"Becoming a Marriage and Family Therapist represents a significant step in the training literature in marriage and family therapy (MFT). It is a challenge to manage and family therapists to apply an evidence-based approach to their work not unlike what MFTs expect of the physicians to whom they take themselves and their families for treatment. It is a plea to assess thoroughly and to demonstrate progress and success with the best science available. It is asking for the field to come of age. I commend this book as an important contribution to the training literature."

Douglas H. Sprenkle, Professor Emeritus, Purdue University
Former Editor, Journal of Marital and Family Therapy

"This book is the single best source that I am aware of for helping marriage and family therapy interns in implementing knowledge and skills as they begin and advance in working with couples and families. It is apparent that Dr. Mead has shared his professional lifetime of clinical supervision and training as he compiled this encyclopedic volume. Practicing professionals, as well as clinical interns, will greatly benefit from studying and applying information contained in this book."

Robert F. Stahmann, Ph.D.
Professor Emeritus, Brigham Young University

Becoming a Marriage and Family Therapist is a practical "how-to" guide designed to help trainee therapists bridge the gap between classroom and consulting room. Drawing on over 40 years' experience, D. Eugene Mead demonstrates that for supervision to result in the positive changes needed to create successful client outcomes, therapists must focus on two basic factors: a good supervisory relationship, and attention to the task of improving therapy skills. The book shows readers how to reinforce these competencies by applying empirically-based methods to each of the core tasks of therapy.

Part I presents generic guidelines for all therapy models, including initial contact, assessment and treatment planning, evaluating treatment delivery, continuous evaluation of therapy outcomes, and terminating therapy. Part II goes on to provide treatment protocols that apply these guidelines to a number of well-known and empirically-supported marriage and family treatments.

The book also provides extended coverage on assessment and beginning treatment with crisis areas, often a difficult aspect for new therapists, and suggests how supervisors can support trainees in these and other challenging areas.

D. Eugene Mead is Emeritus Professor of Marriage and Family Therapy at Brigham Young University, Utah. Over the course of 40 years, he developed and initiated the university's family therapy, sex therapy, marriage and family practicum, and marriage and family therapy supervision classes. He is a member of the American Psychological Association and Clinical Member and Fellow of the American Association for Marriage and Family Therapy (AAMFT), having taught the Approved Supervision course at their Winter Institute. He is the author of the acclaimed Effective Supervision: A Task-Oriented Model for the Mental Health Professions (1990).
Becoming a Marriage and Family Therapist
This book is dedicated to the hundreds of student interns who started to become marriage and family therapists in their first practicum classes at Brigham Young University. It is also dedicated to the doctoral students who enrolled in the supervision course to learn how to supervise others becoming family therapists. Thousands of family members have benefitted from their efforts.
# Contents

List of Figures, Tables, and Boxes ix  
About the Author xi  
Foreword xiii  
Acknowledgments xvii  

**Part I**  
1 Becoming a Competent Marriage and Family Therapist 3  
2 Basic Therapist Skills 17  
3 The Initial Phone Call and Assessing Clients’ Complaints and Goals 63  
4 Establishing a Treatment Plan and Delivering the Planned Treatment 85  
5 Evaluating Adherence to the Treatment Plan and Evaluating Treatment Outcomes 109  
6 Terminating Therapy 135  

**Part II Protocols for Selected Models of Marriage and Family Therapy: Delivering Evidence-Based Treatments**  
Introduction to Part II 147  
7 Protocol for Conducting Gottman Method Couple Therapy 149  
8 Protocol for Conducting Emotionally-Focused Therapy with Couples 195  

Notes 217  

**Appendix A** Person of the Therapist Checklist 219  
**Appendix B** Therapist Self-Soothing Procedures 221  
**Appendix C** Standard Assessment Battery for Marital Relational Problems 223  
**Appendix D** Written Case Progress Notes 235
Contents

Appendix E  Observations of the Couples’ Communication and Problem-solving Behaviors Therapist’s Rating Form Based on Gottman (1999) 237

Appendix F  Clinical Experience Log 239

Appendix G  Preparing a Written Treatment Plan 241

Appendix H  Written Treatment Summary 247

Appendix I  Therapy Tailoring Skills Rating Form 249

Appendix J  Homework Success: Therapist Guidelines 251

Appendix K  Preparation for Supervision Checklist: Couples 253

References 257

Index 285
List of Figures, Tables, and Boxes

Figures

2.1 Questions for a semi-structured screening interview for family violence 55
4.1 An example of a marital Standard Assessment Battery scores record 87
4.2 An example of a scored marital Standard Assessment Battery record 95
5.1 Some combinations of husband’s and wives’ outcome rating scale and revised dyadic adjustment scale scores in terms of levels and trends indicating successful, improving, deteriorating, and extremely distressed client outcomes 122
5.2 Family therapy decision tree 127
5.3 Domains of social support used to cope with significant life stressors 130

Tables

2.1 Categories of suicide risk 34
2.2 Recommended best treatments for depression and anxiety 36
2.3 Risk factors for partner, child, and elder mistreatment 46
G.1 Example of an assessment table in a treatment plan 243

Boxes

1.1 Supervision and Split Alliances 9
2.1 The Supervisor’s Role in Suicide Risk Assessment and Intervention 37
4.1 The Supervisor’s Role in Establishing the Treatment Plan 91
4.2 An Example of a Treatment Plan 93
5.1 Improving Therapists’ Cognitive Processes 115
7.1 Presenting the Gottman Method Couple Therapy Treatment Plan 159
D. Eugene Mead, EdD, is emeritus professor of Marriage and Family Therapy at Brigham Young University. He is a Fellow of the American Association for Marriage and Family Therapy and a member of the American Psychological Association. Joining the Brigham Young University Child Development and Family Relationships Department in 1967 he taught marriage and family therapy for forty years. During that time he developed (a) the behavioral marital and family therapy classes, (b) the practicum classes which provide the students with opportunities to begin practice with couples and families, (c) the sex therapy class, and (d) the supervision class designed to teach doctoral students to supervise master’s level marriage and family therapy students. He also taught supervision at annual meetings and Summer Institutes of the American Association for Marriage and Family Therapy.
D. Eugene Mead’s book, *Becoming a Marriage and Family Therapist*, represents a significant step in the training literature in marriage and family therapy (MFT). It marks a coming of age in that it takes more seriously than any other training volume the importance of MFTs becoming "research informed" (Karam and Sprenkle, 2010). The vast majority of MFTs will not do formal original research as part of their careers, but this volume presents a strong case for the expectation that all MFTs will use research knowledge and research instruments to inform their clinical decision making. The reader will note that the vast majority of physicians do not do original research either. But, how many of us would want to patronize a physician who did not use research knowledge and instruments (e.g., blood pressure tests) to inform clinical decision making?

As a clinical member of the American Association for Marriage and Family Therapy (AAMFT) for forty years, all as an MFT educator, I have seen a lot of models and methods of training come and go. For too much of the history of the discipline, training has relied on a series of “here is my method” volumes based largely on the experience and theoretical preferences of the authors with scant regard for supporting evidence. Typical of Mead’s candor is his warning: “You should be equally cautious about adapting a new technique presented at a workshop or national meeting. Prudent therapists do not chase off after the latest theoretical model no matter how charismatic the presenter. Hyperbole should not be allowed to substitute for scientific evidence” (p. 104).

While acknowledging there are sometimes contradictory findings from research, and typically presenting both sides, Mead’s guidelines for training are grounded in evidence wherever possible. I was also very impressed with his broad command of the psychotherapy research literature. Although this is a volume on MFT training, Mead draws on evidence-based insights from counseling and clinical psychology – especially where this literature addresses themes not yet reported in the MFT research literature.

As strong as his evidence-based orientation is, Mead’s volume makes clear that a scientific approach is not the sterile application of principles by therapists in white lab jackets; and therefore he gives considerable attention throughout to such issues as adapting validated approaches to clients’ needs and characteristics and to “self of the therapist” issues that are usually not well-addressed in empirically-oriented approaches. However, in keeping with the author’s desire to operationalize what some might consider the “soft side” of therapy, Mead includes appendices of instruments he has developed like “A Person of the Therapist Checklist” and “Therapist Self-Soothing Procedures.” Mead’s volume is more oriented toward instrumentation than any training text I have ever reviewed.

Another thing that I appreciated about this volume is its recognition of the moderate common factors stance (Sprenkle, Davis, and Lebow, 2009) – that although empirically validated treatments
have done an excellent job demonstrating that they are superior to no treatment and to many alternative treatments (like “treatments as usual”), there is currently little evidence that one empirically validated MFT treatment is superior to another. So, the research informed therapist will want to (if at all possible) use an empirically validated approach for the problem being presented since these approaches are typically more effective than common “seat of the pants” alternative treatments. At the same time, the research-informed therapist is free to choose from a range of empirically-validated models (when there are multiple models for particular issues) depending on the match of that model to the therapist’s world view, the needs of the client, and the therapist’s and supervisor’s training and skills. So, for example, while both Emotion Focused Therapy (EFT) and Integrative Behavioral Couples Therapy (IBCT) have both produced an impressive body of evidence that they are superior to common alternatives for treating marital distress (that these treatments have demonstrated what Sprenkle et al., 2009, have called “absolute efficacy”), there is currently no research that compares the efficacy of EFT with ICBT (that addresses what Sprenkle et al., 2009, have called “relative efficacy” between MFT models).

So, as Mead notes, one factor (other things being equal) that the therapist might use in making a choice between these two treatment models might be whether the presenting problem is an “attachment injury,” for which EFT would be especially well-suited; or more a communication and problem-solving issue, for which IBCT might be the more potent match. “Other things being equal” is an important qualifier since in some instances therapist or supervisor training would be an over-riding concern in choosing a model from among evidence-based approaches.

Another way in which the current volume acknowledges the moderate common factors approach is that it makes clear that the largest portion of the variance in successful outcomes in empirically validated approaches is because they activate or potentiate common change mechanisms that operate in all successful treatments. That is, the largest portion of the variance in successful treatment is not what is unique about the treatment but common change mechanisms found in all successful treatments. This approach does not gainsay the value of models as important roadmaps for therapeutic success since having a model/roadmap is crucial. It also does not deny that there are some unique aspects of models that are likely especially helpful to certain clients and therapists. It is rather that commonalities (such as building strong therapeutic alliances, helping people to look at their problems differently, engaging in interventions that appear credible to clients) seem to trump unique dimensions when it comes to explaining outcome variance. Also, often what model developers present as unique dimensions are just a variation of a common theme. For example, getting clients to look at their problems differently may be called promoting “insight,” “reframing,” or “building a new narrative.” The names are different but the basic mechanisms of change are often quite similar.

For this reason, Mead devotes the first three chapters of his book to developing basic skills and addressing issues that are largely independent of specific models. Not surprisingly, he has a very comprehensive section on the therapeutic alliance and one of the best sections on split alliances (when, for example, the therapist has a strong relationship with one family member but not with another) I have seen in any text. He also addresses topics like how to be an empathic listener, learning to deal with the therapists own issues like therapist stress, transference and countertransference, personal therapy, and how best to use supervision. In fact, one of the real strengths of this volume is that in almost every chapter he has information on how the therapist can use supervision to address the issue at hand, as well as guidelines for supervisors.

Although a text for beginning therapists, this volume contains one of the most comprehensive discussions I have seen anywhere on dealing with the suicidal client and how to address issues of violence and potential violence, as well as duty to warn and reporting issues. Rather than relegating these issues to peripheral stature at the end of the volume, they are given a prominent place at the beginning – in part because research shows, for example, how widespread family violence is and how infrequently therapists ask about it directly.
During this first part of the volume the author focuses on working through the various stages of therapy in chronological order, beginning with the initial phone call and assessing the clients’ complaints and goals (Chapter 3), progressing to establishing and delivering the treatment plan (Chapter 4), evaluating adherence to the treatment plan and assessing treatment outcomes (Chapter 5), and termination (Chapter 6). Throughout, virtually all suggestions are research informed. Each section is also unusually thorough as Mead specifies, for example, every issue the aspiring therapist might encounter in an initial phone call.

What is unique about this section is that it includes the first call for “continuous” assessment and evaluation using reliable and valid instruments that I have seen in any training text. There is a growing body of evidence that just as “continuous” assessment has revolutionized medicine (e.g., physicians taking blood pressure readings at every consultation and recommending blood tests daily, or more often, if conditions warrant e.g., high blood sugar), so also continuous assessment has the capacity to revolutionize psychotherapy. Scholars like Anker, Duncan, and Sparks (2009) and Lambert, Hansen, and Finch (2001) have demonstrated that therapists who get session-by-session feedback using valid instruments get better results than those who do not, independent of theoretical orientation or presenting problem. Mead specifies that therapists use brief instruments regularly (like the Revised Dyadic Adjustment Scale for Couples (RDAS; Busby, Crane, Larsen, & Christensen, 1995)) and some at each session (like the Outcome Rating Scale (ORS; Miller, Duncan, Sorrell, and Brown, 2005)). Quite refreshing is that rather than just expecting the reader to track down these instruments, where possible many are included in his detailed sets of appendices.

Part II part of the book also contains another “first” for an MFT text. Mead offers two protocols for conducting empirically validated couple therapies – “Gottman Method Couples Therapy” and “Emotion Focused Therapy” with couples. These chapters offer session by session guidelines for implementing these therapies while also incorporating the guidelines for assessment, use of instruments, development of treatment plans, and so forth that Mead has laid out previously in the volume. These protocols are not a substitute for the model developer’s treatment manuals, but rather are guidelines regarding how to use them.

The third section of the volume is a detailed series of appendices that include either the assessment instruments themselves, or information regarding where they can be easily found. These appendices are not only exceptionally useful, but will also save the reader/clinician considerable time, since many are in the public domain and can be photocopied.

Taken as a whole, this book is not for the faint of heart. It is challenging – not in the sense of difficult to comprehend since it is clear and well-written – but because it is a call for clinicians to be rigorous. It is a challenge to marriage and family therapists to apply an evidence-based approach to their work not unlike what MFTs expect of the physicians to whom they take themselves and their families for treatment. It is a plea to assess thoroughly and to demonstrate progress and success with the best science available. It is a call for the field to mature beyond the “truth by assertion” offered by charismatic prophets. It is asking the field to come of age. Gene Mead would not question that there is “art” as well as “science” in therapy, but only that the former needs to be in service of the latter. I commend this book as an important contribution to the training literature. That Becoming a Marriage and Family Therapist was written and published, is a positive sign for the future of MFT.
Acknowledgments

This text grew out of the Brigham Young University Marriage and Therapy programs’ supervision courses that I taught for over forty years. I thank the University administration, faculty, and students for their many contributions. The administration provided the “Marriage and Family Therapy” program with outstanding facilities including consulting rooms with one-way-screens and audio and television recording equipment all of which greatly facilitated supervision of the student interns’ therapy work. The receptionists at the clinic front desk contributed by administering assessment instruments to the arriving clients. Faculty members gave support and helpful criticism and I especially want to thank Doctors Hugh Allred, Leslie Feinauer, James Harper, Joel Moss, and Robert Stahmann for their feedback over the years.

I am especially grateful to the several hundred student interns who allowed me to supervise them in their beginning work with their marriage and family clients. Together we evolved the therapist training program described in this text.

I give special thanks to the families that gave permission to observe their sessions both to me and to the doctoral student supervisors. Without the cooperation of the couples and families who came to the clinic the student interns would not have had the opportunity to learn to become marriage and family therapists.

The author and publisher gratefully acknowledge the permission granted to reproduce the copyright material in this book. I am grateful to the authors of the 563 works that contributed to this text. I thank John Wiley and Sons for permission to quote from Wingate, Joiner, Walker, and Rudd (2004) Empirically informed approaches to topics in suicide risk assessment, Behavioral Sciences & the Law, 22(5), 651–665. Special thanks for permission to use material for several tables in this book. Specifically:

1 Table 2.1 “Categories of suicide risk” is based on material from Joiner, Walker, Rudd, and Jobes (1999) and Wingate, Joiner, Walker, Rudd, and Jobes (2004).

2 Table 2.3 “Risk factors for partner, child, and elder mistreatment” is based on material from Choi and Mayer (2000), Kyriacou et al. (1999), Lachs, Williams, O’Brien, Hurst, and Horwitz, R. (1997), Pillemer and Finkelhor (1988), and Tolan, Gorman-Smith, and Henry (2006).


Every effort has been made to trace the copyright holders and to obtain their permission for the use of copyright material. The publisher apologizes for any errors or omissions in the above lists.
and would be grateful if notified of any corrections that should be incorporated in future reprints or editions of this book.

Special thanks to my editor Karen Shield at John Wiley Ltd. UK who patiently put up with my taking a year-and-a-half long hiatus to serve as a mental health advisor to the Church of Jesus Christ of Latter-day Saints missionaries in Japan and South Korea. Thanks also to Stan Wakefield who acted as an agent to help me connect to Wiley UK.

Finally, I want to acknowledge the support and encouragement from my wife Sherrill and our children Stanley, Marcia, and Christine.
Part I
Chapter 1

Becoming a Competent Marriage and Family Therapist

Introduction

This book is designed to help you make the transition from the classroom to the consulting room. In the classroom you have developed verbal and theoretical knowledge of how to do therapy. In the consulting room you will begin to change your verbal-theoretical knowledge into experiential knowledge. In the classroom you learned to respond to verbal descriptions of client behaviors. In the consulting room you will learn to respond to actual client behaviors in real time. You will begin to feel the responsibility of attempting to help clients deal with the complexities of their lives. Meeting clients for the first time is both exciting and frightening. In this effort you will not be alone. You will have the support and guidance of your supervisor who is an experienced therapist. Therefore, this text is also for supervisors. It will help supervisors provide the support and guidance new therapists need as they work to become competent therapists.

As a new therapist your goal is to become a competent entry-level therapist. Wampold (2001) stated that competent therapists have successful client outcomes. Therefore, your goal should be to help clients achieve their therapy goals. Your supervisor’s goals are to help you become a competent therapist while safeguarding the welfare of your clients. How can you help clients to have successful outcomes? Successful therapy appears to be a function of four factors that appear to be common to all models of therapy (Lambert & Barley, 2002).

The Role of Common Factors in Therapy Outcomes

Research over the past twenty years has found that about 80 percent of clients who undergo psychotherapy are better off than those who do not (Lambert & Barley, 2002). Research has also found that about 40–50 percent of couples and families who complete marital or family therapy have successful outcomes (Shadish & Baldwin, 2002). Why marital and family therapy should be found to be less successful than individual therapy is not known. One could speculate that the difficulty of building and maintaining multiple alliances in families may be a contributory factor (Blow, Sprengle, & Davis, 2007).

When individual therapy models are compared with each other none of the models have been found to be more efficacious than any other (Lambert & Barley, 2002). The same is true for
marriage and family therapy models. When they are compared head-to-head, no marriage or family therapy model is superior (Shadish & Baldwin, 2002, 2005).

There are a few noteworthy exceptions in which specific treatments have been found to be effective for specific classes of problems (Lambert & Barley, 2002). For example, exposure treatments for anxiety, avoidance, and rituals have been found to be superior to other forms of treatment (Lambert, 1992). Similarly, exposure techniques appear to play a significant role in the treatment of panic disorder with agoraphobia (Craske, 1999; Michelson & Marchione, 1991). Also there is considerable support for cognitive behavioral therapy (CBT) as an effective treatment for depression (Clark, Beck, & Alford, 1999). However, even in these specific treatments the common factors appear to play an important part.

Common factors contributions to successful client outcomes

According to the common factors literature there are four factors that make up the variance in therapy outcomes (Hubble, Duncan, & Miller, 1999; Sprenkle, Blow, & Dickey, 1999). The four factors are (1) the alliance, (2) what the clients bring to therapy, (3) the placebo effect, and (4) the treatment techniques. The alliance is the relationship between the clients and the therapist and makes up 30 percent of the therapy outcome variance. What the clients bring to therapy makes up approximately 40 percent of the variance (Lambert & Barley, 2002) and includes their presenting problems, their readiness to change, their social skills, and their support systems (Asay & Lambert, 1999). The third factor is the client’s expectations for a successful outcome, what some call the placebo effect of coming to therapy and makes up 15 percent of the outcome variance (Lambert & Barley, 2002). The fourth factor treatment techniques employed by the therapist are embodied in the therapy model used by the therapist. Therapist techniques are used to maintain the therapeutic conversation between the therapist and the clients (Frank & Frank, 1991, 2004). Treatment techniques are believed to make up the final 15 percent of the outcome variance. These four factors appear to be common to all models of therapy and seem to account for successful client outcomes in both individual psychotherapy (Lambert & Barley, 2002) and in marriage and family therapy (Sprenkle et al., 1999).

Two of these factors, what the clients bring to therapy and the placebo effect, appear to be primarily client factors and not directly open to manipulation by you the therapist. The remaining two factors, the alliance and therapy techniques are factors that you can influence.

Here I will deal with each of the common factors independently although in practice they are difficult to differentiate. For example, the placebo effect may contribute initially to the client’s trust in you thus facilitating the development of the alliance. Building and maintaining the alliance is related to how you employ the treatment techniques (Blow et al., 2007). It is difficult to differentiate the role of the treatment techniques from procedures that build the alliance. The alliance is said to consist of three elements, the clients’ trust in the therapist, the clients’ agreement with the therapist on the goals of therapy, and the clients’ agreement about the techniques needed to achieve their goals (Bordin, 1979). So, at the same time that you are working collaboratively with the clients to clarify and establish their goals they will begin to trust you. As you communicate respect and empathy and exercise care concerning their safety in the sessions, the clients come to trust that you are on their side, both as individuals and as a couple or family. In this way two of the elements of the alliance are being forged, first, agreement on goals and second, trust in you as their therapist.

Next you will propose a treatment plan tailored to fit the clients’ needs and goals. If the clients agree that the treatment is appropriate to help them achieve their goals then the third element of the alliance is being constructed which is agreement on the treatment methods or therapy model. Finally, the treatment model serves as a structure for a continuing conversation about the clients’ problems, needs, and goals while they formulate their solutions and change their behaviors and
relationships (Frank & Frank, 1991, 2004). Thus, while treatment techniques have been found to contribute only 15 percent to the outcome variance, that 15 percent is not trivial.

Although the factors labeled “what the clients bring to therapy” and “client expectations” do not appear to be open to direct manipulation by you as a therapist there are potentially several ways you can influence the clients’ perceptions of the alliance. These will be discussed at length in this chapter. Perhaps what is more important is that the delivery of the therapy techniques and the skill with which they are delivered is directly under your control. It has been shown that therapists vary in their therapy delivering skill (Luborsky et al., 1986) suggesting that therapists can learn how to deliver therapy more effectively. By improving your skills in delivering therapy, you will increase the probability that your clients will have successful outcomes (Blow et al., 2007).

The Therapeutic Alliance

As stated above, the therapy alliance has been found to account for approximately 30 percent of the total outcome variance (Asay & Lambert, 1999). The alliance consists of three factors: (a) the clients’ trust in, or bonding with, the therapist; (b) agreement between clients and therapist on the therapy goals; and (c) the clients’ agreement with the tasks in the treatment plan (Bordin, 1979; Heatherington & Freidlander, 1990; Johnson & Talitman, 1997; Pinsof & Catherall, 1986).

As a therapist you make a positive contribution to the therapy alliance by: (a) communicating respect, caring, and empathy (see Chapter 2); (b) helping clients clarify and establish their goals (see Chapter 3); (c) establishing treatment plans tailored to those goals (Chapter 3); and (d) dealing effectively with breaches in the alliance.

In individual psychotherapy you only need to be concerned with the alliance the client makes with you as the therapist. In family therapy you must be concerned about the alliance each family member makes with you (Friedlander, Escudero, & Heatherington, 2006; Pinsof, 1995). Family members may vary in their goals for therapy. Therefore, each family member will form her or his own alliance with the therapist. When family members’ differ in their alliance with the therapist, the alliance is said to be split (Beck, Friedlander, & Escudero, 2006; Thomas, Werner-Wilson, & Murphy; 2005). Pinsof and Catherall (1986) were the first to define a split alliance. Split alliances occur when one member of the family rates the alliance with the therapist high and another member of the family rates the alliance low. Split alliances may lead to clients deciding to withdraw from therapy before they have reached their goals.

The probable causes of split alliances

In family therapy there may be as many goals for coming to and for staying in therapy as there are family members in the room (Friedlander, Escudero, & Heatherington, 2006). Family members have already formed alliances between each other before they come to therapy. Alliances between family members are what Friedlander and colleagues (2006) call family allegiances and what Garfield (2004) calls family loyalty. Family members may vary in their sense of family unity from total enmeshment to wondering whether or not they intend to remain in the family. It should come as no surprise then that the alliances they form with the therapist vary (Friedlander Friedlander, Escudero, & Heatherington, 2006; Symonds & Horvath, 2004).

The causes of split alliances are not yet well understood. The family power structure may be one factor in split alliances. Differential power may be a function of differences in physical size and development or in role differences between partners and between parents and children. The power hierarchy in the family may make some members vulnerable to other members in terms
of psychological and physical aggression and even abuse (see Chapter 2). Therefore, some family members will be motivated to avoid family therapy and others may be motivated to come in self-defense. You will need to be sensitive to the power issues and be prepared to provide for the safety of each family member. Power differences may also occur between family members based on gender, race, education, and control of family finances.

There appears to be support for the idea that gender influences alliances however, the results are not consistent. Quinn, Dotson, and Jordon (1997) found that wives’ scores on an alliance scale predicted outcome while the husbands’ scores did not. On the other hand, Symonds and Horvath (2004) found that the relationship with the outcome was greater when the male’s alliance was stronger. They also found that the relationship between alliance and outcome was greater when both partners agreed on the strength of the alliance and when the strength of the alliance increased over the course of treatment. Knobloch-Fedders, Pinsof, and Mann (2004) found that individual psychological symptoms in the couple did not predict alliance formation. Similarly Mamodhoussen, Wright, Tremblay, and Poitras-Wright (2005) found that psychiatric symptoms did not predict the alliance but marital adjustment did. In both studies husband’s greater marital distress was a predictor of poor alliance. In the Knobloch-Fedders study women’s marital distress at intake and reports of family-of-origin issues predicted the tendency for a split alliance. However, in the Mamodhoussen study the husband’s marital adjustment and wife’s psychiatric symptoms were associated with split alliances.

Family secrets are another source of alliance difficulties in family therapy (Friedlander et al., 2006). Some family members fear that the secrets will come out while others worry that they will not. In these circumstances the issue of safety in the therapy sessions is a serious issue for family members and therefore for the therapist. As a therapist you must address concerns about safety in the therapy system from the beginning of therapy starting with the initial phone call (See Chapter 3).

It is likely that the therapist will be working with split alliances when spouses or family members have mixed motives, are concerned about differential power, and are concerned about family secrets. Heatherington and Friedlander (1990) and others (Mamodhoussen et al., 2005; Symonds & Horvath, 2004) have empirically verified the existence of split alliances between family members and the therapist. Symonds and Horvath found strong correlations between alliance and outcome when the partners agreed on the strength of the alliance and when the strength of the alliance increased from Session 1 to Session 3. Similarly, Safran, Muran, Samstag, and Stevens (2002) found evidence in individual psychotherapy that alliance predicts positive outcomes if found to be about average, as measured by alliance assessment instruments, or if the scores increase over the course of treatment.

Johnson, Wright, and Ketring (2002) found that in family therapy the alliance scores for family members predicted changes in psychiatric symptom distress for mothers, fathers, and adolescents. Agreement with the therapist on the therapy tasks domain of the alliance was the greatest predictor of the outcome for both mothers and adolescents while agreement on the therapy goals domain was greatest for fathers. Beck et al. (2006) also looked at alliances in families in a qualitative study with four cases. Interestingly, they found direct measures of split alliances with the therapist in only two of the four cases. In the study Beck et al. (2006) found that most of the problems centered on the lack of agreement between family members on goals for being in therapy, rather than disagreeing with the therapist on therapy goals. In two of the cases, which included husbands and fathers, most of the conflict appeared to be between spouses.

It seems clear that as a therapist you will need to guard against forming reciprocal emotional triangles with either partner (Bowen, 1978; Rait, 1998; Thomas et al., 2005). Triangles that form between you and any family member or groups of family members – such as aligning with the parents against an adolescent – seems to have the potential to form rifts in the alliances. In
addition, negativity or defensiveness on your part in response to client negativity may be harmful to the client-therapist alliance.

**Detecting rifts in the alliance**

Client confrontation of the therapist and client withdrawal from the therapist or the treatment program often signal a rupture in the alliance (Safran & Muran, 1996; Safran et al., 2002). Confrontation is observed when the client openly expresses hostility or anger toward you or the therapy process. The far more frequent signal of a rupture is client withdrawal. The client may withdraw from you, the therapy process, or from her or his own emotional processes. Examples of withdrawal include passivity or refusal to talk and coming late or missing sessions. There can be, of course, a mix of ways of expressing alliance rupture in which the client manifests angry or hostile withdrawal.

It would appear that a split alliance in couple or family therapy should be treated as a therapeutic rupture (Friedlander, Escudero, & Heatherington, 2006; Pinsof, 1995). In family therapy one family member may confront you or attack the therapy process while another family member may experience you or the process as positive and helpful. In a split alliance one family member may withdraw from the therapy process, from you, or from interaction with the other family members.

When there is a split alliance two factors are said to determine the strength of the split (Pinsof, 1994). The first is the intensity of the negative alliance of one family member balanced against the degree of positivity in another family member. The second factor is the power of the subsystem, such as the parental subsystem, to influence whether or not family members keep coming to therapy. For example, your strong positive alliance with an adolescent son may not be sufficient to balance a negative alliance with the parents. Pinsof (1994) suggests that you need to give careful attention to the alliance with the most powerful subsystem in an attempt to help the clients continue the therapy. However, this does not justify failure to attend to the alliance with the less powerful subsystems. Thomas et al. (2005) makes it clear that husbands and wives wield alliance power in different ways. Therefore, family therapists must be especially mindful of the alliance with each spouse and between the spouses.

**Learning to detect split alliances**

Alliance ruptures and split alliances occur frequently in therapy. It is therefore important that you become proficient at detecting and in repairing them (Safran et al., 2002). One way to learn to detect and repair split alliances is to assess the alliance at the end of each session. This is especially important in the first three sessions (Symonds & Horvath, 2004) although it remains important throughout the treatment as the alliance is constantly subject to change (Safran et al., 2002). Some therapists assess the alliance at the end of each session by asking something like, “Did I say or do anything in this session that offended you or bothered you in any way?” It takes a great deal of courage on your part to ask such questions and then to accept the feedback without defensiveness. Some therapists find it easier to use one of the many reliable and valid client self-report instruments such as the Session Rating Scale (SRS: Duncan et al., 2003), the System for Observing Family Therapy Alliances self-report form (SOFTA-s: Friedlander et al., 2006), and the Revised Helping Alliance Questionnaire-II (Haq-II: Luborsky et al., 1996). The SRS is recommended as it is short, just 4 items, takes only a minute or two to administer, and it is easily scored in session.
The SRS (Duncan et al., 2003) is a forced choice instrument with the choices separated by a 10 cm line. For example, the first item, entitled “Relationship,” states at the left end “I did not feel heard, understood, or respected.” The opposite end the line (at the 10 cm point) states, “I felt heard, understood, and respected.” Clients are asked to place a mark on the line close to the description that “best fits your experience.” As clients tend to rate their alliance with the therapist high, any mark at 9 cm or less should elicit a therapist enquiry. For example, if a client marked the “relationship” item above at 9 cm or less you might ask, “What happened or didn’t happen in this session that made you feel you were not heard, understood, or respected?” After listening carefully to the client’s reply you should immediately begin attempting to repair the breach by first accepting responsibility for the oversight, second by validating the client’s feelings and thoughts, and third by offering to make changes in subsequent sessions. For example, you might say something like, “I’m sorry I appeared to not be listening at times. You have every right to be offended by my behavior. I will make a greater effort to let you know that I really am listening in the next session. If I look like I’m not paying attention in the future will you tell me right when it happens? I really do want to make our time together as helpful as possible.” The issue should be entered in your case notes to serve as a reminder to change your behavior in the next session. Continuous use of the SRS will make early detection of alliance ruptures easier and facilitate your immediate attempts to repair the alliance.

Another way for you to learn to detect alliance breaches is to use the SOFTA-o which was developed for observers to evaluate therapy alliances (Friedlander, Escudero, Horvath et al., 2006). Friedlander, Escudero, Horvath et al. recommend that you and your supervisor observe your digitally or videotaped recorded sessions and rate each family member’s alliance. The SOFTA-o has a helpful training manual and an online support system to help you learn how to observe alliance breaches. You will increase your ability to recognize breaches in the alliance by reviewing the recordings of your sessions and discussing the clients’ alliance with your supervisor. You can greatly improve your skills as a therapist by frequently and consistently reviewing your videotapes just as athletes and performing artists benefit from reviewing videotapes of their performances.

**Interventions to repair ruptured alliances**

Safran and Muran (1996; Safran et al., 2002) found that therapists who are successful in repairing alliance ruptures recognized the clients’ withdrawal or negative responses earlier than therapists who were not successful. As soon as you detect a breach focus the clients’ attention on the behavior that indicated the rupture in the alliance. Recognize the clients’ expressions of negative feelings, validate those feelings, and then help them express and clarify their feelings. According to Safran et al. (2002) repair attempts generally consist of the therapist: (a) commenting in a nondefensive, noncritical way on the here-and-now communication; (b) accepting responsibility for the therapist’s cognitive, behavioral, and emotional responses to the communication; (c) expressing supporting and soothing behaviors toward the participants; and (d) making expressions of validation and appreciation. For example, if one family member expresses negative feelings toward you and the treatment program you should immediately stop and ask what happened in a noncritical, nonblaming way. You might say something like, “I’m sorry. Did I say or do something that offended you?” After the client explains you might say, “I can see how what I said may have sounded harsh. Let me say that again in a better way.”

Pinsof (1994) derived several techniques from psychoanalytic theory for repairing ruptures to the alliance. Pinsof recommends focusing on the marital couples’ individual and collective experiences of the therapist and the therapy experience. This recommendation fits with Safran and Muran’s (2004) finding that immediate focus on the experience in the session led to alliance repair. Pinsof also recommended changing the therapy context by seeing the spouses individually.
Pinsof and Catherall (1986) recommend focusing on the client or subsystem alliance with the most power in the relationship. This may include giving the most powerful member of the dyad more individual time. Beck et al. (2006) in a qualitative study of four cases found some evidence in two of the cases that split alliances were more a function of the family members’ differences in their family allegiance than in feelings about the therapist. These researchers divided the clients into family subunits for treatment as did Pinsof (1994). Beck et al. (2006) suggests that breaking the session down into subunits allows the therapist to provide a safe therapy context for everyone. However, one could equally well argue that the clients should be seen together to discuss their issues. Seeing the couple or family conjointly seems justified since the differences in the family members allegiance to each other may be the critical element in their split alliance. It seems plausible that family members will benefit from a conjoint conversation about their differing responses to (a) each other, (b) the therapist, (c) the therapy goals, and (d) the treatment interventions – even if this conversation is emotionally highly charged. In this conversation you may act as a coach, being careful not to reciprocate negativity and not to align with one family member or family subgroup against another.

Should you decide to divide the treatment into two or more separate units of the family be sure to review your policies for seeing individual family members in separate sessions before you divide them (see the extended discussion about seeing family members individually in Chapter 3). Important issues of confidentiality and triangulation should be carefully considered and discussed with the clients prior to entering into individual sessions.

**Summary: Establishing and maintaining the therapeutic alliance**

In summary, each family member’s perception of the alliance with the therapist appears to be an important element of successful outcomes. You can facilitate the alliance by communicating respect, care, and empathy while collaborating with the clients to establish the therapy goals and the treatment methods. You will need to attend to the safety needs of each member of the family by avoiding taking sides with one family member or family subunit over another. As Alexander and colleagues (2000) put it, each family member should leave the session feeling that you are on their side (Alexander, Pugh, Parsons, & Sexton, 2000). You can also facilitate the alliance by not reciprocating client negativity. Negativity toward the therapist or the treatment may be the result of a breach in the alliance and should be addressed as soon as it is detected. Another mark of a rift in the alliance is client’s avoidance or escape behavior, such as defensiveness, withdrawing from the therapy process during the session, and/or coming late to or missing sessions. You should confront – in a nondefensive, nonpunishing way – the behavior that is indicative of an alliance rupture as soon as it occurs in the session. Successful therapists make early detection and repair of alliance ruptures one of their hallmarks. Early detection of breaches in the alliance can be facilitated by administering an alliance rating instrument, such as the SRS (Duncan et al., 2003) at the end of each session.

**Box 1.1 Supervision and Split Alliances**

Supervisors should assist beginning therapists to recognize breaches in the therapy alliance and should support therapists’ efforts to repair alliance ruptures. It takes a great deal of courage on the part of therapist-interns to ask clients about any negative feelings they may be having toward the therapy and toward them as therapists. Therefore, if you detect a
potential breach in the alliance you should encourage the therapist-intern to identify and repair it. When the therapist does this the supervisor should make a point to congratulate the therapist on this accomplishment. The administration of an alliance instrument, such as the SRS (Duncan et al., 2003) at the end of each session should be encouraged as that will make it easier for therapist-interns to enquire about possible breaches in the alliance.

To help therapist-interns increase their skill at detecting alliance splits you may wish to review a recorded therapy session together using SOFTA-o (Friedlander, Escudero, Horvath et al., 2006). In this supervision session compare your observations with those of your therapist-intern. The goal should be to strengthen the intern’s skill in detecting alliance splits. By helping interns learn to detect and repair split alliances supervisors will be protecting the welfare of the clients while increasing the competence of the therapist-intern.

Marriage and Family Theories and Evidence-Based Marital and Family Therapy

Family therapists and counselors use therapy models as a vehicle to help clients to establish an alliance and to change from dysfunctional to more functional behavior. The question then becomes – which model should therapist-interns be taught? Individual psychotherapy has over 250 models (Lambert & Barley, 2002) and marriage and family therapy has generated nearly as many (Becvar, 2003). What criteria may be applied to facilitate the decision about which model to use?

The traditional theories of marriage and family therapy were developed by outstanding clinicians responding to specific classes of clients often with specific classes of needs (Becvar, 2003; Spenkle & Blow, 2004). For example, Minuchin’s structural model resulted from his treatment of blue-collar families with physically ill children (Minuchin, Montalvo, Guerney, Rosman, Schumer, 1967). Haley’s (1987) strategic therapy was designed for use with resistant clients. Bowen’s (1978) intergenerational model derived from his work with individuals struggling to overcome attachment issues with their families of origin. Feminist theory grew out of protest against gender oriented power differentials and domestic violence cases where the female victims were blamed (Avis, 1988). Collectively these models came to be known as systems models because they are based on the concept that families form an interpersonal relationship system. A system is a closed or semi-closed set of interacting relationships and the behavior of individual family member is said to be determined by circular causality and feedback within the system (Becvar, 2003). Systems theory has served the field well until recently.

Currently, however, health maintenance organizations, government agencies, and professional accrediting bodies are demanding that mental health services provide evidence of treatment efficacy, effectiveness, and efficiency (Crane, 1995; Hayes, Barlow, & Nelson-Gray, 1999). As a result there has been a turn toward evidence-based practice both in marriage and family therapy and in the mental health field in general (Margison et al., 2000; Patterson, Miller, Carnes, & Wilson, 2004; Weisz, Jensen-Doss, & Hawley, 2006).

Evidence-based models as an alternative to theory-based models

In contrast to the theory-based systems models of marital and family therapy discussed above there are a number of evidence-based models available. Evidence-based practice in mental health is reported to have started in the United Kingdom in the 1990s and has spread to other countries (Norcross, Beutler, & Levant, 2006a). The intent of evidence-based practice is to use the most