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Collaboration in Family Therapy

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Abstract

This article summarizes and illustrates the collaboration strategies used by several family therapies. The strategies used within multisystemic therapy (MST) are emphasized because it has demonstrated high rates of treatment completion and favorable outcomes in multiple clinical trials. Many of the collaboration strategies in family work are common to other forms of evidence-based psychotherapy (e.g., reflective listening, empathy, reframing, and displays of authenticity and flexibility); however, some strategies are unique to family systems treatments, such as the identification of strengths across multiple systems in the youth's social ecology and the maintenance of a family (versus a child) focus during treatment. A case example illustrates collaboration and engagement in the context of MST.

Keywords

Collaboration; family therapy; multisystemic therapy; engagement strategies; therapeutic alliance

Collaboration in Family Therapy

A fundamental assumption of the new generation of evidence-based family therapy approaches is that family engagement and collaboration are essential for therapeutic progress. This assumption follows logically from underlying tenets of family therapy that behavioral health problems are best conceptualized within a systemic framework (Lebow, 2005) – a perspective that emphasizes the multi-determined and reciprocal nature of human behavior (e.g., Bronfenbrenner, 1979). If child and adolescent psychosocial problems are closely linked with family relations and transactions within and between other social systems (e.g., peers, school, neighborhood), and decades of research have demonstrated such associations (e.g., Liberman, 2008), then strategically changing key aspects of family relations should lead to improved youth functioning. Indeed, in reviews of evidence-based psychotherapies for children and adolescents, family-based approaches predominate, especially in the treatment of externalizing problems such as conduct disorder, delinquency, and substance abuse (e.g., Weisz & Kazdin, 2010).

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This article focuses on the engagement and collaboration strategies used by several family therapies with empirical support in treating youths with serious behavior problems and their families. These treatments include functional family therapy (Alexander & Parson, 1982), multidimensional family therapy (Liddle, 2009), brief strategic family therapy (Szapocznik, Hervis, & Schwartz, 2003), multidimensional treatment foster care (Chamberlain, 2003), and multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). The success of these treatments is noteworthy considering the significant challenges posed by the youth and families typically treated by these approaches. For example, youth with conduct problems have high dropout rates; and single parent status, economic disadvantage, minority status, and residing in low-income neighborhoods have been associated with high rates of dropping out of psychotherapy (Gopalan et al., 2010). Yet, these family therapies have not only been successful at engaging such families in treatment, but also proven effective in attenuating a range of serious clinical problems while improving family functioning.

In describing the effective collaboration strategies used by the evidence-based family therapies, those used within MST will be emphasized in this article for several reasons. First, most of these strategies are also used by several of the other evidence-based family therapies – none are unique to MST. Second, with 19 randomized clinical trials, MST has an extensive evidence base (Henggeler, 2011), including favorable treatment effects with violent and chronic juvenile offenders that have been sustained for 22 years (Sawyer & Borduin, 2011). Third, MST has demonstrated high treatment engagement and completion rates when provided in clinical trials and in real world community settings (mstinstitute.org). Finally, the authors are most knowledgeable about MST methods.

Before describing the engagement and collaboration strategies used within MST, it is important to note that these strategies are consistent with findings in the broader psychotherapy literature. For example, the recent APA Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011) concluded that the therapeutic alliance (in individual, youth, and family therapy), therapist empathy, and obtaining client feedback are *demonstrably effective* in promoting favorable client outcomes; and that therapist-client goal consensus, collaboration, and positive regard are *probably effective* in promoting favorable outcomes. As discussed subsequently, evidence-based family therapies target these and related constructs explicitly. Similarly, these therapies have developed strategies for mitigating the use of therapist behaviors that are counterproductive, such as blaming, rigidity, and therapist-centricity. To reiterate: the following description uses MST as an exemplar, but the strategies are common to evidence-based family therapies.

MST Engagement and Collaboration Strategies

Families mandated to MST typically come from clinical populations historically labeled as “resistant” (e.g., juvenile offenders, substance abusing youth). Indeed, many of the families referred to MST have experienced multiple treatment failures. Against this backdrop, MST therapists strive to create strong collaborative relationships with their clients. It is assumed that treatment will not progress until the therapist and key family members (the youth’s caregivers or other adults who have decision-making authority) are engaged and ready to

work on important therapeutic tasks, such as defining problems, setting goals, and implementing interventions to meet those goals.

Therapists utilize several core clinical strategies to enhance collaboration with families. These strategies are culled from various theoretical orientations and help create a climate of engagement while behavioral and systemic interventions are being implemented. The most common engagement strategies used in MST are described next.

Identifying Strengths across Multiple Systems

Families referred for MST often have a history of treatment experiences that focused primarily on individual- and family-level deficits. Therapeutic relationships that are based on a family's weaknesses are difficult to maintain. Thus, in an effort to build strong engagement, MST therapists strive to highlight youth and family strengths throughout treatment. This strength-based approach sets a positive tone for sessions and ultimately motivates clients to address their most difficult problems. Therapists look for potential strengths within multiple contexts, including the individual child (e.g., intelligence, hobbies and interests, social and academic skills), family (e.g., problem-solving ability, affective bonds, financial resources, extended family), peers (e.g., prosocial activities, achievement orientation), school (e.g., management practices, prosocial after-school activities, concerned school personnel), and the neighborhood/community (e.g., concerned and involved neighbors, voluntary associations such as Boys and Girls clubs, recreational opportunities). In addition to facilitating engagement, the identification of strengths helps inform the design of interventions. For example, a concerned neighbor or extended family member might be enlisted to assist with monitoring a youth after school until the caregiver returns home from work.

Of note, MST therapists do not take an unrealistic "Pollyanna" approach when working with families. Creating a false sense of hope is counterproductive when families are ill prepared to succeed. Rather, therapists strive to realistically appraise each family member's abilities and use their strengths to accomplish tasks, while simultaneously working to develop additional strengths needed to attain treatment goals.

Reflective Listening

Reflective listening (Miller & Rollnick, 2002) is a basic clinical skill that demonstrates understanding of the client's experience. Skillful reflective listening requires the therapist to accurately summarize both content and meaning in a way that feels supportive to the client. Although there are many types of reflective responses, those most commonly used by MST therapists include simple, amplified, and double-sided reflections. In a simple reflection, the therapist simply repeats a client's statement verbatim to emphasize the importance of the client's point and to communicate understanding. In an amplified reflection, the therapist reflects back what the client has said in an amplified or more exaggerated form. For example, when a substance-using adolescent expresses doubt about his or her ability to abstain from drugs, an amplified response might be, "You expect to use drugs for the rest of your life." In a double-sided reflection, the therapist reflects back both sides of a client's ambivalence about a particular issue. For example, a caregiver might say, "I could ask my

mother to watch over my son when he gets home from school, but she might view this monitoring as my responsibility." A double-sided therapist response could include, "You think that your mother could be a real source of support in monitoring your son, but you are worried that by asking for this support, she might think of you as an ineffective parent."

Reflective responses are essential early in treatment because they provide an opportunity for clients to share their thoughts and feelings and also determine if the therapist understands their circumstances. Indeed, clinical problem solving is not likely to be effective if the caregiver does not believe that the therapist appreciates what the family is up against. The time invested in listening during initial sessions leads to stronger engagement and more efficient intervention development as treatment progresses.

Empathy

The importance of therapist empathy cuts across schools of psychotherapy. Given its significance, therapists strive to maintain an empathic viewpoint throughout treatment. That is, they demonstrate an intimate understanding of the client's perspective, as though they themselves were experiencing the client's thoughts and feelings (Rogers, 1959).

Maintaining warmth and compassion is easy when the recipient appears deserving. However, displays of compassion are more challenging with clients who do not naturally evoke empathy, such as those who might have abused or neglected their children. Frustration naturally occurs when working with clients who seem to put their own needs before those of their children. Nevertheless, negative bias toward clients increases the likelihood of unproductive communication and premature termination from therapy.

The following phrases can be used to help therapists identify warning signs of bias in their work:

- Therapist – 1, Family – 0 (e.g., "I care more about this child than his mother does" or "If I were in that position, I would…")
- The Grass is Greener on the Waiting List (e.g., "I don't need this. I'll go work with someone who wants my help.")
- Diagnostic Doom (e.g., "She has a raging personality disorder.")
- Ad Hominem Attacks (e.g., disparaging, "below the belt" thoughts about a client's appearance, home, manner/habits, or community. These thoughts are often shared with colleagues under the pretense of "gallows humor.")

By recognizing such warning signs, therapists are better able to monitor their beliefs about clients and reorient themselves toward a strength-based view. As described next, three additional strategies are used in MST to minimize bias and convey empathy. These include perspective taking, data collection, and utilizing "opposite action."

Perspective taking—For this strategy, therapists recall a particular incident or client statement that produced a negative reaction. They then consider the following questions to help understand the client's point of view:

- What underlying message was the client trying to convey when this occurred? What was he or she feeling? What got in the way of the client communicating his or her message in a way that would make me feel more positively?
- How did the client get to this point (today, this month, in their lifetime)? How has communicating in this way been useful for the client in the past?
- How does this situation demonstrate the client's strengths? How does it demonstrate his or her suffering? How can I show the client that he or she does not need to behave in this way to get help from others?

Collecting data—Therapists can also make a conscious effort to seek evidence that refutes their negative attributions. This can be accomplished through the following exercise:

- The therapist records the thought that needs to be disconfirmed (e.g., "The mother doesn't care about her son").
- The therapist then generates a list of client statements or behaviors that suggest effort, motivation for change, or positive feelings – anything that could disconfirm the maladaptive thought.
- The therapist remains patient with the process of finding evidence that disconfirms the maladaptive thought (e.g., "I found one piece of evidence yesterday, today I will try to find two"). The therapist also recognizes that clients are moving targets. For example, a mother might show little evidence that she cares about her son right now, but the therapist remains open to the possibility that this situation is likely temporary.

Utilizing "opposite action"—In Dialectical Behavior Therapy (Linehan, 1993), opposite action is described as a behavior that elicits emotions that are incompatible with the original behavior. For example, a person who is feeling sad might watch a frightening movie, which will induce physical sensations (e.g., heart racing) that are incongruent with sadness. Similarly, a therapist can counteract a negative thought (e.g., "I'm dreading this session. I hope they cancel.") by replacing it with a thought that evokes opposite feelings (e.g., "I've spent the last hour coming up with a plan for this session and feel motivated to accomplish these tasks. They better not cancel!").

Hope and Reinforcement

Many families referred for MST treatment have been told repeatedly by family, friends, and social service professionals "how bad things are" for the child and family. To counter this pessimistic stance, therapists try, through optimism and a "can do" attitude, to engender hope among family members and energize the family to effect change. In some cases, the therapist might need to "hold the hope" for the family early in therapy. That is, the therapist might provide the main source of energy and strength until the family experiences success and develops self-efficacy.

Therapists can build hope and feelings of self-efficacy through the use of positive reinforcement. The therapist strives to find evidence of client effort and improvement,

regardless of how small. For example, a client might be reinforced for simply attending treatment sessions. A client's mere presence in the session is evidence that he or she has not completely given up hope. Saying to a client, "You are here and that means a lot," can help to motivate family members to work on goals. Reinforcing positive in-session behaviors is critical for people who are accustomed to others noticing their mistakes instead of their successes.

When delivering positive reinforcement, MST therapists are mindful of the possibility that comments might come across as condescending if authenticity is not conveyed in the therapist's speech and body language. Strong eye contact and a warm but matter-of-fact tone should accompany reinforcing statements. It is also important to emphasize "natural" as opposed to "artificial" reinforcers when attempting to develop meaningful engagement (Kohlenberg, Hayes, & Tsai, 1993). For example, thanking a historically passive client for expressing frustration with the therapist is an artificial reinforcer because people outside of therapy are unlikely to ever thank the client for displaying anger or frustration. However, attempting to directly address the client's concerns is a natural reinforcer because the client experiences success that he or she could recreate in non-therapeutic situations.

Reframing

Family negativity is often exacerbated by the harsh views that family members have toward each other. For example, an adolescent boy might view his father as hostile and bossy, and the father might have negative views toward his son's lifestyle choices (e.g., dress, friends, and music). Reframing provides an alternative frame of reference aimed at decreasing negative affect.

Reframing involves three stages. First, the therapist validates the perspectives of the family members. For example, the therapist might indicate to the boy, "I understand why you think your dad doesn't like you. He often criticizes the way you dress, acts disgusted by the music you listen to, and thinks your friends are losers." To the father, the therapist might say, "You've tried to give him a proper sense of moral values and respect for authority. But the way he dresses and behaves drives you crazy. In fact, sometimes you think that he is intentionally trying to push your buttons." During the second stage, the therapist provides an alternative perspective that puts the behavior in a benign or even positive light. For example, the therapist might say to the boy, "I wonder if your dad's nagging, negative comments and restrictions are a sign of his love for you. If he didn't care for you so much, he might just let you dress and act however you wanted." To the father, the therapist might say, "Your son's lifestyle choices might just be his way of gaining independence. I suggest we focus on the big issues, like not getting rearrested, and let him have his little rebellions." In the final stage of reframing, the MST therapist checks with family members to assess their agreement with the reframe. The end result should be a mutually agreed-upon alternative for certain types of negative interactions. With this alternative explanation in place, family members can move forward on interventions that require all participants to collaborate.

Authenticity and Flexibility

Therapists strive to be authentic and flexible when working with families. Authenticity means striving to communicate in ways that are honest and consistent. At times, genuine "naming" of a therapeutic issue can help facilitate engagement with clients. For example, if a caregiver expresses doubt about the therapist's ability to help because the therapist and family reside in vastly different neighborhoods, the therapist might say, "You've mentioned that I can't help you because I don't understand what it's like to live in your neighborhood. You are absolutely right, I'm not from here. I have been concerned that I might not understand some things about your situation, get things wrong, or that I am not doing a good job of making you feel supported or understood. Let's spend some time talking about what is working and not working in our interactions together." At other times, an interpersonal strategy helps increase alignment by emphasizing shared experience and refocusing on problem-solving: "I can hear the anger in your voice as you talk about what happened. I can feel myself getting frustrated too -- hearing about what your son did and how the police responded. It's not a good feeling. We better put our heads together to figure out how to get things back on track."

Along with authenticity, flexibility is needed to assure families that the therapist can handle the many problems they face. Flexible people adjust to changes quickly and can make the best of less-than-ideal circumstances. Therapists who conduct home visits, for example, are likely to be confronted with a wide range of situations requiring flexibility and an unflappable attitude. Such circumstances can include physical limitations (e.g., lack of seating in living room) or situational changes (e.g., family has been evicted from their apartment and needs to find new living arrangements immediately). Managing situations with a can do attitude and good humor demonstrates the therapist's willingness to "roll with the punches."

Preparing Families for Their Own Disengagement

Avoiding change (and agents of change, such as therapists) is a natural, expected part of a family's response to treatment. Therapists gain credibility when they can predict treatment glitches, such as avoidance or anger, and then refer back to their predictions when a problem arises. Predicting disengagement is one of the most powerful strategies to prevent its occurrence (or to decrease its intensity and duration). By discussing the prospect of disengagement early in treatment, therapists help normalize fluctuations in motivation during the course of treatment, which can make it easier to bring families back on board when disengagement occurs.

MST therapists use a variety of strategies to reengage families during treatment. These include accessing family supports prior to disengagement, practicing the "foot in the door technique" (i.e., offering to have short, "check-in" sessions), as well as going "above and beyond" to resume contact by leaving friendly notes or food at the home so that family feels welcome to return to treatment.

Maintaining a Family (vs. a Child) Focus

Family therapists recognize that youth-focused treatments are unlikely to yield the types of systemic changes that are critical for sustaining positive outcomes. Thus, a family focus is maintained throughout the treatment process through prioritization of the family's goals, accommodation to the family's needs, and harnessing of family supports.

Prioritizing the family's goals—Each family member is asked to identify his or her desired outcomes for the target adolescent and family, and these outcomes are integrated with the goals specified by community stakeholders (e.g., probation, school) and the therapeutic team. When family members play an active role in setting treatment priorities, they are more likely to collaborate in the development and implementation of intervention strategies.

Accommodating to the family's needs—More often than not, MST therapists work with families that are financially disadvantaged. Demands on such families can be so overwhelming that little time or energy is available for engaging in treatment. Thus, therapists demonstrate flexibility by meeting with family members at locations that are relatively comfortable (e.g., home vs. clinic office) and convenient (e.g., after work). Such flexibility can help facilitate the development of a strong therapist-family alliance.

Harnessing family supports—MST therapists identify community supports by examining the caregiver's social network including extended family, friends, neighbors, co-workers, and community contacts (e.g., church members, participants in neighborhood organizations). Such supports have the potential to provide instrumental aid (e.g., transportation, childcare), emotional support (e.g., empathy, concern, caring, trust), feedback (e.g., support for good parenting, social comparison), and information (e.g., job opportunities). Ultimately, community supports are critical for the long-term maintenance of change, but they can also be used to facilitate the engagement process. A neighbor might care for the family's three young children while the parents meet with the therapist, for example.

Maintaining Productive Communication

Family engagement can be attenuated when therapist-family contact is not maintained through regular sessions or when incompatible communication styles limit session progress. Several strategies can be used to address these common communication barriers.

Addressing missed sessions—Missed sessions early in treatment typically suggests that either the therapist has not demonstrated his or her usefulness to the family or the family does not feel a sense of urgency about the problem. Missed sessions that occur mid-treatment can indicate that a family member is feeling overburdened (e.g., "I need a week off"), a rupture in the therapeutic relationship has occurred (e.g., the client is angry at the therapist), or the client is frustrated with the lack of progress in treatment. Using the "Five P's for Resuming Contact with Clients," as shown in Table 1, can increase communication when treatment has stalled.

Managing different communication styles—Sometimes, a caregiver's communication style does not fit well with a clinician's typical therapeutic approach. For example, a caregiver might speak more forcefully or appear more dominant, and the therapist might have difficulty interrupting or maintaining focus during sessions. These moments can be frustrating as the therapist might feel "run over" and view the caregiver as either intentionally or unintentionally derailing progress. The caregiver can feel isolated or judged if the therapist asserts too much control over the session or seems uncomfortable, and might suspect that the therapist cannot handle the challenges his or her family faces. The following techniques can be used to address these communication problems and maintain collaboration.

Managing venting: Caregivers often view forceful venting as necessary to ensure that the therapist understands the magnitude of the child's problems. During periods of venting, reflective listening is critical. Nevertheless, the therapist should recognize when sufficient venting has occurred. A good rule of thumb is to allow caregivers to vent 5–10 minutes at the beginning of sessions and then redirect the session toward achieving therapeutic goals.

Using the force for good: At times, a forceful communication style (slightly louder volume, firm voice) can be used strategically to help a therapist better match to a caregiver. However, forceful language should only be used for strength-focused content that is intended to (a) praise or (b) infuse hope. It should not be used to argue, or "yes, but" a caregiver, and of course, never to berate a caregiver into changing behavior.

Naming the problem: Caregivers are often relieved when the therapist acknowledges that a communication mismatch is occurring. By using this approach, therapists can increase authenticity in their relationship and model effective communication. For example, a therapist might say,

> Let's put our heads together for a minute to figure out what's going on right now between us. I'm noticing that it's hard for me to get a chance to respond to what you're saying, and it seems like you have to speak very strongly to make sure I understand you. It's hard for me to feel like I'm a part of the conversation. What do you think is happening right now?

Setting explicit boundaries: Agreeing on an agenda and preparing clients for interruptions can help make transitions easier. Below is an example of a therapist's use of this strategy:

> I really want to hear everything that's going on, and I also want to make sure we have plenty of time to meet our goals for today. Now you know that sometimes when we get talking, it's hard for me to jump in. So I might cut in sometimes to make sure that we take care of all the things we want to accomplish today. But I don't want to be rude either. So if there is a time when I stop you and you feel like there was a concern that you did not get to express, can you let me know so we can reserve time at the end of the session to revisit your concern?

Case Illustration

Presenting Problem and Family Description

Ana was a 16-year-old girl of Dominican descent who was referred to MST due to community re-entry problems after 8 months of residential treatment. These problems included delinquent behaviors such as school truancy; running away overnight to spend time with an over-age, gang-affiliated boyfriend; and stealing from the home. Ana was previously diagnosed with Conduct Disorder and Major Depressive Disorder and was being treated with antidepressants at the time of referral. She resided with both parents, whose primary language was Spanish, and two younger siblings in a low-income urban area.

Development of Initial Engagement

At the beginning of treatment, the MST therapist, Marie, and interpreter, Selia, worked with the family at their home to (1) evaluate strengths and needs, (2) obtain multiple perspectives on the family's problems, and (3) prioritize targets for behavior change. Engagement was an immediate concern because Ana's parents expressed reservations about Marie's perceived cultural difference from the family. Similarly, Marie experienced anxiety about the possibility of the family engaging more with the interpreter who was also from the Dominican Republic.

To increase her credibility, Marie prioritized Ana's parents' concerns and used her knowledge of the juvenile justice system to ensure that the family was well prepared for their upcoming court appearance. Marie reported:

> I did a lot of "hands on" things with them: going with them to court and spending a lot more time focusing on preparing for court, because I knew that's where a lot of their anxiety was. They had a fear that everything was going to be pulled out from under them. So I tried to be very practical. That was my avenue to get into the family, to get them through the process. I think through the positive outcomes in court, the judge's reaction to the work that they had done and what I had supported them in doing, like coming up with a very concrete monitoring plan and making sure we "dotted every 'i' and crossed every 't' "-I think that really supported engagement.

The interpreter, Selia, further enhanced the working relationship by expressing culturally appropriate warmth, especially toward Ana's mother. She noted that, "I would kiss the mother on the cheek when greeting her, which I would not necessarily do with other families." She also reported, "I called the mother 'Doña.' That's something that is very respectful, but at the same time it's something sweet. Instead of saying, 'Mrs.' " Any time the family offered food or drink, Selia and Marie would accept, knowing that to refuse might be perceived as aloof behavior.

With an initial working alliance established and the family's legal concerns made less urgent, Marie began targeting family behaviors for change. Marie noted that a supportive, nonjudgmental style (demonstrated mostly through reflective listening) was essential to drawing family members out. Although the pace of treatment felt slower to her than she

preferred, Marie recognized that the parents' anxiety about treatment required her to be particularly respectful of their approach to sessions.

Maintaining Engagement

As treatment progressed, it became evident that Ana's father had difficulty discussing sensitive topics, such as his daughter's risky sexual activity. Marie initially approached this matter directly, leading the father to walk out of a session. Marie recognized that she had made a misstep and acknowledged such during the next session. However, she also stated that the topic needed to be addressed and asked the parents' advice for how to best approach it. Marie and Ana's parents developed a plan in which Marie would check in with them first about the session's agenda and then bring Ana into the room. She noted, "I wanted them to feel like they had some sense of control over the direction it was going. That we still needed to accomplish these ends, but that they could guide us in getting there."

Marie consistently prioritized engagement with Ana's parents to ensure that target behaviors were addressed. Specifically, monitoring of Ana's whereabouts and implementation of rewards and consequences for her behavior were important interventions to several key individuals, including Ana's probation officer. Because the family had limited experience using such parenting approaches, Marie had to be particularly reinforcing and hopeful when expressing her confidence in the family's ability to make changes. Marie emphasized her previous successes treating families with similar problems and recalled the competence the family had demonstrated thus far.

Engagement at Treatment Conclusion

MST with Ana's family concluded successfully after four months and approximately 40 in-person contacts, when the overarching goals for treatment were met. As the end of treatment approached, Marie evaluated the sustainability of changes made by the family by delineating factors that had contributed to their success. When doing so, she observed that Ana had become increasingly disengaged in sessions as termination approached. Soon after, the family was alerted that Ana had been corresponding with her recently incarcerated boyfriend, despite her parents' explicit prohibition. Ana's parents became discouraged at this turn of events and expressed worry that treatment had not been successful. Marie validated this concern but reframed the incident as evidence that Ana's parents had indeed developed skills to monitor and manage such behaviors, which, she noted, would inevitably occur even after treatment concluded. By reorienting the family toward a strength-based view, Marie imbued them with confidence to manage their daughter beyond treatment termination.

Outcome and Prognosis

Due to their achievement of overarching goals and the elimination of referral behaviors, Ana and her family did not require additional services after MST. In the months following termination, Ana successfully completed probation and maintained good attendance and improved grades in school. Ana's parents were able to eliminate contact between Ana and her ex-boyfriend by working with administrators at the prison facility to intercept any attempts at communication (this effort was aided by Ana's increased prosocial peer

involvement in school and decreased interest in maintaining contact with her ex). Given the family's ongoing efforts to monitor Ana's behavior and address any emerging concerns, the family's prognosis is good.

Clinical Practices and Summary

Many of the engagement and collaboration strategies used by MST and other evidence-based family therapies are similar to those used by virtually all psychotherapies (e.g., empathy, goal consensus, focusing on strengths, building alliance, obtaining feedback), but other strategies are derived from systemic conceptualizations and, consequently, are relatively unique to family therapies. The latter include the identification of strengths across multiple systems, harnessing family supports to assist with interventions and during times of disengagement, and the maintenance of a family (versus a child) focus during treatment.

Although research has not examined which combination of collaboration strategies is most effective in engaging families, there is little doubt that these family therapy methods are key to building collaborative relations with families that have traditionally presented substantive barriers to the delivery of mental health or substance abuse treatment. Moreover, these engagement strategies are seen as essential to facilitating the attainment of treatment goals. In family therapy, neither collaboration nor therapist-offered characteristics are viewed as the curative factors. Rather, engagement strategies are viewed as critical preconditions to motivate families to change their styles of functioning to better support the psychosocial needs of their children. Favorable clinical outcomes for youths are driven by the behavior changes that families make.

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Table 1

The Five Ps for Resuming Contact with Clients

Prepare
Obtain releases of information for communicating with the client's social network (e.g., relatives, other caregivers) early in treatment so that these people can be contacted in case of client disengagement. Often, other family members can shed light on reasons why the person has not been available. Others can also pass messages on to that individual (e.g., letting clients know that the therapist is concerned) and can encourage the caregiver to respond to therapist telephone calls.
Persevere
Stopping by a client's residence and leaving notes demonstrates that the therapist is committed to doing whatever it takes to keep the family working toward treatment goals. Although therapists might find it inconvenient to make unscheduled trips to clients' homes, these "above and beyond" attempts can facilitate the development of strong therapist-client relationships.
Practice the "Foot in the Door" Technique
Families who are not maintaining contact are often feeling burdened by other life demands. An offer to bring food to the session might provide incentive for the family to keep a therapy visit. Another effective strategy is to request a 5-minute "check in" session at a time or place the client prefers. Therapists report that family members are often willing to accept a short time commitment and will usually extend the session length once it has begun.
Provide Positive Reinforcement
Anyone who has ever cancelled an appointment at the last minute has experienced the negative response this usually elicits from doctor's offices and other places that depend on booked time slots for income. Clients might "no-show" for appointments (including in-home appointments) and avoid follow-up phone calls from the therapist because they anticipate a negative, scolding reaction. As much as possible, therapists strive to reinforce clients whenever contact is made, so that they feel warmly welcomed back.
Promote Urgency
If the above strategies are not successful, it might be necessary to coordinate a session through other systems working with the family. For example, a family member might be more likely to respond to a phone call from the youth's probation officer. Setting up a meeting with all parties might help clarify expectations about treatment. This strategy, however, should be used carefully so that family members do not see the therapist as having "tattled." Instead, therapists should emphasize their genuine concern, desire to achieve treatment goals, and willingness to receive feedback on ways to better maintain contact with the family in the future.