Establishing a Therapeutic Alliance in Family System Therapy

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Question

In Bowen's family systems therapy with one family member, it is important that the therapist does not engage the patient in a dependent relationship. In other words, the therapist should stay outside the emotional system of the patient, should not be triangled into it; yet, he has to be able to connect with the patient so that the latter will continue to come for therapy. How do you accomplish this difficult task?

Discussion

In family systems therapy, the task is always to connect with the family system rather than with the individual patient. This means that the therapist must try to bring into the context of the family system whatever information he obtains from the individual patient. This is accomplished by not responding to the information as such but by putting it back into the family system. In doing so, the emotional process operating in that particular family can become more quickly apparent to the therapist than if he responded to the content of the individual's information. In addition, this technique will enable the therapist to recognize circuits of family behavior patterns without ever seeing the entire family.

The art of connecting with the patient lies in choosing the issue most important for the patient when he comes in for therapy, and then connecting with that issue on a cognitive rather than on an emotional level. There are a few basic principles to consider in accomplishing this task of connecting with the patient on a cognitive level.

The first one is the decrease of anxiety. It is our belief that therapeutic measures that reduce the anxiety in the patient will enable him to approach his problem more successfully. There are several methods for doing this.

Since the narrow focus on the individual patient often causes anxiety, which then reinforces the symptom – a typical vicious cycle which is hard to break – we encourage the therapist to defocus the symptom by bringing it into context with the patient's emotional family field. This can be accomplished by asking questions such as: "Are you the only one in your family – including the extended family – who has problems with this particu-

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lar issue? How do other family members deal with this issue? What's the rule in your family about how one should deal with this issue or similar issues?" By doing this, the focus of interest will be removed from the patient and extended to the larger family system. This process is usually followed by a decrease in anxiety in the patient, due to removal of the pressure to look within himself for all the causes of the problem and all the answers to it. With the decrease in anxiety comes an increase in objectivity about the problem, an objectivity which can then lead to new insights and understandings which open the door for change. This decrease in anxiety is also experienced by the patient as relief, a circumstance which certainly facilitates a therapeutic alliance.

Another way of decreasing anxiety is to set the symptom in a larger frame of time and context, by asking questions such as: "When did you have more of the symptom? When did you have less? What was the difference in the circumstances? What other events are usually going on in your life when you have a more intense symptom? What is going on when you have a less intense one? Do you see any similarities in the circumstances? Are there any patterns to the process?"

Another technique for decreasing the anxiety concerning the symptom could involve the use of behavioral desensitization techniques.

The most important and basic technique of decreasing anxiety is for the therapist to relate to the patient and his symptoms in a non-anxious way. There are two elements which are extremely important in this technique. The first is that the therapist should not worry about either the patient or his symptom; the second is that the therapist should be careful to be aware of any possible aversive reaction of his own to the symptom. Both of these circumstances will result in the therapist's urgent need to change the symptom immediately. This pressured attitude of the therapist usually increases the patient's anxiety and thereby works against the therapy.

The second principle involves the therapist's goal of enabling the patient to be as independent and self-reliant as possible. The family systems approach has a definite educational component. In this therapy, the patient can gain understanding of the therapeutic process itself. He can even learn the technique of "defocusing" or "enlarging" the focus or "objectifying" the problem by asking himself questions similar to those asked by the therapist. This contrasts sharply with other family therapy techniques, e.g., strategic therapy, in which the therapist makes interventions or gives paradoxical prescriptions which the patient must follow blindly without understanding the therapeutic process. In that type of therapy the patient has to trust the therapist in blind faith without being able

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to learn the technique so that he can use it on his own. The educational process that we have described leads to an educational alliance which rests on a cognitive rather than an emotional level. This therapy, therefore, is an educational process rather than a purely therapeutic one in which a doctor treats a patient. The consequence is that the patient will become increasingly independent of the therapist, exploring and learning more on his own. He will be grateful to the therapist for the teaching, but he will be no more dependent on him than a student is on his teacher. He will become a student who has learned whatever he could learn and is moving into the world.

However, it is important to note the difficulties in this cognitive approach. If the therapist expands the focus too fast from the patient and his symptom without coming up with broader patterns that make sense to the patient, the patient might feel the therapist is not really interested in his problem and, therefore, not helpful. As soon as the therapist helps the patient to see some patterns, the patient becomes fascinated by the process and will usually be eager to learn more about it.

One major concern many people have with a family systems approach is our way of dealing with a patient's feelings; we are often seen as being cold or lacking empathy. Since the family systems therapist relates to emotional issues in an objective way, he treats feelings as he treats symptoms: he does not respond to them directly, thereby encouraging the patient to express them, but sets them into the context of the emotional family system. This certainly does not mean that feelings should be ignored, but that the therapist should be able to go beyond the feelings. The issue of how to deal with feelings is one of the most important differences between family systems therapy and other therapies. In family systems therapy, the therapist does not stay with the emotional symptom by putting it into a feeling concept such as "low self-esteem", "anger", "guilt", etc. He will acknowledge the emotional symptom, then he sets it into a larger context such as an interactional pattern between significant family members. He will ask questions such as: "How does your family react to your feelings? Is there anything they do that influences them? If anything does influence them, how can they make you feel better? Is anyone in your family aware of your intense reaction?" All these techniques are not an avoidance of the feelings by the therapist; they are defocusing techniques which are meant to decrease anxiety and enhance a learning process. A final and cogent point is that this technique requires, from the therapist, a low level of anxiety about these emotional issues. If the therapist handles the above mentioned techniques skillfully, the

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patient will perceive the therapist as not being cold or indifferent but rather as being objective.

In summary, we would say that methods which can facilitate the therapeutic alliance by decreasing anxiety are the following: placing the individual within the context of his emotional system, enhancing the learning process of the patient, and translating emotional concepts into interactional patterns.

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