CHAPTER 1

Introduction

No man is an island.
—John Donne

Whether one's closest social ties are to blood relatives or to individuals not biologically related, everyone belongs to a family. Families morph, adding and subtracting members across the life cycle. Family configurations also vary widely in modern society (Roseneil & Budgeon, 2004; Walsh, 2012), and the importance and meaning of family varies across cultures. Nevertheless, few people would deny belonging to a family.

Families maintain a central role in educating, socializing, caring for, emotionally supporting, and healing their members. Briar-Lawson and colleagues (2001) described families as "comprehensive social welfare institutions" that have more responsibilities for their members than any social or health service providers could ever possibly have. For example, with arguably few exceptions, families never get to discharge their members.[1]

The primacy of the family, in whatever shape it may take, cannot be underestimated. For example, vast health benefits exist for maintaining close family ties. Married individuals live longer, and engage in less risky

[1]In the United States, all 50 states have "safe haven" laws where desperate parents who believe they cannot care for their child can cede their child to the State's care (Child Welfare Information Gateway, 2017). These laws are intended to save infants' lives based on estimates of deaths of unwanted children (Herman-Giddens et al., 2003). I could not locate a credible national estimate of abandoned babies, but some research suggests that the rate is fairly low, with 1,479 total babies surrendered nationally from 1999 to 2008 (Porter, 2010).

behavior, than unmarried people (Waite, 1985, Wang et al., 2020). Parenting and family communication buffer against a number of adolescent and young adult problems, such as substance use (Hawkins et al., 1992), delinquency (Hoeve et al., 2009), obesity (Dallacker et al., 2019; Pinquart, 2014), and leaving school before graduating (Strom & Boster, 2007). Family dissolution due to divorce is recognized as an adverse childhood experience and negatively impacts children if not handled well. Families care for children and adult members with disabilities. Later in the lifespan, millions of family members provide caregiving to their elders, allowing them to age in place (Schulz et al., 2020). It is no wonder that numerous social policies are designed with families in mind, including adoption, taxation, child support, and family leave benefits.

Why, then, do the helping professions and clinical scientists focus primarily on providing services only to individuals? For example, there are twice as many systematic reviews on person-centered versus family-centered health care (Park et al., 2018). This suggests that there exist barriers to implementing family-centered care. Such barriers could include lack of insurance reimbursement for family-centered care (Clawson et al., 2018; Tambling et al., 2020), an inadequately prepared workforce (Goodyear et al., 2017), family members deciding not to engage in services due to family conflict or fear of being scapegoated, and perceptions from clients that family-based intervention is not needed or won't work (McPherson et al., 2017).

WHAT IS "FAMILY" AND "FAMILY-CENTERED CARE"?

In this book **family** is defined as a group of two or more people that regularly provide support to one another, regardless of shared bloodlines or legal arrangements (Holtzman, 2008). Indeed, families presenting to helping professionals take on myriad configurations, including the following: gay, lesbian, transgender, or heteronormative couples who are or are not legally married; parent–child or grandparent–child dyads; a friendship dyad; a long-term mentor and a child in state custody who resides in a group home; or biological parents and their children. This list is clearly not exhaustive (see the box on page 5).

I define **family-centered care** here as any professional or paraprofessional service in which more than one member of a family sees the same helper. Importantly, family members could visit the same helper together at the same time or in separate consultations. Thus, family-centered care is not limited to family therapy or services

The principles of family-centered care are consistent with the spirit of MI.

My Journey of Integrating MI with Family-Centered Care

Early in my career, I was a clinical supervisor of a small adolescent substance use treatment unit. When I started, no family services existed, despite really promising research support for it. Teens met individually with counselors or in groups with other teens. Back then, rallying cries existed for providing more family services. One highly influential paper suggested that providing group therapy to teens could actually make their problems worse because they'd negatively influence each other (Dishion et al., 1999).

When adding family services, we required that one family member attend the teen's initial substance use assessment. We were concerned that families would not attend. I had heard about MI and had received some initial training. To integrate families, but also respect teen autonomy, we developed a family-centered assessment debriefing session where we first met with the teen, then met privately with the parent, and finally met conjointly (Smith & Hall, 2007). MI was used with both parents and teens in hopes that it would help engage them into treatment. It worked, especially for teens who didn't initially think they had problems with substances (Smith et al., 2009).

Because of my positive experiences with engaging families with MI, I ultimately joined the Motivational Interviewing Network of Trainers (MINT; see Appendix). MINT is an international group of MI trainers who want to provide high-quality training and prevent the spread of misinformation about the use of MI. I've more recently been using MI in work with young adult friendship dyads, which I consider "selected families."

THOUGHT QUESTIONS: (1) What motivates you to learn about family-centered care? (2) What are some challenges in providing family-centered care? (3) In your own words, how do you define "family"?

provided by graduates of an accredited marriage and family therapy program. The principles of family-centered care (Bamm et al., 2008), such as recognizing families as strong and unique entities, or engaging families as equal partners in health decisions, are consistent with the spirit with which motivational interviewing (MI) is delivered.

Families often seek care when they have concerns about one of their members. This member will be referred to as the **identified client**. The quintessential identified client is a person with a severe substance use problem receiving a family intervention. In interventions, each member tells the identified client how their behavior is affecting them, encourages the

identified client to seek treatment, and gives ultimatums should future substance use occur. Many people are familiar with family interventions through the popular media. For example, the A&E television show titled *Intervention* showed families providing interventions to loved ones with severe addictions (Kosovski & Smith, 2011). In short, family-centered care sometimes involves recognizing whether the family is seeking treatment due to an identified client's behavior.

Family-centered care exists in several settings. Examples include family psychoeducational groups occurring in residential treatment, case management services provided during elder protection services, primary care appointments where family members are present, and psychiatric services that involve sporadic family involvement during appointments. Because the backgrounds of those providing family-centered care vary widely, I will use the term **helper** throughout this book to refer to the person in the role of providing care. This term is meant to be inclusive, as many professionals work with families, but would not define their work as family therapy.

EFFICACY OF FAMILY MODELS

Voluminous empirical support exists for family-centered interventions. Such interventions are efficacious for adolescent suicidal ideation (Waraan et al., 2023), youth with disruptive behavior problems (Sheidow et al., 2022), substance use disorders (Ariss & Fairbairn, 2020), marital distress (Wood et al., 2005), pediatric obesity treatment (Janicke et al., 2014), and mental health services (Barbato & D'Avanzo, 2008; Riedinger et al., 2017). Although more research is needed, family-centered interventions even show promise in select situations where intimate partner violence occurs (Karakurt et al., 2016). This finding surprised some clinical researchers that were initially reluctant to use family therapies with families experiencing violence, to the point that some studies excluded such families. There is little doubt that family-centered services, if implemented well, can ameliorate a number of health and psychosocial problems.

Potential Mechanisms of Change

What factors account for the success of family-centered care? Clinical science has started moving past the question of what treatments work for most people. This relatively simple question is answered by studying whether a treatment, on average, works for families receiving it. Yet, there are no average families, and treatment responses vary. Thus, we now

concern ourselves with not only knowing what works, but also for whom and why. Understanding why a treatment works is commonly referred to as the mechanism of change. A mechanism of change is a process through which a treatment produces its effect.

Several potential mechanisms of change may operate in family-centered care. First, increasing multiple family members' knowledge about a particular problem is empowering. This is commonly referred to as family psychoeducation, which is important and highly effective for some presenting problems, especially for mental health treatment (Lyman et al., 2014). Second, it may reduce family conflict, which often provokes the presenting problem in the first place. Consider that marital discord is clearly associated with several childhood behavior problems (Reid & Crisafulli, 1990), depression and inflammation (Kiecolt-Glaser, 2018), and likely a host of other reasons families seek care. Treating relational discord and increasing family problem-solving skills among families may produce salubrious effects. For example, increases in family problem-solving skills are longitudinally linked to improvements in diabetes (Wysocki et al., 2008). Finally, family-centered care may also be beneficial because of the ability of family members to check up on each other and hold each other accountable outside of therapy sessions. Perhaps this is why some family-centered care models produce more durable effects than individually based treatments (Liddle et al., 2008).

CHALLENGES IN FAMILY-CENTERED CARE

Although family-centered care is efficacious, helpers often encounter two key challenges. First, families often discontinue care earlier than recommended. Additionally, helpers must hone their communications skills to develop strong therapeutic alliances with families. These two challenges are interrelated. That is, weak alliances are related to premature exits from family-centered care.

Choosing to Leave Care

Often, family members do not engage in treatment. Also, sometimes they choose to leave before receiving enough of a therapeutic dose.[2] For exam-

[2]I refrain from using the term "dropout," especially in reference to family members. Instead, I will use more neutral and person-first terms like "when services end abruptly" or "families who chose to end services." Framing early exits from treatment as "dropout" is inconsistent with the humanizing spirit of MI and emphasis on family members' autonomy.

ple, many people are familiar with the concept of a family intervention when one member suffers from an addiction. As mentioned earlier, in this model, family members confront a loved one with an addiction in an effort to get them into treatment (Kosovksi & Smith, 2011). Although interventions work at engaging loved ones in treatment, one study found that as few as 30% of families completed the intervention (Miller et al., 1999). Widespread implementation of a treatment that 70% of families ultimately choose not to do is difficult to justify. Such a treatment would not reach enough people. Despite their continuing popularity in the mainstream media, little recent research exists on such interventions.

Electing to leave family-centered care early is a common occurrence. Even when families have resources such as good health care insurance, almost one in five clients seeing a trained marriage and family therapist did not return for a second session (Hamilton et al., 2011). This rate may be an underestimate, too, as other studies suggest rates between 20 and 50%, likely depending on the characteristics of families, providers, and settings (Cooper et al., 2018). Hamilton and colleagues (2011) also showed that family therapy clients were 33.2% more likely to leave treatment prematurely compared with clients receiving individual therapy.

Helpers providing family-centered care must grapple with the problem of families not wanting to engage or remain in treatment. McAdams and colleagues' (2018) systematic review identified six actionable strategies to boost family therapy retention, including (1) conveying understanding and support, (2) demonstrating knowledge and support, (3) communicating a genuine desire to help, (4) clearly describing the family therapy process, (5) communicating hope that problems can be resolved, and (6) creating a safe environment. As you will see in later chapters, several of these strategies are consistent with the approach presented in this book, MI. I wrote this book in hopes of introducing this model to helpers who want to increase family engagement.

The transtheoretical model of behavioral change, commonly known as the stages-of-change model, offers a perspective on why families may choose to leave care early (Prochaska et al., 1992) The model suggests that family members may vary on their readiness to make behavioral changes. The theory posits several different stages, including precontemplation, contemplation, preparation, action, and maintenance. Precontemplation involves limited awareness or belief that change is needed. Contemplation, as the moniker suggests, occurs when family members are thinking about whether or not they need to change. Family members in the preparation stage acknowledge the need for change but have not actively started on a plan of action. Those in the action stage have done just that. Finally, those

in maintenance, as the label suggests, have made some changes and work to sustain them.

Limited research exists on the stages-of-change model and retention in family-centered care. One early study by Tambling and Johnson (2008) found that a couple's stage of change did not predict retention or outcomes. Also, men scored lower than women on motivation for change. However, the findings from this early study may have been due to inadequate measurement of the stages of change. That is, in a subsequent study that used a measure of stages of change specific to relationships (i.e., Relational Version of the University of Rhode Island Change Assessment [R-URICA]; Tambling & Ketring, 2014), stage of change did predict outcomes (Tambling & Johnson, 2019). In short, the stages-of-change model seems to be a viable heuristic for thinking about families' readiness to change.

On Therapeutic Alliances

Therapeutic alliances refer to family members' feeling a strong bond to the helper and agreement on what goals will be addressed. Therapeutic alliance is related to both treatment retention and outcomes (Anderson et al., 2019; Del Re et. al., 2021; Friedlander et al., 2018).

An important point is that, no matter what evidence-based practice model a helper uses, they should invest in developing strong communication skills. For example, one recent meta-analysis shows that helpers have varying degrees of skill in developing therapeutic alliances (Del Re et al., 2021). Thus, in addition to developing expertise in clinical methods, helpers should also focus on their communication skills (see the box on page 10).

So, what may be some important dimensions of therapeutic alliances that may be honed by learning MI? Research shows that working on engagement, being able to provide a safe environment, and collaboratively setting goals are critical skills. For example, Sotero and Relvas (2021) reviewed video tapes of 40 family therapy sessions and examined associations between four different dimensions of therapeutic alliance and retention in treatment. Dimensions included engagement, safety, emotional connection, and a shared sense of purpose. They found that engagement, safety, and shared sense of purpose were all higher among retained cases.

Potential Benefits of Learning MI

So much has been written on families leaving care and therapeutic alliance that it is beyond the scope of this book to cover each comprehensively.

However, the point is that MI can strengthen therapeutic alliances and increase retention in family-centered care. Focusing on familial motivation for change would be beneficial. Many families elect to discontinue treatment due to low motivation (D'Aniello et al., 2019). Thus, helpers need to be able to identify families that may be at risk for premature termination of services. Additionally, they should develop skills that effectively engage and retain clients. Throughout this book, I will present concrete examples of how to engage family members reluctant to attend sessions, address how to negotiate goals with high levels of collaboration (i.e., a key aspect of therapeutic alliance), and use other communication skills that may ultimately strengthen alliances.

MI can increase retention in family-centered care.

The Importance of Learning Communication Skills

I once did a training with a community organization tasked with responding to family crises that may result in detention or the need to secure emergency housing for teens. We role-played one such crisis, which involved empathizing with both parental and teen perceptions of family conflict. After the role playing, one of the participants commented on how using the skills in the demonstration could potentially shorten their interactions with families.

Helpers develop certain communication strategies with families, which sometimes are less direct and inefficient. My interpretation of this trainee comment is that there is a persistent need for developing communication skills to build familial motivation. MI is one tool for rapidly developing therapeutic alliances in even the most difficult scenarios. These trainees had substantial expertise in common familial disputes, yet found something new in MI that could benefit their work.

This brings us to a key point. MI is a conversational style to be used in concert with whatever family-centered care model one uses. It is not intended to be a comprehensive family-centered care model. Instead, it may aid helpers in doing the family work they do better. It can help address key challenges in family work through teaching communication skills and a way of being with families.

THOUGHT QUESTIONS: (1) Which of your communication skills do you use well? (2) Which of your communications skills could use improvement? (3) How do you know when you are communicating effectively?

A Taste of MI

MI involves compassionate conversations about change. It is particularly useful for resolving ambivalence about change and assumes that such ambivalence about change is a natural part of the change process. It refrains from pathologizing such reluctance to change. That is, instead of labeling families as "dropouts," "hard to treat," or "resistant," as if these are intrinsic traits, helpers using MI seek to gain an in-depth understanding of their families' motivations. They work to resolve ambivalence about change. Some helpers like to think of MI as a way to guide families though the aforementioned stages of change.

Rather than prescriptively identifying solutions for families, MI seeks to empower families to solve their own problems. Family members are active collaborators in the change process, rather than passive recipients of the helper's wisdom. In other words, this approach achieves much better buy-in from families.

MI is based on Rogerian therapy and has been refined over the past 40 years through numerous process studies where scientists listened carefully to conversations about change. Through this research, clinical scientists have identified what they think are some of the active ingredients that make MI work.

What is particularly stunning about this work is that it turns out that what helpers say impacts what clients say during sessions. It also turns out that what we sometimes label resistance may not be an intrinsic trait of families at all. Instead, it may be a byproduct of how helpers talk to family members. For example, a well-intentioned helper may inadvertently increase a family member's resistance or ambivalence about change. This happens right in front of our very eyes because what clients say during sessions predicts actual change. Thus, part of using MI in family-centered care involves deep listening to family members' statements about change.

MI involves deep listening to family members' statements about change.

At this writing, there exist only a few efforts to integrate MI in family-centered care, most of which are limited to the substance use disorder[3] field. This book seeks to introduce MI to helpers providing a wider range of family-centered services so that additional integration efforts will occur.

[3]Many readers may be accustomed to the term "substance abuse treatment." However, data show that the term "substance abuse" increases stigma (Kelly & Westerhoff, 2010; Kelly et al., 2021).

OPPORTUNITIES FOR USING MI IN FAMILY-CENTERED CARE

Multiple opportunities exist for using MI in family-centered care. Here, I review some common dilemmas in work with families where MI may prove useful:

Scenario 1

A child protection worker meets with two parents who have just lost their children to the child protection system. The task is to communicate the court's expectations for them if they pursue family reunification. There are many requirements, such as obtaining employment, attending all court hearings, increasing home safety, attending parenting classes, and reducing substance use. Families in this situation frequently get angry with their caseworkers. Such families interacting with multiple social service systems often do not trust workers in these systems. It is common for them to miss appointments. The worker is looking for a counseling method where they can treat all families with dignity, motivate families, and communicate the requirements of the court.

Scenario 2

A helper is approached by a 45-year-old woman about relational trouble she has been having with her partner. Her partner exhibits signs of depression, and they have numerous arguments. They have been in a committed relationship for over a decade, but she said she felt they have gradually become more distant the past couple of years. She'd like to try couples counseling but is not sure if her partner will be willing to join her in that venture. She thinks her partner will be defensive and feel singled out. The helper is looking for an effective way to engage with the partner.

Scenario 3

A teenager involved in the criminal legal system is in constant conflict with their parents. The helper worked with them on coping strategies and communication skills that the teen can implement, which led to some improvements. However, frequent fighting continues unabated, and the teen feels that their parents' love is conditional. The helper proposed involving the parents in some sessions. The teen, however, voices some reluctance. The

helper wishes there was a way to broach the subject again but doesn't want to alienate the teenager.

Scenario 4

A caseworker made a plan with an elderly woman and her middle-aged son to transition her from in-home care to living in an assisted living community. Yet, when the helper met with them again, the woman and her son did not complete any of their tasks. The helper recognizes the need to reevaluate whether their goals have changed. Their professional opinion is that conditions at the home are becoming increasingly unsafe, with elevated risks for falling, failing to take medications, and eating inconsistently. The helper feels like they have lost some momentum and wants to revisit the action plan.

MY HOPE FOR THIS BOOK

This book introduces MI (Miller & Rollnick, 2023) to helpers providing family-centered care. It assumes limited knowledge of MI and is meant to help providers integrate it into their work with families. Most of my professional experience using MI involves integrating it into family therapy with adolescents, as well as with friendship dyads. However, I've written this book in a manner in which it can be used whether or not readers are providing family therapy proper. All providers, whether they provide bona fide family therapy or not, will encounter a critical problem in family-centered care, the need to effectively engage families and work with those who appear reluctant to change. This book addresses the problem of motivating a wide range of families across multiple health and social services settings.

I don't present a single, overarching therapy program that integrates MI and a specific family therapy model. However, Chapter 6 reviews various family therapy models and their compatibility with MI. Instead, this book will identify multiple opportunities for using MI, no matter how you want to work with families. I argue that MI could be one plausible strategy for engaging and retaining family members in care. Like any therapy model, MI will not be a panacea for all your families' problems (Miller & Rollnick, 2009). Yet, MI can provide helpers with a framework for thinking about motivation, as well as concrete tools to address common impasses.

SUMMARY

Family-centered care is efficacious for a wide range of psychosocial problems. Yet, helpers vary widely in their communication skills, which affect therapeutic alliances. This in turn leads to families deciding to exit services prematurely, before achieving maximum benefits. MI is a conversational style that can aid helpers in their family work. In Chapter 2, I will define MI and begin discussing how these communication skills can aid family work.