



## CHAPTER 1

# Developing Case Conceptualizations

**W**hen you get to your office, you see that you have a phone message from a woman looking for a family therapy session. She says that she and her husband have three children, the oldest of whom is a 16-year-old boy who refuses to go to school. This is the only information that you have about the family, and now you have a lot of decisions to make. When you call the potential client back, who will you suggest come to the session? How do you want to position yourself with the family, even before they come to the first session? How will your way of viewing the family inform you on what questions to ask and which interventions to make?

These are some of the initial decisions that therapists make before starting a session with a new family. Therapists, however, do not go into a therapy room as blank slates. They come with biases, reflected in how they answer certain questions about family functioning and therapeutic practice. How does a therapist know what to do upon entering the therapy room with a family? What information is important to obtain during the course of therapy? Which techniques of family therapy should be used? What questions should be asked? How should the therapist utilize her own self in the therapy room? What stance or position should she take toward the family? How will the therapist know when to terminate with the family? All of these are questions that family therapists grapple with every time they meet with a new family. The answers to these questions depend on the theoretical orientation of the therapist. This theoretical conceptualization helps guide the therapist in making a multitude of therapeutic decisions.

In therapy, clients come to the therapist because some problem or issue is occurring in their lives that they want reduced or eliminated. How the therapist goes about helping clients do that is the focus of this text. Given the plethora of possible approaches, how does a family therapist know which one to employ? What if the therapist does not like some things about one model, but does like other aspects of the approach? Should the therapist adopt only one theory or have more possibilities in the therapeutic repertoire? What ways of understanding family dynamics and how people change does one theory provide that another might not? How does a therapist

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develop a lens through which to view families and then work with them? To answer these questions, therapists need to have a thorough understanding of various therapeutic approaches.

There are approximately 400 different models of psychotherapy. Of these, there are approximately 50 different family therapy theories, depending on how one defines the distinctions. Each approach has a unique view of how people develop and maintain problems and how the therapist assists in the process of problem resolution. They each enable the therapist to conceptualize how the family came to have its current difficulties, how the family might move forward past these difficulties, and how to orient herself in regards to the family to assist them in this process.

### THE IMPORTANCE OF HAVING A CONCEPTUAL LENS

Therapists need a lens through which to view families, as this leads to a path of interaction in the therapy room that focuses on change. This lens, which is the therapist's frame, allows the therapist to come into contact with information, organize that information, and then know how to use it to help families reach their goals in a time-efficient manner. A therapist's lens, frame, understanding, or conceptualization, whatever it may be called, is the blueprint for engagement. In this text, we use the term *case conceptualization* to refer to the therapist's understanding of how families develop and maintain problems and how the therapist helps them to change. Although developing and utilizing a conceptualization is not a simple proposition, it is extremely important to have one in order to help clients since the appropriate use of case conceptualization has become one sign of effective and quality therapy (Sperry, 2010).

The therapist's conceptual lens is connected to her assumptions about problems. de Shazer (1985) explained this notion:

Therapists need to make some assumptions about the construction of complaints and the nature of solutions to do their job . . . These assumptions can be seen to operate like rules for mapping complaints and problems. If a therapist uses a certain set of assumptions, say "Y," then a certain type of map will develop. (p. 22)

It is this set of assumptions—or framework—that holds together the process of therapy. Within any theory, therapists hold distinct assumptions that lead them to understand and view what is occurring in the therapy room. For instance, assuming that a symptom in one member is a reflection of problematic interactions with other members leads the therapist to understand symptoms as symbols of interpersonal transactions. The therapist would then explore transactions and try to intervene at the relational level rather than the symptom level. Making an assumption that symptoms reflect the self-esteem of various family members leads the therapist to explore how people view themselves. The focus of therapy then would be on exploring how the family members could allow more room for each individual's uniqueness.

Therapists' assumptions play a significant role in therapy, even before the therapist meets with the family for the first time. A therapist's beliefs about problem formation lead to her deciding whom to invite to the first session, whom to talk with first, and what types of questions to ask. Therapists, from the very beginning of therapy, enter the encounter with a specific viewpoint on how people operate, which leads to what they do (and do not do) in the therapy room.

Family members also have their own biases, however, as well as understandings about why family members behave in certain ways. These assumptions temper how they interact, and perhaps perpetuate problem sequences in the family. Therapists must navigate the family's understandings while adhering to their own way of operating. To accomplish this, an understanding of how the theory of problem formation is related to the theory of problem resolution is needed. The therapist's theory not only influences her own way of approaching the case and utilizing certain techniques, but also affects the client's behavior, the therapist's evaluation of that behavior, and the outcome of therapy.

The field of family therapy benefits when practitioners from specific theoretical orientations can explain their understanding of how problems develop and how they are resolved. Therapists who gain an in-depth understanding of an approach then can adopt that model, utilize various pieces of the model, or modify the model. Therapists might also then investigate what core factors are operating in multiple models. In psychotherapy, this exploration has occurred through a focus on factors common to every model of therapy. The common factors approach will be discussed later in this chapter and then again in Chapter 12.

Therapy might be seen, through any approach, as increasing a client's response options. Usually clients come to therapy believing that they have a limited set of possibilities. They cannot move past their present difficulties because they are stuck trying to resolve them with a self-imposed, limited repertoire of behaviors and beliefs. Therapists help clients widen their lens to view more possible choices of action. Just as increasing clients' response options assists them in navigating a wider array of life situations, so increasing therapists' response options assists them in navigating a wider array of therapeutic situations. This text is an attempt to help therapists engaged in family therapy increase their response options and thus be more successful in working with the variety of families and problem situations that show up in therapy offices.

The question then becomes, how do therapists come in contact with various therapeutic approaches? When they are graduate students, therapists usually take on a model favored by the faculty in their graduate program, especially the faculty they have as supervisors in their practicum experience. Consequently, some therapists never get exposure to an approach because no faculty in their program operated from that model. Others go beyond their graduate education to attend lectures, workshops, and trainings in a specific approach to develop greater awareness and efficacy in an unfamiliar model. Psychotherapy conferences might also be a medium to gain exposure to the various techniques and philosophies of new approaches; or, as is the case here, texts can expose family therapists, and even nonfamily therapists, to how a therapist can conceptualize one specific case from many different vantage points.

This text presents nine different family therapy models that the reader can compare, and contrast; then, we hope, they can employ the theoretical understandings and techniques that make the most sense. These models are perhaps the most influential in the history of family therapy. They include Bowen Natural Systems Theory, contextual therapy, Virginia Satir's Growth Model, brief therapy of the Mental Research Institute, strategic family therapy, Milan Systemic Family Therapy, structural family therapy, solution-focused brief therapy, and narrative therapy.

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### DEVELOPING A CONCEPTUALIZATION

Having a conceptual frame is perhaps the therapist's most basic competency (Sperry, 2010). This is because all the other techniques and ways of being as a therapist are fundamentally tied to it. Betan and Binder (2010) consider the conceptual frame to be the "linchpin of clinical practice" (p. 143). Therapists observe, think, and act based on the conceptual frame that they are using. The frame informs them of who to talk with, what to ask, what to say, what not to say, how to be, how not to be, and what to look for when meeting with families. It is how a therapist sees.

A conceptualization is based on the model a therapist uses to organize personal views on what is occurring for herself, the person(s) she is working with, and the interchange between them. A therapeutic model can be defined as "a collection of beliefs or a unifying theory about what is needed to bring about change with a particular client in a particular treatment context" (Anderson, Lunnen, & Ogles, 2010, p. 144). These beliefs form a framework that allows the therapist to negotiate the therapeutic realm.

This conceptual frame, for all therapists, develops over time. Even before graduate school, the therapist has a perspective on how people develop problems, as well as a theory of personhood. This viewpoint usually has been developed through life experience. Through classes and clinical experience, however, family therapists shift their perspectives of problems and change to a more academic foundation, usually taking ideas from their predecessors, namely, the individuals who developed the primary models of family therapy. Over time, therapists may then move beyond established models to develop their own theory of problem formation and change.

None of the originators of the models presented in this text, or any model for that matter, developed the model at one specific time. Therapeutic approaches build on previous knowledge, theory, and techniques from other approaches and contexts, and from fields far removed from family therapy. The following section briefly explains the development of each of the models presented in this text.

### Bowen Natural Systems Theory

Murray Bowen developed Natural Systems Theory. Originally trained as a medical doctor, Bowen based his original understanding of problems and therapy on psychoanalysis (Bowen, 1992). After seeing inconsistencies in the psychoanalytic approach, Bowen shifted to the biological and natural sciences, in particular the theory of evolution, to develop an approach that was more encompassing than simply an explanation of the individual or the family. Bowen's theory focused on all living systems.

Bowen initially researched schizophrenia and later realized that the processes he was seeing in families with a schizophrenic member were present in all families. These processes included an emotional "stuckness" that Bowen initially described as the undifferentiated family ego mass. He realized that individual members in families functioned based on the emotional processes in the family as a whole.

After Bowen moved from the Menninger Clinic to the National Institute of Mental Health, he engaged in a research project in which the whole family of the schizophrenic lived on the hospital campus. Bowen then moved to Georgetown

University, where he fully developed his theory, as well as the Georgetown Family Center, which currently is the Bowen Center for the Study of the Family.

When Bowen initially developed his theory, he delineated six interlocking concepts, which included differentiation of self, triangles, nuclear family emotional process, family projection process, multigenerational transmission process, and sibling position. Several years later he then added two additional concepts, which were emotional cutoff and societal emotional process (Kerr & Bowen, 1988).

### **Contextual Therapy**

Ivan Boszormenyi-Nagy developed contextual therapy. Nagy initially called the foundation of the approach *intergenerational family therapy* (Boszormenyi-Nagy & Spark, 1984). It later came to be called *contextual therapy* to address how people's actions are embedded within the context of ethical relationships and the balance between give and take (Boszormenyi-Nagy, 1987).

As an M.D., Boszormenyi-Nagy originally had training in the psychoanalytic approach, and he attempted to investigate biochemical avenues into psychosis. Nagy entered the therapy field through his mentor, Kalman Gyarfás, who was also a very influential figure for Virginia Satir. Some of Boszormenyi-Nagy's therapeutic influences included object-relations theory, therapeutic communities, intensive individual therapy, and family therapy (Boszormenyi-Nagy, 1987).

The development of contextual therapy shifted from an intrapsychic focus on the individual to an understanding of how intrapsychic and interpersonal processes function together through the context of ethical relationships. The model is predicated on four dimensions of relational reality: facts, psychological needs, transactional systems, and relational accountability. Before he passed away in 2007, Nagy proposed a fifth dimension, the ontic dimension. These dimensions provide a bridge from Boszormenyi-Nagy's roots in individual therapy to his later utilization of family therapy.

### **Satir Growth Model**

Virginia Satir developed an approach that focuses on how individuals in families, and thus families themselves, move toward growth. Satir was one of the originators of family therapy who entered the field as a social worker. She was originally trained through an individual psychoanalytic perspective (Satir, 1986).

Satir was able to consult and work with many of the originators of family therapy, including Murray Bowen, Nathan Ackerman, Salvador Minuchin, Carl Whitaker, Don Jackson, and Jay Haley. She was the first Director of Training of the Mental Research Institute (MRI) in Palo Alto, California, which was based on the communicational research of Gregory Bateson and his team. Satir continued to focus heavily on communication throughout her career.

Satir was one of the first family therapists to posit that the symptom that families came in with was not the real issue, but rather how the individuals coped with the problem. Her 1964 text, *Conjoint Family Therapy*, was one of the first family therapy texts. Satir eventually brought a spiritual understanding into the family therapy realm, holding that people are connected not only to their own bodies and states of being but in relationships as well.



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### **Brief Therapy: Mental Research Institute**

Perhaps more than any of the theories presented in this text, the brief therapy model of the Mental Research Institute (MRI) was a culmination of ideas from many individuals. This therapy approach began as a research program focusing on communication and had nothing to do with therapy. Gregory Bateson, who headed the research team, recruited Jay Haley and John Weakland in 1953 (Haley, 2010), then brought William Fry on board. The team investigated various types of contexts in which communication occurs including film, humor, and paradoxes. After receiving a grant to study schizophrenia, Bateson brought Don Jackson, a psychiatrist, into the group.

The Mental Research Institute was formed by Don Jackson in 1958. Jackson hired Virginia Satir to be the first director of training. In 1965 the Brief Therapy Center was created at the MRI. This was the development of a model of therapy that focused on how people's attempted solutions to difficulties were actually the problem. Therapists implemented a ten-session limit to therapy, which became perhaps one of the first forms of brief therapy. Many family therapists had an association with the MRI, including Jay Haley (see the following section, Strategic Family Therapy), Virginia Satir, and Steve de Shazer (see the Solution-Focused Brief Therapy section later in the chapter). The three main developers of the brief therapy approach of the MRI were Paul Watzlawick, John Weakland, and Richard Fisch.

### **Strategic Family Therapy**

Jay Haley developed strategic family therapy, which toward the end of his career became known as *directive family therapy*. Haley went to graduate school to study communication at Stanford University and happened to meet Gregory Bateson. Through their mutual interest in popular films, Haley joined Bateson's research group and was one of the prime authors of one of the most influential articles in the history of family therapy, "Toward a Theory of Schizophrenia" (Bateson et al., 1956), in which the authors presented the double-bind theory of family relations. This article, written before the team had ever therapeutically worked with a family, helped inform Haley that members in a family are interconnected through rules of communication. Before this time, people's symptoms were seen more as individual and intrapsychic events.

Through Bateson, Haley was introduced to the work of Milton Erickson, a renowned psychiatrist and hypnotherapist. From Erickson, Haley learned the importance of the therapist's being strategic and directive. In 1967, Haley moved to the Philadelphia Child Guidance Clinic and worked closely with Salvador Minuchin and Braulio Montalvo. The three therapists would commute together and exchange ideas while driving to and from the clinic. Through these conversations, a hierarchical aspect of therapy was brought into strategic therapy.

Haley left the Philadelphia Child Guidance Clinic to open the Family Therapy Institute of Washington, DC with his then wife, Cloe Madanes. Eventually, the two divorced, and Haley married Madeleine Richeport, an anthropologist who also had trained with Milton Erickson. Haley was influenced by Bateson, Erickson, Jackson, Watzlawick, Minuchin, Montalvo, Madanes, and Richeport, and the strategic approach is reflective of all of these influences.

## Milan Systemic Family Therapy

Milan Systemic Family Therapy was originally developed by Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata (Boscolo et al., 1987). These psychiatrists originally used a psychoanalytic orientation, but were discouraged by the ineffectiveness of the approach. They encountered the work of the members of the MRI and jointly decided to work from a systemic perspective. Paul Watzlawick of the MRI consulted with them in their early formation.

The Milan team, as they came to be known, introduced working as a team, where one male-female team worked with the family while another male-female team watched behind the mirror. Their approach was initially strategic, focusing on the notion of communication, primarily from the ideas of members of the MRI who had written *Pragmatics of Human Communication* (Watzlawick, Bavelas, & Jackson, 1967). In an effort to develop more of their own systemic view, however, they isolated themselves from other family therapy ideas.

In 1975 the members of the Milan group read *Steps to an Ecology of Mind* (Bateson, 1972), which led to a greater focus on the notion of circularity. The team was shifting away from a strategic approach to a more systemic approach, which led to their seminal article, "Hypothesizing-circularity-neutrality" (Palazzoli, Boscolo, Cecchin, & Prata, 1980a). This shift in their thinking led them to view therapy as less oppositional. In the same year, the team split with Palazzoli and Prata, moving toward a continued focus on strategic interventions and research, while Boscolo and Cecchin continued on the path of circularity and training.

## Structural Family Therapy

Structural family therapy was developed by Salvador Minuchin. Minuchin received his medical degree in Argentina and eventually was trained as a psychoanalyst. He was originally a child psychiatrist, and upon taking a position at the Wiltwyck School for Boys he began to engage in treatment of the family. Through a development of the ideas and techniques developed at Wiltwyck as well as those at the Philadelphia Child Guidance Clinic, Minuchin's approach came to be called *structural family therapy*.

In 1962, Minuchin traveled the United States to meet with, and learn from some of the founders of the family therapy movement (Minuchin, 1987). These individuals included Nathan Ackerman, Lyman Wynne, Theodore Lidz, and a group of people in Palo Alto that included Gregory Bateson, Don Jackson, Virginia Satir, and Jay Haley. The connection between Haley and Minuchin intensified when Minuchin, the director at the Philadelphia Child Guidance Clinic, hired Haley. As Minuchin influenced Haley and Montalvo during their commute to work, Minuchin was very influenced in turn by Montalvo and Haley.

Over the years, Minuchin interacted and worked with several of the field's foremost family therapists (Minuchin, 1987). Carl Whitaker, in particular, was a friend and colleague, with whom he shared a pleasure in the absurd. Minuchin's two landmark texts, *Families and Family Therapy* (Minuchin, 1974) and *Family Therapy Techniques* (Minuchin & Fishman, 1981) became two of the most significant family therapy texts of all time. Minuchin introduced a four-step method of assessing families and couples (Minuchin, Nichols, & Lee, 2007), which will be discussed in greater detail in Chapter 12.

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### **Solution-Focused Brief Therapy**

Solution-Focused Brief Therapy (SFBT) was developed by Steve de Shazer and Insoo Kim Berg in Milwaukee, Wisconsin. de Shazer had roots in Ericksonian hypnotherapy and was influenced by the Mental Research Institute. He also incorporated the philosophical ideas of Wittgenstein and Buddhist thought (de Shazer et al., 2007). Early in his family therapy career, de Shazer based his approach on ecosystemic ideas derived from the theory of Gregory Bateson (de Shazer, 1991).

As originally developed, solution-focused brief therapy was based on the principles of exploring what occurred in clients' lives before the problem arose. In their seminal article that introduced the foundation of the model (de Shazer et al., 1986), however, they had not yet named the model or introduced what was to become the hallmark of the approach, the miracle question. This question was developed by chance when Insoo Kim Berg responded to a client who thought that perhaps only a miracle could help her (de Shazer et al., 2007) by asking the client what would be different if that miracle did happen.

Although there have not been radical shifts in the development of SFBT, the model was built over time. Interventions such as asking about pretreatment change, scaling questions, and various formula tasks entered into the approach, but all were in line with the principles of the model.

### **Narrative Therapy**

Michael White, along with his colleague, David Epston, is the primary developer of narrative therapy. White originally viewed families through a cybernetic lens, based on the work of Gregory Bateson (White, 1986). After meeting Epston at a family therapy conference in Australia, White began to integrate the story analogy with the cybernetic epistemology he was working from (White & Epston, 1990).

White was heavily influenced by philosophers and sociologists such as Bateson, Erving Goffman, Jerome Bruner, and Michel Foucault. Foucault's work, especially, led to a focus on truth and power within the narrative therapy model (White & Epston, 1990). Over time, White developed a means of mapping narrative conversations (White, 2007). The approach evolved to the point that the therapeutic interchanges could be seen as a way to scaffold conversations so that clients can see the dominant and the alternative stories of their lives.

Each of the models just presented was developed by taking principles of one or more different models or ideas and applying them to families. The models have not been, and still are not static entities. They evolve and change based on practitioners exploring the aspects of the model that work best with their own styles, with various types of clients, in various therapeutic contexts, and with different presenting problems.

## **CASE CONCEPTUALIZATION**

The field of family therapy, as well as all other fields of therapy, has been shifting toward an examination of more effective practice. Developing and utilizing a case conceptualization when working with clients is one way of achieving this goal. The ability to develop a case conceptualization can be considered a primary skill and a core competency for therapists (Eells et al., 2005; Betan & Binder, 2010).



Some clinicians and researchers refer to this process as *case formulation* (Eells, 2007; Eells et al., 2005; Kenjelic & Eells, 2007) and others as *case conceptualization* (Betan & Binder, 2010). We will use the latter term to refer to therapists' understanding of how clients develop and maintain problems and the process of working with clients to achieve problem resolution.

Case conceptualizations inform how therapists think and act in the therapy room. Sperry (2010) explained the importance of developing a case conceptualization as follows: "Basically, a case conceptualization is a method and process of summarizing seemingly diverse clinical information about a client into a brief, coherent statement or 'map,' which elucidates the client's basic pattern and which serves to guide the treatment process" (p. 109). These maps allow for the active pursuit of information, integration of the data gathered from the family, and the implementation of a strategy of action. As therapists, we use these conceptualizations to orient how we position ourselves with families, what we pay attention to, and how we intervene.

It is important to develop and employ a case conceptualization, as it provides a framework for the therapist to contact the client and to move the process of therapy forward. This clinical strategy provides the therapist a lens through which to obtain and organize information, explain what is happening for the client, guide the treatment process, anticipate potential challenges, and then prepare for termination (Eells, 2007; Sperry, 2010). Consequently, a case conceptualization starts even before the therapist first meets with a family and is used throughout the whole of the therapy process. It provides the therapist with a theoretical foundation for understanding what the client is like and a rationale for their current functioning (Berman, 2010). In essence, case conceptualization links the client's presenting problem to an appropriate treatment plan (Sperry, 2005a).

### Models of Case Conceptualizations

Case conceptualizations come in many forms and varieties. Some include only an understanding of what is occurring for the client. Others focus more specifically on understanding the client in treatment. For greater effectiveness, the case conceptualization should be applicable to understand the client, the relationship between therapist and client, and what needs to happen in therapy for the resolution of the client's current complaints. This section explains two ways of forming a case conceptualization. The first is used more for individual clients, and the second more for family systems.

Sperry (2010) provided an understanding of case conceptualization that has four components. It begins, after gaining a background of the client, by developing a diagnostic formulation. This aspect focuses on the symptoms that the client is presenting with in therapy. This part of therapy also addresses the type of services the client needs. For instance, a client in a crisis situation might need to be hospitalized to prevent harm to self; or, if there is no threat of harm, outpatient services may be sufficient.

The second aspect of this type of case conceptualization is developing a clinical formulation. Here, the therapist attempts to understand how the symptom developed and how it is currently maintained. The pattern of the client's symptom is understood. For example, in meeting with a client complaining of depression, the therapist would ask questions to ascertain when the depression first started, what the etiology might

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be, times when the depression is greater or lesser, and how the client has attempted to deal with the depression.

Developing a cultural formulation is the third component of the case conceptualization. In this section, the therapist attempts to understand how the client's culture impacts the symptom pattern. Culture may be based on ethnicity, socioeconomic status, geographic region, or a myriad other factors that impact how people develop a sense of self. For the client dealing with depression, their symptoms may be connected to not having a job, living in poverty, living in a country as an immigrant, not engaging in behaviors that coincide with one's religion, or not having a familial support system.

The last component of Sperry's case conceptualization is developing a treatment formulation. The therapist, having obtained a picture of what the symptom is, how it developed, and the larger systems impacting the client, develops a plan of action with the client. This plan comes from how the therapeutic model views problem formation and the theory of change to obtain problem resolution. Thus, a cognitive therapist would understand the depression as a consequence of self-thoughts and would devise interventions to stop the repetitive faulty beliefs that led to—and are maintaining—the depression, while introducing exercises to help teach the client how to fight these irrational beliefs and insert new and more effective thought processes. An existential therapist might explore how the client may be experiencing some type of anxiety, perhaps concerning death, which is leading to the depression.

What has just been presented is a conceptualization primarily geared toward individual clients, although it is also applicable to couples and families. Other case conceptualizations, however, can provide a larger picture that encompasses the whole family. Gehart (2010) provided a model of a systemic case conceptualization that has six components: an introduction to the client, presenting concern, background information, systemic assessment, genogram, and client perspectives. In this model, the case conceptualization begins by identifying who the client is (whether an individual, couple, family, subsystem, or larger system). Information such as demographics would be obtained and used at this point. This initial connection to the client(s) allows the therapist to decide who will attend the first and subsequent sessions.

The second component of this systemic case conceptualization is obtaining a description of the presenting concern. This occurs on several levels, including the perspective of the individual, the family, and the larger system. The therapist would need to be skilled in bringing forth multiple perspectives of what is happening for the family. This information includes the reason that the individuals in the therapy room are coming to therapy, who referred them (if they were referred), how long the problem has been present, the attempted solutions, and any other pertinent problem-related information.

The third component is background information, comprising both recent background and related historical background. Recent background includes the first presence of the symptom, the events that surrounded the development of the symptom, and any possible recent life changes. Historical background information includes a family history, previous therapy, and other symptoms and problems that people have experienced.

Next, the therapist conducts a systemic assessment. This is the foundation of the conceptualization. In this component, the therapist identifies the family's interactional

and relational patterns. The therapist explores the relationships of the nuclear family as well as intergenerational connections. The family is understood both as a whole and through subsystems, such as the marital, parental, and child. Part of this section includes a focus on individual and familial strengths and resources.

The fifth component of the systemic case conceptualization is the genogram. This diagram provides a way for the therapist to view who is in the family and the relational dynamics between members. An advantage of using a genogram is that it provides the therapist a visual representation of the family. Therapists can put as much or as little information on the genogram as they wish, adapting it in a way that will be most useful for them and their clients. This information usually includes ages, births, deaths, mental and physical illnesses, marriages, divorces, and interactional patterns (i.e., disengagement, enmeshment, cutoffs, and conflictual relationships).

The final component is called *client perspectives*. This is when the therapist discusses the key components of the case conceptualization with the client to see whether the client agrees or disagrees. This allows the therapist to verify the information she has about the client and to see whether new meanings about the information might come forth.

As therapists have a better understanding of their own theoretical orientations, they can more easily apply this framework to the families they work with. Familiarity with a model helps therapists function more automatically, quickly understanding and/or adapting their conceptualization to particular cases (Betan & Binder, 2010). At this point, therapists integrate theory into their own personal style and values.

Besides the two different types of case conceptualization just discussed, therapists can orient their understandings based on other variables. These include the category of the client's problem, what the client is asking for and/or needing from therapy, or their own theoretical orientation.

Therapists can use one of three types of conceptualizations: symptom-focused, client-focused, and theory-focused (Sperry, 2005b). Symptom-focused conceptualizations employ a medical and behavior perspective, focusing on what the client's symptoms are and developing goals for reducing them. Therapists vary how they view and what they do with a client based on the category of the problem. People dealing with a crisis are understood differently from those dealing with a child's behavior problems.

Client-focused conceptualizations are based on the client's needs. The theory is built around what is occurring for the client rather from the therapist's experience and perspective. The therapist will change her understanding and approach based on whether the client needs individual, couple, group, or family therapy.

Theory-focused conceptualizations operate through the lens of a specific therapy orientation. These focus on how people develop symptoms and, from the theory, which treatment goals to develop as well as a plan of techniques. We will approach case conceptualization from a theory-focused orientation.

As can be seen, there are many ways to define the term case conceptualization and the intent behind it. We will take a wide view of case conceptualization and use it to explain how a therapist engages a client (whether an individual, couple, or a family). The case conceptualization provides the therapist with two main understandings. First, it provides a framework to conceive how the client developed the symptom and how the symptom is currently being maintained. Second, the case conceptualization provides a framework for how the therapist will engage with the client in therapy so

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that the problem no longer exists. In essence, the case conceptualization provides the therapist with an understanding of the theory of problem formation and the theory of problem resolution.

A therapist using any of the theoretical approaches can use any of the case conceptualization formats just presented. Some aspects of the conceptualization, based on the theory, may receive more attention than others. For instance, a Bowenian therapist would spend more time in the fifth component of the systemic conceptualization—developing a genogram. This information is extremely important for the Bowenian therapist to understand the family's emotional process. A brief therapist from MRI, however, might spend a lot less time, or perhaps no time at all, developing a genogram, but instead focus more on the fourth component of exploring the interactional patterns of the family.

### COMMON FACTORS OF THERAPY

Many researchers have been exploring the common factors of psychotherapy. Common factors can be defined as “ingredients or elements that exist in all forms of psychotherapy” (Hubble et al., 2010, p. 28). Although several researchers have explored the common factors and promote differing universal elements of therapy (see Grencavage & Norcross, 1990; Wampold, 2001), Michael Lambert is at the forefront of this movement. He provided a list of four common curative elements in psychotherapy (Lambert, 1992), which was then augmented by the family therapists Duncan, Hubble, and Miller (1997). These curative elements include extratherapeutic factors; therapy relationship factors (originally called *common factors*); expectancy, hope, and placebo factors; and model and technique factors. These factors are present in all psychotherapy models. They cause and are caused by each other.

The common factors approach is not a therapy model but a framework to understand how psychotherapy theories function. Sprenkle and Blow (2004) have commented that the various therapeutic models “are the vehicles through which the common factors operate” (p. 115). This section explores the common factors and how each of the theories presented operate from each of the four common curative elements.

### Extratherapeutic Factors

Extratherapeutic factors are the single most influential component that leads to client change, accounting for approximately 40 percent of improvement (Lambert, 1992). This factor refers to anything about clients and their environment that leads to change, regardless of whether they are engaged in therapy. All theoretical models of therapy are influenced and benefited by these extratherapeutic factors. What differs is how the approach attempts to access these client factors so that they can be built upon.

Bowenian therapists believe that family members, and thus the family as a system, have resources that they can access when they intellectually understand the nature of the problems they are dealing with (Kerr & Bowen, 1988). People have a better chance of enhancing their level of differentiation of self when they can engage their family members using cognitive/intellectual skills and not just the “automatic” emotional channels that have long been in place. Bowen encouraged clients to either stay in contact or recontact family members as best they could, as these individuals

were ultimately the best resource a person could have to create meaningful change within a given family system. The Bowenian therapist taps into extratherapeutic factors through encouraging the client to reenter or reconsider preexisting relationships with others in new, less emotionally reactive, and more thoughtful ways.

Contextual therapists draw on the clients' extratherapeutic factors when they explore family members' relational resources (Boszormenyi-Nagy & Krasner, 1986). These resources are the factual and relational ways in which people can improve themselves and thus, ways in which they better themselves and other people. Contextual therapists spend more time trying to increase these relational resources—already present within and between people—than trying to focus on problems and symptoms. Boszormenyi-Nagy, Grunbaum, and Ulrich (1991) explained this utilization, “The therapist’s goal is to be a catalyst of resources already potentially present when the family comes for help” (p. 219).

Virginia Satir conceptualized the self in relationship to a mandala (Satir & Baldwin, 1983; Satir et al., 1991). She viewed all people as having access to universal human resources. These resources are contained in the following dimensions: physical, intellectual, emotional, sensual, interactional, nutritional, contextual, and spiritual. These are the resources that clients already have when they come into therapy. By exploring these different, but unified, aspects of the client, the therapist helps the client realize that they already have the resources that they need to learn, grow, and change.

The MRI group focuses on the client's worldview, or *position* (Fisch, Weakland, & Segal, 1982). They consider the client's position to indicate a value that the client has come into therapy with and from which the client operates. The therapist would modify the presentation of information so that it aligns with the client's position, thus enhancing that person's cooperation in therapy. MRI brief therapists attempt to utilize the client's position, thus building on extratherapeutic factors.

Jay Haley sometimes targeted specific characteristics of client families to help lead to change. Families that are more stable and not in a crisis state tend to be resistant to change (Haley, 1987). Haley would access this aspect of family functioning by providing a paradoxical task in therapy. A paradoxical task involves the therapist letting the family know that she is there to help them change but then asking them not to change. By tapping into clients' preexisting resistance, the therapist encourages the family to resist her push for stability, thus moving them toward change.

The Milan group accesses extratherapeutic factors through their viewpoint of normality (Boscolo et al., 1987). They do not try to tell family members what is normal (or at least the therapist's perception of what is normal). As such, they shift from being social control agents to bringing forth the current way that the family views situations. By accepting the system as it is, they work with preexisting factors in the family that might be beneficial in therapy.

Salvador Minuchin built upon extratherapeutic factors through focusing on the strengths that family members and the family as a whole have. Minuchin explained that all people, even those coming to therapy, are doing their best at the present time (Minuchin & Fishman, 1981). Through taking a close position to the family as a way of joining with them, the therapist helps raise family members' sense of self-esteem. This heightening of the family members' status helps connect the therapist to the family. Structural family therapists may also explore how families engage in nurturing, caring, and supportive transactions.



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When solution-focused brief therapists focus on the changes that clients make before the first session (Weiner-Davis, de Shazer, & Gingerich, 1987), they are using the extratherapeutic factors that clients bring with them to help them achieve their goals. Solution-focused brief therapists also enhance extratherapeutic factors when they focus on the client's past successes, coping skills, and client strengths (Bliss, 2005). They might ask questions that elicit from clients their successes and hidden abilities through a process called *self-complimenting* (Berg & DeJong, 2005). Solution-focused therapists also build upon extratherapeutic factors by focusing on exceptions (times when the problem could have happened, but did not). Once these aspects of the client are brought forth and articulated, the client can then use them more, thus increasing their positive change.

Narrative therapists also focus on times when the problem story did not dominate the client's life, which they call *unique outcomes* (White, 2007; White & Epston, 1990). These times of success, before the person ever entered therapy, are usually neglected stories. The narrative therapist gives weight to these unique outcomes, shifting them from something that was lost to something the client gives value to. This connection of what the client has experienced, but did not make meaningful, and the future, or what the client intends for his or her life, allow clients to use aspects of their own lives that were always there but had not been honored.

### Relationship Factors

Therapy relationship factors are the second most influential component that leads to client change, accounting for approximately 30 percent of improvement (Lambert, 1992). This relationship, also known as the *therapeutic alliance*, is twofold: the client's relationship with the therapist, and the therapist's relationship with the client. Wampold (2001) explained that the therapeutic alliance has at least four components, including how the client is impacted by the relationship with the therapist, how the client works collaboratively with the therapist, how the therapist is able to empathically engage and work with the client, and how the therapist and client agree on the goals of therapy. This alliance is the medium in which the techniques and philosophy of the approach are enacted, and it is the cornerstone of successful therapy.

Therapists enter into a relationship with clients as a means of promoting the process of therapy. The more connected the client is to the therapist, the more motivated the client is to participate in treatment (Miller, Duncan, & Hubble, 1997). None of the models can be effectively used without a connection between therapist and client. Although relationship factors are quite individualistic—including what a therapist looks like, how he or she thinks and talks, race, gender, age, ethnicity, and other personal characteristics (and how these characteristics connect or do not connect with the client family)—each theory has generic ways of relating to clients that can potentially enhance the therapeutic relationship.

Bowen's approach to the therapeutic relationship is quite different from most of the other approaches. Bowen encouraged relating to others through thinking, wherever he could, and he believed that the therapist should model this behavior for the client. Bowenian therapists must be well aware of the ways in which they operate within their own family of origin and must work constantly at not getting drawn into the client family's emotional process. The Bowenian therapist seeks not to take

sides and tries to establish and maintain a working relationship with all members of the family system. Otherwise, some family members may feel calmer while others become more anxious (Kerr & Bowen, 1988). The process of therapeutic engagement is called the quest for emotional objectivity. Kerr and Bowen explained, “A therapist is in adequate emotional contact if family members are saying what is important to them emotionally and if they have a sense that the therapist has listened, is interested, and comprehends their respective points of view” (p. 284). The Bowenian therapist does this by taking a central position in the therapy room, acting as a coach where the communication in the room is directed through her. Friedman (1991) explained that, for this kind of therapy to be effective, “it is the ‘being’ of the therapist, the therapist’s presence rather than any specific behavior, that is the agent of change” (p. 152).

Contextual therapists also enter the therapy room without any bias toward one person over another. This is done by using multidirected partiality (Boszormenyi-Nagy & Krasner, 1986). The therapist understands that the interventions made will impact not only every person in the therapy room, but the individuals within their relational webs. The therapist attempts to understand how each person, even those seen negatively by family members, has merit and is humane in some way. Each member of the family has the sense that the therapist understands and accepts them, which is a way to enhance the therapeutic relationship.

The therapist, and model, presented in this text that is perhaps the most premised on relationship factors is Virginia Satir and her Growth Model. Satir et al. (1991) explained, “Much of life’s meaning and satisfaction are based on relationships with other people. Since congruent and genuine relationships are an expression of self-esteem they are some of the indicators in the Satir model of becoming more fully realized” (p. 339). Satir is viewed as perhaps the warmest and most genuine of all the family therapy founders. This warmth allowed her to connect to people, bringing forth her own and the family members’ feelings and compassion for one another.

MRI brief therapists decrease resistance and enhance cooperation in the therapeutic relationship by accepting and utilizing the client’s position (Fisch, Weakland, & Segal, 1982). They work with the person who is a customer for change rather than someone who is a window shopper or is in therapy against their will; that is, they meet people where they are at rather than trying to force them to engage in therapy when they are not ready. Another way in which MRI brief therapists tap into relationship factors is when they take a one-down position, which prevents the client from viewing the therapist in a one-up position and thus in a competitive manner. At times, the therapist does not try to take the expert role, thus asking, in a way, for the client to assist them in understanding. This highlights the importance of the client, connecting the client to the therapist.

Jay Haley, originator of strategic family therapy, developed a five-stage model of a first session (Haley, 1987). The first stage is the social stage, where the therapist comes into contact with each person that is present in the family. This sends a message to the family that everyone is important to the process. Although strategic family therapists engage all of the members of the family in every stage of the session, starting the session by connecting to each person sends an implicit message that the therapist believes every person is important. Because each person is identified and

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held to be important, this process increases family members' motivation to engage in the therapy process. Further, the therapist takes the client's presenting problem seriously. This helps to connect therapist and client since the client is being respected in terms of how he or she views his or her concern.

Milan therapists have a different way of developing the therapeutic relationship in which they use circular questions as a means of creating a strong engagement with families in therapy (Boscolo et al., 1987). Each family member is encouraged to discuss how he or she views the relationship between two or more other family members. This allows family members to feel engaged and connected to the therapist and the therapeutic system. Milan therapists also connect with every member in the family by maintaining a stance of neutrality where each person's viewpoint is accepted, but no single person's view is privileged over that of any other (Palazzoli et al, 1980a). As in Bowenian and contextual therapy, this stance of neutrality allows each person in the family to believe that the therapist understands them and is not taking sides against them. This increases the connection between therapist and client.

Structural family therapists have long discussed the importance of joining with the client family (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Nichols, & Lee, 2007). Minuchin explained the critical importance that joining and making a connection with the family has for therapy: "As I've said, joining is a prerequisite to making family members feel sufficiently understood to trust a therapist who asks them to re-examine their interactions" (Minuchin, Nichols, & Lee, p. 107). Structural family therapists enhance the therapeutic relationship through many means, including adopting the language of the family (Minuchin & Nichols, 1993), its affect and style (Minuchin, 1974), and taking a position of proximity to enhance affiliation with the family members through confirmation (Minuchin & Fishman, 1981). The therapist is a director of action in the room. This position is enhanced when the family sees the therapist as an agent who is working for them.

de Shazer and colleagues from the solution-focused brief therapy model enhance the impact of the therapeutic relationship by not taking an expert stance and using the client's language as a way to connect (Bliss, 2005). Instead of trying to get the client to think based on the therapist's language and position, the therapist listens to what the client wants, focusing on the client's goals for therapy. Solution-focused therapists also enhance their alliance with clients by providing compliments to clients (Berg & DeJong, 2005). By bringing forth what clients are already doing that is good for them, the therapist connects with the client around strengths rather than deficiencies.

Narrative therapists are keenly interested in bringing forth and hearing a client's story. White (2007) called the relationship between therapist and client a *conversational partnership*. The therapist helps to build a scaffolding conversation in which the client, in small steps, can move from what they currently know (usually a problem-saturated description of their lives) to what it is possible for them to know, a description that includes aspects of their lives that were not being acknowledged. This movement, which includes the incorporation of unique outcomes, adds to the client's sense of personal agency. During certain periods of the therapeutic conversation, the therapist takes on the posture of an investigative reporter, recruiting the client into taking a similar position. This joins therapist and client together in an exploration of the problem, as it is separate from the person. Thus, the therapist is not an expert

trying to find the problem within the person, but is a co-investigator with the client in exploring how the problem has been influential in the client's life.

### **Expectancy, Hope, and Placebo Factors**

Expectancy, hope, and placebo factors account for 15 percent of the variance of change (Lambert, 1992). When clients expect therapy to be helpful, it tends to be helpful. Even before therapy begins, clients engage in various types of pretreatment change (Kindsvatter et al., 2010) just by expecting positive things to happen in therapy. In a way, clients enter therapy primed for some type of change and difference in their lives.

Therapists can promote clients' expectancies through their own expectations that therapy will be useful—that the outcome of therapy will be the client making positive changes. Miller, Duncan, and Hubble (1997) explained that “hopefulness results from acknowledging both the client's present difficulties and the possibilities for a better future” (p. 31). Expectancy is also enhanced when the therapist has a clear case formulation, as the therapist will enter into the therapeutic situation with more confidence (Eells et al., 2005; Hill, 2005). When the therapist is confident, clients can sense this, and then they will also expect that therapy will be effective.

Bowen was not a therapist who openly tried to increase a client's sense of hope. Bowen therapists do not want the client to expect the therapist to make the changes for them in their lives. Rather they seek to have family members take a thoughtful, exploratory attitude to their own lives and family relationships to discover the emotional patterns in the family. Their ability to engage the intellectual system in relationships with other family members increases their ability to engage in more thoughtful choices when interacting in the family. The hope and expectancy in this model comes from the Bowen therapist's knowledge that people who dedicate themselves to a process of exploring the family's emotional patterns do better than when they are emotionally driven and functioning alone. The Bowen therapist does not try to overtly provide a sense of hope, however, as doing so would be creating an atmosphere of “false emotionality.” The therapist does not want to suggest that there are short-term fixes to the difficulties of life, but rather that the client's active engagement in the process of discovery can lead to greater understanding and possibly different, more productive, and less emotionally reactive ways of engaging family members.

Contextual therapists increase family members' sense of hope through several means. By taking a position of multidirected partiality and bringing forth the humanity of each person (Boszormenyi-Nagy & Krasner, 1986), the therapist suggests that each person has ways of being that can be healing not only for themselves but also for others. The process of exoneration is another means by which the rigid sense that things will not change shifts. Here, the therapist helps family members to appreciate the predicaments that others were in and how the context rather than internal characteristics led to their behavior. This produces hope that new contexts of interactions will lead to more options for fair and ethical ways of relating.

Satir's therapy included a sense of hopefulness for families that they can and will evolve to be able to cope more effectively (Satir & Baldwin, 1983). Satir explained, “I think one of the most important things I do for people is give them some kind of hope for themselves. But it is not only in relation to me that they get their hope, it is in relation

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to seeing more clearly what they have” (Simon, 1992, p. 169). Satir attempted to tap into family members’ abilities to enhance their own and each other’s self-esteem, which increased their level of hope of difference. Her ability to show people that, at any point in their lives, they have the skills and resources to change produced hope in clients that life would be different.

MRI brief therapists set, from the beginning of therapy, an expectancy of change through contracting with the family for a maximum of ten sessions (Weakland et al., 1974). They do this because they are very focused on the presenting complaint and not attempting personality change. They try to quickly enact change in interaction patterns, usually based on the solutions attempted by the family to solve the problem. When an expectation is articulated by the therapist that the presenting complaint will be addressed to a satisfactory conclusion within this 10-session time-frame, and potential interventions are provided, the family tends to expect change to happen as well.

Strategic therapists tap into a client’s expectancy of change and difference by providing directives for clients. These interventions, implemented from the first session, imply to the client that the therapist believes that clients can change their lives. In a tongue-in-cheek manner, as he was wont to do, Haley explained that someone can fail as a therapist by insisting that a client could change only after years of therapy (Haley, 1969). By entering into a session with an understanding that change can happen quickly, the strategic therapist promotes an expectancy of difference and change. Haley believed it was important to focus on what brought the client into therapy, develop goals to change the problematic situation, and attempt to move the family toward those goals from the beginning of therapy. This happened by focusing on the present rather than the past, exploring how people can interact differently with one another. Thus, the strategic therapist’s focus on change, from the beginning of the therapeutic process, helps to bolster the client’s expectation of change.

Milan therapists draw on the client’s sense of expectancy with their scheduling of sessions. This is similar in some regards to the practice of MRI brief therapists, as they contract for a maximum of 10 sessions; however, Milan therapists tend to space their sessions out for longer durations. Because some of the families with whom the Milan team was working had to travel very long distances in Italy to see them, the team began to see these families once a month rather than once a week (Palazzoli et al., 1978a). They soon realized that these families showed greater improvement than the ones coming weekly. They then adopted the longer time between sessions for all families, believing that their interventions took time to take hold. One other possible explanation of the efficacy of this tactic is that spacing out the sessions provided an implicit message to the clients that their situation was not hopeless, otherwise the therapist would want to see them more often. Milan therapists also ask future questions, which focus on what might be in the future for the family (Boscolo et al., 1987). These questions increase clients’ sense of hope and expectancy of some type of difference in their lives.

Minuchin has consistently focused on engendering hope in clients (Minuchin & Nichols, 1993). One way this occurs is through increasing family members’ self-esteem. Minuchin and Fishman (1981) explained, “In confirming what is positive about people, the therapist becomes a source of self-esteem to the family members” (p. 33). Besides directly pointing out the positives about family members, structural family



therapists create therapeutic contexts that place family members into positions of competence. The structural therapist helps family members become healers for each other. This increases their sense of self and encourages within them a hope for change.

Solution-focused brief therapy is premised upon bringing forth hope and expectation of change for clients (Reiter, 2007, 2010a). The approach has even been described as “the pragmatics of hope and respect” (Berg & Dolan, 2001, p. 1). SFBT therapists do this based on the premises of the approach. Therapists tend to give clients compliments; that is, they focus on things the client is already doing that are helpful to them (de Shazer et al., 1986). The focus on exceptions—times when the problem was not present—also helps clients shift their lens from a problem-focused to a solution-focused viewpoint. When clients see that they have engaged in useful behavior in the past and that the problem has not always been present, they are more likely to expect more times of solutions. SFBT therapists, from the beginning of therapy, observe and explore what clients have previously done so that in the future clients can do more of what has been useful and helpful in the past.

Narrative therapists build upon hope and expectancy by having conversations with clients that shift the focus from the problem-saturated stories, which hold people within a constrained sense of possibilities, to stories that include their own personal agency. The scaffolding conversations that therapists have with clients, which bring up new possibilities of what clients know and how they have more ability to regulate their own lives, help increase the client’s sense of personal agency (White, 2007). The more that clients believe that they can change the course of their life, the more motivation for change they will have, thus increasing their sense of hope for the future and expectancy of positive change.

### **Model and Technique Factors**

Model and technique factors account for the final 15 percent of variance for successful psychotherapeutic outcomes (Lambert, 1992). These refer to the techniques unique to specific models. All therapists employ techniques to move through the process of therapy. These techniques, and perhaps more importantly, the therapist’s belief in the efficacy of these techniques, impact clients. The techniques of a model are connected to how the therapist engages the client, which increases the therapeutic relationship. A therapist’s confidence and comfort in utilizing the model’s techniques also increases the client’s sense of expectancy and hope as the client receives the message that the therapist expects change to occur for the client. Techniques can also be used to enhance the extratherapeutic factors that clients bring into therapy.

This text focuses on the 15 percent of the variance of change based on the therapeutic model the therapist utilizes. This percentage may not seem large, but therapists should utilize every resource they have to improve the chances for successful outcome in therapy. Each model presented in this chapter employs the key elements of the common factors. They all use techniques that tap into the extratherapeutic factors that clients bring into therapy, increase the client’s sense of hope and expectancy, and bolster the therapeutic relationship.

Although Lambert and Ogles (2004) reported that meta-analytic research demonstrates that one model is no better than any other model, holding a therapeutic orientation guides the therapist in negotiating the therapeutic session. The more a therapist

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knows how to navigate a model, the more confident she will be, which will promote a sense of expectation and hope for both therapist and client. A therapist knowledgeable in a specific theory will also find it easier to use the theory to take advantage of the other common factors of the therapeutic relationship—hope and expectancy, and extratherapeutic factors.

The techniques that the family therapist uses must be connected to some coherent therapeutic map. As Minuchin, Nichols, and Lee (2007) explain, “While it is necessary for a therapist to be equipped with some tools to enter into the family system, the tools become counterproductive if there is no conceptual direction behind their application” (p. 11). This text is one attempt to provide a conceptual direction, or more specifically nine directions, and to show how the techniques specific to those approaches work together to provide a framework for understanding the family system and promoting some type of change.

### THE APPROACH FITTING THE PERSON

Therapists struggle with what approach or therapeutic model to operate from when in therapy with various families. Often, therapists adopt the model of their primary supervisor during graduate school. Many university training programs lean toward one model or a small group of models. For instance, a university might have faculty that primarily teach structural and strategic therapies, multigenerational, or the more recent postmodern approaches. This exposes students to a limited range of possibilities in the therapy room.

The particular model adopted should be more relevant for the therapist than just being what he or she was exposed to in graduate school. Family therapists need to find their own therapeutic voice by examining their core values and seeing which theoretical orientation most closely matches their worldview (Simon, 2003, 2006). Therapists are seldom trained to understand themselves to see how the theories they are learning about align with their own belief systems.

Of all the premises, attitudes, and techniques of the various models, family therapists usually are better suited to work through one or several of the approaches, while not having a positive fit for other therapeutic models. Although a therapist could attempt the techniques of a model, the therapist may not have an effective understanding of the model and so may not be able to use it. Thus, therapists should be able to be self-reflective. This will allow them to bring their personal experiences into the therapy room, adopting models and techniques that fit with who they are. All good therapists, however, once they know their therapeutic style, should be encouraged to expand their repertoire of therapeutic skills and beliefs.

To find their voice, therapists need to understand the premises and processes of a particular model. This text provides not only the theory and its concomitant techniques, but more importantly how the theory and techniques are applied. I encourage you to try each of the approaches presented here to see how they fit. Some will fit the first time you put them on; others may take a few wears. Some of the approaches may not be compatible with your style; others may need a few alterations. Experiment to see which approach matches your own style the most and how you might be able to mix and match styles.