INTENSIVE FAMILY SERVICES

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Introductory Note: The following is a technical proposal written to the State of Oregon and not an article developed for a journal. Part A of the proposal dealing with the offeror’s treatment philosophy is included because it contains a succinct statement that integrates a general systems perspective and other Hakomi biases toward doing family work.

Section E of the proposal outlining an approach to multiple impact family therapy is also included for a number of reasons. 1) Hakomi Therapy is in sympathy with general systems approaches to therapy and MIT sessions model what might be the wave of the future - intensive work that mobilizes all possible elements of a system for a short period of time. 2) The MIT description is written with a Hakomi flavor as much as was practical for State expectations. If the principles outlined in the preceding article by Devi Records-Benz ("Work in Progress: The Hakomi Method and Couples") are employed at Step 4 - the intervention phase of the MIT, a genuinely Hakomi approach to this way of working presents itself.

A. STATEMENT OF OFFEROR'S TREATMENT PHILOSOPHY

Introductory Statement. There is a general frustration as well as some basic principles behind the philosophy of this project proposal. The frustration comes out of many years involvement in and observation of the social service delivery system in America where it has been disheartening to witness so much built in self defeat. The self defeat has at least three discernible features. 1) Significant attention is paid to only one part of a cycle that has important multi-determinants. 2) Efforts directed at complimentary parts are done in isolation from each other and sometimes at cross purposes. 3) Efforts are limited in their application though a client may be included in the system over time. Successes are usually demonstrable enough to give some hope to those advocating the programs but defeats are inevitable and call into question the time and money expenditure to those who must ultimately approve support for the programs.

Systems Theory. General systems theory sheds light on both the problems of social service delivery systems and the possibilities for enhanced effectiveness. An organic living system according to Bateson and others is a whole that is made up of parts. An individual is made up of organ and tissue subsystems which in turn are made up of cells, molecules, etc. The individual is part of a sequence of larger systems; family, group,
community, nation. What makes a particular system viable is that the parts communicate within the whole. Football teams that don't huddle or families that communicate dysfunctionally lose their efficacy. Each system has within limits a measure of independence from the suprasystem, a mind of its own which includes the ability to be self-directing, self-correcting. Systems are not simply reactive. They are characterized by complex, non-linear determinism. A simple statement to a family such as "you can trust us" does not lead to a predictable result. That statement stimulus goes through the family's unique information processing channels which determines both the experience and the response of the family. The individuality of systems in general is maintained by boundaries which both protect and allow the transfer of information, matter, and energy (Skynner). Communications across the boundary and coordinations within it are controlled by decider subsystems; the government of a nation, parents of a family, the core organizing beliefs of an individual. The information processing channels set up by decider subsystems are crucial for determining the characteristics of the system.

The general lesson of systems theory is at minimum twofold. An individual therapist who works without regard for metabolic and structural variables on one level or the influence of a person's family on another is reducing his/her chances of success. A family therapist who works without regard for integrity of individual family members on the one hand or the influence of social factors transmitted through work, school, neighbors, peer groups, etc. on the other, is risking limited progress. A program offering job training for minorities that does not attend to issues of transportation, child care, education, job availability, racial discrimination, etc., is not maximizing its potential. Secondly, first order change that does not affect the way information is processed, communications are patterned, interactions are structured is considered, at best, an unstable adjustment and, in essence, no change at all.

The Model. These considerations support the concept of intensive family services coupled with intensive coordination of community resources. More particularly, the multiple impact family therapy - community resource team approach moulded in Pendleton, Oregon seems the best overall approach. Families are dealt with intensively on a time limited basis with all possible resources mobilized on their behalf. The family therapy component aims at connecting the family with its own inner resources that will empower it in the future. The intensive care management component seeks to support the family's efforts to change at its boundary with the community. The community networking facilitates all parties working harmoniously and synchronously with a given family, builds additional trust and cooperative lines of communication within the community itself, and instills first hand confidence and enthusiasm for intensive family-cooperative case work approaches to various social problems. The present proposal is modeled very closely after the Pendleton and Albany projects.
Further Implications. Given the above model and philosophical background, the IFS contract team in conjunction with community representatives are understood to be working at the boundary of the family and its individuals as well as the boundary of the family and its community. Further implications of the model and philosophy for work at both places are outlined below.

Family Implications: A Working Group. In terms of the family and its members, therapy is considered ideally to be happening when the family can become "a working group taking itself under observation" (Scott). In most of everyday life, the family is simply being and doing. In therapy the family is self-consciously attempting to: 1) experience itself; 2) reflect on the organization of that experience (how information is processed, communications are patterned, roles are structured, etc.); 3) slow down and step out of the experience long enough to break automatic habit and reaction patterns; 4) search for the positive meaning and purpose of various behaviors; 5) explore barriers to more direct satisfying functioning; and, 6) practice newly found alternatives to more pleasurable family life. Overall, this process can be described as the family accessing and changing its perspective on problems along with its interactional patterns (Kurtz).

Cooley's justification of multiple-therapists is relevant here. One of the most powerful ways of assisting the family in the above process is to have two therapists doubling for members of a dialoging family pair. They encourage them to pay attention to their own experience, slow down from reacting and relating in habitual modes, be aware of their hopes and fears, wants and desires along with their resistance or hesitation to ask for what they want and clarifying what is intended by the other, etc. While these therapists are closely attuned to and tracking their specific family member, a third therapist is needed to watch over and mediate the exchange in general, and a fourth is needed to track the response of the remaining family members.

This description of therapist involvement clearly indicates that the therapists in general are active. IFS team members initiate much of what happens during treatment and design particular approaches for various predicaments. They take responsibility for influencing the process (Stanton).

Family Implications: Making Contact. However, there are some preconditions and a previous stage in the therapy process that has to occur before active interventions can be made. The previous stage may be referred to as the "making contact" stage (Kurtz). Other therapists talk of joining manoeuvres. The basic point is that families are organic living systems with a mind, will, sense of destiny, and a chosen way of functioning. They will resist and adjust themselves to any interventions that they experience as controlling, manipulative, judgmental, threatening, in short - forceful. The precondition for them being able to work together as a group and turn their awareness inward on their own
process is that they feel safe and secure. That is, they can only turn their awareness inward if they can free it up from being turned outward; keeping watch over the therapists and what they might be up to, what they might be coming at them with, what they are trying to put over on them. Family energy directed at defending against perceived therapeutic forcefulness is understood here as potentially undesirable and taking away valuable resources from the family's work on itself.

This represents a slightly different perspective than some approaches to family work that assume the family to be resistant from the start and mobilized around maintaining homeostasis; approaches that often utilize this resistance against the family through paradoxical interventions that force the family to get better to defeat the therapist. While the philosophy of this proposal does reflect a "do whatever works" attitude, it biases the treatment approach in the direction of attempting to make contact with the family in such a way as to gain their good will, help them feel safe, and generate freedom for the therapist to be active and directive with minimal resistance or power struggles in the forefront. Ideal working conditions and results come when the family feels that they have been contacted, and that the therapists are on their side. That the basic contract is to help the family find more satisfying functioning, to do what the family wants to do, go where they want to go. The therapists' declare through their words, actions and postures that they are allies of the family in achieving satisfaction. Acceptance of the family when they can experience its reality leads to the family's acceptance of the therapist (Stanton).

Family Implications: Utilization of Resistance. The basic assumption is not that the family wants homeostasis at all costs, but that the family is stuck, in a rut, with no sense of viable options, and unhappily secure with a chosen best strategy for dealing with anxiety and tension. It is assumed that families have creative capacities to find and choose new ways of relating and that they will spontaneously move to reorganize around more optimal and satisfying functioning when the barriers to such functioning are worked through. This is the same phenomenon witnessed in the human neurological system (Feldenkrais) and the human psyche (Wilbur). It is further assumed that progress can be made much faster and go much further when resistance is "gone with" and not "confronted and opposed." Any system that feels pushed and threatened automatically resists, pushes back, and mobilizes for defense.

A whole set of techniques in the therapeutic method revolve around these assumptions and the attempt to make and stay in contact. Utilizing, going with the family's initial energy invested in the identified patient (Erikson) and allowing the family to discover and explore for themselves the symptom in a family context (Skynner); tracking verbal and non-verbal clues closely and acknowledging with the family resistance, hesitance, and asking them what they need at
that moment to feel safe, to feel better (Kurtz). In the work itself, the same posture is maintained. If a mother spontaneously covers her eyes, expressing fear and the desire not to see something, a family member might be requested to help her cover her eyes and tell her "you don't have to see anything you don't want to see." Paradoxically, this often has the effect of providing safety, disarming resistance through supporting as opposed to confronting the defense, and allowing the person to do exactly what she needs to do. The confront would be to say, "Yes, mother, you can do it. You can look at this reality. It is important to you and the family. Come on. It is not as frightening as you think." Working with the mother safely in the above case, also gives an example of using paradoxes in a win-win type of format which is characteristic of the method.

**Family Implications: Curative Factors.** The therapists themselves are part of the curative process. They ideally maintain a simultaneous or rapidly alternating stance of being firm, safe, consistent sources of holding and structure, and then playful, explorative, and risk taking (Skynner). They are empathic, genuine, accepting, vulnerable, and flexible. Carl Whitaker adds "crazy" and "inconsistent". Crazy meaning not limited characterologically to one way of being but able to be loving-hateful, tough-tender, and so forth. Inconsistent meaning not delusional, rigid, or impersonally correct, but free to make mistakes, screw up, and risk, an important model for many dysfunctional families to follow.

A number of other curative factors enter into improved family functioning: a sense of family wholeness, that "we are all in this together" (sometimes very hard for a family to achieve who have adopted an older child and find it easier to say "everything was better before he/she came."); learning through reflection on actual life experiences; practicing new ways of relating; a change in information processing or the structure of interactional patterns plus intra-familial subsystem structure. The therapists call attention to progress the family has made, underlining the reality of the self-improvement and empowerment. The therapists are as minimally involved as possible or withdraw as quickly as possible when they have been heavily involved at the start. While goals and curative factors of family work appear rather lofty or idealistic sometimes, Whitaker estimates that a 10% change in the effectiveness of family living is normally quite adequate for producing significant changes.

Though the therapeutic team self consciously makes contact with the family in an attempt to forge a common contract around helping them function with more satisfaction, there is normally an initial unspoken disagreement about what that means. A family might assume they would be happier if the oldest daughter would quit acting out. The IFS team might assume it is a matter of the parents achieving more intimacy so that the daughter's behavior is not the only thing that can bring them meaningfully together. Additional techniques a clinician may use to overcome this discrepancy are outlined in
section E. Consistent with the general systems view that changes in a single member can affect a family system and that changes in a family system can affect an individual, a wide range of methods can be theoretically used. The experiential learning model of the proposal does tend to rule out such interventions as "why" questions, extensive history taking, intellectual understanding of the past, and similar methods that keep the family "talking about" themselves rather than making concrete changes.

Casework Implications. The boundary of the family with its community must be dealt with in a number of ways. The development of a community resource MIT team is of inestimable value in doing so. Theoretically it is not hard for various agencies to realize their common interest in doing so. A CSD family is often potentially or actually a concern also for juvenile, school, ecclesiastical, and various civic authorities. Interventions that are swift and effective are an advantage to the entire community. Effectiveness is obviously enhanced when all parties affected can work in a harmonious and synchronous way toward a common goal. Agency representatives who work together on a team forge closer, more effective working relationships. Problems are more quickly perceived and acted on when community specialists are brainstorming together. A school representative for instance might be very quick to pick up the necessity of an Individualized Educational Plan for a child and know the quickest way to accomplish it.

A team of community specialists inevitably pool much more knowledge than a single person of community resources in general and how to effectively work within various agency systems in particular. This can be crucial in many instances. One person who knows an effective scout group leader can make the difference in getting a child an alternative peer group to one which is involved in anti-social behaviors. Another may know the best way to work across interstate lines to get a mother and father in separate locations together for an MIT session in which it is decided who in fact is going to take responsibility for a child who has been going back and forth like a shuttlecock. The routine case of one worker making referrals to others who work in isolation has often proved dissatisfactory in the experience of the offeror. The community team concept facilitates informal cooperation between agencies when formal referrals have been made. It is good for instance that a juvenile systems counselor keep in touch with a family referred to CSD when he/she might end up with the case again. The juvenile worker might be quite helpful in working cooperatively with the family in terms of letting it know the limits and consequences it is dealing with. Whenever community team members work together on an MIT session, important diagnostic material is revealed that deepens everyone's appreciation for the problem and there is much greater commitment to working on a collectively orchestrated approach. To help insure that the approach is orchestrated well, it is important to have one contact person for the team through whom any changes in the treatment
strategy are monitored, and who can communicate changes to the others as well as receive routine feedback and progress reports. Coordination rarely if ever happens by itself. The IFS primary therapist is the leader designated in this model to assume responsibility for coordinating functions. The coordination and enlistment of community resources goes beyond the members of the team of course. Any number of relevant people might be brought in on a particular case: parent trainers, church leaders, employers, lovers, neighbors, financial planners, metabolic doctors, etc.

In summary, systems theory clearly outlines the importance of dealing with as many aspects of the sub-system and supra-system affecting a family as possible. This proposal intends to implement that philosophy through offering of intensive family services combined with active inclusive casework management.

E. Multiple Impact Therapy.

The MIT team as developed at the treatment planning meeting ideally includes the primary and secondary IFS therapists as well as two or more community resource team members who have the most likelihood of current and continued contact with the family. Additional co-therapists may be present in a family larger than four. Observers important to the family might also be present who have not been trained in family therapy interventions. The following is an outline of how a typical MIT day develops. It is modeled essentially after the Albany and Pendleton experience.

Step 1. - Introduction: The team leader identifies himself or herself to the team members and family members. The tone is informal and efforts are made to help people be comfortable with using first names. The team checks with the family, including all its individual members to ascertain their understanding of why the day is being spent together. The team leader then offers a brief summary of what is expected to happen that day and how the day fits into the total 90 day intensive experience. An emphasis is made on the mutual goal of helping the family find greater satisfaction in its life together. The leader then proposes a number of expectations the team would like to negotiate:

- Everyone is expected to participate and not leave until the session is over.
- If someone gets emotionally upset and feels he or she must take a walk, a team member will go with them.
- Emotional expression and swearing is acceptable but physical violence to family members or property is not.
- We will all eat lunch together.
- Some of the day will be spent with the total group together. Part will be spent with family members paired with team members in separate conferences. Anything shared in individual conferences will be considered fair to share with the total group unless the family member requests the right to broach the subject at his/her discretion.
- The meeting will last as long as necessary, normal 7-10 hrs.
The family is then asked if they have any expectations of their own they would like the team to respect.

The introduction as well as the conduct of the rest of the session is very important in establishing the tone of the entire 90 day project. An MIT session in particular is potentially harmful in that families can readily experience it as a massive forceful intrusion, attempting to defeat their defenses and change family patterning according to some alien self-serving purpose. The entire session can be wasted unhappily in struggles for power, control and survival, ruining all motivation for follow-up work. If however the session is competently and creatively conducted with sensitivity, a family can develop a profound appreciation for such a massive investment of time and energy on their behalf, and find the motivation and sense of safety to focus on their own needs with the aid of the team.

Expected Outcome: The team leader establishes control of the session, family members are contacted, included, set at ease, and a positive tone is set for the rest of the session.

Step 2. - Warm-up: Warm-up exercises serve to further contact between all persons present, lower the anxiety level more, and model both a common level of humanness and a willingness to risk sharing on an intimate level by team members. Team members want to be progressively viewed by the family as competent helpers who carry the compassionate authority of experience, who work more through gently guiding and nurturing along the family's own capabilities than attempting to diagnosis and prescribe as in a traditional doctor patient relationship. Exercises such as: 1) participants describing their place in their family of origin, how than worked for them, whether they wanted to trade places with anyone else in the family at the time; 2) giving a four minute personal history mentioning the best and worst things that ever happened with an additional minute left for questions by others; 3) fantasizing a room with five chairs filled with important people from one's history and sharing what each would want to say to the individual all appropriate as are many others.

Sometimes if the family seems overly serious and isolated, it can be helpful to do an exercise such as assisted stretching. Usually one of the parents is invited to lay on floor and simply start to stretch spontaneously like one would when getting up in the morning. Others are instructed to physically take over the stretch, doing it for the person, being careful to go in the same direction with just the right amount of tension that the person is wanting. The person being stretched is asked to direct the enterprise by offering instructions on exactly how they want to be assisted. The overall effect is that people are mobilized toward pleasure, modeling the aim of the therapy in general. The stretchee has the unique experience of being helped by a number of people to do just what he/she wants to do. Everyone is helping the stretchee by not being too helpful, but listening carefully to directions. Habitual rational thought
processes are being skirted, and the family has an experience of
closeness and success, physically touching each other in a nurturing way.

Expected Outcome: The anxiety level is lowered and more of the working tone for the day is set.

Step 3. – Assessment: The structured family interview conducted routinely in Albany and Pendleton seems to have many advantages in that it: 1) utilizes the family's energy investment in its presenting problem; 2) allows each member to share in safety and become known in depth by at least one team member who becomes a special advocate for that person; 3) allows both family and team to experience family difficulties in communicating; and 4) provides an additional role reversal situation where the family witnesses the team sharing. The particular steps are outlined below:

a. Family members are told that we will now pair up and have individual conferences between family and team members where everyone will be asked to respond to the same set of questions. The family is asked if they would like to choose to talk with a particular team member with whom they might feel a particular connection by this time. If not, team members choose a family member and the pairs find some separate places to talk where there is privacy from the others.

b. Each team member informs their partner that the three questions being asked of everyone are: 1) What is the major problem in your family? 2) What would you change in your family to make things better? and 3) What would you individually have to do or change to help bring about more satisfaction in the family? This one to one interview is structured to last fifteen to twenty minutes.

c. When everyone returns from their individual interviews the family is then instructed to form a circle together with the team on the outside and given the task to discuss and come to some agreement in ten to fifteen minutes about what they understand their major problem to be. Someone in the family is asked to repeat back the instructions for the task. If the feedback is incomplete, the leader emphasizes that the task is for the family to come to a common agreement about their most fundamental problem.

d. No team member interrupts or facilitates while the family works on its task. At the end of the fifteen minute maximum time limit or before, the leader interrupts and asks each family member the following questions: 1) Did you (your family) agree on the major problem? 2) Was this typical of the way family members usually talk to each other and work on solving things? 3) Did you notice anything that was different than usual? 4) Did you like anything about the discussion and if so, why?

e. The family is then asked to move to the outer edge of the circle while the team moves to the inner circle. They are told that the team will now discuss their observations of the family among themselves. The family is asked to simply listen and watch, but not interrupt even if they disagree on some point. They will have a chance to share
their own responses and observations of the team discussion as soon as it is over. The team then discusses how they experience the family, see the family structure, and observe their communication and information processing patterns, drawing on all the information sources of the morning. In particular the team notes the number of interruptions, instances of people talking for others, blaming or justifying statements, I statements, feeling statements, etc. that served to either hinder or help the family in its tasks.

It is crucial that the team sharing be perceptive, matter of fact, compassionate, and non-judgmental. Similarly, it is important to use behavioral descriptions and never employ pathological diagnostic terms. To say a mother and daughter are symbiotically enmeshed is to pose a serious problem with no obvious approach to change. To say mother seems to get anxious when daughter gets involved in interests outside the home and does something to regain daughter's attention is to describe a precess that can be explored. If the team sharing is done well, it will provide the family with the experience of people-listening to them closely, taking them seriously, being realistic and non-judgmental. It will provide the family with hopeful desire that will help them find what they need for more pleasurable functioning within their own resources.

f. When the team is finished talking among themselves they move back until there is one circle again with all participants included. The family's responses to the team sharing are elicited and responded to. A general discussion ensues around the assessment of family functioning in which team and family ideally see the problem as a family systems problem. Solutions are discussed along the lines of new ways of communicating with new combinations of family members working through particular issues with each other, etc. This phase ends as the team focuses on the next intervention to be made.

Expected Outcome: All participants will identify and agree on particular problem areas and commit themselves to learning new ways of resolution.

Step 4. Intervention: There are two possibilities for the next step of directly intervening to effect beneficial change in the family:

a. If there has been enough clarity and energy in the assessment stage, the team can suggest a way to the family to begin addressing their issues. Tasks can be assigned, dialogues set up with specific family members, etc. The effort is to move toward resolution through all the normal steps of clarifying the issues, stating feeling and points of view, being honest about current involvement in the problem, confessing personal needs, negotiating responsibilities and commitments to new ways of functioning. "All the tools from the family therapy section are employed by the MIT team in an effort to "jump in with all four feet and do whatever it takes."

b. If the strategic interview in the assessment stage was concluded quickly by the family or without much energy and participation, or was highly
rational and controlled, the MIT team might find itself without enough material to make satisfying comments or suggestions for interventions. The family has not been sufficiently engaged in the process yet. They are holding back or looking to the team for every move without volunteering anything. In these circumstances it can be helpful to physicalize the issue through doing the family sculpturing exercise outlined by Satir. Sculpturing serves to both further the assessment process and to give lead in for interventions.

A family member is enlisted to be the sculptor. He or she is instructed to physically arrange the family, to build a model of the family that shows how far people are from each other, who is closest to whom, whether people are facing toward or away from each other, what posture they are in by themselves and in relation to others. The other members are asked not to comment but to cooperate. "This is so and so's model and it is right for him/her. Everyone else will have a chance to comment later." When the model is complete and the sculptor has included him/herself, everyone is asked the following questions while remaining in their place: 1) what is your experience like in this position; do you like it, not like it? 2) how much truth do you think there is to this model in general and your position in particular? When everyone responds to these questions, the original sculptor is asked to rearrange the model in a way that is more satisfying to him/her if it is not already OK. When that is accomplished, the others are asked if this new arrangement is also more satisfying to them, and if not, what they would like to change further. Additional interventions flow naturally out of this stage of the sculpturing as team members either ask family members (a) if this is a more satisfying arrangement, what will you have to do to maintain it, or (b) how about you two who have a disagreement on how you want things starting to negotiate further the issues you are concerned about?

Expected Outcome: Family members will begin to address and work through family conflicts together.

Step 5. Impasse: Impasses predictably result since the family has not usually developed new options by this point. Their desire to change bumps up against the typical obstacles they experience, and there is a retreat to the family's chosen way of binding anxiety, that is, to homeostasis, the status quo.

Impasses occur at two levels:

a.. The MIT team allows the family to go as far as it can on its own, not wanting to be overly involved, to foster dependence, or to interfere with spontaneous behavior. When family members do get stuck or back into their normal ruts, a mini-impasse occurs. At this point the team intervenes - coaching, asking questions, or making suggestions that help the process take a new turn and continue moving in a satisfying way. The team does not want the family to dig their hole deeper in the therapeutic setting. The team intervenes. It is quite possible that the family can progress through the day with these types of mini-impasses occurring and the team nurturing
them along.

b. A more major type of impasse can also occur. It can be recognized and anticipated, as Cooley points out, when there is a feeling of frustration and a sense that nothing is being accomplished. The same issues are being cycled through again and again with no resolution. Team members have a sense of working hard and notice that they are talking a lot and that family members are talking more to the team than to each other.

Three steps are taken to utilize the impasse: 1) Some team member raises the issue of the impasse aloud and asks if there is consensus or agreement; 2) The participants take a meta-stance for a moment and analyze the process from a distance, attempting to delineate the main features and give it some name; 3) The team again pairs off with individual family members and goes into separate interviews. The interviews last about a half an hour. The common agenda for these meetings is to have the family member: 1) share and explore as much understanding of the conflict as they can; 2) be in touch with their own feelings, investments, and involvement; 3) become aware of what they personally need that is at stake in the conflict; and 4) develop a sense of what they would be willing to do or negotiate to help resolve the conflict. When these matters are addressed as satisfactorily as possible for the moment, all participants return to a full conference session again.

Expected Outcome: Team members will recognize impasses and use them to further the treatment process.

Step 6. - Polarization: When the full session is resumed, team members will encourage family members to share the information that came out of the individual sessions. Emotional investments and personal needs will be expressed as concretely as possible in addition to more analytic comments that might interpret the dynamics of the conflict. The effort is to put individual positions in the starkest, clearest light possible. Honest I-statements that reflect individual needs are most needed to clarify what is at stake in conflicts with others. Team members become advocates for their individual partners if necessary, encouraging them to be true to themselves and express what they need and want.

This approach de-emphasizes blaming, accusative statements, though strong emotion can be expressed and claimed. The emphasis is on separating or differentiating. The metaphorical model is Brer Rabbit and the Tar Baby. the two characters in the story are reacting through habit patterns, are totally emersed in the interaction, and as the story says of Brer Rabbit, "the harder he hits (the Tar Baby) the stucker he gits." Likewise, families immersed in chronic dysfunctional impasses need to have individual members disengage from the conflict for a moment and separate themselves out so that there is the renewed possibility of coming together again, this time with more awareness of what is needed and wanted. The relationship with the individual team member can be quite important at this juncture, offering the family member realistic hope that they can and should get what they
desire, taking the focus off non-productive accusations of what family members are or are not doing, and helping the family member explore in what ways they would be willing to loosen up their stance and negotiate changes if their own needs were considered fairly in the process.

**Expected Outcome:** The family will experience a crisis or moment of truth as the issues at stake are clearly and honestly stated.

**Step 7. - Breakthrough:** As a result of the polarization, the team anticipates and fosters a breakthrough, normally by getting two or more members at the heart of a conflict talking with each other honestly. The breakthrough ideally revolves around underlying motives and needs becoming clear that were masked by the previous entrenched conflict and that are usually much more available for negotiation. For instance a wife confesses, "The reason I goad you to provoke you is that I become frustrated and feel unimportant when you don't ever get angry at me. I see you getting angry at the kids and feel like I am being left out." The husband responds, "I feel frustrated, confused, and somehow guilty when you demand that kind of response from me, like I'm supposed to be someone I'm not and don't know how to be. Anger is not an easy thing for me and I need time to withdraw and sort out my confusion before I say much." In this example there is the possibility of recognizing and respecting individual differences, not feeling slighted by the other person's responses, and of finding alternative ways of satisfying the underlying need for contact that is being expressed.

This action might also free up the youngest son from needing to be a "bad boy" to furnish mother and father with something to get heated up about together. The breakthrough always needs to be expanded to deal with the other system members involved. If the youngest son has his role called into question he will need some other way of functioning to substitute, such as being a checker-upper on whether the parents are getting their daily time together. Likewise the sister and grandmother might need other ways of feeling important than being professional tattle tales on the boy's behavior. Breakthroughs in terms of positive feelings being expressed are normally predicated on a person feeling that their own needs are being acknowledged.

**Expected Outcome:** The family will experience a new positive interaction based on new information and possibilities that will help them deal with their presenting difficulties.

**Step 8. - Practice:** A breakthrough implies some important change in the way feelings are expressed, needs are negotiated, communications are patterned, coalitions are formed, authority is recognized, duties are carried out or delegated, decisions are arrived at, etc. It is important that the breakthrough didn't "just happen" but that the family becomes aware of how THEY were able to reach a point of more satisfaction together. The practice period is for reinforcing and strengthening what went before to whatever extent is necessary. The new
behavior can be considered a fragile flower in one respect. The practicing period of the MIT day as well as the time left for follow up in the 90 day contract period are used to nurture along this budding development. Encouragement is given, skills are taught, supervised practice on related issues is set up, continued implementation strategies are thought through, changes in duties, home arrangement relationships with outside influences are devised – in short, whatever is needed is done. The point is that the family has a sense of enablement or empowerment that they will be able to use their resources in a new, more satisfying way and that the team will be available in a supportive, advocative role while things are worked through and consolidated in the time left together.

Expected Outcome: Family members will be able to understand the skills they used in finding resolution and develop increased confidence in their ability to use them fruitfully in their ongoing life together.

Step 9. - Closure: The closing sequence of the day functions to summarize, consolidate, celebrate, and plan for followup. Individual members are asked "what did you learn today?" and/or "what would you have to do to keep things the same?" The general results are summarized by the team and the general goals for the rest of the program are discussed by all. Next, a concrete plan for follow-up is agreed upon including: phone contacts between the family and IFS team, a sequence of continuing family therapy sessions, homework to be done by family, IFS team, and/or community resource people. Everyone, family members and MIT team members, specifies what the next step is that they will do. The day concludes with some structured way of participants expressing appreciations to each other, themselves, and the process.

Expected Outcome: The day will terminate successfully with an agreed upon plan for follow-up.

COLLABORATION AND INTEGRATION. Collaboration and integration begins with the establishment of the community resource team in general, and, more particularly, with the identification of relevant community resources for a specific family in the pre-planning evaluation who are then contacted for the treatment planning meeting. The process continues immediately after the MIT session when team members find a place to debrief for an hour or less and re-evaluate the treatment plan in light of the day's discoveries. The primary IFS therapist assumes responsibility for communicating the need for any changes to all parties involved, beginning with his/her supervisor. Once a plan is underway for a specialist's contact with a family, the IFS therapist assumes responsibility for working out a plan of continued contact with the specialist to both give and receive relevant feedback. Collaboration and integration are also enhanced by the inclusion of a community resource person as an ongoing co-therapist with the IFS worker in continued sessions with the family. Additional community resources may be integrated into the program at any time during the treatment period if the need becomes apparent. This is especially indicated if it
appears some agent will be dealing with the family in some follow up role after the 90 day period, as when the family elects to retain some private therapist to consult with when needed.

TELEPHONE CONTACTS. Telephone contacts will be made with each family on a weekly basis at minimum. Psychologically, they will help the family know of the continuing support and interest of the therapist and that he/she continues to assume significant effort by the family on its own behalf. Practically, it will serve to sort out questions, problems, misunderstandings, information etc. that the family has run into while carrying out homework tasks within the family and in contacts with the community. Diagnostically, it will let the therapist know if scheduled contacts from community resource specialists have been happening and going well, and if there is an apparent need to move up the schedule for the next face to face family session.

As stated above, in the family therapy section, the family will have the home and work numbers of their primary and secondary therapists to use as needed during working hours and in extreme circumstances, on a twenty-four hour basis. It is expected that the close contact the therapists make with the family in general, combined with an emphasis on the ability of each family to deal effectively with situations that arise, will minimize the necessity of any off hour calls. Unless some other schedule has been specifically worked out, the primary therapist will also gather progress reports from involved community resources every two weeks.

TERMINATION. At the end of the 90 day treatment period a final interview will be held with the entire family. The family will review where they were at the beginning of the program, what issues emerged, what they learned, and where they are now in their process. A helpful closing exercise that is often responded to by each member with surprising insight is "What would you have to do to go back to the beginning and keep things the same?" Feedback from collaborative community services will also be shared. A follow up plan for the family to carry on by itself is discussed as well as any referral for non-intensive professional services within the community. The interview also serves as an opportunity for the therapists and family members to say goodbye to each other.