Family Availability for the Working Alliance

A Neglected Area in Child Psychiatry Training

William J. Swift, M.D.

Abstract. The notion of a working alliance between therapist and patient is widely recognized as necessary but rarely applied to work with families. This paper outlines a phase scheme which conceptualizes different levels of family availability for the working alliance as seen during the diagnostic work-up. Families at each of the four phases present different overt and covert messages to the clinician. The understanding and exploration of the appropriate issues can help the trainee organize a more effective approach to alliance-building with resistant families and reduce early treatment failures.


Early treatment failure of the dysfunctional family is an oft-observed clinical phenomenon. These failures can often be ascribed to the failure of the family, and especially of the parents, to form a "working alliance" with a therapist. Greenson (1967) described the working alliance (also called the helping or therapeutic alliance) as the "relatively nonneurotic, rational rapport between patient and analyst" (p. 192). He distinguished the working alliance from the real relationship between therapist and patient and the transference relationship. For the purpose of this paper, I would define the working alliance in a conjoint family therapy context as an implicit, quasi-rational contract between therapist and the fami-
ily to work together to try to understand the necessary family dynamics in hope of effecting change. The working alliance grows slowly over time and is only in full bloom when the family is well into treatment. Forming a working alliance with a family needs to be distinguished from “joining” a family (Minuchin, 1974). Joining is the process of establishing rapport with a family; it is more a friendly affiliation or connection than an alliance in pursuit of some common interest. Joining can and should occur at the first diagnostic session, long before the formation of something as complex as a working alliance. Conversely, there can be no working alliance without repeated and persistent joining between therapist and family. Curiously, the working alliance between therapist and family remains a topic of child psychiatry about which little has been written. For example, in the Bibliography of Child Psychiatry (Berlin, 1976), no headings or subheadings devoted specifically to this sort of working alliance could be found nor were any references available in the index.

An exception to this apparent paucity of interest was Solomon’s (1977) paper discussing the stages of the building of the working alliance as the therapeutic interaction evolves. He outlined five stages of the alliance with families that he claimed were invariant and must be negotiated in their proper order for treatment to successfully ensue. They are: (1) discomfort about participating in the evaluation procedure; (2) discomfort arising from membership in the family; (3) exploration of the ways in which family members participate in family pathology in a complementary fashion; (4) change in the problem-solving mechanism of the family; and (5) termination of therapy. He remarked that if a family is unable to progress beyond a specific stage, that stage can represent a logical termination point. He reminds the ambitious therapist that, even if treatment does not eventuate to the stage desired by the therapist, the family may still benefit from the therapy.

Assessment of the family potential for the helping alliance early in the evaluation is critical. The purpose of this paper is to demonstrate that early assessment can be achieved through careful scrutiny of each family member’s perception of why he or she has come for an evaluation and through an empathic awareness of the affectively charged issues underlying the stated percepts. The observations and ideas presented here grew primarily from clinical experience with midrange and severely dysfunctional families (Beavers, 1977) in a number of settings, both public and private.
RATIONALE FOR A PHASE SCHEME

The developmental phase scheme is offered as a set of generalizations useful for clinicians in discerning the family's availability to form a working alliance. The different phases, like Erickson's (1950), are not confined in airtight compartments—a majority of families will be wrestling simultaneously through several phases although, clinically, one does seem to predominate. My thesis is two-fold: (1) that many families, under the right conditions, can progress through the various phases during an evaluation toward greater readiness for an alliance; and (2) that their potential for alliance may well determine the type of treatment eventually offered, e.g., conjoint or concurrent family therapy or predominately child therapy.

The progression through each phase in the development of the helping alliance depends upon clarification and resolution of a pertinent issue. Core issues are illustrated by the use of overt and covert questions asked of the therapist by the parents. The overt questions reflect the rational concerns of the parents and the therapist will often rather easily be able to discern and answer these questions. The covert questions reveal the more deeply held, irrational, and potentially painful side of the same concerns. Clinical vignettes in the paper will be utilized to demonstrate the issues involved.

THE PHASES

Phase I: Denial and Despair

Parents and families at Phase I do not, as in the other phases, ask straightforward questions—rather they make definite but veiled statements to the therapist. This closed system of communication mainly accounts for the early feeling of helplessness experienced by the clinician. The overt statement (with a tag question) might be phrased as "There isn't a problem, is there, Doctor?" The covert statement is "We are not helpable, nothing can ever change, because human relationships seem dangerous and inherently ungratifying." In a sense, the family members appear to be in a state of "pretrust"—despair and cynicism are so pervasive in the family system that trusting a potential helper is beyond their ken.

In my experience these families are rarely self referrals. The
referring school or social agency has grappled with the enormous public problem that they often present and, failing to make gains by employing their usual procedures, have encouraged or demanded that the family seek psychiatric help. The referral source is especially baffled by how treatment plans slowly unravel, despite how cooperative in many ways the family seems. One might say that the family has had a “pseudo” working alliance with the referral source: it has been superficially compliant but its way of coping with the problem has been, in essence, to deny that there is a problem. The prognosis for forming an eventual working alliance is quite poor.

Case 1. Josephine, age 12, and her family were referred by a local school district for psychiatric evaluation. Her family had moved to this school district only six months before and Josephine was manifesting some very disturbing behavior. She was described as withdrawn and withholding, bizarre, excessively silent and anxious, and performing far below her academic potential. She had been placed in a classroom for the developmentally delayed but remained a severe management problem. She had been labelled as mentally retarded since age 3 because of her deviant development and epileptic diathesis. Her parents had been married for 18 years and also had a 9-year-old boy named Bennie. Interestingly, Bennie developed his first psychiatric symptomatology 2 weeks before the evaluation. Pressured by the school officials who saw Josephine as “disturbed” rather than “retarded,” the parents agreed to the evaluation but apparently with a deep, unspoken resistance that was only felt as the evaluation unfolded.

Josephine's lack of communicative skills and withdrawal made individual diagnosis initially difficult. Josephine was functioning at a retarded level but there was also no doubt that she was a psychotic child. While working with the family members, one was struck by the rigidity of their role-taking, their blatant denial of the strangeness of her behavior, and their impermeability to outside influence. A sense of murkiness and mystification permeated the family's interactions with the diagnostic team. The family expressed few concerns about Josephine even in the face of the prodding by the school team. When the team confronted the parents with the seriousness of the emotional disturbance, they responded with bland agreement much closer to denial than assimilation. Therapy was eventually recommended for both the identified patient and her family. At the 3-month follow-up,
mother faithfully recited the need for treatment but then put forth a number of “good” reasons (time, logistics, money) why readily available treatment opportunities had not been engaged.

The diagnostic team had great trouble in joining this family. Thus, the team and the family were relatively unable, at this time, to form a working alliance. The prevailing family mythology (Ferreira, 1963) of Josephine’s hopeless retardation was incongruent with the clinical reality of her psychosis. The family seemed unable to accommodate a new perspective. Very quietly, in a masked way, the parents were telling us, “There is no psychiatric problem, is there? It is merely retardation.” Essentially, the family seemed to be in despair and the specter of potential interference must have been seen as a grave danger to the homeostatis (Jackson, 1965) of this fragile family. To protect themselves from a feared intrusion, the members of Josephine’s family withdrew.

Phase I families can engender the most primitive and, hence, most powerful feelings among helpers; a study of the feelings elicited can almost reveal a family at Phase I. When the therapist gains awareness of the panoply of feelings experienced in and out of the presence of the family, he or she understands with a deeper level of empathy what it is like to be a member of that family. The clinician often feels overrun by intense emotion. In such a situation clinical judgements may well be made primarily on feeling and impulse and one’s capacity to give considered thought can be temporarily lost. Phase I families routinely precipitate a splitting (Main, 1957) among members of a diagnostic team. The “good” workers become overly solicitous and protective of the family and enter unknowingly into a secret partnership of denial and minimization, while the “bad” workers, almost as if infected by the family’s rage and despair, will make heroic efforts to rescue the “victimized” child from the “persecutory” parents.

Phase II: Mistrust

At Phase II the important overt question is, “Is there now a psychiatric problem?” while the covert question might be “If we must seek help now, Doctor, can we trust you, can we trust each other, and can we trust our feelings?” Phase II families typically focus on the child. They do not deny or minimize the significance of the symptomatology as Phase I families do; in fact, they seem inordinately preoccupied with it, often to the exclusion of other facets of the child. They come to an evaluation with their own diagnostic quandary. As the
clinician formulates his differential diagnosis, the family members will, in parallel, be forming one of their own. Their considerations will usually be highly influenced by what is in diagnostic vogue—e.g., today's parents come to practitioners wondering if the symptomatic behavior might not be due to an easily correctable dietary deficiency or excess, or secondary to “hypoglycemia,” or occult seizure disorder. When the child is adopted, genetic concerns may take center stage.

During Phase II, parents seem rather emotionally distant from the troubled child, which, I believe, is largely defensive and tends to diminish at Phase III. Some characteristics of emotional distance include: (1) intense interest in control of the child's behavior coupled with strikingly little emphasis upon the child's inner psychological world and emotional needs; (2) the peculiar sense that the family would be free from the usual human anxieties and concerns if only the child were to conform behaviorally to the family ideal; and (3) initial resistance to family meetings implying transaction among family members and a threat to a family homeostasis, which depends on a safe distance. While Phase I families are on the whole unavailable for a working alliance, Phase II families are ready during the evaluation to entertain, in an embryonic way, the possibility of an alliance.

Mistrust—wariness of the potential helper, secretiveness among family members, and fearfulness about feelings—seems to be the cardinal issue at this phase. As the family, over a number of diagnostic sessions, begins to develop a sense of security in the presence of the therapist, the family's questions around differential diagnosis fade away and there is an acceptance of a psychological origin of the problem behavior. Families who remain fixed at Phase II are likely to "doctor shop" until they find a clinician who gives them the least threatening, most cogenial diagnosis and/or treatment opinion.

Case 2. Mr. and Mrs. D. brought in their 14-year-old daughter Judy for evaluation. As the parents recalled, family life had been uneventful until about a year ago when their daughter withdrew from them, experimented with marijuana, spent time with unacceptable companions, and finally ran away on several occasions. They had attempted to remedy Judy's misbehavior by enrolling her in a boarding school; however, her return home for summer vacation prompted the family's anxiety to rise sharply. Parents and Judy arrived at the office and neglected to bring the
two younger siblings as requested. They were a close-knit family that ran a small family business to which all members contributed. Mother, the family spokesperson, set the tenor for their only interview; “Well, I don’t know if we'll need you. Things with Judy have really gone well of late. I thought we should meet you just in case it all falls apart in the future.” Obviously the parents were worried about Judy’s impulses and fearful that they would become uncontrolled again. A telling point was disclosed by their means of arrival at the clinic: mother had been the motivating force in arranging the treatment, father had agreed after prodding, and Judy had been shanghaied. Her parents neglected to tell her that the “medical appointment” was psychiatric.

During the review of this case, parental anxiety was very high and rather diffuse, and their considered diagnoses appeared to run the gamut from adolescent misadventure to sociopathic personality. They were a frightened family, too frightened to even attempt to answer their own question (“Is there an emotional problem?”) until Judy forced their hand by further acting out. They had by no means reached Phase III, in which they could begin to ask where the emotional problem might reside. Making one visit under the aforementioned circumstances seemed to be a strategy to evaluate a prospective therapist (“Is he trustworthy?”). The failure to bring the two younger siblings and the deception involved in their arrival at the clinic pointed to a breakdown in intrafamilial trust. The one session encounter appeared to express uniquely the family’s trust/mistrust ratio about themselves and about a potential helper.

Phase III: Guilt and Blame

Families at Phase II have a way of moving, sometimes surprisingly quickly, to Phase III. At this phase the overt question is, “What is the nature of the psychiatric problem?” while the covert question is “What will we do with our guilt and blame if we don’t have an identified patient to focus upon?” If Phase II families arrive willing to entertain the possibility of a working alliance, then Phase III families are even more willing to do so; however, their burdensome guilt and blame must be lessened before true collaboration can begin.

As an example, a family comes to a clinic with a symptomatic child and as the evaluation proceeds the parents do come to realize that he has a psychiatric problem. If the family contributes to the problem, the astute diagnostician must now ascertain just how far
the other members of the family can go in seeing their part in the child's problems, whether on a genetic or contemporaneous basis, without being overwhelmed by destructive guilt and blame. Working through Phase III can be a perilous process requiring many weeks or months. The suggestion that the members of a total family and/or subsystem configuration (e.g., a dysfunctional marital union) are contributing to the child's symptomatology presents a massive perturbation to a family system in which the availability of an identified patient plays an important role in maintaining a viable homeostasis. The existence of a labelled patient gives all members of the family the security of knowing where all the "badness" resides. To have disruptive affects—guilt, rage, hate, envy, depression—loosened from their habitual family moorings and set into their own, free floating orbits, detached from the labelled individuals, will be frightening to an unprepared family.

Such a family is being asked to make a quantum leap from a child-focused to a family-focused view. In the presence of initial resistance, this transition can only be effected slowly as the therapist measures as best he or she can, the dosage and timing of each intervention and estimates its probable impact on the family. If the therapist moves too aggressively, the family may experience the potential helper as persecutory and respond by fight and/or flight from what has become a menacing situation.

Case 3 describes a family that began evaluation at Phase III. Individual psychotherapy for the symptomatic child had originally been recommended. Shortly, however, the situation required that conjoint family therapy also be initiated. The family therapist helped facilitate their transition from Phase III to IV (a multiperson perspective) by well-timed reframing statements that maximized the family's availability for a working alliance without provoking the sort of premature guilt and blame (among family members and between therapist and family) that would have been countertherapeutic.

Case 3. Josh, a 14-year-old male, and his family were referred for evaluation by their family physician. He had always done well in school and, as the last born of three children, had always been considered a "delight" by his parents. Within the past months Josh had become symptomatic with a crippling obsessive-compulsive neurosis. Interestingly, father also had experienced intrusive and repetitious thoughts in his early adolescence although never as severe as Josh's. The parents were both striving professionals and the cli-
mate of family life was rather high-pressured and lacking in emotional spontaneity. The parents were genuinely shocked and confused by their son's symptoms and vigorously denied any family conflict. The clinician concluded that Josh was a superego-ridden youngster who had regressed under the impact of the age-specific demands of adolescence for which his childhood of overcompliance had left him poorly prepared. Individual psychotherapy was suggested for two reasons: Josh was verbally skilled and had a bent for self observation, and the contributions of the family to Josh's problems seemed to be on a past rather than a present basis. Shortly after beginning the therapy, mother called saying that Josh's symptoms were becoming more severe and were beginning to disrupt the entire family. Parental anxiety was so high that a referral was hurriedly made to a family therapist while intensive individual work continued. The family therapist first made a contract with the entire family (including the siblings) to meet with them in order that the rest of the family might gain a better understanding of what was ailing Josh and how best to respond to it. It quickly became evident that the parents, in their well-meaning attempts to help their child, had worsened the situation: father relied on exhortation and a "snap-out-of-it" approach while mother tended to be overly protective and anxiously reassuring. Although their symptomatology was not florid, it became obvious that the two older siblings were each having their own difficulties in negotiating adolescence and young adulthood. At this point, the family therapist took a new initiative. He told the family, "Since it is obvious that focusing on Josh and talking about him does not help during these sessions, it would be best to 'defocus' him. Instead of talking about Josh, talk about the family, the way you work together, and your own individual lives within the family. Sometimes a lad like Josh can only change after the rest of the family gives him permission to do so; you can do this by showing him how to talk about himself and his world by doing it yourselves, right here."

The family was quite open to reframing family meetings and within a few appointments the parents began to reveal how wretched and ungratifying their marriage had been for 25 years and how they feared that their conflicts had adversely influenced all the children and not just Josh. Sometime later they stated that their initial minimization of the marital discontent had served to protect them from what seemed to have been the threat of unbearable self-reproach about their children's problems.
Phase III families are second only to Phase I families in the sort of conflicting feelings they elicit during an evaluation. Most difficult are the situations in which the family seems unable or unwilling to make the shift from a child-centered focus to a family-centered one, which becomes troublesome when the clinician concludes that individual therapy is inappropriate or must be combined with conjoint or concurrent family therapy to have any hope of success. At such times, the therapist must negotiate the narrow strait between venting his own frustration at the family's implacability about the nature of the problem and masochistic surrender to neurotic family control. In such circumstances, I agree with Kernberg (1978) that it is best to tell the family that one can't treat the child alone without family involvement and if they can't accept this they might do well to seek out another therapist who might feel comfortable in meeting their wishes. Napier and Whitaker (1978) aptly call this the "battle for structure."

Phase IV: Working Alliance

Few families come to an outpatient psychiatric clinic at Phase IV; more do so in a private practice setting. As outlined in this paper, the Phase IV family has accepted the existence of a psychiatric problem and its nature and, when appropriate, has shifted from a one-person to a multiperson focus. At Phase IV, the overt question might be, "What should we (parents, identified patient, siblings, and therapist) do about this problem?" The more anxiety-laden covert question is, "What unforeseen narcissistic loss must be endured individually and collectively as the price of change?" When Phase IV is reached, the family members have an early, but flourishing, working alliance with the therapist. They are truly in therapy and not, as Napier and Whitaker (1978) remark, merely meeting with a therapist. Parenthetically, Phase IV coincides with Solomon's (1977) Stage 4 or "change stage." As time passes, the helping alliance will deepen and broaden and the expectable problems and overlying resistances in their many guises will be slowly and repeatedly worked through.

At this phase, the therapist has a sense of being let into the family circle as an ex-officio member during the appointment hour. He will no longer feel himself scurrying around the perimeter of the family attempting to infer from the transactional behavior of the family members what the hidden family dynamics are. He will, at times, even enjoy a sense of comfort and security that only a
family can provide its members as well as a real sense of loss when the family has made gains and termination of therapy looms.

**DISCUSSION**

The rational rapport between therapist and family grows slowly over time only because irrational issues are subliminally raised and must be resolved. It is hoped that the conceptualization of family availability for the working alliance, based upon the clinician’s empathic understanding of the family’s perception of the problem and the unspoken, covert issues embedded therein, will help both the trainee and the experienced practitioner organize an effective approach to the perplexing clinical phenomenon of family and parental resistance with which they are daily confronted. The central notion is that during the diagnostic phase the therapist must continually examine the family’s potential for the helping alliance and make appropriate modification in his or her thinking and strategy as needed. If the concerns at each phase in the unfolding of the helping alliance are not addressed, the risk of early treatment failure rises dramatically.

Tseng et al. (1976) attempted a conceptualization in which they described six major family types based on a developmental history of the family, observation of the family transactions, and the impact of diagnostic separation of the child from his family. They also suggested some therapeutic interventions—child, family, or both—appropriate for each diagnostic type. This paper has a similar thrust: rather than attempting to fit the child and family into the Procrustean bed of an abstracted model, it examines the necessity of examining what the family brings to a prospective therapist, specifically the degree of its potential for forming a working alliance. This can be most critical for families at Phase III—their ability or inability to make the shift from a single-person to a multiperson focus may determine the sort of therapeutic approach that should be offered. By recognizing the awesome complexity of a family and by exhibiting an empathic openness and flexibility of approach, we are only imitating the very qualities of a healthy family (Lewis et al., 1976) to which we ask our patients and trainees to strive.
REFERENCES