Description of Therapy

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Introduction

Theoretical Orientation

My theoretical orientation, the Mental Research Institute (MRI) approach, comes from the pioneers of the field; Don Jackson, Jay Haley, Jules Riskin, John Weaklands and Virgina Satir. The first family therapy approaches that were derived from MRI approach were structural and strategic family therapy (Family Solutions Institute, 2005; Sexton, 2003) which serve as the foundational theories of my theoretical orientation along with Attachment Focusesd-Family Therapy. There are many others theories that I utlized such as Cognitive Behavioral Therapy (CBT), Rational Emotional Behavioral Therapy (REBT), Emotional Focused Therapy (EFT), Acceptance and Commitment Therapy (ACT). I pull from theories in an integrative manner in order to enhance my clinical skills, assess the suitability of other theoretical paradigms for clients, or to simply complement or address the limitations of other theories. The center piece of my clinical orientation revolves around the notion that balance and relationship is essential.

How Do Problems Occur

Problems occur when there is a lack of balance. According to the MRI approach, problems occur when normal life difficulties or activities of daily living (ADL) are mishandled; overemphasized or underemphasized, which I understand as a lack of balance (Sexton, Weeks, & Robbins, 2003). From a Structural Family Therapy perspective, problems occur when structures within the family are either rigid or choatic; imbalanced. Strategically, problems occur when there are "rigid and repetitive patterns of interaction that restrict the repertoire of avaliable behaviors" (Sexton, Weeks & Robin, 2003, p. 182). Within Attachment-Focused Family Therapy, problems occur when there is the lack of intersubjective experience, the space between subjective experience in a realtionship (Johnson, 2004, Hughes, 2007). These approaches are integrated by their common thread of balance. For example, when a client such as a family is being seen, I am looking for imbalances in the strucuture of their relationships (e.g., if boundaries are unclear or rigid), how family members communicate (e.g., hierarchy, allainces, coalitions) and if they can flow freely in and out of having an intersubjective expereince.

Conditions for Change

Change occurs, or should I say has a greater likelihood of occurring, when clients feel in-relationship with their therapist and there is a perceived shared meaning of trust, safety, competence and flexibility by the client. Change occurs at the esteem level of Maslow Hierarchy of Needs. After needs such as safety, security and belonging are perceived to be met by the client, a person is now free to reallocate energy and resources to more developed ways of being. Clients typically experience problems when they are in the lower levels of Maslow Hierarchy of Needs and are attempting to get their basic needs met yet are stuck in repetitive patterns of interactions that work in opposition of their actual goal (e.g., MRI attempted solutions). My job as a therapist is creating a safe and structured environment that facilitates an experience that helps clients to become more objective to their vicious cycles (Hayes, Strosahl, & Wilson, 1999) and/or attempted solutions (Sexton, Weeks & Robin, 2003). As an Attachment Focused-Family Therapist who understands the transformative nature of relationship, I use the PACE approach (playfulness, acceptance, curiosity and empathy) to facilitate growth and development that is associated with secure-attachment (Hughes, 2007).

Utilizing the Trauma-Informed Approach in Understanding Change

Due to my special interest in trauma, another way in which I conceptualize change can be explained in discussing how trauma effects the brain. Generally, trauma decreases neuroactivity particularly in the prefrontal cortex which is responsible for higher level cognition such as decision making and is more receptive and open to feedback (Siegel, 2010). The limbic system of the brain is the emotional meaning making system that process fear and detects threats. The limbic system is much less receptive and more reactive in nature. Change, from a trauma-informed perspective, is learning to regain

prefrontal cortex functioning in the presence of limbic brain dominance through mindfulness practices, education of the brain and central nervous system and self-care. Optimal development is when these two specialized functions of the brain are well integrated. Traumatized individuals, through a secure attachment, greatly assists with the integration of the brain.

Cultural Competence

As a culturally competent clinical, I have moved from Sue and Sue (2008) cultural competence model (awareness, knowledge and skills) to the Multi-Phase Model of Psychotherapy, Counseling, Human Rights and Social Justice (MPM), developed by Chung and Bemak (2012). It consists of five stages (a) mental health education, (b) group, family and individual psychotherapy, (c) cultural empowerment, (d) indigenous healing and (e) social justice and human rights. The primary differences between the models is that while Sue and Sue (2008) model encourages increasing one's self awareness of their own biases, gaining knowledge of other diverse groups which ultimately leads to the development of culturally competent skills, the MPM model is more systemic. The MPM model calls for clinicians to be aware of biases within the structure of therapy itself and being elementary in communicating the culture of therapy. Therefore, I have created and continue to improve upon an information page that informs clients of the therapeutic process in detail; https://www.bprtmcs.com/therapy-resources. The MPM Model also urges clinicians to be aware of healing practices salient to the culture of the client and how these indigenous practices are valid but are often discredited by Western medicine or methods of healing. Lastly, the MPM model sees that the burden of change may not be that of the client's but that of the oppressive systems that has discriminated and marginalized them. The MPM model provides a framework for clinicians help to empower and support clients through social activism and advocacy.

References

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