Chapter 6
Disadvantaged, Multi-Stressed Families Adrift in a Sea of Professional Helpers

If the misery of the poor be caused not by the laws of nature, but by our institutions, great is our sin.

—Charles Darwin

Multi-stressed, disadvantaged families that experience moderate to severe difficulties socially, personally, and economically due to sociocultural deprivation (e.g., Bachler et al., 2016; Witkiewitz et al., 2013) often find it difficult to initiate or remain in therapy despite a pressing need for assistance. In many cases, these families seek psychological help only at the insistence of the judicial system, social services, school psychologist, or child protective services. Unfortunately, secondary gain complicates the therapy process when economic assistance comes with the stipulation that the family follow through on the treatment referral.

In this chapter, we describe ways to reduce resistance and facilitate a multi-stressed family's collaboration in the therapy process by providing safety and a "joining with." Note that we use Madsen's (2007) term *multi-stressed* to describe these families, even though the traditional term in the literature is *multiproblem.* In our view, *multi-stressed* is less pejorative because it acknowledges the pernicious interaction of psychological difficulties and external stressors in the lives of these families.

In part, the difficulty in trying to engage a multi-stressed family lies in the clash between the clients' sociocultural context and the professional context. For this reason, alliance empowerment begins by addressing the family's lack of safety. To do so, the therapist must first determine the family's relationship to the referring agency or institution and understand how the family views the therapist's role in relation to that agency. All too often the family, therapist, and referring professional have opposing views on the presenting problems, on how the problems should be approached, on the nature of the therapeutic relationship, or on the agency's authority over the family's life.

In large part, therapy with multi-stressed, disadvantaged families involves the same complexities described in previous chapters of this book. That is, in working with particularly stressed families, we often need to focus on difficulties in the couple's relationship or in the specific challenges of what we call *parenting in isolation*. Not uncommonly, multi-stressed families also require help to reduce an adolescent's risk behaviors or work through relational trauma.

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Despite the many varied problems a particular family may be experiencing, the common denominator is the challenge to the therapeutic alliance due to the referring agency's authority over the family. Although agencies and courts often recommend separate help for the parent(s) and the child(ren), we recommend against offering different therapies for individual family members. Rather, family empowerment requires a concerted treatment plan for the entire family system.

Unique Challenges

Multiproblem or Multi-Treated Families?

Before therapy begins, a disadvantaged family with multiple difficulties has likely received various forms of assistance from social services, the juvenile justice system, housing authorities, religious leaders, the children's school, and so on. In crisis situations, the family typically meets with many professionals—police officers, physicians, and school officials—who rush to intervene.

Some offers of help can either be accepted or rejected by the family, but often psychotherapy is obligatory, even coercive. The provision of economic assistance, for example, while not explicitly coercive, is often conditional on participation in a mental health intervention. Yet how can destitute parents decline participation in a "voluntary" parenting course when they are in dire need of financial help?

Due to this complexity, a multi-stressed family can rapidly become a multi-treated family. All too often, the influence of other professionals is an obstacle for the smooth initiation of family therapy. Indeed, the first challenge involves helping family members see that psychotherapy is unique and distinct from other professional contexts. However, it is often just as confusing for the therapist as it is for the family to sort out the objectives of each recommended or mandated intervention (e.g., individual counseling for the mother, anger management for the father, play therapy for the young child, residential care for the adolescent). In order to collaborate effectively with the various professionals who are already involved with the family, the therapist may not be able to recommend against a mandated intervention, such as anger management training, in favor of conjoint family therapy. To complicate matters further, the family's sense of safety is compromised if the therapist is required to send routine reports to an outside agency about the family's progress in treatment. Not surprisingly, this lack of privacy is a major source of confusion and frustration for the family.

Take the case of Emma, who was referred for family therapy by child protective services. Each of her three children had a different father, none of whom had any contact with Emma.

The first session was saturated with negative SAFETY indicators. Emma insisted that the social workers were wrong about their concerns for the 7- and 11-year-old boys—the "real problem" was her 17-year-old daughter. Responding to this remark,

the therapist inquired about the teenage daughter's difficulties. Emma reacted defensively to these questions, explaining that her daughter did not need a therapist or the psychological evaluation that had apparently been prescribed by a psychiatrist. When the therapist persisted by trying to explore the mother-daughter relationship, Emma expressed mounting anger toward the residential center where her daughter was living. She was adamant that the counselor in the facility had already told the therapist about her conflicts with him over their handling of the daughter's risk behaviors. This was not the case, however.

Interestingly, although Emma thought the psychiatrist was wrong about the severity of her daughter's emotional problems, she was pleased that he was supportive of her fight against the facility. To complicate matters further, while the facility's counselor adamantly disagreed with Emma about how to handle her daughter's acting out, he shared Emma's view that the social workers from child protective services were in error about the vulnerability of the two boys.

The therapist asked Emma to explain her most immediate problem. She answered that since she had been unable to pay the rent on her apartment for several months, she feared that her boys would be removed from the home. The therapist's response to this disclosure prompted a positive shift in the therapeutic relationship:

Therapist:	I have to confess that this whole situation is overwhelming me and I'm lost (EMOTIONAL CONNECTION[1]). I wonder if you're feeling the same way?
Emma (leaning forward) (ENGAGEMENT[2])*:*	You feel lost?
Therapist:	Yes, and very overwhelmed with everything you must be going through. That's why I wonder how you can carry so much heavy weight on your shoulders (EMOTIONAL CONNECTION[3]).
Emma:	Well, there are days I feel like leaving this life of mine, running away, disappearing, I can't take any more…but I have to fight for my children (SAFETY[4]).

[1] Therapist discloses his or her personal reactions or feelings toward the client or the situation.

[2] Client leans forward (in response to a direct question from the therapist).

[3] Therapist (verbally or nonverbally) expresses empathy for the clients' struggle.

[4] Client shows vulnerability (e.g., discusses painful feelings).

Therapist:	I don't want to add to your burden (EMOTIONAL CONNECTION[5]). So I don't want the referral you got to come to the family therapy center to be one more hassle for you. I specially want to keep that from happening, but I don't know what to work on first. Can you help me out (ENGAGEMENT[6])?
Emma (softly)*:*	It's funny that you're asking *me* for help (SAFETY[7]). That's never happened before, and I've had to see a lot of professionals. I think I'd like to talk about what you just said.
Therapist:	How do you feel about all this?
Emma:	Yes, I need some peace of mind to explain how I feel, and about how scared I am about maybe losing my children, every one of them. They've all lost their relationship with their fathers, and I think they blame me.
Therapist:	Would you like me to meet your three children (ENGAGEMENT[8])? I *would* like to meet them.
Emma (fidgeting with her purse strap) (negative SAFETY[9])*:*	Okay, I think maybe you can help me find out how they feel too… ? But, what about the counselor from the [residential] center and the psychiatrist? Will CPS [Child Protective Services] make you write a report about me?
Therapist:	I'll go talk to all of them, but first I want to know about your family's background. And I'll tell you everything I say to them when the time comes—what do you think (SAFETY[10])?

[5] Therapist discloses his or her personal reactions or feelings toward the client or the situation.

[6] Therapist discusses or negotiates therapy goals with client(s).

[7] Client varies her emotional tone during the session.

[8] Therapist asks client(s) whether they are willing to follow a specific suggestion.

[9] Client expresses anxiety nonverbally (e.g., taps or shakes).

[10] Therapist provides structure and guidelines for safety and confidentiality.

Emma had a positive response to this simple exchange, the objective of which was simply to begin building a safe and personal therapeutic alliance, uncontaminated by multiple, contradictory professional opinions—at least, that was Emma's subjective experience of the "help" she had already been offered by others.

Therapy or Social Control?

Like in Emma's case, when the care of a minor child is considered "inadequate" or "negligent," the child protective system often takes on the responsibility normally entrusted to parents. This intervention is essentially one of social control. At the same time, however, when a lack of resources is seen as contributing to the parents' negligence, social services may also offer the family financial, social, and psychological assistance.

In cases of negligence, parents often fail to understand that psychological help involves support rather than control. For this reason, the therapist needs to acknowledge the coerciveness experienced by the family. However, even when the therapist empathizes with the pain caused by children's removal from the home, many parents respond defensively because they see the therapy as part of "what social services are doing to us."

It is particularly challenging to create a safe therapeutic environment when the therapist is required by the authorities to report the family's compliance with treatment to a judge. In other words, therapists are not exempt from some obligations that are meant to be protections but that parents understandably interpret as interference.

Chronic Stress

One characteristic that complicates therapeutic work with disadvantaged, multistressed families is the chronicity of these families' difficulties. Typically, the therapist comes into the picture long after the family has been exposed to multiple, repeated attempts at intervention. In an analysis of the patterns of chronicity in these types of families, Escudero (2013) found the following 7 features to be most common:

1. *Dependence on social services.* "Dependence" is a typical feature of the multistressed family's lifestyle, expressed as helplessness and external attributions for the family's problems. Dependence on the aid provided by social services often becomes part of the problem rather than a tool to cope with and resolve the family's difficulties.

   A pattern of dependence not only characterizes the family itself, but also it reflects the family's ongoing relationship with the social service system.

Unfortunately, social service professionals, who are typically overwhelmed by a large caseload of needy families, tend to develop a paternalistic attitude toward these families that only reinforces their dependence and lack of initiative. Understandably, it is all too easy for a family to transfer its dependent relationship with social services to the family therapist.

2. *Long-term disorders*. By their very nature, some psychological problems and characteristics of family dysfunction require long-term treatment. These difficulties include, among others, severe mental health disorders, addiction, social isolation, and intellectual challenges.

   Some risks to health and safety are repeated across three generations, particularly alcoholism, criminal activity, and violence and abuse. When these kinds of problems are transmitted intergenerationally through the family's values, norms, routines, and lifestyle, the problems tend to be invisible to the family and are thus extremely difficult to dislodge therapeutically.
3. *Sequence of negative life events*. According to Escudero (2013), it is common to discover in the history of multi-stressed families a lengthy chain of negative life events, such as deaths, imprisonments, job losses, evictions, and an urgent need to leave a community or neighborhood and move from one dwelling to another. Sometimes these negative life events are complicated by relational trauma experienced through two or even three generations. In these cases, therapists need to help families recover from a complex set of relational challenges, as described in Chap. 5.
4. *Poverty and social isolation*. Obviously poverty is not exclusively associated with social isolation or marginalization, but it is a common feature of multi-stressed families (Bachler et al., 2016; Witkiewitz et al., 2013). Research indicates that low socioeconomic status is associated with less engaged parental behavior, particularly less parental monitoring, thereby negatively affecting a parent-child attachment and the child's rate of development.

   In general, poverty is a risk factor that contributes to psychosocial disorders and increased vulnerability in the family system (Lund et al., 2011). When there is a lack of employment in the community, especially one in a rural area, many clients need mental health services throughout their lives simply to cope with the adversities that attend poverty (Friedlander, Austin, & Cabrera, 2014).

   In some cases, a family is isolated from the surrounding community. In other cases, the family is part of a marginalized community, a microculture, or an ethnic neighborhood. As discussed later in this chapter, immigrant and refugee families are particularly vulnerable, due to the acculturative stress that accompanies virtually every aspect of their daily life—language, employment, housing, education, and so on. For these families, the therapeutic context is especially threatening. Psychotherapy belongs to a world that is altogether foreign to them.
5. *Frustration with previous professional help*. When a family has a lengthy history of unsuccessful interventions, family members tend to be as frustrated as the professionals. Even when the intervention attempts have been prolonged, it is nonetheless quite common for them to be repeated, each time with similar negative outcomes. These repeated failure experiences logically lead to frustration on

the part of the family and pessimism on the part of the professionals. Invariably, this negativity carries over to the work of building a therapeutic alliance with the family.

6. *A lengthy history of conflict*. Some families have a specific profile in which conflict between the couple or among various family subsystems is perpetuated across two or three generations (Escudero, 2013). Unresolved conflict, involving coercive control as well as physical/sexual violence, often cycles throughout the extended family system, never receiving adequate professional attention.

   In other words, conflict can become a habitual characteristic of a multi-stressed family's lifestyle. In fact, some parents bring each of their children to see a therapist just as a matter of course, so that therapy is a kind of "generational norm" in the family (Friedlander et al., 2014, p. 588).
7. *History of parental rejection.* Often therapists discover evidence of neglect and abandonment in the families of origin of the parents whose children are referred for treatment. Not surprisingly, reactive attachment disorders show up in these children, mirroring the attachment disorders of their parents, who themselves were abandoned or neglected as children and placed in the care of social services.

Disorganization in the Professional Network

The confusion that challenges therapeutic progress is not only located within the multi-stressed families themselves. All too often, the various professionals working with a particular family experience a similar level of confusion, as well as frustration, due to the inherent difficulties of working together to foster change in multi-stressed clients (Escudero, 2013; Madsen, 2007). These difficulties are due to specific sources of disorganization in the network of professionals: lack of coordination, judicial power, negative expectations, and a dilution of responsibilities.

Lack of Coordination Perhaps the primary difficulty that accounts for professional disorganization is a lack of coordination between the professionals who represent the various social service and mental health agencies working with a specific family. Poor coordination occurs when recommendations or requirements in one arm of the network, such as the juvenile justice system or child protective services, are not adequately implemented by the other arm of the network. Indeed, it often seems that a lack of coordination in the lives of family members is mirrored in the network of professionals, as if systemic disorganization were contagious.

Judicial Power In some cases, interventions mandated by a judge are at odds with the therapist's attempts to unify the family, such as when parents can only see their children during supervised visits. The power of the courts can also stall the initiation of conjoint family therapy. Moreover, the social control wielded by family courts can contaminate a family's trust in the therapist and his ability to work effectively with the entire family system.

Consider this case example. A childcare worker in a residential facility for adolescents gained the trust of Saeeda, an "emotionally disturbed" adolescent. Fearfully, Saeeda told the worker that her mother was regularly prostituting herself to make ends meet. Learning this information from the childcare worker, the therapist recommended that Saeeda remain in residential care for the time being, at least until her mother agreed to participate in conjoint family sessions. Unfortunately, however, neither the therapist nor the facility administrator was able to dissuade the family court judge from sending Saeeda home to her mother. Judicial power trumps all.

Negative Expectations It is understandable that with all these constraints, professionals working with multi-stressed families tend to have negative expectations about the possibility of recovery. Unfortunately, negative expectations can become a self-fulfilling prophecy. For this reason, therapists often encounter burnout in the professionals who work with the family. When burnout is suspected, the therapist needs to communicate optimism about the family's potential for change when she coordinates services with these professionals.

Dilution of Responsibilities Dilution of responsibilities occurs when the people in charge of a case delay taking action, when professionals repeatedly evaluate and refer the family elsewhere, or when urgency is required, but it is unclear which agency should take the lead. Indeed, responsibilities can easily become diluted when people working in different areas of a family's life (psychological, economic, legal, educational, and so on) are trying to address urgent risk factors.

In Escudero's (2013) interviews and discussion groups with professionals, dilution of responsibilities emerged as a specific source of disorganization. In fact, rather than criticize the families for this problem, the professionals expressed a frank dissatisfaction with their own work.

No doubt the complexity of the risk factors and the various interventions required by each of these risks account for a dilution of responsibilities. As an example, consider the difficulty in evaluating risk, determining priorities, and coordinating services for a vulnerable family that is simultaneously experiencing addiction, intimate partner violence, child neglect, and school failure. Also, consider how easily family therapy can become stalled when a judicial decision about terminating parental rights delays the family's availability for mental health treatment or when a social worker's indecision about recommending a child's placement outside the home stalls the school psychologist's evaluation of the child's educational needs.

Accommodation to Chaos

Sometimes family members are so accustomed to crisis and chaos that they describe their experience as simply "our way of life." Indeed, when deprivation, conflict, and neglect are the only social context a child experiences, it is no wonder that as an adult he recreates the same kind of family environment.

Consider, for example, Marion, who "refused to see" her 11-year-old daughter's profound depression when it was urgently brought to her attention by the school psychologist. Due to her own history, Marion had no basis for understanding how the girl's suicidal ideation could have been resulted from the father's alcoholism, unpredictability, and abandonment of the family. Rather, Marion thought her daughter was "way better off" after the father left—after all, she herself grew up on the streets, with no parents to protect her.

This kind of denial or minimization of psychological problems is a natural accommodation to chaotic life conditions, including violence and chemical dependence. As explained in Chap. 5, in many cases denial is an unconscious defense mechanism that helps people survive chronic relational trauma. After all, when life's problems seem unsurmountable, denying their existence or the gravity of risk is fully understandable.

Therapists have a tendency to view accommodation to chaos as a perpetuation of "victimization." In therapy, the family presents as helpless in the face of overwhelming external stressors. The parents, feeling victimized despite recognizing their problems, exhibit a complete lack of initiative. Understandably, however, a life filled with unrelenting hardships makes it difficult for people to understand the need for a therapy referral or mandate.

Indeed, victimization is the lived reality for many families. All too many families suffer extreme economic and sociocultural deprivation. All too often racial bias and discrimination are traumatizing. All too often community violence claims the life of an innocent child.

Regardless of the kinds of stressors in a family's life, the therapist needs to explore how the family's worldview (Liu, Soleck, Hopps, Dunstan, & Pickett, 2004) prompted the entrenched external attributions that challenge the clients' engagement in therapy. That is, when family members are accustomed to seeing their problems as entirely caused by outside events or environmental hardships, they have difficulty viewing themselves as capable of finding solutions. A passive response to the therapy is the likely result.

Essentially, the culture of victimized families clashes with the culture of psychotherapy. It is therefore understandable when a multi-stressed family experiences extreme discomfort in the psychotherapeutic context. Not uncommonly, the parents conceal or minimize the extent of problems or psychological symptoms. When concealment is seen as intentional, the therapist is tempted to view the family as resistant. To the contrary, however, conscious concealment should be interpreted as a lack of SAFETY in the therapeutic context. Mistrust is a natural consequence when people are coerced to take part in something that has no meaning for them.

Intrafamilial Conflict Due to Acculturative Stress

In the present context of global migration, many families are creating new lives in countries whose social systems and religious traditions are difficult for them to understand. Invariably, the need to acculturate rapidly to a new culture has a strong

impact on families. For many of these families, severe acculturative stress hinders the adjustment process, particularly when the parents are simultaneously under pressure to learn a new language, find employment and suitable housing, and make important decisions about their children's education.

Rates of acculturation vary across generations, due in part to the comparative rapidity by which children are able to learn a new language. Adolescents, who naturally turn to peers for acceptance, often reject the traditions, values, and norms of their immigrant parents and grandparents. In many cultures, adolescent rebellion is not only unacceptable but also is unexpected. Intense family arguments often arise over virtually any aspect of daily life, from the adolescent's clothing to his choice of friends, food, use of technology, and type of music.

Many immigrant and refugee families view therapists and the context of psychotherapy context with extreme mistrust, especially when the family was mandated by social services or family court to seek professional help. Resistance is not surprising when one family member interprets another family member's willingness to cooperate with the therapist as indicative of disrespect.

Not uncommonly, therapists need to rely on the children to act as translators for their parents. This power imbalance complicates therapeutic progress if the parents view their child's relationship with the therapist as a rejection of the heritage culture.

Multi-stressed families struggling with acculturative stress are likely to refuse the assistance of a therapist if they mistrust the resources offered to them by social services, the health system, or the educational system. Therapists need to recognize an immigrant family's resistance to follow through on a referral as due to the wariness that is a natural part of acculturation.

Often, a strong emotional connection with the family can be made by showing genuine interest in the family's cultural heritage and traditions. Before setting goals or recommending a specific course of action, the therapist can promote safety by explaining the private nature of therapy (within the limits to confidentiality imposed by referring agencies). The challenge of working with clients whose culture differs from that of the therapist is not, of course, exclusive to immigrant and refugee families. Whenever a family is required to seek professional help due to severe child neglect or maltreatment, cultural differences between the therapist and family can be an additional obstacle to overcome.

Recommendations from the Literature

Family Subtypes

Recently, Bodden and Deković (2016) identified characteristics common to families that professionals classify as "multiproblem." The authors sampled children referred for mental health services by their medical providers or other mental health professionals with families that voluntarily sought therapy. The first objective was to contrast the questionnaire responses of 85 families broadly defined as "multiproblem"

(many of whom needed intensive supervision or home visits) with 150 families recruited for participation from the general population through the children's schools. The authors' second objective was to establish cutoff scores on the various measures to identify distinct characteristics of multiproblem families. A final objective was to use cluster analysis to identify subtypes of these families.

Bodden and Deković (2016) concluded that multiproblem families display a broad and complex pattern of stressors in seven domains: child factors, parental factors, child-rearing problems (i.e., inadequate or inconsistent parenting), family functioning problems, contextual problems, social network problems, and mental healthcare problems. Three fairly distinct types of families were identified: (1) *Community-problem families* experience difficulties due to the social context (e.g., financial problems, strained relations with the community, problems with the criminal justice system) rather than due to problems in child, parent, or family functioning. (2) *Multiproblem families* have mental health or behavioral problems, including severe parenting and family functioning difficulties. (3) *Child-focused mild-problem families* have less severe family functioning problems, although the children in these families exhibit externalizing difficulties such as aggressive or oppositional behavior and out-of-home placements (Bodden & Deković, 2016).

In our view, each of these domains presents a different and specific challenge to the therapeutic alliance. What seems most essential is first to identify how an individual family experiences the interaction of these diverse sources of stress and next to initiate therapeutic work in this area.

Collaborative Therapy

W. C. Madsen's (2007) *collaborative therapy model* is an essential reference for working with multi-stressed families. According to Madsen, it is incumbent on therapists to recognize the harsh realities in families' lives without overlooking their abilities, talents, and inherent wisdom for coping with adversity.

This constructive and optimistic perspective describes ways in which therapists can build strong helping relationships with families that are overwhelmed by multiple stressors and continual crises. The term *multi-stressed* communicates Madsen's (2007) empathic understanding of the difficulties and pressures on these families.

The collaborative therapy model has inspired our framework for creating therapeutic alliances from the perspective of SOFTA. In particular, several concepts in the model speak directly to alliance building with multi-stressed families who are also receiving services from other professionals or agencies.

According to Madsen (2007, 2011; Madsen & Gillespie, 2014), therapists first need to understand the other professionals' relational stance with the family. The term *relational stance* refers to the way in which the professional approaches the family or the position taken in relation to the clients. Optimally, this relational position is one that "strengthens respect, connection, curiosity and hope in the therapeutic relationship" (Madsen, 2007, p. 9).

Second, therapists need to help families view themselves as *in a relationship* with the problems in their lives rather than as *having* these problems. In other words, the family is not "the problem," but rather is separate from and "more than" the difficulties that prompt the need for mental health services.

Third, Madsen (2007) uses the term *collaborative inquiry*, which characterizes our fundamental strategy for empowering families through the therapeutic alliance. Basically, using collaborative inquiry, the therapist explores with family members (1) where they want to head in their lives, (2) the challenges that block their way, and (3) how they can best address those challenges. The premise is that the therapist is an *appreciative ally* who shows the family that she is "on their side."

Home-Based Therapy

Researchers studying effective therapeutic work with multi-stressed families have determined that home-based intervention can make a significant difference, especially in the treatment of child and adolescent mental health (Bachler et al., 2016). In many cases, conducting sessions in the family's home is unavoidable. Many multi-stressed parents are not able to take time off work for regular appointments, nor do they have the financial resources for transportation to the therapist's office or for childcare during the adult-only sessions.

Recognizing that achieving positive outcomes in traditional settings with multi-stressed families tends to be very difficult (Curtis, Ronan, & Borduin, 2004), the developers of several home-based family therapy approaches have demonstrated highly favorable client outcomes, with robust effect sizes. These approaches include Multisystemic Family Therapy (MST; Curtis et al., 2004), Multidimensional Family Therapy (MDFT; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009), and outpatient therapeutic family care or Therapeutisch Ambulante Familienbetreuung (TAF; Bachler et al., 2016). Most of these approaches emphasize the working alliance as an essential ingredient of successful home-based treatment.

Focus on Resilience

Traditional psychotherapy overly emphasizes Problems (capitalization intended!), a focus that multi-stressed families tend to experience as defeating, even humiliating. Indeed, all too often problem-saturated therapy reinforces these families' sense of being paralyzed by the many stressors and hardships in their lives.

Over the past two decades, there has been a major shift in the field from a focus on deficits to a focus on resilience, a perspective that emphasizes recognizing and enhancing a family's strengths and resources as a core aspect of therapy (Walsh, 2003, 2017). Interventions are less about "what went wrong" and more about "what can be done" to improve a family's functioning. Research supports this approach as

a powerful way to address the needs of multi-stressed, impoverished clients (e.g., Alexander, Waldron, Robbins, & Neeb, 2013; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Liddle et al., 2009).

The resilience perspective closely aligns with our model of alliance empowerment, since focusing on strengths and abilities encourages family members to become collaborators in the therapeutic process. In our view, the families most in need of feeling empowered are those that are multi-stressed, disorganized, and disadvantaged.

Building Alliances with Mandated or Otherwise Involuntary Clients

The multi-stressed, disadvantaged families we have been describing in this chapter are often mandated to treatment by an authority that has control over some aspect of their lives. Not uncommonly, an entire family is required to receive "family preservation" services following an official finding of negligent or risky parenting by child protective services. In other cases, the juvenile justice system mandates family therapy as part of the rehabilitation of an adolescent who broke the law or was violent in the home or at school.

Even in the absence of a mandate, many families do not voluntarily seek mental health services. Rather, they request therapy after receiving a "strong recommendation" to seek help from school personnel, a physician, community leader, or some other interested third party.

Is it possible to build a strong alliance with involuntary clients? While little research has been published on this topic, two recent studies (Sotero, Major, Escudero, & Relvas, 2016; Sotero, Cunha, Silva, Escudero, & Relvas, in press) used the SOFTA-o to compare alliance behavior in voluntary and involuntary families. Results were encouraging. In general, despite the finding that the involuntary clients had more observably problematic alliances at the start of the therapy, by the fourth session the two groups did not differ significantly. Interestingly, it was not only that the involuntary families had improved alliance-related behavior, but also ratings on the four SOFTA alliance dimensions became more similar over time across the two groups.

The first of the two studies was focused on client behavior (Sotero et al., 2016). A team of trained observers rated each SOFTA dimension from video recordings of Sessions 1 and 4. The sample consisted of 20 involuntary and 20 voluntary families seen in brief family therapy at a university center. Among the 20 involuntary families, 6 were legally mandated by the courts, and 5 were referred by the child's school, 5 by mental health services, and 4 by health centers. In contrast, all 20 voluntary families were self-referred. The problems described by the families in both groups were complex, including intrafamilial conflict and family ruptures due to separation, divorce, and death.

The researchers had a meticulous method for selecting comparable families from a large sample of clinical cases seen over 8 years. This process ensured that the only difference between the groups was the referral condition, i.e., self-referred versus referred by a third party. A second basis for inclusion in the study was a detailed analysis of the archived clinical record to determine how family members had described their reasons for seeking assistance. In the involuntary group, over half of the participating family members had clearly stated not wanting, needing, or believing in the usefulness of therapy. Inclusion in the voluntary group required that none of the participating family members expressed this sentiment.

Observations of the families' first session showed that the voluntary families demonstrated significantly more alliance-related behavior than did the involuntary clients on all four SOFTA dimensions (Sotero et al., 2016). That is, compared to the voluntary families, those that had been pressured to seek help demonstrated significantly less ENGAGEMENT, CONNECTION, SAFETY, and a more problematic SHARED PURPOSE or within-family alliance.

In the fourth session, however, the only group difference was the clients' observed levels of engagement in treatment. That is, ENGAGEMENT was significantly lower among the involuntary families, despite an average shift from negative to positive SOFTA-o ratings. Additionally, it was notable that the evolution of SAFETY differed for the two groups, with the voluntary families demonstrating more problematic behavior on this alliance dimension as therapy progressed. The authors concluded that in the first few sessions, feeling comfortable in the therapeutic context is as essential for voluntary clients as it is for involuntary clients (Sotero et al., 2016).

In the second study of the series, Sotero et al. (in press) used the same sample to compare the therapists' observable SOFTA behaviors across the two groups. In Session 1, therapists who worked with the involuntary families, compared with those who saw the voluntary families, were significantly more focused on building engagement and promoting a shared sense of purpose within the family. This result is not surprising. When clients are not motivated to participate in treatment, it is considerably more challenging to encourage and sustain their cooperation.

In Session 4, however, no therapist differences were found, similar to the convergence of client behaviors across the groups in the earlier study (Sotero et al., in press). That is, the group differences observed in the therapists' contributions to the alliance in Session 1 faded as the therapy went on. By the fourth session, the involuntary families apparently did not require a greater focus on alliance building than did the voluntary families.

This line of research with mandated or otherwise involuntary clients is still exploratory. Nonetheless, Sotero et al.'s (2016, in press) results underscore the importance of alliance building with particularly challenging cases. Taken together with Walsh's (2017) perspective on fostering resilience, Sotero et al.'s results suggest that by paying close attention to client engagement and within-family collaboration, therapists can make a major difference in the lives of multi-stressed families, even those who do not voluntarily seek professional help.

Alliance-Empowering Strategies

Create an "Affected Community"

To build alliances in a multi-stressed, disorganized context, the first priority is to help the family acquire a sense of unity about the therapeutic work. Typically, unity has two obstacles: (1) conflict within the family, resulting in the disengagement of one or more members (Minuchin, 1974), and (2) multiple and diverse issues simultaneously demanding the family's attention (parenting problems, a housing crisis, financial stress, health problems, dependence on social services, and so on). Together, these obstacles can compromise the development of a strong expanded or within-family alliance.

A felt unity within the family regarding the therapy is the essence of the SOFTA's Shared Sense of Purpose within the Family. Indeed, the SHARED PURPOSE behavioral indicators (see Tables 1.1 and 1.2) can serve as a guide for "joining with" in order to strengthen the within-family alliance. However, before focusing on family members' willingness to collaborate with one another, it is important to help them see that (a) in one way or another, everyone in the family is affected by its internal difficulties and external stressors and (b) even though the various problems affect each person differently, they can best be addressed through a shared effort.

This general strategy relies heavily on reframing in order to define common or shared goals and create what Escudero (2013) called the *affected community*. Essentially, this term refers to the sense that everyone is affected by the family's struggles and therefore has a unique perspective to share in overcoming the problems. The therapeutic objective is simply to promote an open and collaborative attitude within the family.

The task of creating an "affected community" is particularly challenging when working with multi-stressed families, since these clients typically have conflicting priorities for improvement or problem resolution. Within-family conflict and blame are also commonplace. Of course, each case is individual and thus has unique characteristics that facilitate or hinder an expansion of the alliance.

Friedlander, Escudero, and Heatherington (2006) recommended two interventions that can help family members develop a shared value about the therapy: (1) identify a common external "enemy" and (2) unite family members against any problem or situation that threatens to break up the family unit. First, by finding an external enemy, family members can ask for and receive help to handle some person (the bad landlord, the verbally abusive uncle) or some situation (impending eviction, acculturative stress) that is causing difficulties for the family. Optimally, everyone participating in the therapy will agree that coordinated action is necessary to confront the problematic person or circumstance. The therapist can then describe herself as the family's ally in this struggle.

One caveat is in order, however. This intervention is only effective if the family members do not use the "external enemy" (or scapegoat) as a justification for inaction and if they also recognize their own need to change. As an example, it would be

counterproductive to align family members against the teenage son who is creating havoc with his antisocial behavior and illegal drug use. On the other hand, it would be helpful to unite family members around the need to understand the boy and contain his behavior, so that everyone has a stake in the outcome.

Another strategy involves suggesting to family members that avoiding a problematic situation can potentially break them apart (cf. Friedlander, Heatherington, Johnson, & Skowron, 1994). Since most families would rather stay together, pointing out the possibility of a rupture can facilitate a united sense of purpose about preventing the family's dissolution. Of course, the therapist must carefully convey the impression that the situation is an opportunity for action and growth, not one that will invariably destroy the family. As an example, multi-stressed families are all too often faced with the threatened removal of the children. When the therapist can help the parents see that this negative consequence is avoidable if they work together (to coordinate their parenting practices and better nurture the children), this common goal can be highly motivating.

Other traumatic contexts can also bring a family together, such as uniting family members to protect a survivor after the sexual predator has been imprisoned or to share their grief over the death of an important family member. When handled with sensitivity, all of these circumstances can generate a strong within-family alliance that keeps clients in treatment and facilitates their attainment of mutually agreed-upon goals.

Clarify Who Is the "Real Client"

Mandates to seek mental health services usually come from child protective services, family court, or some agency or institution outside the therapist's practice setting. Even when the therapist is an independent practitioner who accepts a mandated referral, the family will likely consider the referral source to be the therapist's "real client." This perception is reinforced when the therapist is employed by that agency or institution.

With mandated or "highly recommended" clients, it is essential to establish a safe start to the therapy. As mentioned earlier, the therapist needs to clarify her relationship with the family as well as her relationship with the agency or professionals who mandated, recommended, or prescribed the treatment. Even when the therapist provides details about the obligatory structure, such as the frequency of sessions, duration of treatment, and requirement to file routine reports, families usually need time to process the information before feeling safe enough to engage productively in the therapy.

Therapists should not interpret a family's request for details or repetition of the required procedures as evidence of "resistance" or "defensiveness." It is only natural to be wary of any situation that is coercive. Mandates are indeed coercive, since the consequence for not following through can break a family apart.

The therapist version of the SOFTA-o contains specific interventions that contribute to a family's ENGAGEMENT and SAFETY (see Table 1.2). These include explaining how therapy works, providing structure and guidelines for privacy and confidentiality, inviting family members to inquire about intimidating aspects of the therapy (e.g., recording equipment, reports to third parties, treatment team observation, one-way mirror, etc.), asking clients what they would prefer to discuss, and encouraging family members to articulate their goals for the therapy. In other words, the therapist needs to make it clear that the family is the "real client."

Visit the Family's Home

Compared to home visits, seeing families in a private consulting office or community clinic gives therapists more control over what takes place in treatment. However, offices are not comfortable for many disadvantaged families, especially if they are also required to see other professionals in buildings located at a distance from their communities. With families that are highly fearful of mental health interventions, providing therapy in the home may be the only way to engage them.

Regardless of the reason for home visits, this approach to family therapy has some distinct advantages. Meeting families where they live makes the therapeutic process seem natural. This is not a trivial point, since these families' typical experience of office visits tends to be quite impersonal. Children in particular are more comfortable at home, surrounded by their belongings and feeling free to move about during the sessions.

Perhaps the greatest advantage to meeting families at home is that it provides a window into the life of the family. That is, home visits allow the therapist to observe specific aspects of the family's functioning up close, including the parents' disciplinary practices, how the family organizes its time and space, the nature of the children's activities, and so on.

Nonetheless, sometimes unpredictable events that occur during a home visit are difficult to manage, even risky. Some clients are more likely to scream or engage in physical conflict at home than in an office. Some clients feel more free to get up and leave the room when they dislike what is being said about them. Some clients are rude to the therapist if they believe she is "spying" on them in order to report their shortcomings to authorities.

For this reason, therapists need to approach home visits with caution. Optimally, the therapist should meet the family in the office for the first session. If this is not possible, it is advisable to become familiar with the details of the case before visiting the home. Additionally, we recommend four tasks to facilitate a positive response to home-based therapy: (1) manage the time and duration of the appointments, (2) determine an appropriate space in which to hold the sessions, and set ground rules around (3) what can or cannot be done during the sessions (e.g., opening the door but not eating or texting) and (4) the technical aspects of the therapy (appropriate and inappropriate topics, taking turns to speak, etc.) (Escudero, 2009).

In other words, as the professional person in the situation, the therapist has a certain "authority" to structure the time, space, and content of the sessions. However, since the physical space belongs to the family, there is a kind of paradox: While the therapist is visiting the family for professional reasons, he is nonetheless a guest. Behaving like a good guest (arriving on time, complimenting the family on aspects of the home or its décor, inquiring about family pictures or unfamiliar objects, and so on) helps set family members at ease. A sense of comfort is readily observable when, for example, family members show up on time for the appointment or offer the therapist a cup of coffee.

With respect to alliance building, home visits have two other distinct advantages. First, holding sessions in the home allows family members to feel somewhat empowered, which can easily be observed through their natural and open interactions with one another (a positive SHARED PURPOSE indicator). Second, the inherent hierarchy in any therapeutic relationship is reduced somewhat when the therapist is the family's "guest." After all, the therapist is coming to the family rather than the reverse.

Convey Optimism

The lifestyle that accompanies a low social class has been described as a kind of microculture or worldview (e.g., Liu et al., 2004). In working with multi-stressed, disadvantaged clients, the therapist needs to understand this worldview in general as well as from each family's unique perspective.

When inquiring about the family's lifestyle, it is important to avoid being judgmental. Rather, as we emphasized in previous chapters, in order to foster strong emotional connections with clients, therapists need to approach their subjective experiences with respect, showing genuine interest in everything they endured in the past and how they choose to live in the present. Of course, showing interest is not equivalent to approving a client's risk behavior.

To empower the family through the alliance, the therapist needs to pay close attention to any aspect of the family's way of life that can serve as a resource. Despite the many obstacles and hardships, it is important to stay optimistic about the family's potential for change. When the problems are many and the professional helpers are many, a great deal of optimism is required.

Optimism is the conviction that not only "can" a family change but that it "will" change. For the therapist's optimism to be a motivating force for the family—and not seem unrealistic or naïve—the therapist needs to establish small, incremental goals and amplify any and all improvements.

Conveying optimism is especially difficult when a family has serious problems in multiple aspects of their lives. How, for example, can clients stay the course when they are on the verge of eviction from their home, where they are the sole caregivers for a disabled parent with dementia, and one of the teenagers has begun engaging in criminal activity? On the other hand, let's say that for the first time ever, the father

joined the mother for a family conference at the children's school. If the therapist applauds the father's initiative, family members might protest that "it's not such a big deal" or that this small change can have no real impact on their many other problems.

This kind of pessimism is understandable, but the therapist cannot allow it to taint the therapeutic work. Rather, this is precisely the moment when the therapist's perseverance can have an impact. Optimism is conveyed by appreciating small changes and explaining to family members that what seems minor to them now can sow the seeds for a more meaningful change in the future.

When a therapist insists that meaningful change is gradual and the family's goals can be achieved, this optimistic perspective can create a "virtuous circle." That is, engagement in therapy requires positive emotional bonds, and small improvements that a family experiences as a result of the therapy can raise their hopes and improve their trust in and connection to the therapist. In other words, the downward spiral of a disorganized, disadvantaged lifestyle can be transformed into an upward spiral of improved family functioning.

One complication, however, is the frequent occurrence of crisis in the lives of disadvantaged, multi-stressed families. When life is progressing reasonably well, unexpected events can cause a crisis that throws off the therapist as well as the family. It is important to remember that crisis situations are common when a family is suffering multiple hardships and when the only response to stress they know is to increase their risk behaviors (e.g., alcohol or opioid use, sexual acting out, gambling). Crises may not ever be eliminated, but better coping strategies can be learned.

With respect to the alliance, when a crisis occurs, family members have a tendency to devalue everything they have achieved to date. In a crisis, the loss of a sense of safety is not only experienced by the family, but also by the therapist, who can easily begin to doubt himself and his ability to facilitate change. Not uncommonly, the therapist may also doubt the family's ability—or motivation—to make improvements.

Optimism can be regained, however. To do so, therapists need to stay current with best practices in working with poor and disadvantaged families, seek consultation and supervision, and attend relevant clinical trainings. By understanding the worldview of people from the lower social classes, the therapist can build a strong relationship with the family to sustain their collaboration whenever a new crisis occurs.

Serve as a Bridge for Specialized Treatment

The psychological and behavioral changes that result from therapy can generate a cascade of improvements in many areas of a family's life. Generally, when clients' motivation starts to pay off, they see some success in, for example, coordinating their parenting efforts or communicating with greater openness. At this point in treatment, family members often have the energy to turn their attention to external difficulties

with finances, housing, employment, or education. It is natural for multi-stressed, disadvantaged families to expect the therapist's help in overcoming these kinds of outside obstacles. However, it is important to explain to the family the kinds of changes that can and cannot reasonably be attained in a psychotherapeutic context.

Nevertheless, families often bring urgent situations to the therapist's attention. The parents' immediate priority may be, for example, to attend to the 18-year-old's recent arrest in order to prevent his incarceration. Of course, the therapist can discuss this crisis with the family, exploring what may have contributed to the boy's criminal activity and discussing how the parents can address the situation without resuming their destructive patterns of aggressive conflict. In other words, the therapist can unite the parents around the new problem and help them increase the resolve to improve their parenting. The therapist needs to be clear, however, that he cannot intervene with judicial officials on the family's behalf in this situation or in any other legal matter.

Communicating the realistic limits of family therapy is essential when building alliances with multi-stressed families. However, some problems, like drug addiction and severe mental illness, naturally seem like they should be addressed in the conjoint therapy. When the therapist determines that a family member's problem is beyond his expertise or requires a specialized treatment that would be better addressed by another provider, how should he handle the referral without hindering the therapeutic alliance?

In our view, two responses need to be avoided: (1) withdrawing altogether after referring the family to a specialized service, such as a drug treatment facility, and (2) continuing the conjoint therapy without helping the family receive specialized care for the affected individual (Escudero, 2013). Naturally, any family would feel abandoned if the therapist "gives up" by discontinuing the conjoint treatment. On the other hand, any family would feel frustrated, even betrayed, if the therapist generates unrealistic expectations for improvement without helping the family obtain the kind of care that is clearly required.

In these circumstances, the most advisable strategy is to expand the alliance by creating an "affected community." As described earlier, the therapist can help family members understand that since everyone is affected by the severe difficulty experienced by one of them, concerted action is needed to address the situation. In doing so, the therapist can educate family members about the specialized intervention and arrange for the necessary services with professionals in the outside agency or treatment center. Facing the situation together is fully compatible with family empowerment, the goal of which is to improve family functioning without creating confusion about what psychotherapy can or cannot do.

Case Example: The Difús Family

The Difús family lived in a village in a rural area, where they rented a dwelling a short distance from the village center. The father, Begory (46), had always worked as a day laborer, while Aicha (38), the mother, worked at home, caring for their children and tending an orchard and some small farm animals.

The parents were from Haiti, where they had met as a young couple. Ten years previously, they immigrated with Begory's parents and their three children, Richo (a boy of 16), Kerline (a girl of 14), and Frandy (a boy of 9). The family lived in a mostly Haitian community but had little contact with neighbors.

Referred by social services, the family requested an appointment at a family therapy center located in the nearest town, about 10 miles from their home. Having a signed release of information from the parents, the social worker who made the referral informed the therapist about the parents' neglect of their two adolescents, Richo and Kerline, who were engaged in various risk behaviors. The worker emphasized the highly charged conflicts in the family, particularly between the teenagers and their father. Additionally, the worker mentioned that recently, in a state of emotional crisis, Aicha had been seen by emergency services at the local hospital. However, after a brief stay in the crisis unit, she did not follow through with the recommended psychiatric referral for a more thorough evaluation.

Over the past year, social services had been pressuring Aicha and Begory to seek help at the family therapy center, with no success. Now, however, several critical events had prompted the parents to accept the referral for treatment. These incidents were detailed in the social worker's formal report to the therapist. The report also outlined the family risks that social services expected to be targeted in therapy.

The first incident was an urgent call from Aicha on the social services' emergency line. She phoned because Richo, who had not been at home for the previous 8 days, was not responding to calls or texts on his cell phone. Responding to the emergency call, the local police opened a case file and searched for the boy. During the investigation, the police found out from the father, who was not aware of Aicha's call to the emergency line, that Richo had been working in a friend's warehouse and all was well.

After being informed of Richo's whereabouts, Aicha explained to the police that she was expected to meet with social services the following day and was afraid of the consequences if she count not account for Richo's whereabouts. The family was receiving financial assistance from social services, and the caseworkers were well aware that Richo was having serious difficulties at home and at school. In addition to conflicts with his parents, he had a habit of drinking and wandering the streets alone until very late at night. Although the parents had made several complaints about their son to the school and to social services, he continually refused to obey them. The parents felt helpless to discipline him due to the 16-year-old's size and physical strength.

The second incident detailed in the social worker's report was also a complaint, but this time it had to do with Kerline, the 14-year-old daughter. Two months earlier, Aicha had called the local police station to report that Kerline had disappeared for 3 days, she was truant from school, and the parents could not handle her. The police managed to reach the girl by phone, but she lied about her whereabouts. In short order, however, she was located at the home of her paternal grandparents, several miles away. According to the worker's report, on being informed that Kerline was found, Aicha asked the police to allow her daughter to stay with the grandparents.

The police report concluded that, based on all the evidence, including conversations with the grandparents and Kerline, the family's obvious disorganization had likely resulted in child neglect. More disturbing still, the worker's report revealed that Kerline had told the police officer that she was afraid to return home because Richo had threatened her with a knife.

The social worker's report also described the latest crisis that had led the parents—finally—to accept the referral for family therapy. Aicha had made yet another urgent call to police, reporting that her husband had hit Kerline during a disagreement about a TV show that the girl was watching. A formal investigation by child protective services resulted in the determination that a small bruise on Kerline's wrist was the result of child abuse.

The following day, Kerline was taken into foster care and Begory was detained by the police. However, after taking his sworn statement, the family court judge approved Begory's provisional release. Kerline returned home with an apparent lack of concern after having forcefully rejected the social worker's recommendation to keep her in foster care. Since both parents now accepted the referral for family therapy and indicated their commitment to follow through, it was decided to allow Kerline to remain at home.

The first therapy session involved the entire family. The therapist easily uncovered a longstanding pattern of conflict and chaotic communication among family members, particularly a great deal of verbal aggression between the two adolescents. Everyone showed a lack of respect for the mother, and the amount of hostility Kerline directed at her father was remarkable.

The father tended to downplay all of these problems and minimize the seriousness of the crisis events described above. The therapist had the impression that Begory's decision to attend the session was strongly influenced by his fear of the police.

For her part, Aicha came across as sincere and open but quite helpless and ineffective. It was clear that none of her attempts to impose rules was supported by her husband, who aligned with the children against her to disavow his own parental responsibilities.

During the initial session, it also became evident that 16-year-old Richo enjoyed a level of freedom that put him at great risk. He boasted that he knew about robberies and drug use in the community. He had no interest in studying but rather hoped to find a job as a gardener. He explained that on weekends he usually went to his grandparents' home—he had no rules there, and sometimes he slept elsewhere.

According to Aicha, Kerline's academic performance had been satisfactory until the previous year, when she began skipping classes and her grades dropped precipitously. Aicha also worried about Kerline's relationships with older boys who, like her daughter, also refused to study.

For her part, Kerline described feeling rebellious. She bitterly complained about the parents' differential treatment of her and Richo—while she was pressured "about everything," he was not expected to do anything. Notably, she denied having been abused by her father, stating that "what happened was just a simple discussion."

Frandy (9) was a mystery for the therapist. He had hardly been mentioned in the report from social services. In the session he was affectionate with his mother and seemed quite used to a way of life with little structure and much conflict. He was at grade level in school, according to Aicha. Although the teacher said that Frandy was "well behaved," she thought he was "overly anxious."

The therapist concluded the first conjoint session by thanking the family members for their participation and openness. She suggested that for the next appointment, her preference was to see them separately in two groups, the parents and then the children.

The family's response to this suggestion was somewhat discouraging. Begory asked if he were "required" to come, explaining that unless he took a job that was somewhat distant from the family center, they would have no money for food. Aicha asked what social services would "do" if Richo and Kerline kept fighting and refused to obey their parents. Richo said that since he was "self-sufficient," he did not need therapy, but he would come so as not to disappoint his father. Kerline warned that if Richo did not attend the session, she would not feel obliged to do so either. For his part, Frandy seemed complacent—he had no questions about any of it.

Begory did attend the next session after all. Alone with the parents, the therapist spent considerable time learning about their history as a couple and why they had decided to leave Haiti. The therapist's goal was to gain the parents' trust by demonstrating that she was not judging them.

Unfortunately, Aicha's responses to these questions seemed to provoke considerable anxiety in her husband. Silent throughout this conversation, Begory became more withdrawn nonverbally and seemed defensive when Aicha was describing their previous life in Haiti (negative SAFETY[11]). Recognizing the potential for a split alliance, the therapist focused on SAFETY and her personal connection with Begory in order to understand and then reduce his defensiveness:

Therapist: Begory (ENGAGEMENT[12]), it seems like the things your wife is telling me about your life in Haiti and your first years in this country are making you uncomfortable (SAFETY[13]). I don't want either of you to tell me something you'd rather not talk about. This isn't an investigation. We're here to help…I'm just a family therapist (EMOTIONAL CONNECTION[14]).

Begory: But I figure everything we talk about will have to be told to the police or to social services.

Therapist: I just have to make a report about seeing you and how the therapy is going, but that'll be in three months. And I have no problem telling you about the notes I take after each session. I don't need to file my first report for three months (SAFETY[15]). Does this help?

[11] Client expresses anxiety nonverbally.

[12] Therapist pulls in quiet client by addressing him specifically.

[13] Therapist acknowledges that therapy involves discussing private matters.

[14] Therapist reassures a client's emotional vulnerability.

[15] Therapist provides structure and guidelines for safety.

Begory: Yes, thank you. When I did what Aicha wants, to discipline our children, I was taken to the police station!

Therapist: You have my commitment to tell you, session by session, the observations I'm making and I'll read you my report before sending it (EMOTIONAL CONNECTION[16]). (pause) What you said about supporting Aicha and ending up getting detained by the police interests me a lot. Aicha, what do you think about that?

Aicha: It's true. You (looks at Begory) *have* to work, but I need help to get more control over what the kids do. (to the therapist) And he's trying. But he's hard on them 'cause he's never had to deal with kids' problems before.

Begory: We've had some very hard years, and it's true that Aicha has been handling the kids by herself.

Aicha: I didn't want to talk about these problems, but I think I should [do so] *here*… (SAFETY[17]).

Therapist: I get the idea that you feel helpless with all these crises the last few months and with all the fighting between Richo and Kerline.

Aicha: Yes! we can't do it any more, and we worry that Frandy'll wind up getting hurt.

Begory (to Aicha)*:* You're right (SHARED PURPOSE[18]). Actually it's gotten way out of hand. We've got lots of problems because I can't find work close to home. It's been a horrible year.

Therapist: I understand. And it strikes me that you all feel a great affection and concern for Frandy. Even his brother and sister worry about him (SHARED PURPOSE[19]).

Aicha: Yeah. We're actually a very close family. We just don't know how to keep calm when we're all together.

Begory: I'm scared if I try to lay down the law with the kids, I'll get reported to the police or CPS.

Therapist: I appreciate your honesty, Begory (EMOTIONAL CONNECTION[20]). Do you think we could use the therapy sessions to talk about how you can support each other to be more effective parents (ENGAGEMENT[21])?

Aicha: I think we need it.

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[16] Therapist reassures a client's emotional vulnerability.

[17] Client implies that therapy is a safe place.

[18] Family members validate each other's point of view.

[19] Therapist draws attention to clients' shared feelings.

[20] Therapist discloses her personal reactions to the client.

[21] Therapist asks clients whether they are willing to follow a specific suggestion.

Begory (to the therapist): And do you have some ideas?

Therapist (to Begory)*:* Well, I think we could start by your finding out what exactly Aicha needs from you, what she is asking from you, since she's the one who's been most concerned about the children's problems. What do you think?

Aicha (excitedly SAFETY[22]): I need you (Begory) to listen to me! *Nobody* listens to me… sometimes I feel invisible.

Therapist (to Aicha)*:* I think now Begory *is* listening to you. That's a first step, and here we're not going to judge what was done right or wrong in the past (SAFETY[23]). Our goal is simply to help you tell him what your needs are and what you want from him (ENGAGEMENT[24]).

Aicha felt very supported by this intervention, and Begory seemed reassured. This exchange resulted in a compromise between the parents about not blaming each other over past mistakes (SHARED PURPOSE[25]) and an agreement with the therapist to work on improving their effectiveness with the children (ENGAGEMENT[26]).

In doing so, the therapist pointed out the importance of telling her the family story in order to recall their dreams about leaving Haiti to start a new life for the family. It was quite poignant for the therapist to discover a true love story beneath all the stressors and problems.

In her first session with the three siblings, the therapist's objective was to find some common ground in order to strengthen their relationships with each other and build a within-system alliance about the therapy. Although the initial plan was to have Frandy attend only a portion of the session (so as not to burden this young child with the arguments between the teenagers), it turned out that he was key to creating an atmosphere of cooperation.

Surprisingly, the adolescents were much calmer with their parents absent from the session. The therapist began by asking Frandy to "introduce" her to Kerline and Richo by describing the best and worst aspects of his siblings' personalities. A very outgoing child, Frandy, found it amusing to play this role. With some help from the therapist, he spoke very highly of both teenagers, particularly when describing their unique talents. He had nothing to say about their negative attributes.

With good humor, Kerline and Richo acknowledged Frandy's positive descriptions of them (SHARED PURPOSE[27]). Next, the therapist asked the two teenagers

[22] Client varies her emotional tone during the session; client shows vulnerability (e.g., discusses painful feelings).

[23] Therapist helps clients talk truthfully and not defensively with one another.

[24] Therapist explains how therapy works.

[25] Family members offer to compromise.

[26] Clients indicate agreement with the therapist's goals.

[27] Family members share a lighthearted moment with each other.

how they saw their parents' desperation over the past year. Kerline responded by expressing tremendous guilt about her fights with Begory, explaining that she only wanted him to help her mother out a little more. Richo apparently did not realize that his mother was feeling overwhelmed:

Richo:	I guess it's because my dad works a lot and sometimes has to go far away to work. My mom has always taken care of everything, but now it's bad.
Kerline (angrily exclaiming, to Richo)*:*	It's that *you're* always saying you're going to leave home and you don't realize that makes *you* the problem (negative SHARED PURPOSE[28])!
Therapist (to Kerline)*:*	You mean Richo doesn't realize that you need him at home? Do you really need him (SAFETY[29])?
Richo (very surprised, to Kerline):	But how?! You're always fighting with *me* and you say everything I do bothers you.
Therapist (to Richo)*:*	I think Kerline's upset because you're thinking of leaving and not helping her out. Maybe your sister needs you more than you think.
Frandy (interrupting, to Richo):	I don't want you to go, either!
Kerline (to Richo):	See…Frandy needs an older brother, just like maybe I do, too (SHARED PURPOSE[30]). When you're not at home I get nervous that mom's overwhelmed and I don't know what to do (SAFETY[31]).
Therapist:	Richo! Did you ever think they'd be asking you for help (SAFETY[32])?
Richo:	No, and that's the truth!…But don't I get to look out for my own life? Who helps *me*?
Frandy (interrupting again):	Do you have problems with any gang?
Therapist (smiling)*:*	I have a great Therapy Assistant right here (pointing to Frandy) (EMOTIONAL CONNECTION[33])! Richo, do you want to talk about these problems now (ENGAGEMENT[34])? Or we could also do it another time.

[28] Family members blame each other.

[29] Therapist actively protects one family member from another (e.g., from blame).

[30] Family members validate each other's point of view.

[31] Client varies her emotional tone during the session.

[32] Therapist helps clients to talk truthfully and not defensively with each other.

[33] Therapist shares a lighthearted moment with the client(s).

[34] Therapist asks client(s) what they want to talk about in the session.

Richo: Can I talk about them some other time?
Therapist: Do you mean some other time "alone"?
Richo: No, not alone. But only with Kerline.
Therapist: If Frandy agrees (Frandy nods), we can do it next time. Is that okay with you, too, Kerline (ENGAGEMENT[35])?
Kerline: Sure…(softly) When we were little, Richo always told me his problems.
Richo (to Kerline)*:* And you did too (SHARED PURPOSE[36])!
Therapist: I really like the idea that we can use this therapy to get back the closeness you two had years before (SHARED PURPOSE[37]). Do you think it'll help with the tension you feel at home?
Kerline: Right now, in our house you can't talk about anything. We argue for no reason. We need someone like you to trust (EMOTIONAL CONNECTION[38]).
Therapist: Thank you, Kerline. Richo, do you feel the same way?
Richo: I'd be embarrassed if my friends knew I came to therapy…they'd tell me I'm crazy. (pause) But it seems okay. (to Kerline) I didn't think Mom was in such a bad way.
Kerline (to Richo)*:* I'm not going to tell your friends.
Therapist: Well, maybe today, with the help of my Assistant Therapist (smiling at Frandy, who nods with an amused expression), we could think of some little thing that during the week would help your mom out a little. Do you agree (ENGAGEMENT[39])? Any ideas?
Frandy (raising his hand): Me! I want to be the one to find the "answer" (ENGAGEMENT[40]).

This was the beginning of a long and arduous therapy with the Difús family. The format involved varying the sessions with the parents and siblings, as well as holding individual sessions, mostly with Aicha and Richo. Early on, the therapist was able to convince Aicha to be evaluated by her physician to determine whether her emotional difficulties required pharmacological help. This referral turned out to be quite helpful.

[35] Therapist asks client(s) whether they are willing to follow a specific suggestion.
[36] Family members validate each other's point of view.
[37] Therapist draws attention to clients' shred experiences.
[38] Client verbalizes trust in the therapist.
[39] Therapist asks client(s) whether they are willing to do a specific homework assignment.
[40] Client agrees to do homework assignment.

Although each member of the family had different concerns and personal goals, the therapist facilitated an expanded alliance in which everyone agreed to be of help to everyone else. Richo, for example, pursued his desire to leave school and be officially emancipated, but he also accepted that his brother and sister needed him to stay close. Kerline wanted more freedom and for her parents to recognize her artistic talent, but she also agreed that she needed to negotiate the rules with her parents and then follow them.

The therapeutic work with Aicha and Begory was perhaps the most complicated part of the treatment. It took the parents quite a while to learn how to coordinate their efforts and share the household responsibilities. Begory came from a highly traditional family in terms of gender roles, whereas Aicha's family of origin was quite disorganized and chaotic. For this reason, the couple sessions focused a fair amount on their respective histories and, notably, on how their Haitian culture and experiences as immigrants affected each of them and their relationship.

Final Thoughts

Construction of a strong therapeutic alliance with a multi-stressed family requires a broad, systemic view of the treatment context. This perspective should cover not only the various areas of stress and difficulty in the family's life but also the history of previous interventions and the other professionals' ongoing relationship with the family.

Creating a safe, personal context for open and honest disclosures requires family members to fully understand the nature of therapy and how it differs from other professional assistance or therapeutic interventions they may have received in the past. Creating safety also often requires conflict management among all the professionals involved in the case so as not to dilute the conjoint family work.

The work to unite the family around a strong SHARED PURPOSE can best be done by creating an "affected community" to work with the therapist toward a common vision, such as maintaining the integrity and dignity of the family. The ENGAGEMENT dimension of the alliance, in particular, requires perseverance and optimism on the part of the therapist to sustain the family's willingness to do the hard work necessary for making therapeutic progress.

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