Working for Families with Dysfunctional Children: An Approach and Structure for the First Family Therapy Interview

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ABSTRACT: A preplanned and structured format for conducting the first family treatment interview is presented in which the assessment task is seen as an opportunity to help a family succeed in constructively, coherently, and logically looking at itself, the "problem" child, and the problems with which it is attempting to deal. Strategies of modelling openness and competence are suggested. Building on the family's perceptions and plan in the empathic and respectful way is postulated as a way of avoiding power struggles and setting the stage for collaboration. The model is designed to provide a successful first session for the family and therapist, during which they complete a challenging task.

This article will discuss a structured approach to initial interviews with families which perceive a child as the problem, outlining tasks and ways of beginning a process of reframing, partializing and problem solving that respond to the family's dilemma. When a family comes into treatment around the problem of a dysfunctional child whose misbehavior and problems are presented initially as the only difficulty, the task of the first session is to address the family's quandary and to begin with its perception of the problem. When the professional takes care to demonstrate empathy, respect, and congruence from the beginning, a cooperative atmosphere and context for collaborative work can be established. The first session is an opportunity to offer an initial experience of the helper and of therapy which will set rules for the following sessions and impact on the success of the entire therapeutic effort.

The First Impression

When we meet a family for the first time, they are also meeting us and making up their minds about our manner, effectiveness, and persona. It is important that the therapist present himself or herself in a good light, demonstrated competence, and give the family an introduction and orient-
tation to the tasks ahead. What we do in the first interview is usually taken by the family as an indication of how we will proceed further. Much of what we do should be consciously planned to model behaviors which demonstrate ways of working with charged situations and offer examples of how a person faced with the family’s problems might best proceed.

There is a natural tendency in first sessions to focus on the material, the family’s impact on the therapist, and assessment; the idea of preplanning one’s own behaviors may seem distasteful, or even dishonest, to some therapists. Others may believe that it is necessary to let family “pathology” bloom into full flower in the first session as a part of assessment. It seems to me that such tactics overlook an important opportunity: the assessment task itself can be framed as an opportunity for the family to succeed in constructively, coherently, and logically looking at itself, the child, and the problems with which it is attempting to deal. This task, successfully completed, can lead to early gains in objectivity, partializing, and problem solving behavior. Assessment is not merely a way in which the therapist can better understand the situation and plan treatment, but a way of getting the family itself organized so that it may more effectively deal with the situation.

In line with these assumptions, the first interview is planned to have a structure which will help the family and the therapist understand the presenting problems both historically and interactionally, demonstrate to the family that there are different ways in which the situation can be understood and dealt with, and present the therapist as a model of such approaches.

The “Resistant” Family

Families do not always come voluntarily into treatment because of a desire to change or improve themselves; they may see themselves as doing well, except for the symptomatic behaviors of the identified patient, or they may come as a result of coercive pressures from a school or social agency.

Symptoms are almost always functional or symbolic representations of problems or dilemmas which are not being solved or expressed in the family’s life. This is particularly applicable to a child’s symptoms. It has been fashionable to frame the situation in a way which sees the child as being self-sacrificing in a way which “benefits” the family, and to frame the family as a defective homeostatic system with a need to maintain itself at all costs.

Such framings set up an adversary situation in which, the therapist may begin to see himself or herself as a secret agent or rescuer of the child and in need of special techniques and coercive schemes which will enable the therapist to “motivate” or trick families into better behaviors. Unfor-