Course-EC-2 Paper 2 (Psychotherapy) Unit 1; Sem IV
By
Prof. (Dr.) Md. Iftekhar Hossain,
Head of Department, P.G Department of Psychology
Patna University
Contact No-993408701, E-mail-iftekharpupatna786@gmail.com

FAMILY THERAPY

Families are composed of units of individuals engaged in continuing interrelationships that significantly influence mutual behaviours. Pathology in one member can have a determining effect on the entire family system, which, in turn, will modulate the degree and form of individual dysfunctions. Therapeutic interventions therefore must concern themselves with the organizational distortions of the family as a system. It follows from this that correction of psychopathology in any one or more members presuppose a restructuring of the family organization, which is, to say the least, a difficult undertaking. At the start of treatment, the therapist is usually confronted with the fact that the family, dysfunctional as it may be, has reached a level of stability (homeostasis) that tends to resist modification. Attempts to alter faulty indigenous communication pattern or efforts to move family boundaries outwardly toward remedial community resources are apt to be resisted. Family therapy is designed to deal with these rigidities.

Family therapy is essentially organized within the framework of three schools:

1. Structural family therapy,
2. Strategic family therapy, and
3. Intergenerational family therapy.

Structural family therapy focuses on the behaviour of the family during the treatment session, and searches for patterns of alliance between two or more members as well as the firmness of their boundaries.

Strategic family therapy emphasizes the symptomatic consequences of bad problem-solving. Homework is often assigned in the form of tasks for the different members, sometimes employing ambiguous instructions. Patterns of

communication may also be explored family problem-solving tactics investigated, and certain remedial or paradoxical tasks prescribed.

Intergenerational family therapy searches for patterns of "fusion" and "differentiation" that are passed along from one generation to another.

GOALS

Most family therapists share the primary goal of improving communication within the family and deemphasize the problems of the individual in favour of treating the problems of the family as a whole. However, once we get beyond such general statements, there seems to be some disarray
of purposes and goals. For example, many therapists who talk about the family system still seem to view family therapy as a kind of context in which to solve an individual's problems. Seeing the family together becomes a technique (perhaps a more efficient one) for inducing changes in the individual patient. Other family therapists are devoted to the philosophy that regarding the family as a unit and working with it as such will enhance that unit. Although this may benefit the individual members, the real focus is on the family. As in most enterprises, the largest number of family therapists falls somewhere between the two extremes.

Varieties of Family Therapy

There are many types of family therapy. The following are some of the types

Conjoint Family Therapy

In *conjoint family therapy*, the entire family is seen at the same time by one therapist. In some varieties of this approach, the therapist plays a rather passive, nondirective role. In other varieties, the therapist is an active force, directing the conversation, assigning tasks to various family members, imparting direct instruction regarding human relations, and so on.

Concurrent Family Therapy.

In *concurrent family therapy*, one therapist sees all family members, but in individual sessions. The overall goals are the same as those in conjoint therapy. In some instances, the therapist may conduct traditional psychotherapy with the principal patient but also occasionally see other members of the family. As a matter of fact, it is perhaps unfortunate that the last variation is not used more often as a part of traditional psychotherapy. Because it is often the case that an

individual patient's problems can be understood better and dealt with better in collaboration with significant others in the patient's life, the use of such arrangements should facilitate the therapeutic process.

Collaborative Family Therapy.

In *collaborative family therapy*, each family member sees a different therapist. The therapist's then get together to discuss their patients and the family as a whole.

Behavioural Approaches to Family Therapy.

Some clinicians have viewed family relations in terms of reinforcement contingencies and skills training. The role of the therapist is to generate a behavioural analysis of family problems. This analysis helps identify the behaviours whose frequency should be increased or decreased as well as the rewards that are maintaining undesirable behaviours or that will enhance desired behaviours. *Behavioural family therapy* then becomes a process of inducing family members to dispense the appropriate social reinforcements to one another for the desired behaviours. Given the recent developments in cognitive behavioural therapy, it is not surprising that this approach has found its way into the family therapy enterprise. Similar to cognitive-behavioural therapy for the individual, the family version involves teaching individual family members to self-monitor problematic behaviours and patterns of thinking, to develop new skills (communication, problem resolution, negotiation, conflict management), and to challenge interpretations of family events and reframe these interpretations if necessary .

Multi systemic Therapy. A more recent mode of family therapy, *multisystemic therapy* (MST) was developed as an intervention for juvenile offenders and their families. The model behind MST assumes that clinical problems are determined by multiple factors, including the individual, the family, the school environment, and the neighbourhood. These influences are viewed as "systems" of influence within which each person operates. MST sees the family as the most important link in changing problematic behaviour, and this approach is characterized by several key components:
(a) treatment is delivered in the person's home, school, or other community locations;
(b) MST therapists are available for consultation 24 hours a day, 7 days a week;
(c) the caseloads of MST therapists are kept intentionally low (4 to 6 families) in order to provide intensive services to each family;
(d) MST therapists serve on a team in order to provide continuity of services and to be available for back-up should the need arise. MST uses several

evidence based techniques (e.g., cognitive-behavioural), and both individual and family outcomes are tracked.

In family therapy sessions are usually held once weekly for 1 ½ to 2 hours. It goes without saying that the goals of selective problem solving will require fewer sessions than those of extensive reconstructive changes in the family members. Video recording with playback is a strikingly useful tool, and among the techniques is "cross confrontation," during which a family unit is exposed to tape recorded excerpts demonstrating interactions. Insofar as actual techniques are concerned (supportive, re educative, and reconstructive), the existing styles are many even within the same practice models—structural, behavioural, psychodynamic, family systems, strategic, or experiential. The total interview consists of seven tasks.

The first task ("Main Problem") involves interviewing each family member separately, starting with the father, then the mother and the children in order of their age. Each is asked to discuss briefly: "What do you think is the main problem in your family?" They are each requested not to discuss their answers with other family members until later. Then the same question is asked of the group as a whole, gathered together in the interviewer's office. They are requested to arrive at some kind of consensus. This will expose the interactions and defenses of the members.

The second task ("Plan Something") is composed of a number of parts:
(1) The family as a whole is requested to "plan something to do as a family." This enables the therapist to see how the family approaches joint decisions.
(2) Next each parent is requested to plan something with all of the children and then the children to plan something that they can all do together.
(3) The father and mother are asked to plan something that they can do as a couple. This reveals data of the operation of family subunits.

The third task ("The Meeting") includes the husband and wife only. The question asked them is, "How, out of all the people in the world, did you two get together?" The role each spouse plays in answering this is noted.

The fourth task ("The Proverb") consists of giving the husband and wife a copy of the proverb, "A rolling stone gathers no moss." Five minutes are devoted to getting the meaning from the couple and coming to a conclusion. They then are asked to call the children in and teach them the meaning of the proverb. This enables the therapist to perceive how the parents operate as peers and then as parents, how they teach things to their children, and how the children react.

The fifth task ("Main Fault and Main Asset") requires that the family sit around a table; then each person is given a blank card on which to write the main fault of the person to the left. The therapist, after stating that this will be done, writes two cards and adds them to the others. These contain the words "too good" and "too weak." The therapist then shuffles the cards and reads out the fault written on the top card. Each person is asked in turn to identify which family member has this fault. This exposes the negative value system of the family and prepares the family for the phase of treatment when the task is assigned to avoid open and direct criticism.

Following this, each person is requested to identify his or her own main fault. This is succeeded by the assignment for each person to write on a card what he or she admires most about the person to the left. The therapist also fills out two cards:
(1) "Always speak clearly" and
(2) "Always lets you know where you stand." Experience shows that this part of the task, which is most difficult, exposes the positive value system of the family.

The sixth task ("Who is in charge") consists of asking the family, "Who do you think is in charge of the family?" This yields clues regarding how members perceive the leadership structure and their feelings about it.

The seventh task ("Recognition of Resemblance and Difference") requests the husband and wife to identify which of the children is like him or her and which like the other spouse. Then each child is asked which parent he or she believes to resemble most and the similar and the similar and different characteristics possessed in relation to both parents. The parents are also asked how each is like and unlike the other spouse. These points to the family identification processes.

Family therapy is highly desirable because the problems do not start or stop with the patient. The least that can be accomplished is the achievement of better lines of family communication and a softening of scapegoating. Family therapy may be one of the most effective ways of reducing re hospitalization, in addition to safeguarding maintenance medication. Many problem families exist, the members sometimes being entangled in complex interpersonal difficulties that seem impossible to unravel. The untrained therapist is apt to encounter insuperable difficulties with these families. On the other hand, an effective family therapist may accomplish good results impossible to achieve by another method.