but that it is an accumulation of each individual's behavior. Thus, it is important to observe clients' shift from their initial blaming perspective to a systemic one that encompasses the family organization and behaviors as the source of conflict (Minuchin & Fishman, 1981).

In the current study, raters used the Guidelines for Rating Change from Linear to Systemic Perspective to make these ratings. This scale is a seven-point, Likert-like scale with "one" meaning the family member is "strongly convinced that the identified patient is the problem and that the other family members do not play a significant role. The client rejects the idea that he or she plays a role in the problem," and "seven" meaning the client is "strongly convinced that the problem is not entirely in the identified patient, but rather that other family members, including himself or herself, play a significant role in the problem." These ratings were made at the end of each session. After each family member was rated independently, the raters were asked to discuss their ratings, but not to change their answers during the discussion period. In addition, four tapes were given to raters to

be completed on their own time due to the time constraint of data collection. The raters were asked to follow the same instructions and to complete these ratings by themselves.

## CHAPTER V

### Results

#### Study 2

Two raters were excluded from the analyses due to incomplete data. In addition, five interventions were excluded from being rated during the sessions because it was not clear whom these interventions were directed towards or there was not a clear response from the clients to rate.

#### *Ratings of Understanding and Acceptance*

In order to analyze the data, an initial reliability analysis was conducted to reduce the number of raters for analysis to three as per previous research (Nichols & Fellenberg, 2000). The reliability analysis yielded high reliability between the remaining 10 raters ( $\alpha = .963$ ). The reliability between the three raters who were most highly correlated with each other was then calculated ( $\alpha = .921$ ), and the average of these raters' data were used in subsequent analyses.

A one-way ANOVA was conducted in order to examine the effect of the interventions on ratings of understanding and acceptance in the clients. Table 2 shows the number of instances and average ratings of understanding and acceptance for each intervention. There was a significant effect of intervention type on clients' understanding and acceptance of the interventions,  $F(25, 264) = 5.66, p < .01$ . Although the ANOVA was significant, it is difficult to discern whether there were truly significant differences between the interventions due to the small number of instances of interventions in each session. For example, *Therapist describes how enmeshed family member invites*

*interference* occurs only twice across the ten sessions (see Table 2 for the number of occurrences of all interventions).

Therefore, another one-way AVOVA was conducted with the interventions that occurred most often in the sessions to determine if any significant differences existed between them. Four interventions met the criteria of  $N \geq 20$  occurrences across the 10 sessions. These interventions were: *Therapist describes an organizational problem in the family*, *Therapist describes a family member's role in perpetuating an interactional problem*, *Therapist initiates an enactment*, and *Therapist describes a problematic interactional pattern involving the roles of two family members*.

**TABLE 2**  
**Average Ratings of Understanding and Acceptance**

Intervention	<i>N</i>	<i>M</i>	<i>SD</i>
Blocks third person from interrupting	6	6.50	0.84
Describes how enmeshed family member invites interference.	2	5.50	0.71
Describes an organizational problem in the family (i.e. a family structural problem involving more than two persons).	45	5.20	1.30
Describes a family member's role in perpetuating an interactional problem.	27	4.85	1.63
Asks for past history about how family member learned to respond in a problematic way.	2	5.50	2.12
Points out (to an enmeshed family member) that he or she has a resource (a disengaged member) who could be approached more.	3	6.00	1.00
Points out that the identified patient has behaved in the session more productively than the presenting complaint would have suggested.	5	5.60	0.89
Tells enmeshed family member that he or she should allow disengaged members to develop a relationship.	2	6.50	0.71
Praises family member(s) for behaving productively in the session.	11	5.90	1.76
Tells enmeshed family member that he or she should develop more outside relationships.	2	5.50	2.12
Tells family that they are doing something wrong that is perpetuating the presenting problem. (They are stuck in a rut.)	9	5.22	1.50
Asks family member what other family member does to provoke a certain response from him or her.	12	6.75	0.45
Asks family member if he or she responds in a certain way to certain behaviors from other family member(s).	12	5.83	1.40
Asks family member how he or she wants other family member(s) to behave differently toward him or her.	8	6.50	0.53
Describes a problematic interactional pattern involving the roles of two family members.	26	5.61	1.42
Asks family member how he or she tries to get a desired response from other family member(s).	2	7.00	0.00
Asks about the emotional feeling behind a family member's actions.	12	6.83	0.40
Tells disengaged family member that he or she needs to initiate contact with someone.	1	6.00	-
Asks family members what they are doing that might be contributing to a problem.	2	7.00	0.00
Describes how the presenting complaint is a function of interactional problems in the family.	5	4.80	2.20
Initiates an enactment—directs family to talk (or interact) with each other.	44	6.64	1.04
Asks family member(s) if they play specified roles in a problem dynamic.	2	7.00	0.00
Asks family member(s) what were the intentions that made them act a certain way.	3	6.33	0.60
Asks family member(s) how they will change to improve an interaction in the family.	7	4.86	1.70
Suggests how family members should behave differently to improve their interactions.	12	5.00	1.20

*Note.* *M* represents the average rating of understanding and acceptance on the Client Intervention Rating Scale.

(These interventions were relabeled “one,” “two,” “three,” and “four” respectively for purposes of analysis.) The one-way ANOVA was significant,  $F(3,183) = 17.04, p <$

.01, and Tukey's post-hoc tests revealed significant differences between interventions one (*Therapist describes an organizational problem in the family*) and three (*Therapist initiates an enactment*), two (*Therapist describes a family member's role in perpetuating an interactional problem*) and three (*Therapist initiates an enactment*), and three (*Therapist initiates an enactment*) and four (*Therapist describes a problematic interactional pattern involving the roles of two family members*).

#### *Ratings of Shift from a Linear to Systemic Perspective*

Two clients were excluded from analyses due to incomplete data for these clients on the shift from a linear to systemic perspective variable.

As in the previous analysis, a second reliability test was conducted to reduce the number of raters to three for analysis as per previous research (Nichols & Fellenberg, 2000). Once again, this test yielded high reliability between the ten raters ( $\alpha = .952$ ). The reliability between the three raters who were most highly correlated with each other was then calculated ( $\alpha = .875$ ), and the average of these raters' data were used in subsequent analyses.

The four interventions used for the analysis of understanding and acceptance were also used to analyze the possible effect that they had on the clients' ratings of overall shift. In order to accomplish this, four new intervention variables were created. Each of the 28 clients received either a "1" (yes) or "0" (no) to indicate whether or not each of the four interventions occurred directly to them in their respective sessions. Four independent samples t-tests were conducted on the overall shift variable for each of the four interventions: one (*Therapist describes an organizational problem in the family*), two (*Therapist describes a family member's role in perpetuating an interactional problem*),

three (*Therapist initiates an enactment*), and four (*Therapist describes a problematic interactional pattern involving the roles of two family members*). The independent samples t-test showed a significant difference between the “yes” group (M= 5.40, SD= 0.99) and the “no” group (M= 4.52, SD= 1.09) for intervention number four;  $t(26) = 2.16$ ,  $p < .05$ . No other tests were significant.

## CHAPTER VI

### Discussion

Families often come to therapy with a fixed, narrow view of their problems; typically blaming one family member as the primary cause of the family's problems (Nichols, 2013). Focusing exclusively on individual patients and their problems often obscures the influence of family interactions on perpetuating these problems, and their underutilized potential for helping to solve them (Hoffman, 1981). Therefore, it is the job of a therapist to help the family understand that their view is limited because their narrow focus on the symptomatic family member often obscures the contributing influence of family interactions. Observing how therapists use different techniques to convey the systemic complications to a family is imperative to gaining insight into a family's problems (Nichols, 2013).

The purpose of the present studies was to develop a catalogue of techniques that experienced family therapists use to help move clients from their initial blaming perspectives of family problems to more systemic, organizational views of their problems, in which family members come to recognize that each family member plays a role in maintaining the conflict as well as having a potential role in resolving it.

#### *Summary of Results*

In Study 1, a catalogue of 25 techniques was developed across 10 structural family therapy sessions. These techniques were classified on the basis of a category-based filtering model in which developing categories were recorded until they could fit into already-existing categories or would become new categories in and of themselves (Sollenborn & Funk, 2002). Whether dialogue was considered a technique that promoted

a systemic perspective was based on the criteria that they were questions or statements that challenged family members to see their role in the conflict and to see that the conflict was a result of organizational and interactive problems in the family. Table 1 shows the categories of intervention and the number of times each occurred across the 10 sessions. The most frequent interventions were: *Therapist initiates an enactment*; *Therapist describes the structural problem in the family*; *Therapist describes family member's role in perpetuating an interactional problem*; and *Therapist describes problematic interactional pattern between family members*.

In Study 2, the extent to which the 25 interventions developed in Study 1 contributed to change from clients' initial linear perspectives to more systemic views of their interactions was examined via ratings by undergraduates. It was found that interventions: one (*Therapist describes an organizational problem in the family*) and three (*Therapist initiates an enactment*), two (*Therapist describes a family member's role in perpetuating an interactional problem*) and three (*Therapist initiates an enactment*), and three (*Therapist initiates an enactment*) and four (*Therapist describes a problematic interactional pattern involving the roles of two family members*) were significantly different from one another. Thus, intervention three (*Therapist initiates an enactment*) was shown to be significantly different from the other three interventions tested. In addition, *Therapist describes a problematic interactional pattern involving the roles of two family members*, appeared to contribute to higher ratings of overall shift from a linear to systemic perspective variable in clients who received this intervention as opposed to those clients who did not.

### *Implications*

The results from this study suggest that technique “three” (*Therapist initiates an enactment*) is a critical component of structural family therapy. This technique is the only one of the 25 observed that directly asks clients to talk to each other in a guided fashion. It is important to note that this intervention does not simply ask clients to talk to each other, but instead asks them to talk in a manner that is productive and centers around a specific component of their conflict (Minuchin & Fishman, 1981). For example, “Can you talk to Keisha about why it bothers you when she doesn’t listen?”

Enactments serve as a useful bridge from clients’ initial limited perceptions of their problems to a direct in-session transaction of these problems. Enactments are a way for therapists to bring problematic interactions directly into sessions where they are available to be observed and modified. For example, in one session, a husband and wife were bickering about the wife’s need to exert control over the husband. The therapist intervened and said, “Can you talk to her about why it frustrates you when she needs to take control of everything?” The clients then proceeded to talk to each other about this problem. Initiating enactments possibly led to higher ratings of understanding and acceptance in clients because the nature of enactments is to elucidate problematic interactions between clients.

In addition, technique number “four” (*Therapist describes a problematic interactional pattern involving the roles of two family members*) appeared to lead to higher ratings of overall shift from a linear to systemic perspective in the clients who received this intervention in their respective sessions. This intervention involves painting a picture of what the interactional styles are between clients and how they are problematic. For example, “Your wife tells you she needs space, but you continue to

smother her, which causes her to distance herself further and further from you.” This intervention makes evident the ways in which the interactions between and the roles played by the individuals are problematic, potentially resulting in higher ratings of overall shift from believing that an individual family member is the sole problem to understanding an individual’s *part* in the conflict.

### *Limitations of the Study*

Before delving into the clinical significance of these findings, it is important to acknowledge the limitations of this study.

#### *Small Sample Size*

The generalizability of these findings is limited by the small sample of videotaped therapy sessions ( $N = 10$ ) and therapists ( $N = 3$ ). This study had the advantage of using three highly experienced therapists, and therefore the findings may reflect the best practices of therapy. Therefore, the techniques employed by these experts may be worthy of emulation. However, the fact that the three therapists were all male and all practitioners of the same general approach to therapy may limit the generalizability of these findings. Future studies should examine therapy sessions from female practitioners as well as male practitioners and should explore the use of interventions in different approaches to family therapy.

#### *Small Number of Intervention Occurrences*

Due to the small number of occurrences of most interventions, the variety of analyses that could be conducted was limited. In Study 2, only four of the 25 interventions could be tested because they occurred enough times in the sessions to accurately compare their effects.

### *Undergraduate Solo Ratings*

Due to the time constraint of data collection, undergraduate raters were given four of the videotaped sessions to rate on their own time. Thus, weekly meetings were not held for these particular sessions, and neither the other raters nor the researchers were present for the rating of these sessions. Therefore, data from certain interventions within these sessions had to be excluded from analyses as a result of incomplete ratings for some of these interventions across individuals. In addition, in meetings where all raters met together, each rating could be discussed afterwards, and this was not possible for sessions that were completed on raters' own time. In future research, all ratings should be conducted in the weekly meetings.

### *Clinical Implications*

The therapeutic challenge for systems-oriented family therapists is to meet with families in varying degrees of crisis who often have fixed, linear points of view about their problems. A therapist's goal, on one hand, is to be understanding of the family's problem but, on the other hand, to gradually help the family expand their breadth of understanding of their situation. In this study, we observed over two-dozen techniques used by therapists that may prove useful in guiding clients towards a more systemic view of their problems. The most frequently used technique was: *Therapist initiates an enactment—directs family to talk (or interact) with each other.*

As described in the literature, an enactment is a technique used by therapists to engage clients in more productive ways of communicating by focusing their conversations on target problems (Minuchin, 1974). For example, in one session with a married couple having communication problems, the therapist asked the husband, "Can

you talk to her about your need to be understood?” The husband then said, “I need you to listen to me and not shut me out.” Before the enactment, it looked as though the wife was not aware of disregarding her husband as a result of being over-involved with her children. However, after observing them talk together, the interactional dynamics between them became evident. Initiating enactments is a way for a therapist to encourage and observe interactions between family members so that they can target problematic interactional patterns between them (Nichols, 2013).

Another frequent intervention was: *Therapist describes the structural problem in the family* (involving more than two persons). This involves a therapist describing that problems exist in the family because of the way two or more family members were enmeshed with or disengaged from each other. For example, in a session with a family whose mother was over-involved with her teenage daughters to the point of ignoring her husband, the therapist said to the mother, “It’s clear that the girls disrespect their father. It seems like they think of you more like a sister than a parent.” Here, the therapist was pointing out that a problem exists because the mother is disengaged with her husband and enmeshed with her daughters, creating a coalition of the three women against the husband.

“You two aren’t very good at this. You talk like 12-year-olds, and that’s why James doesn’t take you seriously.” This is an example of *Therapist describes family member(s)’ role in perpetuating an interactional problem*. This intervention is very useful in pointing out when and how a family member is unaware that he or she is exacerbating a problem. It is important for a therapist to not be overly critical when using this intervention so as not to offend individuals or provoke resistance, but to gently point

out the moments when a client's behavior is perpetuating a problem in the session so that family members can work on changing their behavior at home as well as in the session.

As is evident, some of these interventions are fairly blunt. What we observed, however, was that therapists had prepared the way for this kind of directness by gentle questioning in step one. When therapists described a problematic pattern of interaction, that pattern had generally become clear after exploring the context of the presenting complaint. Therefore, it was less a matter of interpreting something the clients did not see and more a matter of putting into words something that had become apparent. In the case of the previously mentioned pursuer-distancer couple with the "intolerant husband," for example, the therapist began by asking questions about the husband's and wife's complaints, which turned out to be reciprocal of each other: he wanted more independence; she wanted more togetherness. Only after initiating an enactment and observing how the pair interacted did the therapist point out to the woman that she "was coming on like the North Wind, blowing and blowing, which only made the man bundle up his coat more." The therapist then pointed out to the man that by "bundling up his coat," rather than taking it off, he was only encouraging "the North Wind" to bluster more in order to win her bet with the sun about who could make the man take off his coat. In other words, the wife was the pursuer in the relationship. She smothered him because she was in constant need of closeness, which in turn, caused the husband, the distancer in the relationship, to move further away from her.

A similar intervention is: *Therapist describes problematic interactional pattern between (typically two) family members*. The goal of this intervention is to make family members understand that their usual patterns of interaction are unproductive and need to

be changed in order for their problems to be resolved. An example of a problematic interaction is a teenage son acting out because he wants attention from his parents: “Do you have enough privacy? Maybe you don’t want privacy. You have your parents very involved. Do you like them to be? Do you get something out of it?” Here, the therapist is pointing out to the son that he seems to be acting out because he needs attention from his parents, which is problematic because his getting into trouble causes turmoil for the family. In this case, the cue for the parents would be to spend more time with their child in order to prevent him from getting into trouble as a result of needing more attention from them.

### *Qualitative Observations*

Because we observed many of hours of therapy, we made a wealth of observations that were not directly captured by our qualitative data. Here is some of what we observed.

Some of the sessions studied were consultations led by experienced structural family therapists. Consultants serve as a liaison between a client family and their regular therapist and determine what the next step should be in treatment. When clients enter therapy, they tend to have a sense of what is bothering them about their family’s conflict, but do not seem to have a grasp on the kinds of patterns or interactions that may be perpetuating those conflicts. This is why helping them realize their problematic interactional patterns is critical for enacting change. We observed this technique—*Therapist describes a problematic interactional pattern involving the roles of two family members*—as being a promising contributor to clients realizing their individual roles in their families’ conflict. Therapists often begin sessions by making small talk to make

families comfortable in the clinical setting. Sometimes this will involve asking them what they have learned from previous sessions and reviewing what they hope to improve.

Therapists may begin with polite social conversation to put families at ease, but experienced therapists move quickly to ask clients about their problems. While inexperienced therapists may try to ingratiate themselves by prolonging this social phase, experienced therapists demonstrate their professionalism by getting quickly to the problems at hand.

Family members typically begin by complaining about the behavior of other family members with whom they are unhappy. Structural family therapists listen to these complaints so that clients feel heard, but instead of accepting those complaints at face value, therapists will redirect clients by asking them what the other family member can do to make a situation better. In this way, complaints are turned into positive requests to other family members, rather than criticisms. In one session, for example, the therapist asked a wife, "What can he [your husband] do to make you feel more taken care of?" The wife replied, "I don't want to be criticized." The therapist then asked, "Are there positive things he can do?" The wife answered, "When he hugs me, I love it." Here, the therapist turned the wife's complaint ("I don't want to be criticized") into a request by asking her to describe the types of things her husband can do that are positive.

Another type of complaint is that clients attempt to diagnose other family members as having a disorder that interferes with the family's functioning. The problem with this medical-model thinking is that it is often a way of reinforcing the notion that one person is *the* problem and that only that person needs to change. For example, a husband said, "I think my wife is depressed." Instead of exploring the symptoms of this

supposed depression, the therapist asked both of them what was going on between them. It turned out that the wife was angry at her husband's lack of participation in the family and his tendency to disparage her opinions. She did not have an illness; she was not depressed; she had complaints and was hurt and angry. When family members attempt to diagnose a family member, the therapist's goal is to make the family understand that the diagnosis is often an excuse and serves to steer the focus away from the interactional problem at hand rather than placing the blame on an individual family member as an excuse for the family's problems.

Parents typically come to therapy with complaints about their children's behavior. Experienced family therapists listen to these complaints for only for a short time before talking with children to find out if they are capable of responding in a mature and appropriate way. In doing so, the therapist is not out to prove that the parents are wrong—the problem is their interactions, not the child. Rather, the therapist is trying to show that the children's behavior is flexible and, that if approached in certain ways, they can be responsible. Thus, the problem is not either in the child or between parents and child, but rather a little bit of both. In one session, for example, a mother and father began by complaining about their 11-year-old boy, saying that he does not listen to authority, is disrespectful, and acts out in school. The therapist then started a conversation with the boy and afterwards said to the parents, "See, he was respectful to me just now." The therapist stayed on this positive note and elaborated on the fact that the son was acting appropriately in the session. The therapist talked to the child in order to steer away from the parents' complaining and to point out that the child is not just a problem, but that his behavior may vary depending on the interpersonal context.

After exploring their initial feelings and thought processes enough to where the clients feel safe to express themselves, the therapist moves on to challenging the clients with various interventions. When therapists make interventions, clients might not initially understand what they are being asked to do or they may resist altogether. It is reasonable and natural for clients not to immediately understand and accept what they are being told. Experienced therapists calmly persevere in facilitating the intervention at hand with restatements, questions, or encouraging interactions.

In enactments, for example, therapists might move clients' chairs closer together to encourage interactions between them. Enactments can be a tricky intervention in that therapists have to achieve a balance between letting the clients converse with each other without interrupting and intervening so frequently that the conversation does not flow naturally. Some therapists tell clients what to say and intervene as soon as the enactment is not productive.

In addition, therapists sometimes intervene to coach and control enactments. Unfortunately, this robs them of authenticity, and while clients may learn to parrot "I-statements" and so on, they do not learn to talk back and forth productively when the therapist is not there directing the conversation. Although experienced therapists in this study did not control conversations with frequent interruptions and coaching, some of the therapists intervened in such a way as to side with one client in order to make one of the clients understand how he or she needs to change first instead of trying to get them both to change at the same time. This has nothing to do with a therapist's emotional response to the clients, but rather a technique used to promote productive interactions. Thus, therapy is a balancing act between giving each person a chance to voice his or her

concerns versus moving him or her towards understanding the problematic interactional patterns between family members and teaching them how to change things for the better. It is oftentimes that family members fail to acknowledge and understand what other family members are asking of them until and unless they feel that their complaints have been heard. Therefore, an empathic acknowledgement of each family member's feelings and points of view is a prerequisite to hearing and understanding what other family members are asking of them (Minuchin & Fishman, 1981).

### *Conclusions*

It is hoped that the findings of this study will be useful to family therapists in their efforts to help client families begin to understand some of the interactional influences of their problems. In developing their four-step model of systemic assessment, Salvador Minuchin and his colleagues provided a blueprint for therapists to help families appreciate the systemic context of their problems. The aim of these studies was to catalogue the techniques that experienced family therapists used to translate this four-stage strategy into specific tactics by which to help clients shift towards understanding their roles in their families' conflict so that they can change for the better. We hope that this study will be a useful first step in describing specific tactics by which therapists can implement positive change within families.

## REFERENCES

- Allen-Eckert, H., Fong, E., Nichols, M. P., Watson, N., & Liddle, H. (2001). Development of the family therapy enactment rating scale. *Family Process, 40*(4), 469-478.
- Anderson, S.C. (1968). Effects of confrontation by high- and low- functioning therapists. *Journal of Counseling Psychology, 15*(5), 411-416.
- Berenson, B.G., Mitchell, K.M., & Laney, R.C. (1968). Level of therapist functioning, types of confrontation, and type of patient. *Journal of Clinical Psychology, 24*(1), 111-113.
- Burck, C., Frosh, S., Strickland-Clark, L., & Morgan, K. (1998). The process of enabling change: a study of therapist interventions in family therapy. *Journal of Family Therapy, 20*, 253-267.
- DiGiacomo, T.M. (2011). The effective use of confrontation in family therapy: A process study. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 72*(4-B), 2433.
- Freud, S. (1909). Analysis of a phobia in a five-year-old boy. *Collected papers, Vol. III*. New York: Basic Books, 1959.
- Friedlander, M. L., Wildman, J., Heatherington, L., & Skowron, E.A. (1994). What we do and don't know about the process of family therapy. *Journal of Family Psychology, 8*(4), 390-416.
- Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

- Gurman, A. S. & Kniskern, D. P. (1991). *Handbook of family therapy* (2<sup>nd</sup> ed.). New York: Brunner-Mazel.
- Hammond, R.T. (2006). The role of empathy in structural family therapy: A process study. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 67(3-B), 1701.
- Hoffman, L. (1981). *Foundations of family therapy*. New York: Basic Books.
- Howe, G. W. & Varga, C. (2010). Research on family intervention: Family treatment and prevention programs. In M. P. Nichols, *Family therapy: Concepts and methods*: (10th ed.) Boston, MA: Allyn & Bacon.
- Kerr, M. E. & Bowen, M. (1988). *Family evaluation*. New York: Norton.
- Lambert, M. J. (2004). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. (5th ed., pp. 631-633). New York: John Wiley & Sons, Inc.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Minuchin, S. & Fishman, H.C. (1981). *Family therapy techniques*. Cambridge: Harvard University Press.
- Minuchin, S., Nichols, M. P., & Lee, W. Y. (2007). *Assessing families and couples: From symptom to system*. Boston: Allyn & Bacon.
- Nichols, M. P. (2008). *Inside family therapy*. (2<sup>nd</sup> ed.) Boston: Allyn & Bacon.
- Nichols, M. P. (2012). *Family therapy: Concepts and methods*. (10<sup>th</sup> ed.) Boston: Allyn & Bacon.

- Nichols, M. P., & Fellenberg, S. (2000). The effective use of enactments in family therapy: A discovery-oriented process study. *Journal of Marital and Family Therapy, 26*(2), 143-152.
- Nichols, M.P. & Paolino, T.J. (1986). *Basic techniques of psychodynamic psychotherapy: Foundations of clinical practice*. New York: Gardner Press.
- Risely, L.M. (2010). *Increasing father's involvement in family therapy: A discovery oriented process study*. Unpublished manuscript.
- Schlesinger, H. J. (2003). *The texture of treatment: On the matter of psychoanalytic treatment*. Hillsdale, NJ: Analytic Press.
- Sollenborn, M., & Funk, P. (2002). Category-based filtering and user stereotype cases to reduce the latency problem in recommender systems. *ECCBR '02 Proceedings of the 6<sup>th</sup> European Conference on Advances in Case Based Reasoning*, 395-420.
- Stanton, M., & Welsh, R. (2012). Systemic thinking in couple and family psychology research and practice. *Couple and Family Psychology: Research and Practice, 1*(1), 14-30.
- Williams, L. M., Edwards, T. M., Patterson, J., & Chamow, L. (2011). *Essential assessment skills for couple and family therapists*. New York: Guilford Press.
- Woolley, S. R., Butler, M. H., & Wampler, K. S. (2000). Unraveling change in therapy: Three different process research methodologies. *American Journal of Family Therapy, 28*(4), 311-327.

## APPENDIX A

### General Guidelines for Undergraduate Raters

1. Please remember that the information on the tapes is confidential and therefore should not be discussed outside of these meeting sessions.
2. You will be asked to rate the extent to which the client(s) understand and accept what the therapist is saying in each intervention as the tapes are paused.
3. As you rate the interventions as they occur, ask yourself whether the client(s) have a positive or negative response to the interventions. Do not let the wording of the rating scale confuse you. It is meant to be a guide.
4. Responses to interventions may last more than a few seconds. Therefore, do not be afraid to change your rating if you notice that the clients' responses have changed over the course of an intervention.
5. Record your rating on the appropriate rating sheets. Please make sure to indicate your name, the name of the tape, and the intervention number. This is very important for keeping the data organized. You will find the numbers for interventions on each tape's info sheet.
6. When rating the interventions, please keep in mind that you have to take into account two levels of the rating: 1. Whether the client understands what the therapist is saying to them, and 2. Whether the client accepts what the therapist is saying to them. These are both crucial elements in your ratings.
7. Remember that the guidelines are not the absolute answer to how to conduct the ratings. They are provided to give you some guidance, but ultimately you will have to use your best subjective judgment.
8. Finally, do not hesitate to ask me any questions.

## APPENDIX B

## Client Intervention Rating Scale

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1	2	3	4	5	6	7
No Under- Standing and No Acceptance						Clear Under- standing and Clear Accepting
(-)						(+)

1: No understanding and acceptance.

2: Very little understanding and acceptance.

3: Little understanding and acceptance.

4: Neutral—neither clearly understands and accepts no clearly doesn't understand and accepts.

5: Somewhat understands and accepts.

6: Moderately understands and accepts.

7: Clearly understands and accepts.

## APPENDIX C

### Guidelines for Rating Change from Linear to Systemic Perspective

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1	2	3	4	5	6	7
(-)						(+)

1. Strongly convinced that the identified patient is the problem and that other family members do not play a significant role. Client rejects the idea that he or she plays a role in the problem.
  
2. Moderately convinced that the identified patient is the problem and that other family members do not play a significant role. Client doesn't accept the idea that he or she plays a role in the problem.
  
3. Somewhat convinced that the identified patient is the problem and that other family members do not play a significant role. Client doesn't seem to accept the idea that the idea that he or she plays a role in the problem.
  
4. Neutral—not convinced that only the identified patient is the problem nor convinced that others play a significant role. Seems undecided.
  
5. Somewhat convinced that the problem is not entirely in the identified patient, but rather that other family members, including himself or herself, play a significant role in the problem.
  
6. Moderately, but not totally, convinced that the problem is not entirely in the identified patient person, but rather that the other family members, including himself or herself, play a significant role in the problem.
  
7. Strongly convinced that the problem is not entirely in the identified patient, but rather that other family members, including himself or herself, play a significant role in the problem.

## VITA

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Sydney Tafuri earned her B.A. in Psychology from The College of William and Mary in 2011. As an undergraduate, she has worked with the late Dr. David P. McCabe at Colorado State University in cognitive psychology with a focus on working and episodic memory in younger and older adults. Sydney graduated Magna Cum Laude. After graduation, she went on to pursue her Master's in Experimental Psychology at The College of William and Mary working with Dr. Michael P. Nichols in systemic family therapy research.