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The influence of context on the assessment of family interaction: a clinical study*

Families: Are we seeing them as they really are?

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A clinical study to compare clinically-observed with task-elicited family interaction was carried out as follows. Twelve families receiving family therapy were administered a series of tasks by tape-recorder. The therapist and an independent observer recorded interaction patterns in six dimensions (Alliance, Parenting, Marital Relationship, Communication, Affective Status and Boundary Integrity) and the results were compared with what was known clinically. Except for conflict the Task Interview revealed the main clinical features; however, it also revealed significant new information in all cases but one. The study has implications for clinical work.

Introduction

One of the axioms of family therapy is that context affects behaviour. In particular, introduction of the therapist into the family is said to alter the family system, indeed to produce a new system, the therapist-family system (Haley, 1970; Minuchin, 1974). Despite this assertion, therapists regularly describe the family as if their own presence were irrelevant and most take no action to compensate for the distortion they introduce. To our knowledge there has been no systematic exploration of the effects on interaction produced by the therapist. Nor is it established that these effects are significant enough to warrant attention.

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In order to view the family interacting in the absence of a therapist, the Family Studies Group at the Hospital for Sick Children has developed a Family Task Interview which is administered by audiotape (Kinston, 1978). Similar interviews have been used in other studies, though their methodological adequacy has not been fully assessed (Watzlawick, 1966; Lewis *et al.*, 1976; Elbert *et al.*, 1964).

The aim of the study reported in this paper was to see whether families would demonstrate similar interactional patterns in the audiotape task interview context as in the clinical context. Our hypotheses were, first, that already noted and familiar clinical features would be revealed, in other words, the family task interview would be clinically validated; and, second, that some major differences in family interaction would be observed, in other words, the family therapy axiom would be affirmed. We had no preconception as to what these differences might be but did not expect them to be the same for each family. We were not interested in minor degrees of emphasis or detail, but only in clinically significant and easily observed new patterns of interaction.

Methods

The sample for the study was obtained by two social workers approaching, consecutively, families in their caseloads which were currently engaged in family therapy. Families were excluded if they did not have at least one child over the age of five years. The social workers explained that this was a study about families and family life and was not specifically part of ongoing or future treatment. Parents were given a simple outline of the procedure involved. Families were approached in this manner until each social worker had recruited six families. Fourteen families in all were approached; two refused because they did not wish to be exposed to more interviews. Basic data concerning the sample is presented in Table 1.

Each family was assessed by their own therapist based on her clinical knowledge of them using clinical categories developed by the Family Studies Group (Loader et al., 1981). This alerted the therapist to the key features of family interaction.* For purposes of this study, the therapists

* This assessment may not have been accurate in the sense of being a reliable account of interaction which independent observation would have confirmed. Our study however was concerned, in the family therapy tradition, with the reality of family interaction as determined and acted upon by the involved clinician. The question we asked, and emphasized in the title of the paper, was whether this reality altered in the different contexts.

TABLE 1. *Basic data on sample* (n = 12)

	No. of families
Presenting problem	
Pre-school behaviour disorder	2
Conduct disorder	6
Neurotic or psychosomatic disturbance	3
Anorexia nervosa	1
Family type	
Two-parent	8
Single-parent	2
Extended family	2
No. of children	
One	0
Two	11
Three	0
Four	1
Age of identified patient	
0–5 years	3
6–8 years	6
9–11 years	1
12–14 years	2
Social class	
I	0
II	3
III	6
IV	3
V	0
Cultural origins	
English	9
Asian	3

were asked to focus on six dimensions of interaction: Alliance, Parenting, Marital Relationship, Communication, Affective Status, Boundary Integrity. Then each family attended the hospital for the task interview. This was administered by the social worker not known to the family and was observed on closed-circuit television by both workers and videotaped with the families' permission.

The families were settled into an interview room empty except for necessary furniture, a tape-recorder and two videocameras. The tape instructed them to perform six tasks, each lasting about ten minutes: (1) Plan something to do together; (2) Build a tower with blocks; (3) Discuss likes and dislikes; (4) Sort cards into logical groups; (5) Discuss feelings about an imaginary accident; (6) Choose a proverb and explain it. This interview has been in use for some time and we knew that families experienced the procedure as a natural opportunity to do things together. The family task interview is described in full elsewhere (Kinston, 1978).

The therapist and observer assessed the elicited interaction using the six dimensions listed above. A number of other measures and questionnaires were administered to each family after the interview as part of other research. At this time the family's therapist completed a Comparison Questionnaire which contained the following questions: Were the main features of the family as you know them clinically exposed by the task interview? What did the task interview add to your previous clinical picture of the family? What aspects of family interaction known to you were not revealed by the task interview?

About one week later each family received a brief questionaire enquiring about their experience of the interview. Six months later, both workers reviewed each family's videotape and again made independent observations of the family interaction using the six dimensions. The family's therapist completed a second comparison questionnaire. At this point the workers compared notes to establish whether there were discrepancies between the therapist's and the observer's views. They recorded any differences, and attempted to reach a consensus over the gross manifestations of interaction at the task interview.

As both social workers were leaving the Department, therapy for all families had been transferred or concluded prior to the commencement of the task interviews. From that point clinical contact with the families and joint discussion were explicitly avoided.

Results

The findings reported are drawn from the comparison questionnaires and the joint discussion of observer and therapist following the second viewing. The two workers agreed on the principal features of family interaction as revealed by the task interview for all twelve families. This allowed us to interpret the comparison questionnaires with some confidence. Table 2 provides an overall summary of the findings.

TABLE 2. *Summary of results*

	No. of families (n = 12)
Main clinical features	
Revealed	9
Not revealed	3
New clinically significant information	
Gained	11
Not gained	1

The task interview revealed the main clinical characteristics of nine of the twelve families. In three families, conflict felt by the clinician to be crucial was absent. In the P. family this was severe general family conflict; in the other two it was marital conflict. In the first of these latter families, the parents had decided to separate prior to the interview and seemed determined not to let differences come to the fore. In the other, the parents had recently decided not to take up an offer of marital therapy. In the remaining families, conflict, both crucial and subsidiary, was revealed by the task interview.

For eleven of the twelve families, significant new information was gained from the task interview. (The twelfth family was the P. family

TABLE 3. *Information gained about family interaction from family task interview (F.T.I.)*
(Families could score on more than one dimension)

	No. of families (n = 12)	
Dimension of interaction	First Viewing of F.T.I.	Second viewing of F.T.I.
Alliances	6	9
Parenting	3	3
Marital relationship	2	2
Communication	2	4
Affective status	2	5
Boundary integrity	1	5

mentioned above.) The dimensions most involved in the new information varied from family to family and these are recorded in Table 3. The dimensions are used for convenience and are not mutually exclusive. The second viewing proved to be significant not only in confirming the initial findings, but in providing additional information. This was most marked in the dimensions of affective status and boundary integrity (see Table 3).

In a clinical study such as this, results are best communicated through detailed description. In the examples which follow, it will be clear that our categorization of the new information is not definitive and overlap is frequent.

Alliances

Significant new information was obtained in six families at first viewing and nine at the second.

The E. family (therapist: C.B.) consisted of Mother, Father, Maternal Grandmother, Peter (fifteen) and Jill (thirteen) who had anorexia nervosa. The clinical picture was of a family struggling to deal with an intrusive maternal grandmother who had come to live with them a year ago. Father was peripheral and intergenerational boundaries were very unclear. The clinical hypothesis was that Jill's anorectic symptoms were an attempt both to assert herself and to force the family to clarify the issue of authority. In the task interview, a striking alliance was observed between Mother and Peter, who mirrored each other, sitting close together with the same posture, and lighting cigarettes at the same time. They turned to each other for intimate conversation, to the exclusion of other family members. This alliance had not been noted before; it seemed amenable to change and central to the family's difficulties.

The V. family (therapist: J.S.) consisted of Mother, Father, Paul (eight), with severe ulcerative colitis, and Alex (six). Clinically the family had presented as a sensitive caring family who seemed to be functioning within normal limits. Therapy had focused on establishing more successful management of Paul's anxious and controlling behaviour. During the task interview, Alex's liveliness and good humour provided him with physical and verbal contact with both parents but little with Paul, who was allowed to dominate him. Throughout, Paul repeatedly urged family members to finish tasks according to instructions and later urgently called attention to the parking meter outside. Father and Paul did not look at or speak to each other at all. During one task, parental decision-making was hampered by Father's uncertainty which was only resolved when Paul intervened by moving forward and eagerly making suggestions. The poor relationship between the siblings, and between Father and Paul, had not been previously identified in clinical sessions, and seemed significant in the light of

Paul's worrying in the family. Subsequent therapy based on this premise led to marked amelioration of the colitis.

Parenting

In three families, the task interviews revealed aspects of parenting not noted before.

The M. family (therapist: C.B.) consisting of Mother, Father, Siri (six-year-old girl) and Isar (five-year-old boy), had been referred following Isar's admission to hospital with suspected lead poisoning resulting from eating paint. Mr and Mrs M. were Ugandan Asians who had been expelled by Amin. They were reluctant to admit that they were having difficulties in parenting and only agreed to treatment when the serious consequences of Isar's behaviour had been impressed upon them. During clinical sessions, there was no evidence of behaviour problems; the children played quietly or Isar sat on his father's lap. Mr and Mrs M. admitted that Isar had frequent temper tantrums at home and reported that he had developed severe asthmatic attacks since his admission. Clinical work focused on helping parents to manage the asthma. In the task interview, a very different picture of the family emerged. Mother sat knitting throughout and had no contact with the children except to offer them sweets on one occasion. The two parents hardly looked at or spoke to each other. Father interacted with, or rather reacted to, the children. Siri gave him the lead by her unusually arrogant and exhibitionistic behaviour. Both children rushed around the room in an overexcited way, in complete contrast to their calmness in treatment interviews. For the first time the therapist observed parenting problems.

The C. family (therapist: C.B.) consisted of Mother, Andrew (thirteen), Nicky (ten), Ann (seven) and Karen (four). Nicky had been referred for severe headbanging, continual screaming, and disruptive behaviour. Emotional needs of all family members were often left unmet. During therapy, Father died of cancer. Following this, Mother's difficulties in controlling and disciplining the children worsened and she became even less able to be warm and accepting. In clinical sessions, Mother and Andrew were locked in continual battle, while the other children either looked on, joined in or argued among themselves. As a result, the therapist often had to take control. The clinical focus had been on helping the family mourn and adjust to their new rôles. In the task interview, Mother managed the children extremely well. She gave each child space and attention in a very sensitive way, and while maintaining control, fostered an atmosphere in which the children could relate to each other. This difference in parental management amazed the therapist.

Marital relationship

The task interview provided new information concerning the marital relationship in two families.

The Q. Family (therapist: C.B.) consisted of Mother, Father, Steven (five) and Neil (two and a half). They had been referred because the parents felt unable to cope with Steven's disobedience and sulkiness. In clinical sessions, Mother presented as passive and withdrawn and the parental couple were almost completely unable to talk to each other. They agreed that their relationship was very poor, that they shared few interests and each felt angry with the other. Steven was co-operative and well-behaved in the clinical context, if a little quiet. Clinical work had centred on an attempt to improve communication between the parents as this appeared to be the principal difficulty. During the task interview, Steven kicked Mother, tried to leave the room, and interfered with the tape-recorder. He completely ignored Father's remonstrations. Mother was lively and active, and continually countered Father's attempts to discipline Steven by encouraging his rebellious behaviour and relating to him in a teasing, sexualized way. This demonstrated vividly how Mr and Mrs Q. triangulated Steven into their marital conflict and clarified the dynamics of the family's difficulties.

Another family, the L.s (therapist: J.S.) consisted of an unsophisticated working class couple with two children, Noah (five) and Ali (one), who were referred because of Noah's general developmental delay and behaviour problems. The atmosphere in clinical interviews was uneasy and chaotic: Noah quickly became frenzied, running in circles around the room, and unable to pay attention unless physically held. Mr L. assumed the rôle of a traditional authoritarian father. He attempted to manage the situation by repeatedly ordering family members about but often contradicted himself and created confusion. His own high level of anxiety rarely allowed him to listen and he could not benefit from his wife's comments. Mrs L., for her part, seemed to accept this situation quite happily. These communication problems made it impossible for the parents to respond to Noah's problems consistently. During the task interview, the L.s were all much more at ease; both parents responded to the situation in thier own way and at their own pace. Mr L. remained dominant but this no longer excluded his wife and at one point, they sat quietly holding hands, gazing at each other, while the children played happily in front of them. The relaxed intimacy of this scene was remarkable. The warmth and affection the L.s demonstrated for each other had never appeared in the clinical situation.

Communication

New information had been gained concerning communication in two of the families at first viewing, four at the second.

In the M. family described above under *Parenting*, both parents had described their problems clearly to the therapist in clinical sessions. There had been joint discussions which included the children. Mother was quiet but spoke to and looked at others appropriately. Topics were taken up and developed in a

natural way. During the task interview, the parents did not talk to each other at all. What little Mother said confirmed the fact that she understood what was happening. However there was no direct interchange between her and the others. Issues were not discussed and the task instructions became opportunities for the children to set up their own private games.

Affective status

Additional information concerning affective status had been revealed for two families at first viewing, and five at the second.

This was particularly so in the W. family (therapist: J.S.) consisting of Mother, Father, Conrad (five), referred with night terrors, and Liza (three). Both parents were compliant with the therapists, but it was clear that Mother was overprotective of both children, while Father remained quietly inactive and left everything to her. This seemed to reflect the domestic arrangement in which Mr C.'s work kept him mostly absent from home. In sessions, his inarticulacy embarrassed him, and reinforced or contributed to his wish to stay peripheral. He ignored attempts made by Conrad to engage him. The sessions were quiet and everyone behaved in a calm reasonable fashion. As a result the treatment plan had been to involve Mr W. more and attempt to build up his relationship with Conrad. During the introduction to the task interview, the presence of the videocameras was routinely explained. Conrad initially appeared inquisitive about the cameras but this soon developed into anxious concern about being watched and later became an hysterical preoccupation which was allowed to dominate the family. Both parents tried to reassure Conrad saying the cameras were not working and were certainly not looking at him. The parents' blatant and futile attempt to handle Conrad's fears and hysteria by distortion and lies revealed the unsatisfactory nature of the treatment plan. The W.'s difficulty in acknowledging and responding appropriately to negative feelings and their poor perception of the emotional needs of the children were evident for the first time.

Boundary integrity

In the area of boundary integrity, new information was obtained for one family at the first viewing of the task interview and for five families at the second viewing.

The F. family (therapist: J.S.) consisted of Mother, David (seven) and Tricia (four). They had been referred for help with David's encopresis, enuresis and behaviour problems which developed after Father's death in a road accident a year before. In clinical sessions, Mother was depressed and overburdened, whilst Tricia played quietly beside her. David showed his jealousy of Tricia by often trying to push her aside. He was challenging and attention-seeking and

Mother's attempts to handle this had little success. Therapy focused on encouraging the family to acknowledge and share the unresolved grief and anger about Father's death, and to assist Mother in her transition to the rôle of single parent. During the task interview, the family atmosphere heightened and there was a feeling of confusion and panic. Mother remained seated, passive and difficult to hear, while David became excited and made repeated demands to leave the room. Tricia soon joined in as Mother vacillated between clear refusal and attempts to reason or distract. In a futile effort to gain control, she sought support from the instructions of the tape-recorder. Later, first David and then Tricia were either ignored by Mother in her efforts to gain co-operation of the other child. Alternatively, they were put in a parental rôle to gain assistance. As tension rose, Tricia sought the comfort of Mother's lap and David responded by racing around the room. In the subsequent confusion, the three family members became physically merged in a whirlpool of smacking and cuddling. For the first time the confusion between parent and child rôles in this family, and the marked lack of differentiation between family members was demonstrated and identified.

Families' experience of the F.T.I.

The families themselves were asked about their experience of the task interview. Judged on aspects of comfort, helpfulness, and interest, five families found it a positive experience, three a neutral one, and four a negative one. A similar range of responses has been obtained in studies of conventional clinical interviews (Burck, 1979).

Discussion

A task interview was administered to a group of disturbed families and the interaction compared to that known from regular clinical interviews. Except for conflict, the task interview revealed the essential clinical features familiar to the therapists, thereby confirming our first hypothesis. The task interview also revealed significant new information about family interaction in all but one of the families, thereby confirming our second hypothesis. This additional information could be in any of the dimensions of interaction and is therefore probably a therapist-absence effect as well as a specific effect of the interview. The occasional absence of expected conflict by contrast might well be specific to the interview which was designed to be minimally stressful. There was no evidence for systematic bias such as a particular aspect of interaction regularly missed or overemphasized by either therapist.

Observer

Without an observer new to the family, it would have been difficult to know whether the therapist's description of the interaction was a valid reflection of the family system or distorted by the therapist's new attitude to the family now she was outside. In the event this was not a serious problem: the observer and therapist discussed their perception of the families using the six dimensions and came to consensus without difficulty. The observer, having no clinical focus on the family obtained a broader picture of the interaction than the therapist who was still clinically and therapeutically focused. It was the combination of the observer's assessment of the content of the interaction in the task interview, and the therapist's knowledge of the family and the meaning of this content, which most clearly confirmed the significance of the new information gained.

Other explanations

The method used in this study (see footnote, p. 360) does not enable us to distinguish whether family interaction was actually different or not in the two contexts. It only demonstrates that the therapist's assessment altered. From the clinical point of view this is the crucial finding. The clinician treats the family on the basis of his assessments not with some externally validated ruler, and to have placed an observer in therapy would have spoiled the naturalistic research style which we regarded as essential for clinical conviction in the results. Nevertheless it is a not unreasonable assumption that the family interaction, as would have been judged by an outside observer present throughout therapy, was indeed different in the task interview. If this were so, although the task-centred rather than therapist-centred nature of the interview would appear to be most significant, it could be argued that other variables determined the outcome.

For example: (1) The use of closed-circuit television allows the family to be seen as a whole in a way that a therapist sitting in with the family cannot; (2) The results may be due to the absence of therapy or therapeutic purposes, rather than the therapist himself; (3) The families' attitude to therapy may have affected their performance in the study; (4) The fact that they were all losing their therapist may have been important; (5) The task interview took place in surroundings different to the clinical interviews. These explanations, singly or in combination, may have influenced the results, but they seem subsidiary. We suggest

that the most convincing reason for the altered interaction is the move from the therapist-centred format to the task-centred one. Only further studies of this type which control for the various other possibilities can disentangle the contribution of each.

Dimensions of interaction

Alliances was the most significant area to which new information was categorized. We concluded that the alliances seen in clinical work are those of the therapeutic rather than the family system, and that the presence of the therapist modifies patterns of alliance. We also noted that the therapist seemed to focus in her clinical work on certain alliances and ignored or underused others. This applied particularly to sibling relationships and parent-non-identified patient relationships.

The gain in information concerning *parenting* seemed to have its base in the fact that therapeutic activity had obscured parenting skills. In some families, the therapist apparently augments parenting resources, while in others she blocks or diminishes them, in both cases unconsciously. The *marital relationship* was considered separately because of its importance. Aspects of the relationship may be hidden by the pace of therapy or in the presence of an outsider. Alternatively, the therapist may either make the session so safe or so confronting that conflict gets revealed. In such activity, as in much therapeutic work, the therapist inevitably influences the pattern and style of *communication.*

Affective status refers to the way families acknowledge, experience and deal with feelings. In observing the task interview, we were struck by how painful it was to watch some of these families struggle with difficulties. It led us to believe that we may sometimes intervene in clinical sessions because of an unwillingness or even inability to tolerate discomfort. As in previous F.T.I. studies, families which appeared to suffer often reported that they found the F.T.I. a useful, interesting or positive experience.

The therapists were emotionally involved, possibly enmeshed, with their families at the time of the first viewing, but had achieved greater distance and balance at the second, six months later. Several families were than recognized as having revealed new information on affects. A similar phenomenon occurred with regard to recognition of new *boundary issues.* In each case the families were more enmeshed than was recognised either during clinical work or at the initial viewing.

Conclusion

This study illustrates the powerful nature of the bond between families and their therapists and the substantial effect of therapists on the family interaction. The presence of the therapist transforms the family system and the family distorts the therapist's perception when it assimilates him. As well as confirming these basic axioms of the family therapy approach, the study has some practical implications. It seems that a task interview administered in the absence of a therapist can be a useful, even necessary, aid to therapy, particularly when concurrently observed by another clinician. First, it may reveal significant new information as to how the family members interact, particularly in the areas of alliances, affective status and boundaries. Second, it may give the therapist some distance from the system which is to be changed. This can enable him to reconsider the family's strengths, especially the oft-neglected capacity for emotional support and understanding, and their use within the therapeutic plan.

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