

Behavioral family therapy



**ASSIGN
BUSTER**

Behavioral family therapy focuses on numerous techniques such as operant conditioning, education, communication and problem solving, and contingency management. These techniques were developed through numerous years of observation and research done by researchers known as Gerald Patterson and Robert Liberman. Many issues can be addressed by Behavioral family therapy such as anorexia, alcoholism, mental illness, childhood developmental issues, marital issues, and family problems. By addressing the family's problem directly, the therapist attempts to place the therapy in the family's hands and during this process engagement in the therapy becomes exceedingly important. Behavioral family therapy aims to find the process that fits the family, not fitting a family inside a therapeutic process.

Keywords: Behavioral family therapy, communication, mental illness, therapeutic alliance, engagement

Behavioral family therapy, also known as BFT, is a type of therapy that focuses on the family as a unit (Lipps, 1999). This family intervention looks at the elements of information giving and skills achievement, as well as aiming to reduce relapses by supporting and improving communication and problem solving skills (Campbell, 2004). With the support of empirical studies, BFT has developed its approach over years of research and practice. Behavioral family therapy not only addresses behavioral issues within the family, but individual family members with mental disorders as well. This type of therapy covers a broad scope of different types of families and issues.

Beginning information on behavioral family therapy started with simple cases regarding children that included bedtime tantrums, nocturnal enuresis, aggressive behavior, and language training with autistic children (Falloon, 1991). Outside of working with children, spouses were involved in BFT to support in the desensitization of anxiety disorders (Falloon, 1991).

During these early stages of behavioral family therapy the techniques were individually centered rather than family focused, but the family was still considered a large part in the individual's life.

During the start of behavioral family therapy it was thought that negative behaviors from family members came from other family member's operant reinforcements. From this concept, it was concluded that the strategies used in behavioral family therapy should involve changing; not only the family member with the negative behavior, but the family member's behavior who was reinforcing the negative behavior (Falloon, 1991). During therapy, therapists instructed family members with specific directions on how they should respond to undesirable behavior. While in session, the therapist would then mimic the appropriate behavior towards the undesired behavior when a family member was displaying the negative behavior. The success of the treatment was founded on how many times the deviant behavior occurred, and then the amount the deviant behavior decreased.

A pioneer in Behavioral family therapy, Gerald Patterson, created an understanding that laboratory experiments are much different than clinical experiments due to the complexity of the family life style (Falloon, 1991). He was a key individual when it came to formulating behavioral family therapy.

Patterson provided several research studies that employed several different therapeutic techniques. One strategy that Patterson tried to incorporate into therapy was to develop a method to move the therapist's role as the key mediator away from the family, so that the family would be able to make use of social-learning techniques by themselves (Falloon, 1991). In order to change the behavior within the family, Patterson found that it was important to not only change the parent's behavior, but the other family member's behavior as well, so that the family could then create a sense of reciprocity (Falloon, 1991). Patterson also noted in his research that the coercion of family members only increased the negative responses and only provided a short term correction to the negative problem (Falloon, 1991). Patterson created the pathway for behavioral family therapy through his research and application in the therapy session.

Other strategies that elevated behavioral family therapy to its current status, were suggested through research done by several other researchers. One strategy includes the "give to get" approach. The "give to get" approach is when a family member unconditionally and positively rewards another family member's behavior; specifically, with a family member that they are in conflict with (Falloon, 1991). The thought behind this approach is that it is much more likely that the family member's behavior will change in order to please someone, who pleases them (Falloon, 1991). Another strategy includes the contingency contract. The contingency contract is an approach where each family member creates a list of behaviors that the individual will perform for other family members (Falloon, 1991). After deciding between family members which behaviors will be able to be performed, a contract is

drawn up. These behaviors serve as tokens that are exchanged as rewards for their targeted positive behaviors, not negative behaviors (Falloon, 1991). These strategies are ways for therapists to help families change negative behaviors into positive behaviors by working together and implementing approaches that work for that specific family system.

Robert Liberman was a psychologist that worked with mentally ill adult population within the guidelines of behavioral family therapy. Liberman furthered Behavioral family therapy by including two strategies, role rehearsal and modeling (Falloon, 1991). These strategies were used by Liberman with therapeutic alliance and a detailed assessment of functional relationships. Liberman not only looked at the symptoms the family was having, but the interaction patterns, achievement of short and long term goals, and the extra familial issues that affect the family system (Falloon, 1991). The extra familial issues that affect the family system include education, social-services, and medical services. Liberman had the idea to include the extra familial factors within the therapy so that the symptoms were not the only focus in the sessions, but the long term achievement of stability. In a family system with an individual with a mental illness, Liberman found it important to look at all aspects that would affect the family (Falloon, 1991).

Within behavioral family therapy there are several behavioral-changing strategies that are used, which include contingency contracting, operant conditioning, and communication-skills training (Falloon, 1991). These strategies are applied to produce a specific change that is within the family's therapeutic goals. During therapy the therapist makes the decision when to

<https://assignbuster.com/behavioral-family-therapy/>

use certain strategies based on the family's functioning. When reviewing behavioral family therapy, the practice of therapy has found that only a few interventions were used across a broad range of therapy (Falloon, 1991). These interventions include education, communication and problem solving training, operant conditioning approaches, and contingency management (Falloon, 1991). Education can vary in the way it is displayed. Educating families about issues they deal with in their family, such as mental illness or the development of child milestones can provide families with the information they need to reach their goals. Communication training provides families with the ability to directly transfer information from one family member to another member. Effective communication can provide resolution to problems and attainment to their goals (Falloon, 1991). Operant conditioning strategies include time-out and shaping procedures to increase sought-after behaviors. Operant conditioning approaches are often taught to parents with children or families who have severe disabilities (Falloon, 1991). Operant conditioning goes along with education in that both deal with training and learning. The contingency contract is used to substitute hostile, coercive, blaming patterns of family behavior with more satisfying behaviors (Falloon, 1991).

The therapist's role in behavioral family therapy is to maintain a supportive therapeutic alliance and to be able to keep an ongoing assessment of the family so that accurate interventions can be used (Falloon, 1991). As the therapist, it is important to look at the responses made by the family member and use those responses to help the family best cope with their situation. Encouraging family members to take advantage of their strengths

by focusing on their own feedback will allow the family members to move towards resolving problems and reaching goals (Falloon, 1991). It is important for the therapist to convey positive and negative feelings in a direct manner that works towards positive behavior within the family. The therapist is the individual who matches the intervention to the family (Falloon, 1991). It is important for the therapist to match the intervention to the family instead of forcing the family into an intervention that may not be able to assist the family with their goals (Falloon, 1991). Not only are interventions thoroughly thought through, but the termination of therapy begins in the beginning of therapy. The therapist tells the family members how many sessions the family will be given and reminds the family every other session that the termination period is getting closer. By the therapist planning the termination in the beginning it gives the family a chance to become independent from the therapist (Falloon, 1991).

Behavioral family therapy can be used with several different types of issues. Three common issues that were found in the research were schizophrenia, anorexia nervosa, and alcohol abuse issues. Past research supports that family interventions for schizophrenic members demonstrates helpful engagement in the family (James, Cushway, & Fadden, 2006). James, Cushway, & Fadden (2006) provide statistical reasoning that behavioral family therapy has a lower dropout rate than other familial therapy groups by twelve percent. Once families became engaged in behavioral family therapy the entire family was more likely to stay engaged (James, Cushway, & Fadden, 2006). Those families who do not begin engaged or stay engaged in the therapeutic process are more likely to drop out. In James, Cushway, &

Fadden's (2006) qualitative research it was found that the more reflective the therapist was towards the family the more engaged the family was able to become with the therapy. Being reflective becomes important when creating a therapeutic alliance because reflection creates trust between the family and therapist. The therapeutic alliance in behavioral family therapy becomes the most important quality due to the amount of change that is going to occur (James, Cushway, & Fadden, 2006). When working with schizophrenia, a therapist tends to work harder to gain that therapeutic alliance. This could be due to the family not wanting to change what already works with certain members, or that the family members do not trust anyone making changes in their family when they are worried about the outcome of the mentally ill family member. Being able to engage with each member of the family, including a schizophrenic member, will gain the therapist a trusting relationship; which will in turn, help the family create positive change in their familial structure.

Anorexia nervosa and alcohol problems are both issues that behavioral family therapy can address. Ball & Mitchell (2004) found through their research that with anorexic clients and their families BFT had shown a high trend towards less negative communication after treatment. The research had also shown that significant improvements over time included eating attitudes and behaviors, self-esteem, depression, and state anxiety (Ball & Mitchell, 2004). Regarding alcohol problems, Lipps (1999) found that reinforcement is important in behavioral family therapy. When involving the family in the process of changing an alcoholic's behavior supporting the reinforcement from the family towards the family member is particularly

important. It is important for family members to reinforce the modification of the environment so that drinking behaviors are changed (Lipps, 1999).

Operant conditioning can also be utilized with changing an alcoholic's behavior with family members. When behavioral family therapy addresses alcoholism it assumes that environmental factors manipulate behavior from members (Lipps, 1999). Both, anorexia and alcoholism use a type of reinforcement to work within the context of behavioral family therapy to push for changes within family members.

Due to the openness of behavioral family therapy, my family and I went through BFT numerous times, but each time there was a different situation being addressed. Going through behavioral family therapy for the first time when I was younger, my family and I needed help dealing with my ADHD. I was having trouble in school and at home. Our therapist worked with my parents in training them how to respond to desirable behaviors and how to ignore negative behaviors. I was reinforced through the behaviors that my parents displayed towards me. Eventually, my behavior started to change into more positive and desirable ways. I began doing my homework and started doing my chores at home. Concentration was hard for me, but in time with behavioral therapy and medication my ability to concentrate gradually increased. Behavioral family therapy has helped me and my family deal with a hardship. By working through this hardship with my family in therapy I learned to love school and I am now in my masters, somewhere my parents and I never thought I'd be.

Behavioral family therapy addresses numerous issues and involves several interventions that can be used to work within the specific family system. This

<https://assignbuster.com/behavioral-family-therapy/>

type of therapy not only puts the family members in the driver seat, but allows the family to work, support, and value the relationships and changes in their system (Campbell, 2004). Behavioral family therapy also allows the family to acquire new skills and these new skills help open communication and trust within the family (Campbell, 2004). Overall, behavioral family therapy gives the family choices in how they want to run their sessions. The therapist allows the family to run the session while educating and teaching the family techniques along the way. Along with the numerous techniques, it is important for individuals going into BFT to take control and engage in their therapy. Without trying and wanting change, behavioral family therapy can only give the family what the family wants to take from the therapy.