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# Family therapists' responses to monopolizing, blaming, critical and unempathic behavior in parents

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Andrew Sussman  
Family Therapists' responses  
to monopolizing, blaming,  
critical and unempathic  
behavior in parents

## ABSTRACT

This research was designed to address the question: "How do family therapists respond to monopolizing, blaming, critical and unempathic behavior from parents in family therapy. I was interested to see if they viewed the presentation as resistance, narcissism, or was it attributed to something else? I was also interested in the therapist's background, theoretical framework, training, and how they viewed family interventions. I hypothesized that family therapists would respond to monopolizing, blaming, critical and unempathic behavior in parents in a way that was influenced more by clinical practice experience than theoretical orientation.

The instrument was a survey with closed and open-ended questions developed by the researcher. Nineteen clinicians that met my criteria for being a family therapist completed the survey. Nearly half (44%) of the clinicians had more than twenty years of family therapy experience.

A significant finding was that family clinicians were influenced by several theories, but tended to adhere most to one particular theoretical framework. There was a significant difference in mean age ( $t(8)=3.326, p=.01$ ), between those who viewed this behavior as narcissism ( $m=44.5$ ) and those that did not ( $m=59.5$ ). Clinicians that avoided labeling this behavior were older, more experienced and possibly "truer" family therapists. There was also a plethora of creative approaches found that diverted from theory. The study revealed the decrease in family therapy training in current social work

programs and a cautionary statement of letting H.M.O's "cost-effective" goals affect family therapy education, training, and research in social work schools.

FAMILY THERAPISTS' RESPONSES TO MONOPOLIZING, BLAMING,  
CRITICAL AND UNEMPATHIC BEHAVIOR IN PARENTS

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2009

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## CHAPTER I

### INTRODUCTION

"In my family there were problems, habitual problem solvers, and preferred solutions"

(Salvador Minuchin, 1981, p. 75).

While psychodynamic individual treatment focuses on the individual's past, struggles, strengths, and the relationship between client and clinician, family therapy focuses on the whole family as the client. Family therapy is an altogether different endeavor where most family therapists view the relationships between the family members in the room as more important than the relationship between clinician and individual family members.

Family Systems Therapists (FST) think systemically in that change is viewed in light of the systems of interactions between family members. As compared to psychodynamic or psychoanalytic individual treatment, FST places less emphasis on the cause of the problem, and more on how to practically affect the patterns and systems of relating in a positive manner (Nichols and Schwartz, 2006).

Still, one must take into consideration the great range of ideas and techniques that fall under family therapy. "Having a "family systems" orientation to therapy" describes a general perspective but does little to explain any given school's underlying theoretical assumptions, or philosophy of intervention..." (Anderson & Stewart, 1983, p. 12).

Psychodynamic models of family therapy are "those that attempt to integrate ideas from psychoanalytic and object relations theory with principles of family systems...What distinguishes this group of therapists is their respect for the influence of historical family processes, in particular early object relations, on individual development and thus on the current relationships established and maintained by individuals. Family pathology generally is viewed as the result of a developmental failure in the family of origin....." (Anderson, 1983, p. 14).

Last year, my first year internship was at the McCauley institute, San Francisco's only adolescent inpatient psychiatric unit. My primary clinical intervention was to conduct family therapy with the adolescents who were patients on the unit and their families. I also took part in a Brief Strategic Family Therapy (BSFT) training with Pamela Parkinson at A Better Way in Berkeley, California. In both instances, I found working with families to be a very complex, dynamic and powerful experience. Family patterns and roles were revealed quickly in the sessions.

In both settings families presented with very challenging issues. In working with families, both myself and other clinicians found it particularly challenging when a parent monopolized the sessions and blamed, shamed and sometimes bullied other family members and the clinicians.

Some schools of thought view this behavior as resistance to treatment. Freud viewed resistance as a "Patients unconscious avoidance of or distraction from the analytical work" (Beutler, Moleiro, & Talebi, 2002, p. 130). Surprising to some, Freud was in fact interested in how groups function. His concept of resistance applies to groups "because group members seeking to ward off anxiety, may oppose the progress of



treatment by being silent or hostile, missing sessions, and avoiding painful topics" (Nichols and Schwartz, 2006, p. 50). In the literature review, this study will begin by examining some family therapy literature which views the monopolizing, blaming, shaming and bullying behavior of parents as resistance.

Secondly, sometimes such behavior is so pervasive and destructive that clinicians may view it as evidence of narcissism reflecting the parent's individual character make up. This style can be particularly difficult to treat in both individual and family settings. The narcissistic parent would likely exhibit behaviors such as externalizing blame, criticism and a lack of empathy. Some family theorists explore how treatment would differ with such clients (Guttman and Villeneuve, 1994 & MacFarlane, 2004), and the literature review shall investigate this approach as well.

It's important to note that there is not clear consensus on the concept of Narcissistic Personality Disorder (NPD). "Despite common clinical usage, the concept of narcissistic personality disorder is highly controversial and of uncertain validity. The vast majority of the literature on narcissistic personality disorder has been theoretical and clinical rather than empirical" (Clarkin, Levy, Reynoso et.al, in Fowler, Lilienfeld & O'Donohue's eds, 2007, p. 233). Consequently, the empirical research on family therapy with narcissistic parents, and/or those diagnosed with NPD is even rarer or non-existent, and this is why my literature review will be largely theoretical.

Thirdly, another prominent conceptualization of this behavior in parents focuses primarily on blaming. This way of responding to family conflict has been studied, particularly from a constructionist/narrative perspective, and has important findings and implications for the current research. Constructionist and narrative approaches to family

therapy "seek to engage clients in a joint project to think and talk about their lives in ways that highlight possibilities....and solutions rather than problems" (Friedlander, Heatherington, & Marrs, 2000, p. 133). While this is understandable theoretically, there are disagreements as to how this translates into actual clinical practice with family members who blame. This literature will also be explored.

It's clear that there is a lack of agreement as to how to best approach this presentation in parents and that it can be can be debilitating to family clinicians. It is critical to get a clearer sense of what family clinicians actually do in practice with this sort of dynamic in a family. To best understand their responses, it's important to know in what ways theory informs their interventions. In addition, do years of experience or age affect their strategies more so than their theoretical orientation? Or, is it a combination of both, or can it be attributed to other factors? This research will explore these questions.

This research was designed to address the question: "How do family therapists respond to monopolizing, blaming, critical and unempathic behavior from parents in family therapy. I was interested to see if they viewed the presentation as resistance, narcissism, or was it attributed to something else? I was also interested in the therapist's background, theoretical framework, training, and how they viewed family interventions. Furthermore, I was interested in any other factors that influenced their interventions in this situation. I hypothesized that family therapists would respond to monopolizing, blaming, critical and unempathic behavior in parents in a way that was influenced more by clinical practice experience than theoretical orientation. The instrument was a survey with fixed and open-ended questions developed by the researcher. Nineteen family clinicians that met my criteria as being a family therapist completed the survey.

## CHAPTER II

### LITERATURE REVIEW

In this study, I seek to understand how family therapists conceptualize and respond to blaming, monopolizing, shaming, controlling, and bullying behavior from parents in treatment. While there are many ways that a family clinician could think about and respond to this presentation in parents, I will focus on those most prevalent in the literature. One of these conceptualizations is viewing the parents behavior as a form of resistance to treatment. Another, is understanding it as evident of narcissism in the parent, and lastly, as simply blaming. While much is written theoretically about family therapy, there is not extensive empirical research on what clinicians actually do in the room with this dynamic.

#### *Resistance*

##### *Psychoanalytic Origins*

Resistance originated within the psychoanalytic tradition. "It is for all analysts a central notion in understanding how the therapeutic process proceeds" (Wachtel, 1982, p. xiv) It is important to distinguish it from an active, conscious resistance as we think of the word in other contexts. Wachtel (1982) further explicates this difference. "The concept refers not to any willful malevolence or opposition on the patient's part but instead to the difficulties inherent in attempting to encounter and master feelings and experiences that have previously seemed so overwhelming they must be avoided and denied at all costs" (p. xix) There is a protective mechanism implied in the process of

resisting. It is also necessary to see that it is not simply episodic, but more pervasive.

“Resistance and conflict are almost identical. Not something that periodically comes up to disrupt therapy. It’s the track of the patient’s conflict about changing, the way in which the sincere desire to change confronts the fears, misconceptions, and prior adaptive strategies that make change difficult” (Wachtel, 1982, p. xix)

“Resistance in therapy is opposition to change. Freud demonstrated that psychological symptoms serve a purpose that, once it is understood, explains their necessity for the patient.” (Franz Basch in Wachtel's eds, 1982 p. 3). This expands further on the concept that clinicians need to understand resistance in a very different way from the connotations this word has outside of therapy. Franz Basch further explains:

“Resistance has acquired an undeserved pejorative flavor. Resistance is a much more frustrating phenomena if we believe on some level that the patient is willfully opposing us and could, if he were only a nicer person and less bent on making our life miserable, do something about it. However, the way Freud initially described it, resistance is not an interpersonal problem, that is, something that the patient is doing to the therapist, but instead an intrapsychic one that is bringing a struggle within the patient into the foreground of the treatment. Looked at it that way resistance becomes a guide to the therapist, indicating where he can profitably concentrate his efforts. I realize that that is often easier said than done.” (Franz Basch, *Dynamic Psychotherapy and Its Frustration*, in Wachtel's eds, 1982 p. 4).

This further explains how the resistance, from its psychoanalytic origins, is not a conscious, active process asserted by the patient, but more an unconscious, intrapsychic one. It is also, not something to forcibly combat, but more of a guide, a source of information, and a direction to proceed in delicately.

### *Resistance in Family Therapy*

As family therapy developed, some came to view resistance as reasonable and believed that families should resist change. The family needs to be assured that they can trust the therapist and feel secure enough to lower their defenses. In this view, family therapists work with families as partners, creating a safe, non-blaming environment (Nichols and Schwartz, 2006). This study will also examine the literature on resistance in family therapy and how different family clinicians propose to respond to it.

"Family members resist by scapegoating, superficial chatting, prolonged dependency on the therapist, refusing to allow therapeutic suggestions, and allowing difficult family members to stay home" (Nichols and Schwartz, 2006, p. 50). Over time, "resistance" came to mean anything a patient did to make therapy or a particular intervention less effective. (Miller & Rollnick 2002).

Family systems therapists (FSTs) view resistance as a "blueprint" of the therapeutic work to come. "Resistance," according to this approach is nothing more than the family's display of its inability to adapt effectively to the situation at hand and to collaborate with one another to seek help" (Hervis, Schwartz, & Szapocznik, 2003, p. 45).

Brief Strategic Family Therapy (BSFT) is a family prevention and treatment approach that began in the 1970's. It's clinical and research population has been primarily Latino and African American families in Miami at the Center for Family Studies at the University of Miami, Florida. "BSFT has clearly articulated goals (e.g., improvements in family interventions and reduction or prevention of child/adolescent behavioral

problems)...." (Gonzalo, Perez, Robbins, Szapocznik in L'Abate and Kazantzis eds, 2006, p.133). BSFT initially used a structural family therapy approach, as developed by Salvador Minuchin and colleagues at the Philadelphia Child Guidance Center (Minuchin and Fishman, 1981). Structural family therapy is present-focused, respects the population's hierarchical family values, and provides a strong basis for "therapists assuming a leadership role with the family." (Gonzalo, Perez, Robbins, Szapocznik in L'Abate and Kazantzis eds, 2006, p.133). Similarly both BSFT and structural family therapy worked largely with Latino and African American families. Over time BSFT developed and "integrated strategic aspects of family therapy through a program of clinical research and practice....(Gonzalo et al. in L'Abate and Kazantzis eds, 2006, p.133)BSFT is best articulated around three central constructs: System, Structure/Patterns of Interactions, and Strategy (Gonzalo et al. in L'Abate and Kazantzis eds, 2006, p.134)

Much of the research in BSFT focuses on the adolescent drug abuser as the identified patient, and sometimes the resistant family member. According to my conversations with Pamela Parkinson, PhD, who trains therapists within an evidence-based (BSFT) approach, while adolescent drug use is the focus of the research and is not about a monopolizing, critical parent lacking empathy, the research is still relevant since it uses similar techniques which would be used with a monopolizing, critical parent. Nevertheless, there is a lack of specific research looking at monopolizing, critical and blaming parents as a form of resistance within this heavily researched approach (Brickman, Foote, Hervis, et al., 1988; Hervis, Schwartz, & Szapocznik, 2003; Szapocznik & Kurtines, 1989; Szapocznik & Williams, 2000). This lends further credence to the need for my study. BSFT and strategic structural family therapists believe

that resistance within the family stems from two systems properties (Brickman, Foote, Hervis, et al., 1988). The first system property is that the family is a self-regulated system. The system will try to maintain structural balance or status quo, "with *structure* defined as repetitive patterns of interactions" (Brickman et al., 1988, p. 552). Secondly, the symptom, or resistance, is a means for self-regulation (Brickman et al., 1988).

"Within the structural family framework, the family is conceptualized as a natural social system that establishes routine patterns of transacting business among its members and with its environment. These repetitive patterns of interactions define a family's structural organization. Dysfunction may result from a particular family systems' way of organizing itself in an attempt to cope with internal or external changes and stresses" (Brickman et al., 1988, p. 553). Joining and restructuring are two traditional structural family therapy goals.

For the family resistance characterized with a powerful identified patient (IP), the therapist needs to join with this member. In engaging with the "powerful" drug-abusing adolescent, it was especially important to meet the IP on his or her own "turf." (Brickman et al., 1988, p. 553).

Other families were characterized by an ambivalent mother, that may have called for help, but was likely to protect the IP, and ambivalent about involving her husband. In such instances "the therapist typically bypassed the mother (with her permission) and went directly to the father to place him in a more central role in bringing the family into treatment." (Brickman et al., 1988, p. 553)

This engagement was sometimes characterized by "more thorough joining, inquiring about family interactions, inquiring about the problems, values and interests of

family members, supporting and establishing an alliance with the caller (family member who is in contact with therapist)" (Brickman et al., 1988, p. 554).

This more pro-active approach to countering resistance through joining and getting families in for treatment showed that the strategic structural systems approach to engaging was far more effective in getting families into treatment. In this study, the subjects were 108 Latino families "in which an adolescent was suspected of, or was observed, using drugs." (Brickman et al., 1988, p. 552) Those families that were engaged with the strategic structural systems approach engaged in treatment at a rate of 93% compared to 42% for the control group, and 77% of families completed treatment compared to 25% for the control group (Brickman et al., 1988, p.552). While not specifically addressing the described parental behavior of this thesis, this study shows the effectiveness of creatively re-thinking how to join with the most powerful family member, regardless of who that may be, and that it is imperative to successful treatment. Such an approach has positive implications for practice with often powerful, monopolizing, and blaming parents in family treatment. Furthermore, when in contact with the resistant member, Hervis suggests the therapist reframe the purpose and nature of treatment to her or him. To a powerful adolescent IP the therapist might say, " I want you to come into counseling to help me change some of the things that are going on in your family"" (Hervis et al. 2003, p. 50). Further along in treatment and when the therapist has joined with the member, the therapist repositions his or her place as more of the chief facilitator of the therapy (Hervis et al., 2003).

One of the drawbacks of this research relates to internal validity. Specifically that during the course of this research, there was a loss of the second therapist due to a serious



illness early in the study and no suitable replacement was found. With this condition, it is not possible to state that the great differences in engagement between the experimental and control groups was not due to the individual characteristics of the therapist. The same therapist saw both the control and experimental group, but the original design was to have two therapists seeing both control and experimental groups. (Brickman et al., 1988).

To reiterate, families that were engaged with the strategic structural systems approach engaged in treatment at a rate of 93% compared to 42% for the control group, and 77% of families completed treatment compared to 25% for the control group (Brickman et al., 1988). Further replication with several therapists is needed for the results to be more powerful. Although my study is not conducting an experimental intervention, getting feedback from several therapists on what has and has not worked in responding to this behavior has the advantage of finding techniques and methods that can be generalized and are not simply due to individual characteristics of a therapist, unless stated as such.

While this research exemplifies the positive effect of engaging families with this creative approach, another limitation is that long-term effects of these interventions are not explored. While they state that 77% completed treatment compared to 25% for the control group (Brickman et al., 1988), the research does not specify how many sessions this was or length of time in treatment, but they do state that it was not a long-term study. My study will ask family therapists to comment on their interventions and experience over time (early, middle and later stages of treatment) with a family, thus addressing a limitation of this research.

In engaging resistant families and family members, Weidman (FST) describes one of his main principles: "If possible, try to reframe in positive terms a family member's resistance to participating in treatment. If the resistance is seen as bad and if the therapist and family are angry or confrontive, a power struggle which can only be destructive may ensue." (Weidman, 1985, p. 100).

With a dominating family member who continually interrupts others, Weidman (1985) will not refrain from politely, but firmly reminding the family member that everyone must be heard. However, he articulates a possible way of reframing the behavior. "Another approach is to reframe the interrupter's behavior as "doing all the work for the family." "This person often feels overwhelmed because she feels the complete weight of responsibility for the family" (Weidman, 1985, p. 103). This type of reframe seems focused on empathic attunement and understanding of the dominating parents' plight.

Psychoanalytic Family Therapists (PFTs) view resistance as a product of previous life encounters. Menninger (1958) wrote " Resistance is not something that crops up occasionally to "impede" the course of treatment; It is omnipresent. It is a fascinating, dramatic production, on par with the creation of a dream in that the patient's resistances make use of his typical defenses and more stable character traits." (As Cited by Love, 1993, p.176).

Resistance is used in PFT to understand and help families. "Consequently, analytic therapists today regard resistances as disguised or primitive forms of communication rather than as obstacles to recovery" (Spotnitz, 1961, p. 64). In the vein of a monopolizing, critical parent, "The presence of destructive resistance appears to be

related to destructive experiences in the life histories of the individuals who use them. They seem to need both to repeat those experiences in the group as victim and to victimize others through identification with the original aggressor..." (Rosenthal, 1976, As cited by Love, 1993, p.177)

PFT's (Psychoanalytic Family Therapists) conceptualize and *respond* to resistant parents in a way that Love, (1991) writes, distinguishes them from FST's (Family System Therapists) "The modern analytic family therapist, although aware of marital dysfunction, initially goes along with the family's perceptions and requests.....In this regard, the particular treatment approach of modern psychoanalysis is different from the systems approach where the family is asked to adapt to the perception that the "system" is dysfunctional...." (Love, 1991, p. 177).

For example, a parent's interference in their child's therapy is viewed as a "disguised cry for help," (Love, 1991, p. 177) and a resistance requiring attention. "The parents often communicate through their resistance to the treatment of their children that they now need and can benefit from help for themselves." (Love, 1991, p. 177). The function of questions and demands is understood as the vital road to the study of resistance to the families' central task in treatment, "namely, relating and understanding their family's life story," that is, " to say everything. " (Love, 1991, p. 177-178).

Love and Mayer (1959) describe how going along with the resistant family may play out over the course of treatment. "It is important to remember that emotionally resistive parents recoil from reality....It therefore seems imperative, especially in the initial stages of contact, for the therapist to join with them in their stubborn denial that something is wrong with them or their children. He will try to enlist the cooperation of

an adult ego, which in fact may not exist. ....he will ally himself with them psychologically, looking at the world from their viewpoint, and speak their symbolic language. Thus, they may be enabled to verbalize hostile and dependent feelings and to modify their defiant attitude. " (Love and Mayer, 1959. As cited by Love, 1991, p. 179).

Over time, the joining and mirroring dissolves preoedipal resistance displayed through denial and projection. The family members are then able to further individuate. As they mature, their self esteem grows (Love, 1991, p. 179). Thus, they can then "recollect and verbalize more spontaneously and progressively negative as well as positive feelings and experiences." (Love, 1991, p. 179).

### *Narcissism*

#### *Origins and Psychoanalytic view*

From the myth of Narcissus, we can begin to see the roots of this term and the narcissistic client who is wholly self-absorbed with an "impermeable style " (Curlette, Kern, & Schneider, 2007, p. 124). Such individuals have been described as "being incapable of forming loving attachments, as such attachments are viewed as disempowerment" (Curlette, et al., 2007, p.124). The family history of such individuals is often linked with childhood psychological ,verbal or physical abuse by caregivers and other authority figures (Summers & Summers, 2006, p. 401).

It is important to note that one can not diminish the impact on the therapist when treating clients with narcissistic personalities. The experience of having a client who demands precise recommendations while at the same time rejects the therapist's feedback is a common experience in such treatment. Therapists often get caught up in this dynamic

and feel compelled to disengage from the relationship or end things prematurely as they feel devalued by the narcissists' projections (Dimaggio, Fiore, Salvatore, & Carcione, 2007). The defenses put up against attachment in shielding the individuals from experiencing further narcissistic wounds make it very difficult for narcissistic patients to bond with others (Dimaggio et al., 2007).

#### *Parental Narcissism in Family Therapy*

To investigate the roots of narcissism in the family system, Biderman, Ramsey, Reeves & Watson (1996) surveyed 370 undergraduate students. The students were given the O'Brien (1987) Multiphasic Narcissism Inventory (OMNI) to measure pathological narcissism. Higher incidences of pathological narcissism with these students was correlated with their perceptions of having parents who were either permissive or authoritarian. Both the authoritarian and permissive parent scenarios are consistent with Kohut's (1977) psychology of the self in the formation of narcissism in that both situations create a situation for the child where they experience inappropriate levels of frustration. The former is too frustrating and the latter, not enough. The studies strengths are that they demonstrate the impact of narcissistic parenting and how narcissism is transmitted to the next generation in a destructive cycle. Some potential weaknesses exist in that the student participants received extra credit in their undergraduate psychology class for participation. While this practice may be common, I have some concerns with the validity considering this practice. With an average age of 18.8 years and this being an introductory class, I have some concerns about the comfort level of participants to be completely honest. Expecting extra credit for this test in what may be their first class in college, there may be a desire for participants to produce results that they expect the

researchers are seeking. The sample was also 88% White, 8% African-American and 4% other (Biderman et.al, 1996). While this was the sample obtained at the University of Tennessee at Chattanooga, it does not represent a diverse sample in terms of race. While this study aims at tracing the origins of narcissism in these particular students to particular parenting styles (permissive and authoritarian), it says nothing of treatment modalities to best treat narcissism. Furthermore, additional research would be needed to rule out the many other extraneous variables which are not accounted for. Some of these possible influences on the development of the students' character could be the level of conflict between their parents, other aspects of parenting styles such as attunement and sensitivity and presence or absence of other sources of support such as siblings and other relatives.

Much has been written about the origins of narcissism stemming from inadequate parenting (Freud, 1914, Kernberg, 1975, & Kohut, 1977) and this research (Biderman et.al, 1996) without taking considerable measures to rule out other variables as stated above, does not focus at all on treatment practices. In contrast, my research focuses on how clinicians respond in treatment, to parental behavior which some clinicians may define as narcissistic. This area is far less researched and is important to conduct at this time.

In the psychoanalytic literature much is written about the clinician's experience of working with narcissists and how we must be aware of our own reactions. Jones (1987) describes the challenge of doing family work with such clients. Such work can easily lead the clinician to being engulfed or helplessly excluded from the family system. Jones explores the critical temptation that clinicians may feel to respond to such devaluation

with direct confrontation. Dysfunction of the whole system, increased rigidity, and resistance will likely result if direct confrontation is employed. A more cautious, slow, diplomatic approach is recommended in response to this sort of devaluation and this can take some time (Jones, 1987). Such an intervention may offer the empathy the client never had so that she or he is able to eventually employ it in other relationships as a giver, and not just an exploiter and taker (Jones, 1987).

The chilling portrayal of the narcissistic parent, particularly with high levels of marital conflict and divorce, led to the introduction of the term, Narcissistic Parental Alienator (NPA). This term describes parental narcissism at a very extreme and destructive level. With deceit being the hallmark of such narcissists, reference to Sun Tzu's *Art of War* and Machiavelli is used to further the point. Both Machiavelli and Sun Tzu have been referred to as "masters of deception and winning at all costs" (Summers & Summers, 2006, p.400). "Narcissists lie, manipulate, and speak in mixed messages. They cannot part with their illusions, and if their illusions are gone, they may still exist, but they have ceased to live" (Summers & Summers, 2006, p.399). This exemplifies some of the most destructive and hurtful effects of narcissistic parents, though such a negative description does not appear to leave much room for their humaneness, which they still possess. With the NPA, no hope appears to be offered as to how to effectively work with these individuals and the destructive family dynamic.

Additional rigid reactions to narcissism, particularly linked with fathers, is offered by Lund (1995), who provides generalizations about such families and fathers who are contemptuous of their wives. They are portrayed as narcissistic, successful, and as looking down on those not as successful or as righteous as they are. While this is perhaps

true of some narcissistic fathers, it does not provide the full dimension of the person. Such descriptions, when not combined with empathy and a broader picture of the person, pathologizes that person in a way that has led some family therapists to refrain from using the term "narcissistic."

Love (1991) offers some more hopeful findings in their (PFT) focused work with narcissistic mothers. In this description, "Narcissistic mothers, suffering from feelings of worthlessness, failed to perceive differences between themselves and their children." (Love, 1991, p. 172). The plea for their child's treatment really being a plea for themselves.

The therapist needs to be particularly sensitive to this dynamic. "Failure to recognize the disguised plea led to termination of contact" and "Recognition led to continuation of treatment." (Love, 1991, p. 172). "In their ongoing treatment relationship it was important to distinguish with the narcissistic mothers their various requests, infantile wishes, and maturational needs. They then experienced feelings of being worthwhile and were more successful in differentiating themselves from their children." (Love, 1991, p. 172).

Lebeau (1988) describes how family therapy is an ideal environment to address narcissism in families, though it requires great skill and understanding. She proposes an intervention whereby family members are taught to learn to understand each other's pathology. Rather than the therapist offering the empathy, which is still present, the emphasis is on the members' learning to feel this for each other. With family work there are more opportunities for mirroring and practicing together. The crux of her intervention, however, is a two-fold effort. In working with the narcissist, the therapist



simultaneously, and gently, dismembers the false grandiose self while helping the healthy ego, stunted in early development, to start to grow and flourish. It is imperative that these two processes are addressed at the same time as the narcissistic defenses are not easily given up, and it's only possible when the merits of a healthier ego are felt, and can lure the patients from the defenses that has seemed to work for them for years (Lebeau, 1988).

In a similar light of holding multiple views simultaneously, Guttman and Villeneuve (1994) point out that family therapy with narcissistic borderline parents requires both a systemic and psychodynamic approach at the same time. Additionally, this particular family dynamic is so challenging for therapists that they argue for using a co-therapist. The added support of another therapist can assist in staying focused and not getting pulled into a narcissistic parent's dynamic, while also offering an opportunity for modeling empathetic communication.

Love (1991) highlights the importance of joining with all family members in psychoanalytic family therapy. The issue of who actually comes to treatment is explored. The more passive, psychoanalytic approach Love proposed accepts all of the family's claims and projections. They are given room to where a narcissistic parent could essentially structure treatment. The belief is that over time such individuals will eventually join in treatment once they feel safe. "Going with the resistance" is important, but its application to brief treatment may be difficult when working with the whole family is the goal.

### *Blaming and Responses*

A study (Alexander, 1973) performed in the 1970's reveals the shift in focus from individual to family systems and the relationships within a family. The research with 22 "normal" families and 20 "deviant" families showed that the deviant families responded with defensive communication and dis-integration when confronted with stress. The labeling of certain families as deviant seems reflective of another era. Nevertheless it is an important study because it stressed how pervasive and unproductive blaming and lack of integration can be in confronting life's challenges, particularly when a child reaches adolescence (Alexander, 1973). The important differentiation with the two groups of families was that the adolescents in the "deviant" family "had to meet the following criteria: a) referral to the Salt Lake County Juvenile Detention Center as a runaway or ungovernable (13 were first offenses, 6 were second offenses, and 1 was a third offense" (Alexander, 1973, p. 224). The "normal" families were "randomly selected from a list of potential families whose children had been described by their teachers as "average" and "well adjusted." (Alexander, 1973, p. 225) The adolescent did not have any psychological, legal or delinquent background. All the families were given the same questionnaire of 17 opinion statements by an administrator. After this, the administrator left the room and left the family with discussion topics "(such as, "What are good parents?") and asked the family to discuss these topics. ." (Alexander, 1973, p. 225). The families were videotaped during this 2<sup>nd</sup> phase, and the last phase, where they would be given the original questionnaire and asked to come up with a family decision on the questions. In every case, the maladaptive family systems generated significantly higher

rates of defensive communications, as compared to the normal families." (Alexander, 1973, p. 226). Despite one rater being assigned to each family with additional raters serving as reliability probes, the researchers do not state if the raters had knowledge or not of which type of family they were rating. Without such statements, it is likely that this was not a blind study and therefore, results are less reliable. This is a major limitation of the study.

A very different approach more than 20 years later, shows the importance of the therapist's views and of therapist's taking a more empathetic stance (Bry & Melidonis, 1995). When therapists respond to the disintegration and blaming as described in the Alexander (1973) study with a focus on exceptions to the blame and only positive aspects of the adolescent's behavior, it is not surprising that families responded by mirroring the therapist's focus. This is essential strengths-based work, but needs to be reinforced over time as the family's behavior returns to baseline levels once the therapist ceased this approach (Bry & Melidonis, 1995).

Four families were seen in a family crisis clinic and in treatment with family therapist, Greer G. Melidonis, who participated in the study. The study focused on, and was successful in showing that a family decreased blaming statements when a therapist "began responding to families blaming statements by inquiring about exceptions to the problems and attending only to reports of positive adolescent behavior. This exceptions condition continued in the first segment of the second therapy session, after which time the therapist returned to baseline behavioral family therapy." (Bry & Melidonis, 1995, p. 451). As hypothesized, blaming statements decreased and positive statements increased

during this time, but returned to baseline when the therapist stopped focusing on these exceptions. This method does not seem to validate blaming on any level.

The low sample size must be taken into consideration in generalizing these findings. As is often the case, the adolescent was the IP (identified patient). While this is the avenue for many families coming into treatment, the family problems listed were "temper tantrums, poor school grades, family conflict, adolescent running away behavior, truancy and shoplifting." (Bry & Melidonis, 1995, p. 452). Noticeably, only one of these problems involved the family, "family conflict." While this is often the case, this research did not address this identifying problem as blaming, the adolescent specifically, by definition.

Another concern and limitation of this study was that Greer G. Melidonis was both the therapist and primary research coder and this raises questions about coder objectivity (Bry & Melidonis, 1995). Additionally, there are some other remaining questions: "How will the alteration in family verbal behavior affect the adolescent problems? Was the entire family responding to the intervention or were some members more verbal than other?" (Bry & Melidonis, 1995, 455). Another weakness is that these changes in family behavior were limited to the therapeutic setting. While these changes may have been evident outside of therapy, the researchers did not inquire into reports of family interactions outside of therapy. Such changes are obviously far more important than how a family presents in treatment as they may be simply pleasing the therapist or responding to her modeling temporarily.

For my study in particular, I would need to know if these were parents, siblings or grandparents who were blaming. Also, this study transpired over only 2 therapy sessions.

The validity of the therapist response to exceptions to the problems and attending only to reports of positive adolescent behavior needs to be tested over a longer treatment period to truly reflect how therapists respond to blaming, shaming critical parental behavior in family therapy.

Further investigation of family therapists' understanding of, and experience with blame in family therapy reveals the debilitating impact it can have on even experienced clinicians. The qualitative study by Bowen, Madill, & Stratton (2005) showed how much past relationships affected how families presented. That this negativity was so prevalent where it affected the hopefulness of clinicians reflects the power of such blame (Bowen, et al., 2005).

In order to further understand blaming in family therapy, the research focused on therapists accounts and understanding of blame in systemic therapy. The research analyzed how therapists talk about families who blame and discuss what this says about the helpful and hindering aspects of the clinical interactions.

Semi-structured interviews were conducted with five experienced family therapists to obtain their understanding of blaming events in family therapy. The referral problems ranged from child soiling, child with asthma, mother with eating disorder, family bereavement, and adjustment to a step family. The therapists were shown video clips of family therapy which contained instances of blame within the therapy, then asked several open-ended questions regarding the clips (Bowen, et al., 2005).

The therapist's interviews were analyzed using a qualitative methodology. In the analysis, core themes were identified as well as categories within them. Of these, the most prevalent theme was related to "an unhealthy allocation of responsibility for

problems" (Bowen, et al., 2005, p. 315). This goes back to the initial source of referral where there is a bias against children and they are often thought of as the problem. It becomes difficult to pull the family together as a unit, as parents, and sometimes, therapists come to think that it's the child who needs to change (Bowen, et al., 2005).

The next most prevalent theme was identified as "family identity and cohesion" (Bowen, et al., 2005, p. 309). In this, the families' difficulties were understood as having little tolerance for the different ways of coping and priorities of other family members. Also, sometimes exaggerated, long-standing complaints were voiced repetitively over time. In another aspect of this theme, the families "commitment to each other" (Bowen, et al., 2005, p. 309) was a factor as some "family members often felt more responsible for each other than was reasonable, which may then lead to a problem of destructive blaming in the future." (Bowen, et al., 2005, p. 318).

The research posits that predetermined factors, such as a parent's childhood experience of abuse, has a strong influence on their parenting style. This was understood as being very fearful and excessively controlling in regards to their parenting style (Bowen, et al., 2005, p. 314).

Using the research of therapist observing the blame, a model was created which created categories and themes related to blame." The model suggests plausibly that within an episode of blaming we (therapists) may be pushed towards ways of thinking that are culturally bound and not consistent with any of the current theories of therapeutic thinking" (Bowen, et al., 2005, p. 325). For example, the researcher points out that we "live in a culture imbued with blaming and all have family experiences from early childhood onwards in which we have had intense feelings in relation to blame. " (Bowen,

et al., 2005, p. 325). Therapists may focus on rigid, problematic thinking of the family in ways that are too narrow in considering other possibilities.

In assessing the clinical implication of the study, the authors further assert the difficulty and complexity of being effective with families that blame in therapy. A weakness exists in that the authors do not offer a clear strategy in responding to blame, but imply use of multiple theories as each theory may only address one of the many themes found in the understanding of blaming (Bowen, et al., 2005, p. 326). "Hence there is a need to develop a therapy that can resolve this discrepancy." (Bowen, et al., 2005, p. 327). They warn against inflexibility, technique focused therapy, "at the expense of listening to the dialectical content and style of family conversations." (Bowen, et al., 2005, p. 326)

While the therapist participants were able to view the same instances of blame, they were not aware of the history and context in which this occurred. This would have provided a broader understanding of the families history and dynamics. Furthermore, as mentioned, the research's strength was in eliciting the therapist understanding of the blame and stressing how complex a dynamic this is. It was also effective in showing how therapists get pulled into the families blaming and how it can affect their thinking and interventions. A deficit still exists in not addressing the next important step, which is how the therapists would take all this into account and respond to the blaming. My research asks the same questions of how the therapists think about, define and may be affected by this behavior, but also, importantly, how would therapists intervene? The omission of this essential piece in this study and many others was further motivation for me and demonstrates the need for my study.

Constructionist and narrative approaches have looked at blame, its' detrimental effects on families and specific ways to intervene. "At least theoretically, therapeutic conversations (Gilligan & Price, 1993) vary in their specific practices, but share a focus on generating new ways to *imagine* and *image* the interpersonal worlds of family members" (Friedlander, Heatherington, & Marrs, 2000, p. 133). These approaches to family therapy "seek to engage clients in a joint project to think and talk about their lives in ways that highlight possibilities.....and solutions rather than problems" (Friedlander, Heatherington, & Marrs, 2000, p. 133). "Indeed, the expression of blame provides therapists who espouse a "not-knowing, nonexpert" ideology, a key element in constructionist and narrative therapy, with a curious dilemma since it is generally agreed and has been empirically demonstrated that blaming conversations are not healthy ones." (Friedlander, et. al, 2000, p. 141-142). Friedlander writes "We acknowledged the evidence that blame is a powerful attribution that, when expressed, provokes shame (Zuk & Zuk, 1989, anger and defensiveness (Buttney, 1990), obstructs intimacy (Greenberg & Johnson, 1988), and hinders problem-solving (Friedlander, Heatherington, Johnson, and Skownron, 1994)" (Friedlander, et. al, 2000, p 134). Furthermore, there are disagreements within these theories as to how to respond to blame.

From one perspective, "blame can be acknowledged by a therapist but should neither be confronted nor advised against. From another perspective, blame can prompt any number of therapist responses, including confrontation and advice" (Friedlander et.al., 2000, p. 134).

Hoffman (1992) advocates for a narrative approach where the therapist assumes a "not-knowing" non-expert stance (p.28) as the conversation which unfolds is most



important and the therapist should not "talk or manipulate" the client away from his ideas or position (p. 35). In regards to the blaming parent, this would likely translate to engaging with and being open to hearing more about and validating their blame of other family members.

Clarfield and Efran (1992) counter this approach and assert that a constructionist approach does not mean a therapist must avoid direct confrontation. Certain views from patients may not be necessarily valid and helpful in treatment and warrant an active intervention. The study by Friedlander, Heatherington, and Marrs (2000) included seven full-length interviews (therapy sessions) of prominent therapists providing narrative or constructionist family therapy and focused specifically on their responses to blame during therapy. The study included theorists Michael White and Ivan and Jeri Inger, as well as five other well-known family therapists. Six of these sessions were family sessions and one was a couples session.

The responses were categorized after the data had been obtained and the most frequent was identified as *ignoring/diverting*. "It should be noted that the term *ignoring* refers to deliberately not acknowledging the blame by interrupting, shifting the topic, or focusing on a nonblame aspect of the client's message" (Friedlander et. al, 2000, p. 140). This is a far more active and confrontational approach than one expects from a narrative or constructionist family therapist. "Indeed, following each of the blaming markers in the seven interviews, the therapists intervened in some way. In other words, ignoring did not take the form of simply allowing the blame to continue. Some kind of diversionary tactic was employed in every instance" (Friedlander et. al, 2000, p. 140). "In one interview, for example, a brother had been criticizing his sister's behavior; the therapist, anticipating

continued blame, interrupted to ask him a question that focused on his own feelings." (Friedlander et. al, 2000, p. 140). In another interview, the the therapist interrupted a mother who had been pressing her daughter to recount her misbehavior. The intervention replaced the mother's questioning with an opportunity for the daughter to say something positive about herself (Friedlander et. al, 2000)

"Blame on the part of a family member provides a challenge for all therapists, but perhaps more so for those who work from a narrative or constructionist perspective. If therapists want to avoid confronting their clients' versions of reality, what should they do when family members engage in mutual blame?" (Friedlander et. al, 2000, p. 141) This research illustrates how blame leads family therapists and theorists to find therapeutic interventions which may starkly contrast with their theoretical framework. Highlighting this adaptation that therapists make is one of its strengths. Additionally, the research shows what narrative/constructionist family therapists actually do in the room when confronted with blame. These interventions, coming from some of the major theorists is particularly important as it exemplifies that even they stray from a strict adherence to theory when confronted with blame.

A weakness of the research is the small sample size. There were only seven interviews. While blame decreased in session after the therapist intervened, the data only provides interviews of the therapist with a single family. How can one know that these particular interventions were not due to particular characteristics of the family?

Analyzing videotapes and categorizing interventions may be helpful didactically, but I think caution is advised before extrapolating this data and making assumptions without also having access to the therapists understanding and reason for interventions. My

research asks family therapists how they would intervene with a blaming, critical, monopolizing parent as presented in a vignette (Appendix A). And, of great importance, and lacking in this study, my research fills in the gaps, by asking clinicians what informs their thinking, what they would do as treatment evolved over time. This reflects another deficit in that the researchers are only seeing a single interview. We do not know how they would respond to blame over time. For example, in the Brief Strategic Family Therapy (BSFT) model, Hervis et al, 2003 notes that while the initial focus is on joining with the family members, over time the structure changes and the repositions his or her place as more of the chief facilitator of the therapy. Analyzing this data and drawing conclusions can be misleading without having the full scope of the therapists understanding and reasons for interventions.

Qualitative research by Stratton (2003) examined how responsibility and blame is attributed during family therapy. With a particular focus on attributions, an analysis was done on eight families in therapy over 10 sessions by videotape. The sample consisted of "six families with step-parents and a further two families in which all of the children were adopted and attending family therapy. Two contained both step- and biological children, and discussions sometimes concerned biological children of the step-parent who were living in different households. " (Stratton, 2003, (b) p. 141). For this study, the Leeds Attributional Coding System (LACS: Stratton et al., 1988) was used. It is "a manual which specifies fully the process of identifying and coding attributions." (Stratton, 2003, p. 141). This was done so the coding was consistent, annotated and interpretable. "Each attribution was coded on five attributional dimensions. In summary, definitions are as follows: Stable or Unstable (Will the cause operate reliably in the future?), Global or

Specific (Has it a range of important outcomes?) Internal or External (Does it originate within that person or thing?) Personal or Universal (Does the attribution differentiate that person or things from others?), and Controllable or Uncontrollable (Could the person or thing influence the outcome?)" (Stratton, 2003, p. 141-142).

The researchers found 1799 attributions or an average of 225 per family or just over four per minute (Stratton, 2003). In treatment, all of the families presented their children as "influencing the outcomes and as being affected by them, so the children were being given considerable-but not generally overwhelming-responsibility for the issues. It is particularly interesting that parents presented children as agents more often than themselves, but saw themselves as targets more often than their children...Furthermore these tendencies were stronger when considering only the (rather common) negative outcomes, where parents very rarely described their actions as affecting the children" (Stratton, 2003, p. 153-154). This pattern of parental attribution looks very much like blaming the children.

An example in which the child is being blamed and given responsibility for problems is exemplified in the following excerpt. The parent states:" If I (parent) stop pushing....B (child) is actually going to walk all over us. Because of the situation we're in...he causes conflict" (Stratton, 2003, p. 149).

More specifically, in looking at the definition of *Personal vs. Universal* in the following examples, *personal* attributions are made by parents about their child. The cause is true because this child was involved. "When he gets angry...he can get quite violent sometimes" (Stratton, 2003, p. 148). In contrast, *universal attributions*, the cause would be true for people in general, made by parents about themselves were:

"Those things concerned me (what J was doing)... I thought her behavior was becoming a little reckless.....it shouldn't be like this (having four children to look after when on call)" (Stratton, 2003, p. 148).

When focusing on negative attributions alone, parents were observed to see causes as Internal to child and External to themselves. "In their negative attributions about their children, parents generally saw the causes as more controllable and much more personal for the child than for the parent" (Stratton, 2003, p. 154). These findings are somewhat disturbing in this display of parents who locate blame within their children alone, affecting them greatly, and of which they feel their children could and should end on their own.

The research reveals some interesting findings regarding the different groups of parents and their relationships with their children. "Biological parents were least likely to choose causes in which the child had the main responsibility. Both step-and adoptive parents allocated more responsibility to the child, especially for negative outcomes, but the adoptive parents were also more likely to present a child as responsible for positive outcomes" (Stratton, 2003 (b), p. 174).

An example of a biological mother stating that her child did not have the main responsibility is illustrated with the following statements: "*Bio-mum*: You (Dad) have got angry with P and hit him...that's what it's (P's rages against his mother are) about." (Stratton, 2003 (b), p. 169). In contrast, adoptive and stepfathers allocated more responsibility for negative outcomes to their children (Stratton, 2003 (b)).

"Stepfathers saw causes as internal, especially when they involved a child. However their major difference in attributing was to describe the child as having far more

control over negative outcomes than did parents themselves." (Stratton, 2003 (b), p. 174). Not surprisingly, the children, likely internalizing this blame, described causes as more internal to themselves or this may be a strategy devised to avoid more problems (Stratton, 2003 (b)).

The research highlights important patterns of interaction, though the small sample size is a deficit and thus one can't make generalizations to the population as a whole from these results. Nevertheless, examining the multiple dimensions of blame, where each family member feel it is located, and whether it can be easily altered, for example has therapeutic implications. Such a process of inquiry in family treatment could lend itself to other important questions. The therapist may then ask "who else is to blame?... Does the child ever have different behavior?. . Who else can influence the choices that a child makes? How can he/she be helped to do differently?

Another weakness to this study, and in family therapy studies like this, are that the family may present a version of their interactions dissimilar to those outside this setting. As Stratton writes (2003 (b)) families may be displaying a more extreme version of their interactions to recruit the therapist to see how serious their difficulties are.

While this research fleshes out the complexities of blame, family therapists have been looking at this for some time (Bowen, Madill, & Stratton, 2005, Minuchin, 1982, Nichols, & Schwartz, 2006). While understanding the dynamics of how families blame is important, at this point I feel there is a breadth of different viewpoints on the subject of blame. What's more important, and what my study asks is taking into consideration how family therapists understand causation, what is their intervention, what is the next step? I feel that the focus of understanding how blame, or whatever clinicians call blaming,

shaming, and critical behavior plays out in family therapy is reflected in my studies' questions which ask clinicians how they conceptualize this behavior. Equally or possibly more importantly, I ask how this understanding relates to what they actually do in treatment, and what they do. With such an in-depth organization and understanding of blame, Stratton's research could be greatly improved by taking the next step and focusing on treatment interventions.

In considering blame, research has been performed which focused on how a specific type of questioning can elicit feelings of freedom and acceptance within a family. Such feelings are inconsistent with blaming. The research, tested Tomm's (1988) model that circular/reflexive questioning by family therapists elicited feelings of freedom and acceptance, and that strategic/linear questioning tend to elicit feelings of judgement and constraint (Cornille, Dozier, Hicks, 1998).

"Lineal questions involve an investigative intent whereby the therapist is attempting to unravel a complex mystery. The focus is on teasing things apart so that the origin of the problem is discovered. This questioning style is familiar and hence not surprising to most people entering therapy. If inappropriately used, however, lineal questions can serve to maintain a family's pathogenic perceptions and beliefs" (Cornille, Dozier, Hicks, 1998, p. 190).

An example of this type of questioning is illustrated in the following scenario:

*Ther:* What problems brought you in to see me today?

*Wife:* It's mainly depression.

*Ther:* Who gets depressed?

*Wife:* My husband.

*Ther:* What gets you so depressed?

*Husb:* I don't know." (Cornille, Dozier, Hicks, 1998, p. 191).

"Strategic questioning," from Tomm's (1988) model has a corrective intent.

"The therapist attempts to influence the family in a specific manner and assumes that instructive interaction is possible. The question indirectly tells family members how they erred and how they ought to behave. Strategic questions tend

to have a constraining effect on the family because the therapist is attempting to influence the family to think or do what he or she thinks is more healthy or correct, thus limiting the family's options" (Cornille, Dozier, Hicks, 1998, p. 193).

This type of questioning tends to put the therapist in opposition to the family.

The "circular questions" are those which "reflect an exploratory intent in which the therapist is attempting to bring forth "patterns that connect" persons, objects, actions, perceptions, ideas, feelings, events, beliefs, contexts" (Cornille, Dozier, Hicks, 1998, p. 192). This questioning opens the dialogue without an agenda and can be illustrated with an opening question from a therapist such as:

"How is it that we find ourselves together today?" (Cornille, Dozier, Hicks, 1998, p. 192)

The fourth type of questions are "reflexive questions." " Reflexive questions are driven by a facilitative intent. The therapist is attempting to guide or coach his clients to mobilize their own problem-solving resources" (Cornille, Dozier, Hicks, 1998, p. 193).

These questions are described as somewhat hypothetical and non-threatening. An example is:

*"Ther:* If you were to share with him how worried you were and how it was getting you down, what do you imagine he might think or do?" (Cornille, Dozier, Hicks, 1998, p. 193).

In Cornille, Dozier, & Hicks study (1988), three groups of forty intact families (n=120) consisting of a mother, father and adolescent son comprised the sample. The sons attended " the developmental research school of a large southeastern university....Participation by students and parents in the school's research activities is strongly encouraged." (Cornille et al., 1998, p. 194). Information regarding this school and its research practices and goals would be useful in better understanding the sample, but was not offered. We do know that the student body of "1500 (kindergarten through 12<sup>th</sup> grade) is preselected to represent a stratified sample of the states population in terms of race and family income." (Cornille et al., 1988, p. 194) Out of 96 families, 40



accepted a mailed invitation to participate in the study. The sons were between 15 and 18 and 75% of the families were white, 20.8% black and 4.2% identified as "other" (Cornille et al., 1998).

The families were randomly selected to view one of four 5 minute videotapes. Each video segment displayed a family therapy intake session with use of one of the four questioning styles (linear, strategic, circular or reflexive) as described above. The videotaped family and therapists were all professional actors. The content validity was assessed and approved by Tomm and two marriage and family doctoral students trained in Tomm's theory and method as correctly portraying his model of questioning. This model reflects Tomm's four questioning styles (linear, strategic, circular or reflexive) and that circular/reflexive questioning by family therapists elicited feelings of freedom and acceptance, and that strategic/linear questioning tend to elicit feelings of judgement and constraint (Cornille, Dozier, Hicks, 1998). Additionally, the family actors were not aware of the intentions and assumptions that the therapist actor was instructed to follow with regard to each of the four questioning styles. All member of the family completed the Family Therapy Alliance Scale (FTAS), "a 29-item, 7 point Likert-type FTAS.....The FTAS measures clients perceptions of the alliance on ther Interpersonal and three Content subscales..... The results indicated that circular and reflexive questioning styles elicited significantly higher ( $p<.001$ ) alliance scores on the FTAS than did either lineal or strategic questions" (Cornille et al., 1998, p. 195).

It is not clear why this research was conducted with nonclinical subjects (actors) and this is a weakness of the study. Another weakness lies in the inherent concern of validity with this design. "The family members could have done any of the following: (a)

identified with their corresponding role; (b) reacted to the taped family member's reaction to the therapist; (c) had a personal reaction to the therapist on the tape; (d) reacted to the questions themselves; (e) or a sum or interaction of a, b, c, and d." (Cornille et al., 1998, p. 196). Measures could have been taken to account for these threats to reliability such as using a camera angle behind the family so the nonverbal reactions of the taped family could not be seen by the participants (Cornille et al., 1998). On the other hand, the study does indicate that circular and reflexive questions help to build a therapeutic alliance in the early stages of treatment. While "joining" at the outset is extremely important, my study will be designed to investigate what type of questions are effective according to family therapists in middle and later stages of treatment as well, an essential component. The present study is also limited by only including families with one male child of a particular age, whereas my study will have therapists reflect on their experiences doing family therapy with a more diverse and varied representation of families.

In summarizing the relevant literature, it's important to reiterate the lack of specific literature or empirical research on how family therapists respond to blaming, shaming, critical, and unempathic parental behavior in family therapy.

Within the research on resistance it's clear there are different ways to understand and intervene. Family Systems Therapy (FST) view resistance more in the present and as a sign of the work to come. Brief Strategic Family Therapy (BSFT) with its roots in family systems and structural therapy think similarly. Resistance to them is also evidence of the family's difficulty adapting to a situation, and structural imbalances that need restructuring.

The methods used by these schools of thought are joining and restructuring. This respects the current structure by accepting "who is powerful." They advocate reasoning and working with whoever is at the top of the hierarchy in an empathic way. The eventual goal for the therapist is to assume a leadership role.

Psychoanalytic Family Therapy (PFT) differentiates resistance by noting the importance of a family's history and how much the past plays a role in the presence of these resistances. More of this literature, though not empirically based, views resistance as often expressed unconsciously and as in psychoanalysis, actions often have more meaning embedded in them. They also, do not feel resistance is an obstacle to therapy, but more of a guide. They too, go along with resistance, similar to the joining of FST. Evidence of a tension between approaches, PFT distinguish themselves from FST in not asking families to adapt to the notion that the "system" is dysfunctional. In a similar adversarial vein, FST state that PFT focus on individual histories and pathologize resistance in families.

Over time, it is not so much what Psychoanalytic Family Therapists PFT's "do" in treatment, but what unfolds. In the therapist allying with the resistant parents, seeing things from their view and being empathic, their defenses and projections dissolve, and as Love (1991) puts it "The family members are then able to further individuate. As they mature, their self esteem grows (p. 179). Thus, they can then "recollect and verbalize more spontaneously and progressively negative as well as positive feelings and experiences." (Love, 1991, p. 179). This process does resemble a maturation process from childhood and dysfunction and one can see the FST's claim that there is a pathologizing element.

As previously mentioned, in viewing this presentation as evidence of parental narcissism, the dearth of empirical evidence is reflective of the lack of such research on narcissism and narcissistic personality disorder. This more theoretical conceptualization is confined to a PFT (Psychoanalytic Family Therapy) perspective as such characterological understandings are not part of other forms of family therapy.

The understanding of this presentation as narcissistic is not necessarily separate from a view of it as resistance, but a sub-set. Within psychoanalytic theory, the narcissistic presentation is often understood as a form of resistance.

The literature emphasized the enormous challenge of working with such parents and how family therapists can easily be tempted into confronting the defensive projections of the narcissistic parent. Instead of this, what's consistently proposed is being empathic and attuned to the parent's early unconscious conflicts and underlying meaning of their behavior and statements.

In practice the PFT's goal is similar to that with resistance, helping them to differentiate from their children, mature, and effect stunted early development. That once safe enough, the parent will give up the narcissistic defenses and false self while allowing the healthy ego, stunted early in life to grow. This understanding does focus more on the individual parents presentation as the problem and in some instances, finds the setting of family therapy, while extremely challenging, to be an opportune venue for this work.

Similar to working with resistances in psychoanalytic family therapy, "going with the resistance" or narcissists projections and assertions is advised. Again, there is a similarity here with BSFT's approach to joining with "powerful identified patients." There is a consistent thread of using mirroring and modeling empathy. Some propose this

be done within the family and others advocate for using a co-therapist for support and for this modeling.

The last prominent conceptualization of blaming provided detailed descriptions of how blame can look and play out in families, though the studies lacked clear corresponding interventions to the blame. The research in this area that suggested or tested different interventions (Bry & Melidonis, 1995, Friedlander et al, 2000) lacked a consistent clear focus. Furthermore, those that purported a specific response had great limitations in reliability.

For example, Bry & Melidonis' (1995) research showed how families that blame responded positively to the therapist taking an empathic stance and focusing on exceptions to blame, but the sample size of only four families and concerns with coder objectivity effects the influence of this research.

In Cornille, Dozier, and Hicks' (1998) research which tested another response to blame, "circular and reflexive questioning," this was not family therapy, but families viewing and responding to a dramatization of an intake session with family actors.

Other research points to the debilitating affect blame can have on family therapists and how pervasive it is in our culture (Bowen et al., 2005). They also note how it forces family clinicians to stray from their theoretical framework, (Friedlander, 2000, Bowen et al., 2005) similar to some of the PFT research that believes in viewing this behavior as narcissistic (Guttman and Villeneuve, 1994). The Guttman and Villeneuve (1994) study propose co-therapy as an intervention to support the therapist. In contrast, the research focusing on blame only state the potential use of multiple theories (Bowen et

al., 2005) and straying from one's theoretical framework within constructive and narrative family therapy (Friedlander, 2000).

Even though constructive and narrative therapists have looked at responses to blame, the only certainty is a lack of cohesiveness and clarity within this theoretical framework. This lack of clarity of interventions has led me to view blame as a prominent facet of the parents' presentation, but the research is not strong enough to warrant it as a separate question of conceptualization on its own.

Consequently, blaming was integrated into the general presentation of blaming, shaming, critical behavior with a lack of empathy and not treated as a separate category in my survey.

## CHAPTER III

### METHODOLOGY

The purpose of this research was to examine how family therapists conceptualize and respond to monopolizing, blaming, shaming and bullying behavior from parents in family treatment.

#### *Sample*

For this research, a family therapist was defined as a licensed PhD, PsyD, M.F.T, or equivalent licensed marriage and family therapist or L.C.S.W or equivalent licensed social worker that conducts family therapy for ten percent or more of their current caseload, or ten percent cumulatively over the past three years. A family therapist may also be defined as one meeting the above licensing requirements and who has a minimum of 10 years experience of practicing family therapy and/or training, supervising, or teaching others family therapy combined and they need not be currently carrying a family therapy caseload. In an effort to achieve the desired sample size, I broadened the scope of the clinicians' type of training.

Table 1

Demographics

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n=19		Female n=15 (79%)	Male n=4 (21%)
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Race			
	White	18 (95%)	
	Other (Haitian)	1 (5%)	
Mean Age	All Participants	52 years	
Degree			
	M.S.W.	10 (53%)	
	Ph.D.	4 (21%)	
	Psy.d.	3 (16%)	
	M.F.T.	2 (11%)	
	Other	1 (5%)	
Years of Family Therapy Experience			
	6-9 years	3 (17%)	
	10-14 years	5 (27%)	
	15-19 years	2 (11%)	
	20+ years	8 (44%)	
Current (mean) percentage of Family Therapy			
	All Participants	32%	
Settings			
	Private Practice	8 (44%)	
	Inpatient	6 (32%)	
	Outpatient Clinic	9 (47%)	
	Other	4 (21%)	

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There were 19 family clinicians (n=19) that participated in my study and completed the survey (Appendix B). 14 were female and five were male. The goal of recruiting a more diverse sample was not achieved. Of the 19 participants, 18 were White and one participant identified as Haitian. The age range was from 31 to 67. The average age of all participants was 52 years and the median age was 50 years old. Eight participants had M.S.W. degrees and this was the most prevalent degrees. Two of these eight M.S.W. participants went on to obtain doctorate degrees. Three family clinicians had Psy.D.'s and four had Ph.D.'s. Two participants held other master's level degrees. The remaining four family clinicians did not provide their degree.

The overall sample had more years of family experience than expected. The largest category, eight participants had twenty years or more of family therapy experience. Five participants had 10-14 years of experience. All of the participants had at least six years of family therapy experience.

The average current caseload of the participants was 32 percent, ranging from 0 percent to 100 percent. Sixteen of the participants had ten years or more combined training, supervision, and/or teaching family therapy. Most participants practiced family therapy in a variety of settings with only three that practiced exclusively in a private practice. Participants worked in the survey's (Appendix B) categories such as inpatient, outpatient, private practice, but also stated practicing family therapy in private nonprofit agencies, child and family organizations, residential, school based programs, and in residential drug treatment facilities.

Overall, this was a smaller sample than expected, but the participants had more years of family therapy experience than anticipated, and a great depth of knowledge as evident by the high percentage of family therapy supervisors, teachers and trainers.

The survey (Appendix B) was designed to delineate family clinicians' theoretical orientation, education, years of experience and explored if this influenced their interventions with the described behaviors in parents. The survey did not exclude participants based on race, gender, ethnicity, or age as I hoped to recruit a diverse sample. There appears to be a lack of diversity among therapists in general. For example, while Smith School for Social Work has made efforts to recruit more students of color, the majority are still white women. In retrospect, a more diverse sample may have been obtained through contacting family agencies that worked with families of color. This effort assumes staff reflects the client population they serve and this is not always the case.

### *Research Questions*

There are so many different views of this behavior and how the therapist should respond to it. I was interested in exploring the following research questions: How do family therapists respond to monopolizing, blaming, critical and unempathic behavior from parents in family therapy. I was also interested in how family therapists conceptualized this behavior. Specifically, did they think of this behavior as resistance to treatment or as representative of narcissism in the parent, or was it attributed to something else? I was also interested in the therapist's background, training, current theoretical framework used and how this influenced their interventions with monopolizing, blaming, critical and unempathic behavior in parents. Furthermore, I was

interested in any other factors that effected family therapists interventions in this situation.

I hypothesized that therapists responded to monopolizing, blaming, critical and unempathic behavior in parents in a way that was influenced more by clinical practice experience than their theoretical orientation.

### *Research Design*

This study was conducted using a quantitative and qualitative fixed method design. The study was descriptive because a descriptive study gives more information about a situation in order to clarify if there are certain phenomena at play. I also used this approach because there is a lack of research on this subject. It was not my intention to manipulate any variables.

### *Recruitment*

The means of recruitment for this survey was through my professional contacts and through contacting family therapy organizations nationwide. I sent my recruitment flyer (Appendix D) containing the survey link to The Association of Family Therapists of Northern California (AFTNC) for distribution and followed up with a voicemail. With my relationship with Pamela Parkinson, Director of Training at " A Better Way," in Berkeley, CA, she agreed to distribute my anonymous survey to her contacts in The Brief Strategic Family Therapy (BSFT) network of clinicians. The recruitment flier was also circulated via email to family therapy professors, supervisors and psychoanalytic and systemic family clinicians nationwide for distribution to settings known to conduct family therapy.

The recruitment email described the purpose of the survey (Appendix B) and the inclusion criteria for participation, and had a weblink to the survey. The first page of the survey monkey weblink was the Informed Consent (Appendix C).

### *Ethics and Safeguards*

The Informed Consent outlined the study in greater detail, including the potential benefits and risks of participation, the ethical standards and measures to protect confidentiality, and the researcher's contact information for questions and comments. Each participant agreed to the Informed Consent. Potential risks for participating in the study was that clinicians could experience difficult emotions while reflecting on the vignette in the survey or their past experiences as a therapist or even perhaps in their own family of origin. These risks were stated in the Informed Consent. Survey Monkey does not collect any names or addresses from the participants. Any identifying information from qualitative data will be disguised during presentations to protect confidentiality. Data will be stored in a locked file for a minimum of three years as required by Federal regulations and then destroyed if no longer needed. The researcher received approval from the Smith College School for Social Work Human Subjects Review Committee to conduct this study (see Appendix E).

Participants may benefit in several ways by taking part in the study. They will be able to share their experiences and interventions doing family therapy. From my conversations with family therapists, the particular dynamic of monopolizing, critical parental behavior with a lack of empathy is a very challenging one. Knowing that one is contributing to a better understanding of this can be beneficial to participants.

### *Data Collection*

Data collected for this study took place through Survey Monkey, a web-based service used to help create survey instruments and electronically collect responses. Information was collected solely through the online survey.

The use of a survey for data collection has strengths and limitations. The guaranteed anonymity is a major advantage. Survey Monkey does not collect any names or addresses from the participants. Survey Monkey reports information for the group and not for an individual so it collects demographic information if you want, but does not link it to any particular individual.

A weakness of the electronic questionnaire is that it excludes respondents without email or internet access. This has become less of a concern in our internet based lives where the large majority of professionals have such access. Another strength of the online survey is its easy access to those who use the internet. Snowball sampling and dissemination to other potential participants is also easily achieved over the internet and saves considerable time and money.

One advantage of creating the survey instrument is that it was created specifically for this study. However, a limitation is that this type of instrument has not been tested before (Anastas, 1999).

In the survey, participants were asked some demographic information. Information regarding age, race, gender as well as their general educational background was explored in part to illuminate whether I have been successful in recruiting a diverse sample and could generalize my results from the sample to the larger population of family therapists. Also, this was important to see if these factors related to their interventions in family therapy. Respondents were asked specific information regarding

their training and theoretical orientation. This section gathered information designed to help me in understanding each respondent's theoretical framework and how that influenced their approaches to these types of parental behavior.

### *Data Analysis*

Descriptive statistics were used to describe the sample population itself. The survey data was processed through Survey Monkey ([www.surveymonkey.com](http://www.surveymonkey.com)), the online instrument used to collect the responses. Survey Monkey provided reports and Smith's statistical consultant, Marjorie Postal provided additional analysis.

Inferential statistics were also used to describe how variables related to each other such as t-tests between subgroups as a function of age, degree, or any other characteristics that are clearly associated with particular responses. Content analysis was used for the qualitative open-ended questions and themes and exceptions were observed. This researcher did the content analysis. Findings and Discussion chapters of this research to follow.

## CHAPTER IV

### FINDINGS

The study was designed to explore how family therapists responded to monopolizing, bullying, shaming and unempathic behavior by parents in family therapy. I was also interested in how they conceptualize this presentation. Participants read the vignette (Appendix A) describing Mr. Brown's behavior and then answered the questions below Table 2.

Table 2

Views of Mr. Brown's Behavior (Bx) and Mean Age

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	Mean Age (in years)
All Participants (n=19)	52

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Views of Mr. Brown's Bx	Mean Age (in years)
Views Bx as Narcissism (n=6)	45
Views Bx as Resistance (n=5)	47
Does NOT view Bx as Narcissism (n=11)	60

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Question 1: With a parent displaying monopolizing, blaming, shaming, critical behavior with a lack of empathy similar to Mr. Brown, I view this behavior as narcissistic.

The average age of all family therapists participants ( $n = 19$ ) was 52 years old. 11 participants did not view Mr. Brown's behavior as narcissistic when asked the question above. Their average age was 60 years old. These participants were then directed to the following,

Question 2: Viewing monopolizing, blaming, shaming, critical behavior with a lack of empathy from a parent towards others in family therapy as narcissistic is NOT useful.

Of the 11 participants, six agreed and two strongly agreed with the above statement regarding narcissism. There were several references to the negative effect of such "labeling."

Question 3: I view Mr. Brown's behavior as resistance to treatment

There was a significant difference in mean age by BRNARC ( $t(8)=3.326, p=.01$ ), with the mean age of those who agreed ( $m=44.5$ ) lower than those who disagreed ( $m=59.5$ ). Of the 11 participants discussed above that did not view Mr. Brown's behavior as narcissistic, ten out of 11 also did not view his behavior as resistance to treatment either. Of these 11 participants, those that disagreed with the idea of viewing this behavior as narcissism had an average age of 60 years (See Table 2). Those that also believed that viewing the behavior as narcissistic as not useful had an average age of 58 years.

Both these groups of individuals were older than the group of participants as a whole in the study (mean = 52 years). Not surprisingly given their older age, they also had the most years of family therapy experience. Of the eight family therapists that had



20 plus years of family therapy experience, six of them were in this category. It appears that these individuals do not think labeling is useful.

One participant stated "Once a person is labeled with a personality disorder it's harder to look for the function and need for his behavior to himself" Speaking to the labeling as well as the desperation that may ensue, another wrote, "too often, a therapist may feel that an Axis II diagnosis cannot be helped and, therefore, feels defeated at the outset." This is a valid point as I've noticed in my clinical training that some clinicians were weary to work with Axis II (personality disordered) patients. The reasons for this were that such disorders are characterological, ego-syntonic, and patients were "demanding and difficult" and behaviors rarely changed. A clinician of multiple theories wrote "Although always an interesting hypotheses, I don't get caught up too quick in such loaded terms such as narcissism, borderline or especially anti-social."

In contrast, those family therapists that viewed Mr. Brown's described monopolizing, blaming, shaming and unempathic behavior as narcissistic (n =6) had an average age of 45 years. Those that viewed this behavior as resistance had an average age of 47 years. Both groups were much younger than the previously described group. These individuals were younger than the mean age of the sample as a whole and younger than those who did not label the behaviors as narcissistic.

*Theoretical Orientation:*

Question 4: My theoretical Orientation(s) in Family Therapy are (Choose all that apply)

Seventeen participants answered the above question. It was surprising to see that 15 of the 17 participants chose more than one theoretical orientation in family therapy. Seven of these 15 had three or more theoretical orientations in family therapy or chose "eclectic" in explaining their orientation. The researcher had not anticipated each participant subscribing to multiple theories. Such findings are important as they limit the study's ability to differentiate views on resistance and narcissism stemming from single theoretical orientations.

Ten of the 17 participants had a psychodynamic/psychoanalytic as well as a structural (family systems) theoretical orientation to family therapy. All but three of the participants stated that their theoretical orientation in family therapy was a prominent influence in their intervention with Mr. Brown's behavior. These three also described their theoretical orientations in family therapy in the most eclectic ways. Some narrative descriptions of their orientations follows: "A mix, mostly experimental..." Another clinician wrote "Existential, humanistic, Interpersonal psychology, object relations, developmental" in describing their theoretical orientation in family therapy.

It was not possible to explore statistical significance of theoretical orientation and views of Mr. Brown's behavior as narcissism, or resistance because of the small sample size and because individuals primarily chose multiple theoretical orientations in family therapy.

Despite this, participants commented in ways that clearly reflected certain theoretical orientations. Still, their choosing multiple theoretical orientations complicated this. After reading the vignette, participants were asked the following question:

Question 5: How would you respond to Mr. Brown's behavior in family therapy? Please provide a brief statement for each stage of treatment (1-Early, 2-Middle and 3-Later phases of treatment)

The two participants that chose only a structural (family systems) orientation responded in ways consistent with the literature. One stated:

1. Try to engage with all family members. 2. Understand that the conflict between the father and son might suggest underlying marital conflicts. 3. Understand the developmental phase of the adolescent launching and its effect on family homestasis.

Along these same lines the other structural family therapist wrote: "Bring the conversation back to Mr. and Mrs. Brown."

Joining and understanding things from Mr. Brown's perspective and use of positive reframes was noted by other family therapists that had a structural orientation in addition to other frameworks. One participant with a psychodynamic, cognitive behavior, structural and developmental orientation stated:

Join with him (Mr. Brown) around his obvious caring for his family (or they would not be there) and highlight how hard he works on behalf of taking care of everyone. Empathize with how difficult it must be to carry such significant responsibilities at work AND to have to be there for his family at this tough time.....Use positive reframes by representing his directiveness and interrupting in sessions as evidence of his concern and desire to help the family in whatever ways he can.

This approach and reframe very much focused on empathic attunement and understanding of the dominating parents' plight.

Contrasting this approach, (in response to the above question) other participants described making a clearer acknowledgment of Mr. Brown's behavior in ways that did not frame it positively. This acknowledgment was done in several different ways. One participant with an "eclectic" family therapy orientation states building rapport initially and not confronting him, "but in middle and late phases of treatment I would verbalize my experience. Also I would create safety so others could speak to this dynamic as well." Similarly a structural and narrative therapist would "encourage other family members to share their experience regarding each other and Mr. Brown. Ground rules have to be set about no interruptions." Another wrote in the 3<sup>rd</sup> stage "confronting the behavior more directly...." A family clinician with a multi theoretical background began by writing "1. Establish the rule of no interrupting in therapy, and be consistent in enforcing it." These clinicians that confronted Mr. Brown's behavior more directly had less systemic (structural) responses throughout their narratives.

Some family clinicians exhibited a more psychoanalytic approach in identifying Mr. Brown's behavior as narcissistic, and in their response to him. Investigation of his history played a far more important role. A multi theoretical clinician responded to the vignette question above in a way reflecting this approach. This clinician reflected on current work with a mother that has little empathy for her daughter. " I have empathy for both her daughter and for this mother. I hope this will help her have empathy for her daughter. Mother needs some support/empathy prior to having empathy for her daughter."

To the same question, another responded "with all narcissistic defenses, it is key that the patient feel understood and not blamed for his actions."

Two other clinicians, both with psychoanalytic and structural orientations made clear reference to the importance of Mr. Brown's history.

If he responds to my influence and softens his approach to other family members I would get him to talk about his experiences as an adolescent and what his relationship to his parents was.

Similarly, another states,

I would probably be working under the premise that Mr. Brown came to be the way he is through a series of dynamic events. To the extent that we would need to understand these dynamics in order to better understand him, we might need to explore some of his own history in therapy. He may or may not be comfortable with this; however, if these dynamics, or any other family member's dynamics (for example, substance abuse) are interfering with the family's progress, we might suggest individual support/ intervention with a separate therapist.

In the second quote, the therapist believes that Mr. Brown's narcissistic presentation must be addressed analytically. It is presented by this clinician as so pervasive that separate individual treatment might be indicated.

This is in stark contrast to another psychodynamic/structural identified clinician that strongly disagreed with viewing Mr. Brown's behavior as narcissistic, and did not feel Mr. Brown would be difficult to work with at all. She states:

This presentation of a parent is often very TYPICAL in family therapy....Using these strategies, (positive Reframing, empathy) in my experience, results in these behaviors decreasing significantly and wonderful work happening on behalf of the client and rest of the family. Thus, I would likely not have to worry too much about how to respond to Mr. Brown's behavior in the other stages of the treatment.

It's notable that with the similarly identified theoretical frameworks, there is a very different approach to this presentation and to family therapy in general. While only two clinicians identified as having only one theoretical orientation, it appeared that many

of the clinicians adhered to one particular framework throughout the survey, despite choosing several.

*Family Therapy Caseload:*

Table 3

Clinicians view of Mr. Brown's Behavior (Bx) and percent of family therapy caseload

n=19	View Bx as Narcissism n=6	View Bx as Resistance n=5	Viewing Bx as Narcissism <u>not</u> Useful n=8
<b>Percent of Caseload Devoted to Family Therapy</b>			
Currently	12%	16%	53%
Combined practice, training, supervising, teaching	23%	30%	45%

Question: Please estimate percent of caseload devoted to family therapy.

- Currently ?
- Cumulatively over last three years?
- Ten years or more combined practice, training, supervising, teaching family therapy?

The average current family therapy caseload of all participants was 26 percent.

The average current family therapy caseload of those that viewed Mr. Brown's behavior as narcissistic was just 12 percent. For ten years or more of combined practice, training,

supervising and teaching family therapy their average was 23 percent. In contrast, the family clinicians that felt viewing Mr. Brown's behavior as narcissistic was not useful currently carried an average 45 percent family therapy caseload. For ten years or more combined practice, training, supervising and teaching family therapy their average was 53 percent. For the participants that viewed Mr. Brown's behavior as resistance, the average current caseload was 16 percent. For ten years or more of combined practice, training, supervising and teaching family therapy their average was 30 percent. So, those that didn't view Mr. Brown's behavior as resistance or narcissism did more family therapy work than the other participants (see Table 3).

In summary those clinicians that viewed Mr. Brown's behavior as narcissistic had the smallest current family therapy caseloads. They also had the lowest percentage of clinicians teaching, training, and supervising family therapy. This is also true for those who viewed it as resistance. It's necessary to note these categories were not mutually exclusive and those viewing the behavior as narcissistic and resistances were often the same clinicians. For example, five family clinicians viewed Mr. Brown's behavior as resistance. Four of these five clinicians also viewed his behavior as narcissistic. It seems that these clinicians are more comfortable labeling.

#### *Other Approaches:*

One notable finding was the prevalence of other "unconventional" approaches that were not anticipated. A clinician that specialized in "helping adult and children of narcissism" emphasized an approach where family members

reverse role with him (Mr. Brown) and speak as him, have Mr. brown speak as each family member in response to his behavior/statements. 2. Explore through doubling techniques (by family members) the deeper emotional voice continue role playing with "who does Mr. Brown remind Mr. Brown of?" Have him role play with that person and role reverse.

Doubling is a technique where a participant, often asked by the therapist, supplements the role (self, role reversal) of the client usually by standing behind them and saying things that the client might want to say or is withholding. In this way one is able to hear things that may (or not) reflect what they feel or think. In this way the doubling can help provoke deeper emotions, mental catharsis, insight, and transformation (Farmer and Geller in Gershoni's eds, 2003)

Another structural/narrative clinician responded that they'd use the "'Holy Mackerel" approach to comment on the feeling messages in a manner that simultaneously noted the inevitable hurt between members and admired self-portraits being offered by each family member." I am not sure, but surmise that the "Holy Mackerel" approach is a technique whereby the therapist expresses his or her own bafflement to get the family to take their issues seriously.

One clinician said "I would ask to talk with him alone and would talk to him a bit about how he is behaving and see whether he is aware of his interrupting" and his feelings towards other family members. This clinician would also have "meetings alone" with the son, the mother and then possibly "the couple together or with father and son to continue the discussion of the problem..."

A clinician viewing Mr. Brown's behavior as narcissistic notes "A difficult personality type for example a narcissist, I would utilize dialectical interventions



combined with systemic interventions." There were also multiple concerns about a history of violence and possible abuse as well.

In summary, participants chose multiple theoretical orientations, but their descriptions adhered to a particular framework. There were different views regarding acknowledgment, confrontation and understanding of his behavior. The family therapists that did not label his behavior as narcissism or resistance were older, had more family therapy experience and currently held a larger family therapy caseload. These findings will be discussed in greater depth in the following discussion chapter.

## CHAPTER V

### DISCUSSION

The research findings illuminate the complexity of family therapy. One finding that surprised me involved the theoretical orientation of family clinicians. The researcher was wrong to assume that clinicians would choose one particular framework for family therapy. Perhaps this is because clinicians are exposed to many theoretical frameworks in their education and training. This belief was influenced by my mentors and supervisors in the clinical social work field that describe themselves this way (as adhering to one particular theoretical orientation).

Hypothesis: Family therapists respond to monopolizing, blaming, critical and unempathic behavior in parents in a way that is influenced more by clinical practice experience than theoretical orientation.

It was not true that clinicians ascribed to a particular central theory in their practice and therefore this question could not be statistically assessed. However their comments often paralleled the literature as described in Chapter IV. In this way, they were responding to this type of presentation in a way that was more from theory than just clinical practice. These responses were not consistent with my hypothesis. The question then is: Are they simply regurgitating theory and possibly denying the real impact of this behavior? This unanswered question may be the more important one. A weakness of the whole study is that it's not real practice, just a vignette. So, perhaps many of these clinicians would be forced to respond very differently from what they claim, when

actually in the room with a monopolizing, blaming, shaming parent. The small sample size limits statistics and the ability to generalize the findings.

### *Age*

While strict adherence to a single theory was not a clear factor, it was found that those that viewed this behavior as narcissistic or resistance were considerably younger and had a smaller family therapy caseload. They were also far less involved with family therapy supervising and teaching. This finding was a surprise and was not mentioned at all in the literature. While those older clinicians of various theoretical frames often felt such terms, particularly narcissism, were negative labeling, the younger ones used the term quite freely.

The findings that the older clinicians frowned on labeling and were far more engaged in family therapy may be reflective of the changing times within the field of psychotherapy and family therapy. Some of the older clinicians were educated at a time when family therapy had a stronger influence in the general field of therapy and in education. The well known pioneers of family therapy such as Salvador Minuchin, Virginia Satir and Murray Bowen were all at their heights during the 1960's and 1970's. They were all also more systems oriented as psychoanalytic family therapy, more of an anomaly, is not what people think of when they think of family therapy. Satir died in 1988 and Bowen in 1990. Minuchin, now in his 80's, is semi-retired today, but has an active family therapy training institute in New York. It is likely that the older, more systems oriented clinicians practice in a way reflective of the heyday of family therapy. The suggestion here is not that family therapy is of the past. There is a community of

family therapists who are very committed to its teaching and development, but over time it appears that the movement is not what it was because of several possible factors.

One must take into consideration the HMO movement and its emphasis on evidence based treatment approaches. Gawinski, Lyman, McDaniel, et al., (1994) wrote: "For the most part, the field of family therapy itself has not done much in the way of convincing empirical research which demonstrates the efficacy of its treatments"(p.121). Those conducting research in BSFT might dispute this claim, but I think this is the perception, whether true or not.

Consequently, the decreased viability of family therapy today is reflected in my own graduate studies at Smith SSW. There is only one compulsory introductory family therapy course. The more advanced family therapy courses are rare. As a training ground for tomorrow's social work clinicians, the dearth of courses is likely reflective of the decreased demand for family therapy skills. Further evidence of today's younger clinicians having less of a need for family therapy experience was noted at my internship at Kaiser Permanente psychiatry in San Francisco, the largest H.M.O. on the west coast. At this placement, family therapy was no longer a service offered to members. Only individual, evidence based CBT was available.

It makes sense that the younger clinicians were more willing to consider individual pathology, what would be considered "labeling" from the perspective of the older, more systems oriented clinicians. From the psychodynamic perspective, narcissism and resistance do not have to be pejorative terms but are used as ways of diagnostically understanding patients to best help them. As one of the clinicians wrote in my study, a

major consideration with Mr. Brown was "how narcissistically fragile he appears to be, which would determine how able he is to integrate interpretations."

#### Theoretical Orientation

My central question of how family therapists respond to monopolizing, blaming, shaming and unempathic behavior was answered in a plethora of ways. As stated in the findings the two clinicians that chose only a structural (family systems) orientation responded in ways consistent with the literature. One clinician stated "Understand the developmental phase of the adolescent launching and its effect on family homeostasis." This quote emphasizing engaging in the initial stage is consistent with structural theory and BSFT, which grew out of structural theory as discussed in the Literature Review. There is a clear point to appreciating family structure and "homeostasis" as being affected by the conflict as consistent with the literature (Brickman et al., 1988). Noting how the father-son conflict may be reflective of marital conflicts reflects the hierarchical importance of parental relationships, and how this is a systemic issue, not one of individual characteristics of Mr. Brown.

Along these same lines, the other structural family therapist wrote: "Bring the conversation back to Mr. and Mrs. Brown." Structural theory views this as an effort to restore balance and authority to the family system (Minuchin and Fishman, 1981). While theory views things this way I wonder how Mr. Brown would respond to the conversation being consistently brought back to him and his wife. It was not stated above, but I think it's even more important that this is done in a way that respects him and is brought back delicately, asking him in a way, for approval. The concern is that if Mr. Brown senses it's being brought back to him in a way that feels blaming, he'd likely react negatively.

Joining through positive reframes and empathic attunement from the participant that stated "highlight how hard he works on behalf of taking care of everyone" was discussed in the Findings section. This participant with a psychodynamic, cognitive behavior, structural and developmental orientation described a solid family systems approach to resistance. Weidman (1985) states "... reframe the interrupter's behavior as "doing all the work for the family." This person often feels overwhelmed because she feels the complete weight of responsibility for the family" (p. 103). The participants comments mirror this literature, yet she identifies also as psychodynamic and cognitive-behavioral.

The family clinicians that viewed Mr. Brown's behavior as narcissistic and exhibited a more psychoanalytic approach were also often consistent with the literature. The literature describes the parental narcissism as evidence of early developmental losses and the joining and mirroring by the therapist helps the parent slowly mature and verbalize positive and negative feelings in seeing the therapist do this (Love, 1991). The multi theoretical clinician that reflected on current work with a mother that had little empathy for her daughter and modeled empathy embodied this. The other responses that stressed the importance of looking at the dynamics of Mr. Brown's childhood were described in a way consistent with the psychoanalytic literature (Freud, 1914, Kernberg, 1975, & Kohut, 1977). These clinicians with structural and psychodynamic orientations clearly leaned towards individual history and make little mention of structural balance or homeostasis. It's as if their stated structural (systems) orientation is dormant or forgotten.

In considering this behavior as narcissistic, the literature clearly emphasized this as a psychodynamic/psychoanalytic family therapy perspective. It is not even discussed

in the structural or family systems theory or research. My findings revealed a different reality in practice. Many of those who viewed this behavior as narcissistic also identified as structural/systems clinicians in addition to other frameworks. Even one clinician identifying solely as a structural/systems therapist agreed Mr. Brown's behavior was narcissism. And yet, some clinicians that thought this term was not useful, said they were psychodynamic clinicians, in addition to other frameworks.

While most clinicians identified as multi-theoretical, it appeared that a particular framework may be at the core of their view of family therapy. While there was not a clearly illustrated connection between theoretical framework and intervention, usually one frameworks' consistent thread ran throughout their answers showing that one view was more central to their work. Perhaps, over time, clinicians come to have a central framework and then take parts of other theories that appeal to them.

Perhaps having a strong view that narcissism was not useful, and having very central systemic views, as one clinician did, even stating "Mr. Brown would be easy to work with as a family systems clinician" did not mean that clinicians couldn't also use some aspects of psychodynamic theory. They likely drew on psychodynamic concepts to a lesser extent.

In following these clinicians that did not identify solely as structural, but whose answers consistently reflected this, their interventions and views were consistent with the structural family therapy literature. They regularly described understanding how the hierarchical structure of the family was out of balance, joining with all, but especially the most powerful individual, in this case, Mr. Brown. Ways of engaging and joining with Mr. Brown were "positive reframes" such as understanding his "directiveness and

interrupting in sessions as evidence of his concern and desire to help the family." These methods are consistent with those described in BSFT literature (Weidman, 1985, Brickman, 1988).

Similarly, some therapists identifying with multiple theories, answered in ways consistent with the PFT literature. They had no qualms about using the term "narcissism" and paid great attention to Mr. Brown's early developmental history, in line with the literature. The suggestions that this exposure in front of his family may be too threatening and individual treatment might be indicated is important. Like the PFT literature (Love, 1991, Kohut, 1977) it stresses the personal history and developmental issues, but takes it even a step further. There's the suggestion that his individual, characterological issues, ie. "narcissism" are so important to address," to understand" and that this is essential, and may warrant another form or treatment that is purely focused on this understanding.

In retrospect, I think the question regarding participant's family therapy theoretical orientation should have been phrased differently. Better understanding the weight of each orientation could have been achieved by asking clinicians to rank the influence of each theory in their family practice, supervision etc." This could have provided a better guide to their central theoretical views rather than allowing them to "choose all that apply" without regard to the strength of each. This was a weakness in my survey instrument (Appendix B), reflects the limitation of creating it myself, and it not being previously tested. Future studies could address this issue.

Of the five clinicians that viewed Mr. Brown's behavior as resistance, four of them also viewed it as narcissism. This congruence lends itself to considering the concept



of narcissistic resistance. This concept has been somewhat obscure in psychoanalytic literature. This may be linked to the fact that Freud omitted it from his classical list of resistances (Segel, 1969). Some, but not all psychoanalytic clinicians, may view narcissism as a form of resistance, but others, (Margolis, 1984, Segel, 1969) and one in this study, viewed it as part of the broader category of defensive communication. None of the clinicians use the term "narcissistic resistance." When describing her intervention while viewing him as narcissistic, this one clinician states "with all narcissistic defenses, it is key that the patient feels understood..." Similar to the literature, (Segel, 1969) this clinician seems to view narcissism as part of the larger category of defenses. The study could be improved by asking clinicians their thoughts on the term, "narcissistic resistance."

#### *Family Therapy Caseload*

The findings were that those clinicians that viewed Mr. Brown's behavior as narcissism or resistance had smaller family therapy caseloads and had a lower percentage of family therapy training, supervising and teaching than those that did not view the behavior as either. These clinicians could be viewed as less "family-focused" therapists. This is connected to them being younger, and likely having less exposure in school as explored above. In this light, the question: How do family therapists respond to blaming, shaming, monopolizing behavior from parents could be viewed as more correctly answered by those older clinicians that have had more exposure, training, and are currently doing more family therapy. Their answer was that they avoided labeling, used positive reframes and respected the hierarchical structure of the family.

On the other hand, just because the younger, more individual, psychoanalytically oriented clinicians may not have a high percentage of family therapy, and may be less "family-focused" therapists, does not mean that their intervention would be less effective. In fact, far more of clinical work today is moving towards evidence based and empirically tested. In managed care, this is primarily focused on individual therapy research. So, these younger clinicians may lean towards interventions that address the history and individual plight of Mr. Brown and other parents in a way that is more research-proven. While this may be so, we must be careful not to generalize because of the small sample size. We must also be aware that these less "family-focused" therapists were also more psychodynamically oriented. Despite the existence of evidence based individual psychodynamic research, the perception put forth by H.M.O's and the insurance industry is that short-term CBT (cognitive behavioral therapy) is the only research proven therapy. Further research with a larger sample size containing therapists with CBT, Psychodynamic and other orientations is needed.

#### *Other Approaches*

There was a plethora of "other" non-traditional approaches to Mr. Brown's behavior in my study. Such findings may speak to how pervasively challenging this presentation is, and that it requires different, creative and specialized interventions. One of the participants identified theoretically as "a mix, mostly experiential" and reports that she specialized in "helping adult and children of narcissism." She made reference to learning from "Chris Farmer Phd (UK family therapist, psychodramatist) and Marcia Geller (CT). " Conceived and developed by

Jacob L. Moreno, MD, psychodrama employs guided dramatic action to examine problems or issues raised by an individual (psychodrama) or a group (sociodrama). Using experiential methods, sociometry, role theory, and group dynamics, psychodrama facilitates insight, personal growth, and integration on cognitive, affective, and behavioral levels." (American Society of Group Psychotherapy and Psychodrama, 2006). The methods of psychodrama have been used with systemic and Bowenian family therapy. They're described as being commonly done in a group, couple or family setting and focus more on helping relationships rather than on an individual pathology (Farmer and Geller in Gershoni's eds., 2003). The literature on psychodrama does not appear to reflect a focus on narcissism and this seems to be the specialization of this particular participant that is also a psychodrama therapist. The use of role plays and doubling may be helpful to work with this particular presentation that this therapist views as narcissism. Further research in this area is recommended. Nevertheless, her stated specialization of using psychodrama in "working with parents and children of narcissism "lends itself to the view that this is a special problem requiring special interventions. Furthermore, the psychodrama interventions, "The Holy Mackerel Approach" and the Bowenian oriented way of speaking alone with Mr. Brown and other family members support the use of new and creative responses. Additionally, the acknowledgement of his behavior ranging from "asking him if he knew he was doing this" to creating ground rules on "no interruptions" reflect the need to address the behavior directly. These responses seem to be saying that this behavior causes real problems to other members in family therapy and it needs to be handled in ways outside of ones

theoretical framework and usual practice. This tied in with some of the PFT work on narcissism by Guttman and Villeneuve (1994) that recommended conjoint family therapy as this presentation was so potentially damaging and challenging for therapists that added support was needed. Such notions support the hypothesis in a way by departing from theory and traditional techniques. One clinician seems to support the hypothesis in her noting the importance of experience and style over conceptualization by stating:

You may view behavior in whatever way helps you to understand the individual and/ or the family better; however, it is how you intervene with the family, your style, that makes the most difference. I believe with experience one becomes better able to hold his/ her opinions in such a way as not to influence a judgmental, negative experience for clients.

A clinician viewing Mr. Brown's behavior as narcissistic notes "A difficult personality type for example a narcissist, I would utilize dialectical interventions combined with systemic interventions." This clinician did not expand on this intervention as to how this might look. Dialectical behavior therapy (DBT) is a psychological method developed by Marsha Linehan, a psychology researcher, to treat patients with borderline personality disorder (BPD). It combines standard cognitive-behavioral techniques for emotion regulation and reality-testing with mindfulness, distress tolerance, and acceptance largely derived from Buddhist meditative practice. It's the first therapy that has been experimentally demonstrated to be effective for treating BPD (Dimeff and Linehan, 2001).

The use of acceptance of where the narcissistic parent is at, inherent in DBT, could be a helpful way of reducing the defensive nature of a narcissist. In my experience,

an important difference is that those with BPD are more often seen in treatment, suffer from great emotional distress, suicidal ideation and attempts. They more often can come to view their lives as needing change and though very difficult, would engage in treatment and want to change these behaviors. Those with NPD are grandiose, critical, blame others and are not often seen in treatment on their own accord. While this could be helpful, it may not be recognizing the resistance of narcissists who often see everyone else but themselves as the problem.

*Implications for social work practice, theory, and research*

The study's implications for the field of social work are that clinicians view this very damaging behavior differently. The lack of agreement reflects the great range of theories and interventions inherent in social work. The study showed that younger social workers and other clinicians may be moving away from family therapy training and education that was more prevalent in the past. This view, reflective of satisfying the demands put forth by H.M.O's and the privatized health care industry on the whole is a cautionary one in the author's view. Social workers need to be conscientious of not passively complying with profit-driven claims of what is deemed "best practice" as this may be the most cost-effective, but not necessarily the most effective therapeutically. Social work graduate programs should also resist altering programs that conform to these limited ways of practicing as it stunts creativity and new ways of thinking. At the same time, there are implications for family therapists to advocate more for their modality and distribute their current research more to social work educational institutions and the health care industry.

Theoretically, social work needs to address this behavior more directly, as it's not addressed specifically in the literature. Both clinicians with structural and psychodynamic backgrounds responded consistently with a particular theoretical framework, though this research had limitations in determining what that was because I did not ask them to rank the relative influence of various theories. Related to this, it appears that family clinicians may operate from a central theoretical framework and use aspects from other frameworks to a lesser extent. The prevalence of non-traditional techniques and interventions reflects how challenging this behavior can be and how interventions may be formed outside of theory and more through creativity, experience and one's own style. More research is needed in this area.

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## Appendix A

### Vignette

#### 1. PLEASE READ THE SHORT VIGNETTE BELOW AND ANSWER THE CORRESPONDING QUESTIONS:

The Brown family has been in family therapy weekly for 2 weeks. The family consists of an adolescent boy, his mother and father. The family has been referred because of conflicts between Mr. Brown and his son. In therapy Mr. Brown boasts of his successes in business, how important his role is in his company, and how hard he works. During sessions, he often monopolizes therapy by interrupting other family members and the therapist, claiming he knows the best course of action to take. He blames and criticizes other family members for conflicts and has expressed little empathy towards them, but states he's a very loving, caring father. **How would you respond to Mr. Brown's behavior in family therapy?** Please provide a brief statement for each stage of treatment (1-Early, 2-Middle and 3-Later phases of treatment)

Appendix B

Survey

1. Gender (Please choose one)

- Male
- Female
- Transgender M – F
- Transgender F - M

2. Race/Ethnicity (Read and choose the best match)

- African American/Black
- Asian American
- Alaskan Native/Native American
- Caucasian/White
- Native Hawaiiin/Pacific Islander
- Multi-Racial (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_
- Hispanic/Latino/Latina

3. Please enter your Age \_\_\_\_\_ in years

Education and Employment Info

4. What year did you graduate from your graduate program (s)? \_\_\_\_\_(Year)

5. Degree:

- Please choose all that apply:
- PhD
- PsyD \_\_\_\_\_
- MSW \_\_\_\_\_
- MFT \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

6. Total years of family therapy experience

- 3-5 Years \_\_\_\_\_
- 6-9 Years \_\_\_\_\_
- 10-14 Years \_\_\_\_\_
- 15-19 Years \_\_\_\_\_

20+ Years \_\_\_\_

7. Total years of general post-licensure experience:

0-4 Years \_\_\_\_

5-9 Years \_\_\_\_

10-19 Years \_\_\_\_

20+ Years \_\_\_\_

8. Please estimate percent of caseload devoted to family therapy:

a) currently \_\_\_\_\_%

b) cumulatively over last 3 years \_\_\_\_\_%

c) 10 years or more combined practice, training, supervising, teaching family therapy  
\_\_\_\_\_%

9. What setting do you/**did you** primarily conduct family therapy in? Please choose all that apply:

1 Private practice

2 Inpatient setting

3 Outpatient clinic

4 Other (please specify) \_\_\_\_\_

10. What is the frequency which you generally conduct therapy with a family?  
(enter a numerical value)

\_\_\_\_\_ times per month

### **Therapeutic Interventions**

Please read the short vignette below and answer the corresponding questions:

The Brown family has been in family therapy weekly for 2 weeks. The family consists of an adolescent boy and mother and father. The family has been referred because of conflicts between Mr. Brown and his son. In therapy Mr. Brown boasts of his successes in business, how important his role is in his company, and how hard he works. During sessions, he often monopolizes therapy by interrupting other family members and the therapist, claiming he knows the best course of action to take. He blames and criticizes other family members for conflicts and has expressed little empathy towards them, but states he's a very loving, caring father.

11. How would you respond to Mr. Brown's behavior in family therapy? Please provide a brief statement for each stage of treatment (1-Early, 2-Middle and 3-Later phases of treatment)

**TEXT BOX**

12. My theoretical orientation is a prominent influence in the above intervention

- 1 Strongly Agree
- 2 Agree
- 3 Neither Agree nor Disagree
- 4 Disagree
- 5 Strongly Disagree

13. My theoretical Orientation (s) in Family Therapy are (Choose all that apply)

- 1 Psychodynamic/Psychoanalytic
- 2 Behavioral (Cognitive or Dialectical)
- 3 Structural (Family Systems)
- 4 Narrative
- 5 (Other) \_\_\_\_\_ Please specify

14. Please describe any other important factors that would prominently influence your interventions with Mr. Brown and his family and his behavior towards others in family therapy?

**TEXT BOX**

15. I view Mr. Brown's behavior as resistance to treatment.

- 1 Strongly Agree
- 2 Agree
- 3 Neither Agree nor Disagree (skip to # 17)
- 4 Disagree (skip to # 17)
- 5 Strongly Disagree (skip to # 17)

16. In viewing Mr. Brown's behavior as resistance to treatment, my interventions are influenced by this perception

- 1 Strongly Agree
- 2 Agree
- 3 Neither Agree nor Disagree
- 4 Disagree

5 Strongly Disagree

Briefly explain below

**TEXT BOX**

17. With a parent displaying monopolizing, blaming, shaming, critical behavior with a lack of empathy similar to Mr. Brown, I view this behavior as narcissistic.

1 Strongly Agree

2 Agree

3 Neither Agree nor Disagree (skip to #20)

4 Disagree (skip to #20)

5 Strongly Disagree (skip to #20)

18. I would view these behaviors as narcissistic in a parent, and my interventions are influenced by this perception:

1 Strongly Agree

2 Agree

3 Neither Agree nor Disagree

4 Disagree

5 Strongly Disagree

19. (If applicable) Or Skip to #20

Briefly describe your interventions over time when viewing these behaviors from a parent as narcissistic

20. Viewing monopolizing, blaming, shaming, critical behavior with a lack of empathy from a parent towards others in family therapy as narcissistic is NOT useful

1 Strongly Agree

2 Agree

3 Neither Agree nor Disagree

4 Disagree

5 Strongly Disagree

Please explain

**TEXT BOX**

## Appendix C

### Informed Consent

Dear Potential Research Participant,

My name is Andrew Sussman and I am conducting a survey of family therapists' response to parent's displaying blaming, monopolizing, shaming behavior with a lack of empathy towards their partners, their children and even their clinician in family therapy. This research study is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work, and may also be used in future presentations and publications.

Your participation is requested if you are a licensed PhD, PsyD, M.F.T, or L.C.S.W. You must be able to read and write in English because the survey will be conducted in English only. You must conduct family therapy for 10 percent or more of your current caseload, or 10 percent cumulatively of your caseload over the past 3 years or Participants may have a minimum of 10 years experience of practicing family therapy and/or training/supervising/teaching others family therapy combined. These participants need not be carrying a current family therapy caseload.

If you choose to participate, you will answer an anonymous survey accessed over the internet regarding your beliefs and practices about interventions with families using both open and closed ended questions. The online questionnaire should take approximately 5-20 minutes. There will be specific questions regarding your gender and background as well as professional training and development, in order to help me establish whether I have succeeded in recruiting a diverse sample.

A potential risk of participating in this study is the possibility that you might feel some discomfort while reflecting on and sharing about your experience during family therapy or perhaps from your own family of origin or some other past or present circumstance.

Your participation is voluntary. You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to others' knowledge about family therapy. It is my hope that this study will help family therapists have a better understanding of treating and communicating with families, particularly those with the above described dynamic.

**Strict confidentiality will be maintained, as is consistent with federal regulations and the mandates of the social work profession. You will never be asked to identify yourself in the survey and your survey responses will be completely anonymous. The data provided will be stored in a locked file for a minimum of three years and then destroyed if no longer needed.** Your anonymous data may be used in other educational

activities or publications, as well as in preparation for my master's thesis. If you provide narrative information in the survey dialog boxes that could be potentially identifying, all such identifying details will be removed from the thesis report and will never be connected with your demographic question responses. All data will be reported as a group as opposed to individually.

The study is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study by exiting the online survey at any time before submitting the survey. However, once you have completed the survey and sent it in, you will no longer be able to withdraw from this study as your responses are anonymous, and there would be no way to identify your particular survey to exclude your information.

If you have any questions about this survey, please contact me by email at [andrewsussman@smith.edu](mailto:andrewsussman@smith.edu). You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

**CHECKING "I AGREE" BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Please print a copy of this page for your records by going to file at the top of this browser page and selecting "print"

Thank you for considering participation in my study.

Sincerely,

Andrew Sussman  
MSW Candidate

I Agree

I do NOT Agree



## Appendix D

### Recruitment Flier

As you may know, I am working on my social work master's thesis on family therapy. I am particularly interested in how family therapists' respond to parent's displaying monopolizing, blaming, shaming behavior with a lack of empathy towards their partners, their children and even their clinician in family therapy. If you know anyone that might fit the criteria below, please pass along the link.

Participant must meet the following criteria:

1. A licensed PhD, PsyD, M.F.T. or equivalent licensed marriage and family therapist or L.C.S.W. or equivalent licensed social worker.
2. Participants must read and write in English because the survey will be conducted in English only.
3. Participants must conduct family therapy for 10 percent or more of their current caseload, or 10 percent cumulatively of their caseload over the past 3 years

or

Participants may have a minimum of 10 years experience of practicing family therapy and/or training/supervising/teaching others family therapy combined. These participants need not be carrying a current family therapy caseload.

If you know of anyone that might fit these criteria, please direct them to my link:

[http://www.surveymonkey.com/s.aspx?sm=RmABEdNCh\\_2f37m8Vy\\_2bg2AfA\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=RmABEdNCh_2f37m8Vy_2bg2AfA_3d_3d)

Please feel free to contact me at [asussman@smith.edu](mailto:asussman@smith.edu) if you have any questions or concerns.

Thank you so much for helping me distribute this important study.

Andrew Sussman

Candidate for Master's in Clinical Social work

## Appendix E

### HSRC Approval Letter

March 11, 2009

Andrew Sussman

Dear Andrew,

Your final revised materials have been reviewed and we now approve your project.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor