



Leeds Systemic Family Therapy Manual

**Ms. Helen Pote
Dr. Peter Stratton
Prof. David Cottrell
Ms. Paula Boston
Prof. David Shapiro
Ms Helga Hanks**

**Leeds Family Therapy & Research Centre
School of Psychology
University of Leeds
Leeds, LS2 9JT**

This manual was developed through an **MRC Small Project Grant**,
Number G9700249. Principle Investigator Dr. P. Stratton.
Please refer to as: Pote, H., Stratton, P., Cottrell, D., Boston, P., Shapiro, D., and
Hanks, H. (2000). *The Leeds Systemic Family Therapy Manual*, Leeds, LFTRC.
© No part of this document should be reprinted without the permission of the authors.

Table of Contents

1. Introduction	6
1.1 Origins of the Manual	6
1.2 Aims and applicability of the manual	6
1.3 Notes on use of manual	7
1.4 Ethical and Culturally Sensitive Practice	8
1.5 Clinical Examples	8
2. Guiding Principles	9
2.1 Systems Focus	9
2.2 Circularity	9
2.3 Connections and Patterns	9
2.4 Narratives and Language	10
2.5 Constructivism	10
2.6 Social Constructionism	10
2.7 Cultural Context	10
2.8 Power	10
2.9 Co-constructed therapy	11
2.10 Self-Reflexivity	11
2.11 Strengths and Solutions	11
3. Outline of Therapeutic Change	12
3.1 Models of Therapeutic Change	12
3.2 Overview of Specific Goals	13
4. Outline of Therapist Interventions	14
4.1 Linear Questioning	14
4.2 Circular Questions	14
4.3 Statements	15
4.4 Reflecting Teams	16
4.5 Child Centred Interventions	18

5. Therapeutic Setting	19
5.1 Convening Sessions	19
5.2 Team	19
5.3 Video	20
5.4 Pre-therapy Preparation	20
5.5 Pre and Post Session Preparation	21
5.6 Correspondence	22
5.7 Case Notes	22
5.8 Session Notes	22
6. Initial sessions	23
6.1 Outline Therapy Boundaries & Structure	23
6.2 Engage and Involve all family members	24
6.3 Gather and Clarify Information	25
6.4 Establish Goals and Objectives of Therapy	25
✓ Initial Session Checklist for Therapists	26
7. Middle sessions	27
7.1 Develop engagement	27
7.2 Gather Information and Focus Discussion	27
7.3 Identify & Explore Beliefs	28
7.4 Work towards change at the level of behaviours and beliefs	30
7.5 Return to Objectives and Goals of Therapy	37
✓ Middle Sessions Checklist for Therapists	38
8. End sessions	39
8.1 Gather Information and Focus Discussion	39
8.2 Continue to work towards change at the level of behaviours and beliefs	40
8.3 Develop family understanding about behaviours and beliefs	41
8.4 Collaborative ending decisions	41
8.5 Review the process of therapy	42
✓ End Session Checklist for Therapists	42

9. Indirect Work	43
9.1 Child Protection	43
9.2 Clarifying therapy with referrer present	43
9.3 Identifying network and clarifying relationships	43
9.4 Assessing risk	44
9.5 Correspondence	44
10. Proscribed Practices	45
10.1 Advice	45
10.2 Interpretation	45
10.3 Un-transparent/Closed Practice	45
10.4 Therapist monologues	45
10.5 Consistently siding with one person	45
10.6 Working in the transference	46
10.7 Inattention to use of language	46
10.8 Reflections	46
10.9 Polarised position	46
10.10 Sticking in one time frame	46
10.11 Agreeing / not challenging ideas	46
10.12 Ignoring information that contradicts hypothesis	46
10.13 Dismissing ideas	47
10.14 Inappropriate affect	47
10.15 Ignoring family affect	47
10.16 Ignoring difference	47

Appendices

Appendix 1: Sample Appointment Letter	48
Appendix II: Sample Video Consent Form	49
Appendix III: Sample Referrer letter	50
Appendix IV: Post-assessment letter to referrer	51
Appendix V: Closing letter to referrer	52

Figures

Figure 1: Models of Therapeutic Change	12
---	-----------

Tables

Table 1: Perceptions that are helpful in achieving change	13
--	-----------

1. Introduction

1.1 Origins of the Manual

The manual was developed through a research project funded by the Medical Research Council. The team developing the manual comprised of a group of experienced family therapists working at Leeds Family Therapy & Research Centre (LFTRC). LFTRC is a centre working systemically with individuals, couples and families across the age span, as well as with professional systems.

The therapists contributing to this manual have historically been influenced by Milan Systemic family therapy models, and would now describe their practice as being influenced by Post-Milan and Narrative Models.

1.2 Aims and applicability of the manual

The manual is principally designed as a research tool for outcome studies in which the effectiveness of systemic therapy can be assessed. It therefore aims to offer a framework and guidelines for the implementation of systemic family therapy, so that therapists can offer a unified version of therapy, with some flexibility to express their own creativity.

For this purpose the manual should be used in conjunction with the accompanying adherence protocol. This is designed to assess the degree to which therapists are able to adhere to the methods outlined throughout the manual.

For research purposes the manual is designed for use by trained family therapists or other trained therapists with experience in family therapy. The manual's function is to guide therapeutic work with families in a clinic setting. Therapists using the manual will be expected to be working as part of a systemic family therapy team. Details on the composition of therapy teams are outlined later. **v Section 5.2**

The manual can also be used less formally as a framework for training and supervision, in developing skills for trainee family therapists.

1.3 Notes on use of manual

As with any interpersonally focused therapy, systemic family therapy does not follow a rigidly prescribed treatment sequence (Lambert & Ogles 1988). In using the manual therapists should consider the following guidelines:

- Therapists should first become familiar with the guiding principles which will influence all aspects of the therapy that they carry out using this manual. They should consider the guiding principles which are influencing them currently and the connections they make between these principles. **v Section 2.**
- They should then consider the section concerning models of change, and consider the model of change that is influencing their own therapeutic practice. **v Section 3.**
- After these more theoretical aspects have been addressed, the therapist should begin to consider the general interventions used, thinking carefully about the descriptions of these interventions, and how they may translate into their own practice. **v Section 4.**
- The manual then turns to guidelines for convening sessions, and setting up the therapy itself. Therapists should therefore begin to follow the guidelines of the manual from the moment they take referrals, in order to consider systemic issues in convening therapy. **v Section 5.**
- Therapists should then use the manual to more specifically guide therapy sessions, reading the practical guidelines outlined for the beginning middle and end of therapy, and following the goals defined for each of these stages. Therapists' checklists are provided at the end of each of these sections to help therapists consider whether they have covered all aspects of the guidelines. **v Sections 6, 7, & 8.**
- Therapists should go on to consider the aspects of indirect work that support the family therapy which should still be managed following the systemic guiding principles. **v Section 9.**
- Finally, therapists should consider the proscribed practices which should not form a significant proportion of their work, and refer back to these during the course of therapy to ensure proscribed practices do not emerge during the course of therapy. **v Section 10.**

This manual has an accompanying questionnaire for therapists and an adherence protocol to assess the degree to which therapist practice reflects that of the manual. This may be used as a personal check for therapists or trainers using the manual, or more formally by an independent researcher to assess adherence when the manual is being used as a research tool.

1.4 Ethical & Culturally Sensitive Practice

In using this manual therapists should pay keen attention to ensuring their practice is both ethical and culturally sensitive. Their practice should comply with the Association for Family Therapy and Systemic Practice (AFT): Code of Conduct and Ethical Guidelines. Therapists should remain curious and open minded in working with families, and this may be especially important where the individuals/families are of a different gender, cultural or societal background to that of the therapist. Care should be taken in the assumptions and agendas therapists develop during therapy in this regard.

1.5 Clinical Examples

All of the clinical material used in this manual has been adapted from extracts of therapy undertaken at Leeds Family Therapy & Research Centre. Identifying details have been removed from the material, and the dialogue modified to protect confidentiality. We would like to thank all of the families and therapists who have given permission for the therapy they undertook to be used for research. Without this permission the research project to develop this manual would not have been possible.

2. Guiding Principles

These principles are based at the level of theory, and should be used to guide therapists' practice whilst using this manual in work with families. Therapists should be familiar with all of the principles though they may privilege different principles according to their current interests and the needs of the family with which they are working. The therapist should consider the principles flexibly and decide which might best fit with the issues with which the family are struggling and the therapists own current constructions. The principle of self-reflexivity may be particular helpful in enabling the therapist to reach this. **vSection 2.10**

In devising this manual therapists considered their own constructions of how these principles might connect. Therapists should consider for themselves the connections they are currently making between these principles and the effect this may have on their work with families.

2.1 Systems Focus

In working systemically the central focus should be upon the system rather than the individual, particularly in relation to the difficulties and issues that the family system brings to therapy. The system may usefully be thought of as the household or a wider family system, and may include friends, people in institutions (school, work, church). A consistent view is that these difficulties do not arise within individuals but in the relationships, interactions and language that develop between individuals.

2.2 Circularity

Patterns of behaviour develop within systems, which are repetitive and circular in nature and also constantly evolving. Behaviour and beliefs that are perceived as difficulties will also therefore develop in a circular fashion, being affected by and affecting all members of the system.

2.3 Connections and Patterns

In understanding relationships and difficulties within systems it will be important for the therapist to consider the connections between circular patterns of behaviour, and the connections between the beliefs and behaviours within systems. The process of therapy should enable family members to consider these connections from new and/or different perspectives.

2.4 Narratives and Language

Behaviours and beliefs form the basis of stories or narratives, which are constructed by, around, and between individuals and the system itself. The language that is used to describe these narratives and the interactions between individuals constructs the reality of their everyday lives. The stories that people live often match the stories that are told about individuals, but at times when stories lived and stories told are incongruous change may occur, at the levels of lived behaviours and/or the construction of new narratives.

2.5 Constructivism

This is the idea that people form autonomous meaning systems and will interpret and make sense of information from this frame of reference. In social interactions understanding is constrained and affected by this meaning system, and people cannot make assumptions about what meaning will be attributed to the information they offer/contribute to others. Thus there is only the possibility of perturbing other people's meaning systems.

2.6 Social Constructionism

In working with systems in the process of change at the level of behaviour or narratives, it will be important to consider ideas of social constructionism. Relevant is the idea that meaning is created in the social interactions that take place between people and is thus context dependent and constantly changing, this takes precedence over the concept of a single external reality.

2.7 Cultural Context

The therapist should consider the importance of context, in relation to the cultural meanings and narratives within which people live their lives, including issues of race, gender, disability and class etc. The relationship between these narratives, the therapeutic relationship and its context, as well as the wider context for the therapeutic team and the family should be an important consideration at the point of referral and throughout the therapy.

2.8 Power

The therapist should take a reflexive stance in relation to the power differentials that exist within the therapeutic relationship, and within the family relationships.

2.9 Co-constructed therapy

In therapeutic interactions reality is co-constructed between the therapist (and team) and the people with whom they meet. They form part of the same system, and share responsibility for change and the process of therapy. Particular attention should thus be paid to the contributions that all members of the therapeutic system make in the process of change.

2.10 Self-Reflexivity

The therapist should aim to apply systemic thinking to themselves and thus reject any thinking about families and their processes that does not also apply to therapists and therapy. Self-reflexivity focuses especially on the effect of the therapy process on the therapist and the way that this is a source of (resource for) change in the family. In order to use self-reflexivity it will be necessary for the therapist to be alert to their own constructions, functioning and prejudices so that they can use their self effectively with the family.

2.11 Strengths and Solutions

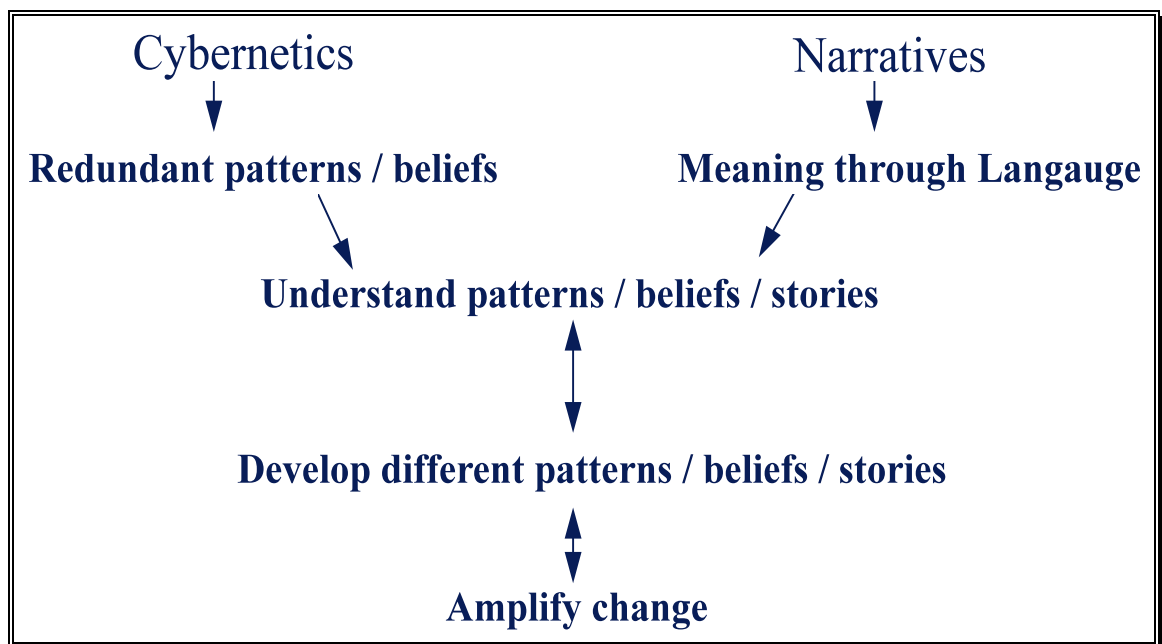
The therapist should take a non-pathologising, positive view of the family system, and the current difficulties they are struggling with. A family system that enters the therapeutic system should be considered as a system that owns a wealth of strengths and solutions in the face of difficult situations. It is important for the therapist to recognise that there is a multi-versa of possibilities available for each family in the process of change, and the family themselves will be in the best position to generate suitable solutions. The therapist can facilitate this process by attending to the strengths and solutions in the stories that the family system brings to therapy.

3. Outline of Therapeutic Change

3.1 Models of Therapeutic Change

In systemic work many different models of change have been hypothesised. In using this manual therapists should consider the model of change outlined in Figure 1.

Figure 1. Model of Therapeutic Change



Therapists are working with families to understand the patterns of behaviour, beliefs or stories that have developed in family systems, and the wider context in which they live. Through the process of understanding these behaviour patterns, beliefs or stories, therapists will begin to introduce new or different information. Therapists may also use active strategies to introduce this new information. The information will affect the development of behavioural patterns, beliefs and stories and the influence they have on the family. It therefore helps the family to develop new perceptions or actions that they can use to tackle the difficulties with which they are struggling. New perceptions that are often helpful to families in achieving change, are outlined in Table 1. Once change is beginning to occur, therapists highlight this process to families, enabling them to develop further changes and develop their understanding of how change was possible. This will develop the family's resources in coping with future struggles.

It will be important for therapists to consider the model of change with which they are currently working and consider what aspects of this model of change they are currently privileging. What is their overall aim during the process of therapy?

Table 1: Perceptions that are helpful in achieving change

Initial Perception of Struggles	Developing Perception of Struggles
Located in the individual	Arising from the system
Uncontrollable/Unchangeable	Temporary
Intrinsic	Accidental
Blameworthy	Redundant
Sinister	Well meaning but mistaken
Linear	Circular
Partisan	Neutral

3.2 Overview of Specific Goals

Within each stage of therapy there are also specific goals that the therapist should be considering. The goals are listed here and elaborated within sections 6, 7 & 8.

Goals during initial session

1. Outline Therapy Boundaries & Structure
2. Engage and Involve all family members
3. Gather and Clarify Information
4. Establish Goals and Objectives of Therapy

Goals during middle sessions

1. Develop and Monitor Engagement
2. Gather Information and Focus Discussion
3. Identify & Explore Beliefs
4. Work towards change at the level of beliefs and behaviours
5. Return to Objectives and Goals of Therapy

Goals during ending sessions

1. Gather Information and Focus Discussion
2. Continue to work towards change at the level of behaviours and beliefs
3. Develop family understanding about behaviours and beliefs
4. Secure Collaborative Decision re: Ending
5. Review the process of therapy

4. Outline of Therapist Interventions

Therapists have a range of interventions open to them in working with the family to

co-create change. The 4 interventions listed below are those which are most commonly used in systemic family therapy and should be used in therapist's practice throughout the course of therapy. The degree to which each of these interventions will be used will vary throughout the course of therapy, and therapists' should follow the guidelines below regarding this. Additional interventions that are used less frequently are highlighted in the appropriate stage of therapy. ⇒ **Sections 6, 7, & 8.**

4.1 Linear Questioning

Direct linear questions can often be useful in gathering information from the system and clarifying information given, especially at the beginning of therapy. Linear questions can be built up in a circular manner around the family by asking different family members the same/similar linear questions.

Linear Questions Examples

- How old are you?
- Where do you go to school?
- What do you do if you are upset?
- What do you do after that?

4.2 Circular Questions

Circular questions are aimed at looking at difference and therefore are a way of introducing new information into the system. They are effective at illuminating the interconnectedness of the family sub-systems and ideas. A variety of circular questions may be used by the therapist as outlined in Table 2. These may be more or less appropriate as therapy progresses.

The use of particular types of circular questioning at different stages of the therapy will be highlighted throughout the manual. The time scale of circular questions often changes fluidly between the past, present, future.

Circular Question Examples	
Type of Circular Question	Examples
About another's state / behaviour / beliefs	What do you think John is feeling? What do you think John is feeling when he shouts at you? What ideas do you think John might have about that?
Offering alternative perspectives	What does John think of your school performance? If I asked a teacher what would they say about it?
About relationships - direct - indirect	Do the girls really dislike each other? How do the children react when they see you arguing?
Circular Definitions	When you and John raise your voices and Jill starts crying what does John do then?
About possible futures	What will you think in 5 years time? Miracle question: Imagine you woke up tomorrow morning and all the difficulties you were experiencing currently had disappeared, how would things be different? What effect would that have upon your relationship with x?
Ranking	Who is most likely to get upset when father is away, and who next is most upset? On a scale of one to ten, how close do you think James and Sue feel when they argue?

Though many family members will be able to answer circular questions, and think about information in a circular manner, younger children or those with developmental difficulties, may find it cognitively impossible to view events from another person's perspective.

v Section 4.5

4.3 Statements

Statements are used by the therapist for 3 main functions:

- To clarify and acknowledge a communication from the family
- To comment on the position or emotional state of a member of the family
- To introduce therapist/team ideas, directly or in the form of a reflecting team.

vSection 4.4

In using statements therapists should ensure that they are not of long duration, and do

not become therapist monologues. Statements should also be delivered in such a manner that they are open to question or comment from the family and not viewed as conclusive statements. Statements are sometimes used as a way of organising information before a question is formulated to the family.

Statement Examples

- So let me make sure I have understood this, you feel if you didn't go out at all, your mum and dad would feel reassured that you would be safe. Have I got that right?
- I can see this is very upsetting, and remains an area of great distress for you. Who would be most likely to comfort you when you are feeling like this?
- You were talking a lot about trust, and about how sometimes you had struggled with developing trust as a child, and later as an adult. How much do you feel trust is around now in your relationship with John?

4.4 Reflecting Teams

Reflecting teams aim to introduce the therapy team's ideas into the therapy in a reflexive manner. There are many different models for reflecting teams, and in turn these are often adapted to suit the wishes and needs of the family in therapy. A general model for introducing and implementing reflecting teams is outlined below.

1. Reflecting teams can be introduced during the therapy session or at the end of the session.
2. The format of the reflecting team should be negotiated with the family.
3. The reflecting team may consist of some or all of the therapy team as seems appropriate relative to the size of the team and wishes of the family.
4. The family should be offered a range of formats including:
 - Reflecting team joining family and therapist in room.
 - Family and therapist observing reflecting team through the one way screen.
5. In offering their reflections to the family, team members should ensure they:
 - are respectful of family, therapist and team members,
 - hold a tentative and curious stance,
 - stay connected to the ideas of the previous contributor,
 - stay connected with the language used by the family,
 - use age appropriate language,
 - do not overwhelm the family with too many ideas,
 - keep the duration of the reflecting team to no more than 10 minutes.
6. The therapist should take responsibility for monitoring the effect of the reflecting team on the family.

7. The family should always be given the opportunity to offer their comments on the therapy team's reflections and ideas.
8. Feedback should be gained from the family about how comfortable and useful they found the process of the reflecting team, and the ideas the reflecting team shared.

Reflecting Team Example

A reflecting team is used at the end of a session with a father, stepmother, and their two teenage children. Much of the session has been focused on the difficulties the parents are experiencing in setting consistent boundaries for the children, especially as they have different parenting styles. They have touched on the transition to becoming a stepfamily.

RT1: I suppose what struck me in listening to the discussion today was how much Jean and John seem to have been thinking about pulling together as parents to help give Jack and Jodie clear boundaries of what they can and can't do in this family, without wanting to come down too hard on their freedom.

RT2: I was wondering how this pulling together process is affected by the fact that John had to do a lot of the decision making and parenting on his own for a number of years. Does it feel like a welcome relief to share things with Jean, or does the extra negotiating make it harder?

RT3: I suppose that would depend on what are the family's ideas about sharing out roles. I mean I was wondering whether they see the role of a stepparent as being any different from that of a parent in their family.

RT1: Yes sometimes the roles can be quite different, each one having its pros and cons. Sometimes a stepparent can bring a fresh perspective on things, take a step back and look at things in a different way, like Jean felt she often did. A parent might enjoy a special relationship of understanding because they have been closer to the child for longer. It may be that these differences could be used to complement each other.

RT3: I was thinking these things might be influenced a lot by gender, because Jean was saying she and Jodie have developed a closer relationship, partly because they were both women, and there were different expectations of the things Jean might be able to do as a step-mum.

RT2: It feels like these things take time to negotiate though, and I wonder if this period of negotiation is what the family are still struggling with, because it might take longer when the children are teenagers, and have plenty of ideas themselves about how things should be.

RT1: I wondered what ideas the family had of how to take this negotiation further, if it is something they feel might be worthwhile pursuing. Is it something they would like to discuss here, with us, or do they feel the negotiation will just evolve naturally?

Th: Perhaps we can leave it there then, and I will take your ideas up with the family.

4.5 Child Centred Interventions

It will be important for therapists to bear in mind the needs of children within therapy session. Interventions will need to be tailored to fit their development level, both cognitively and emotionally. Particularly:

- The process and implicit rules of therapy may be particularly confusing and anxiety provoking for children. Engagement should therefore focus on aspects of the world which the child is familiar or is likely to enjoy. Therapists should use a friendly manner, and try not to raise issues which are likely to provoke anxiety. It may also be necessary for therapists to clearly and explicitly explain parts of the therapeutic process which children may find confusing.
- Questions will need to be adapted so that children can understand the meaning of questions and the form of answers that are required. This may require therapist's to give concrete examples or use names of individuals to whom they are referring. This is particularly relevant for circular questions which require respondents to take another's perspective. **ν Section 4.2**
- Children are likely to use multiple channels for communication. It is important for therapists not to rely solely on verbal channels in communicating with children. Drawings, play, and puppetry may all be helpful in enabling children to communicate their ideas, and therapists should be comfortable in using these methods with children.

5. Therapeutic Setting

5.1 Convening Sessions

In setting up the initial therapy session, therapists should begin by discussing the referral information within the therapy team. In deciding whom to invite to the first session attention should be paid to the following factors:

- Who is living in the household?
- Who else is mentioned as important members of the family system?
- Recent family life events, that may affect attendance e.g. childbirth / separation.
- Is further information required from referrers before therapy can commence?
- What professional systems are involved with the family? In relation to:
 - i. The presenting issues.
 - ii. Other issues, such as child protection.
- Would it be helpful to initiate a professional / network meeting prior to the therapy commencing?

Therapists should first write to the family, using the letter template provided. **v Appendix I.**

A follow up phone call should then be made one week before the initial session to discuss the therapy. As it is likely that the therapist will only speak to one member of the family during this phonecall, therapists should ask whoever they speak to, to convey the message to the rest of the family. The topics to be covered in the phone call are:

- Team working
- Attendance issues, who will be coming, how to get there, and ambivalence about attending.
- Therapist's interest in hearing everyone's ideas
- Video recording
- Confidentiality

5.2 Team

The team within which you are working should comply with the following guidelines:

- Include at least two qualified family therapists (eligible for UKCP registration)
- One of the qualified therapists should meet with the family whilst the other forms part of the observing team.
- Team members should have read and incorporated the guiding principles into their thinking. **v Section 2**
- Teams should include therapist and family activities in their observations.
- Teams should have at least one method for observing the therapist, e.g. one way mirror, in room observation
- Teams should have at least one method of communication between team and therapist, e.g. telephone, earbug, interruptions.

5.3 Video

There should be capacity to video therapy sessions and permission to video therapeutic work should be sought from the family in a manner which clearly discusses the video permission they are granting. **v Section 6.1**

Permission should be confirmed by using the form provided. **v Appendix II.**

5.4 Pre-therapy preparation

In preparing for the first session the therapist and the team should meet for at least 15 minutes before the session begins and address the following issues:

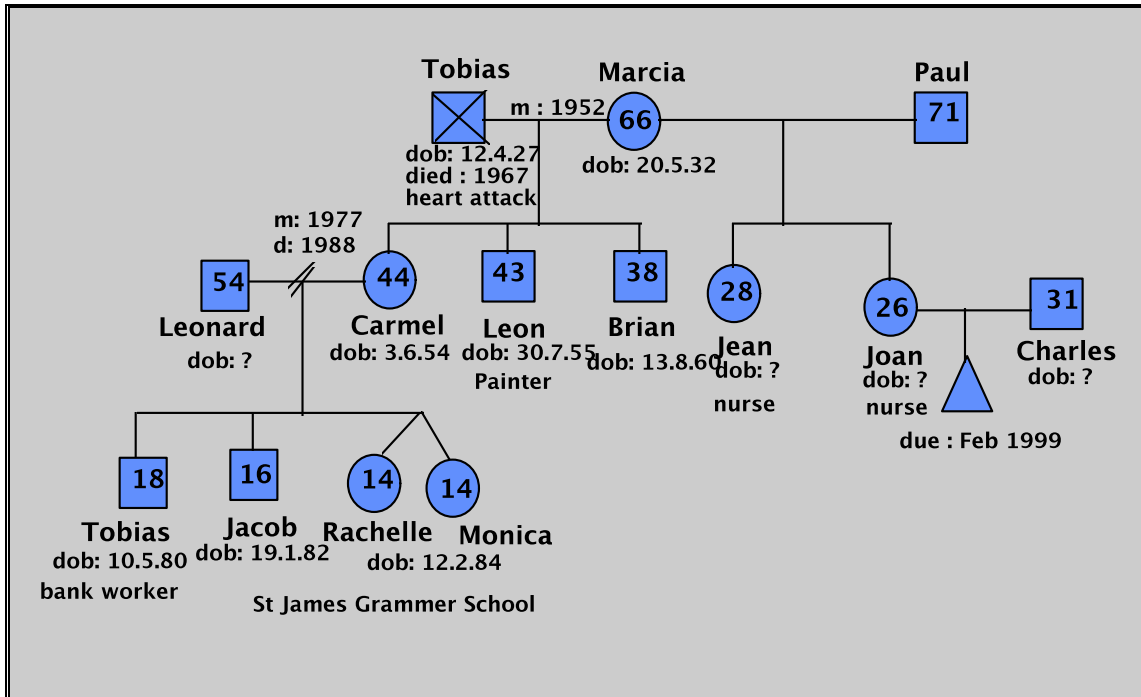
- Construct a genogram from referral information **v Genogram example**
- Summarise the main themes from the referral
- Consider the recent life events of the family
- Consider difficulties which may arise around engagement and how to address these
- Consider broader system issues, and define who is in the network
- Brainstorm themes/hypotheses/formulations which may be relevant to the family

Genograms

Genograms are a means to visually conceptualise the family and wider system, in terms of its members and relationships. They should include the following information:

- All members of the family system, including adopted/fostered members
- Delineation of the household
- All members of the wider system
- Dates of birth
- Deaths, with dates
- Partnerships and marriages, with dates
- Separations and divorces, with dates
- Pregnancies, miscarriages, and terminations, with dates
- Occupations / Schooling

Any information that is missing from the referral information should be noted and enquired about during the initial session of therapy.



5.5 Pre & Post Session Preparation

The therapist and therapy team should allow 15 minutes before and after each session to prepare for their meeting with the family and review the progress of therapy. Issues to be addressed in these discussions should include:

Pre-Session

- Summary of the main themes from previous session
- Information which requires clarification from previous session
- Between session contact the therapist has had with the family/wider system
- The current formulation/themes/hypothesis of the issues with which the family are bringing
- Ways forward for the current session which are being considered
- Any team – therapist issues which need to be addressed
- Any family – family/team issues which need to be addressed

Post-session

- Review of main interventions and family's response
- Ideas for future sessions, themes/issues to follow up,
E.g. narrative prompts, unexplored areas, facts to check
- Feedback to therapist of team observations
- Therapist's reflections on issues evoked for them by the session
- Review of important information shared, e.g. life events, elements of genogram

5.6 Correspondence

Letters should be used throughout therapy to maintain contact with the family system

and the wider network, as illustrated in this manual. **v Appendices I, III, IV, V.** Throughout this contact, the team's writing of the letters should always consider the guiding principles outlined in Section 2. Particularly important are issues of connecting with the whole system and not locating pathology within individuals. Particular attention to the language used will be important so that correspondence can be both easily understood, and reflect the contributions of the family to therapy.

5.7 Case notes

All written records should be non-pejorative, legible, dated, signed, with no abbreviations. Alterations and Corrections should be clearly marked and signed.

Case notes should include:

- Family information sheet
- Genogram
- Referral information/letter
- All other written communications to and from the centre
- Record of attendance
- Sessions notes
- Notes on telephone contacts to and from the centre

5.8 Session notes

The therapy team should make session notes for each meeting between the therapist and family/wider system. In this way case notes form an observational record of the process of therapy.

Session notes should include :

- Date and number of session
- Who attended therapy
- Therapist/Team member names
- Main themes of the session – including key language used by family
- Team observations – clearly labelled as impressions
- Record of interventions
- Key points/ideas/decisions to follow up in later sessions

Team members should record session notes on the record form provided.

⇒ **Appendix VI**

6. Initial sessions

Initial sessions of therapy consist of the first and second session of therapy. If a family seems well engaged, and if all of the goals for initial sessions have been covered during the first session, therapists may proceed to the goals for middle session. v Section 7. If this is not the case therapists' should continue to focus on the goals for initial session for a second session.

Goals during initial session

1. Outline Therapy Boundaries & Structure
2. Engage and Involve all family members
3. Gather and Clarify Information
4. Establish Goals and Objectives of Therapy

6.1. Outline Therapy Boundaries & Structure

During the initial stages of therapy it is important for the therapist to set the boundaries of therapy by sharing some information with the family / professional system which informs them about the process of therapy, and orientates them to the first meeting. This information is most easily shared by simple statements made by the therapist, these should include:

- **Introductions**

The therapist should introduce himself or herself as a team member and explain the role and context within which they work (the team and the centre).

- **Team working**

The therapist should explain that they work as part of a team, and that the team's role is to generate ideas and help the therapist understand the family / system. The therapist should explain how many team members there are, and the professional background of the team members. The technical equipment used should be explained including the use of the one way screen / phone / earbug.

- **Video**

The therapist should explain that family sessions are usually videod, but that the cameras are NOT yet switched on. The purpose of the filming (research / review) should be explicitly stated, as should the storage of videotapes, and who has access to the tapes.

The choice of whether to proceed with video should then be given, and the forms completed at the end of the meeting, giving the family a chance to decide then that the video can be erased. v **Appendix II**

- **Confidentiality**

The confidentiality of the videotapes and any information discussed in the session should be outlined. Specific statements about the boundaries of confidentiality should be made in relation to other systems, and with regard to child protection issues.

- **Structure of the session**

Information should be given on the length of the meeting, the breaks, and the use of team feedback through messages or reflecting teams. Explain that during the break, videoing will stop and the screen will be covered.

- **Structure of therapy**

Explain that if the family/team decide to meet again, that the meetings will be approximately every 4 weeks, on the same day, and the same place. Explain that the length of therapy will be decided together by the family / team in accordance with their needs and wishes.

- **Questions**

Time should then be spent giving the family an opportunity to ask questions and meet the team. Agreement to proceed with videoing should be confirmed, and the family informed that the video will now be switched on.

6.2 Engage and Involve all family members

- **Supportive environment:** Initially it is very important for the therapist to provide a warm, supportive and empathic environment, to increase trust and rapport and to build the therapeutic relationship. The therapist must work to help the family feel understood, accepted, comfortable and less anxious. This may include making the room comfortable and safe for younger children, and making it clear they are free to play/draw during the session.
- **Hear from everyone:** Therapists should try to hear from all members of the system/family, initially connecting with them all at an individual level, and assessing the level of contribution they feel they are able to make to the discussion, from either verbal or non-verbal cues. The therapist should try to make sure that everyone in the system is able to contribute to the discussion if they wish.
- **Neutrality:** The therapist is trying not only to hear everyone's views but also to establish their interest in different perspectives that may be held within the system. At this point unless serious concerns arise regarding safety/confidentiality the therapist should remain neutral to the difficulties and issues that the family are presenting and their views about them.

6.3 Gather and Clarify Information

Information should be gathered by the therapist to orientate them to the system and enable them to hear more about the issues the family is bringing to therapy. Information should be obtained on the following topics:

- **The Context of therapy:** decision to come to therapy, relationship with referrer, previous experiences of therapy, concerns or dilemmas, and their expectations of what would be a successful therapy outcome.
- **The System:** Gathering information about the system and its relationship to other systems will be important in beginning to develop a broader picture of the family composition, relationships, history, and family patterns. Information should therefore not only be factual, in relation to who is in the system, how old are they etc., but also the relationships and roles they have developed within the system. Information concerning the system should be collated and added to the genogram generated in pre-therapy preparation. **Section 5.4**
- **The Presenting difficulties or issues:** If the family are introducing information about the difficulties it will be important to follow this up, and open up a wider dialogue about the difficulties, hearing everyone's perspective. Attention should be paid at this early stage to tracking the behaviour patterns that are defined as difficult, though some exploration of explanations and beliefs that have developed around the difficulties may be appropriate.
- **Solutions and Successes to date:** It is important to gain some awareness of the actions the family has taken to try and address the difficulties, and their evaluation of the effectiveness of these measures. If the family are finding it difficult to generate concrete examples of things they have tried, hypothetical ideas for future solutions may bring ideas forward for discussion.

Attention should be paid to collecting information in a circular manner. Although it will be appropriate to ask linear questions in collecting information, especially at this early stage of therapy, circularity can be maintained by linking multiple linear questions between family members in a circular way.

6.4 Establish Goals and Objectives of Therapy

The therapist should consider with the system what are their goals and objectives for therapy. What are the family hoping to get from the meeting today and the therapy in broader terms, and what are their different views about this and how might this impact on the therapy?

The establishment of goals should be achieved in a way which expresses the **Possibility of Change**, and should convey the expectation that change is possible, and likely to occur, that the therapy team may be able to work with the family towards this. This intention is to build the family's confidence in their ability to make changes.

Initial Session Checklist for Therapists

Now you have finished the initial session/s of therapy:

- ✓ Do you know who is in the family?
- ✓ Have you outlined the way you work and the setting?
- ✓ Have you introduced the therapy team to the family?
- ✓ Have you discussed issues of confidentiality?
- ✓ Have you given the family a chance to ask questions about the therapeutic process?
- ✓ Have you begun to engage all members of the family?
- ✓ Do you know the important people in the wider system/network?
- ✓ Do you have a clear idea of the difficulties/issues with which the family are struggling?
- ✓ Have you heard views of the difficulties from each family member?
- ✓ Do you have an idea of the solutions and strategies that the family have tried so far?
- ✓ Do you have an idea about the family's strengths?
- ✓ Do you have an idea about what the family would like to change or be different?
- ✓ Have you remembered to obtain written video permission?
- ✓ Have you written to the referrer to inform them of the appointment?

v Appendix III

7. Middle Sessions

Goals during middle sessions

1. Develop and Monitor Engagement
2. Gather Information and Focus Discussion
3. Identify & Explore Beliefs
4. Work towards change at the level of beliefs and behaviours
5. Return to Objectives and Goals of Therapy

7.1 Develop engagement

The therapist should pay particular attention to developing a co-constructed therapeutic relationship. In addition to attending to the three aspects of engagement from the initial meeting (supportive environment/hearing from everyone/neutrality), attention should be paid to:

- Creating and offering choices about the process of therapy
- Resolving issues in the family-therapist-team system as they arise. This will require therapists to allow sufficient time for team discussions pre and post sessions (vSection 5.5), and time within sessions to discuss the process of therapy with families and any concerns or questions they have in relation to this.

7.2 Gather Information & Focus Discussion

Information is still gathered by the therapist, but more of an emphasis should be paid to focusing this discussion, so that issues and areas for discussion from the initial broad discussions may be looked at in greater detail or from different perspectives. The therapist plays a role in developing this discussion to develop themes and keep the discussion focused. Information may often focus on the following topics:

- **The presenting difficulties or issues:** The therapist will still be gathering information about the difficulties and issues presented. They will look more closely at the consequences/effects of behaviours. They should be tracking behavioural patterns, and giving feedback to the family about the behavioural or emotional interactions and sequences which are discussed or observed. Therapists' should be collecting this information in a manner that enables circular descriptions of behaviour to develop.

- **The family and wider system:** The therapist will still gather information about the family and wider system as is necessary to understand the information and stories being presented by the family. The gathering of information about the family should have reduced considerably from the initial sessions. As the therapist becomes more familiar with who is in the family and their roles, the focus of information should turn more to relationships.
- **Solutions & Successes:** The focus on the successes and solutions available to the family should be steadily increasing throughout therapy.

7.3 Identify & Explore Beliefs

The therapist should identify and explore the family's thoughts, beliefs, myths or attitudes, which may be contributing to their dilemmas and difficulties.

The therapist should be beginning to develop a picture of the ideas and beliefs that inform and influence behaviour, as they are gathering a circular description of the difficulties with which the family are struggling. Circular questions which build up circular descriptions of behaviour can also be used to explore the beliefs and assumptions which lie behind those behaviours.

Example:

Father and stepmother in the family are talking about their parents' beliefs about childcare, in relation to being offered numerous solutions from grandparents and friends about how to manage the teenage years. The therapist is trying to explore ideas about childcare, where these have developed from, and how they might develop in the future.

Fa: Well my mother would have a lot to say about that. I mean if we were ever like that there was a firm hand. We would have never have got away with it.

Th: And where do you think your ideas and values about how to manage the children come from, your own parents?

Fa: Well, not really so much from my parents, I mean I would disagree with a lot of their ideas about how to do things. I think really I have got more of my guides from the church, that's what has really shaped me.

Th: And when was it you started to take on the ideas of the church.

Fa: Well I suppose in my late teens, early twenties really, but I have always been interested. Jane (stepmother) has been going since a child and I would say your family were more strongly Christian than mine were, wouldn't you?

Mo: Yes, I have always gone to church.

Th: What are the values from the church that have influenced you as parents?

Mo: Well really a sense of sharing, we feel it's important for us both to take some interest in the children, and show them we care, not just one or other of us. But, I don't know whether we always manage it.

Th: (to the teenage children) When you two are parents where do you think your values will come from?

Son: Well neither of them, well... I suppose I am a bit like dad, maybe I'd be a bit like him.

Th: (To son) And if you were a parent, in their situation as parents now, what might you advise them to do?

The exploration of family beliefs should be used by the therapist to look at a range of family activities, and not just the presenting difficulties. Therapists should explore the family's beliefs in relation to:

- The **presenting difficulties**.
E.g. What ideas has your wife come up with to explain the behaviour John is showing?
How do you understand the idea that James is less concerned about the behaviour than Jill?
- **Relationships** within the **family** and with the **wider system**.
E.g. Who feels it is most important to keep liaising with the school over this issue?
What would your church have to say about how families cope with loss and bereavement?
- **Solutions** that have been tried or hypothesised.
E.g. What gave you the confidence to keep going with this new idea?
What gave you the idea to try and tackle things in this manner?
- **Successes** in all areas of family life and relationships to the wider system.
E.g. Would that be judged as a success in your family?
If John's grandparents were here would they see that as a success, or would they have different ideas about success?
- **Therapy process**, beliefs about therapy
E.g. What led to your decision not to bring the children to today's meeting?
In what ways do you think Jill was disappointed with the therapy she went to last year?
- **Family behaviour** during therapy.
E.g. Jill is looking distressed, what do you think was so upsetting for her in talking about the difficulties you are experiencing?
How do you understand John's anger with the way that things have gone in today's meeting?

7.4 Work towards change at the level of beliefs and behaviours

- **Challenge existing patterns and assumptions:** To move with the family to a position where they are able to query their own beliefs, perceptions and feelings. The therapist should actively query the family's existing beliefs, assumptions or behaviours. The use of circular questioning, alternative perspective and possible futures questioning may be particularly helpful in achieving this.

Example:

A 12-year-old child (John) is discussing how he feels to blame when things in the family go wrong, or there are arguments between he and his mother. The therapist begins by clarifying what are the child's assumptions, then begins to challenge some of the linear aspects of them.

John: Well I know it must be me, cause I am the one who always gets shouted at.

Th: So do you sometimes feel you are to blame for things that happen at home?

John: Well mainly.

Th: Who would be able to convince you otherwise?

John: Well sometimes Nan says things are not my fault, and that me and mum should listen more to each other, but, I figure it must be me or mum who is at fault.

Th: Does it have to be either your mum to blame or you to blame?

John: Well I don't know, we are all right together sometimes.

Th: How would your Nan explain the times when you and your mum do get on well together?

John: Well she says we are alright when we stop and listen, sometimes we can just bite off each other's heads you see, over nothing, when no-one has really done anything wrong.

- **Provide distance between the family and the problem:** Providing distance to try and free the family from the pressure of the difficulties, so that they are more able to consider and reflect upon them. Alternative perspective circular questions and those aimed at looking at possible futures can often be helpful in achieving this.

Example:

The therapist is talking alone to a mother who has been attending therapy with her children. Since the separation from her partner she has been finding coping with the demands of the childcare increasingly arduous, and at times has felt very low about her ability to carry on and cope. The therapist is trying to work towards creating some distance between the mother and the situation in which she finds herself, to allow a space for reflection on the position she is in.

Mary: Sometimes I feel so inadequate as a mother, I find myself constantly doubting my own judgement.

Th: If we met with a group of single parents, do you think that would be a concern for most of them? Would they say making parental decisions alone is very demanding

because they may not have immediate confirmation from another adult?

Mary: Well maybe, but it is so hard because though there is not another adult there, the children are quick enough to say, other mums don't do that, or so and so's mum would let them do this or that.

Th: When your children grow up, do you think they will more fully appreciate the job you do, and your determination to do your best by them?

Mary: Well I hope so, I think sometimes they know now how hard things are for me on my own, how much more running around I have to do, and sometimes how exhausted I am.

Th: When they become parents of their own children, do you think they will see how hard you have been trying to be both mum and dad at times?

- **Externalise**

One specific way of providing distance between the family and the difficulties, which is particularly useful if the difficulties are seen to reside within one family member is to externalise the problem. That is to give the problem an external, objective reality outside of the person. This can be useful in mobilising the family's resources to unite in working towards solutions and new ways of thinking which challenge the difficulties.

Example:

The therapist is talking to a 10-year-old boy (Max) during the course of a family meeting. Max has been describing how bad tempered he can be, especially at school. Family members have been agreeing that Max is bad tempered. The therapist is working to externalise the temper from Max, in order that he and his family find ways they can have an influence on the tempers.

Th: Can we give this bad temper a name?

Max: Well, it's a sort of me at my angriest, a mad max I suppose.

Th: When mad max is around, what effect does he have on your friendships at school?

Max: Well, that when it can be at its worst, mad max can get me to be very argumentative, my friends stay well away from me.

Th: So when mad max is around they stay away. What happens when mad max isn't there?

Max: Well I tend to play football with my mates.

- **Reframe:** Reframe some of the constraining ideas presented by the family. Relabelling in a positive way, ideas and descriptions given by family members, in a manner which is consistent with their realities. Circular questions are often most helpful in opening up reframes with the family.

Example

A father is defining himself and his parenting behaviour as the ‘problem’ in relation to his children’s teenage struggles. The therapist works towards redefining the descriptions of behaviour as less problematic and offering some positives for the family.

Cl: I think I’m basically just too inconsistent, it depends what mood I am in, or how busy I am, as to what answer the kids will get from me.

Th: I am just wondering, this inconsistency, who is it a problem for?

Cl: Well them, I think. They don’t know where they stand half the time.

Th: Does it leave people not knowing where they stand or does it leave people having to make up their own minds?

Cl: Well both, I’ve never really thought about it like that, but I feel like I don’t always think before I react.

Th: Tell me Jane, what are some of the helpful things about your dad just reacting sometimes?

- **Open up new stories/explanations:** Either by facilitating the family’s evolution of new ideas and narratives, or by the introduction of these ideas by the therapist. All family members will have stories about their lives, the lives of other family members, and the life of the family. They will prioritise certain information from the world around them to build these stories and neglect other aspects. Exploration of neglected information may open up the development of stories which are more helpful to the family in coping with their concerns. Information which is neglected often concerns:
 - Successes
 - Solutions
 - Exceptions
 - Alternative views from the network
 - Other strengths

The therapist should pay particular attention to enquiring about this information as therapy progresses, using circular questions so that the information is provided in a non-threatening manner. Often circular questions, which are aimed at offering alternative perspectives, can be helpful to this aim. As information is likely to remain neglected by the family even if introduced into the therapeutic conversation, it can often be helpful to emphasise neglected information by therapist statements and reflecting team messages.

Example:

Mother: Cindy has always wanted to be a nurse. She entered nurse training but as usual she made a mess of it. She always does things the hard way. She continued to dream of going away to college, and get on in some way even after she had failed her exams. She is now doing volunteer auxiliary nursing.

Th: She has continued to work as an auxiliary nurse, she really sounds determined. It seems impressive that she has found another way to fulfil her ambition, and not let herself get discouraged. Where does she get that determination from?

- **Elicit Solutions:** It will be helpful to gather information from the family about solutions for the difficulties that they have tried or would consider useful. Ideas generated by them are usually most helpful and linear questions are often used to develop an overview of solutions that the family have tried or thought of. If the family are finding it difficult to generate successes circular future orientated questions – such as the miracle question - can be helpful. However at times it may be useful for the therapist or therapy team to offer ideas to begin a process whereby the family can generate solutions. If this is necessary ideas should be tentative and flexible enough to allow the family to disregard them or build upon them.

Example:

The therapist is talking to a mother and her three children. They are having difficulties getting along together, which is intensified by the cramped living accommodation, and their feelings that they don't have space for themselves.

Th: So it seems important for you to be able to keep things private, to have space that is your very own. What ideas have you come up with to achieve this?

Mo: Well we tried letting the children lock their rooms, so that they wouldn't be in and out of each other's rooms, arguing about stuff. But it's just seemed to cause more arguments, they would just stand outside each other's doors screaming to be let in.

Th: So what else did you try then?

Mo: Well we have tried just about everything, you name it we have tried it.

Th: Jane, what does your mum mean? Tell me a bit more about all the things your family have tried.

Jane: Well when the keys got taken off us, I said Jack and Jodie had to knock on my door, but they never did, especially him. So mum said we would have to play down stairs all the time, which didn't last long, because when I had a friend round I wanted to go upstairs.

Th: So Jack, your sister says you have all being trying hard with ideas about this, can you tell me any other things that have been tried?

Jack: Nothing else.

Th: Well can you think of other things you think might help which you haven't tried yet?

Jack: No, nothing seems to work.

Th: Imagine in a month's time Jane and Jodie had stopped coming into your room, what would have had to happened to make that possible?

Jack: Well mum might have really told them off when they did it, and said no TV and stuff like that.

Th: Jodie do you think that would stop Jack coming into your room if your mum said that to him?

Jodie: No, he would do it anyway.

Th: What do you think might help Jack to stop coming in?

Jodie: No computer.

- **Amplify change:** In order to maximise the change or potential change that is occurring throughout the course of therapy it will be important for the therapist to focus on statements the family present about progress. Initially these aspects may be minimal, or presented in a manner by the family which denies the magnitude of the effort or progress they have made. The therapist should focus on descriptions of actions where the family could be seen to have initiated or implemented change, in a manner which is positive but sensitive to the family's level of confidence that change has occurred.

Example:

A 10-year old boy (Jake) is talking about a time when he and he had been pleased about his behaviour, against a context of difficulties in relationships and communication with his father, as well as difficulties at school. The therapist explores the event in more detail to emphasise the success and implications of this for their relationship.

Jake: Well last Thursday we went to the park, and I went on a school trip, and we got to go on a fair ride, and the teacher said I had been really good.

Th: That sounds like a really nice time, does your mum know about this?

Jake: Yeah, I told her what the teacher had said.

Th: How did your mum react to the good news?

Jake: She was pleased I think.

Th: How did you know? How could you tell your mum was pleased?

Jake: She looked quite happy, and she said we could go to McDonalds on the way home.

Th: (to mother) So you were able to show Jake how pleased you were, how did you feel he responded to that?

Fa: I was quite surprised actually, we went to McDonalds and he didn't play up at all, and he told me about the day, which is a bit of a first for him.

Th: So you noticed you were able to talk more together, what made that possible?

Fa: Well I don't know, really.

Th: Did you notice you were more relaxed at all?

Fa: Well I suppose that did help, we had a bit of time together because we were out just the two of us, and I wasn't wound up so much, cause I was really pleased that he had behaved himself all day?

Th: What would make it possible for you to both find other times in the week when you could have a bit more time just the two of you, to feel more relaxed and talk.

- **Enhance mastery:** To encourage the family to gain a sense of mastery or control over their situation, their thoughts, feelings and behaviours. This should enable the family members to take responsibility for their own roles and actions, and for the process of change. In addition should enable family members to gain an awareness of the actions and motivations of other people in their family in achieving change.

Example:

A mother and her two children aged 5 and 7 years are attending a late middle session of therapy. The parents separated 3 years ago, and the mother has been finding managing the children's behaviour difficult since this time. The therapist and family have been working together through the therapy to identify the things that the mother is doing well in relation to managing the children's behaviour and managing her own low feelings. The therapist is commenting on this process and highlighting the mother's own stories of competence which are often lost.

Mo: Well I feel like things have been going quite well with the kids, they have been behaving really well most times, but I don't know sometimes I still feel low, I wonder whether I am doing ok. What do you think?

Th: We would predict many of the things you have been telling me about today, about things being up and down at this stage. I hesitate to advise a family who have come up with such good ideas and solutions on their own. Especially when most of them seem to be having the desired effect. What have you been thinking of trying most recently?

Mo: Well I'm not sure sometimes I feel it's right to take a sympathetic approach to the kids, then other times I come down on them hard, you know, if they are playing up.

Th: If Josie (mother's friend) were looking in on how you were managing them now, would she say you are combining these two approaches, or are you sticking with one or the other?

Mo: Well she'd see a mix of the both I think, I mean I try and judge each situation as it comes.

Th: So do you feel you are becoming more confident in trusting your judgement about what is right for the kids and when?

Mo: Well a bit yes, I mean they don't pull the wool over my eyes, I know when they are just playing up or when they are really upset.

Th: So when did you decide to be a bit more flexible about how you dealt with the situations at home?

- **Introduce therapist/team ideas:** May include the therapist sharing their ideas

and hypothesis about the family, individual, or difficulties, for a variety of reasons. Including:

- Normalise difficulties
- Move the family to new ideas
- Connect family's ideas
- Suggest ways to organise the discussion, e.g. Enactments.

Example:

A mother, her social worker and the therapist are having a session. The mother begins to discuss her experiences of violence from her ex-partner when she was first married, in her early twenties. As the mother is taking a rather critical stance towards her own actions at that time, the therapist normalises her reactions to the violence, to try to begin to open up less critical stories and reframe the mother's actions at the time as understandable rather than 'weak'.

Mo: I suppose I should have been stronger, and not let him trample all over me. My mum used to say just get out, leave him, and I did for a while, I did try, but then I weakened and let him back even though I thought why I am I doing this? What about the kids? I really should have tried to be stronger.

Th: Was your mum the only person with whom you shared this?

Mo: Well I tried to talk to my friend but I felt a bit bad, because all the same stuff had happened to her, and I just told her to leave and lost patience with her, and then I ended up being just as weak as she was.

Th: From talking to other women who have lived with violence like you have, I often hear a similar story that they feel they should leave, but it is easier said than done when you are living with that fear on a day to day basis.

Mo: That was it really, the fear, it kept me weak, and I loved him.

Th: Women tell me they hold onto a hope that if only they did a bit better, were a bit stronger, their partner will change, so they keep trying over and over again. Did that happen for you?

Mo: Yes, I took him back more than once you see, lots, but then I thought no more, not with the kids seeing things and all that.

Th: What gave you the strength to put the kids first, and keep sticking to it?

7.5 Return to Objectives and Goals of Therapy

The therapist should return to the issues of goals for therapy as therapy progresses:

- i. If goals seemed unclear during the initial stages of therapy, it may take some time and thought with the family for them to consider the areas they want to change in therapy, or to find priorities for change.
- ii. If goals are achieved, so that goals can be renegotiated, perhaps for change at a wider system level, or a decision to move towards the end of therapy is made
- iii. If goals change due to changing circumstances for the family.

Example:

Things are beginning to improve for a family whose initial concerns were the suicide attempt made by their daughter. She is no longer suicidal and seems to be getting happier at home and at school. The therapist discusses with the family whether they are happy with this progress, and whether they are left with other issues they would like to bring to therapy.

Fa: I mean I think we are all lot more relaxed about Janice now, she was in her room for hours at the weekend, and I realised at the end of the day that I hadn't gone and checked on her once, and I figured that was because I was beginning to trust her again, I mean I didn't have to watch her every 5 minutes, or worry what she was up to.

Th: So it seems like all of you are feeling that your concerns that Janice will harm herself are less now, and Janice you said you felt a bit happier at school. Now these changes are taking place, has it left you with different ideas about what it could be helpful for us to discuss here?

Janice: Nothing much else to say.

Th: John do you think there are things which Janice might appreciate us talking about here?

John: Well I know she doesn't like talking about it, and I think that's half the trouble, but I think maybe we need to think about how to help Janice cope with all the stuff that goes on at school, all the bullying.

Th: Janice, is that one of the most difficult things for you to talk about?

Janice: Yes.

Th: Would it be helpful to think with you and your family how we could make talking about it easier?

Janice: I'm not sure, there is nothing they can do anyway.

Fa: Me and your mum think if you could talk a bit though, you would like have a shoulder to cry on and not feel alone.

Th: Do you feel you mum and dad might be able to help support you Janice?

Janice: Yes I suppose so, I did talk to mum once and I felt better.

Th: Would that be something we could try to develop here.

Janice: Well I will give it a go.

Middle Sessions Checklist for Therapists

Now you are nearing the end of the middle sessions of therapy:

- ✓ Have you continued to engage the family in the work together?
 - ✓ Have you addressed problems in working together as they have arisen?
 - ✓ Have you developed a circular description of the interactions and difficulties with which the family are struggling?
 - ✓ Are you developing a clear idea about the strengths and resources the family are drawing upon?
 - ✓ Are you working with the family to generate new solutions for the issues they are bringing?
 - ✓ Have you begun to explore the family's beliefs and ideas about the interactions and relationships in their family?
 - ✓ Has there begun to be a shift in the interactions in which the family are engaged?
 - ✓ Have you challenged the family's beliefs about the issues that they are discussing?
 - ✓ Have you worked with the family to open up new stories/explanations about the difficulties they are experiencing?
 - ✓ Have you worked to reframe the difficulties or struggles that the family are experiencing?
 - ✓ Have you introduced distance between the family and the difficulties or tried to externalise the difficulties?
 - ✓ Have you tried to amplify the successes and change that the family achieved?
 - ✓ Are you working with the family to try and increase the sense of mastery and control they feel they have over the difficulties?
 - ✓ Have you reconsidered with the family if they are achieving change in the way they had hoped?
 - ✓ Have you written to the referrer to inform them of the progress of therapy?
- v Appendix IV.

8. End sessions

Goals during ending sessions

1. Gather Information and Focus Discussion
2. Continue to work towards change at the level of behaviours and beliefs
3. Develop family understanding about behaviours and beliefs
4. Secure Collaborative Decision re: Ending
5. Review the process of therapy

8.1 Gather Information & Focus Discussion

Information gathering and focusing the information brought by the family to sessions is still important towards the end of therapy, though the focus of the information is likely to be considerably different.

- **The Presenting difficulties or issues:** There will still be a lot of information shared about the difficulties with which the family are struggling, though the focus will be on changes that have arisen concerning these issues over the course of therapy.
- **Solutions and Successes to date:** There should be a considerable amount of discussion about the solutions that the family are now implementing in relation to the difficulties, as well as the successes they feel they have achieved so far, and those they are looking forward to in the future. If the family are slipping into focusing on the difficulties, it will be important to enquire further about the successes about which the therapist has heard over the course of therapy, which the family are currently neglecting.
- **The System / Wider system:** There should be a considerable decrease in the amount of information shared about the system and wider system. Of the information that is shared it is likely to be in relation to how the difficulties are showing/decreasing in other contexts. Also supports in the wider network which may be drawn upon once therapy has concluded are often explored.

8.2 Continue to work towards change at the level of behaviours and beliefs

As in middle sessions the therapist and family are continuing to work towards change at the levels of belief and behaviour. The methods they use can incorporate any of those highlighted in the middle session. See section 7.4. However it is more common in end sessions for the focus to be on the following methods:

- **Amplifying change:** In order to maximise the change or potential change that is occurring throughout the course of therapy it will be important for the therapist to focus on statements the family present about progress. Initially these aspects may be minimal, or presented in a manner by the family which denies the magnitude of the effort or progress they have made. The therapist should focus on descriptions of actions where the family could be seen to have initiated or implemented change, in a manner, which is positive, but sensitive to the family's level of confidence that change has occurred.
- **Enhancing mastery:** To encourage the family to gain a sense of mastery or control over their situation, their thoughts, feelings and behaviours. This is to enable the family members to take responsibility for their own roles and actions, and for the process of change. In addition should enable family members to gain an awareness of the actions and motivations of other people in their family in achieving change.
- **Challenging existing patterns and assumptions:** To move with the family to a position where they are able to query their own beliefs, perceptions and feelings. The therapist should actively query the family's existing beliefs, assumptions or behaviours. The use of circular questioning, alternative perspective, and possible futures questioning may be particularly helpful in achieving this.
- **Reframing:** Reframe some of the constraining ideas presented by the family. Relabelling in a positive way, ideas and descriptions given by family members, in a manner which is consistent with their realities. Circular questions are often most helpful in opening up reframes with the family.
- **Developing new stories and explanations:** Either by facilitating the family's generation of new ideas and narratives, or the introduction of these ideas by the therapist. All family members will have stories about their lives, the lives of other family members, and the life of the family. They will prioritise certain information from the world around them to build these stories and neglect other aspects. Exploration of neglected information may open up the development of stories to become stories that are more helpful to the family in coping with their concerns. Information which is often neglected often concerns:
 - Successes & Solutions
 - Strengths
 - Exceptions
 - Alternative views from the network

8.3 Develop family understanding about behaviours and beliefs

As therapy ends it will be important for the therapist to work with the family to develop and encourage their understanding of the process of the development of difficulties. This may be helpful in equipping the family with the ability to recognise the development of such processes in the future. Particular attention should be paid to:

- Underlying family interactional patterns.
- Motivations for assumptions, behaviours and feelings.
- Understanding of a family member's reactions to other's behaviours.

8.4 Collaborative ending decision

The timing of ending is not always obvious and in aiming to make the ending process a collaborative process the therapist and therapy team should be alert to a number of signals in sessions which may indicate that therapy may soon draw to a close. These include:

- **Positive feedback from the family:** the family situation or the issues they presented are reported as improved or improving. The family report having made changes in other areas of their lives.
- **Negative feedback from the therapy:** The family report dissatisfaction about the therapy, or the progress they are making. This is often done through expressing the views of a family member absent from therapy.
- **Therapist notices changes:** Missed sessions by the family. Changes in the level of engagement in therapy. Therapist notices positive changes in the way the family are interacting during sessions, for example they are beginning to use new narratives, or are beginning to comment in a different way on their relationships and the issues with which they are struggling. The relationship to therapy may change, with the family becoming more confident in their own abilities, resources and solutions, and attributing change to this.

If it seems that ending therapy is indicated it is important for the therapist to hear from everyone their thoughts and feelings about ending therapy and make this a collaborative decision. To do this the therapist and therapy team must share their thoughts about ending with each other and the family. The team should consider the following issues and then gather the family's views on these.

- Whether the family might feel it was appropriate to end therapy, do they feel they have achieved what they set out to achieve?
- How might the family prefer to end therapy, would they like a follow up appointment or would they like to re-contact the team if necessary?
- Might the family feel it would be important to engineer systems of support, before therapy ends?
- With whom should the team share information about the therapy and what has been achieved, e.g. referrer, school.
- A useful and engaging way of saying goodbye to the family.

Once this information has been shared decisions should be reached about:

- When therapy will end.

- What follow up arrangements will be made.
- What the family might do if difficulties should arise again.
- Who will be contacted post therapy.

8.5 Review the process of therapy

It will be helpful for the therapist to invite the family to review the process of therapy. This may be useful for the team and family in relation to prevention of future difficulties, and to empower the family in any future contact with therapeutic services.

Issues that should be considered include:

- What has been gained/lost for the family through therapy?
- Any misunderstandings not addressed during therapy should be clarified and addressed.
- Reasons for therapist's behaviours and procedures used.
- What might the family do differently if future difficulties arise?

End Sessions Checklist for Therapists

Before you end therapy check:

- ✓ Do the family have an understanding of the issues which they are happy with?
- ✓ Are the family happy with the ways of interacting that they are currently developing?
- ✓ Have you continued to amplify change, enhance mastery, challenge existing patterns and assumptions, reframe concerns and difficulties, and develop new stories and explanations of difficulties?
- ✓ Have you discussed ending therapy with the family, and listened to their wishes about ending?
- ✓ Have you reviewed with the family the goals outlined in the initial and middle stages of therapy?
- ✓ Have you considered contingency plans for the family when future difficulties arise?
- ✓ Have you reviewed with the family what was useful and not useful about therapy?
- ✓ Have you discussed how to re-engage with therapy if required?
- ✓ Have you written a closing summary of the work to the referrer? v Appendix V

9. Indirect Work

There are many areas of systemic work, which although they do not directly involve the presence of the family, are essential in supporting the ongoing work with the family. Directions for conducting this non-direct work are therefore outlined below. Therapists are reminded that the guiding principles outlined at the beginning of this manual will also be applicable to the non-direct work outlined in this section.

9.1 Child Protection

Therapists should abide by the local child protection procedures outlined by their area. Wherever possible the local procedures should be carried out using the systemic principles described in section 2. It may be necessary to move from the domain of therapy to the domain of protection but the manner in which this is achieved should retain a systemic focus, and not preclude the possibility of moving back into the domain of therapy at a later stage. Therapists should inform the family that they are now not talking with them in their therapeutic role as they have serious concerns about the safety of a family member. Particular attention should be paid to bearing the needs of the system in mind whilst still prioritising the needs of the child for protection, the language and narratives about abuse and protection, and the co-construction of the relationship. If at all possible, without placing the child at further risk, therapists should discuss the child protection issues with the family, and keep them informed of any protective procedures that the therapist is to instigate.

9.2 Clarifying therapy with referrer present

In situations where referrals are vague, complex, or involve a network of professionals, it may be necessary to clarify the nature and boundaries of the referral over the telephone, or in person. This ideally should be done with the referrer and family at a pre-therapy meeting, where the multiple views about therapy, its utility and limits, can be shared between all members of the system. However in referrals where there may be tensions in the referring relationship, or issues of advocacy may limit the family's ability to communicate their ideas and wishes, separate contacts should be used to clarify therapy, before therapy commences.

9.3 Identifying the network and clarifying relationships

It is important for the therapy team to identify the components of the family's network from the referral information given and during the assessment process. This includes professional and extended family contact, as well as other relationships, friendships and occupational aspects of the family's life. This should be done for current relationships as well as important contacts in the family's history. Important life events such as illnesses, hospitalisations, and periods of separation can be built into this picture. This information should be used in relation to the therapeutic goals and in relation to contact with the wider system that the therapy team and family participates in during therapy.

If the family are participating in any other therapeutic activity during the time they are attending family therapy, for example individual or couple therapy, the boundaries of the work should be clarified in relation to the current goals for family therapy.

In addition, in identifying the network and clarifying relationships, the boundaries of confidentiality and the family's wishes concerning this should be discussed and clearly stated to all members of the network.

9.4 Assessing risk

At times during therapy it will be necessary to consider the risk which one or more member of the family poses in relation to their own well being or the well being of a family member. The risk may be in relation to a number of issues, for example, child protection, domestic violence, or suicide attempts. Therapists should bring their concerns into the discussion with the family to hear their own views of the risks. It is important that the therapist's and family's concerns are identified, in a manner which opens up communication and leads to the establishment of contingency plans to monitor or prevent further risks. In relation to suicidal ideation it may be necessary for the therapist to move outside the domain of therapy and complete a full psychiatric risk assessment, or refer to someone able to complete this. Again this should be a process in which the family are actively involved and therapists should inform the family that they are now not talking with them in their therapeutic role as they have serious concerns about the risks to a family member.

10. Proscribed Practices

The proscribed practices described below are things that would not be included in a routine therapy session. It may be that on one or two occasions it is appropriate to use one of these approaches, however they must be used within a systemic framework, that is, using the guiding principles outlined at the start of this manual.

Team members should monitor sessions for proscribed interventions, and record these, together with any justification, in session notes? ⇒ **Section 5.8**

10.1 Advice

As a systemic therapist you would not usually offer direct advice to the family about their interactions or the difficulties they are experiencing. If the family ask for advice about a particular issue with which they are struggling or the therapist feels advice may be appropriate in helping the family work towards their goals, advice may be offered in a non-directive or reflexive manner. Options should be presented as choices about which the family can make their own decisions.

10.2 Interpretation

Psychodynamic interpretations about the meaning of symptoms or interactions in relation to individual or trauma would not be usual for systemic therapists. Rather, meanings are explored in relational and interactional terms between members of the system.

10.3 Un-transparent/Closed Practice

Therapists should not remain closed about their working practices, ways of thinking and understanding the difficulties with which the family are struggling. They should try to remain transparent by explaining their practices at the beginning of therapy, and during therapy as appropriate.

10.4 Therapist monologues

In the co-created process of therapy therapists should not find themselves lecturing or using long monologues in their interactions with the family. The process should be more like a sharing of ideas between therapist and family, and between family members.

10.5 Consistently siding with one person

In taking a neutral stance therapists should not find themselves consistently siding with one person in the family. It may be necessary at times, for ethical or therapeutic reasons, to align oneself with a member of the family, but if therapy is to continue, this should not be a constant state.

10.6 Working in the transference

Therapists should be paying attention to the relational and engagement issues between themselves and the family with which they are working but they should not use the relational aspects between themselves and the family as the tool of therapy, that is work within the transference.

10.7 Inattention to use of language

Therapists should not be inattentive to the use of language used by the family. They should pay attention to the both the words and phrases used, and the meanings attributed to these.

10.8 Reflections

Therapist's simple reflections of the points or phrases that are used by the family should be kept to a minimum. Reflections may be used to enhance engagement and to develop the family's sense of being listened to and understood, but when used, reflections should be followed by questions, and increased curiosity about the issues presented.

10.9 Polarised position

Therapists should avoid taking a position which is polarised from that of the family, or a position which is likely to escalate to a polarised position. Therapists should be thinking about how to take a position which connects to the ideas of the family, whilst still questioning those ideas, and allowing them to remain curious. The therapeutic team can enable the therapist to achieve this by presenting the multiple perspectives from which the family situation can be understood.

10.11 Sticking in one time frame

Therapists should not stick in one time frame, but move the focus of their questions and discussion between the past, present and future.

10.11 Agreeing / not challenging ideas

Therapists should not be in a continual state of agreement with the family's ideas. They should remain curious and challenging about the nature and content of these ideas, in order to introduce new unexplored possibilities and ideas.

10.12 Ignoring information that contradicts hypothesis

Therapists should not ignore, or minimise information presented by the family which contradicts their own ideas and hypotheses, rather they should take this information seriously and use it to modify and expand their working ideas.

10.13 Dismissing ideas

The ideas presented by the family about the difficulties with which they are struggling, or the process of therapy itself should not be dismissed by the therapist.

10.14 Inappropriate affect

The therapist's affect should match that of the family, and would be considered inappropriate if it remained dissimilar from family for an extended period of time. One example might be if the family were feeling optimistic about change and the progress they were making, and the therapist remained pessimistic. There may be times, when a mismatch of affect is used transiently, in order for the therapists to take a position in relation to the family as a way of questioning or challenging their ideas.

10.15 Ignoring family affect

Therapists should pay attention to the affect that the family is showing in the session, and not ignore strong expressions of affect during the sessions. This may be particularly relevant when a member of the family shows distress during the meeting, either by sad or angry behaviour.

10.16 Ignoring difference

Therapists should not ignore issues of difference between themselves and the family or within the family. These may be differences in views, beliefs, gender, abilities, class or race, and should be raised by the therapist in a sensitive and open manner for further exploration.

Appendix 1: Sample Appointment Letter

Appointment letters should include:

- Referral source and name of referrer
- Invitation to the whole family
- Reasons why all the household should attend
- Date, time and place
- Confirmation request
- Brief explanation of teamwork
- Main therapists name

Dear Mr & Mrs Smith & Jodie and Jonathan,

We have heard from your GP, Dr. Jones, that it might be worthwhile exploring whether family therapy could be of help to you all. We would therefore like to offer you an appointment to come along and meet us at our Family Therapy and Research Centre on **Wednesday 13th July at 4.30pm.**

This first session would be to discuss the issues that concern you and to decide whether family therapy might be useful. We find it helpful to meet all members of the family or household so that we can learn how things are from everyone's point of view. We hope to see as many of you as possible for this first appointment.

We work as a team in order to generate more ideas which we hope to share with you. There are about 5 people in the team, but the person who will be talking with you most directly is Dr. Peter Stratton.

Enclosed is a map giving directions to the clinic, which is situated in the Department of Psychology at Leeds University.

Please let us know whether or not you can attend, as soon as possible by telephoning our secretary on the above number. It is important that you give us this information as we have a waiting list for appointments.

Yours sincerely,

Dr Peter Stratton
Family Therapist
On behalf of Leeds Family Therapy Team

Appendix II: Sample Video Consent Form

Consent Form for the Use of Video Tape

We give consent for the use of these video recordings for the following purposes:

1. To help the **team** deliver a more effective service to our family. For the purposes of supervision and in order to plan future therapy sessions. Confidentiality will always be maintained. Viewing will be confined to the regular members of your family therapy team.
2. For **teaching & research**, in order to develop our service through training other therapists, and improving the service for families through research. Such tapes are only shown to audiences of professional clinicians and researchers who are warned about the importance of confidentiality.

Please delete as appropriate.

Signed:

Dated:

You are entitled to change your mind about the consent given above at any time.

All video material is stored in locked cabinets and every effort will be made to ensure confidentiality. No video material will be identified using your family's name.

Signed:

All Family Members

Dated:

Member of Family Therapy Team

Appendix III: Sample Referrer letter

This letter is to be sent to the referrers when first appointment sent out. It should include:

- Referral date
- Referral reason
- Family name & address
- Date of appointment
- Proposed future contact
- Contact person

Dear Dr. Jones

**Re: Smith Family
11 James Avenue, Leeds, LS2**

Further to your referral of the Smith family, for help concerning bereavement issues, in March 1998, we have offered them an appointment at the Leeds Family Therapy and Research Centre on **Wednesday 13th July at 4.30pm.**

We will keep you informed of their progress should they go ahead with family therapy. If in the meantime you have any further issues regarding this family please contact Dr. Peter Stratton.

Yours sincerely

**Dr Peter Stratton
Family Therapist
On behalf of Leeds Family Therapy Team**

Appendix IV: Post-assessment letter to referrer

A letter should be sent to the referrer once an assessment is completed or when the initial goals of therapy are clarified with the family. This letter should include:

- Number of assessment sessions attended
- Who attended
- Brief family composition
- Referrers concerns
- Family's concerns
- Systemic Formulation/Understanding of Difficulties
- Agreed Goals for Therapy
- Agreed liaison with other systems

Dear Dr. Jones

Re: Smith Family
11 James Avenue, Leeds, LS2

I have now seen the Smith family on 2 occasions following your referral for help with bereavement issues following the death of the eldest child in the family, Julie. Mr & Mrs Smith attended alone for the first meeting, as they were concerned to give us a picture of the difficulties without upsetting the children. This was followed up with a meeting with the whole family.

As you know the family consist of Mr & Mrs Smith, and their 2 children Jodie (6 years) & John (9 years), both of whom are attending Jacob School. The eldest child of the family, Julie, died in a car crash in September 1997.

Mr & Mrs Smith outlined to us their concerns that their children were expressing no grief relating to the death of their elder sister Julie. They were concerned about how the loss was affecting them in both their achievement and behaviour at school, and expressed a wish that they were more able to talk about the issue as a family. The children were quite cautious about discussing this issue initially, and expressed a desire not to upset their parents further by talking about Julie's death.

It seemed that although this was a topic all the family felt would be helpful to discuss more openly, no one dared to begin the conversation, as they were concerned not to bring further distress to members of their family. The children had carried this silence to school, and would not talk to any of Julie's old friends about her, yet consistently showed distress through their behaviour and lack of concentration.

It was therefore decided to try and begin to talk about Julie's death and the impact this had had on the whole family in our meetings. The children very much wanted this to be at their pace, and we have been thinking with them about ways to help the process of talking easier.

We also plan to make links with Jacob school, to discuss how the children might show

their distress in different ways at school.

I will contact you again once therapy has ended to discuss the utility of these interventions for the family.

Yours sincerely,

Dr Peter Stratton
Family Therapist
On behalf of The Leeds Family Therapy Team

Appendix V: Closing letter to referrer

A letter should be sent to the referrer after therapy has ended and should include:

- Reasons and date of original referral.
- Number of meetings held
- Who attended the meetings
- The family's concerns
- Systemic Formulation/Understanding of Difficulties
- Themes covered in meetings
- Utility of therapy for the family
- Evaluation of current state
- Future plans
- Copies to other agencies involved, with family's permission

Dear Dr Jones

**Re: Smith family
11 James Avenue, Leeds, LS2.**

You will remember you referred the Smith family for family therapy in March 1998, for help with bereavement issues.

The family attended for 5 appointments. We saw them last in November 1998 and a further appointment for December was cancelled. All members of the family attended meetings following an initial meeting with Mr & Mrs Smith alone.

The parents outlined to us their concerns that their 2 children Jodie (6years) & John (9years), were expressing no grief relating to the death of their elder sister Julie, who died in a car crash in September 1997. Mr & Mrs Smith were concerned about how the loss was affecting them in both their achievement and behaviour at school, and expressed a wish that they were more able to talk about the issue as a family.

Our 5 meetings were spent looking at the effect Julie's death had had on both the parents and the children, and the stories they had developed for understanding what had happened. At the family's request we also invited the Headmistress of the children's school, Mrs Small, to look at ways the children could express their grief about Julie's death within the school setting. In addition we thought about ways they might be supported to develop their concentration, when distracted or upset at school.

The family used all of the meetings to their fullest, and communication concerning the bereavement improved very rapidly. The children also reported feeling happier at school.

We had planned to continue, but the family phoned and left a message to say they felt things had improved at home and at school and they would contact us again if the need arose. We left it with them that we would be very happy to see them again if requested.

Yours sincerely

Dr Peter Stratton
Family Therapist
On behalf of The Leeds Family Therapy Team

c.c. Mrs Small, Headmistress, Jacob school

Appendix VI : Session Notes Record Form

SYSTEMIC FAMILY THERPY MANUAL SESSION NOTES Record Sheet

Date of Session

Session Number

Who attended therapy?

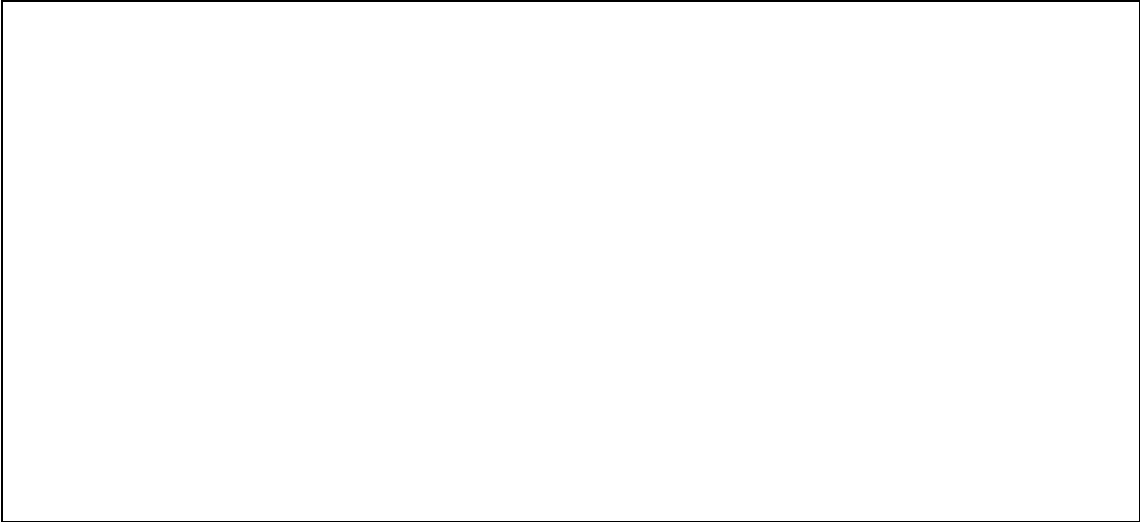
Therapist name

Team member names

Main themes of the session
family

Include key language used by

Main themes continued



Team observations	Clearly labelled as impressions
--------------------------	---------------------------------

Interventions

--

Key points/ideas/decisions to follow up in later sessions
1.
2.
3.

Proscribed Practices included in session	Justification
1.	

<p>2.</p> <p>3.</p>	
---------------------	--