PHASES OF FAMILY THERAPY PROCESS: 
A Framework for Clinicians and Researchers

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Early proponents of family therapy needed to meet three major goals in order to establish its legitimacy as a viable treatment modality. First, to attract potential practitioners, the early writers needed to present popular, conceptually viable and persuasive models for changing problematic family situations. Second, to develop support among consumers and other potential funding sources, proponents needed to demonstrate empirically the effectiveness of family-based treatment. Third, so that new generations of therapists could be trained, theorists and researchers needed to identify, articulate, and examine critically the various elements that were hypothesized to be important in the intervention process with families.

The first goal, clinical popularity, clearly has been attained, but we have not been so successful in meeting the second and third goals. Clinical popularity far exceeds the degree of research support, and journals continue to reflect discussions and controversy about basic conceptual issues. One needs only to note the state of recent discussions about epistemological issues (for example, 23) and criticisms of the adequacy of the theoretical substratum of family therapy (for example, 14, 15).

Certainly, there is sufficient empirical evidence to justify continued confidence in and development of mini-models of family therapy. However, with the emergence of several new and popular intervention approaches (for example, cognitive-behavioral therapy with individuals) as well as the resurgence of biologically based treatments, family therapy must redouble its efforts to develop empirical support in order to remain a viable treatment modality.

Unfortunately, several problems face the family therapy researcher, including the fact that the "ultimate outcome" of family therapy remains difficult to identify. Both conceptually and operationally, dif-

1. Editor's Note: See discussion of this concept by Olson (Chapter 5).
ferent family therapy models differ as to goals or desired outcomes of intervention, be they the cessation of problematic behaviors, the individuation of family members, the modification of relationship structures (for example, enmeshment), the absence of symptoms for a period of time after termination, a "positive" divorce process, and so on. As long as different models of family therapy coexist, the variable nature of outcome definitions will continue to be a source of confusion for researchers and occasionally outright contention among adherents of certain models. To add complexity, it appears that outcome often becomes an issue of punctuation. That is, clinicians often see an early positive outcome as merely getting family members to attend a session together. Other "positive outcomes" include having family members express themselves in certain ways, continue to attend sessions, commit themselves to attempting changes, maintain changes without direct therapist support, and so on. Each of these "outcomes," of course, can also be seen as "process" measures that relate to or at least predict a successful "ultimate outcome."

Thus, family therapy can no longer be considered a homogeneous process that has a unitary and concomitantly validated outcome at a particular point in time. Instead, family therapy involves a series of steps, each of which involves a set of processes, yet each of which could be seen as representing an outcome in its own right. For example, whether or not families return for a second session could be regarded as an outcome measure of first-session processes. Similarly, the degree to which family members adhere to therapeutic directives in the third session can be regarded as one outcome measure of the degree of success of earlier joining. Viewed in this way, the concepts of process and outcome appear to be somewhat arbitrary; this situation is problematic for traditional "linear-cause" thinkers but not at all inconsistent with the basic assumptions of systems-based family therapies—not inconsistent, but nevertheless complex.

For both the clinician and researcher, solutions to these complexities lie in conceptual, methodological, and statistical developments. At the conceptual level, we must continue to develop clear theoretical and operational articulations of basic concepts, goals, and intervention processes. At the methodological and statistical level, theorists and researchers must work together to apply new research methodologies and statistical techniques to subtle clinical phenomena (5, 12).

As one step in working together, in this chapter I offer a framework, designed to be useful to both clinicians and researchers, for articulating the basic processes in family therapy. In doing so, I will not discuss specific family therapy models in detail, nor describe the new methodological and statistical tools available. Such discussions exist elsewhere. Instead, I will adopt a broader perspective and describe the generic features of family intervention that I believe exist in most if not all family therapy models.

**THE PHASES OF INTERVENTION**

Although different family models derive from divergent theoretical assumptions and emphasize different assessment and change techniques, at a generic level, all family therapies must deal with certain major tasks: 1) initiating the process of intervention (getting acquainted, joining, and so on); 2) assessing salient issues and variables and creating intervention strategies; 3) modifying negative or otherwise unproductive cognitive, emotional, and motivational processes; 4) changing overt problem behaviors and developing adaptive, long-term interaction patterns; and 5) terminating the therapy in such a way that the family can go it alone. In different family therapy models, these tasks and strategies to deal with them receive varying degrees of emphasis. Different models deal with these tasks in different sequences; they may repeat them and/or they may deal with them simultaneously—but these tasks all occur. They have been analyzed in the Anatomy of Intervention Model (AIM), which is described below and in greater detail in Alexander, Barton, Walbran, and Mas (2) and Warburton and Alexander (27).

An additional task, that of deciding if family therapy is to occur at all, also must be faced. However, this review will not consider this issue for two reasons. First, it has been raised and dealt with eloquently by Wynne and his associates (29, 30); second, because we are particularly interested in linking process with outcome, I will focus on family therapy only in the context where it occurs. The process of deciding whether family therapy should or should not occur may require both a different conceptual approach and different research tools.

Table 1 describes the major tasks of intervention that have been organized into phases of activity, each with distinctive goals and a requisite set of therapist skills necessary to carry out appropriate activities. For example, the goals and techniques of the Assessment/Understanding Phase center on understanding the family. These goals and techniques are different from the goals and techniques of the Induction/Motivation Phase, which are designed to develop a positive therapeutic relationship, to enhance motivation for change, to modify negative attributions, and to deal with early indices of resistance. While

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2. Table 1 and the related discussion were presented at the NIMH/Family Process conference and were delivered in large part from the chapter by Warburton and Alexander in L'Abate's edited, two-volume Handbook of Family Psychology and Therapy, 1985 (27). Several significant modifications have been made, particularly in terminology. These modifications have been suggested by Lyman Wynne, to whom I am indebted.
### Table 1: Anatomy of Intervention Model

<table>
<thead>
<tr>
<th>Therapist Dimensions</th>
<th>Therapist Goals</th>
<th>Therapist Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Process</td>
<td>Maintain change &amp; independence</td>
<td>Facilitate generalization of change into future.</td>
</tr>
<tr>
<td>Therapeutic Process</td>
<td>Institute individual &amp; interactive change programs</td>
<td>Structure &amp; monitor performance in/outside sessions.</td>
</tr>
<tr>
<td>Therapeutic Process</td>
<td>Institute motivational change</td>
<td>Structure/teaching-the-teaching skills.</td>
</tr>
<tr>
<td>Therapeutic Process</td>
<td>Institute emotional change</td>
<td>Insure attainment of spontaneous &amp; adaptive family processes.</td>
</tr>
<tr>
<td>Therapeutic Process</td>
<td>Institute cognitive change</td>
<td>Blend of all skills used in other components.</td>
</tr>
<tr>
<td>Therapeutic Process</td>
<td>Institute behavioral change</td>
<td>Structure/teaching-the-teaching skills.</td>
</tr>
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</table>

**The Introduction Phase of Intervention**

Families and therapists come together at a first session with a number of expectations about what will happen. Some time ago, Frank (10) identified the importance of the "credible ritual" as an important component of psychotherapeutic healing. A major part of establishing a credible ritual is the presentation of the person who will perform the ritual, the family therapist. Thus, for the initial contact to be as productive as possible, the therapist must appear credible as a helper to the family. The best therapist will fail at the task of moving a family toward its desired goals during subsequent phases of treatment if the family finds the therapist unconvincing as a change agent.

As the shorter-term marital and family therapies become highly used as modes of treatment, the initial client and therapist biases and expectations about stimulus characteristics increase in importance (6, 7, 13, 22). Because stimulus characteristics of the therapist and the setting are superficially observable, they are different from therapeutic skills that must be demonstrated over time as the therapist engages in the therapy process itself. A number of attributes generate credibility, especially overt characteristics such as gender, race, physical size, age, dress, and office equipment, all of which have been noted in the literature (24, 28) as having some effect on initial impressions and on the interactions that follow. Different families and family members, of course, view these factors in different ways. To use a personal example, twenty years ago the author (being relatively young) was seen as credible by delinquents; but, at the beginning of the first session, parents of those delinquents often were somewhat dubious about a therapist who was clearly too young to have adolescent children. Now, of course, parents see me as obviously credible, but the delinquents are initially dubious that, given my age, I can understand their perspective.

With regard to credibility, a number of tactics have been used to influence clients' perceptions positively. These include matching client and therapist characteristics, joining in obvious mannerisms and self-disclosures, and using the family's stereotypes (see 17). As a matter of fact, the popular community-psychology emphasis on community-based
crisis clinics and the use of indigenous paraprofessionals (19) reflect the potential importance of therapist characteristics. Of course, therapist characteristics often cannot be easily changed or matched to each family. In this case, therapists must deal with initial, nonproductive reactions in subsequent phases, as described below.

The Assessment/Understanding Phase

Beyond establishing credibility in the first session, the therapist must collect enough information about a family to begin to make sense of the subtleties and complexities of its interactions. Intelligence, perceptive-ness, and use of a clear conceptual model allow the therapist enough objectivity and distance to understand a family member’s behavior within the context of the family, as opposed to being engaged by it. Obviously, the therapeutic goal of understanding a family requires considerable cognitive skill because only occasionally, and only through luck, can we change something we do not understand. The therapist must be able to create a context in which the family will provide the information relevant to the family’s potential for change, and be capable of generating meaningful hypotheses about what the information means. In turn, this will lead to the development of therapeutic solutions firmly based on the integration of assessment information.

The assessment phase is probably one of the least understood and researched phases of therapy in terms of therapist characteristics or skills. Assessment skills have not had entire models of intervention built around them like the relationship skills of the Induction/Motivation Phase (for example, in the client-centered model) and the structuring or technical skills of the Behavior-Change Phase (for example, in behavioral models). The importance of cognitive and intellectual skills essential to the understanding of a family are thus underrepresented in the literature.

An additional problem derives from the relative lack of technical aids to assess families, in contrast to individual therapy in which numerous assessment and psychometric devices have been used to assist the practitioner. Whereas psychometric devices such as behavioral observation, checklists, supervision, and consultation have assisted both individual and family practitioners’ assessment of individual members, few useful tools have been devised for the assessment of relationships (9). Certainly, none have achieved the popularity and widespread use of individual assessment tools such as the MMPI and the WAIS.

To make things even more difficult, in the Assessment phase the therapist must be competent; in the Introduction Phase the therapist simply had to appear competent. There seems to be considerable literature to indicate that experience helps at this point (16). The seasoned clinician is more likely to be skilled at deciphering the vast amounts of information presented in initial sessions than is the novice. Much of the extraneous noise may be automatically screened out by the more experienced therapist, allowing attention to be focused on the relevant behavior. Unfortunately for the researcher, this makes it difficult to tease out the overt and covert processes that the therapist is using. For the less experienced therapist, it is the Assessment/Understanding Phase that requires a clear conceptual model of therapy. Without a clear conceptual model as a guide, therapists may quickly find themselves mired in confusion.

An additional problem is the fact that while therapists are assessing the family, they are simultaneously having an impact upon the family. Therefore, assessment becomes a dual process of evaluating what the family is like “on its own,” and assessing how it is responding to the therapist’s stimulus characteristics and interpersonal maneuvers. If these reactions are nonproductive, it may require that two phases of intervention be conducted simultaneously. During the assessment phase, problems of considerable resistance must be handled if they occur. Therapists may have to use the relationship skills associated with the Induction/Motivation Phase (see below). In this case, the therapist must remember that relational skills are used in addition to (not instead of) cognitive skills. Assessment is also a phase frequently returned to in later stages of the intervention when the therapist questions previous assumptions or needs to gain new information. This creates a complex situation for the therapist, but an even more difficult one for the researcher. Once again, however, at least acknowledging this situation will allow researchers to begin to tease apart conceptually (if not operationally) the variables operating at this and other stages of intervention.

The Induction/Motivation Phase

This is the phase of intervention that creates the climate in which families are willing to change and have the motivation to do so. It is assumed that it is the therapist’s, not the family’s, responsibility to move the clients through this phase of treatment. Family therapists in particular use such techniques as relabeling (3, 4) or reframing (17) to influence family members’ cognition and affect. These techniques are contingent upon the family because they react to and depend upon what family members say, do, and feel. Relabeling and reframing will not be successful if they do not “make sense” to the phenomenological reality of the family, and if they are not acceptable (18). Thus, therapists need relational skills and interpersonal sensitivity, skills variously described

3. Editor’s Note: In Chapter 1, Stanton recommends research on the specific point of how or whether academic degrees make any difference in the ways in which family therapists actually function.
in the literature as affect-behavior integration, humor, and nonblaming (1), as empathy, genuineness, and nonpossessive warmth (20, 25), and as interpersonal manner (21). These skills are necessary in order to provide a motivational climate conducive to the application of techniques for behavior change, and are necessary early in the process of intervention (3).

Relational skills appear to be a necessary but not sufficient ingredient for change (21). It is this "necessary but not sufficient" phrase that can be the nemesis of the family therapist. Because the therapist works hard to create the context for change, to get the family reframed or redefined, to overcome resistance, and to establish likability, the temptation to remain in this phase of treatment is seductive. There are in fact schools of therapy that imply that the application of relational skills alone is enough to accomplish successfully all of the intervention. However, the majority of family therapy models maintain that specific techniques designed to change behavior directly must also be applied.

The Behavior-Change Phase

The therapist's goal in most marriage and family therapy approaches is to produce change in patterns of interaction by using specific techniques that focus on specific aspects of behavior, feelings, and thoughts or beliefs. The class of therapist attributes necessary to produce actual change are called structuring skills. Because the therapist must instruct the family to do things differently, the therapist must present these techniques in a clear, direct, and understandable way. Negotiation skills, communication skills, time out, relaxation techniques, techniques for behavioral contracting are examples of these techniques, and the specific techniques depend on the therapist's treatment model. If the therapist's structuring skills are not sufficiently developed at this phase, the family may fail to comply because they have not understood the directions. Thus, for example, a behavioral contract between a teenage child and the parent may not have been sufficiently specific in terms of expectations and sanctions. This would reflect a therapist skill problem. On the other hand, if the therapist reviews the contract and perceives that the degree of specificity was adequate and that both teenager and parents understood the contract, the family resistance would alert the therapist (through a sensitivity to performance) that earlier assessments and assumptions about the family were erroneous, and additional assessment is necessary to determine why.

Generalization/Termination Phase

The goal of most families and therapists is a positive change in the family system that will be maintained after the therapist ceases involvement. Just as therapists need to assess their impact on a system as they begin treatment, so they must be cognizant of the effect that their leaving will create. Although most models of therapy make reference to the importance of termination, few models of therapy operationalize criteria for decision-making about termination. It is generally assumed that some combination of problem cessation, changes in family structure, behavior generalization, and/or the attainment of problem-solving skills and adaptive attitudes constitute indications to the therapist that the family is ready for termination (2). However, if the family has not understood sufficiently from the Behavior-Change Phase of intervention, or if assessment was inaccurate, generalization and maintenance of new patterns of behavior cannot be expected.

Further, if positive changes are dependent on continued therapist involvement, the therapist must help the family learn to function independently. This stage of intervention often takes on an "as-if" quality because the therapist must guess how the family will behave without him or her, and also guess about future contexts. This contrasts with other phases in which scanning is almost exclusively on the "here-and-now" process.

Therapists in this phase of treatment need to rely on a combination of skills because termination contains a microcosm or condensation of the entire therapeutic experience and repertoire. In order to answer the question of appropriateness of termination, a therapist must summarize the entirety of the intervention process, mentally reviewing each phase in order to understand the current situation. This summary then provides clues as to whether there is likely to be a successful termination. This phase rarely represents a focus for research, yet it may have a great deal to do with the maintenance of positive treatment effects.

IMPLICATIONS FOR FAMILY THERAPY RESEARCH

In family therapy research that links process and outcome measures, it is essential to differentiate the phases of intervention and the distinctive therapist skills required in each. Otherwise, different studies that tap different phases will produce different findings, and measures linking process to outcome will tend to be correlated at only a modest level, if at all. As we have seen, therapist relationship skills, such as warmth, are relatively more important in some phases (for example, induction) than in others (for example, Assessment). Studies linking therapist warmth with outcome will lead to different findings if this warmth is measured when some therapists are performing assessment techniques, whereas others are performing induction, and others applying a structured communication technique.

Identifying the phases of intervention also underlines the point that process and outcome represent arbitrary distinctions. For example, in a recent study we looked at the impact of therapist gender on the
expression of defensive and supportive communications between mothers and therapists and fathers and therapists (28). In this study, therapist gender represented the independent variable, and supportiveness/defensiveness in the first session represented the outcome of interest (the dependent variable). In another study, therapist supportiveness/defensiveness represented the independent (process) variable, and posttreatment marital adjustment scores represented the outcome (dependent) variable (26). Finally, another study examined how well marital adjustment scores (independent variable) could predict marital interactions as an outcome (dependent variable). In other words, the "process" measures in one study represented another study's "outcome" measures. Family therapy research, particularly that which uses newer data-analytic models such as structural equations (8, 11; see also chapters 14 and 16), will proceed more coherently and effectively if process and outcome are seen by researchers as merely "punctuations" in a complex, ongoing phenomenon.

This framework also forces family therapy researchers and theorists to unconfound goals and techniques. Even those family therapists who have argued that behavior has meaning only in its context have often tended to behave as though techniques exist independently of the context. As one example, some writers have recommended that in order to "join" the family, the therapist should use a language system similar to the family's (3). In most circumstances this technique does help meet the goal of joining the family. However, some families interpret such therapist behavior as demeaning or otherwise inappropriate. In such a case, the goal of joining the family would not be accomplished—in fact, the opposite result may occur. The AIM framework helps us to understand that the specific activities undertaken by a therapist may take a variety of forms, and it reminds us that certain goals do not necessarily always imply certain techniques.

Another important contribution of this framework is a separation of generic versus specific components. Researchers have struggled with this issue for quite some time, and will continue to do so. The AIM framework reminds researchers to separate the generic elements of intervention, which are present in all family therapies, from the specific applications that are unique to one or a few models. For example, we all attempt to motivate clients, but some do it by focusing on symptoms, some by switching the focus to relationships rather than symptoms, some by using prompts such as family games, and so on. Although it does not solve the problem of developing measures for both generic and specific levels, the framework helps to clarify the difference.

Finally, the AIM framework emphasizes the role of the therapist in therapy research. Many research projects attempt to evaluate specific techniques or models as if these techniques or models existed independently of therapists. An earlier review of 285 family and individual therapy studies in five major journals uncovered only one article formally addressing the issues of therapist characteristics (2). This shortcoming is astonishing because the myriad techniques we use must, with very few exceptions, be performed by a therapist. AIM reminds us that in order to perform the techniques, therapists require specific skills—skills that differ from technique to technique, from phase to phase of intervention, and maybe from model to model.

In conclusion, I recommend that investigators who attempt to link the processes of therapy to outcome carefully articulate the phase(s) of intervention that represent the focus of the research. The investigators also should take care to articulate the hypothesized relationship between the measures during that phase and the outcomes being used. Finally, the investigators should discuss how they are dealing with additional variables that may operate during that phase, as well as those variables operating during other phases that may confound the process-outcome relationship being studied.

REFERENCES


5. Editor's Note: Some problems and illnesses, such as grieving and schizophrenia, have well-defined phases through which they characteristically pass. This means that there are two kinds of phases—phases of crisis resolution or illness and phases of intervention—that need to be related to one another. More broadly, a similar point can be made about phases of individual and family development in the life cycle. Consideration of the appropriateness with which phase of intervention and phase of illness/life cycle are matched is a clinical and research issue of great importance—and great neglect. Alexander's delineation of the phases of family therapy process is a major contribution.
PHASES OF FAMILY THERAPY PROCESS


