

**Engaging Reluctant Families in Helping Relationships:  
A Research Based Intervention  
and a Workbook for Implementing That Approach**

Thomas A. Cornille

Ann K. Mullis

Ronald L. Mullis

Florida State University

Family Institute

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Requests for additional information can be made to the first author at Florida State University Family Institute, 226 Sandels Bldg., Florida State University, Tallahassee, FL 32306 at [tcornil@garnet.acns.fsu.edu](mailto:tcornil@garnet.acns.fsu.edu).

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ABSTRACT

This paper describes the use of a research based approach to helping families follow through with initial appointments. Many family service agencies have found that families will call to make a first appointment and then not keep that scheduled meeting. The Family Partnership Project was developed by a university based research unit and a non-profit agency that works with at risk youth and their families. Together, we demonstrated that counselors can increase their engagement rates by at least 15% by using a laboratory developed approach to engaging families. A worksheet developed for use by counselors is provided with this paper.

## INTRODUCTION

One of the more difficult challenges for managers of non-profit family service agencies is the organization of the intake process. Once families seek or are referred for agency services, the agency commits time and resources to beginning that working relationship. However, a significant number of families who schedule intake appointments fail to keep that meeting. One such agency sought out the assistance of a university based family institute to explore what might be done to deal more effectively with this situation. This paper describes the beginning experiences of the partnership that was formed.

The underpinnings of the Family Partnership Project grow out of a shared value system (see Appendix 1.) Those values include mutual respect for the strengths of each partner, the rights of families to have access to the best treatment available, and the desire to learn more about the process of change. The agency's strength is reflected in the strong sense of respect that the community has for its services. It is seen as a vital resource for families in distress and routinely receives referrals both from families directly and from other agencies such as the courts, police, schools, and health care providers. The Family Institute is viewed as a respectful, knowledgeable resource about state of the art family based interventions, and expert in training skilled clinicians.

The first phase of the Family Partnership Project focused on improving the engagement rates of the non-residential counseling services of the agency. The paradox of beginning family therapy is that when families are most in need of assistance, they are also least likely to seek outside advice. It is a time when they can be most uncomfortable with asking for help from strangers, even when the professional agency is well known in the community. After the counselors began seeing client families at the Family Partnership Office, they raised the

concern about scheduling appointments with families who request help and then having the family fail to keep that initial appointment. The counseling staff requested that the research team evaluate existing information from the agency files about how often families request help and identify the characteristics of those who keep and those who do not keep the first appointment.

The FSU Family Institute team reviewed the engagement rates at the agency for the previous year. The team found that about 60% of families who request an appointment to begin counseling services keep their appointment. We have since learned that this experience is similar in some other agencies in the Florida Network. The Network is a consortium of 33 similar agencies that work with at risk youth and their families.

The research team identified two factors associated with obstacles to families making use of scheduled first appointments. First, the team divided the group of families that had scheduled a first appointment into two groups, those that kept the first appointment and those that did not keep that appointment. Then, the information gathered during the first phone contact with a family member was examined for differences between the two groups. The two characteristics that were significantly different between the two groups were: the source of the referral and the perception of the caller that the adolescent family member was out of control. When the family was self referred and the view of the caller was that the adolescent member was not out of control, most families (84%) kept their scheduled first appointment. On the other hand, only 30% of families who were referred to the agency by other community agencies and who viewed the adolescent member as being out of control kept their scheduled first appointment. Between these two extreme groups, about half of families with one of these

characteristics keep their first appointment (family referred and beyond control - 58%; agency referred and not beyond control - 56%).

Structural systems engagement.

Based on this information, the team searched research literature for a validated approach to engaging families more effectively. The University of Miami Family Studies Center had developed and thoroughly tested one such approach (Structural systems engagement) in a laboratory setting (Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban, Hervis, & Kurtines, 1988). One concern about such an approach was how well it could be used in a non-profit agency without all of the structures that a randomized clinical trial inherently provides. To address this concern, training was set up for some of the staff in the agency.

In October 1998, one of the developers of the University of Miami Structural Engagement Manual (Hervis, Szapocznik, & Santisteban, undated) provided a one-day workshop for six of the staff from CCYS and six doctoral students from the FSU Interdivisional Program in Marriage and Family Therapy.

According to the Structural Systems Engagement Model, four patterns of family dynamics are related to families not following through with scheduled first appointments. These patterns have been labeled: 1) The Family with the Powerful Identified Patient; 2) The Family where the Caller is Protecting the System; 3) The Family with a Disengaged Parent; and 4) The Family fearing an Expose'. For each pattern, the University of Miami staff has tested and refined specific interventions for use by the counselor. Once the workshop participants became familiar with each pattern and ways of identifying it in the context of phone calls requesting assistance, the presenter identified steps to be followed to reduce/remove the obstacles to the family keeping the first appointment. Discussions and

role-plays were used to help the participants integrate the training into the context of CCYS' procedures for offering services to families.

Following the training, members of the university and agency teams met and selected collaborators, so that one member of the university team worked on an ongoing basis with the same member of the agency team between October, 1998 and March, 1999. The doctoral students received additional training in the utilization of the manual and advised the CCYS staff members about ways of refining their use of the manual. Additionally, in January, 1999 the university team developed a worksheet (see Appendix 2) that the counseling staff could use to increase their familiarity of the Miami Structural Engagement Manual. The members of both teams met and reviewed the worksheet and have used it to focus their efforts to engage families.

Analysis of this training cycle produced the following results. During fall, 1998 (October 1 - December 31, 1998) the agency received 106 referrals. During spring, 1999 (January - March, 1999), it received 80 referrals. In the fall, participants had engagement rates of 53.1% in comparison to 49% for non-participants, and in the spring (following the implementation of the Structural Systems Engagement Worksheet), participants had engagement rates of 55.6% in comparison to 50.1% for non-participants. The therapists who participated in the training had somewhat higher engagement rates than the staff members who did not participate. Additionally, there was a small increase in engagement for the participants between fall, 1998 and spring, 1999. One difficulty of pilot testing within the same agency is that the staff may have discussed training experiences with one another, and possibly influenced one other. At the same time, this pilot experience has permitted us to better understand the workings of the agency in dealing with referrals and its record keeping.

The majority of those collaborative relationships continued through much of 1999.

However, as is common in non-profit agencies, there has been a great deal of turnover in staff at the agency during the project. By September 2000 none of the agency staff members who participated in the training are still in counseling positions in the agency. Several have since left the agency, and two have been promoted to supervisory positions. As a result, agency administrators decided to repeat the training in September 2000 with their clinical supervisor and 10 new counseling staff and interns.

Following the experience of applying the Structural Engagement Approach at the agency, we concluded that it was appropriate to provide that training at several other agencies that are part of the Florida Network. In December 1999, a one-day training program was provided for 20 counseling staff from both agencies at the central administrative office of the Youth Crisis Center in Jacksonville. Again Dr. Olga Hervis from the University of Miami provided the training, using the University of Miami Structural Engagement Manual, described above.

Comparisons were made at each agency for three month periods immediately prior and following the training to determine the extent that the training affected the engagement rates at each agency. Based on that evaluation, it was determined that staff at both agencies improved their engagement rates at least 15% as a result of the training. However, the two agencies were different from one another, both in the beginning engagement rates and in several other important aspects that have increased our knowledge about the process of implementing this type of service in non-profit agencies. Those differences are detailed in the following section.

Administratively, the two centers appear quite different. Agency Y had recently undergone a major reorganization of its counseling services during 1999. Agency Y and other member agencies of the Florida Network deal with contract quotas as part of their funding with the Department of Juvenile Justice. In order to comply with those quotas, the administrators decided to design a more directive managerial style, where accountability and performance standards were emphasized openly. The administrators saw the training as an opportunity to strengthen the model that they had put in place as a result of the reorganization. For that agency, case managers became responsible for meeting with the family for the first appointment after the family requested services. After the first meeting, if the family wanted to continue services at the agency, a counselor would then be assigned to work with the family. Prior to the re-organization, case managers worked with schools to deal with truant youth, and they had received training about working with youth and their families to make use of available services, rather than providing counseling services directly.

Given this context, the case managers and counselors who were working at agency Y were directed by the administration to participate in the training. Thirteen staff members participated in the training.

On the other hand, the agency C operates with three distinct regions, each with its own director. The central administrators at agency C manage these sites in a less directive and more collaborative manner than the one described by administrators at agency Y. Although the director of the overall agency C had endorsed the engagement training, each region was free to decide whether to participate. Only one of the three regions, Central Office, decided to support their staff in attending. Although the agency has approximately 15 non-residential

staff in the three regions, only 8 staff participated in the training. Of those staff, 3 were non-residential counselors or case managers, 2 were supervisors, and 3 were residential staff.

Following the training in December, Dr. Cornille and one other team member (Sandy Barlow) traveled to Jacksonville and Gainesville in the spring every other week for six meetings. During those meetings with participants, the training and current case examples were discussed to clarify and reinforce the material from the training manual. Logistically, it was not possible to meet with the staff from St. Augustine during that period. In the meetings with the case managers at agency Y, all of the staff participated in all of the follow-up meetings, with the administrators openly directing the staff that this was an expected activity. Case managers and counselors dealt with both the changes that were part of the reorganization and also ways that they could use the engagement approach to better serve the clients seeking help at the agency. Clearly that staff was committed to assisting the families that came to the agency, and at the same time, were struggling with a period of uncertainty in agency structure and protocol.

When the follow-up meetings took place in Gainesville, administrators took a more casual position about staff participation. During those meetings, five staff members consistently participated; a supervisor, two counselors who worked in the residential program, a new case counselor who viewed the video tape of the training, and one outreach case manager, who routinely conducted first appointments. One of the case managers who participated in the December training had left the agency early in the spring.

In examining the results of the training, similarities and differences in effects were found in the two agencies. In agency Y, during fall, 1999, the case managers had engagement rates at the Northside office of **33%**, with 95 families scheduling first appointments and 31 keeping

those appointments. In contrast, the engagement rates following the training increased to **59%** for January and February following the training with 51 of 86 families keeping their first appointments. Since all of the staff at the agency Y office participated in the training, there was no comparison group information within the agency.

For the staff of the agency C, engagement rates of the counselors prior to the training for the non-residential services averaged **35%**, with about 65% of families with scheduled first appointments failing to keep that appointment. Since a number of the staff did not participate in the training, it was possible to compare engagement rates within that agency. For those staff of agency C who did not participate in the training, their engagement rates during the spring of 2000 were **40%**.

One outreach counselor who participated in the training and the follow-up meetings had an engagement rate of **81% in comparison to 63%** prior to the training. The engagement rate of that staff person was higher than the average prior to the training, and increased during the follow-up period by 18%. The new staff member had an engagement rate, after watching the video of the training, and participating in the follow-up discussions had an engagement rate of **70%**. Clearly, these two staff members were doing something substantially more effective in engagement than the staff who had not participated in the training.

From a research standpoint, there are some cautions that need to be made explicit before simply deciding that the improvement in engagement rates was due solely to the training process. In conversations with staff at both agencies, they pointed out that improved rates could have been influenced by other factors besides the training. For example, they thought that families might follow through with appointments after the holidays because of pressure from schools. Also, increased attention within the agency about improving engagement might

have affected the efforts that they put into getting the families in for their first appointment.

In this type of services evaluation, it is not possible to control for these types of influences.

Because most of the Florida Network agencies employ recently trained therapists, it is important to balance training of these therapists in specific techniques with opportunities for training in the essential skills for family therapists. This shortened instrument, which combines generic and theory specific skills, will provide a format for assessing the clinical training of the therapists who participate in the partnership projects, and the ways in which the training addresses both specific protocols and essential skills.

We plan to share the information and knowledge that has unfolded during this project with other agencies in the state and country. Activities under this objective will not be initiated formally until after the first phase of evaluation in CCYS is completed. Discussions have begun with the administration of the Florida Network about the next phase of the project. Based on the experiences with three of the member agencies, and the knowledge developed during those collaborations, the opportunities for improved effectiveness and efficiency will be shared with all of the other member agencies and then with the agencies that are part of the Southeastern Network of Youth and Family Services. Simultaneously, this knowledge will be shared with professional groups and educators in family services to encourage further dissemination of this information.

#### Policy and Programmatic Implications.

As we finished the field test of the Miami Structural Engagement Manual at the partner agency, agency Y, and the agency C, we have found that use of that approach has the potential for benefiting both clients and the agency when used consistently. However, we have also learned that any approach that relies on phone contacts with prospective clients

prior to the first session must address limitations placed on the agency by funding agencies.

Such contacts are not considered a direct service by some funding agencies. Efforts will need to be made in the next phase of the partnership to persuade funding sources to reconsider this policy, which penalizes both client families and the agencies providing these services.

In working with settings that provide non-clinical family services, such as schools, parent education programs for fathers and reading programs for young parents, these programs often struggle with families requesting assistance but not following through with scheduled meetings. We have found that recognition of the systemic dynamics of these families helps agency staff to become more successful in engaging families. The SSE model presented in this paper focuses on levels of family patterns that interfere with family functioning. In prevention and early intervention programs, the patterns in families might not be toxic, but developing an appreciation for engaging a number of family members before the first meeting has proven to be a useful strategy. In work with school teachers, we have recommended calls or notes to parents that is "good news", so that any later call to them about a problem can be seen in a more positive constructive context.

#### Research Implications.

It has been demonstrated that this approach can be used effectively within non-profit agencies and that its use can result in improvements in engagement rates of about 15% over approaches that are typically used. For agencies like the partner agency, that worked with 600 families during FY 1998, use of that approach could result in an additional 90 families being able to make use of much needed services in a timely manner.

Because agencies like the partner agency regularly hire new staff, a mechanism needs to be developed to ensure that the approach to engaging families is consistent among staff

members. All of the training workshops that have been conducted by the partnership group have been video-taped. In the next phase of the partnership, a training CD will be developed by FSU FI in consultation with the University of Miami and the partner agency. How well this approach to training therapists to use the Structural Engagement Model works will need to be evaluated in the next phase of the partnership.

The model developed by the University of Miami relies on a structural family therapy approach that casts the therapist in a role of strategist and expert. Other models, such as the LINK approach developed by Landau (Landau, Stanton, Brinkman-Sull, Ikle, McCormick, Garrett, Baciewicz, Shea, & Wamboldt, 1999), are grounded in a more collaborative set of interventions. In the next phase of the partnership, tests will be conducted to determine the extent that style of the therapist and the problem solving approach of the family match best with either of these extreme approaches.

In addition, the issues identified by counseling staff at the partner agency have not been limited to engagement. The partnership will continue to examine links between the issues identified by agency staff and models tested in university laboratories to better serve families and youth at risk.

#### Overall Process Model.

As we moved through the testing of the Engagement Manual in the three identified agencies in the Florida Network, we have identified an underlying process that can be used in the next phase of this partnership. The steps of this process are:

- (1) Identifying the target issue;
- (2) Collecting information about the current impact that the agency is having in this area;
- (3) Identifying alternative validated approaches;

- (4) Examining those models to determine if the alternative approach could be better than the current protocol (and assuming so);
- (5) Providing manual specific training to agency staff; and
- (6) Re-assessing the impact that the agency has in that area.

These steps will be repeated with new issues that the agency staff select as areas where they wish to focus the attention of the partnership team. For example, agency staff members have identified families who have adopted an at-risk child as families in need of special attention. They have experienced a number of treatment failures with these families, and in some cases, adoptions have been dissolved after the child has been part of the family for several years. We will examine how many families have come to the agency with this issue in the recent past and how effective the service has been. Simultaneously, we will examine the research foundation of various validated manuals in family therapy. If we find that it has been tested adequately and the findings suggest that it would help families with children who are poorly attached in their family, we would develop training for a limited number of therapists at the agency. If the results are positive, we will offer this information and training to staff in other agencies in the Florida Network.

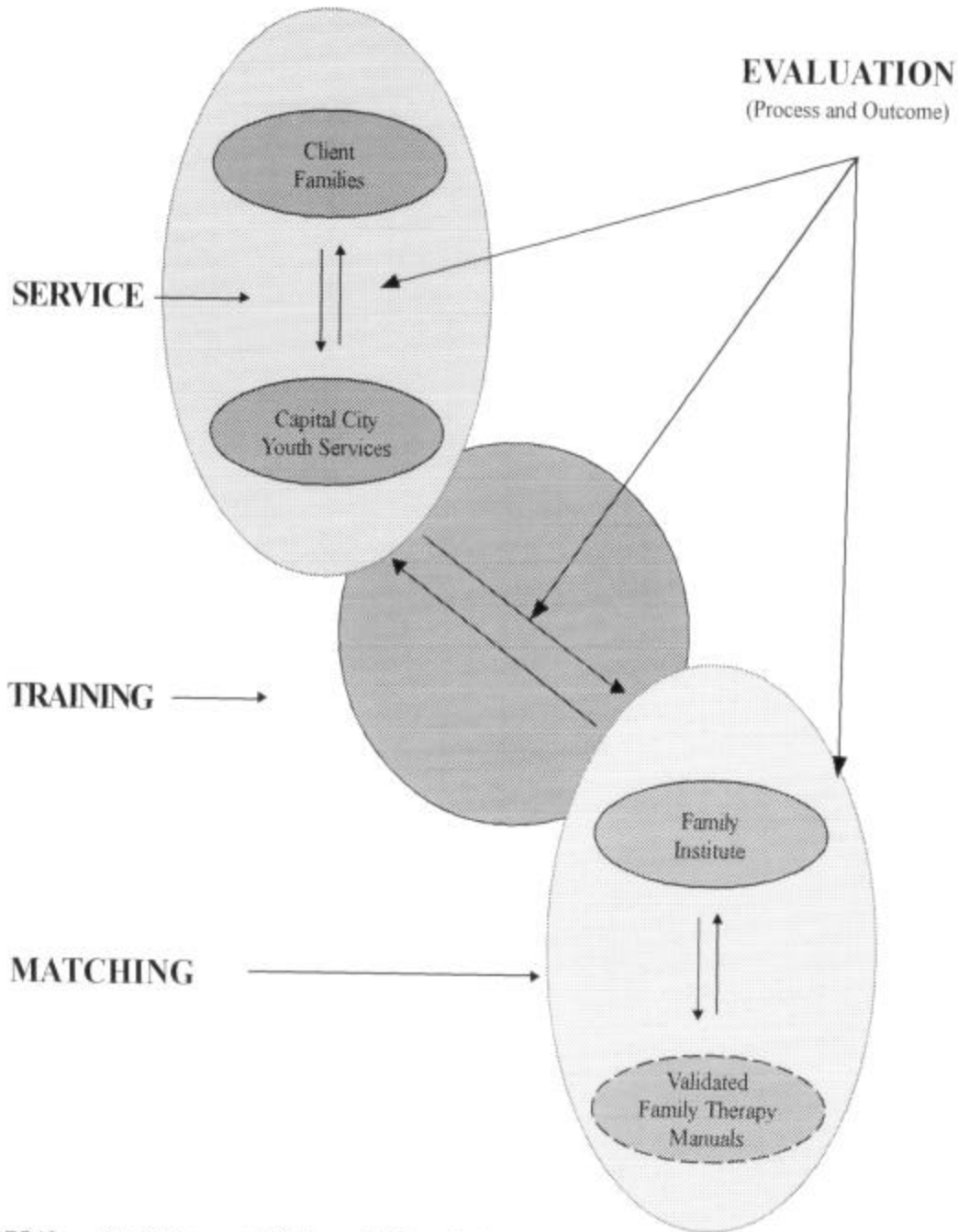
### Conclusion.

In conclusion, this collaboration has been a very productive one in the development of the Partnership Project. We are looking forward to the continued collaborative efforts of the partnership and are excited by the level of enthusiasm that other agencies are expressing about becoming active members of this partnership. The Family Partnership Project was grounded in appreciation and respect of the complementary strengths of the two founding organizations. The

agency indeed provides priceless services to hundreds of at risk youth and families yearly in their service area. The FSU Family Institute has demonstrated the ability to identify potentially useful validated approaches to strengthen and improve the effectiveness and efficiency of the agency and similar agencies in serving those families. Our combined efforts in the training process of staff at these agencies have been both worthwhile and practical. The training has in helped the staff in these agencies to reach out to the families who are most likely to struggle with making use of professionals outside the family. In the next phase of the partnership, we expect to grow both in the number of partners and in the areas of clinical investigation identified by the staff of the Florida Network of Youth and Family Services.

APPENDIX 1  
FAMILY PARTNERSHIP PROJECT

**Partnership of Capital City Youth Services &  
Florida State University Family Institute**



**GOAL:** Provide the most effective and efficient family services to promote competent families which prevent juvenile delinquency.

## APPENDIX 2

### JESSIE BALL DUPONT FAMILY PARTNERSHIP PROJECT

#### **STRUCTURAL SYSTEMS ENGAGEMENT WORKSHEET**

#### *REMINDERS AFTER RECEIVING GREEN INTAKE SHEET AND BEFORE INITIAL FAMILY CONTACT*

#### **Diagnostic questions about the family system:**

- ◆ Why has this particular family member chosen to seek therapy?
- ! How does the caller frame the difficulties in the family?
- ! What possible alternative perspectives may exist?
- ! Who does the caller believe will resist being engaged in therapy?
- ! Does the caller go out of their way to justify this resistant behavior?
- ! What might the powerful member's perspective/frame be?
- ! How does each individual's position in the family change as a result of establishing a relationship with me?
- ! How does my position in the system dislodge or move family members from their accustomed positions?
- ! How can my position within this newly formed system either increase or decrease the probability that the entire family will engage in therapy?
- ! What would be the effect (structurally) of my contacting family members directly?
- ! Now that I am part of the system, how does each member view me, and can I be seen as a threat to each individual's role?
- ! How does each member want to use me to change the balance of power within the family?

## **Structural tools to reduce resistance**

### **Reframing**

Offering a positive view to replace the resistant family view.

### **Reversals**

Coaching a family member to behave differently to lower family resistance.

### **Detriangulation**

Directly engaging all family members who are in conflict.

### **Opening Up Closed Systems**

Activating the system by creating a crises, or magnifying the affect related to the problem.

### **Shifting Alliances**

Joining with each family member around their view of the problem. Avoid forming a coalition with the initial caller.

### **Task Setting**

Primary task is to negotiate; who will come, what is expected of each member, and what he or she might gain by participating. Other tasks move toward this goal.

STRUCTURAL SYSTEMS ENGAGEMENT WORKSHEET

Callers Name: \_\_\_\_\_

IP's Name \_\_\_\_\_  
\_\_\_\_\_

Therapist Name: \_\_\_\_\_

Referral Source: \_\_\_\_\_  
\_\_\_\_\_

Date Contacted: \_\_\_\_\_

Youth Beyond Control (y/n): \_\_\_\_\_

Consultant Initials: \_\_\_\_\_

Youth uncooperative (y/n): \_\_\_\_\_

Other Intake Sheet Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I Beginning to Form the Therapeutic System**

A. I am calling to set up the first appointment for the whole family to come in.  
**(Join with the initial caller)**

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Confidence Level: \_\_\_\_%

1. If you are able to set up the first appointment for the whole family, and your confidence level is 80% or higher that they will come then stop the procedure now.
2. If you meet with uncertainty or resistance, and your confidence level is less than 80% that they will come then, continue procedure with step B.

B. "Help me to understand how each person is being affected by the problem."  
or "Let me make sure that I understand who is in the family."  
**(Identify who will be included in the therapeutic system)**

Content issues B what are the needs, agendas, goal, and styles of each family member (or other person connected to the presenting issue)

Caller's Name: _____	Name: _____
Content Issues: _____	Relation to Caller: _____



## II Diagnosing Resistance Patterns

### A. Structural Map Symbols:

Minuchin, S. (1974.) Families and Family therapy. Cambridge, MA: Harvard University Press.

### **B. Structural Map of this family** (for assessment and planning restructuring of resistance:)

### III. Restructuring to overcome Resistance

#### A. Identify the family pattern of resistance.

1. **Identifying The Powerful Identified Patient (IP)** - Youth holds very high power position in the family hierarchy.
  - a) Parents are unable to bring the youth into therapy.
  - b) Parents report being overpowered or feeling overwhelmed by the IP.
  
2. **Identifying The Disengaged Parent** -- Couple is avoiding intense marital conflict by IP triangulation and symptom bearing detouring.
  - a) Is there cohesiveness in the parental subsystem? NO
  - b) Is IP closely aligned with one parent? YES
  - c) Is one parent distant from the other parent and IP? YES
  - d) Is one parent refusing to enter treatment? YES
  - e) Is aligned parent over involved and ineffectual in providing limits? YES
  - f) Is disengaged parent overwhelmed and unable to relate to issues with the child? YES
  
3. **Identifying The Caller Protecting the System**- Caller is fearful that any change might damage the family system beyond repair.
  - a) Caller gives up on the therapist's alternative solutions easily
  - b) Caller provides justifications for why other family members cannot alter their behavior and/or come to therapy
  - c) Caller agrees that other family members' reasons for failing to attend therapy are valid
  
4. **Identifying Therapy As An Expose** - One or more members of the family feel that the exploratory nature of therapy is threatening because of very sensitive areas.
  - a) Conventional approaches such as, there are many issues in your family that need to be addressed will serve only to exacerbate the family's fear and reduce the probability of engagement
  - b) Family members may fear being made scapegoat or that some dark secret will be revealed.
  - c) An air of secretiveness and suspicion may pervade initial contact.

### 1. Intervention for The Powerful Identified Patient

**a) DON'T MEET WITH THE PARENTS WITHOUT THE ADOLESCENT IP**

**b) Coach the parents in presenting therapy as something that can lead to everyone's agenda being considered.**

*Do you feel like your life is being controlled by your child? That must be overwhelming for you. Perhaps we can approach family therapy with \_\_\_\_ by finding something good for him/her in this process.*

---

**c) Contact the powerful IP directly.**

*You've been struggling with this situation for so long, what if I talk to directly.*

---

**d) Reframe therapy to portray the IP as an individual who can bring about change rather than the person who will be changed.**

*It feels like the whole point of this therapy business is about changing you, doesn't it? How about looking at it as a place where you can be heard and where you can help bring about changes in your family.*

---

### 2. Intervention for The Disengaged Parent

**a) DO NOT SEE ALIGNED PARENT AND CHILD ALONE. THIS IS A WASTE OF TIME SINCE SYMPTOM CAN'T BE LET GO UNTIL IT HAS ACHIEVED ITS MISSION OF ENGAGING THE OTHER PARENT.**

**b) Empathize with caller's frustration over spouse's disengagement**

*"It sounds like you're frustrated by not having your husband/wife more involved. Is that right?"*

---

**c) Ask caller to help you get disengaged parent into session**

*"Okay so you're interested in your husband/wife getting more involved with the family? How can we begin that process by getting him/her involved here?"*

---

**d) If get resistance like "Oh he'll/she'll never come", try:**

*"Sounds like it's been difficult for you to get your husband/wife involved. How would you feel about me calling him/her directly? Sometimes that works."*

---

**e) Call disengaged parent. Be sure to approach in a way that insulates marital conflict. Present therapy as a focused process only to deal (initially) with IP's behavior, not global marital issues. "I am interested in**

*getting together to discuss the issues you are having related to your son/daughter. Would you be available to help deal with your son's/daughter's problems?" OR*

*"It's nice to talk to \_\_\_\_'s father/mother. It's important to me to hear your perspective and to know your ideas of how we can deal with this situation. <pause while listening> Those sound like good places to start. I'd like to set up an appointment to continue with this process with the whole family."*

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### **3. Intervention for The Caller Protecting the System**

**(a) Caution! LESS IS MORE. REMEMBER THE TAR BABY.** Making a lot of suggestions can snowball - the more invested the therapist is, the more resistant the caller becomes.

**(b) Empathize.**

*AI can imagine that this situation has felt like the family is falling apart.*

---

**(c) Form an alliance with the caller's perceived reasons and need for therapy.**

*AI understand how important it is for you to get these problems dealt with.*

---

**(d) Align with the caller by reframing the nature of the problem in terms of the caller being overtaxed with their role and demands of the family.**

*It must be difficult and exhausting to be responsible for dealing with this problem.*

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**(e) Form a collaborative agreement with the caller to work "together" in achieving the "caller's goal" of bringing in all family members**

*Let's work together to get your goal of getting the rest of the family to work on this problem.*

---

**(f) Ask permission to contact unwilling participants directly.**

*I would like to help you with this goal by calling the others myself. Would that be ok with you?*

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### **4. Intervention for Therapy As An Exposee**

**a) Reframing the therapeutic enterprise - focus is specific and agreeable to all.**

*What is one specific thing that you all could agree to work towards that would benefit everyone?*

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**b) Family must be assured that they will be capable of controlling the direction of therapy, except in cases where there is mandatory reporting**

(i.e., child abuse, risks of suicide, homicide)

*I want you to know that we will only discuss what you agree to talk about. We are only concerned with helping you with \_\_\_\_\_[specific problem/goal] and will avoid anything that you don't want to deal with or discuss.)*

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