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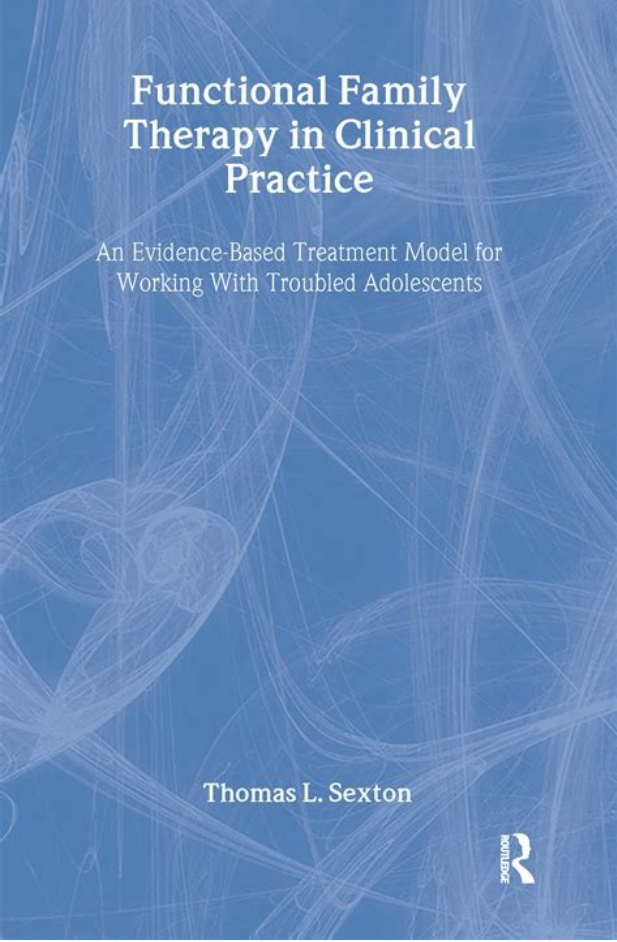
Functional family therapy clinical training manual

Functional family therapy techniques. How does functional family therapy work. Functional family therapy examples. What is functional family therapy.

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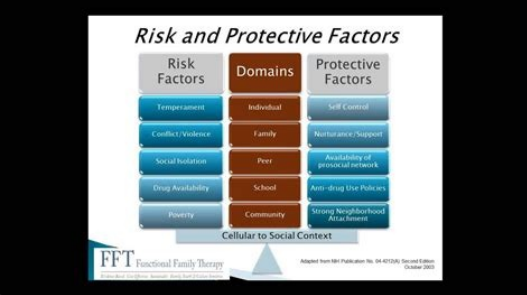


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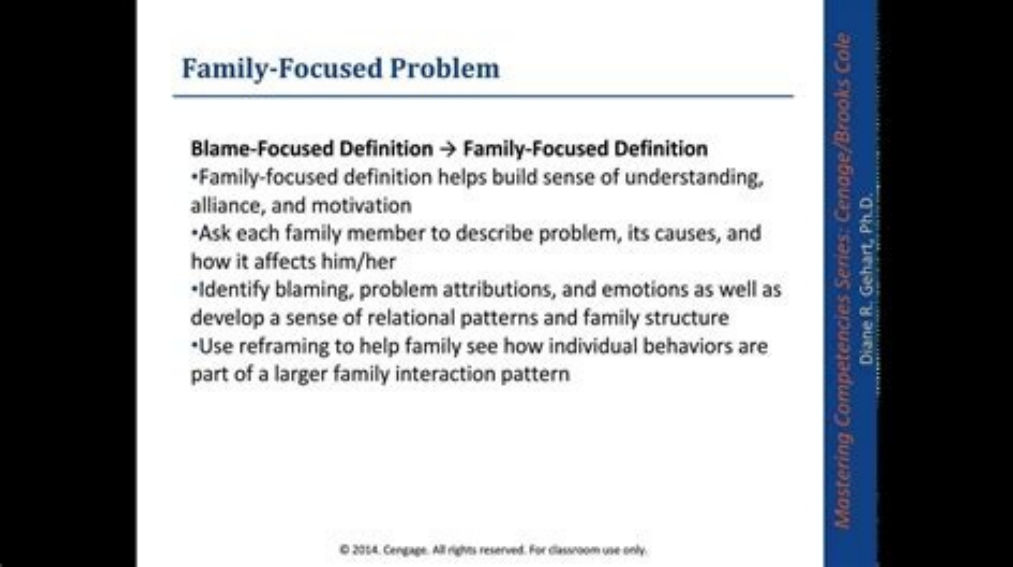
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Journal of Contemporary Psychotherapy, 40, 175.CrossRef Google Scholar Sexton, T. L., & Fisher, A. (2015). Integrating ongoing measurement into the clinical decision making process with Measurement Feedback Systems. In J. Magnavita (Ed.) Clinical Decision-Making in Behavioral and Mental Health Practice. American Psychological Association Press. Google Scholar Sexton, T. L., & Stanton, M. (2016). Systems theories. In J. Norcoross & G. Vandenbos (Eds.), APA handbook of clinical psychology. Washington, DC: APA. Google Scholar ...systematic, phasic, and integrated "Map" Engagement Behavior Change Generalization Goal-Skills Assessment Intervention Motivation Behavior Change Generalization Early Middle Late Time The engagement and motivation phase begins with the first con-tact between the therapist and family. The first experience of the family over the entire session, not from any single thing said or done by a therapist. Engagement and motivation also require that a mutual and family focused definition of the "problem" emerge. Having struggled with the behavior problems of their adolescent and/or parent for some Clinical Training Manual 57 time, it is only natural that each family member comes to therapy with well-defined explanations for the problems they experience. These definitions may exist in emotional ("it hurts and I am angry"), behavioral ("stay away from me", "you don't deserve a break") or cognitive terms ("you are just trying to hurt me", "why does he/she intentionally do this?"). The cognitive sets, or problem definitions, that family members possess represent the meanings that contribute to the emotional intensity that is often behind the anger, blaming, and negativity seen in the interpersonal interactions between family members. A family focused problem definition is one in which everyone in the family has some responsibility and thus, some part in the problem. However, no family member has blame for the state of affairs in the family. The difficult goal is the reduction of blame while retain-ing a sense of responsibility for one's own actions. A family focused problem definition has a number of important therapeutic functions. First, it contributes to the reduction of blam-ing and negative interactions among family members and thus produces hope and a sense of motivation. Second, it helps individual family members reattribute the intent and causes of behaviors from malevolent to benevolent, and thus alters the emotional attributions associated with problem behavior. Third, the family focused problem definition helps identify potential solutions that may have otherwise been difficult to identify. Finally, the family focused problem definition helps organize therapy and becomes the major theme that explains the problems of the family and thus organizes behavior change efforts. In fact, without this redefinition to include all family members, it is almost impossible to get everyone in the family involved in the behavior change phase. A Assesseessm meen nt/ n th hee EE n nggaaggeem meen nt/ M Mo otivaatio on n P Ph haassee Assessment is an ongoing activity throughout the engagement and motivation phase in two primary areas. First, the therapist assesses the process issues of the phase and judges the progress of each of the phase goals in order to determine what interventions need to occur. The therapist also begins to develop a multisystemic understand-ing of the individuals, family, and relational context of the family. To accomplish this the assessment is focused on identifying the problem Functional Family Therapy Clinical Training Manual 58 sequences that underlie the relational system of the family. Assessing these issues helps the therapist understand the family well enough to "match to" them and begin to plan for the behavior change phase. It is important to note that unlike some models, assessment at this phase is heavily based on observation rather than direct questioning or intervention. It is also important to note that assessment of client risk factors is not the primary activity of the therapist. Instead, the therapist is reframing (which includes a strong focus on possible underlying strengths) and developing a relational focus to accomplish the pri-mary goals of the phase (e.g. negativity/blame reduction, developing a family focus, etc.). Thus it is critical that the therapist not become a detective doing traditional assessment but instead stay open to observation while being therapeutic and pursuing the primary phase goals. Page 2 Pattern of degree of relational control and influence over time When X relates to Y, the relational pattern(behavioral sequences in the relationship)of X's behavior is characterized by: 1-up + 1-up Symmetrical: Exchange = Behavioral Degree of control or influence Degree of control or influence based relationship aimed at alleviating the critical risk factors that increase the likelihood (i.e. facilitate and maintain) symptomatic behavior. The therapist is the expert on the change process. You are the professional in regard to the process event. The critical within-thera-py events that must take place for successful change to occur. The change process is your domain; you are the expert in this regard. As a result you purposefully influence and direct the process of therapy in particular directions. At the same time, the family and its members are the experts in their life, their individual emotions, their biases, and their journey. Successful therapy involves empowering the family to become unstuck and to pursue their goals and values in ways that do not increase the risk of future problems. In order to facilitate this process you are purposeful and clinically responsive. Thus we have two experts, with different tasks, who must both do their part for therapy to be successful. This requires a partnership—a cooperation—an alliance based relationship and alliance based motivation to overcome successfully the difficult problems family members face. ALLIANCE-BASED MOTIVATION. Motivation is a frequently studied construct that represents a central feature in most theoretical approaches to therapy. The dictionary definition of motivation is an "incentive to action." In the context of therapy, motivation often is viewed as a static construct; a condition (incentive) that exists within clients that moves them to change. In fact, a number of change mod-els suggest that the focus of early assessment should be on assessing clients readiness or stage of change; this often leads community practitioners to choose or at least prefer clients who are "ready" for change However, in the 30-year history of FFT the majority of our families contain one or more members who are not motivated to change; in fact, many at first present as unwilling to even begin the change process, and some are intensely motivated to maintain the negative situation. As a result, FFT has developed strategies and techniques to create the motivation to change, leading to high suc-cess rates even in populations characterized as "resistant to change." Accomplishing this has required that FFT follow an "empower-ment" rather than a "manage"empower-ment" philosophy and strategy of change (Alexander & Sexton, 2002; Sexton & Alexander, 2002). Clinical Training Manual 47 According to FFT a change process which is maintained is one in which the therapist is successful in developing an atmosphere of hope, expectation of change, a sense of responsibility (internal locus of control), and a positive sense of alliance which is shared by the family. This sense of alliance is not only between each family mem-ber and the therapist, but among family memmber-s as well. When they come to us family members often have very little sense of alliance with one another, or there are maladaptive subsystem alliances that maintain the maladaptive family patterns. Thus our first goal in FFT is to begin to develop positive within-family alliances, which then become the platform for long-term change and the difficult steps that are necessary to produce such change. To be clear, it is perhaps misleading to suggest that our youth and families are "not motivated." FFT views most clients coming to therapy as motivated to some sort of action. Unfortunately, they are motivated to maintain or engage in actions that do not produce suc-cessful resolution of the presenting concern. From the FFT perspective, therapeutic motivation occurs when the incentive to action results in new and adaptive patterns. Thus FFT defines thera-peutic motivation (an incentive to change or to act) as the primary initial therapeutic goal. In turn, attaining this goal is based princi-pally on alliance, a relational process, which emerges from specific therapeutic and clinically responsive strategies of the FFT therapist. As such motivation has an intrapersonal (within the client), a family interpersonal (between family members), and a therapeutic (between therapist and each family member) component. When activated in a therapeutic way, each of these components contributes to producing an incentive to action, a push to change that is critical for successful family therapy. The centrality of alliance is not unique to FFT. Alliance is a well-defined construct in psychotherapy literature, and is usually well-defined as agreement on the tasks and goals within the context of

an emotional bond. • The within family alliance is demonstrated by family members overcoming their negativity and working together to the same end, with agreement on how to get there within the context of an emotional bond. • The family - therapist relationship is similar to the relationship between family members and the therapist. It is Functional Family Therapy Clinical Training Manual 48 increasingly clear from therapy process research that alliance is critical and additionally, in the family therapy context this alliance needs to be balanced. Balanced alliance occurs when the therapist develops roughly similar levels of working alliance with parent(s) and youth, even when one or more enter the therapy process with exceptionally aversive behavioral pat-terns (Robbins, Turner, & Alexander, in press).

The centrality of motivation is not unique to FFT, however it is viewed quite differently than in other approaches. Intrapersonal (within client) motivation includes a cognitive component which is related to the way in which clients understand the problem, and an affective or emotional component which is related to the way in which a person feels about the problem or concerns. At the point that families enter therapy, the cognitive and affective/emotional components of their attributions about the “problem,” and each other, generally reflect considerable blame and negativity. Successful motivation (for posi-tive action) occurs when the therapist helps family members to view the “presenting concern” as one to which all members contribute but for which none are to be blamed. In addition, motivation is enhanced when the FFT therapist, through interpersonal processes such as reframing, helps all family members experience reductions in negativity and blaming, and instead provides reasons to feel hope and an expectation of potential success. These intervention process-es, and related strategies such as sequencing and non-blaming, are described in a later section of this manual. THE ROLE OF RESPECT AND UNDERSTANDING. It is diffi-cult if not impossible for most of us to “respect” someone who attacks someone else with a fist or gun. It is difficult to respect a parent who continues to use drugs when such drug use has been implicated in their child’s behavioral problems. It is difficult to respect a youth who, in the first ten minutes of an intake session of the first session, blurts out: “Fuck you” (to mother), “Fuck you” (to grandmother with whom the youth and mother lives), and “Fuck you bitch...get outta my face” (to you, the therapist). Such behaviors evoke, at least in most of us, negative emotional reactions, critical judgment, and what some might call counter trans-ference. We are human beings with our own parents, children, and friends, some of whom have been injured emotionally and physically by the very same behaviors. Some of us, in fact, have been abused Clinical Training Manual 49 ourselves, some of us have struggled with the residual self concept that emerged from a stern rejecting parent, some of us have worked in shelters or on crisis phone lines and experienced the conse-quences of the behavioral patterns we must work with in FFT. In this context, the goal of providing hope and establishing a positive and balanced alliance is far from a trivial task.

And yet, with-out it our hope of creating a positive change process which can and will be maintained is unlikely. Years of clinical experience and vol-umes of psychotherapy research support this core contention of FFT. How does FFT meet this critical initial goal of intervention despite—or even with the help of—our own negative reactions? The answer lies within a subtle but essential restatement of the role of respect and understanding. Specifically, FFT argues that developing a positive and balanced alliance requires relentless effort to under-stand and respect the youth and families on their own terms. It is the Functional Family Therapy Clinical Training Manual 50 Page 3 Source Responsibility (“I”) Directness (“you”) Feel Impact Statements Active Listening (“you feel...”) Behavioral Specificity/ alternatives Active Listening (“you want...”) Assertion Validation + Brevity Negotiation Want Impact Statements Affect expression, validation, & regulation focusd. The following are principles that are most useful with the adolescents and families often involved in FFT. 1. Contracting involves having family members identify specific things they would like other family members to do in exchange for tangible or agreed upon consequences. Contracting is particularly important to adolescents because it involves a mutual involvement of parent and youth. It is also useful in FFT because contracting requires involvement of all members of the system. Contracting should initially be conducted within an FFT session where the process can be guided by the therapist. Initial contracting should be as positive and successful as possible.

Any contracting intervention needs to be based on the principles of good communication and involve: behavioral specificity, presentation with alternatives, clear source responsibility, and an active listening response. The goals of contracting must be realistic, obtainable, and eas-ily identified. Finally, contracting must match the relational assessment of the family members and may be built on the organizing theme developed in the engagement/motivation phase.

2. Appropriate consequences are an important parenting tool. In fact, many parents come into therapy wanting new ways to use consequences. Unfortunately many times this request is like asking for a “bigger hammer” to force youth into compliance. With appropriate use of consequences parents can reinforce and sanction behaviors of their children and adolescents in ways that help promote change. In FFT the use of conse-quences involves both positive reinforcement and penalty-based sanctions. There are two basic types of conse-quences that can be used by parents. • Response-cost techniques are a useful framework that helps parents set non-coercive yet clear and firm penalties for certain pre-identified behaviors. These parenting tech-niques are most useful for preadolescents and younger children but can provide an important framework for delivering consequences to adolescents as well.

For response-cost techniques to work, the expected behaviors and penalties should be fair and clearly stated, and Clinical Training Manual 79 augmented by any technical aids necessary (e.g. notes, contracts, reminders etc.). Response-cost techniques involve both penalties and rewards. • Action-related consequences represent another potential parenting tool when used correctly by parents. Action-related consequences are those natural real world results/consequences of an adolescent’s behavior (e.g., school detention, legal trouble). Action-related conse-quences are not initiated by parents but instead used, in a non-coercive way, as a predetermined clearly identifiable action that will result from the youth’s behavior. • Changes in parenting practices around consequences, response cost, and action related consequences, take place within family sessions guided by FFT therapists in a way that is consistent with the organizing theme while matching the relational functions of the family.

It is very important that parents see consequences as a way to guide rather than force a youth’s behavior. It is equally impor-tant that parents recognize that parenting changes may not result in immediate changes by the youth. Thus, it is critical that the use of consequences by parents be done in a way that is: • non-blaming and • supportive • while firm, • consistent, • and with informed consent (e.g. with everyone know-ing the rules prior to the use of consequences). 3. Relationship building is an often times overlooked parenting technique. When families come into therapy they are in crisis mode, looking for answers to difficult problems. It is challeng-ing at those times to remember that successful parentchalleng-ing is built upon a foundation of an alliance-based relationship between the youth and the parent. Thus, we often use relation-ship building as a parenting technique. In times of trouble the negative and blaming behavioral interactions among youth and parent are common.

Relationship building is nothing more than a specific, guided and purposeful attempt by both Functional Family Therapy Clinical Training Manual 80 the youth and the parent to engage in small, non-conflicted, behaviors that will be appreciated by the other. These small behaviors must be meaningful to the other, must be done as an offer without expectation of a return, and must be done daily without request. Like other parenting techniques, relationship building is an activity that should begin during FFT therapy sessions guided by the therapist and built into activities of the family over time. PRINCIPLES OF SUCCESSFUL PROBLEM SOLVING. Much of the problem solving that takes place between youth and their fami-lies/parents is accomplished through the negotiation process described in the communication section. There are times, however, when issues arise that require a more “formal” or specific procedure for working together. In fact, problems and struggles are a part of everyday life for all families. Using an effective problem solving strategy helps families overcome these struggles in a way that main-tains alliance while specifically targeting changes and strategies for change. As noted above, successful problem solving builds on the strategies of positive communication. There are a variety of problem solving models available. The system described below contains the critical elements of successful problem solving. The steps include: 1. Identify the problem. The goal is to identify the specific problem to be solved (in behaviorally specific and concrete ways). Identifying a problem to be solved can be more difficult than it may seem because problem solving needs to be alliance based and collaboratively done. Thus, the approach to identifying the problem must also be based on source responsibility, active listening, and the presentation of alternatives. 2. Identifying the outcome desired is a critical step in having all involved working to the same end. As with problem identifica-tion it will require specificity of the outcome and the manner in which the outcomes are determined (e.g. with openness and alternatives) is crucial to the success of joint outcome determi-nation. 4. Agreeing on what it takes to “do” or accomplish the goal should clarify the sub-goals (e.g. the steps to completing the task for each involved) and may also include contracts to specify time frames and specific agreed upon steps and outcomes. Clinical Training Manual 81 5. Before problem solving ends, it is useful to brainstorm all of the barriers or ways that the plan might go wrong. When these issues are identified, the plan may need to be altered. These steps help sensitize all involved to potential pitfalls and enhance successful completion of the process. 6. Coming back and reevaluating to see if goals are met allows for problem solving to have accountability and be seen as a collaborative process that engages youth and parents in a process of constant improvement. Problem solving is successful when it takes place within a rela-tional context of alliance, collaboration, and “working together.” It is a successful strategy to alter risky behaviors when it is part of a comprehensive behavior change plan that matches to the family.

Thus, problem solving is best initiated after communication training and within session guided by the FFT therapist to ensure success. Once experienced as a useful alternative, the family may take the strategy and use it in programmed ways as “homework.” PRINCIPLES OF CONFLICT MANAGEMENT. There are times when past events and rigid and entrenched negative problem interaction patterns are quite difficult to “solve” or negotiate to a successful resolution. Given the sometimes lengthy history of prob-lems and strong emotion that accompany therapy it is no surprise that some “old” issues seem almost impossible to change in tradi-tional ways. Conflict management is a strategy to use in these situations. By managing conflicts and keeping them from getting “out of control” the family has the emotional and psychological space to find new ways of working together that ultimately will over-come past hurt and struggle. Conflict management is not a strategy to “solve” the problem but instead to contain it so that it does not interfere with other behavior change activities.

In many ways the best way to manage the types of conflicts not open to negotiation and problem solving is to avoid the situations and triggers that set off the automatic chain reaction of spiraling negativity. Avoiding such situations requires the therapist to have clearly identified the aspects of the central problem pattern (see rela-tional function assessment section). Avoidance of the early triggers of spiraling negativity and conflict often times involves the interruption of the pattern. This might take the form of a parent and youth end-Functional Family Therapy Clinical Training Manual 82 ing a conversation for a time out when it gets to a certain level of negativity, it might involve a parent not asking about a “hot” topic or a youth not bringing up old situations and events that serve as trig-gers. The goal is to avoid the automatic verbal or physical triggers that begin the pattern. If successful, it might be that the family uses communication or problem solving to identify a more long-term solution. Conflict management can also play a role when the seem-ingly out of control patterns are under way. Here the goal is to contain the conflict and not let it spread and “infect” other successes and objectives in behavior change. To contain such a conflict it requires the therapist to help both parties adopt three states: • Remaining issue focused helps reduce conflict by keeping the target a specific issue and not a “whole relationship” or “all that we have worked toward.” The goal for the therapist is to clarify the specific issue at hand and isolate it from other areas of the family life. • Adopting a conciliatory set or a willingness to talk communi-cates the emotional aspect that contributes to a climate that promotes the reduction of a conflict. • Staying present oriented keeps the focus on conflict reduction rather than on “rehearsing” and solving. Reframing is a useful therapist tool to use in helping focus the conversation and emotional climate in the above directions. It might also be helpful for the therapist to “talk through” the issue with the person feeling the conflict and unable to use other solutions (e.g. negotiation) by directing them through the following questions. The process of asking these questions, rather than the specific answers, is what promotes movement toward an issue focused, present oriented, conciliatory climate. 1. Exactly what is the issue of concern to you? 2. Exactly what would satisfy you? 3. How important is that goal to you? 4.

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