NINTH EDITION



Family Therapy

AN OVERVIEW

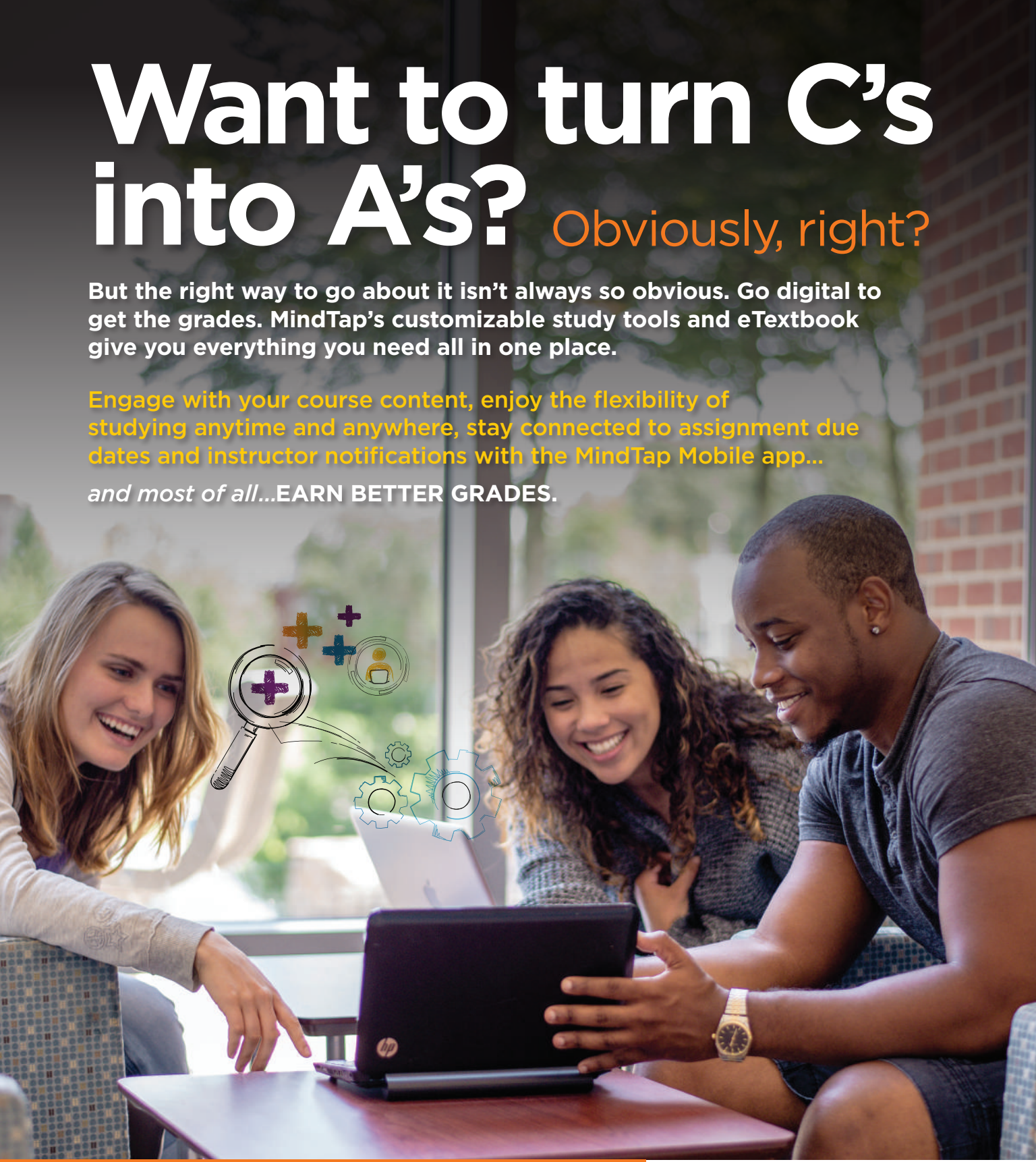
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Family Therapy

AN OVERVIEW

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Dedication to Herb Goldenberg, 1926–2008

To Herb, whose compassion, integrity, intelligence, and unwavering support nourished our relationship and made this book possible. Thank you for the life, the love, and the family.

Irene Goldenberg

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Foreword by Michael White

Michael White had a special place in our hearts, both personally and professionally. He is sorely missed.

Irene Goldenberg



The publication of this text represents an achievement of extraordinary scope in which Irene and Herbert Goldenberg bring together more than five decades of developments in the ideas and practices of family therapy. Extraordinary scope, because in doing this these authors have not been content to incorporate just the principal developments in this field. In the space of this one text, Irene and Herbert Goldenberg also trace many of the tributaries that have branched out of those developments in ideas and practice that have been accorded mainstream status in the field of family therapy.

Before reading this text, I had made some assumptions about it. To cover the history of developments in a field like family therapy, one in which there has been little orthodoxy and great diversity, would surely require considerable economy of writing. *Overview*, a word from the book's title, seemed to my mind to imply a very limited perspective. I was expecting the sort of academic writing that would provide a reasoned gloss of developments through the history of family therapy. I had forecast the sort of dry account of these developments that is intended to provide the reader with a passing knowledge of this broad subject matter. I had assumed that the authors of such a text would have little option but to rein in their ambitions for the reader's engagement with this material and to keep modest their hopes for the reader's experience of its reading—perhaps simply to hope to kindle the reader's interest in specific ideas that might be pursued through consulting more dedicated sources.

Not so! Upon reading this book I discovered that Herbert and Irene Goldenberg had not been content to offer their readers a summary account of developments that simply conveys a passing knowledge of this material. Despite the limitations associated with an economy in writing imposed by the circumstances, these authors have produced a highly engaging text that introduces the reader to the profundity of the principal ideas and practices of family therapy, while at the same time rendering the complexities associated with these ideas and practices readily available to the comprehension of the reader. Rather than acquainting the reader with a passing knowledge, this text takes him or her to a vantage point that allows a vital, close-up view of the terrain.

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How is this achieved? This text does not constitute the expected "armchair exposition." Instead, it is alive with the adventures initiated and the journeys traveled through the history of family therapy. The reader gains a strong sense of the authors' significant personal experiences of these adventures and journeys, of their intimate familiarity with many expeditions into new territories of ideas and practices. In the reading of this text, one is left with no doubt that Herbert and Irene Goldenberg have been at the scene, actively joining with others over many years in explorations of new forms of human inquiry. In this recounting, these authors succeed in evoking the original spirit of these developments in human inquiry and the inspiration that was an outcome of numerous efforts to think beyond what has been routinely thought about people's lives and their relationships. These authors also succeed in conveying to the reader the excitement of these adventures and journeys—the sense of actually undertaking these expeditions.

The authors also engage readers vitally through user-friendly writing devices that provide a scaffold for comprehension of the text. The text is organized with functional headings and subheadings, with topics divided into six parts: "Fundamentals of Family Psychology," "The Development and Practice of Family Therapy," "The Established Schools of Family Therapy," "New Directions in Family Therapy," "Clinical Research: The Synergy of Science and Practice," and "Family Theories and Family Therapies: An Overview." Each chapter is thoughtfully structured and replete with helpful and concise summaries and recommended readings. The judicious use of tables, illustrations, and quotes contributes to this easy-to-use composition. Particularly important is the even-handed and respectful way in which Irene and Herbert Goldenberg present the various developments in the history of family therapy and the available critiques of these developments. This fair-mindedness encourages the reader's fuller involvement with the text—it recruits the reader's contemplation and rouses his or her fascination.

I believe there is something for everybody to be found in this book. For those new to the field of family therapy, this book provides a gripping account of the history of developments in the family therapy field, of the continuities and discontinuities in these developments, and of many context- and era-specific influences that have contributed to the shape of these developments. For other readers, this book offers a ready reference to, and will instigate further explorations of, those developments that have most captured their imaginations and exercised their minds. For yet other readers, this text provides a source of renewed reflection on the history of their own family therapy practice and will encourage a richer appreciation of the traditions of thought that have shaped their work. And, of course, this text gives many readers an opportunity to become more fully acquainted with traditions in thought and practice that they might not otherwise be familiar with.

Apart from these comments about what is in store for you as you open the pages of this book, I will include here a few comments about the authors. Although there is much that can be said about their own contributions to the family therapy field over a considerable period of its development, my desire here is to say something about the personae of Irene and Herbert Goldenberg, for I would like you to get to know them just a little as I have known them.

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Although I had been expecting this book to represent a relatively limited summary of the history of developments in the field of family therapy, I was nonetheless not surprised to find these expectations so contradicted in my reading of this text. I had met Herbert and Irene Goldenberg on various occasions over the years, principally in the context of workshops that I have given in the Los Angeles area. I first became aware of their presence in these workshops some years ago. I recall, toward the end of one of these events, being asked some particularly thought-provoking, searching, and persistent questions about some of the ideas and practices I had been discussing. In this workshop context, the questions—coming in particular from two people in the room—provided a foundation for conversations that contributed to significant clarification of certain similarities and distinctions in a range of ideas and practices.

At the end of the workshop, I approached these two figures for personal introductions. Through this and my subsequent contacts with Herbert and Irene Goldenberg, I have come to admire the breadth of their experience, the scope of their knowledge, and their capacity for thoughtfulness. All of these qualities are so evident in this book. But they have contributed much more than this to the family therapy field. I have also come to admire the part that their strong social consciousness and their generosity of spirit play in their personal and professional worlds. Herbert and Irene Goldenberg are always quick to recognize transgressions of the principles of fairness, equality, and justice; and they are never tardy in naming these transgressions. They are also quick to offer support to those who have experienced unfairness, inequality, and injustice. And, in their efforts to challenge these wrongs, Herbert and Irene Goldenberg manage to stay true to their principles of understanding and to their appreciation of difference and diversity. In this way they make it possible for people to find new places in which to stand in the territories of their lives and work. When I am in the presence of Irene and Herbert Goldenberg, I know that I am in good company.

Michael White (*1948–2008)*
Codirector of Dulwich Centre
Adelaide, South Australia

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Preface

With each new edition of *Family Therapy: An Overvi*ew, we have the opportunity to tell once more the evolving story of the profession. Even in the four years since the eighth edition, the theory and clinical practice of family therapy have changed in important ways that affect everyone involved. Students, researchers, professors, and clinicians all need to know not only the origins and history of family therapy but the very latest in what it means to work as a family therapist. Changes emerge from within the field as well as in response to a wide range of pressures and other influences from society at large. In *Family Therapy*, ninth edition, we strive to honor our past as well as understand and explain present-day developments.

Our Mission in Writing *Family Therapy: An Overview*

The purpose of our book is to convey to new and returning readers alike the excitement of the field as it develops over time. We hope to impart to readers an attitude of theoretical and clinical openness that appreciates past, present, and future developments. We feel it is important to constantly challenge our own biases whether in working with clients or in considering different theoretical approaches to our work. Indeed, the ninth edition goes further than previous editions in considering the clinical value of integrating theories both in terms of expanding personal boundaries and in better appreciating how the diversity of our client population reminds us that no one approach to practice can tell us the whole story about how best to work. Postmodernism reminds us again and again that there is no final truth about our theories and practices. As clinicians, we must continually challenge ourselves to accept and celebrate this revelation. We can never know it all, but we can keep learning. *Family Therapy*, ninth edition, is designed to help support this lifelong commitment to personal and professional growth. Indeed, our commitment to revising the book reflects our own ongoing commitment to remaining open to challenging our own biases and remaining open to change.

The Tradition and Present-Day Developments

Family therapy, with its revolutionary emphasis on systems thinking and the search for identifiable and recurrent family patterns, first emerged in the mid-1950s. By the 1970s, having been inspired by such trailblazers as Virginia Satir, Salvador Minuchin, Jay Haley, and Carl Whitaker, many who were accustomed to working with individuals had "caught the bug"—become convinced of the therapeutic power of understanding individual behavior in the context of the family system. The more we learned, the more we came to grasp the influence of larger systems—race, social class, gender, ethnicity, sexual orientation—on the functioning of the family and its individual members. Postmodern thinking introduced us to the further

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importance of language and belief systems in understanding how people construct their views of reality.

The initial edition of this book attempted to provide a comprehensive textbook offering an overview of the field—not merely a biased description of any one of the specific models then vying for the clinician's attention—based on the assumption that an even-handed account could prove a useful guide to others interested in entering the field of family therapy. As stated in the first edition, published in 1980, the goal was to offer readers a balanced presentation of the major theoretical underpinnings and clinical practices in the field. We promised not only to provide an overview of the evolving viewpoints, perspectives, values, intervention techniques, and goals of family therapy but also to attempt to keep pace with the field's clinical and research developments. That promise continues to be the goal in this latest edition.

What's New in the Ninth Edition?

We have introduced new features to the text in this edition to reflect important issues in family therapy and advances in the field. These features include:

- **Highlighted material on key themes of family therapy.** Framed boxes in select colors with an icon designating special themes throughout the text:

  
  Family Diversity. We have added boxes to highlight individual and group diversity perspectives, issues, and research relevant to the chapter content throughout the book so that students are challenged to think about how the material relates to diverse populations.

  
  Thinking Like a Clinician. Many new and revised boxes present clinical challenges and opportunities for the reader to respond to and learn from. Readers are asked to address clinical situations—many taken from real-life therapy situations—from different theoretical perspectives. These boxes are intended to heighten self-exploration regarding individual thoughts, feelings, and experiences relative to the different models presented.

  
  Evidence-Based Practice boxes. Recent research relevant to the chapter content and the practice of family therapy is featured in these boxes.

  
  Case Study. Examples of therapy cases that illustrate the material in that chapter, these boxes help students apply the concepts to family therapy.

  
  Clinical Note. These boxes feature succinct information or suggestions about using the chapter ideas in family therapy.

  
  Therapeutic Encounter. Clinical vignettes and dialogue are featured in these boxes to provide insight into the way in which ideas manifest in the words of the clients and the therapist.

- **Inclusion of professions that practice family therapy.** Examples and material throughout the text illustrate that family therapists come from many professions, including social work (CSWE), MFT (AAMFT), psychology (APA), and counseling (CACREP).

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- **Updated references and cited material.** Every chapter in this edition includes up-to-date references and presents the latest thinking about its issues. Materials from sources (for example, family therapy models or figures and model depictions, as well as direct quotations) have been updated to the latest published versions.
- **Learning Objectives.** Each chapter begins with select student learning objectives that align with the content of the chapter. Content specific to each objective is identified throughout the text.
- **Increased attention to LGBTQ families.** More attention is given to LBGTQ issues throughout the book, including chapter content and the student exercises. Several of the Thinking Like a Clinician boxes raise real-life issues faced by LBGTQ families.
- **More concise content.** We carefully edited the entire volume to provide valuable information aligned to the reading assignments of contemporary classes.
- **New Recommended Readings.** Many chapters feature new or updated texts in the recommended readings section at the end of each chapter. These may help faculty and students reference source materials for themes in the chapter.

In addition to the general changes just outlined, we have made many chapter-specific changes that reflect today's knowledge and clinical practice. The following are included among the important more specific changes:

- **Chapter 1:** Enhanced coverage of social and cultural diversity in family therapy with new material on family forms and diversity perspectives, including a new Family Diversity box focused on how family therapists may assist minority families experiencing natural disasters.
- **Chapter 2:** An increased focus on *family* life cycle development, including expanded coverage of dynamics related to divorce, single-parent families, remarried families, and families with gay or lesbian members. A new figure depicting recent demographics of one-parent families demonstrates key aspects of these families.
- **Chapter 3:** Now titled "Diversity in Family Functioning," this chapter provides a foundation for developing a multicultural framework and sequences from culture and ethnicity to gender issues to socioeconomic diversity and social justice perspectives in family therapy. Recent research, demographics, and theoretical-clinical applications are provided.
- **Chapter 4:** Now titled "Systems Theory and Systemic Thinking," this chapter presents systemic thinking as a paradigm shift from typical Western thought. It presents a new figure to convey a systemic perspective and recent examples of systemic concepts in the practice of family therapy. The section on critiques of systems theory has been revised to reflect recent developments. There are new insets on social media and the family and systemic thinking.
- **Chapter 5:** We clearly delineate the progress of family therapy across decades. New material regarding core competencies for family therapy, including standards created by different professional organizations, is provided in this edition.

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- **Chapter 6:** We explicitly include the legal and ethical perspectives on family therapy by different professional organizations, referencing the ethics codes of those organizations. A new table that compares the ethics codes of four organizations is provided. We reference recent advances in professional practice, including the Affordable Care Act. Information on the practice of and ethical problems associated with "e-therapy" is also included.
- **Chapter 8:** We added material on the assessment and measurement of differentiation in Bowen theory, as well as research about the use of Bowen constructs with diverse populations.
- **Chapter 9:** There is new material about research on therapist practices and the client's experience of emotion in symbolic-experiential family therapy. Material is added on steps in the change process in emotionally focused therapy and recent research that demonstrates evidence for the effectiveness of the approach.
- **Chapter 10:** Material addressing research evidence for the structural model, particularly with diverse populations, is added.
- **Chapter 11:** Information on brief strategic family therapy and the substantial evidence for its effectiveness is added.
- **Chapter 12:** Clarifies the relationship of behavioral and cognitive-behavioral approaches to couple and family therapy. There is a new section on the Gottman method, including an outline of his research-based predictors of divorce and overview of the Sound Relationship House model, with diagram. There is a new summary of recent research regarding behavioral couple and family therapy. Finally, there is substantial new material on functional family therapy and sex therapy, as well as diversity aspects of all the models.
- **Chapter 13:** Recent advances in each model are described. New material on the evidence for solution-focused brief therapy and the use of the approaches with diverse populations is presented.
- **Chapter 14:** A recent model of the life narrative, including a figure, is presented. We also clarify ideas like "the absent but implicit" and "externalizing" in Michael White's thinking and the way techniques like letter writing may adapt with new technology. There is new material about the way narrative functions in diverse populations and the creative use of postpositivist thinking and methods to demonstrate the clinical effectiveness of narrative therapy.
- **Chapter 15:** This chapter is now titled "Population-Based Family Treatments" to capture the variety of client populations served by family therapy. It has significant new material about families and schools; individual mental disorders in the family context (depression, anxiety, substance abuse, eating disorders, schizophrenia); primary medical care and the family; gay and lesbian families; relationship education (including updates on Prepare-Enrich and PREP); family violence; and divorce and stepparenting; all feature recent research and clinical applications.
- **Chapter 16:** This chapter is now titled "Evidence-Based Family Therapy" to recognize the importance of connecting research and practice in contemporary

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family therapy. We present the value of both qualitative and quantitative methods in family therapy research, as well as ways postmodern therapies can demonstrate evidence for effectiveness. There is new material on assessment, including sections on couple assessment and individual assessment in family therapy, and new content on process research, including intersession client input techniques. The findings of three major family therapy review studies are included in the outcome research section, and a new table depicts the evidence for family therapy with particular issues.

- **Chapter 17:** New material is provided on common factors and the role they play in interaction with model-specific change factors in effective family therapy. We clarify the difference between eclecticism without theoretical unification and integration based on some unifying rationale, noting challenges to theoretical integration, yet highlighting recent approaches that advocate for or attempt integration in a coherent fashion. A student exercise in formulation of a personal theoretical orientation has been enhanced for this edition.

Ancillaries

Cengage Learning is committed to providing the most effective and up-to-date ancillaries our audience requires. As with past editions, *Family Therapy: An Overview* is supported with teaching and learning supplements to enhance the course experience. These are outlined below.

MindTap® Counseling MindTap® for Goldenberg/Stanton/Goldenberg's Family Therapy: An Overview, 9th Edition is the digital learning solution that helps instructors engage and transform today's students into critical thinkers and provides students with the tools needed to better manage their limited time, with the ability to complete assignments whenever and wherever they are ready to learn.

Cengage Learning Testing Powered by Cognero® Cengage Learning Testing Powered by Cognero® is a flexible, online system that allows you to: import, edit, and manipulate content from the text's test bank or elsewhere, including your own favorite test questions; create multiple test versions in an instant; and deliver tests from your LMS, your classroom, or wherever you want.

Acknowledgments

This is to acknowledge my new co-author, Mark Stanton. Without his superb up to the minute knowledge, his extraordinary editing skills and his general overall knowledge of the field, I could never have accomplished the completion of this book. He has the best work habits of any academic that I have worked with over my many years.

Thank you Mark!

Irene Goldenberg

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We would like to express our appreciation to Michael Lee, Doctor of Psychology student at Azusa Pacific University, for his outstanding work as a research assistant on this edition. Mark Stanton is grateful for the support he received from his wife, Kathy, and his children, April, Erin, Chelse, and Sean.

In every edition of *Family Therapy: An Overview*, we pay keen attention to the needs of instructors and their students in preparing our new manuscript. The ninth edition is no exception. We wish to thank the following reviewers for their insights as the new edition was evolving. Their comments and suggestions for change were invaluable resources in the preparation of the ninth edition:

Rebecca Koltz – Montana State University
Catherine Weigel Foy – Northwestern University
Cindy Silitsky – St. Thomas University
Victoria Fitton – Michigan State University
Gary Bischof – Western Michigan University

Irene Goldenberg and Mark Stanton

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1

Adopting a Family Relationship Framework



LEARNING OBJECTIVES

- LO 1 Describe the diversity of contemporary families
- LO 2 Explain the importance of family structure and interactive patterns
- LO 3 Justify a resiliency-based understanding of family dynamics
- LO 4 Explain how gender, race, and ethnicity influence families and family therapy
- LO 5 Discuss the evolution of family therapy from cybernetics to constructivism

A family is far more than a collection of individuals sharing a specific physical and psychological space. While families occur in a diversity of forms, cultures, and complexities in today's rapidly changing society, each may be considered a natural, sustained social **system**[1] with properties:

- an evolved set of rules
- many assigned and ascribed roles for its members
- an organized power structure
- intricate overt and covert forms of communication
- numerous ways of negotiating and problem solving that permit various tasks to be performed effectively

The relationships among members of this microculture are deep and multilayered, and they are based largely on a shared history, internalized perceptions, and assumptions about the world, and a sense of purpose. Within such a system, individuals are tied to one another by powerful, durable, reciprocal, multigenerational emotional attachments and loyalties that may fluctuate in intensity and psychological distance between members over time yet persist over the lifetime of the family.

Each family system is itself embedded in a community and society at large. It is molded by its existence at a particular place and time in history and shaped further by a multitude of interlocking phenomena, such as race, ethnicity, socioeconomic status, family life cycle stage, number of generations in this country, immigration status, sexual

[1]Terms in **boldface** are defined in the Glossary at the back of the book.

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orientation, religious affiliation, the physical and mental health of its members, level of educational attainment, and family values and belief systems.

All these factors and many others influence the system's development, beliefs, standards for acceptable behavior, degree of flexibility in meeting both normal developmental challenges and unanticipated crises, and in general its adaptability and stability over time.

Before turning to these influences, we shall examine several basic ideas that characterize most family systems.

Family Systems: Fundamental Concepts

All families create and socialize new members, and although most ultimately give these members autonomy and do not expect them to live under the same roof into adulthood, family membership remains intact for life. The power of the family is such that despite the possible separation of members by vast distances, sometimes even by death, the family's influence remains (Kaye, 1985). Even when a family member experiences a temporary or permanent sense of alienation from the family, he or she can never truly relinquish family membership. Should divorce occur, co-parenting may continue, and the former marriage continues to be recognized with the designation of "ex-spouse" (McGoldrick & Shibusawa, 2012). For most of us, relationships with siblings are likely to represent our longest continuous commitments (Cicirelli, 1995).

As McGoldrick, Carter, and Garcia-Preto (2010) point out, families are subject to unique constraints. A business organization may fire an employee viewed as dysfunctional, or an employee may resign if the structure or values of the company are not to their liking. The pressures of family membership allow few such exits, even for those who move a great geographic distance from their family of origin. Further, unlike members of nonfamily systems, who can generally be replaced if they leave, family members are irreplaceable. Should a parent leave or die, for example, and another person be brought in to fill a parenting role, the substitute, regardless of successful effort, can never replace in the same way the lost parent's personal and emotional ties to the remaining members.

Growth and change in families and the individual members who compose them occur concurrently, and understanding their interactions is essential in carrying out any reparative or preventive work (Nichols & Pace-Nichols, 2000). In the process of growing up, family members develop individual identities but nevertheless remain attached to the family group, which in turn maintains an evolving identity or collective image of its own. These family members do not live in isolation but rather are dependent on one another—not merely for money, food, clothing, and shelter but also for love, affection, mutual commitment, companionship, socialization, the expectation of long-lasting relationships, and fulfillment of other intangible needs. They maintain a history by telling and retelling their family "story" from one generation to the next, thus ensuring a sense of family continuity and shaping the expectations of members regarding the future. To function successfully, members need to adapt to the changing needs and demands of fellow family members as well as the changing expectations of the larger kinship network, the community, and society in general (DeGenova, Stinnett, & Stinnett, 2011).

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Apart from its survival as a system, a well-functioning family encourages the realization of the individual potential of its members—allowing them freedom for exploration and self-discovery along with protection and the instillation of a sense of security.

Constantine (1986) distinguishes between what he calls "enabled" and "disabled" family systems. The former succeeds at balancing system needs as a family unit while simultaneously facilitating the interests of all its members as individuals. Enabled families invent procedures that attempt to satisfy the conflicting interests of their members. Constantine maintains that to do less, or to prevail at the expense of certain members, reflects family disablement, often manifested in unstable, rigid, or chaotic family patterns.

Some families, unfortunately, are so depleted as a result of external or internal stress (poverty, migration to a country where they lack language skills or understanding of unfamiliar customs, serious health problems, legal issues, unforeseen accidents) that they may need community support. Low-income families receiving social assistance and working-poor families in particular may increase their chances for success and self-sufficiency when they receive such social support. Pigott and Monaco (2004), Canadian community workers in a multiservice center in Toronto, describe the debilitating effects of poverty and living in inadequate housing in unsafe neighborhoods. Often led by a lone parent or parents who are unavailable or working for long periods, with few siblings and limited contact with grandparents, such families feel isolated and defeated. They need social networks (healthcare facilities, after-school programs, recreation centers, libraries, community agencies). Being a part of such a social system often represents a step toward reducing isolation and increasing the possibilities of more effective self-care and improved quality of life.

LO 1 Today's Families: A Pluralistic View

Traditionally, entrance into a family system has been seen to occur only through *birth*, *adoption*, or *marriage*. Today's outlook, however, makes room for other *committed* family households beyond legally married heterosexual couples and their children (McGoldrick & Carter, 2010). There are further divisions and complexities within each type of family structure, brought about by early or later marriages, interracial coupling, foster parenting, informal kinship adoptions, social class position, and so forth. In general, an inclusive 21st-century definition of family must go beyond traditional thinking to include people who choose to spend their lives together in a kinship relationship despite the lack of legal sanctions or bloodlines.

It no longer is realistic to speak of a typical American family, since contemporary life is filled with families with differing living arrangements, styles of living, and organizational patterns. As Goldenberg and Goldenberg (2002) observe:

> The idealized, nostalgic portrait of the American nuclear family depicts a carefree, white family with a suburban residence, sole-provider father in a 9–5 job, and a full-time, stay-at-home mother always available when the children return from school. Both parents are dedicated to child-rearing and remain together for life; children are educated in a neighborhood school and attend church with their parents on Sunday; plenty of money and supportive grandparents are available. (p. 10)

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Not only is such a depiction of intact (middle-class) family life alien to the vast majority of people today, but there is doubt about whether it ever existed (Coontz, 1992). Although divorce was less common in the past, families were often disrupted by the early death of a parent or by abandonment by a breadwinner. Changes such as remarriage, child placement with relatives, foster care, and orphanages often followed. So, despite the idealized picture of family life, the risk of not growing up in an intact family has been a part of American life for some time (Walsh, 2012b).

Marriage and intact family life, as Coontz (2005) observes, may be viewed as a social invention that in its earliest form emerged from the division of labor between men and women in early societies and served to ensure family survival and efficiency, as men and women were assigned different but collaborative, complementary roles. Today's occupational opportunities, the evolution of women's rights, a more flexible commitment to marriage as a permanent union, and the expectation of greater love and intimacy in marriage have changed expectations regarding marriage. What has broadened our view of family life is the visible impact of working mothers, single-parent households, dual-earner families, long-term unmarried cohabiting couples, never-married couples with children, stepfamilies, adoptive families, and same-sex couples living together with or without children. Even our very sense of kinship itself has become more fluid over the recent past, as suggested by high divorce and remarriage rates (Diderich, 2008).

Just as our view of how families are formed has changed, so too has our understanding of the structure of family life. We turn now to the structural aspects of the family.

LO 2 Family Structure

Families typically develop certain basic structural characteristics and interactive patterns that they utilize to respond to internal and external stresses. These are founded on shared assumptions and family narratives and determine the manner in which families adapt and cope with life changes and challenges.

Basic Structural Characteristics

Whether traditional or innovative, adaptive or maladaptive, efficiently or chaotically organized, married or committed life partners with or without children, a family inevitably attempts, with varying degrees of success, to arrange itself into as functional or enabling a group as possible so that it can meet its shared needs and goals without consistently or systematically preventing particular members from meeting their individual needs and goals (Kantor & Lehr, 1975). To facilitate the cohesive process, a family typically develops rules that outline and allocate the roles and functions of its members. Those who live together for any length of time develop repeatable, preferred patterns for negotiating and arranging their lives.

Even in a family crisis situation or where there is severe conflict between members, families are typically resistant to change and often engage in corrective maneuvers to reestablish familiar interactive patterns. Regardless of format (e.g., **nuclear family** or **stepfamily**) or ultimate success, all families should work at promoting positive relationships among members, attend to the personal needs of their constituents, and prepare to cope with developmental or maturational changes (such as children leaving home) as well as unplanned or unexpected

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crises (job dislocation or loss, divorce, death of a key member, a sudden acute illness). Sometimes, families will reorganize to develop their own special styles in order to adjust to the challenges of life.

Family Interactive Patterns

Families typically display stable, collaborative, purposeful, and recurring patterns of interactive sequences. These largely go unnoticed by outsiders, frequently are unstated, and are not always understood by the participants themselves. Nonverbal exchange patterns among family members, in particular, represent subtle, coded transactions that transmit family rules and functions governing the range of acceptable behaviors tolerated by the family (for instance, that a son does not speak before his father speaks, and he himself can take his turn only after his wife has spoken). Such patterned interactions are jointly engaged-in, highly predictable transactional patterns generated by all family members on cue, as though each participant feels compelled to play a well-rehearsed part, like it or not.

Minuchin, Lee, and Simon (1996) illustrate this point with the following easily recognizable examples:

> The complementary construction of family members requires long periods of negotiating, compromising, rearranging, and competing. These transactions are usually invisible, not only because context and subject constantly change but also because they are generally the essence of minutiae. Who passes the sugar? Who checks the map for directions, chooses the movie, changes the channel? Who responds to whom, when, and in what manner? This is the cement by which families solidify their relationships. (p. 30)

Shared family rituals—holiday celebrations, christenings, confirmations, bar and bat mitzvahs, graduations, weddings, funerals, wakes—are part of ongoing family interaction patterns that help ensure family identity and continuity. Rituals are symbolic actions that help families adapt to change rather than struggle against it at the same time that they reaffirm their group unity in dealing with a life transition. They anchor family members to the past, providing a sense of family history and rootedness, while at the same time implying future family interactions. Participating in rituals links the members not only to the family system but also to the wider community and culture (Imber-Black, 2010).

Family Narratives and Assumptions

A family is a maker of meaning (Constantine, 1986), and our individual judgment about what constitutes reality is a function of the beliefs and stories that the family (as well as the culture) imparts about their experiences (Becvar, 2000). Throughout the course of its development, a family fashions and helps instill fundamental and enduring assumptions about the world in which it lives. As a result, the meanings and understandings we attribute to events and situations we encounter are embedded in our family's social, cultural, and historical experiences (Anderson, Burney, & Levin, 1999). Box 1.1: Thinking Like a Clinician is designed to help you appreciate how therapists might begin to appreciate the importance of family narratives.

The narratives or stories a family recounts help explain or justify their structure and interactive patterns. Despite any differences or disagreements between members, the core of family

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BOX 1.1 THINKING LIKE A CLINICIAN

Appreciating Family Narratives

Alert therapists pay attention to the unfolding narratives of the families with whom they work. To gain experience in listening to narrative developments, respond to the following prompts as you consider the narrative of your own family.

What family mementos or stories connect your family to a previous generation?	
How does your family express its problems or limitations (by anger, attacking the outside world, withdrawing from the outside world, etc.)?	
What roles do you find the family has assigned to individual members (such as "brother is the smart one," "sister is the athlete," or "father is the depressed one," etc.)? Can you discuss your role?	
Have any losses (of a home, job, family members through death, etc.) affected the way your family values itself?	
Does your family strongly identify with an ethnic, racial, or religious heritage?	
Has your family retained its socioeconomic position over generations?	
Have gender or sexual identity issues been important in your family narrative (gay parents, transgender family member, etc.)? Describe.	
What is the role of education in your family?	
How important is achievement (monetary, social class, education, athletic, etc.) as a value to your family?	
Describe an important family ritual, and explain how it influences the family's appreciation and understanding of itself.	

membership is based on acceptance of and belief in a set of abiding suppositions or shared constructs about the family itself and its relationship to its social environment. These constructs are often limited by social class expectations and restraints that influence what members of that class consider to be possible, acceptable, conceivable, or attainable in their lifetimes. Language and dialogue thus play crucial roles in how human beings come to know the world and how they interpret or make sense of their subsequent experiences.

Some families generally view the world as trustworthy, orderly, predictable, masterable; they are likely to view themselves as competent, to encourage individual input by their members, and to feel comfortable, perhaps enjoyably challenged, as a group coping with life. Other families perceive their environment as mostly menacing, unstable, and thus unpredictable and potentially dangerous; in their view, the outside world appears confusing and at times chaotic, so they band together, insist on agreement from all members on all issues, and in that way protect themselves against intrusion and threat. Thus, the narrative a family develops about itself, which is derived largely from its history, passed on from one generation to the next, and influenced by social class expectations, has a powerful impact on its functioning.

The ways in which individuals and their families characteristically deal with their lives are not based on some objective or "true" view of reality but rather on family social constructions—unchallenged views

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of reality created and perpetuated in conversation with one another, possibly carried on over generations. Such views may act as blinders or restraints—limitations a family places upon itself by its beliefs and values—that prevent its members from noticing other aspects of their lives or seeing other behavioral options. Members of these families typically construct a rationale for why undesirable behavior continues and how they have no alternative but to live their lives in spite of it (Atwood, 1997).

In the **postmodern** outlook, there is no "true" reality, only the family's collectively agreed-upon set of constructions, created through language and knowledge that is relational and generatively based, that the family calls reality. As we will illustrate throughout the book, the postmodern view has had a powerful influence on how many family therapists view family life—the social basis for acquiring knowledge—and how these therapists work collaboratively with families to generate new possibilities and co-construct alternative narratives (Gerson, 2010; White, 2007).

LO 3 Family Resiliency

One aspect of the family is its **resiliency**, that is, its ability to thrive and maintain relatively stable psychological and physical functioning even under adverse conditions. All families face challenges and upheavals during their life cycle from within and without their structure; some are expectable strains (brought on by such potential crises as retirement or divorce or remarriage), while others are sudden and untimely (an unforeseen job loss, the unexpected death of a key family member or family friend, a holdup or rape or other violent and life-threatening experience, an earthquake or flood). However, not all families react to these potentially disturbing and disruptive events in the same way. Some may experience prolonged distress from which they seem never to recover; others suffer less intensely and for shorter periods. For some families, recovery may appear to come quickly, but they later begin to experience unexpected health problems or somehow never again enjoy life the way they once did. Nevertheless, there are large numbers who manage to cope with the temporary upheaval or loss, rebound, and move on to the next challenge. This ability to thrive and maintain relatively stable psychological and physical functioning after extremely aversive experiences, often showing only minor, transient disruption, reveals a great deal about a family's resilience (Bonanno, 2004). Box 1.2 presents such a case.

Few if any families can expect to avoid exposure to stress, loss, or potentially traumatic events at some points in their life cycle. At the same time, as illustrated in Box 1.2, families have the potential for growth and repair in response to distress, threat, trauma, or crisis, emerging stronger and more resourceful than before (Walsh, 2012a). A family as a whole, or one or more of its members, may manifest dysfunctional behavior during periods of persistent stress, but family processes may mediate the person's recovery, allowing the family system to rally, buffer stress, reduce the chances of dysfunction, and support optimal adaptation.

Rather than view resiliency as a rare or special set of qualities a family may or may not possess, Masten (2001) contends that such recuperative skills are common phenomena arising from ordinary adaptive processes successfully mastered by most children in the process of development. She maintains that a relatively small set of global factors support resilience in

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BOX 1.2 CASE STUDY

A Traumatized Family Rebounds from a Sudden Crisis

When Hurricane Katrina hit New Orleans in 2005, thousands of lives were disrupted as people lost their homes and possessions, their jobs, and sometimes loved ones who were caught up in the subsequent floods. Paul and Margaret, both in their early 30s and near the beginning of their careers, had come to New Orleans 3 years earlier, he as an architect, she as a real estate broker. When forced to leave their newly purchased home, which had been devastated by the hurricane, they were unable to recover any articles or possessions. With their 1-year-old daughter, Christine, they fled in their car to the West Coast to move in with his parents for an indefinite period as they planned their suddenly disrupted future.

Although their marriage had been a relatively stable one, it now faced several crises simultaneously: addressing questions of how to earn a living, where to live, how to arrange child care, how to resume a social life, and so forth. Living with Paul's parents was difficult, since the house was crowded, his mother was ill, his father was upset by the intrusion of the baby, and Paul and Margaret felt too old to now be living with and be largely supported by his parents. Arguments broke out between family members, and in general the home was filled with tensions between the couples.

Despite the strain on their relationship, Paul and Margaret, each with a history of personal as well as professional achievement, ultimately retained their belief that together they would meet the challenge. After a short period in which both felt downcast and despondent, Paul looked up old high school friends, finally landing a job at a construction company, where his architectural skills made him a desired employee. Margaret, no longer able to afford child care and struggling with the responsibilities of being a full-time mom, began to recognize some of the satisfactions that came with being a stay-at-home mother, something she had not contemplated in the past. With no choice but to make decisions regarding where and how they would live, they reassessed their priorities, recognized how much being together as a family meant to them, and acknowledged that they were young people with resources who would learn to adapt.

Initially confused and despairing, feeling desperate at times during their first months in a new environment, they gradually realized that they needed to reorganize their lives to face the new challenges. The new situation was hardly to their liking, but they had each other, their child, and faith in their relationship. Forming new friendships, retaining a sense of humor, and recasting the crisis they faced as a challenge rather than a defeat all helped. As they moved into their new small apartment, they retained the dream of returning to New Orleans soon, better prepared as a family to deal with future adversity.

children: connection to competent and caring adults in the family and community, cognitive and self-regulating skills, a positive view of oneself, and motivation to be effective in the environment. Moving away from a search for deficits or pathology in families in favor of seeking its strengths and potentials—family resiliencies—is part of the evolving movement of *positive psychology* (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). Here, researchers and therapists have begun to study the nature of effective functioning and adaptation, paying close attention to human capabilities and adaptive systems in individuals and families.

Walsh (2012a) identifies some key family processes in family resilience: (a) a consistent and positive *belief system* that provides shared values and assumptions so as to offer guidelines for meaning and future action (e.g., viewing disruptions as milestones on their shared life passages without assigning blame and recasting a crisis as a manageable challenge);

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(b) the family's *organizational processes* (how effectively it organizes its resources) that provide the "shock absorbers" when confronted with stress (e.g., remaining flexible, open to change, connected to each other); and (c) a set of family *communication/problem-solving processes* that are clear, consistent, and congruent and that establish a climate of mutual trust and open expression among its members (maintaining a shared range of feeling, shared decisions, creative brainstorming). Boyd-Franklin (2010) notes that working with ethnic minority families during trauma requires culturally sensitive interventions (see Box 1.3).

While some families may be (temporarily) shattered by crises, others emerge strengthened and more resourceful. Rather than view a symptomatic family member as a vulnerable victim, thus pathologizing the family, the emerging viewpoint is that while problems may certainly exist within the family, family competencies nevertheless can be harnessed to promote self-corrective changes. Resilience should not be considered a static set of strengths or qualities but as a developmental process unique to each family that enables families to create adaptive responses to stress and, in some cases, to thrive and grow in their response to the stressors (Hawley, 2000). Adopting a resiliency-based approach in working with families calls for identifying and fortifying those key interactional processes that enable families to withstand and rebound from disruptive challenges.

How the family organizes itself, how it retains its cohesion, how openly it communicates and problem solves together to cope with the threat largely forecasts its ability to recover. An affirming belief system aids the process. The support of a network of friends, extended family, clergy, neighbors, employers, and fellow employees and the availability of community



BOX 1.3 FAMILY DIVERSITY

Therapy for ethnic minority families following disasters

Boyd-Franklin (2010) explored how African-American families adapted to Hurricane Katrina in order to inform family therapists as they provide services to ethnic minority families following disasters. Her key points include:

- Disasters require cultural sensitivity and respectful treatment that understands the different perspectives of cultural and racial groups. For example, many African Americans believed that race contributed to slow government response to the tragedy while few Whites endorsed that rationale
- Therapist insensitivity to perceived racism may exacerbate the trauma for African-American families
- Family therapists need to recognize that anger in the face of perceived racism may be a healthy response and facilitate coping
- Disasters that require relocation may fragment kin networks in collectivistic cultures, upsetting the support mechanisms typically used by the families
- Ethnic minority children, adolescents, and the elderly may have special needs in the aftermath of trauma and therapists must pay attention to these concerns
- Spirituality and religion may be especially important to some ethnic minority families in coping with tragedy
- Family systems therapy is appropriate for collectivistic ethnic minority families because it is strengths-based and facilitates resilience
- Family systems approaches recognize the need to assist families as they interface with a variety of agencies and organizations in the aftermath of trauma

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resources often contribute to family recovery. See Box 1.3 for a discussion of the role of spirituality within the family as an affirming belief system.

As Karpel (1986) emphasizes, even chaotic, disorganized, abusive, and multiproblem families have resources. Here he is referring to the rootedness, intimacy, support, and meaning a family can provide. In poor families, especially, the members need to feel their self-worth, dignity, and purpose; resilience is facilitated for them if they experience a sense of control over their lives rather than viewing themselves as helpless victims of an uncaring society (Aponte, 1994, 1999).

In general, what factors increase the likelihood of greater family resiliency? Goldenberg and Goldenberg (2002) suggest the following:

> All families possess the resources, and thus the potential, for resilience. In traditional families, usually organized according to some form of generational hierarchy, those with greater resilience are able to balance intergenerational continuity and change and to maintain ties among the past, the present, and the future without getting stuck in the past or cut off from it. Clarity and ease of communication also characterize such families; a clear set of expectations about roles and relationships within the family is provided. In whatever type of family form—whether led by never-married mothers, stepfathers, two working parents, or grandparents—resilient families respect individual differences and the separate needs of family members. These families have mastered successful problem-solving strategies by developing reparative, resiliency-enabling processes that promote endurance and survival. (p. 12)

The resiliency construct challenges the family therapist to attend to the family's resources that can be mobilized to deal with a present crisis or adversity (as opposed to a deficit-focusing model directed at detecting what's wrong with the family). It is intended to have an empowering or enabling effect as it encourages the family to search for resiliencies, including previously untapped resources, within its network of relationships. Successfully managing a crisis together deepens the family bond and strengthens its confidence in its capacity to prevent or manage future adversities.

LO 4 Gender, Race, and Ethnicity and Family Therapy

In our discussion of resiliency, we noted that often strains on the family occur from outside the family system. Indeed, and much more broadly, the structure, interactive patterns, narratives, and assumptions of a given family have many and varied influences from the outside world. As we note throughout the book, the family and the social universe within which the family finds itself are mutually informing in a complex and ever-changing relationship. Two of the most influential social forces that affect the creation, development, and meaning making of a family are gender and cultural diversity, to which we now turn.

Gender Roles and Gender Ideology

Typically, indoctrination into different socially based gender role behavior in the family begins early in life for males and females. While biology undoubtedly plays a determining role in gender differences, most of the differences (value systems, personality characteristics, roles, problem-solving techniques, attitudes toward sexuality, etc.) result from learning that is reinforced by society and passed down across generations (Philpot, 2000). As a result of their differing socialization experiences, supported by general societal (and specific cultural) stereotypes, members of each sex for the most part develop distinct behavioral expectations and are granted

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disparate opportunities and privileges. Males and females typically grow up with different senses of entitlement, exercise differing degrees of power, and have differing life experiences.

Gender shapes our individual identity and expectations, our role and status within our family, and the real and perceived life choices open to us (Haddock, Zimmerman, & Lyness, 2003). Men traditionally have played the more powerful role in most heterosexual families: a man's career moves and personal interests were apt to be prioritized; less was expected of him in carrying out household chores; he was likely to be granted the major (or final) influence in family decisions; his leisure time and discretionary spending were given primary attention; and he was expected to have less emotional investment in family relationships.

However, as society's awareness of the crucial role of gender—as a determinant of personal identity, sociocultural privilege, or oppression—has grown in recent decades, largely because of women's increased employment and the feminist movement, so has recognition of the need to overcome gender inequalities and stereotypes that limit psychological functioning for both sexes (see Chapter 3) and for men and women to co-construct new interactive patterns (Avis, 1996). As a consequence, gender-role changes in recent decades have had a powerful impact on family structure and functioning. As the percentage of women in paid employment has risen, couples have needed to redefine at-home responsibilities of men and women; and overall, the pattern of gender-linked behaviors, expectations, and attitudes regarding a family's sex-defined roles has begun to change. See Box 1.4: Evidence-Based Practice to learn more



BOX 1.4 EVIDENCE-BASED PRACTICE

Dual Work Families

Today's average American family is apt to have two working adults and to rely on the income of both partners for economic survival. Typically, they face a major challenge in determining how best to balance work and nonwork tasks (Barnett & Hyde, 2001). Employed married women now spend less time in child care and household tasks than they did 30 years ago, and correspondingly, their employed husbands spend more time on those home-based activities. Inevitably, such shifts have caused striking changes in the relationships between men and women; in many cases, they have resulted in family instability as couples try to work out differences in their gender-role ideologies (the extent to which they hold traditional or nontraditional views of the social roles of men and women). Fraenkel and Capstick (2012) have examined the challenges of navigating work and family responsibilities in two-parent, two-income families, recognizing that race, ethnicity, immigration status, gender identity, sexual orientation, and social class play a decisive role in how such families manage best to cope. In single-parent households, the sole parent is almost certain to be working outside the home (Galinsky, 1999).

Barnett and Hyde (2001) suggest that the father who spends long hours caring for his children while his wife works a different shift may resent child caregiving because he perceives it as a "woman's job" and thus may get little benefit from his new father role. Similarly, if a wife works outside the home but prefers to be at home because she believes it is a woman's duty to be a full-time mother, she may not benefit from her new work role. Men have often been socialized to believe they are carrying out their role within the family by working, while working women sometimes worry that they are being bad mothers (Coltrane, 1998). In general, those who adopt a more egalitarian attitude benefit more from combining work and family roles than do those with more traditional gender-role ideologies.

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about how contemporary two-income families and gender ideology affect each other. Male and female role differences have become less clearly defined today as many families, especially those led by the younger generations, struggle to find more flexible, if not yet fully worked-out, patterns for living together harmoniously in a dual-working household. Time pressures, how best to juggle work and family obligations, who takes time off from work to care for a sick child—these are some of the day-to-day issues two-income families typically face. In the case of working-class dual earners, a sick child may become a family crisis if their jobs do not permit time off for either parent.

Cultural Diversity and the Family

Cultural factors, largely overlooked by family therapists in the past, now play a central role in our understanding of family life. Increased immigration, particularly over the last 20 years—the largest two-decade influx in American history—has added substantially to our appreciation of the primacy of *cultural diversity* in our society. Values, rituals, common transactional patterns, ways of communicating—even the very definition of "family" in different cultures—all require examination if unbiased and comprehensive family assessment and effective counseling are to be provided (Aponte & Wohl, 2000). The importance of kinship networks, the roles of extended family members, expectations regarding male and female behavioral patterns, levels of acculturation and ethnic identification, and socioeconomic power or lack thereof vary for different groups and have an impact on how (and how well) families function.

For example, while the historically dominant American (Anglo) definition of family typically focuses on the intact nuclear family, Italians tend to refer to family as the entire network of aunts, uncles, cousins, and grandparents—all of whom are likely to be involved in family decision making. African Americans are apt to think of family as a wide network of kin plus long-time friends and other community members. For the Chinese, family includes all their ancestors and descendants (Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1999).

In *Ethnicity and Family Therapy*, McGoldrick, Giordano, and Pearce (2005) present descriptions of common structural patterns between families from more than 40 different ethnic groups, underscoring that family therapy clients from each group may make different assumptions about the therapeutic process, emphasize different family issues of importance to them, and bring different problem-solving tools and resources in dealing with those issues. Boyd-Franklin (2003a) has elaborated on African-American life experiences, as has Hayden (2001) in describing Irish-American life and Falicov (2013) in offering guidance in considering the cultural context while working with Latino families.

McGoldrick and Ashton (2012) emphasize the need for clinicians to examine the various facets of their own identity, their own **ethnicity** and cultural heritage—and to become aware of their own cultural biases and prejudices—in order to increase their flexibility and

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competence to work with clients they are likely to encounter in our multicultural society. As they note:

> Cultural competence requires not a cookbook approach to cultural differences but an appreciation for the often hidden cultural aspects of our psychological, spiritual, and physical selves, a profound respect for the limitations of our own cultural perspective and the ability to deal respectfully with those whose values differ from our own. (p. 239)

Social class differences also add to diversity between families, shaping the resources, expectations, opportunities, privileges, and options of their members (Kliman, 2010). Depending to a large extent on social class membership, work may be fulfilling or demoralizing; a means to achieving upward mobility or a dead end; filled with satisfactions or boredom; or, in the case of the underclass, frequently nonexistent (Wilson, 1996).

Kliman and Madsen (1999) emphasize that more than family income is involved in class definitions; the interplay of ethnicity, religion, and education also influences perceived social status. As they illustrate:

> A professor is seen as being in a higher class than a contractor who has equal income—unless the professor is a Latina single mother and the contractor is an Anglo-American man from "an old family." Women's and children's class standing plummets after divorce. A Black executive has less effective class standing than White subordinates when trying to hail a cab, join a country club, buy an elegant house, or insure his children's class stability. In restaurants and hotels, Whites may ask him to serve them. (p. 89)

Boyd-Franklin and Karger (2012) draw attention to the complex interplay of race and social class. Beyond the simplistic equation of Whites as middle class and Blacks as poor, considerable variety occurs within each group. They note, for example, that a Black family classified as poor because of low income may have middle-class values, aspirations, and expectations for their children.

In describing a complex interaction of ethnicity, social class, and gender, Sarmiento and Cardenal (2009) note how differently the relationship between depression and poor family functioning are experienced by Latino men and women. Further, they indicate that the pressure to acculturate affects Latinos differently. Non-Latino therapists will need to appreciate a very wide range of factors to work successfully with members of this population. See Chapter 3 for more details.

Social class and a family's socioeconomic status have only recently been given sustained scholarly attention. In addition to the impact of material wealth or its absence on the family, the experience of classism—a bias against people from social classes different from one's own—may also have an impact on family functioning. Liu (2010) notes that the impact of social class and classism on mental health functioning crosses racial, ethnic, and social lines and significantly contributes to a sense of well-being. He argues that any attempt to understand individuals must include an understanding of how economic issues contribute to experienced difficulties. As with any other bias, therapists need to explore their own reactions to working with people of social classes and economic statuses different from their own.

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Those most vulnerable to poverty are nonwhite minorities, single mothers, children under 18, and the elderly (Lott & Bullock, 2001). As we describe family behavior patterns throughout this text, it is important to bear in mind how client lives are constrained by the larger forces of racial, cultural, sexual, and class-based inequalities (McGoldrick & Hardy, 2008). In addition to these forces, we may add the impact of differences in terms of religion, sexual orientation, gender, and immigration status. Indeed, it no longer makes sense to consider any of these forces as separate influences when working with people therapeutically. They all interact and contribute to the context within which therapists may begin to understand both clients and themselves (Rastogi & Thomas, 2009).

Impact of Gender and Cultural Influences on the Therapist and Therapy

As we have noted throughout this chapter and will continue to do throughout the book, an expanded view of family life compels therapists to broaden their own understanding of what life is like for those whose backgrounds may be quite different from their own. Culturally competent therapists continually reexamine their thoughts and feelings about others (Ponterotto, Casas, Suzuki, & Alexander, 2010).

For example, therapists need to consider how gender has influenced their personal development. Knudson-Martin and Laughlin (2005) note, for example, that it is not unusual for heterosexual therapists working with families led by same-sex partners to experience unintentional bias. They suggest that family therapy has been based on a view of sex and gender that creates a dichotomous sense of self and other (therapist and gay person) in which the "other" becomes a "type" rather than a living and breathing person. They note that the unintentional creation of categories may limit flexibility in working together and advocate a "postgender" approach organized around a relationship model based on equity rather than gender. Alternatively, the emergence of polyamory, a multiple-partner form of family in which adults openly consent to intimate relationships with more than one person, may challenge family therapists who identify with monogamy (Anapol, 2010).

Therapists also need to consider whether the gender of the therapist matters in therapeutic outcomes. Clients select therapists based on many criteria such as the therapist's age, race, religion, and sexual orientation. Of course, gender is also a factor in selecting a therapist. In family therapy the gender of the therapist may cause difficulties as when, for example, the father insists on seeing a male therapist when his wife and daughter would prefer a female therapist. While gender choice might affect the beginning of therapy, research suggests that the gender of the therapist does not appear to influence clinical outcomes, except in some cases involving adolescents. However, other criteria may moderate or mediate the impact of gender (Blow, Timm, & Cox, 2008).

An additional element in this process of self-discovery is for therapists to learn how biases felt toward people from backgrounds different from their own may influence the therapy. Even well-intending therapists may encounter obstacles to effective work when an unexpected bias emerges. See Box 1.5: Thinking Like a Clinician to help explore your own possible biases.

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BOX 1.5 THINKING LIKE A CLINICIAN

Assessing One's Own Possible Biases

Imagine that each of the following "clients" enters your therapy office. Try to picture each one in turn, and then write down any thoughts and feelings about the person or people that occur to you. This exercise is personal and need not be shared with anyone, so be as honest with yourself as possible. Do any of your reactions surprise you? In what way or ways? Could any of your reactions interfere with your ability to work with the client? If so, how?

- An extremely underweight 15-year-old girl
- A father with tattoos of naked women on his arms
- A boy wearing eye makeup and lipstick
- Parents of a 12-year-old boy who are in their 60s
- (If you are straight) A lesbian couple who kiss each other just as they sit down
- (If you are gay) A straight couple who kiss each other just as they sit down
- A family with seven children
- An African-American man with his White girlfriend
- A transgender individual considering gender-related surgery
- A severely overweight boy eating an ice cream cone
- A pregnant mother who is obviously intoxicated
- Two gay men with their adopted Asian-American daughter
- A client obviously much wealthier or much poorer than you

The impact of such forces as race, ethnicity, gender, sexuality, socioeconomic status, and so forth on client and therapist identity development are so important that we take them up in greater detail in Chapter 3.

Shifting Perspectives of Family Therapy

Scientific models help shape the boundaries of a discipline and set the agenda regarding the subject matter and methodology to be followed in seeking answers. When one set of attitudes, philosophies, viewpoints, procedures, or methodologies dominates scientific thinking—known as a **paradigm**—solutions to problems are sought within the perspective of that school of thought. However, should serious problems arise that do not appear to be explained by the prevailing paradigm, scientific efforts typically occur in an attempt to replace the existing system with a more appropriate rationale.

Shifting Paradigm: From Individual Psyche to Family System

During the first half of the 20th century, psychotherapy, most often in the form of Freudian, or classical, psychoanalysis, tended to focus on the inner world—the **intrapsychic** world—of an individual, even as family relationships were seen as influencing it. Although Freud wrote extensively on the family's influence on an individual's personality, he generally advocated

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not involving family members in the treatment of his patients (see Chapter 7), preferring instead to explore the patient's unconscious fantasy world. In time, however, some therapists and theorists came to believe that the singular focus on the individual's unconscious life was sometimes inadequate for understanding or treating the individual's problems. The old belief system started to yield to a newer one that took into account actual rather than just fantasied family relationships in the therapeutic experience.

Once an old belief system is replaced, perspectives shift, and previous events take on new meaning (Stanton, 2009). The resulting transition to a new paradigm, according to Capra (2002), constitutes a scientific revolution. Precisely such a revolution in the thinking of many psychotherapists took place in the 1950s, considered the period when family therapy began (Goldenberg, Goldenberg, & Goldenberg Pelavin, 2014).

The Origins of Family Therapy: A New Paradigm Begins to Take Shape

More than simply another treatment method, family therapy represents a "whole new way of conceptualizing human problems, of understanding behavior, the development of symptoms, and their resolution" (Sluzki, 1978, p. 366). The perspective of family therapy demonstrates a paradigm shift calling for a new set of premises and methods for collecting and interpreting family data. Beyond a concern with the individual's personality characteristics or repetitive behavior patterns, beyond even a concern with what transpires between people (where individuals remain the unit of study), this conceptual leap focuses attention on the family as subject matter. It is the family as a functioning transactional system, as an entity in itself, more than the sum of the inputs of its participants, that provides the context for understanding individual functioning.

By bringing systems theory to the study of families, family therapy represents a major epistemological revolution in the behavioral sciences. Put simply, **epistemology** refers to how one goes about gaining knowledge and drawing conclusions about the world. Family therapists commonly use the term to indicate a conceptual framework or belief system. Epistemology refers to the rules used to make sense of experience and the descriptive language used to interpret incoming information. Such rules, not necessarily consciously stated, determine the underlying assumptions we make in our day-to-day behavior as therapists and theorists as we attempt to understand what is happening around us and how we can bring about change.

Without negating the significance of individual intrapsychic dynamics, today's broader view of human problems focuses on the family context in which individual behavior currently occurs (rather than as recalled from the past). While bearing in mind the often complex ways in which individual behavior contributes to that interaction, such an **interpersonal** perspective—as opposed to an intrapsychic one—regards all behavior as part of a sequence of ongoing, interactional, recursive, or recurring events with no obvious beginning or end. Rather than attempt to discover the answer to why something occurred by searching the past of each of the players, the family relational view directs the clinician's attention beyond the individual to *transaction patterns* currently taking place within the family.

People and events are assumed to exist in a context of mutual influence and interaction, as participants share in each other's destiny. Within such a framework, all family members are

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embedded in a network of relationships, and helping families change their structure, typical interactive patterns, or belief systems alters each member's behavior. Clinicians with a systems outlook concern themselves with understanding *what* is occurring (say, conflict between a troubled marital pair), *how* it occurs (observing its current repetitive patterns), and *when* it occurs (whenever issues over power and control arise) rather than searching for *why* it is occurring. That is, systems-oriented clinicians are more interested in the *process* of what they are observing in the couple's interactions than in the *content* of those transactions. For example, a therapist working with a couple quarreling over spending money is likely to draw their attention to the trouble they are having making decisions together rather than focusing specifically on finances. How power and control in the family are distributed, who does or does not feel heard, what gender roles influence their outlooks, where these differences transfer to other areas of their relationship, what past resentments poison their ability to work in partnership to resolve problems—answers to these questions reveal how they relate to one another more than the specific problems around spending money. Box 1.6 illustrates such a situation.



BOX 1.6 CASE STUDY

A Couple in Conflict Seek Help over Money Issues

Bob and Tess had been married for 10 years and had two children, an 8-year-old boy and a 6-year-old girl, when they contacted a family therapist. They were immediately hostile to one another in the first session, calling each other names, threatening divorce. She said she could no longer deal with her husband's "pinchpenny" behavior—his checking on the groceries she brought home to see if she had bought something he thought unnecessary, yelling if she bought the children toys or planned "expensive" birthday parties, refusing to send them to after-school activities because of the cost.

Bob had his own list of grievances. He worked hard for his money, he argued, and she never seemed to have enough. Although he claimed to be giving her a generous amount each month, she managed to spend it all, whereupon she would run up a credit card bill she could not pay and then came to him each month to be "bailed out" with additional cash. According to Bob, if she wanted special activities for the children, he did not object, but she would have to give up other things to live within her budget. Needless to say, they did not agree on what the size of that budget should be. He insisted that it was his right to control the budget because he was the man and the wage earner.

As they talked about themselves, the therapist noted that while Tess came from a middle-class family whose father had gone bankrupt several times, Bob was brought up in a working-class family, where he learned to live frugally and watch expenditures. In their early years together, before the children were born, Tess worked in an office, kept her earnings separate from his, and used her own money to buy what she needed. There was little conflict. No thought was given to combining incomes, nor did they see any need to do so since the system they had worked out didn't seem to need fixing. The couple got along well, had a good sexual relationship, spent time with a large social circle, and considered themselves reasonably content and working in partnership.

That changed very soon after the children arrived. Bob complained about his wife's lack of

(Continued)

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sexual interest and what he considered her rejection of him in favor of the children. He shouted about her "spendthrift" ways and became livid about the children being overindulged with "things." Tess resented his unwillingness to help with the children and especially his eating alone, in front of the television set, when he arrived home from work. Soon they slept in separate rooms—she in their bed (in which the children frequently joined her), he on the living room couch, having fallen asleep watching late-night television. Each began to complain to the children about the other, trying to elicit their help to change the other's behavior and to prevent the couple from divorcing.

The therapist reminded them that they once had been able to resolve problems together and wondered what each needed in order to be able to do so again. He redirected them to consider previous struggles for power and control, recognizing that this was an unresolved issue they had never faced. While they were encouraged to work on a budget—regarding their money as "family" income and outlay they needed to work on collaboratively—the major focus of the therapy turned to helping them gain greater awareness of the process taking place between them. They began to examine how they undermined each other, how seeking alliances with the children was destructive, how their sex life stalemate reflected their unresolved power issues, how they needed to work in partnership if they wished to keep their marriage from self-destructing. Bob began to comprehend Tess's sense of fatigue and loneliness in raising the children by herself, and she tried to understand his sense of powerlessness and despair in making her hear his point of view. As they listened, fought, defended themselves, each slowly began to understand the viewpoint of the other and to feel less victimized. The therapist continued to build upon their earlier success together, emphasizing their resiliency.

Bob returned to their bed, tried to get home early from work on the day of the children's after-school sports events, and said he was willing, if not eager, to provide more money and not try to control her spending about specific items. She, in turn, offered to be more careful about living within a budget they worked on together. Tess gained a better understanding of their financial situation, and Bob came to realize that the money belonged to them both and that together they could decide how best to spend it. As they felt supported by one another, they were able to give up their underlying power struggle and resist reverting to stereotypic gender roles.

Recasting the individual as a unit of a larger system, such as the family,[2] enables us to search for recurring patterns of interaction in which that person might engage. Our conceptualization of what that person does, what his or her motives are for doing so, and how that behavior can be changed therapeutically takes on new dimensions as we shift our attention to the broader context in which that person functions. From this new wide-angle perspective, psychopathology or dysfunctional behavior can be redefined as more the product of a struggle between persons than simply the result of opposing forces within each of the participants.

[2]The family, in turn, is itself part of a larger system, and its experiences are often profoundly influenced by involvements with the workplace, the school system, the healthcare system, the legal system, and so forth, in addition to reflecting aspects of the particular family's cultural background, ethnicity, race, and social class. An **ecosystemic approach** (McDaniel, Lusterman, & Philpot, 2001) in assessment and treatment takes into account the multiple systems in which the family is embedded. We'll elaborate on some of these systems-within-systems issues in Chapter 4.

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Various therapeutic consequences follow from such a shift of perspective. When the locus of pathology is defined as internal, the property of a single individual or **monad**, the therapist focuses on individual processes and behavior patterns. If the dysfunctional behavior is viewed as a reflection of a flawed relationship between members of a **dyad** or **triad**, then it is the relationship that becomes the center of therapeutic attention and the target of intervention strategies. The role of therapist as collaborator with couples or entire families as they alter their transactional patterns replaces the therapist as psychological sleuth seeking to uncover and decipher what goes on within the mind of the individual.

If successful, family therapy alters the system, helping families replace their previously limiting and self-defeating repetitive interactive patterns or opening up the style and manner of communicating with one another across generations through a consideration of new options or beliefs. Within this changed family context, enriched relationship skills, improved communication abilities, and enhanced problem-solving capabilities may lead to more rewarding interpersonal experiences, in most cases extending beyond the family.

LO 5 Cybernetics: The Paradigm Shift Continues

With the shift from focusing on the individual to the family system came many new epistemological approaches to theory and clinical practice. One of vital importance to the history of family therapy is the theory of cybernetics. Concerned with patterns and processes, the systems outlook proposes a **cybernetic** epistemology as an alternative to our habitual ways of knowing and thinking. Historically, the science of cybernetics was born during the early 1940s in a series of wartime interdisciplinary conferences in New York City sponsored by the Josiah Macy Foundation and attended by a cross-section of the leading scientists, engineers, mathematicians, and social scientists of the time. The conferees addressed, among other things, the study of communication in reference to regulation and control (e.g., the wartime problems of guided missiles and rockets) through the operation of **feedback** mechanisms.

Norbert Wiener (1948), the mathematician who coined the term *cybernetics* and who was to become a principal player in the development of computers, was especially interested in information processing and how feedback mechanisms operate in controlling both simple and complex systems. Wiener chose the term *cybernetics* from the Greek word for "steersman," suggestive of an overall governing or regulating system or organization for guiding or piloting a ship by means of feedback cycles. To Wiener, cybernetics represented the science of communication and control in humans as well as in machines.

These Macy conferences made an important breakthrough by providing a new and exciting epistemology—a new paradigm—for conceptualizing how systems retain their stability through self-regulation as a result of reinserting the results of past performance into current functioning. Perhaps even more significant, a way to change patterns of future performance by altering feedback information was emerging. Researchers from both the physical and social sciences began to explore how these systems or cybernetics notions could be applied to various fields in which both living and nonliving entities could be governed by self-regulating

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feedback loops that become activated to correct errors or deviations in the system and thus restore stability in the process of reaching its preprogrammed goal.

Thus, what we now think of as simple or **first-order cybernetics** grew out of communication engineering and computer science as a means of understanding the general principles of how systems of all kinds are self-regulated and thus maintain their stability. Attention was directed toward structure—patterns of organization—and control through feedback cycles. Universal laws or codes were sought to explain what governs all systems. It was assumed further that the system being observed was separate from the observer, who could objectively study and carry out changes in the system while remaining outside of the system itself.

It was Gregory Bateson, an English-born anthropologist and ethnologist who worked for the U.S. Office of Strategic Services in India during World War II, who took away from these conferences some of these mathematical and engineering concepts and applied them to the social and behavioral sciences. Bateson (1972), increasingly concerned with epistemological issues, understood that cybernetics, with its emphasis on self-correcting feedback mechanisms, pointed to the inseparable relationship between stability and change when he later noted:

> All changes can be understood as the effort to maintain some constancy and all constancy as maintained through change. (p. 381)

Although Wiener himself had begun to reformulate psychological constructs (e.g., Freud's idea of an unconscious) in information-processing terms, Bateson (1972) deserves the major credit for seeing how cybernetic principles apply to human communication processes, including those associated with psychopathology. Attempting to understand how families in various cultures sustain stability, he introduced the notion that a family might be analogous to a cybernetic system in its use of self-regulating feedback mechanisms to maintain balance and constancy. While Bateson himself remained outside the realm of family therapy, his cybernetic ideas are generally considered to have provided the field of family therapy with its intellectual foundation.

Bateson's later (1956) contributions to a daring **double-bind** theory of schizophrenia as a relationship phenomenon rather than an intrapsychic disorder were monumental in describing an important psychiatric entity in transactional communication terms, specifically in drawing attention to the family context that gave the symptoms meaning. Although this theory regarding the origin of schizophrenia later proved to be incomplete, if not inaccurate, its effort to look beyond the symptomatic person to family transactions was groundbreaking in directing researchers to examine what occurs in the exchange of information and the process of relationships between persons, as in a family. We will return to Bateson and the "double-bind" theory in Chapter 5.



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Gregory Bateson, Ph.D.

Reciprocal Determinism

Adopting a relationship outlook inevitably shifts attention from *content* to *process*. Rather than dwelling on historical facts as explanations for

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current problems (Felicite: "Our problem began when my husband, Enrique, lost his job and our son Jorge went to work"), this new perspective focuses on the sequence of linked communication exchanges within a cybernetic family system ("With Enrique out of work, our son Jorge is contributing more money and seems to be dominating us; I submit to Jorge's demands more and more, and I suppose Enrique is resentful"). Note how the latter statement shifts attention from the linear sequential actions of individuals to the transactions occurring among them. The "facts" of the case (content) are static and not nearly as clinically illuminating as is the family interactional pattern (process) and its cultural context.

Content is the language of **linear causality**—the view that one event causes the next in unidirectional stimulus-response fashion. While such a view may be appropriate for understanding simple mechanical situations (where the machinery does not have too many parts and the parts do not interact much), it is woefully inadequate for dealing with situations exhibiting organized complexity, such as what transpires within a family.

From a cybernetic or systems standpoint, concerned with wholes, a precise part-by-part analysis (such as searching for specific childhood traumatic events as causes of current adult problems) is viewed as too reductionistic and inferential to be of much explanatory value. Instead, argue opponents of linear thinking, parts are better understood by the functions they serve in the whole.

In the physical world, the world of Newton, it makes some sense to talk of causality in linear terms: A causes B, which acts upon C, causing D. In human relationships, however, this "billiard ball" model, which proposes that a force moves in one direction only and affects objects in its path, rarely—if ever—applies. Consequently, *any search for the "real" or ultimate cause of any interpersonal event is pointless*. A does not cause B, nor does B cause A; both cause each other. Explanations cannot be found in the action of the parts but in the system as a whole—its communication patterns, complex relationships, and mutual influences.

If content is the language of linear causality, then process is the language of **circular causality**. The emphasis here is on forces moving in many directions simultaneously, not simply a single event caused by a previous one. Within a family, any action by one member affects all other members and the family as a whole; each member's response in turn prompts other responses that affect all other members, whose further reactions provoke still other responses, and so forth. Such a reverberating effect in turn affects the first person, in a continuous series of circular loops or recurring chains of influence.

Problems are not caused by past situations in this view, but rather by ongoing, interactive, mutually influencing family processes. Parents who ask quarreling children, "Who started the fight?" are almost certain to hear, "He (she) started it; I'm only hitting back." Both children are correct, both are incorrect; it all depends on where in the communication loop the parent begins the investigation. Nor is such mutual participation limited to pairs. Within a large family, for example, a multitude of such chains exist. Who started what is usually impossible to decipher and really of little consequence in resolving the interpersonal conflict. Reciprocity is the underlying principle in all relationships. Change calls for altering the process, not discovering the original culprit. See Box 1.7 for an example contrasting linear and circular causality.

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BOX 1.7 CLINICAL NOTE

Contrasting Linear and Circular Causality

Note the following contrasts between statements based on linear and circular causality:

LINEAR: A disturbed mother produces disturbed children.

IMPLICATION: Mother's emotional problems cause similar problems in other family members.

CIRCULAR: A middle-aged woman, struggling with what she perceives as an inattentive husband, forms an alliance with her 20-year-old son, paying less attention to her teenage daughter. The daughter, feeling rejected, turns to her peers and flirts with promiscuous behavior, to the considerable distress of her parents. The son, not quite ready to become independent, feels he must remain at home because his mother needs his attention. The mother blames her problems on what she considers a distant husband, who in turn feels criticized and excluded from the family. As he protects himself by further distancing himself from her, their sexual relationship suffers. The children respond to the ensuing coldness between the parents in different ways: the son by withdrawing further from friends, remaining at home with his mother as much as possible, and the daughter by pulling away from the family and leaning on a rebellious peer group as models.

IMPLICATION: Behavior has at least as much to do with the interactional context in which it occurs as with the inner mental processes or emotional problems of any of the players.

What should be clear from this example is that family processes affect individual behavior, and individuals within the family system affect family processes, in a recursive manner. Within the family context, every action provokes a circular sequence that in turn helps change the original action. The family who brings a defiant adolescent to therapy and wonders why the therapist wants to see all the family members together is learning that the therapist believes all participants must look at the family context as the locus of the difficulty. To point a finger at one family member as the cause of the family's distress is to ignore dysfunctional patterns between members that perpetuate the problem.

Second-Order Cybernetics and Postmodernism

The theoretical movement from linear or causal to cybernetic or circular epistemology has been influenced by postmodernism. The postmodern view, increasingly popular today among family therapists, is a philosophical outlook that rejects the notion that there exists an objectively knowable universe discoverable by objective science and instead argues that there are multiple views of reality ungoverned by universal laws. Postmodernism in family therapy represents a break with first-order cybernetically based notions, raising skepticism regarding the meaning attached to symptomatic behavior. Postmodernists reject the notion that a family member's problems necessarily reflect underlying family conflict. From their **constructivist**[3]

[3]*Constructivism* and its related postmodern theory of *social constructionism* (Becvar, 2000) offer new, influential epistemological explanations regarding how we know what we know. The former argues that each of our perceptions is not an exact replica of the world but rather a point of view seen through the limiting lens of assumptions we make about people. The latter argues that we cannot perceive a true, objective reality, adding that the reality each of us does construct is mediated through language and is socially determined through our relationships with others and the culture's shared set of assumptions. That is, we experience reality in and through language in terms of the prepackaged thoughts of our society.

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perspective, families tell themselves stories (narratives) and develop beliefs about themselves. These constructions, in turn, organize their experiences and play a powerful role in shaping their lives. In some cases, such stories come to represent dominant and burdensome discourses that lead them to believe they have limited options and are doomed to repeat their self-defeating behavior.

The clinical thrust of the postmodern perspective calls for creating a therapeutic environment in which therapist and family members together can share the subjective ideas, perceptions, beliefs, and interpretations each participant gives to family experiences. As its members explore new information, the family is free to create a new perception of reality, allowing itself to experiment with alternative family narratives. Postmodern family therapists such as social worker Lynn Hoffman (2002) are advocates of **second-order cybernetics**, a postsystems reappraisal of cybernetic theorizing that insists there can be no outside, independent observer of a system, since anyone attempting to observe and change a system is by definition a participant who both influences and in turn is influenced by that system. (In contrast, the first-order cybernetic paradigm conceives of two separate systems—the therapist system and the problem-client family system—in which the therapist remains an external observer, an expert who attempts to effect changes by means of interventions from the outside.)

Second-order cyberneticists contend that in doing family therapy, the therapist must be aware that several individuals are present, each with his or her own view of reality and description of the family. Thus, these cyberneticists emphasize that objectivity per se does not exist; so-called objective descriptions of families are merely social constructions that may say more about the describer than about the family. Rather than be discovered through so-called objective means, the family's "reality" is nothing more than the agreed-upon consensus that occurs through the social interaction of its members (Real, 1990).

From this new perspective, a family is composed of multiple perspectives—multiple realities—and the therapist, no longer seen as an outside observer of (or expert on) the problem situation, has a part in constructing the reality being observed. The therapist does not operate as if she or he or any single family member can reveal the "truth" about the family or its problems. Just as with the other participants, what the therapist sees as existing in the family is a product of his or her particular set of assumptions about families and their problems. There are multiple "truths" about every family, not one universal "truth." The therapist, then, can no longer consider any member's viewpoint as a distortion of some presumably correct interpretation of reality that the therapist (or that a particular family member) alone can see.

In this view, humans are seen as observing systems who describe, distinguish, and delineate through the use of language. But since none of us sees an objective universe, each family's interpretation of reality is limited by the "stories" members tell themselves about themselves as individuals or as a family. These "stories" not only reflect but, more importantly, define and give meaning to the family's experiences, and in that sense they are self-perpetuating. Rather than talk of a family's "reality testing," advocates of this view argue that we should speak of "consensus testing." Family therapy in the postmodern era, then, becomes a form of family

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"conversation" to which the therapist is invited. The therapist and family together generate a new narrative, in effect transforming the pathologizing tale that presumably brought the family to therapy (Doherty, 1991). According to Weingarten (1998), to benefit from the unfolding conversation or narrative, therapists and family members should pay attention to the "small and the ordinary" interactions that come up during a session. By attending to specific words, gestures, minor asides, trivial actions, and so forth, participants gain new opportunities to generate new meaning.

Beginning in the late 1970s, some family therapists sympathetic to the cybernetic ideas of Bateson (1972) began to pay attention to the theories of Chilean biologist Humberto Maturana (1978), cognitive scientist Francisco Varela (1979), cyberneticist Heinz von Foerster (1981), and cognitive psychologist Ernst von Glaserfeld (1987), all of whom urged the abandonment of the simple cybernetic notion that a living system could be observed, studied objectively, and changed from the outside. Instead, they placed the observer in that which was being observed. Family therapists such as Hoffman (1990) applied many of these ideas to their work, adopting a second-order cybernetic model—one in which the observing therapist is an integral and recursive part of the family system being observed, co-constructing with family members the meaning of their lives. Instead of providing answers to the family's problems, the therapist and family members together search for meaning and in the process "re-author" lives and relationships.

While first-order cybernetics might well remain the primary focus for many therapists who see family systems as analogous to mechanical systems, these second-order cyberneticists argue that living systems should not be seen as objects that can be programmed from the outside but rather as self-creating, independent entities. Slovik and Griffith (1992) maintain that the latter group's efforts represent a backlash against what critics perceive as the potential dangers of controlling, manipulative, and authoritarian intervention tactics and strategies. As Hoffman (1990) illustrates:

> A first-order view in family therapy would assume that it is possible to influence another person or family by using this or that technique: I program you; I teach you; I instruct you. A second-order view would mean that therapists include themselves as part of what must change; they do not stand outside. (p. 5)

So considerable controversy exists over how a troubled and dysfunctional family is best helped to change. Is the family therapist an outside expert, a powerful, take-charge change agent who enters a family to observe, disrupt its customary interactive patterns, and then design strategies to alter the family's self-defeating, repetitive patterns? Or is the family therapist a part of the process necessary for change, with his or her own "reality," who creates a context for change through therapeutic conversation and dialogue in the hope of evolving new meaning by changing family premises and assumptions? Should family therapists be action oriented and push for behavioral change or focus attention on how language creates a reality for people? Minuchin (1991) questions the extent to which constructivist approaches recognize the institutions and socioeconomic conditions that influence how people live, pointing out that families living in poverty, for example, have been stripped of much of the power to write their own stories.

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The Identified Patient as Seen from the Different Family Therapy Perspectives

In family therapy, the family member with the presenting problem or symptom is called the **identified patient** (IP). Family therapists were among the first to recognize that when the IP came for help, his or her entire family was hurting and also needed assistance. As we have seen, different family therapy perspectives would "see" the IP in different ways. Early classical psychoanalytic therapists, for example, might understand the IP's symptoms as an expression of intrapsychic conflict with origins in family dynamics and would likely work with her or him in one-on-one therapy. Family members likely would not be included in treatment.

Early family therapists started to understand the IP's symptoms from a systems perspective. Family therapy pioneer Virginia Satir (1964), for example, contended that the IP was expressing the family's disequilibrium or, in her terms, the family's "pain." Perhaps the IP was expressing what other family members were thinking or feeling but were unable (or afraid) to acknowledge. Or was the IP's symptomatic behavior (drug addiction, failure to leave home, temper tantrums, dropping out of school) diverting attention from other family problems? The therapist's task became one of refocusing attention, not allowing the symptomatic behavior to obscure other conflicts within the family.

Another early thesis was that symptoms had a function: they represented a sign that the family had become destabilized and was attempting to reestablish equilibrium. This view that symptoms have a protective purpose in helping maintain family stability—in effect, that dysfunctional families need a "sick" member and are willing to sacrifice that person for the sake of family well-being—was initially a mainstay of many family therapy founders. They concluded that the IP's symptoms represented stabilizing devices used to help relieve family stress and bring the family back into the normal range of its customary behavior. In this sense, the IP's actions may be based on a desire, although not usually a planned or premeditated one, to "help" other family members. For example, Haley (1979) described disturbed young people who do not leave home as willingly sacrificing themselves in order to protect and maintain family stability. According to Boszormenyi-Nagy and Ulrich (1981), family loyalty may evoke symptomatic behavior when a child "feels obligated to save the parents and their marriage from the threat of destruction" (p. 169).

Other family therapy pioneers, such as Salvador Minuchin (Minuchin & Fishman, 1981), viewed symptomatic behavior as a reaction to a family under stress and unable to accommodate to changing circumstances and not particularly as a protective solution to retain family balance. In this view, all family members are equally "symptomatic," despite efforts by the family to locate the problem as residing in one family member. Minuchin sees the IP's symptoms as rooted in dysfunctional family transactions; it is the flawed family structure or inflexibility when new behavior is called for that maintains the symptomatic behavior in the IP. Change calls for the therapist to understand the family context in which the dysfunctional transactions transpire and then to attempt with family members as a group to change that existing context in order to permit new interactional possibilities to emerge.

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A less purposeful or deterministic view of the appearance and maintenance of symptoms in a family member was offered by Watzlawick, Weakland, and Fisch (1974), who contend that symptoms or problems arise from repeated use of the same flawed solutions rather than being a sign of family system dysfunction. It was their belief that problems (or symptoms) are created and maintained because of the repeated attempt to apply an unworkable solution that only serves to make matters worse and that ultimately the attempted solution, repeated without variation, becomes the problem. These authors argue that the family therapist must help the family find new solutions to the original problem if the symptomatic behavior is to be alleviated.

As mentioned earlier, postmodern family therapists believe that the therapist is implicated in the work of therapy. Their physical presence and verbal interventions contribute to the exploration of existing family stories and the "writing" of new stories that change the family's understanding of itself. An important exponent of postmodern family therapy is Michael White (1989, 2007; White & Morgan, 2006), who believes that the stories struggling families tell themselves contribute to a feeling of oppression rather than protection or stabilization by symptomatic behavior in the family. His therapeutic efforts—a form of **narrative therapy** (see Chapter 14), especially his posing of deconstructing questions—represent a collaboration with the family directed at helping explore their ongoing stories and, together with them, co-constructing new stories that hold new possibilities. By rewriting family stories in such a way that new experiences become possible, White gets family members to unite in order to take back control of their lives from the oppressive set of symptoms. In the process, he believes families are freed to view themselves as a healthy unit struggling against a troublesome external problem rather than seeing themselves as an inherently flawed and disabled group of people.

Barnes (2004) seeks to explain what all systemic approaches to family therapy have in common, however they are further conceptualized, by identifying four principles that underlie all of them, as follows:

- People in families are intimately connected, and focusing on the beliefs different members hold about these connections can be a more valid way of understanding and promoting change in problem-related behavior than by focusing on the perspective of any one individual.
- Family members living in close proximity over time set up patterns of interacting made up of relatively stable sequences of speech and behavior.
- Patterns of interactions, beliefs, and behaviors that therapists observe and engage with can be understood as the context of the presenting problems and can be considered both the "cause" and the "effect," acting as feedback loops that create the "fit" between problem and family. Here we see how circular patterns of interaction rather than linear models of cause and effect influence mutual influence and mutually regulated learning.
- Problems within patterns of family life are often related to dilemmas in adapting to some environmental influence or change.

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From this perspective, family therapy looks at the current family context that includes experiences of the here-and-now among members and how members speak about the past. Therapists listen to the ways in which current and past relationships form patterns and "conversations" within each person's mind that influence their beliefs and daily practices. They also listen to the ways in which each member's inner and outer conversations (i.e., inner dialogues and outer conversations with other people) are arranged, privileged, and expressed as an important way of understanding how individuals behave in families, experience intimate relationships, and engage in wider social situations. For Barnes, individual identity is "self-negotiated" in relation to others.

SUMMARY

A family is a natural social system that occurs in a diversity of forms today and represents a diversity of cultural heritages. Embedded in society at large, it is shaped by a multitude of factors, such as its place and time in history, race, ethnicity, socioeconomic status, religious affiliation, and number of generations in this country. The way it functions—establishes rules, communicates, and negotiates differences among members—has numerous implications for the development and well-being of its members. Families display a recurring pattern of interactional sequences in which all members participate.

Those considered to be enabled families succeed at balancing the needs of their members and the family system as a whole. Gender roles and ideologies, cultural background, and social class considerations play decisive roles in behavioral expectations and attitudes. The meanings, understandings, and assumptions a family makes about the world reflect the narratives and stories it has created about itself. Its relational resiliency may enable it to confront and manage disruptive experiences; that resiliency is forged through adversity, not despite it.

Adopting a relationship perspective, family therapists do not negate the significance of individual intrapsychic processes but take the broader view that individual behavior is better understood as occurring within the primary network of a family's social system. Such a paradigm shift from traditional ways of understanding a person's behavior calls for a systemic epistemology in which feedback mechanisms are seen to operate to produce both stability and change. The circular causality involved in what transpires between people within a family forces the family therapist to focus on understanding family processes rather than to seek linear explanations.

While most family therapists adhere to some form of a systemic epistemology, there is a developing schism between those who operate from a first- to a second-order cybernetic model. The latter represents the increasingly influential theories of constructivism and social constructionism.

Different models of family therapy consider the identified patients in different ways. Early family therapists believed the symptom itself acts to stabilize the system and relieve family stress. Others viewed symptomatic behavior more as a reaction to family stress than as a protective solution to restore family balance. In another view, it is the repeated but unworkable solutions that themselves become the problem. From a postmodern perspective, breaking with traditional cybernetic notions, symptoms are seen as oppressive, and the family is urged to unite to take back control of its members' lives from these burdensome symptoms.

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2

Family Development: Continuity and Change



LEARNING OBJECTIVES

- LO 1 Understand the family life cycle model
- LO 2 Recognize how individual family diversity may modify that family's life cycle
- LO 3 Learn the stages of the family life cycle

While family life is an ongoing and interactive process that is by no means linear, it exists in the linear dimension of time. From a multigenerational perspective, generations have a life-shaping impact on each other as families move through family life cycle stages (McGoldrick, Carter, & Garcia-Preto, 2011). As one generation deals with issues of aging, another is attempting to cope with children leaving home, while still another may be planning careers or beginning to experience intimate adult relationships. Each generation in this system influences and is influenced by the other.

Because the **family life cycle** evolves in stages rather than in a smooth and orderly flow of growth, a family can expect periods of transition and change followed by relative stability and then change once again, as it attempts to cope with changing life circumstances and demands. Developmental change can be likened to the paradigm shifts noted in Chapter 1: the family organization is interacting with internal and external pressures that in time will occasion a shift to a new paradigm of family experience. In the process, the family's relationship system—roles assigned to members, closeness between members, boundaries—is continuously being defined and redefined.

In this chapter, we adopt a developmental framework to understand how families typically advance through a series of milestones. We emphasize the issues and tasks to be dealt with at each stage of family life. A family that falters or loses its developmental momentum may need family therapy in order to move forward in fostering each member's individual development (McGoldrick & Shibusawa, 2012).

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LO 1 Developing a Life Cycle Perspective

Advocates contend that the family life cycle perspective offers a positive view of the family's capacity to retain its stability and continuity at the same time that it evolves and changes its structure as new relational processes occur. It is not that a competent family passes through a particular stage stress free or without resisting change but rather that it has the resilience to use its strengths, resources, and effective interpersonal processes to master the necessary transitions. The more resilient the family, the more capably it reorganizes to deal with disruptions and bounces back after temporarily being thrown off course because of developmental transitions (Walsh, 2012a). Interpersonal conflicts that develop within a family may signal the family's inability to negotiate a particular life cycle passage or transition point; here the family is thought to have become "stuck" between stages of the life cycle and to be in need of reorganizing in order to better accommodate to the changing needs of its members.

Identifying Developmental Tasks

Different family life cycle stages call for the mastery of specific developmental tasks by its members. **Developmental tasks** refer to those activities or experiences that need to be mastered at various stages in the family life cycle to enable the family to move to the next developmental stage. Individual developmental tasks fold into family developmental tasks. Some tasks are universal (e.g., infant attachment to caregivers), while some may be more culture bound (e.g., the task of developing an individual identity is less commonly found in collectivistic cultures that emphasize community commitment over individual advancement); see Masten and Tellegen (2012). Contemporary middle-class American society expects adolescents to behave differently from younger children or from adults; young adults, economic circumstances permitting, are encouraged to develop independence and autonomy. However, developing competencies in a dangerous inner-city environment may call for survival skills that the larger society may consider inappropriate. Different times, such as periods of war, often require different survival skills.

Developmental tasks define role expectations throughout the life cycle. Newly married couples must develop a process for gaining greater closeness and interdependence; the nature of their involvement with one another inevitably changes once they have a child. Parents must remain involved with young children in a way that would be smothering for adolescents (Minuchin, Lee, & Simon, 2006). Family life cycle advocates argue that the family that has difficulty navigating a particular phase may be temporarily vulnerable—but not necessarily dysfunctional—and may need help before feeling empowered to manage the turning point.

Conceptualizing the Life Cycle: Some Preliminary Cautions

It is important to note a few words of caution before introducing the life cycle concepts: Any generalizations in the family life cycle model should be seen within the context of a particular class, culture, and historical period (early 21st-century America) and thus are open to periodic revision as changes occur in the larger society. In addition, individual family differences in ethnicity, culture, language, socioeconomic status, sexual identity, degree of acculturation,

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spirituality, and experiences with family violence may modify the nature of the stages and the developmental tasks that must be accomplished. Couples who do not have children experience a very different family life cycle. Box 2.1 highlights some diversity factors that should be considered in understanding variations in the family life cycle.

One further caution: It is useful to remember that transitions from one stage to the next are rarely accomplished as neatly in real life as stage theory would suggest. Mastering a significant life cycle transition calls for changes in the family system, not merely rearrangements of accommodations between members (which typically go on unnoticed throughout family life). Most transitions occur over several years, and life stages often merge into one another, so that a family may be trying to cope with the same issues and challenges over several stages. The key point to remember here, as Gerson (1995) observes, is that

> each transition requires a family to change, to reset priorities, and to organize to meet the challenges of the new life cycle stage. Therapists can learn much about a family and how it is coping and functioning by assessing how that family meets the challenges of each life cycle transition. (p. 91)



BOX 2.1 FAMILY DIVERSITY

LO 2 Family Diversity May Modify Life Cycle Stages

Despite the view held by most family therapists that the life course of families evolves through a predictable sequence of stages that are fairly universal, a variety of individual family differences may change the exact nature of a family life cycle stage for that family, including:

- Ethnicity
- Culture
- Socioeconomic status
- Sexual identity
- Spirituality
- Family violence
- Physical or mental illness
- Substance abuse

In addition, the family's migration history or degree of acculturation, gender roles, intergenerational hierarchies, child-rearing attitudes and patterns, and the role of the elderly may be important in the way the family navigates a life cycle stage, and these issues are relevant in therapeutic work to help families accomplish the tasks of those stages. Attention should be given to the family's religious and spiritual aspects so therapists can appreciate how the family's faith beliefs and practices affect their interactions (Walsh, 2010).

A heightened awareness of these differences is particularly important when the background of the family is different from the family background of the therapist. For example, a non-Native American therapist needs to appreciate that many young Native Americans, seeking an escape from poverty and finding a lack of employment opportunity on the reservation, frequently move to urban areas, thus weakening their ties to the traditional kinship network of Native American family life and its customary stages of development (Sue & Sue, 2013). The non-Native American therapist needs to be sensitive to these shifting values in Native American culture and appreciate the pressures they may impart on individuals and families from that tradition. In her ecosystemic approach to working with Latino families, Falicov (2014) contends that the family therapy encounter is really an engagement between the therapist's and the family's cultural and personal constructions about family life.

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The Family Life Cycle Framework

Most families, regardless of structure or composition or cultural heritage, progress through certain predictable marker events or phases (such as marriage, the birth of a first child, children leaving home, death of grandparents). Each stage is precipitated by a particular life event—what Zilbach (1989) refers to as a *family stage marker*—demanding change and a new adaptation. These passages may occur because of a sudden major change in family composition (e.g., birth of twins) or perhaps due to a major shift in autonomy (a family member starting kindergarten, entering adolescence, moving away from home). In other cases, external factors stress the family and demand new adaptations—a move to a new community, a change in career, coping with a natural disaster, or perhaps a change in economic circumstances. The family, as a developmental system, typically must attempt to deal with the developmental tasks (or unforeseen set of problems) that require mastery and resolution.

LO 3 Family Life Cycle Stages

Relationships between parents, siblings, and extended family members all undergo transitions as the family proceeds through the life cycle. Table 2.1 proposes a series of discrete stages, starting with single young adults leaving home, marrying, having children, launching those children into the world, and living together in later life. While the stages outlined obviously do not fit every family, especially considering our diverse society, the table draws attention to the multigenerational nature of family life as the family continues to change and evolve.

Continuity and Change Throughout the Family Life Cycle

If every family lives in an ever-changing context, a key question becomes: Is the family under stress flexible enough to allow new interactive patterns to emerge to meet the developmental needs of its members? The answer tells us how easily and how well the family manages conflict and negotiates the transitions between stages. Successful management of challenges in one stage has a significant impact on its ability to effectively carry out the tasks of the subsequent stage. Should the family become destabilized as its members struggle to accommodate change (e.g., the father and mother develop violent disagreements about how late their teenage daughter may stay out on Saturday night and what friends she may be with), one or more family members may become symptomatic (the daughter becomes angry and withdrawn; the mother becomes depressed; the father feels isolated and alone; and the parents' marriage deteriorates). The more rigid the family's interactive pattern, the less likely the members will be able to negotiate differences, the more the family will be stressed by the need to change, and the more likely symptoms will develop within the family system.

As Zilbach (1989) notes, during each stage, family development proceeds through family task accomplishment, and family characteristics of the previous period are carried over into the next stage. If any tasks are incomplete or impeded, development is delayed or suspended, and these difficulties are carried into the subsequent stage of family development. For example, parents may experience fears of separating from a young child and allowing that child to move out of the immediate family to day care, preschool, or kindergarten. That same fear, unresolved, may later cause conflict between parents and the child in adolescence as separation

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again becomes a family issue when the adolescent seeks greater freedom and self-direction; still later, it may delay separation from the family by a young adult.

Both continuity and change characterize the family system as it progresses through time. In some cases the changes are orderly, gradual, and continuous; in others they may be sudden, disruptive, and discontinuous. Both call for transformations in the organization of the system. As an example of the latter, a family may suddenly be confronted by unexpected catastrophic events (serious financial reverses, a terrorist attack, death of a young child, or a random drive-by shooting). Such crises disrupt the family's normal developmental flow and inevitably produce relationship changes within the family system. The unusual or unanticipated timing of a major event may be particularly traumatic precisely because it upsets the sequence and disturbs the rhythm of the expected course of life. Examples include the death of a parent during one's childhood, teenage marriage, a first marriage postponed until late in life, or a child born to parents in midlife (McGoldrick, Carter, & Garcia-Preto, 2011).

TABLE 2.1 Stages of the family life cycle

Family Life Cycle Stage	Emotional Process of Transition: Key Principles	Second-Order Changes in Family Status Required to Proceed Developmentally
Leaving home: Emerging young adults	Accepting emotional and financial responsibility for self	a. Differentiation of self in relation to family of origin b. Development of intimate peer relationships c. Establishment of self in respect to work and financial independence d. Establishment of self in community and larger society e. Spirituality
Joining of families through marriage/ union	Commitment to new system	a. Formation of partner systems b. Realignment of relationships with extended family, friends, and larger community and social system to include new partners
Families with young children	Accepting new members into the system	a. Adjustment of couple system to make space for children b. Collaboration in child-rearing, financial, and household tasks c. Realignment of relationships with extended family to include parenting and grandparenting roles d. Realignment of relationships with community and larger social system to include new family structure and relationships
Families with adolescents	Increasing flexibility of family boundaries to permit children's independence and grandparents' frailties	a. Shift of parent–child relationships to permit adolescent to move into and out of system b. Refocus on midlife couple and career issues c. Begin shift toward caring for older generation d. Realignment with community and larger social system to include shifting family of emerging adolescent and parents in new formation pattern of relating

(Continued)

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Launching children and moving on at midlife	Accepting a multitude of exits from and entries into the family system	a. Renegotiation of couple system as a dyad b. Development of adult-to-adult relationships between parents and grown children c. Realignment of relationships to include in-laws and grandchildren d. Realignment of relationships with community and larger social system to include new structure and constellation of family relationships e. Exploration of new interests/career given the freedom from child-care responsibilities f. Dealing with care needs, disabilities, and death of parents (grandparents)
Families in late middle age	Accepting the shifting generational roles	a. Maintaining of own and/or couple functioning and interests in face of physiological decline: exploration of new familial and social role options b. Support for more central role of middle generation c. Realignment of the system in relation to community and larger social system to acknowledge changed pattern of family relationships at this stage d. Making room in the system for the wisdom and experience of the elders e. Supporting older generation without overfunctioning for them
Families nearing the end of life	Accepting the realities of limitations and death and the completion of one cycle of life	a. Dealing with loss of spouse, siblings, and other peers b. Making preparations for death and legacy c. Managing reversed roles in caretaking between middle and older generations d. Realignment of relationships with larger community and social system to acknowledge changing life cycle relationships

Source: McGoldrick, Carter, and Garcia-Preto, 2011, pp. 16–17.

Certain discontinuous changes are so disruptive to family life that they suddenly and profoundly transform a family system so that it never returns to its former way of functioning. Hoffman (1988) points particularly to events that affect family membership—events representing *family gains* (children acquired through remarriage) or *family losses* (separation of parents, death). Transitions that require major shifts in roles (a young mother with a preschool child returns to work outside the home, a husband loses his job and cannot find reemployment) may produce discontinuous change in the family system.

Many family therapists believe that symptoms in a family member are especially likely to appear at these periods of change, signaling the family's difficulty in negotiating a transition. However, not all continuous or discontinuous change leads to symptomatic behavior. The stress of a transition may give the family an opportunity to break out of its customary coping patterns and develop more productive, growth-enhancing responses to change. Families that have developed effective collaborative ways of coping with adversity and hardship—what Walsh (2010c) calls *relational resilience*—may emerge hardier.

For example, a childless couple who are thinking about becoming parents (considered a continuous life change) may postpone the event because they view it as restricting mobility,

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increasing responsibility, interrupting sleep, and constricting their social life; or they may welcome parenthood as a move to strengthen the family and invest in its future. (They may, of course, feel both reluctance and eagerness to become parents.) The discontinuous changes in remarriage may result in disequilibrium, role confusion, and heightened conflict in the new family, or they may provide a second chance to form a more mature, stable relationship. The family therapist is responsible for helping the family see the full range of its choices, including the possibilities of generating new solutions; the shared belief of the therapist and family in the adaptability of the family system and its potential for growth and self-healing is crucial in helping families engineer change.

A Family Life Cycle Stage Model

Family sociologists such as Evelyn Duvall and Reuben Hill first proposed a developmental framework for studying families in the late 1940s in an effort to account for regularities in family life over time (Duvall & Hill, 1948). The major thrust of this early contribution was to plot the stages through which families typically pass and to predict the approximate time when each stage is reached. As we shall see, more recent theorists have refined the notion of typical stages in family life.

The Developmental Stages

Individual life cycles take place within the family life cycle, and the interplay between the two affects what takes place in each. The relationship system within a family expands, contracts, and realigns over the family's life span, and the family must be flexible enough to sustain the entry and exit of members as well as bolster its members' efforts to move on in their own personal development. Families that become derailed in their life cycle (and correspondingly derail individual efforts at independence) need help in getting back on developmental track. A major goal of family therapy in such situations is to reestablish the family's developmental momentum, utilizing the family's inherent but previously unused strengths.

Family therapists also need to appreciate how a family's work life affects family development. The high rate of dual employment for parents can exert significant pressure on the current family cycle stage. Similarly, high divorce rates, single-parent adoptions, children born out of wedlock to teenagers or later in life to older women, the prevalence of unmarried couples, and numerous stepfamily arrangements have complicated the oversimplified picture of what constitutes normal family development. And finally, families in which both parents are same-sex partners continue to bring unique pressures to bear on the family system. Nevertheless, the life cycle outlook provides a useful organizing framework for understanding a family's conflicts and negotiations, flexibility in adapting to changing conditions, and the appearance of problematic or symptomatic behavior at a particularly treacherous crossroad. Perhaps its major value is to establish a template for family difficulties, reveal linkages over generations, and focus on family resilience and continuity.

Family Transitions and Symptomatic Behavior

The family life-cycle perspective offers a valuable context for understanding individual and family dysfunction, especially for advocates of the structural position (Chapter 9), who argue that problems develop within a family with a dysfunctional structure when the family

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encounters a transition point but lacks the flexibility to adapt to the changing conditions. For example, a young husband and wife who have not achieved sufficient separation from their parents to be able to establish their own independent marital unit may experience considerable distress, conflict, and confusion when they prepare to enter the next phase of their family life—the birth and rearing of their own children.

Strategists (Chapter 11) also view the appearance of symptoms as a signal that the family is unable to move on to the next stage; as one example, Haley (1979) argues that some families may need therapeutic help in solving problems evoked by a young adult member ready to leave home and embark on a more independent life. In general, Haley views individual symptomatology as arising from an interruption of the family's normal developmental process, and thus he is likely to direct his efforts at helping the family as a whole resolve the impasse that they are experiencing as a group.

Family Life Cycles: A Multidimensional, Multicultural, and Multigenerational Perspective

The most prominent contemporary family life cycle model is presented by McGoldrick, Carter, and Preto-Garcia (2011), who broadened the framework to include a multidimensional, multicultural, multigenerational perspective along with individual, family, and sociocultural perspectives. They provide a more encompassing, intergenerational view of the impact of multiple stresses on a family's ability to navigate transitions. They believe the flow of anxiety within a family is related to both "vertical" and "horizontal" stressors (see Figure 2.1). Vertical stressors are patterns of relating and functioning transmitted historically through generations—family attitudes, stories,[1] expectations, secrets, taboos, and loaded family issues passed along from grandparents to parents to children. Members of all families receive such legacies while growing up, listening to family narratives concerning family experiences that formed the basis for a "family line" or set of prejudgments in viewing new events and situations. The vertical axis also includes any biological heritage, genetic makeup, temperament, and possible congenital disabilities within the family. Any racism, sexism, poverty, homophobic attitudes, as well as family prejudices and patterns of relating carried over from earlier generations add to these vertical stressors. The vertical axis represents those aspects of our lives that are "the hand we are dealt. What we do with them is the question" (McGoldrick & Shibusawa, 2012, p. 378).

Horizontal stressors describe the events experienced by the family as it moves forward through time, coping with changes and transitions of the life cycle—the predictable developmental stresses as well as unexpected, traumatic ones (such as an untimely death, birth of a handicapped child, a serious accident, migration). Major traumatic experiences—terrorism, war, economic depression, and natural disasters—are included here, as are social policies affecting the family.

[1]As we noted in Chapter 1, in discussing the constructivist view of the appearance of symptomatic behavior in a family member, each family's self-picture is at least partly based on "stories" it has created about itself. These stories often are passed along over generations and may be a source of comfort (how we Sinclairs always come through adversity whatever the odds) or despair (how we Garcias always end up with the short end of the stick, regardless of our efforts). Similarly, a group's history, especially a legacy of trauma, affects future generations (the Holocaust on Jews and Germans, slavery on African Americans and slave-owning groups). The current interest in genealogy represents an effort to feel part of the continuity of one's family's history.

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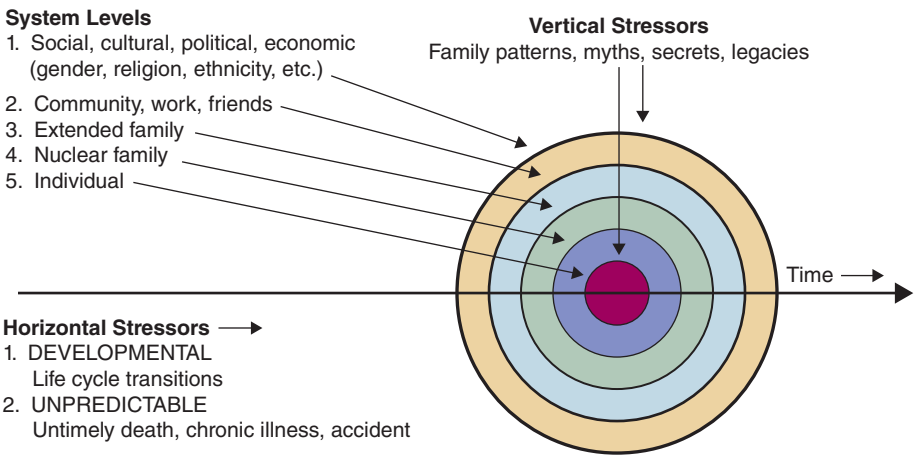


FIGURE 2.1 Horizontal and vertical stressors

With enough stress on the horizontal axis, any family will appear dysfunctional. For a family that is full of stress on the vertical axis, even a small amount of horizontal stress can disrupt the family system. Any amount of horizontal stress (say, the revelation of a teenage girl's pregnancy or the "coming out" of a homosexual adolescent boy) can cause great disruption to a family whose vertical axis is already intensely stressed. Should such an event occur at a transition point (in our examples, late adolescence), family dysfunction—temporary or longer lasting—is likely to occur. As McGoldrick and Shibusawa (2012) observe:

> The anxiety engendered where the vertical and horizontal axes converge, and the interaction of the various systems and how they work together to support or impede one another, are key determinants of how well the family will manage its transitions through life. (p. 380)



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In general, the greater the anxiety "inherited" from previous generations at any transition point (say, anxieties over being parents and raising children, passed on by one's parents), the more anxiety-producing and dysfunctional this point will be for the young person expecting the first child. In this example, when horizontal (or developmental) stresses intersect with vertical (or transgenerational) stresses, there is a quantum leap in anxiety in the system. Concurrent external stresses—death, illness, financial setbacks, moving to a new and unfamiliar community—add to the stress. The point where the axes converge, then, becomes a key determinant of how well the family will manage the transition point. So it is imperative for family therapists to attend not only to a family's current life cycle stresses but also to their connections to family themes handed down over generations.

Critiques of the Stage Model

While the stage model of family development offers a valuable context for conceptualizing individual and family dysfunction, its shortcomings too require acknowledgment. The

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concept is essentially descriptive rather than explanatory. By attending primarily to intact families, it reflects an ever-decreasing portion of American society at a time in history when a diversity of lifestyles and a variety of living arrangements are prevalent and functional. The approach fails to account for individual differences in the timing of nodal events (e.g., postponed marriages and/or delayed pregnancies). By strongly suggesting that what transpires within the stages is all important, this approach does a disservice to the equally important—perhaps more important—transitions between stages, which are key periods of change. Its arbitrary punctuations of stages tend to obscure the ongoing and relationship-based flow of family life. Box 2.2 describes the unique struggles of immigrant families in North America.

While family development models are linear, family life is anything but—it does not begin at any particular point, nor does it have a clear-cut ending point. Fox (2006) cites the model of Combrinck-Graham that views family movement through time as cyclical, or more accurately, proceeding in a spiral. That is, at certain times family members are tightly involved with one another. Combrinck-Graham considers these times of pulling together, as when a new child is born or a serious illness in a family member occurs, as *centripetal* periods. At other times (starting school, beginning a career), individual moves take precedence, and *centrifugal* periods occur. In this formulation, there is an oscillation in family life, not the tidy and continuous unidirectional flow suggested by stage theory. At times the family members tend to be oriented inward; at other times they move toward interests outside the family. Combrinck-Graham contends that three-generational families are likely to alternate between centripetal and centrifugal states (keeping members together and pushing them apart, respectively) as events occurring in a particular life cycle period call for greater interdependence or individuation.

Breunlin (1988) agrees that family development is rarely a discrete and discontinuous shift from one life stage to a subsequent stage separated by arbitrary transitions but rather occurs as gradual oscillations (or microtransitions) between stages as the family makes its way to the next developmental level. He emphasizes that families are far more complex than the stage model suggests and that in reality development in most families, as we noted earlier, involves multiple simultaneous transitions as various members are undergoing differing degrees of interlocking life changes.

Laszloffy (2002) finds two conceptual flaws in the life-cycle approach to studying families. First, defining the specific number, types, and timing of stages perpetuates the assumption of universality—that all families, regardless of composition or culture, develop in the same order, ignoring the infinite variations possible among families. Second, she argues that the life-cycle approach is biased toward a single generation (such as launching a family member) and fails to attend to the intergenerational and interactional complexities of families (launching and the reciprocal leaving stage).

While these modifications more accurately describe what actually occurs, the life cycle concept nevertheless offers a workable organizing schema for assessing family functioning and planning interventions. Family therapists have attempted to wed a systems epistemology to this more sociologically focused developmental framework, going beyond the arbitrary punctuations of stage theory in order to view families as composed of interconnected members engaged in ongoing, interactive processes with one another.

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BOX 2.2 FAMILY DIVERSITY

Migration and the Life Cycle

Immigrants to North America are a diverse group in economic background, race, ethnicity, and religious beliefs and practices (Booth, Crouter, & Landale, 1997). In contrast to the early years of the previous century, when most new entrants came almost exclusively from Europe, today's immigrants are primarily from Latin America and Asia. While some come as documented migrants, others, such as those from Mexico and Central America, are frequently undocumented and must attempt to gain entry through illegal means. Nearly 80% of all immigrants are people of color. One in five children in the United States today is a child of an immigrant family (Suarez-Orozco & Suarez-Orozco, 2001).

For most immigrant families, migration is a major life event because of its potential peril as they seek refuge in an unfamiliar land. From premigration stress (often leaving home and loved ones) to the stress of the migration experience itself (especially for undocumented individuals) to learning to survive in a strange environment, the dislocation process is filled with duress alongside hope for a better future. Postmigration adjustments often involve a struggle and a sense of depletion (Sluzki, 1979). In many cases, familiar family and occupational roles are lost. Family elders may lose status within the family as a result of assimilating more slowly to the language and lifestyle of the new land than do their adolescent family members. For example, a parent who was an engineer or teacher in the old country may be able to find work only in lower-status jobs as a construction worker or manicurist.

The reasons for migration (war, famine, relief from political or religious persecution) are often significant, and its accompanying acculturative consequences (problems with employment, housing, language, xenophobia, and discrimination) may be traumatic and affect life-cycle development. Wong and Mock (1997) describe role reversals in immigrant Asian families, as children gain quicker proficiency in the use of English than their parents, undermining traditional cultural norms of parental authority. Falicov (2014) points to the cross-cultural dilemmas as Latino families try to make sense of adapting to American life and raise children according to the style of the dominant culture. Among Mexican American families, migration may be more than a one-time event, as illegal border crossers who have been apprehended and deported try again for entry or simply leave, returning as work becomes available. Such an ongoing and prolonged process calls for parent–child separations, as parents attempt to immigrate ahead of their children, or in other cases send the children ahead; in either case, the breaking of ties within the nuclear family may have long-term negative consequences (Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002).

Fleeing one's native country is likely to be far more traumatic and to be filled with intense ambivalence than a voluntary relocation seeking a more prosperous life. Whether members of a family migrate together or in sequence may also affect their adaptation. Educational level, social class, gender, age at the time of immigration, community support in the new land, as well as the family's developmental stage of the family life cycle all are significant factors in adaptation. The experience of racial, religious, or anti-immigration discrimination or lack of economic opportunity all negatively influence the migration experience (Falicov, 2012).

The Stages of Family Development

Family therapists are apt to depart from the traditional sociological view of the family life cycle commencing at the time of marriage, arguing that single young adults must first complete their primary developmental task: separating from the family of origin without cutting off from them and fleeing to a substitute emotional refuge (Fulmer, 2011). This successful

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completion of the emerging adult tasks allows the individual to transition to the time in life when marrying and creating families is a primary concern.

"Coupling" and Preparing for Parenthood

From the mid-20th century to today, the average age at which people marry has increased from the early 20s to mid- and late 20s for both women and men, although women tend to marry a bit earlier than men (Liu, Elliott, & Umberson, 2009). The later age of marriage or partnership seems at least in part to be due to more people pursuing higher education.

Also, more people today than ever before live together before marrying. The statuses of premarital cohabitation versus living together as married people seem to show differences. For example, 39% of cohabiting households include children, and the odds of a couple staying together 2 years after the birth of a child are six times greater in marriage relationships than in cohabiting relationships (Bumpass & Lu, 2000). Cohabitation also seems to have unique gender-related aspects. In one study (Rhoades, Stanley, & Markman, 2012), men who cohabited premaritally are less dedicated in marriage than men who did not. And for couples who cohabited before engagement, men are also less dedicated to their wives.

COUPLING

Characteristic of the adult stages is the couple's move from *independence* to *interdependence* in this stage—what Gerson (1995) labels *coupling*. Whether in a heterosexual union involving marriage or cohabitation or a same-sex pairing (hence the generic term *coupling*), the two people must decide to commit to one another. Especially in the case of a legal marriage, more than a union of two people is involved; the mating represents a change in two established family systems and the formation of a subsystem (the new couple) in each. Less formally bound by family traditions than couples in the past and thus with fewer models to emulate, today's young, newly married pair must go about differentiating themselves as a couple with primary allegiance to one another and only secondary allegiance to their families of origin. (Both sets of parents must also let go.)

Commitment to the partnership is the key to managing the transition of detaching sufficiently from each of their families and forming a new cohesive paired unit. In some cases, living with a succession of partners may precede finding the ultimate mate. Early marriages may represent a cultural norm (e.g., Latinos) or an effort to escape their families of origin and create a family they never had. On the other hand, fear of intimacy and commitment may delay marriage for many men; for older women with careers, there may be fear of losing their independence once married.

CREATING A FAMILY

Ideally when people form families, both partners need to feel they are part of a "we" without sacrificing an "I"—a sense of self as separate and autonomous. This sense of I and we tends to occur once a person senses her- or himself as having crossed the line into adulthood (most often during young adulthood). Even if the couple have lived together before marriage and have established a satisfying and fulfilling sexual pattern, the transition to becoming marital partners represents a significant milestone, with numerous adjustments (negotiating a level of emotional intimacy, working out power arrangements, deciding whether

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to have children and when, determining their degree of connection to their extended families and friends, as well as which family traditions to retain and which to modify or abandon) required as they become husband and wife (Almeida, Woods, Messineo, & Font, 1998). The adjustment problems may become even more formidable if partners have different ethnic, racial, or religious backgrounds and bring different assumptions and expectations into the new marriage.

Each partner in an intact relationship has acquired from his or her family a set of antecedent patterns, traditions, and expectations for marital interaction and family life. In a sense, the two have come from separate "cultures" with differing customs, values, rituals, beliefs, gender roles, prejudices, aspirations, and experiences. Parts of both paradigms must be retained so that each person maintains a sense of self; the two paradigms must also be reconciled in order for the couple to have a life in common.

In the process of reconciling these differences, spouses arrive at new transactional patterns—accommodations or tacit agreements to disagree—that then become familiar and ultimately their preferred or habitual way of interacting with each other. For some, such commitment comes easily—they want to be together whenever possible, share private thoughts and intimacies, experience no problem pooling their earnings, call each other at work one or more times a day, and focus on growing closer as a marital couple. For others, such a connection is fraught with hesitations; reluctant to abandon the life they led as single persons, they insist on maintaining separate bank accounts, taking separate vacations, and pursuing weekend activities with friends or separate families of origin rather than spending time together. For this latter group, learning to cooperate and compromise over differences takes a longer time; in some cases it is never achieved.

BEGINNING A FAMILY As in the case of marriage, the age when one becomes a parent has increased over the years. The delay is largely due to people settling down later in life, after completing higher education (Kokko, Pulkkinen, & Mesiäninen, 2009).

In creating a family, the partners must not only provide for their basic physical needs but also continually negotiate such personal issues as when and how to sleep, eat, make love, fight, and make up. They must decide how to celebrate holidays, plan vacations, spend money, and do household chores, what to watch on television (and who holds the remote control), or what other forms of entertainment they both enjoy. They are obliged to decide which family traditions and rituals to retain from each of their pasts and which they wish to generate as their own. Together they need to determine the degree of closeness to or distance from each of their families of origin they wish to maintain. Each has to gain admission to the other's family, in some cases as the first person to do so in many years.

The Arrival of Children

In the case of a married or committed couple, at first the system tends to be loosely organized, and the spouses' roles are flexible and often interchangeable. The structure of a family without children allows for a wide variety of solutions to immediate problems. For example, either or both of the partners may prepare dinner at home; they may choose to eat out at a restaurant;

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they may drop in at a friend's or relative's house for a meal; they may eat separately or together. When there are children to be fed, however, a more formal and specific arrangement will have to be formulated in advance of dinnertime. Beyond making room for children in their lives, psychologically as well as physically, the couple must more clearly define the distribution of duties and division of labor: Who will shop, pick up the children at a child-care center or at a relative's home, prepare meals, wash the dishes, put their offspring to bed, handle the increased laundry load, and get the children ready in the morning? The commitment of husband and wife, then, to become mother and father represents a significant transition point in a family's life, changing forever the relatively simple playing out of roles between mates who are childless. As Karpel and Strauss (1983) observe, virtually all patterns of time, schedule, expenditures, leisure, use of space in the home, and especially relationships with in-laws and friends are likely to become reorganized around the child.

The arrival of children—the family *expansion* phase (Gerson, 1995)—thus represents the most significant milestone in the life cycle of the family. When the couple become parents, both "move up" a generation and now must provide care for a younger generation. Other members of the family suprasystem also move up a notch—parental siblings become uncles and aunts; nieces and nephews now become cousins; the parents of the new mother and father become grandparents. Overall, a vertical realignment occurs for new family and extended family together. A major task for new parents is to integrate their new relationships to the child with their previously existing relationship with one another. A revised sense of individual identity is likely to occur once the partners become parents, and relative commitments to work and family must be reconsidered.

Making this transition, taking and sharing child-care responsibilities, practicing patience, setting limits, tolerating restrictions on free time and mobility—all these tasks must be mastered in the expanding family system. Young parents, particularly if both are employed full time, must now juggle schedules and attempt to find an acceptable balance between work and domestic responsibilities. At the same time, the couple needs to redefine and redistribute household and child-care chores, decide how they will earn a living with one breadwinner for a period of time, and determine how best to resume sexual and social activities. The formerly childless couple must find new ways of maintaining and nurturing their relationship despite the substantial decrease in time and energy for private moments together (Kaslow, Smith, & Croft, 2000). Cohabiting couples may be particularly vulnerable to the stresses of transition to parenthood because a cohabiting new father is more likely to experience less confidence in the relationship and a greater sense of being trapped in the relationship (Dush et al., 2014).

A young middle-class couple's previously egalitarian role structure and dual earning capacity may break down. They may resort to more traditional male–female divisions of labor, earnings, and power, which may create unexpected conflicts and additional stress. Older parents must learn to accommodate young children in an already established or perhaps fixed pattern of relationships, often without being able to call upon elderly grandparents for support. Regardless of ethnic group or social class, however, the birth of children, as Hines (2011) observes, hastens a young couple's need to connect (or reconnect) to the extended family network—perhaps for occasional child care and almost certainly for emotional if not financial

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support. This is especially true in Latino families, where an intricate network of grandparents and other relatives typically helps with child care, in addition to providing "lots of coaching and advice" (Falicov, 2014, p. 419).

Coping with Adolescence

When children reach adolescence, the family faces new organizational challenges, particularly around autonomy and independence. Parents may no longer be able to maintain complete authority, but they cannot abdicate authority altogether. Here the family is not dealing with entrances and exits into the system but rather with a basic restructuring of interactive processes to allow the teenager more independence (Harway & Wexler, 1996). The task becomes even more complex in immigrant families, as the adolescent's normal striving for self-directed behavior is accelerated through assimilation into mainstream American society, while the parents may continue to adhere to their traditional cultural values of parental authority and control (Schwartz et al., 2013). In low-income African-American, Latino, or Asian families, adolescents are often expected to fulfill adult caretaking duties for younger siblings or to contribute financially to the home yet to remain obedient and respectful of parents (Preto, 2010). In such cases, becoming independent may not have the same meaning that it does for Anglo American middle-class groups.

Rule changing, limit setting, and role renegotiations are all necessary as adolescents seek greater self-determination, depending less on parents and moving toward their peer culture for guidance and support. Adolescents must strike a balance on their own, forging an identity and beginning to establish autonomy from the family. Teenagers who remain too childlike and dependent or who become too isolated and withdrawn from the family put a strain on the family system. Too rapid an exit from family life by adolescents may also impair a family's ability to adapt. Parents, too, need to come to terms with their teenager's rapidly changing social and sexual behavior. Depending on the spacing of children, parents may find themselves dealing with issues relevant to differing ages and life-cycle stages at the same time. Rebellion is not uncommon—in political or religious views, dress, drugs, music, curfew violations, gang behavior, ear piercing, tattoos—as adolescents attempt to gain distance from parental rules.

An important development during adolescence that often has an impact on the family is the onset and maturation of the teen's sexuality. Questions of if and when a teenager experiences sex can come up with particular intensity, especially when parents and teenage child disagree. Statistically, the average age for a person's first experience of sexual intercourse for both young men and women is about 17 years old (Martinez, 2013). Research with African-American early adolescents suggests that early sexual activity increases a sense of self-esteem and strengthens self-concepts in both girls and boys of age 10 to 12, but these developments can lead to an increase of risky behavior (Houlihan et al., 2008).

All of this is likely to occur while simultaneous strains on the system may be taking place: (a) "midlife crises" in which one or both middle-aged parents question not only career choices but also perhaps their earlier marital choices (for some women, this may represent the first opportunity to pursue a career without child-care responsibilities, leading to family dislocations and role changes); and (b) the need to care for impaired grandparents, necessitating

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role reversals between parents and now-dependent grandparents, perhaps calling for changing caretaking arrangements regarding the older generation.

Leaving Home

Gerson (1995) refers to the next period as one of *contraction*; McGoldrick and Shibusawa (2012) describe this phase of the intact family's life cycle as "launching children and moving on" (p. 391). Unlike in earlier times, today the low birth rate coupled with longer life expectancy means that this stage now covers a lengthy period; parents frequently launch their families almost 20 years before retirement. They must come to accept their children's independent role and eventual creation of their own families. This stage, beginning with the exit by grown children from the family home, proceeds with the later reentry of their spouses and children into the family system.

Creating adult-to-adult relationships with their children is an important developmental task for parents at this stage, as is the expansion of the family to include the spouses, children, and in-laws of their married children. Once again, assimilated young adults from immigrant families may find their desire for freedom and autonomy in conflict with their parents, such as in Latino families, in which children are expected to remain in the parental home until they are married or well into their 20s (Santisteban, Coatsworth, Briones, Kurtines, & Szapocznik, 2012).

Reorganizing Generational Boundaries

Parents also need to reassess their relationship with one another now that their children no longer reside at home. Sometimes couples view this change as an opportunity for freedom from child-rearing responsibilities and perhaps, if economically feasible, a chance to travel or explore other activities postponed for financial reasons or time restraints while they cared for their children. These families see a chance to strengthen their marital bond. In other families, marital strains covered over while they raised children together may resurface with the children gone, leading to increased marital strife or feelings of depression and loneliness over life becoming empty and meaningless. It is not uncommon for such parents to hold onto their offspring, especially the last child.

Parents now need to cope with moving up a notch to grandparent positions. At the same time, increased caretaking responsibilities for their own needy and dependent parents, especially by women, is likely. Another family life-cycle stage is reached by the time the children enter their 40s, when another level of intimacy is achieved between generations and when the old hierarchical boundaries, ideally, are replaced by a greater peer relationship (Garcia-Preto & Blacker, 2011). In some cases, the renewal of the parent–grandparent relationship provides an opportunity to resolve earlier interpersonal conflicts; in other cases, it may simply exacerbate unresolved conflict from earlier days. A major transition point for the middle-aged adult is apt to involve the death of elderly parents.

Retirement, Illness, Widowhood

Froma Walsh (2010a) suggests that changes brought about by retirement, widowhood, grandparenthood, and chronic illness/caregiving all represent major challenges for the entire family

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system as it attempts to cope with loss and tries to reorganize itself. Retirement is likely to mean more than a loss of income; loss of identity, status, purpose, and being an important part of a community also are involved, and family relationships must be renegotiated. Retired parents must now cope with a dramatic increase in their daily time together, as well as coming to terms with one's own limitations and illness.

Some families will have to confront the physical and cognitive declines that older members often experience. Many elderly people experience simple forgetting, for example; but others endure more serious losses of cognitive capacity in the forms of dementia or Alzheimer's disease. Alzheimer's disease is a degenerative disease characterized by progressive cognitive decline and such symptoms as confusion, memory loss, mood swings, and the loss of physical functioning. This disease is implicated in from 60 to 70% of the cases of dementia among elderly people. Caring for cognitively and physically impaired family members can place great strain—financial, emotional, and otherwise—on other family members.

Recent advances in medicine and other factors have extended the lifespan of men and women in the United States; and with more years have come longer periods of chronic illness and the need for family caregivers to attend to elderly and ill family members. Shifrin (2009) notes that due to varying family structures and living situations, the caregiver in these cases is not always the parent or adult child. Increasingly, the caregiver role has been taken by children, adolescents, and emerging adults. In addition, in cases in which parents are unable to take care of their children, grandparents, because of their longer lives, are available to take care of them. One result of this extended caregiving development is that the caregiving role at any point in life may affect a person's development and add stressors but may also create rewards that influence the caregiver's identity and well-being.

A grandparent's death may be the young child's first encounter with separation and loss and, at the same time, may be a reminder to the parents of their own mortality. Illness in elderly parents calls for role reversals with their children; the process is often a source of struggle and embarrassment. Litwin and Shiovitz-Ezra (2011) identified types of social networks of older persons, finding that those who worked at maintaining a network of relationships with family and friends demonstrate improved well-being (decreased anxiety, less loneliness, and more happiness).

To appreciate the impact of family-cycle development on couples and families, therapists can turn to their own families for guidance. See Box 2.3: Thinking Like a Clinician to explore this dimension of your own experience.

LO 2 Other Developmental Sequences in Families

Early family developmental approaches could hardly be expected to have anticipated life circumstances over 75 years later. Divorce, an unusual phenomenon at that time, today has become a recognized fact of American life, with approximately 1 million divorces occurring annually in this country (Centers for Disease Control and Prevention, 2009). Divorce inevitably touches family members at every generation and throughout the nuclear as well as extended families, having a powerful, disruptive impact on all family members, parents and

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BOX 2.3 THINKING LIKE A CLINICIAN

Attachment Injuries May Result in Rage

Use these questions to explore the stages of your own family's development. Did any symptomatic behavior arise at these transition points? How can knowing about your own experience help you to appreciate the similar experiences of others? These questions may also be used in therapy to help families address life-cycle challenges.

- Looking back over your entire life, can you identify some of the developmental stages described in this chapter as they apply to your family experience? Can you identify times when your family was unable to achieve a developmental task?

_____

_____

- How did life change in your family as children were born or young adults left home? Did your family behave differently? If yes, how?

_____

_____

- Did your parents divorce while you were living at home? If so, what happened to you and your siblings? How did the divorce change your family life?

_____

_____

- Has your family experienced any traumatic events? How old was each family member at the time? What were individual reactions? Did it disrupt the family interaction at the time? Did your family recover? If so, what characteristics of the family helped? If not, in what areas do you think your family could use help?

_____

_____

- Were you raised by a single parent? If so, what impact did that have on family life?

_____

_____

- Were you raised in a family with gay, lesbian, or transgender family members? If so, did this play a role in any of the life cycle stages or tasks?

_____

_____

- How has your family reacted to the death of one of its members or someone close? Do you sense any enduring changes in the family due to that experience?

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children alike. It typically occurs in stages, often marked by stress, ambivalence, indecision, self-doubt, and uncertainty, even when both partners agree that the marriage is no longer viable. When children are involved, particularly young children, the decision becomes all the more deliberate and painful. Divorce typically involves a change in residence, possible decline in standard of living, and change in relationship structure. Most families, however, demonstrate the ability to make the necessary adjustments, particularly if the former mates provide mutually supportive co-parenting and facilitate continued contact with both parents (Amato, 2010).

Single-Parent–Led Families

One-parent households, which now represent one in four families with children under 18 in the United States, come in a variety of sizes (reflecting the number of children and the number of previous divorces), composition (with or without friends or extended families), and situations (with or without the involvement of ex-mates, with or without financial resources, living alone or with parents; Anderson, 2012). Figure 2.2 summarizes key data related to one-parent families in the United States (Vespa, Lewis, & Kredier, 2013).

Most single-parent–led families are the product of divorce, although in recent years their numbers have swelled due to the rise in the social acceptance of single women of all socioeconomic situations having children outside marriage. These include not only teenage mothers but also women who become parents in an uncommitted relationship or through adoption, donor insemination, or surrogacy (Anderson & Anderson, 2011). Single males who gain custody of their children following a divorce or who as single parents adopt children—practically unheard of until two decades ago—now represent a significant proportion of all single-parent families (Vespa et al., 2013). (We'll consider adoptions by gay and lesbian couples and the use of artificial insemination in a later section.)

In most contemporary postdivorce situations, largely due to efforts of the men's movement, joint legal custody is common so that both ex-partners retain legal authority as parents and share, depending on their ability and willingness to do so, in the decisions regarding the raising of their children. In such situations, members of the extended family—grandparents, aunts, and uncles—often continue to play key supporting roles (Everett & Volgy Everett, 2000). This trend may be especially significant in the case of minority, low-income single-parent families, where a broad support system is common and often may prove essential. More than half of all African-American children (55%) and 31% of Hispanic children live with single parents (Vespa, Lewis, & Kreider, 2013), and *informal adoptions* (in which African-American relatives or friends care for children when birth parents are temporarily or permanently unable to do so) have a history that goes back to slavery days. As Lindblad-Goldberg (2006) demonstrated in her work with 126 successful African-American, female-headed, single-parent households, many of the social and psychological problems of growing up in a single-parent–led family are more a function of family poverty than of an inevitable breakdown of the family structure.

The most glaring difference between two-parent families and those headed by divorced or never-married mothers is the disparity in economic well-being; the latter, particularly those

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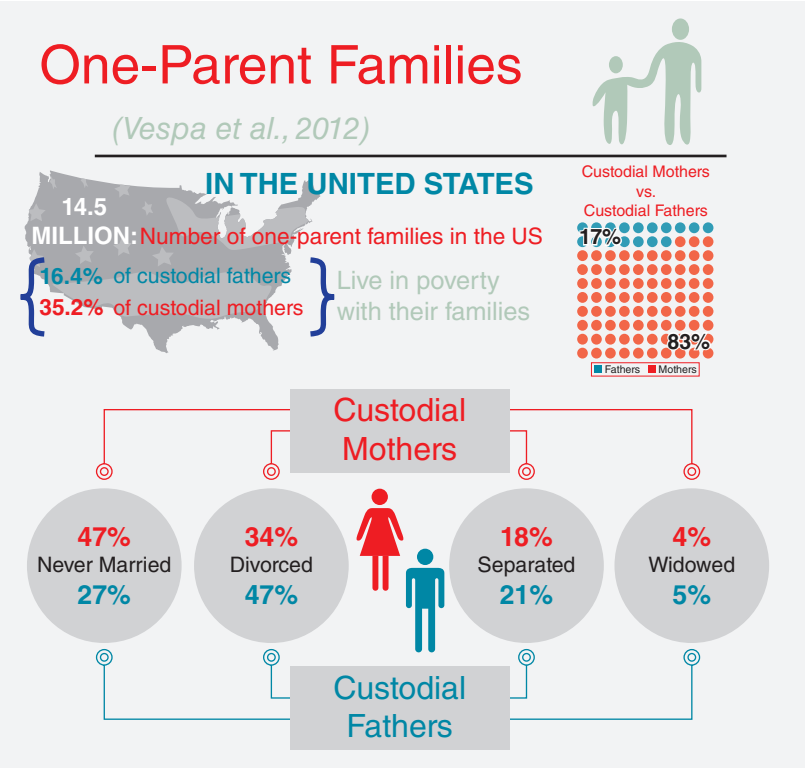


FIGURE 2.2 One-parent families

with young children, are likely to be worse off financially than any other type of family organization (see Figure 2.2). Mother-headed families especially are characterized by a high rate of poverty, a high percentage of minority representation, and relatively low education. The chronic experience of poverty, violence, family conflict, and substance abuse impacts family development (Anderson & Anderson, 2011). Some may take romantic partners into the household for financial, sexual, or protective purposes. If these relationships are positive and enduring, this can provide support to the family process; on the other hand, this may result in conflictual live-in relationships (disagreements over child discipline or conflicting loyalties between the children and the new romantic partner) that can include child abuse, but they fear leaving because of an inability to survive financially on their own (Anderson, 2012). Many nonresident fathers do not pay child support or do so sporadically; this is especially severe for single mothers who never married. In some poor families, although regular financial support from fathers is not forthcoming, help in the form of occasional groceries, diapers, child care, labor around the house, and some small, intermittent monetary contributions may occur. Therapy may help single mothers navigate the challenges to encourage such positive father involvement.

The divorced mother with physical custody of her children usually must deal not only with lowered economic status but also with grief and self-blame, loneliness, and an inadequate

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support system. She must also deal with child-care arrangements, custody and visitation problems, and more. Frequently she carries the entire burden of raising a child alone in what is often an emotionally and physically unstable environment (Greene et al., 2012), balancing the multiple responsibilities of work and family. Despite these obstacles, resiliency is often present, and as Anderson (2012) observes:

> Most single parents provide the structure, values, and nurturance that their children need, while they simultaneously manage a household, a job, and at least a marginal social life, without the assistance of a partner... their homes are not "broken," their lives are not miserable, and although their children may have problems, most eventually thrive. (p. 130)

Single fathers with custody also experience financial pressures, although these problems are likely to be less severe than those of single mothers. Because commitment to job and career have probably been the highest priority for these single fathers, a shift in focus is necessary, and not being able to spend sufficient time with their children is often a major complaint. Those who opt for a close, nurturing relationship with their children must often learn new roles, change their circle of friends, and rebuild their social lives (Seibt, 1996). Frequently they turn to extended family members, girlfriends, or ex-wives for help with child care, and as Anderson (2012) observes, in contrast to single mothers, single fathers are often viewed as noble for the parenting efforts.

In the following case in Box 2.4, a religious couple splits into two single-parent households following their marital breakup.

While sole custody still remains the most common situation, **joint legal custody**, increasingly awarded by the courts, allows both parents equal authority regarding their children's general welfare, education, and so on. The children may reside with one parent, but both parents have equal access to them. This **binuclear family** (Ahrons, 2011) arrangement, of course, works out best when the former marital partners are each caring and committed parents, are able to cooperate, have relatively equal and consistent parenting skills, and are able to work together without continuing old animosities (Goldenberg & Goldenberg, 2002). The point here is that while the nuclear family no longer lives as one unit, divorce has not ended the family but simply restructured (and frequently expanded) it.

In McGoldrick, Carter, and Garcia-Preto's (2011) family life cycle outlook, divorce represents an interruption or dislocation (a "detour") similar to those produced with any shifts, gains, and losses in family membership. As we have noted, relationship changes must be addressed and a new set of developmental tasks dealt with (see Table 2.2) before the divorcing family can move forward. Thus, divorce adds another family life cycle stage, as the family regroups and tries to deal with the physical and emotional losses and changes before rejoining the "main road" in their developmental journey. Should either ex-spouse remarry, still another stage must occur as all members absorb new members into the family system and go about redefining roles and relationships.

Remarried Families

Remarriage today is nearly as common as first marriages. Approximately 69% of divorced women and 78% of divorced men remarry, and almost one in three marriages in a year (31%)

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BOX 2.4 CASE STUDY

A Religious Couple Divides into Two Single-Parent Households

Joseph and Sarah, both previously married, were Orthodox Jews who took their religion seriously. They met at temple services, were attracted to one another physically as well as spiritually, and after knowing each other for a year, they decided to marry. Joseph, 40, an accountant, had custody of his two daughters from his earlier marriage, and Sarah, 39, childless but eager to have a family, agreed to take on parental responsibility.

Consistent with their religious beliefs, they were eager to have children together, but Sarah found it difficult to get pregnant. By the time she was in her mid-40s, they had attempted a variety of assisted reproduction techniques, mostly ending in failure and frustration. Joseph was ready to give up when Sarah got pregnant with a son and, the following year, using the same reproductive procedure, gave birth to a daughter.

Now the parents of four children, Sarah and Joseph were exhausted—physically, financially, emotionally. Religious beliefs, which had been a cornerstone of their relationship, soon became an area of conflict. Even though their religious devotion had been a source of their original connection to one another, they now began to struggle over its observance; Sarah wanted more strict involvement in religious rituals and synagogue attendance, while her husband was comfortable with his current degree of participation. As she became more critical of him, he withdrew, which led to further angry interaction between them. After 10 years of marriage, they got divorced.

One immediate effect was a serious drop in income for both ex-partners. Joseph's older children had moved out with him, creating two single-parent households, and Joseph refused to let Sarah visit with them. She insisted that their younger children continue to attend religious school, but he refused to pay for it, claiming the divorce had strapped him of any money beyond the amount required for daily necessities. Sarah tried turning to the Orthodox community, normally cohesive and supportive, but soon found that community focused on family life, and she felt further isolated. Turning to her parents, she found that they opposed the divorce, blamed her for the breakup, and refused to offer more than minimal assistance.

Under the stress of being an older mother and single parent, and without feedback from the other parent, Sarah's child-rearing techniques became more fixed and unbending, and frequent mother–child conflicts ensued. The children were distressed by the loss of contact with their half-siblings, as well as the constant bickering over finances whenever the parents were together. Sarah complained of feeling isolated, impoverished, and unable to develop a social network. Joseph also felt overwhelmed by the task of raising teenage daughters on his own, although he sometimes asked women friends or his mother for help when he felt particularly burdened. Both parents felt lonely, fatigued, depressed, and discouraged about a future alone.

are remarriages (Lamidi & Cruz, 2014). Single life is short lived for most divorced persons: The median interval before remarriage for previously divorced men is 2.3 years, and for women 2.5 years. About 30% of all divorced persons remarry within 12 months of becoming divorced (Ganong & Coleman, 1994). Pasley and Garneau (2012) estimate that 65% of remarriages create stepfamilies, with the most common being stepmother–stepfather (blended) or stepfather–biological mother families.

Structurally, remarriage and consequent stepfamily life is complex, since a variety of parental figures, siblings, and extended family members from current and previous marriages

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TABLE 2.2 Additional stage of the family life cycle for divorcing families

Phase	Task	Emotional Process of Transition: Prerequisite Attitude	Developmental Issues
Divorce	The decision to divorce	Acceptance of inability to resolve marital problems sufficiently to continue relationship	Acceptance of one's own part in the failure of the marriage
	Planning breakup of the system	Supporting viable arrangements for all parts of the system	a. Working cooperatively on problems of custody, visitation, and finances b. Dealing with extended family about the divorce
	Separation	a. Willingness to continue cooperative co-parental relationship and joint financial support of children b. Working on resolution of attachment to spouse	a. Mourning loss of intact family b. Restructuring marital and parent–child relationships and finances; adaptation to living apart c. Realignment of relationships with extended family; staying connected with spouse's extended family
	The divorce	More work on emotional divorce: overcoming hurt, anger, guilt, etc.	a. Mourning loss of intact family; giving up fantasies of reunion b. Retrieving hopes, dreams, expectations from the marriage c. Staying connected with extended families
Postdivorce family	Single parent (custodial household or primary residence)	Willingness to maintain financial responsibilities, continue parental contact with ex-spouse, and support contact of children with ex-spouse and his or her family	a. Making flexible visitation arrangement with ex-spouse and family b. Rebuilding own financial resources c. Rebuilding own social network
	Single parent (noncustodial)	Willingness to maintain financial responsibilities and parental contact with ex-spouse and to support custodial parent's relationship with children	a. Finding ways to continue effective parenting b. Maintaining financial responsibilities to ex-spouse and children c. Rebuilding own social network

Source: McGoldrick, Carter, and Garcia-Preto, 2011, p. 320

are apt to be involved. Children are often called upon to reside in two households for varying periods during an ordinary week, where they must deal with different rules (bedtime, curfew, table manners), ambiguous boundaries, and different roles (an only child in one home, the oldest of several stepsiblings in another). Previous parent–child relationships, which predated the new marriage, inevitably undergo changes as the new system makes room for new members and changing responsibilities and obligations (Ganong, Coleman, & Jamison, 2011).

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Financial problems may plague a newly remarried family and lead to acrimony and competition between, say, a new (working) wife and a former (nonworking) wife who is receiving monthly spousal support payments.

Adaptation to remarriage becomes still more complex if spouses come from different cultural backgrounds or different individual life-cycle phases (e.g., an older man with adult children marrying a young woman with no children or young children). Moreover, being an effective stepparent to a young child and to an adolescent is likely to be different because of their different developmental needs (Ganong, Coleman, & Jamison, 2011). An additional problem often arises because the nonresident biological father (or mother) looms in the background, may remain a major factor in the family system, and may cause loyalty conflicts in children between the absent parent and the stepparent.

Remarriage involves transition from a former household to an integrated stepfamily household, a process Pasley and Garneau (2012) liken to the acculturation experience of immigrating to a new country. New adaptations become necessary, new situations must be faced, membership in two households must be worked out. New food, new rules, new customs, new loyalties, perhaps new languages and lifestyles all add to the complex problems of transition. For many families, it may take up to 6 years before the stepparents can form a solid couple bond and work as a team to deal with the challenges of stepfamily life. Particularly apt to hasten the integration process is the ability and willingness of stepparent and stepchildren to engage in relationship building and maintaining behaviors (Ganong, Coleman, & Jamison, 2011).

Adding to their previous adaptation to a single-parent household, now the entire family must struggle with fears related to investing in new relationships and forming a new family. Pasley and Garneau (2012) suggest that most stepfamilies have several distinctive characteristics: They typically have "greater structural complexity, lack of common history among family members, incongruent family life cycles among members, and development of parent–child bonds prior to spousal bonds" (p. 158). Goldenberg and Goldenberg (2002) add that there may be difficulties in assuming parental roles with stepchildren, rivalries and jealousies may develop between stepchildren, and competition between the biological mother and the stepmother may occur. Despite these hazards—typically involving disorganization, reorganization, sometimes relocation, and the reassigning of roles (Berger, 2000)—resilient, well-functioning stepfamilies are more the rule than the exception.

From a family life cycle view, more Americans than ever before are experiencing transitions from nuclear family to single-parent or binuclear family, to remarried family or stepfamily, all within a brief time period (Pasley & Garneau, 2012). The resulting stepfamilies (far more often a stepfather and custodial mother rather than the reverse) must undergo an entire new stage of the family life cycle before gaining stability (see Table 2.3). One glimpse of the complexity involved comes from McGoldrick and Carter (2011): "As the first marriage signifies the joining of two families, so a second marriage involves the interweaving of three, four, or more families whose previous life cycle courses have been disrupted by death or divorce" (p. 322).

Stepfamily development occurs in stages, and each stage in the process calls for gradually renegotiating and reorganizing a complex and dynamic network of relationships. Therapy to

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TABLE 2.3 Additional stage of family life cycle for remarrying families

Task	Emotional Process of Transition: Prerequisite Attitude	Developmental Issues
Entering new relationship	Recovery from loss of first marriage (adequate emotional divorce)	Recommit to marriage and to forming a family with readiness to deal with complexity and ambiguity
Conceptualizing and planning new marriage and family	Accepting one's own fears and those of new spouse and children about forming new family Accepting need for time and patience for adjustment to complexity and ambiguity of: 1. Multiple new roles 2. Boundaries: space, time, membership, and authority 3. Affective issues: guilt, loyalty conflicts, desire for mutuality, unresolvable past hurts	a. Working on openness in the new relationships to avoid pseudomutuality b. Plan for maintenance of cooperative financial and co-parental relationships with ex-spouses c. Planning to help children deal with fears, loyalty conflicts, and membership in two systems d. Realignment of relationships with extended family to include new spouse and children e. Planning maintenance of connections for children with extended family of ex-spouse
Remarriage and reconstruction of family	Final resolution of attachment to previous spouse and ideal of "intact" family; acceptance of a different model of family with permeable boundaries	a. Restructuring family boundaries to allow for inclusion of new spouse-stepparent b. Realignment of relationships and financial arrangements throughout subsystems to permit interweaving of several systems c. Make room for relationships of all children with all parents, grandparents, and other extended family d. Share memories and histories to enhance stepfamily integration
Renegotiation of Remarried Family at all future life cycle transitions	Accepting evolving relationships of transformed remarried family	a. Changes as each child graduates, marries, dies, or becomes ill b. Changes as each spouse forms new couple relationship, remarries, moves, becomes ill, or dies

Source: McGoldrick, Carter, and Garcia-Preto, 2011, p. 321.

assist stepfamilies may move from understanding the specific structure of the stepfamily to defining subsystems within the stepfamily to normalize the experience and increase empathy to assisting co-parenting and increasing communication (Browning & Artelt, 2012). Those stepparents who demand "instant love" are likely to end up feeling frustrated and rejected. On the other hand, relationships within stepfamilies that are allowed to blossom slowly often lead to caring and loving bonds that last a lifetime (Pasley & Garneau, 2012). In some cases, the stepparent may provide a model that expands a child's choice of roles in life or that offers a positive view of husband–wife relationships not seen before.

Families with Gay or Lesbian Members

From a life-cycle perspective, young gays and lesbians face the same normative demands to become independent adults as do their heterosexual counterparts, but simultaneously they

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must also learn to cope with the psychological toll of living in a stigmatizing larger society (Green, 2012). Parents often provide social support as young adults manage the transition, but gay and lesbian young adults report lower levels of parental support than do heterosexual peers, with a direct link to increased depressive symptoms, suicidal ideation, and substance use (Needham & Austin, 2010). Frequently, their prolonged unmarried status leads others to consider them not fully functioning adults. (The same is sometimes true of straight men and women.) Especially for those who choose to remain private about their homosexuality, often due to fears regarding family reaction, they may allow the family of origin's view to be perpetuated that they have not yet found the right opposite-sex partner. When a young gay adult is openly living together with a same-sex partner, some parents may be pleased that their child is in a stable relationship, while others may be further distressed since they can no longer deny their gay child's sexual identity. Currently, research is focused on how the family may be a resource to assist the healthy development of gay, lesbian, bisexual, and transgender young adults (LaSala, 2013).

In developmental terms, adolescence and young adulthood for gays and lesbians is likely to be destabilizing, as the young person with homoerotic interests experiences considerable anxiety, secrecy, and shame over same-sex feelings, all without being able to share these thoughts or feelings with family members or friends. While "coming out" may be painful and occur in stages (sometimes over a lifetime) with different people (family, friends, employers), it is during the young adult period that the struggle to establish a gay identity typically begins (Chandler, 1997). Coupling for gay men may follow a lengthy period of experimentation with connection and sometimes periods of celibacy. Young lesbians are apt to bond earlier into stable couplehood than do gay men, and because their identity is partially expressed as part of a partnership, they are more likely than gay men to present themselves as a couple to their families (Fulmer, 2011). Attitudes among gay and lesbian youth toward the likelihood of marriage and parenting are changing rapidly as laws and national acceptance change (Green, 2012).



Michael Hall/Taxi/Getty Images

Gay and lesbian parents face the same challenges as heterosexual couples in raising their children, but often with the additional social pressures of family and community disapproval.

Families led by gay or lesbian couples are as varied and diverse as heterosexual families: Some are childless couples; others are formed after heterosexual marriages ended. Still others may opt for parenthood by adopting a child (see Box 2.5), choosing artificial insemination, or utilizing a surrogate. They come from all racial,

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BOX 2.5 CASE STUDY

A Lesbian Couple Adopts a Child

Many of the problems faced by a same-sex couple adopting an older child, as we illustrate here, are similar to those encountered by heterosexual couples: inexperience as parents, the possibility of preadoption trauma to the adoptee, difficulty bonding, special needs of the child or parents, subsequent conflict between the adults. For gay or lesbian parents, there is the additional question of whether the state will recognize the adoption as legal and how custody and visitation rights will be adjudicated should the couple separate in the future.

Celia, 27, and Brenda, 29, had been lesbian live-in partners for 4 years and had talked from time to time about adopting a child together. Celia, from San Salvador, had been married briefly 8 years earlier, but the marriage had ended in divorce. She had wanted a child while married, but the marriage was rocky, with numerous separations, so both decided it would not be wise to bring a child into such an unstable situation. Brenda, Australian by birth, had never married but had been involved in raising two children of a woman friend with whom she had had a previous sexual relationship. Celia and Brenda had been in an exclusive union since shortly after they met, and both were quite involved in the lesbian community, from which they received considerable social support.

A parenting opportunity arose one day when Dora, Celia's 21-year-old unmarried sister and the mother of a 5-year-old boy, announced that she wanted to return to school and told Celia she was considering putting her son, Richardo, up for adoption.

Not wanting the boy to be placed with strangers and accustomed to coming to the aid of her younger sister in times of stress, Celia offered to adopt Richardo. Dora, who trusted her older sister and felt burdened raising Richardo by herself (he was the result of a one-night stand when she was 16), readily agreed. Celia and Brenda had had a good relationship with the boy since his birth, and they were certain the transition would be easy, that Richardo would thrive, and that raising a child together would strengthen their relationship and enrich their lives. Unfortunately, this would not prove to be the case.

Soon after Celia adopted Richardo, she and Brenda began to face the prospects of parenting and the multiple ways in which their lives had begun to change as a result of their new living arrangement. At first they tried to create a new life and identity for Richardo, offering him his own room in their large house and immediately changing his name to Rick. They instructed him to call them "Mommy" and "Auntie Brenda" and asked him to try to feel a part of this three-member family. Brenda, more experienced with raising children, quit her part-time job at the public library and assumed most of the at-home parenting responsibilities.

Celia continued working full time as a legal secretary to support the household. However, the social support previously offered by the women's network of lesbian and gay friends began to dwindle, as few in the community were involved in raising children.

At first Celia and Brenda were pleased with the parenting arrangement they had worked out together, but after 6 months or so they began to question its workability. Celia grew envious of Brenda's close relationship with her adopted son, doubting her own ability to deal with Rick in the easy manner that Brenda, more experienced with children, seemed to have. As Celia withdrew from the parenting role, Brenda became increasingly frustrated, resenting that she was carrying out the day-to-day parenting duties with no legal authorization to make decisions regarding Rick. Moreover, Celia's family of origin treated her with suspicion, refusing to acknowledge Brenda's rights regarding child-rearing decisions.

As tensions mounted, Rick began to exhibit problematic behavior at home and at school. He developed various behavioral signs of increased

(Continued)

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anxiety (sleeping problems, eating problems, discipline problems). Finally, Rick confessed that he was afraid of being "unadopted" if Celia and Brenda separated and of losing his close relationship with Brenda. His schoolwork suffered accordingly. At a parent–teacher conference attended by both Celia and Brenda, the teacher reported that Rick was easily distractible and hyperactive in the classroom and that she thought he needed counseling. Recognizing all the signs of increased dysfunction, but knowing they all wanted to stay together, the three made an appointment with a family counselor for the next week (Goldenberg & Goldenberg, 2002, pp. 17–18).

religious, and ethnic backgrounds, and, depending on their community's tolerance for same-sex relationships, may make their relationship visible or keep it private (Ariel & McPherson, 2000). Despite greater public visibility and recent movement toward equal treatment, many are marginalized by the larger heterosexual society, possess limited civil and legal rights, face employment discrimination, and must deal with unwelcoming and unsafe environments, including bullying and the threat of violent assault (Green, 2012).

Regardless of family genesis, and again like their heterosexual counterparts, gays and lesbians are part of a complex, multigenerational family system populated by their family of origin and a family of choice consisting of friends, partners, and/or children (Ashton, 2011). They are raised within the dominant cultural norms and beliefs, make many of the same assumptions about relationships, negotiate roles and responsibilities, and are likely to belong to mainstream families.

At the same time, their unique experiences with a homophobic and largely unaccepting society (often including members of their family of origin) makes their same-sex family life less comfortably visible to the dominant heterosexual world. However, this is changing, although the extent of the change is dependent on the geographic region in which one lives and the nature of personal ties. In 2015, the United States Supreme Court ruled that same-sex couples are guaranteed the right to marry by the Due Process Clause and the Equal Protection Clause of the 14th amendment to the United States Constitution. This change will affect very large numbers of people who now have the option to wed. In some states, it remains unlawful for a gay couple to adopt a child together, while other states allow the procedure (Green, 2012). If an adoption does occur, according to Adams and Benson (2005), previously rejecting family members may more readily accept their new role (grandparents, uncles, and aunts), perhaps because having children makes the adopting couple seem more like a mainstream family.

It is difficult to determine the exact number of gay or lesbian parents, although the year 2010 census identified 646,464 same-sex–couple households spread across all counties in the United States, about 1% of all couple households (O'Connell & Feliz, 2011). Many more are likely to have remained closeted, keeping their sexual preferences to themselves for fear of negative attitudes or reprisals from neighbors, employers, or coworkers. Laws against adoption by same-sex couples often add to the stress surrounding adoption, with the nonadopting parent often remaining hidden (thus back "in" after having "come out") while his or her mate

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goes through the lengthy adoption process as a single parent. The applicant may or may not reveal a gay or lesbian lifestyle to the adoption agency. Others, with children and having gone from a heterosexual to a homosexual identity, may find they need to conceal their current partnership from the courts for fear of losing custody or visitation rights. While such factors make exact counts impossible, it is estimated that in the United States, 37 to 38% of lesbian, gay, bisexual, or transgender identified-individuals have had a child, totaling an estimated 3 million LGBT parents (Gates, 2013). If we add same-sex couples that have adopted children and those who have had children through donor insemination or through surrogate mothers, there may be from 12 to 15 million children residing in homes with gay parents in the United States (Goldenberg, Goldenberg, & Goldenberg Pelavin, 2014). About 19% of all gay and lesbian couples are raising children (Gates, 2013).

Gay and lesbian parents are likely to have life cycle stresses and transitions similar to those of heterosexual families (such as adjusting to new parenthood, sending children off to school) in addition to some unique to their homosexual lifestyle—for example, deciding whether to "come out" or remain "in the closet" to other possibly homophobic parents; figuring out how to help their child fit into the mainstream with his or her peers while preserving the parents' homosexual identity (Carlson, 1996). Contrary to some myths, there is no evidence that gay or lesbian adults are less fit parents than their heterosexual counterparts (Gartrell, Deck, Rodas, Peyser, & Banks, 2005).

Nevertheless, gay parenting does present unique problems throughout the family life cycle. Ashton (2011) indicates that these are likely to arise beginning with the preschool and school-age years and proceed through all the stages of the family life cycle. During adolescence, when conformity to peer group pressures is likely to be particularly strong, children may attempt to distance themselves from their parents. While this is a developmental task common to all adolescents struggling to find their own identities, for children of same-sex marriages, hiding their parents' sexual identity may be especially fraught with conflict. Still later, telling a future mate—or possibly worse, his or her parents—about one's gay or lesbian parents is often stressful. Navigating these life cycle stages may be hazardous at times, but doing so successfully may help the children grow up with greater tolerance for diversity than might ordinarily be the case. Nevertheless, the negative impact of marginalization, social disapproval, and discrimination by the majority culture should not be underestimated and has many effects similar to those experienced by other minority groups (Snow, 2004).

A major study by Abbie Goldberg (2010) both confirms previous research outcomes and casts new light on a range of issues (and nonissues) in gay and lesbian family life. Her work shows once again that children of gay, lesbian, and bisexual parents are not significantly different from children of heterosexual parents in terms of general mental health. They are no more likely than other children to be gay or lesbian themselves, although daughters of lesbian parents seem more willing to consider this possibility whether or not they wind up forming lesbian relationships themselves. Indeed, children of gay and lesbian parents tend to be generally less gender stereotyped than children of heterosexual parents. They are also more likely to

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BOX 2.6 CLINICAL NOTE

Heterosexual Therapists Working with Gay and Lesbian Couples

Bepko and Johnson (2000/2007) address issues that come up for heterosexual therapists working with gay and lesbian couples. They caution the therapist to distinguish problems internal to the specific couple from problems due to gender and cultural biases. They suggest that therapists need to be sensitive to the external sociocultural and family sources of stress on the couple, including homophobia and heterosexism; gender stereotyping (such as gay men are feminine or lesbians are "like men"); issues associated with coming out as a couple; and conditions of social support enjoyed or not by the gay or lesbian couple. They also argue the importance for the heterosexual therapist to know about issues important to the gay and lesbian community and to avoid pathologizing what may be considered normative behaviors for couples in that community. And finally, they encourage heterosexual therapists to be able to identify and work with their own homophobic and heterosexist assumptions.

be encouraged to be independent than conforming than are children of heterosexual parents. Goldberg's research did identify a stress in families led by lesbians in terms of the role taken by the nonbiological parent, who, being neither the biological mother nor a father, had to construct some sort of parental role for herself and explain it to the outside world. Breastfeeding lesbian mothers spent more time with their child at birth than the nonbiological mother, who generally had to go back to work to earn the family livelihood; but later in life, this discrepancy fades when work responsibilities of lesbian parents tend to balance out. Goldberg's research also suggests that there is not much difference between being a boy raised by lesbian parents or a girl raised by gay parents beyond boys being more likely than girls to be teased for having two mothers. And finally, research suggests that it may be more difficult for gay parents than for lesbian parents to deal with the outside world due to stereotyped assumptions that men don't know what they are doing and that they aren't nurturing.

SUMMARY

Generations within a family have an enduring, reciprocal, life-shaping impact on one another as they move through family life cycle stages. In this multigenerational view, continuity and change characterize family life as the family system progresses through transitions over time. While the progression is generally orderly and sequenced, certain discontinuous changes may be particularly disruptive. Socioeconomic status and cultural background influence the options, opportunities, and resources available to families for coping with unforeseeable demands for adaptation. The appearance of symptomatic behavior in a family member at transition points in the family life cycle may signal that the family is having difficulty in negotiating change.

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The family life cycle perspective—dividing family development into a series of stages through which each family inevitably passes—offers an organizing theme for viewing the family as a system moving through time. Specific developmental tasks are expected to be accomplished at each stage en route. Family therapists, particularly structuralists and strategists, are especially interested in how families navigate transitional periods between stages. Passing expected milestones as well as dealing with unexpected crises may temporarily threaten the family's usual developmental progress, causing realignments in the family's organization. Among immigrant families, migration presents an especially stressful set of circumstances that may be traumatic and negatively affect family life cycle development.

Intact families typically proceed chronologically through a series of family growth phases—coupling (partners moving from independence to interdependence), expansion (accommodating children), and, later, contracting (as children move on). Old hierarchical boundaries between parents and children are likely to be replaced by a greater peer relationship as the children reach middle age. Retirement, grandparenthood, widowhood, and chronic illness/caregiving all represent major adaptational challenges for the family system as parents reach old age.

Alternative families, such as those led by single parents (as a result of divorce, adoption, out-of-wedlock births, donor insemination, widowhood) or those for which remarriage has created a stepfamily (most often a stepfather and custodial mother) inevitably experience disruptions in the family life cycle before resuming their orderly development.

Families led by gay or lesbian couples are likely to experience life cycle stresses and transitions similar to those of heterosexual families, in addition to those unique to their marginalized status in society. Children raised by gay or lesbian parents are apt to develop patterns of gender-role behavior similar to those developed by all other children.

RECOMMENDED READINGS

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3

Diversity in Family Functioning

LEARNING OBJECTIVES

- LO 1 Understand how ethnicity and culture impact family life
- LO 2 Describe gender in family therapy from a feminist perspective
- LO 3 Recognize how men's studies have contributed to gender role awareness
- LO 4 Explain the characteristics of a gender-sensitive family therapist
- LO 5 Describe the effects of socioeconomic status and poverty on family functioning

Any comprehensive attempt to understand individual or family functioning must take into account a variety of diversity influences that shape the lives and experiences of women and men. Largely fueled by postmodern and feminist inquiry, **gender**, race or **ethnicity**, **culture**, sexual identity, spirituality, and socioeconomic status are all now recognized as powerful influences on personal and family perspectives and behavior patterns (Goldenberg & Goldenberg, 1999). Not only do these forces shape the characteristics of clients, they also inform the way therapists understand and perform their work. Some mental health practitioners have extended their interest in social, political, and historical forces on clinical practice to include a professional commitment to understanding therapy as a means of achieving social justice (Jun, 2010; Toporek et al., 2006). For these advocates, it is no longer enough for practitioners to appreciate how these forces have influenced the experiences of their clients, especially those who have reported oppression by the majority culture. They define clinical practice as a means of working toward access to justice and equity for all marginalized individuals and groups.

Kliman (1994) stresses the *interactive* nature of these factors so that one cannot really be considered without the others; for example, the experience of being male or female shapes and is in turn shaped by being working poor or middle class or wealthy and by being Chinese American or

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African American or a Salvadoran refugee. Gender[1], culture, ethnicity, and socioeconomic status must be considered in relationship to one another by a therapist who tries to make sense of a client family's hierarchical arrangement, for example, or the family's social attitudes, expectations, or relationship to the majority culture.

Sarmiento and Cardemil (2009) show how ethnic background, socioeconomic status, and immigration status with the associated issues of acculturation to life in the United States relate to family functioning and the experience of depression in immigrant Latino families. They found that poor family functioning and a high degree of acculturative stress (the stresses associated with living in a new culture) yield higher levels of depressive symptoms, especially among women. The depression among women is also associated with family-related factors, whereas male depression was more likely linked to other factors, such as employment and financial stressors. They attributed these differences to the cultural traditions of marianismo and machismo among Latino women and men, respectively. In Latino culture, according to these researchers, Latinas (women) are expected to be caring, nurturing, and self-sacrificing while always prioritizing the needs of family over their own needs. Women who adhere to these traditions were found to be susceptible to greater family conflict and to more experiences of depression. Men adhering to the values of machismo, on the other hand, feel pressure to financially support and otherwise protect their families.

To be fully competent, a therapist must take into account his or her own cultural background, socioeconomic status, race, ethnicity, sexual orientation, religion, life cycle stage, and so forth in working with families from different backgrounds, being especially alert to how these factors interact with those same factors in the client family. This typically requires clinical training to adopt a contextual lens (Esmiol, Knudson-Martin, & Delgado, 2012). Christopher, Wendt, Marecek, and Goodman (2014) refer to the need for therapists to adopt a cultural hermeneutic that facilitates development of "a practical understanding of everyday lived experience" (p. 4) when interacting with a different culture. See Box 3.1 for an evidence-based report on how therapist background interacts with client gender.

In the case of gender, both the feminist movement and men's studies have drawn attention to the effects of sexist attitudes and patriarchal behavior on family functioning. Gender inequities are being addressed regarding sex-based role assignments within family groups as well as the wider culture that defines what relationships are possible within families and who is available to participate in those relationships (McGoldrick, Anderson, & Walsh, 1989). One result of the societal challenge to fixed gender roles and expectations has been a reassessment of family therapy models that were based on men's experiences and value systems, not recognizing that women's experiences and values might be different. This male perspective regarding stereotyped gender roles determined what constitutes "healthy" family functioning

[1]It is important to draw a distinction between *sex* (the biological differences between men and women) and *gender* (the culturally prescribed norms and roles played by men and women). In this chapter we emphasize the latter as an organizing principle of family relationships and as the basis of behavior society considers "masculine" or "feminine." Levant and Philpot (2002) note that gender roles are psychological and socially constructed entities, bring with them certain advantages and disadvantages for men and women alike, and perhaps most important from a therapeutic viewpoint, are not fixed but subject to change.

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BOX 3.1 EVIDENCE-BASED PRACTICE

Therapists' Background Influences Assessment and Treatment

Hertlein and Piercy (2008) surveyed 508 marriage and family therapists to investigate how treatment decisions might vary in terms of the gender of the client and the background variables (socioeconomic status, race, ethnicity, etc.) of the therapist. The specific clinical issue they examined was how the therapists understood and treated cases of social media infidelity (when a person in a committed relationship makes contact with someone via social media and engages in behaviors ranging from flirting, to emotional connection, to sexual gratification). The therapists responded to several typical Internet infidelity scenarios in which the person initiating the infidelity was the same for half of one sample. Investigators also asked the therapist-participants to respond to how they might assess and treat each presenting problem posed by the scenarios. They were asked to evaluate the severity of the problem posed, offer a prognosis, estimate the number of sessions necessary for treatment, and indicate the text to which they would focus individually or relationally. The results indicated that there were differences in how therapists assessed and treated clients based on client gender, therapists' age and gender, how religious therapists reported themselves to be, and the extent of the therapists' personal experience with infidelity. The results clearly show how diversity variables affected treatment approaches and outcomes.

in these models, and as a consequence, Philpot (2004) proposes **gender-sensitive family therapy** that attempts to overcome confining sex-role stereotyping by therapists in clinical interventions. She suggests that therapists be attuned to the gender-role messages that clients (and therapists) grow up absorbing and, perhaps more important, to help clients (and oneself) recognize, label, and challenge sexist-based messages.

There has also been increased attention to the varied perspectives and lifestyles of the different cultural groups that make up our society. These efforts attend to a larger sociocultural context to broaden our understanding of cultural influences on family norms, values, belief systems, and behavior patterns. Attention to *multiculturalism* has also challenged any previously entrenched ethnocentric views by family therapists of what constitutes a "healthy" family. As Goldenberg and Goldenberg (1999) contend, a family therapist today must take a client family's cultural background into account in order to avoid pathologizing ethnic minority families whose behavior is unfamiliar, taking care not to misdiagnose or mislabel family behavior in the process. This requires the therapist to be aware of how these very same factors helped shape their own personalities and professional capacities.

LO 1 Multicultural and Culture-Specific Considerations

Understanding families requires a grasp of the cultural context (race, ethnic group membership, religion, socioeconomic status, sexual orientation) in which that family functions and the subsequent cultural norms by which it lives. Culture—shared, learned knowledge, attitudes, and behavior transmitted from one generation to the next—affects families in various ways, some

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BOX 3.2 CLINICAL NOTE

Recognizing Strengths in African-American Families

It is important for therapists to understand how different groups understand and experience their strengths. Bell-Tolliver, Burgess, and Brock (2009), building on the pioneering work of Robert B. Hill, interviewed 30 African-American psychotherapists who used a strengths perspective in working with African-American families to identify those strengths and clarify how to use them clinically. Hill (1971, 2003) identified five strengths for this population: (a) strong kinship bonds; (b) a strong work orientation; (c) adaptability of family roles; (d) strong achievement orientation; and (e) strong religious orientations. To these, Bell-Tolliver and colleagues added (f) increased willingness of African-American families (than in Hill's time) to seek therapy, and (g) family structure. Then the researchers identified strategies for therapists to consider using the identified strengths in treatment:

- Utilization of beliefs, attitudes, and strategies for building trust between therapist and clients that rely on affirmations, praise, and encouragement
- An appreciation that many clients want therapists to understand the history and current struggles of African-American families, especially with respect to racism
- Listening and being curious about strengths
- The use of storytelling
- The appropriate incorporation of spirituality in the therapy

Both strengths and any notion of what constitutes pathology must be understood as being influenced by gender and cultural factors.

trivial, others central to their functioning. It is interwoven with our worldview. Language, norms, values, ideals, customs, music, and food preferences are all largely determined by cultural factors (McGoldrick & Ashton, 2012).

Culture-Sensitive Therapy

As family therapists have attempted to apply existing therapy models to previously underserved cultural groups,[2] they have also had to gain greater awareness of their own cultural background and values and to examine the possible impact of these factors in pathologizing ethnic minority families whose values, gender roles, discipline practices, forms of emotional expression, and so forth are different from theirs or those of other cultures (Fontes & Thomas, 1996). Efforts are underway to develop a *culture-sensitive therapy* (Prochaska & Norcross, 2014)—one that recognizes, for example, that the White middle-class cultural outlook from which most therapists operate (prizing individual choice, self-sufficiency, independence) is not embraced by all ethnic groups with which those therapists come into contact. In many Asian families, for example, interdependence within the family is expected, as it is that family members will subordinate individual needs to those of the family and society at large (McGoldrick & Ashton, 2012).

[2]According to the 2010 survey of California practicing marriage and family therapists, Riemersma (2010) reports that 89% were of European-American background, a percentage that has dropped from 94% over 15 years. These therapists indicate that they regularly treat other cultures.

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The evolving view of cultural diversity recognizes that members of racial and ethnic groups retain their cultural identities while sharing common elements with the dominant American culture (Axelson, 1999). In many instances, ethnic values and identifications may influence family life patterns for several generations after immigration to this country. Acculturation is an ongoing process that usually occurs over multiple generations, as families confront changing gender-role expectations, child-rearing practices, intergenerational relationships, family boundaries, and so forth common in the dominant culture to which they have migrated. At the same time, immigrant families often must face changes in social level to lower-status jobs, ethnic prejudice and discrimination, the acceptance of minority status in the new land, and in some cases the fear of deportation.

Clearly, family therapists need to be culturally sensitive to the ever-increasing diversity among client families if they are to deal with such families effectively (Aponte & Wohl, 2000). On the other hand, they must be careful not to blindly adopt an ethnically focused view that stereotypes all members of a particular group as homogeneous and thus responds to a client family as if it were a cultural prototype. Here it is useful to note Falicov's (2014) reminder regarding ethnically diverse groups that a variety of other factors—educational level, social class, religion, and stage of acculturation into American society, to name but a few—also influence family behavior patterns. Moreover, individual family members differ from each other in their degree of acculturation as well as in their adherence to cultural values (Sue & Sue, 2012).

Developing a Multicultural Framework

A multicultural outlook champions a general, culturally sensitive approach with families and urges therapists to expand their attitudes, beliefs, knowledge, and skills to become more culturally literate and culturally competent (Sue et al., 1998). *Culturally competent* therapists take client cultural histories into account before undertaking assessments, forming judgments, and initiating intervention procedures. They assume there is no single theory of personality applicable to all families but instead urge the adoption of a pluralistic outlook that calls for multiple perspectives rooted in and sensitive to particular cultures (Prochaska & Norcross, 2014).

More than learning about specific cultures, many advocates of multiculturalism (Pedersen, 2000; Ponterotto, Casas, Suzuki, & Alexander, 2010) urge the adoption of an open, flexible attitude about diverse cultures and cultural influences but not one tied to any specific cultural group. At the same time, they advocate that therapists gain greater awareness of their own values, assumptions, and beliefs, understanding that these are not absolutes but arise from the therapist's own cultural heritage. Sue and Sue (2012) emphasize the importance of adopting a broad viewpoint in working therapeutically with "culturally different" client populations and learning a set of appropriate intervention techniques suited to diverse clients. See Box 3.3 for exercises to enhance your multicultural awareness.

Hernandez, Siegel, and Almeida (2009) offer a cultural context model for working with families from different backgrounds. The model uses three processes to facilitate change in therapy: (a) the development of critical consciousness, (b) a deepened sense of empowerment,

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BOX 3.3 CLINICAL NOTE

Cultural Sharing

We generally begin training with cultural sharing to convey from the outset that all clinical interactions require building cultural bridges from different perspectives and to engage students in exploring their cultural backgrounds. We ask students in a training group to introduce themselves by: (1) describing themselves ethnically, (2) describing who in their family influenced their sense of ethnic identity, (3) discussing which groups other than their own they think they understand best, and (4) discussing how they think their own family members would react to being referred for therapy for a psychological problem. At times we use exercises that enable trainees to have mini-conversations with others in their training group to discuss cultural issues such as:

- Describe something you like most about your cultural background and something you find hardest to deal with.
- Describe how your family was "gendered"—that is, what were the rules for gender behavior, and who in your family did not conform to its gender stereotypes?
- What is your class background, and what changes have you or others in your family made because of education, marriage, money, or status?
- Describe a time when you felt "other" in a group and how you and others dealt with this "otherness."
- Describe what you were taught growing up about race and how your consciousness about this may have changed over time.

(McGoldrick & Hardy, 2008, pp. 453–454)

and (c) accountability. These processes help in four domains of family experience: (a) conversational, (b) behavioral, (c) ritual, and (d) community building. By working with families alone and in larger groups of others from similar backgrounds (in both same-gender and mixed-gender versions), the authors strive to create a collective experience that moves family systems and individuals within these systems to explore the impact of dominant patriarchal discourses on the cultural lives of both men and women and, through their heightened self-awareness, to new levels of empowerment and accountability.

Cultural Specificity and Family Systems

Those family therapists who advocate a culture-specific approach urge more detailed knowledge of common culturally based family patterns of unfamiliar groups. McGoldrick, Giordano, and Garcia-Preto (2005) bring together several dozen experts to provide detailed knowledge about a wide variety of racial and ethnic groupings. Their description of different lifestyles and value systems underscores that we are increasingly a heterogeneous society, a pluralistic one made up of varying races and ethnic groups, as millions migrate here seeking a better life. The majority of the total population growth in the United States between 2000 and 2010 was due to the growth of the Hispanic population; the Asian population had the highest group percentage increase (43%) and increased to 5% of the total population

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(Humes, Jones, & Ramirez, 2011). Similarly, Pedersen, Draguns, Lonner, and Trimble (2008) offer detailed assistance in working with clients from a substantial range of specific backgrounds.

One way to assess the impact of a family's cultural heritage on its identity is to learn as much as possible about that specific culture before assessing the family. This undertaking is valuable in determining the extent to which its members identify with their ethnic background and to ascertain the relationship of ethnicity issues to the presenting problem (Giordano & Carini-Giordano, 1995). Just as it would be a mistake to judge the family behavior of clients from another culture as deviant because it is unfamiliar, so therapists must also be careful not to overlook or minimize deviant behavior by simply attributing it to cultural differences.

Taking gender, social class position, sexual orientation, religion, and racial or ethnic identification into account, a comprehensive understanding of a family's development and current functioning must assess its cultural group's kinship networks, socialization experiences, communication styles, typical male–female interactive patterns, the role of the extended family, and similar culturally linked attitudinal and behavioral arrangements (Goldenberg & Goldenberg, 1993).

Family therapists must try to distinguish between a client family's patterns that are *universal* (common to a wide variety of families), *culture specific* (common to a group, such as African Americans or Cuban Americans or perhaps lesbian families), or *idiosyncratic* (unique to this particular family) in their assessment of family functioning. That is, they must



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Suppose this family presented for family therapy. Do you think the race of the therapist would have any impact on the treatment? Why or why not?

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discriminate between those family situations in which cultural issues are relevant and those in which cultural issues are tangential, but this requires examination of the ecosystemic context of the family (Falicov, 2014). In this regard, Boyd-Franklin (2002) notes that unlike the dominant cultural norms, African Americans adhere to cultural values that stress a collective identity, family connectedness, and interdependence. Her research (Boyd-Franklin, Franklin, & Toussaint, 2000) with African-American parents reveals their special concerns about their children, particularly their sons: survival issues such as racial profiling, the disproportionate number tracked into special education and juvenile justice programs, drug and alcohol abuse, gangs, violence, and so forth.

Family therapists also must keep in mind that while gaining awareness of differences that might be attributable to ethnicity or racial characteristics of a specific group is typically helpful, there is also a risk in assuming uniformity among families sharing a common cultural background. Fontes and Thomas (1996) caution that while a culture-specific family therapy outlook offers useful guidelines, these guidelines should not be considered recipe books for working with individual families. Even if they share the same cultural background, different families have divergent histories, may come from different socioeconomic status, or may show different degrees of acculturation. As an example, these authors observe that members of a Mexican-American family may identify themselves primarily as Catholic, or Californian, or professional, or Democrat; their country of origin or cultural background may actually be peripheral to the way they live their lives. Ultimately, the therapist's task is to understand how the client family developed and currently views its culture.

Family therapists must exercise caution before using norms from the majority cultural matrix in assessing the attitudes, beliefs, and transactional patterns of those whose cultural patterns differ from theirs. Lack of cultural understanding by therapists, especially White therapists, is frequently cited as a barrier to family therapy in some cultures (Awosan, Sandberg, & Hall, 2011). The idea of being "color blind" to racial differences is no virtue if it means denial of differences in experiences, history, and social existence between themselves and their clients. The myth of sameness in effect denies the importance of color in the lives of African-American families and thus closes off an opportunity for therapists and family members to deal with sensitive race-related issues (Boyd-Franklin, 2003a). In Box 3.4, we illustrate a culturally sensitive approach to a family of Mexican heritage. What the family presents as a school truancy problem can be seen in a broader social context as a sociocultural problem.

Further, in working with acculturational and adaptational issues with immigrant families (Berry, 1997), therapists need to take care to distinguish between recently arrived immigrant families, immigrant American families (foreign-born parents, American-born or American-educated children), and immigrant-descendent families (Ho, Rasheed, & Rasheed, 2004). Each has a specific set of adaptational problems—economic, educational, cognitive, affective, emotional. Acculturation has been found to involve differences in each family regarding the mix of continued endorsement of the culture of origin and adoption of elements of the new host culture; family processes may mediate acculturation effects on

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BOX 3.4 CASE STUDY

Counseling a Latino Family

The Ortiz family, consisting of Roberto, 47, the father; Margarita, 44, the mother; and two daughters, Magdalena, 12, and Rosina, 10, had never been to a counselor before, and they arrived together at the school counseling office for their early evening appointment with little prior understanding of what the process entailed. Unaware that they could talk to a counselor at school about child-related problems at home, they were summoned by the school authorities as a result of poor and sporadic school attendance by the children during the previous 6 months. Magdalena had actually stopped attending, and her younger sister, Rosina, had recently begun to copy her sister's behavior, although she did go to class some days.

Arranging for the Ortiz family to come to counseling presented several problems. Although Mrs. Ortiz had been in this country for two decades, having arrived from El Salvador by illegally crossing the border at Tijuana, Mexico, with an older brother when she was 25, she spoke English poorly; and she felt self-conscious about her speech in front of the school authorities. Mr. Ortiz, himself an undocumented immigrant from rural Mexico, had been in this country longer and had taken classes in English soon after arriving. He, too, had to be persuaded that all the family members needed to be present. Both parents had recently been granted amnesty under federal immigration regulations and had looked forward to their children having better lives in the United States. Needless to say, both parents were very upset upon learning their children were school truants.

The school counseling office arranged for Augusto Diaz, one of the counselors, to see the Ortiz family. Of Mexican heritage, Mr. Diaz was a third-generation Latino American who himself had learned Spanish in high school, never having heard it spoken at home growing up. He was sensitive to what each of the Ortiz family members was feeling and to the proper protocol for reaching this family. He began respectfully by addressing the father as the head of the house, thanking him for allowing his family to attend but indicating that the children could not be allowed to skip school and that there were legal consequences if they continued to do so. Aware that Mrs. Ortiz seemed to be having trouble following his English, Mr. Diaz enlisted Magdalena as translator. From time to time, he used Spanish words or idioms when appropriate, although he himself was quite self-conscious about his Americanized Spanish. He, too, turned to Magdalena when uncertain of whether he had said in Spanish exactly what he had intended.

The first session was essentially designed to familiarize the family with what they could expect from counseling, to build trust in the counselor, and to show them that he was interested in their situation and would try to help. Mr. Diaz encouraged all family members to participate and commented several times on the father's strength in bringing his family in to discuss these issues. They arranged another evening appointment for the following week, at a time that would not interfere with Mr. Ortiz's daytime gardening job or Mrs. Ortiz's daytime occupation as a domestic worker.

When Mr. Ortiz finally felt comfortable enough to share his thoughts, he said that girls did not need higher education, that his daughters already knew how to read and write, and that had he had boys it would have been different. He was upset, however, that they were disobedient and disrespectful in not telling the parents that they were not attending school but lying instead about how they spent their days. Although Mrs. Ortiz seemed to agree, she also revealed that she herself was suspicious of the school as well as most of what transpired in her adopted country. She hinted that she knew about the truancy, adding that she was afraid for her children in the mixed Hispanic–African-American neighborhood in which they lived and was just as happy that they stayed home rather than being influenced by their rougher classmates. Mrs. Ortiz saw her daughters'

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being home as an opportunity for some help for her after a long day and as good training for their eventual marriages.

Both Magdalena and Rosina, mute unless asked direct questions in the first two sessions, began to open up in the middle of the third family meeting. They admitted feeling isolated at school, especially because their parents would not allow them to bring classmates home or to visit others after dark. They confessed to being intimidated by gangs, something they had been afraid to reveal to their parents, who, they felt, would not understand. Staying away from school had started as a result of Magdalena's being attacked by an older girl on the school playground, after which the girl warned her to stay away or she would be seriously hurt. Rosina usually followed her older sister's lead and was certain that if her sister was afraid then the danger was real.

By the fifth session, the counselor, having gained the respect of the family members, had succeeded in opening up family communication. Mrs. Ortiz expressed an interest in learning English better, and the counselor guided her to a class in English as a second language (ESL) at the high school at night. Mr. Ortiz was persuaded to allow his wife to go out in the evening to attend class with one of their neighbors, another woman from El Salvador. He was pleased that she was trying to improve her English, which would lead eventually to gaining citizenship and thus to greater security for the family. Her mother's learning English would also free Magdalena from her pivotal role as translator and pseudo-adult in the family. As Mr. Diaz learned of the family's need for other special services, such as filling out various insurance forms and income tax returns, he directed them to the local Catholic church, where some volunteers were helping parishioners with such problems.

The children were given added support by their mother, who walked them to school every day before she left for work. At the counselor's request, the school looked into the situation of the girl who had threatened Magdalena. That older girl still looked menacing, but as Magdalena and Rosina joined other children in the playground rather than being social isolates, they felt safer, and soon the terrorizing stopped. Magdalena joined the school drill team, and Rosina expressed an interest in learning to play an instrument and joining the school band.

The counselor, in an active, problem-solving way, was able to act successfully as a social intermediary among the family, the school, and the church. Mr. Diaz mobilized the Ortiz family to make better use of neighborhood and institutional resources and feel more a part of the overall community, thereby aiding them to solve the presenting truancy problem.

(Goldenberg & Goldenberg, 2002, pp. 331–333)

the development of behavior problems (Santisteban et al., 2012) and depressive symptoms (Perez, Dawson, & Suárez-Orozco, 2011). Therefore, it may be beneficial to tailor interventions to the specific cultural characteristics of the family in therapy (Santisteban, Mena, & Abalo, 2013).

Gender Issues in Families and Family Therapy

Men and women experience family life both similarly and differently, in their families of origin and in the families they form through marriage or partnership. Typically, they are reared with different role expectations, beliefs, values, attitudes, goals, and opportunities. Generally speaking, men and women, beginning early in life, learn different problem-solving techniques, cultivate different communication styles, develop different perspectives on sexuality, and hold

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different expectations for relationships. For example, while women traditionally are socialized to develop attitudes and behavior that derive from a primary value of *affiliation* (cooperation, nurturing, emotional expressiveness, compassion), men are likely to be raised to value *autonomy* (power, aggressiveness, competitiveness, rationality). While both sexes are subject to gender-role expectations, Hyde and Else-Quest (2012) suggest that women are more apt to face social disapproval and punishment for refusing to acquiesce to socially determined rules and expectations. A woman may be pejoratively labeled if she exhibits too much of what is considered the masculine characteristic of assertiveness. Similarly, men may be disparaged if they appear too passive, emotional, sensitive, or vulnerable—qualities that are considered the province of women. The pairing of an overtly "bossy" woman and a "meek, compliant" husband often provokes discomfort in others and subsequent hostile or denigrating remarks because of its unexpected role reversal.

These gender differences in perception and behavior result from a complex interactive process between culture and biological forces. As Knudson-Martin (2012) observes, despite efforts to promote gender equality, many inequities continue to exist and result in overt and covert impacts on family life. She suggests that gender impacts family structure (decision making, prioritization of interests, power), emotion and meaning in the family (societal influences on the interpretation of behavior and affect), and skills (the stereotypical restriction of skill and trait development by gender prescriptions).

In addition, there are ethnic differences in gender socialization. Research in Latino/a families suggests a continuing tendency to socialize daughters according to traditional gender expectations, emphasizing stereotypical feminine behavior (Raffaelli & Ontai, 2004). But there is variation within each culture, and individual cultures are in the process of transition, so culture-sensitive therapy may appropriately include dialogue regarding sociocultural attitudes toward gender (Knudson-Martin, 2012).

While the broad strokes of men's lives seem to follow a more or less direct course largely laid out to them early in life by social expectations and indoctrination, women's lives in general may seem more varied. They typically experience more starts, stops, interruptions, and detours as they are called upon to accommodate to the needs of parents, husbands, children, and other family responsibilities (Bateson, 2001). Men and women typically enter marriage or alternative relationships and parenthood with different ideas of what will be expected of them. Not surprisingly, they have different family experiences. The roles of sex, physical and psychological intimacy, ease and frequency of open communication, relationships with family members, power in the family domain, emotional responsiveness, fidelity, household responsibilities, and financial concerns may all differ in the perceptions of husbands and wives (McGoldrick, 2010). Moreover, those differing experiences and expectations may lay the groundwork for future conflict resulting from their polarizing gender training, outlook, priorities, and senses of entitlement. Knudson-Martin (2012) encourages parents to prepare their children for gender equality by considering relative status (do both daughters and sons have the power to set relationship agendas?), attention to others (expecting boys and girls to attend to emotions and needs in others), accommodation

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patterns (expecting balance in accommodation between girls and boys), and well-being (boys and girls are expected to balance individual accomplishment with responsibility to relationships).

LO 2 Feminism and Family Therapy

The family therapy field has been relatively slow in recognizing the extent to which the gender-role messages all of us experience during our lifetimes typically affect our current family life (Enns, 2004). As McGoldrick, Anderson, and Walsh (1989) point out, many early family therapists operated in a gender-free fashion, as if family members were interchangeable units of a system with equal power[3] and control (and thus equal responsibility) over the outcome of interactions occurring within the family. The larger social, historical, economic, and political context of family life in a patriarchal society generally was overlooked; therapists by and large felt comfortable taking a neutral stance regarding a family's gender arrangement, thus running the risk of tacitly approving traditional values oppressive to women. The overall result, typically, was for family therapists to perpetuate a myth of equality between men and women within a family seeking their help (Hare-Mustin & Marecek, 1990).

However, beginning in the 1970s, an increasing number of family therapists, primarily women at first, began to challenge the underlying assumptions about gender that put women at a disadvantage. Several pioneering studies (Avis, 1985; Gilligan, 1982; Goldner, 1985; Hare-Mustin, 1978; Miller, 1976) faulted existing family therapy models for failing to pay sufficient attention to gender and power differences in male–female relationships, in effect ignoring how these gender patterns influence internal family interaction, the social context of family life. Not yet offering an alternative **feminist family therapy** position[4]—that was to come in the late 1980s—these critics nevertheless argued that family therapists, reflecting the larger society, often (wittingly or unwittingly) reinforced traditional gender roles (Avis, 1996) and endorsed traditional male/female roles that depreciate qualities (dependency, nurturing, emotional expressiveness) traditionally associated with women while extolling qualities (aggressiveness, competitiveness, rationality) held in high regard by men. Attempting to correct this gender bias, these

[3]Power within a family typically is gained in various ways: by gender, age, earning power, respect, or fear. In society at large, power is unequally distributed based on such factors as gender, class, race, religion, ethnicity, age, sexual orientation, profession, and degree of physical ability (Fontes & Thomas, 1996). Although gender roles are in transition, and women have assumed powerful positions (business executives, astronauts, Supreme Court justices, foreign heads of state), Risman (1998) points out that overall men still have more power and status than women in all cultural groups.

[4]There is no single entity labeled feminist family therapy, since there are therapists practicing from all of the approaches we will consider later in this text who may regard themselves as feminist-informed and thus may take a variety of approaches with families. Rather, as Avis (1996) emphasizes, feminist family therapy is a "*perspective* on gender relations, a lens through which a therapist views his or her clients" (p. 223). Regardless of theoretical outlook, all address gender and power imbalances in their clients' lives and all advocate empowerment and egalitarianism as goals (Worell & Remer, 2002; Enns, 2004).

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feminist-informed therapists began to challenge the social, cultural, historic, economic, and political conditions that shaped not only the unique development and experiences of women but also their relationships with men.

The Women's Project in Family Therapy, co-led by Marianne Walters, Betty Carter, Peggy Papp, and Olga Silverstein—begun in 1977 and continuing for almost 30 years—examined gender patterns in family relationships as well as patriarchal assumptions underlying classic family therapy approaches. These family therapists offered a female-informed clinical perspective that challenged the field's conventional wisdom. They argued that a field devoted to families had, paradoxically, relied on outdated blueprints of male-determined, stereotypic sex roles and gender-defined functions within families. Their text, *The Invisible Web* (Walters, Carter, Papp, & Silverstein, 1989), describes their experiences in applying a feminist perspective to their understanding of gender- and power-based family issues. This project had enormous influence in the field, moving family therapists to look beyond what is occurring within the family and to consider the influence of broader social and cultural forces (Simon, 1997).

Feminist Reexamination of Family Therapy Theory and Practice

Since early family therapy was largely defined by men, inevitably male language and attitudes dominated early theories. Hoffman (1990) notes that a male bias was built into family concepts that take the heterosexual, patriarchal family as the norm, arguing that terms such as "overinvolved mother" or "enmeshed family" are sexist and tend to blame mothers in particular for family problems.

Feminist-informed therapists consider such cybernetic concepts as "circular causality" (to designate a repetitive pattern of mutually reinforcing behavior in a male–female relationship) especially unacceptable. They insist this systems-based concept implies that each participant has equal power and control in a transaction, which they dispute. Particularly in the case of physical abuse (rape, battering, incest) by men against women, they reject the cybernetic notion that both partners are engaging in a mutual causal pattern and that it is the subsequent behavioral sequence, for which they are both responsible, that results in the violent episode (Goldner, Penn, Sheinberg, & Walker, 1990).



Newscom

Rachel Hare-Mustin, Ph.D.

Feminists are critical of the implication that no one therefore is to blame—a violation without a violator—thus clearing the aggressor of responsibility. They emphasize greater masculine power in human relationships, the superior physical strength of men, and the corresponding vulnerability of women. They contend that the cybernetic epistemology tends to blame the victim for colluding in her own victimization either as a co-responsible participant or by remaining in the relationship. Avis (1996) points out that implying that all interactional behavior originates within the interaction itself makes it impossible to search for causes outside the interaction; here she cites such external possible causes as "cultural beliefs about appropriate gender behavior, a preexisting propensity to use violent behavior, or differences in power with which each partner enters the relationship" (p. 225).

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Rachel Hare-Mustin (1987) describes gender as the "basic category on which the world is organized" (p. 15); according to Knudson-Martin (2012), gender is "a socially created construct that consists of expectations, characteristics, and behaviors that members of a culture consider appropriate for males or females" (p. 325). Hare-Mustin, often credited with being the first to raise feminist issues among family therapists, suggested that commonly observed male–female behavioral differences simply reflect established gender arrangements in society rather than any essential set of differences in the nature of men and women. A woman's typically greater concern with relationships, according to Hare-Mustin, can best be understood as a need to please others when one lacks power. In this view, a woman's behavior reflects her less powerful role position vis-à-vis a man's rather than resulting from an inherent weakness of character. *Where the powerful advocate rules and rationality, the weak espouse relatedness*. Hare-Mustin (1987) offers the following example:

> Thus, in husband–wife conflicts, husbands use logic, wives call on caring. But, in parent–child conflicts, parents, including mothers, emphasize rules; it is the children who appeal for understanding. Society rewards rationality, not emotions, but which is used is associated with who has the power, and not primarily with being male or female. (p. 22)

Gender, Work, and Family Life

The entry of women at all socioeconomic levels, whether single, cohabiting, married, or heads of single-parent households, into the world of paid work has had a profound effect on evolving male–female relationships. The workplace is now half female, and although many dynamics have changed, many remain the same (Hochschild & Machung, 2012). In recent years, women have been marrying later (or choosing not to marry at all) and are having fewer children. Couples who do decide to become parents, as noted earlier, must rearrange the family system and renegotiate the roles each plays, particularly if the wife continues to work outside the home, as the overwhelming majority do. Women, especially single mothers or women among the poor, minority, immigrant, and undereducated populations, have always been part of the workforce. What is new is the influx of married women, including those with young children, into work outside the home (Goldenberg & Goldenberg, 2002); see Box 3.5.

Breaking out of stereotypic male–female roles regarding domestic and work responsibilities is essential to contemporary family therapy. Working wives continue to bear the major responsibility for child care and most household chores, although men now are more involved in the rearing of preschool children and helping with daily domestic tasks than in the past. Women are likely to take on the major obligation of caring for sick children or elderly family members, maintaining contact with the families of origin of both partners, and sustaining friendships.

With the children out of the house and forming families of their own, men and women may find themselves with differing priorities (McGoldrick, 2010). Men may wish to seek greater closeness to their wives, while the latter may begin to feel energized about developing their own lives, perhaps through resumed careers or other activities outside the home. If serious marital tension leads to divorce, as it sometimes does at this stage, McGoldrick and associates contend that women are especially vulnerable. Not only are they less likely than men to remarry, but their embeddedness in relationships, their orientation toward

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BOX 3.5 EVIDENCE-BASED PRACTICE

Changing Educational, Work, and Family Roles

Changes in work and family roles for men and women have occurred at an astonishingly fast pace in the last 30 years. Women now complete graduate and professional schools at a rate equal to or greater than that of men. They now constitute half the U.S. labor force and can expect to spend at least 30 years in the paid workforce. The modal American family today is a dual-earner family, and 40% of white, college-educated women earn as much as or more than their husbands (Barnett & Hyde, 2001). The "feminization" of professional ranks (law, medicine, pharmacy, business administration) should continue to increase as older, male-dominated groups retire. However, certain hot-button items remain for many working women: equality of pay, maternity leave, flexible time for family responsibilities (Cox & Alm, 2005).

Men are spending more time on child care and household tasks than in the past, while employed women are doing somewhat less as couples navigate toward increased equity. Barnett and Hyde (2001) suggest that multiple roles are beneficial for both men and women. Beyond added income, frequently necessary in today's economy, women have opened up opportunities to experience success and to participate in challenging experiences outside the home.

interdependence, their lifelong subordination of achievement to caring for others, and their conflicts over competitive success may make them especially susceptible to despair.

Finally, since women are apt to outlive men, many may find themselves alone and financially impoverished. Very likely they will turn to their daughters (or perhaps daughters-in-law) for support and care, since women in our society shoulder most of the eldercare, with the possible exception of managing finances for the elderly.

LO 3 Men's Studies and Gender-Role Awareness

To be gender sensitive (or feminist informed) is to be aware of the differences in behavior, attitudes, and socialization experiences of growing up masculine or feminine, especially in terms of differences in power, status, position, and privilege within the family and in society in general. Brooks (1992) observes that past "gender blindness" by family therapists was first detected by women and thus focused principally on the woman's perspective. However, he reminds us that men too have been subjected to substantial role constraints and disadvantages as a result of their masculine socialization experiences. They too may have suffered from sexist therapeutic interventions that have condoned restricting men to a narrow range of family roles (such as breadwinner) while robbing them of the experience of participating in roles (say, child rearing) usually assigned to women. Levant and Philpot (2002) suggest that this type of gender-role restraint is inherently traumatic to men because it truncates their natural emotionality. Knudson-Martin (2012) argues for a model of a "mutually supportive relationship" that assumes that men value relational skills and want to attend to their partners, advancing equality.

Men's studies extend feminist explorations by attending to role restrictions in men's lives. These socialized gender restrictions may hinder individual or interpersonal fulfillment. O'Neil (2013) notes that the fear of femininity results in socialization and norms that program men

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BOX 3.6 CLINICAL NOTE

Transition into Parenthood

The transition into parenthood by couples who have always cared about equality in their relationship can introduce stresses into the relationship. This period often involves new or revived struggles over gender roles, the division of labor in the household, an equal share of the parenting, and the maintenance of a previous sense of egalitarianism. Often marital satisfaction decreases with the birth of a child. Many women, even when the relationship had at first been more or less equal, will with the birth of their child find themselves with a disproportionate share of household labor, especially when they return to work. Therapists working with these couples may help them in the following ways:

- Nurture constructive communication patterns between the new parents.
- Help the couple manage affect and to maintain emotional intimacy.
- Make the couple aware of any shifts in power relations between them.
- Support the renegotiation of roles.
- Encourage increased parenting for the father.

(Koivunen, Rothaupt, & Wolfgram, 2009)

toward curtailed emotional expressiveness, conflicts between work and family relations, restricted affectionate behavior between men, and concern with success, power, and competition. Proof of masculinity from this perspective often derives from the ability to display power and control, most likely at the expense of women and children. Curtailed emotional expressiveness can have devastating effects on men, especially on adolescents. For example, Irene Paz Pruitt (2007) indicates that while adolescent males are less likely than adolescent females to report depression, they have serious risks associated with the disorder, including suicide, future substance abuse, and a greater likelihood toward future illegal activity. O'Neil (2013) documents extensive research in multiple cultures over the last 30 years that find that gender role conflict is significantly correlated with more than 70 intrapersonal (depression, anxiety, substance abuse) and interpersonal (lower capacity for intimacy, lower relationship satisfaction) psychological problems. Racial identity, culture, and acculturation factors interact with gender role conflict in a complex manner.

Whether warranted or not, men have a reputation for avoiding and even demeaning therapy. This assumption might introduce challenges in working with any specific man in therapy. To test the premise that men's lack of awareness of relational problems—another common assumption about men—contributes to their reluctance to consider, seek, and benefit from couple therapy, Moynehan and Adams (2007) examined a group of couples and found no gender differences in the frequency or pattern of initial problem reports or improvement rates. Other research suggests the benefit of addressing gender socialization and sensitive gender issues in treatment with men while noting that a lack of therapist awareness of male gender role conflicts and biased assumptions may be harmful (Mahalik et al., 2012). Falicov (2010) argues that family therapists working with Latino clients must reexamine cultural terms, like "machismo," to ensure that they avoid simplistic negative perspectives and include positive cultural traits also denoted by the terms. Stereotypes about men (as about women) may negatively affect therapeutic interventions. Box 3.7: Thinking Like a Clinician presents ways for therapists to challenge any stereotypes.

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BOX 3.7 THINKING LIKE A CLINICIAN

Challenging Stereotypes

Consider how you would work in psychotherapy with the following scenario and family. Although an emphasis is placed on the father's experience as a man, consider how race, culture, socioeconomic status, other gender-related matters, and age contribute to your understanding. Use the prompts to help guide your thinking.

An African-American family enters treatment for the first time because its members are always fighting and, as the wife/mother noticed, they don't seem to spend much time together anymore. As the session proceeds, she mentions that while she appreciates the affluent life that her husband—the sole income earner—provides, she misses him and wants him to spend more time with her at home. He becomes irritated and cold, saying, "It's hard to have it both ways, Sweetheart. If I don't work, you don't get your fancy gym membership and Mercedes Benz." She looks away, and you wonder if she might be feeling shame. The teenage son says, "Actually, I don't care if you're never home." The father shoots the young man an angry look. You expect the father to blow up, but instead he becomes silent and you notice his eyes watering. Very quietly, he says, "Apparently, my family doesn't understand how much I love them. They don't understand that as the man, I give my life to work to provide the very best for them that I can."

How might you intervene?

1. What do you notice about how family members interact? Consider their use of language and physical gestures.
2. You know the family is affluent. Does this fact influence any thoughts or emotional reactions you have? Discuss your feelings.
3. How would you describe the interaction between husband and wife?
4. What questions might you consider asking them with respect to the use by their parents and grandparents of money?
5. What might you ask them about the background of the family that would have bearing on the present interactions?
6. How do your own finances, culture, ethnicity, age, and gender influence your perspective? What did you learn about yourself in this exercise?

One interpersonal area in which gender, asymmetrical power, and control intersect is family violence and sexual abuse. Masculine gender role norms play a role in such violence. Substantial research indicates significant evidence for the relationship between adherence to masculine gender roles and intimate partner violence, and certain types of violence (psychological, physical, sexual) may relate specifically to particular types of masculine gender role stress (Moore et al., 2008). On the other hand, masculine discrepancy stress (perceived failure to fulfil society's masculine gender role expectations) may also create distress that results in intimate partner violence (Reidy et al., 2014). Goldner (1998), writing from a feminist perspective, acknowledges that both partners are involved in woman battering but that the violent behavior is the man's responsibility and that it is important not to blame the victim (e.g., believing that "she provoked it"). Brooks (1992) argues that to be successful, any antiviolence program must be gender sensitive and include the preventive antiviolence resocialization of men so that they will not rely on violence as an interpersonal strategy.

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In Box 3.8, a social worker attempts to deal with a difficult case of wife abuse using a **genogram** (see fuller discussion in Chapter 8) to help the couple recognize their family histories in regard to the use of alcohol and, in the husband's case, of violence.

BOX 3.8 CASE STUDY

A Couple Confronts Domestic Violence

Jim Kull is referred by the Rock County District Attorney's Office to the Rock County Domestic Violence Program. He was arrested two nights ago for an incident in which his wife, Diane, received several severe bruises on her body and her face. Kris Koeffler, a social worker, has an interview with Jim. Jim is an involuntary client and is reluctant to discuss the incident. Kris informs Jim he has a right not to discuss it, but if he chooses not to, she is obligated to inform the district attorney that he refused services. She adds that in such cases, the district attorney usually files a battery charge with the court, which may lead to jail time.

Jim reluctantly states that he and his wife had a disagreement, which ended with her slapping him and him defending himself by throwing a few punches. He adds that yesterday, when he was in jail, he was informed that she left home with the children and is now staying at a women's shelter. He is further worried she may contact an attorney and seek a divorce.

Kris inquires about the specifics of the "disagreement." Jim indicates he came home after having a few beers, his dinner was cold, and he "got on" Diane for not cleaning the house. He adds that Diane then started "mouthing off," which eventually escalated into them pushing and hitting each other. Kris then inquires whether such incidents had occurred in the past. Jim indicates "a few times" and then adds that getting physical with his wife is the only way for him to "make her shape up." He indicates he works all day long as a carpenter while his wife sits home watching soap operas. He feels she is not doing her "fair share"; he states the house looks like a "pigpen."

Kris asks Jim if he feels getting physical with his wife is justifiable. He responds with "sure," and adds that his dad frequently told him "spare the rod and spoil both the wife and the kids." Kris asks if his father was at times abusive to him when he was a child. He indicates that he was and adds that to this day he detests his dad for being abusive to him and his mother.

Kris then suggests they draw a "family tree," focusing on three areas: episodes of heavy drinking, episodes of physical abuse, and traditional versus modern gender stereotypes. Kris explains that a traditional gender stereotype includes the husband as the primary decision maker and the wife as submissive to him and primarily responsible for domestic tasks. The modern gender stereotype involves an egalitarian relationship between husband and wife. After an initial reluctance (related to his expressing confusion as to how such a "tree" would help him get his wife back), Jim agrees to cooperate in drawing such a "tree." (The resulting genogram is presented in Figure 3.1.)

The genogram helps Jim see that he and his wife are products of family systems that have strikingly different values and customs. In his family, the males tend to drink heavily, have a traditional view of marriage, and tend to use physical force in interactions with their spouses. (Jim adds that his father also physically abused his brother and sister when they were younger.) On questioning, Jim mentions he frequently spanks his children and has struck them "once or twice." Kris asks Jim how he feels about repeating the same patterns of abuse with his wife and children that he despises his father for using. Tears come to his eyes, and he says "not good."

Kris and Jim then discuss courses of action that he might take to change his family interactions and how he might best approach his wife in requesting that she and the children return. Jim agrees to attend Alcoholics Anonymous (AA) meetings, as well as a therapy group for batterers. After a month of attending these weekly meetings, he contacts Diane and asks her to return. Diane agrees to return *if* he stops drinking (since most of the

(*Continued*)

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abuse occurred when he was intoxicated), *if* he agrees to continue to attend group therapy and AA meetings, and *if* he agrees to go to counseling with her. Jim readily agrees. (Diane's parents, who have never liked her husband, express their disapproval.)

For the first few months, Jim is on his best behavior and there is considerable harmony in the family. Then one day, on his birthday, he decides to stop for a few beers after work. He drinks until he is intoxicated. When he finally arrives home, he starts to verbally and physically abuse Diane and the children. For Diane, this is the last straw. She takes her children to her parents' house, where they stay for several days until they are able to find and move into an apartment. She also files for divorce and follows through in obtaining one.

In many ways, this case is not a "success." In reality, many social work cases are not successful. The genogram, however, is useful in helping Jim realize that he has acquired and is now acting out certain dysfunctional family patterns. Unfortunately, he is not ready to make lasting changes. Perhaps in the future he will be more committed. At the present time he has returned to drinking heavily.

(Zastrow, 1999, pp. 188–189)

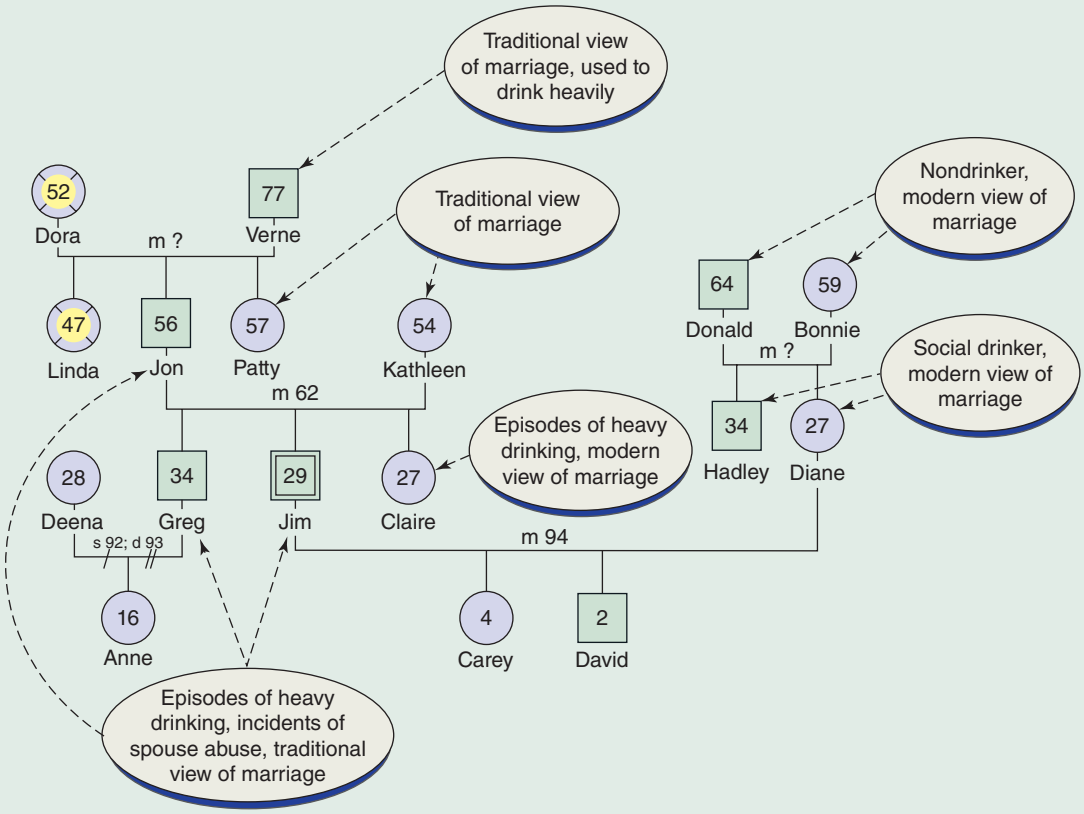


FIGURE 3.1 **Sample genogram: The Jim and Diane Kull family**

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LO 4 Therapy from a Gender-Sensitive Perspective

Gender-sensitive family therapy is intended to liberate and empower both male and female clients, enabling them to move beyond prescribed roles determined by their biological status to ones in which they can exercise choice. In practice this means overcoming internalized social norms and expectations for every client; gender stereotypes in male as well as female clients require examination. Gender-sensitive therapy is action oriented, not merely nonsexist in viewpoint. Nonsexist counseling attempts to avoid reinforcing stereotypical thinking regarding gender roles and power differentials in most male–female relationships; gender-sensitive family therapy proactively helps clients recognize the limitations on their perceived alternatives imposed by internalizing these stereotypes. See Box 3.9 for gender-sensitive family therapy techniques.

LO 5 Socioeconomic Status and Family Functioning

Every cultural group has socioeconomic divisions, and each socioeconomic status is made up of members from different cultural groups. Men and women in each socioeconomic class experience life differently from one another, differently from their counterparts in other classes, and differently from others of the same class but from another cultural group.

No one group is monolithic: Not all African Americans are poor; not all Whites are middle class. In actuality, most of the nation's poor are White, although people of color are disproportionately represented among the poor. Increasingly it takes two parents—and two paychecks—to maintain a household's grip on middle-class status in the United States today.

BOX 3.9 CLINICAL NOTE

Example of Gender-Sensitive Family Therapy Techniques

Knudson-Martin (2012) notes that therapists need to appreciate the pervasiveness of gender influences on all aspects of a relationship and seek to replace gender structures and influences with an emphasis on equality. She provides examples of gender-sensitive family therapy techniques:

- Value relational skills
- Promote a wider range of gendered experience
- Interrupt dominance patterns
- Identify values that promote equality
- Raise conversation about the social context
- Help men attend
- Support silenced voices
- Help families develop their own model of equality
- Promote policies and practices that support gender equality
- Be proactive

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Socioeconomic differences act as primary dividers within a society. Not only do they largely determine access to many resources (including therapy), but they also are influential in shaping beliefs, values, and behaviors (Ho, Rasheed, & Rasheed, 2004). Kliman (2011) categorizes families as ruling class, professional-managerial class, working class, and underclass to denote the long-term dynamics in families that extend beyond annual income, especially for young people launching from these families. She notes substantial differences in attitude, perspective, and interpretation of behavior based on class identity. Despite our society's cherished myth that we are all middle class (or have equal opportunity to become middle class), the facts indicate otherwise: more than 14.5% of all American families live below the poverty line, numbering more than 45 million people, and many more live just above it. Almost 20% of children live in poverty and almost 10$ of seniors aged 65 and above live in poverty (U.S. Census Bureau, 2013).

Access to power is also largely determined by socioeconomic status. As Aponte (1994) observes:

> The poor are dependent upon and vulnerable to the overreaching power of society. They cannot insulate themselves from society's ills. They cannot buy their children private schooling when the public school fails. They cannot buy into an upscale neighborhood when their housing project becomes too dangerous. When society stumbles, its poorest citizens are tossed about and often crushed. (p. 8)

Poor African-American families, embedded in a context of chronic unemployment and discrimination, are particularly limited in their abilities to function in ways that permit family members to thrive. The decline in marriage rates among African Americans, coupled with the increased number of teenage mothers, has added to their family crises.

Kliman (2011) notes the persistent effect of social class membership because it impacts health (access to healthcare and utilization of services when needed), diet, ability to make long-term decisions versus required focus on immediate needs, and employment conditions (for instance, the comparison of executives who can work well past age 65 because their work conditions do not require physical exertion versus those forced to retire on limited funds because they are unable to continue to perform manual labor). Aponte (1987), too, emphasizes the creation of what he terms *underorganized* (rather than disorganized) families. Living in such situations through generations, families of whatever racial background "learn to view as normal their own impotence" (p. 2). They are forced to accept their dependence upon the community's network of social institutions (welfare, public housing, publicly funded healthcare) without the necessary political or economic power to influence outcomes. Where fatherless homes predominate, roles lose their distinctiveness, and children may grow up too quickly while being at the same time intellectually and emotionally stunted in development.

Life cycle progression among the poor is often accelerated by teenage pregnancy. The life cycle stages we described in Chapter 2 for middle-class, intact families are often fast-forwarded; the "launching" stage for a young mother's children, for example, may occur when she is still at *her* mother's home. Hines (2011) calls this the condensed life cycle because individuals become parents and grandparents at very early ages. Such early childbearing further decreases a young woman's already limited prospects for financial security, steady job

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expectations, educational attainment, and marital stability. Several generations of family are likely to be alive at the same time in the basic family unit. Such kinship groups at times function as "multiple-parent families" with reciprocal obligations to one another, sharing meager resources as efficiently as possible.

The family therapist, likely to be professional-managerial class (in viewpoint if not necessarily in origin), must be careful not to regard being poor as synonymous with leading a chaotic, disorganized life, because, for example, long-term planning may not be present. It is essential to distinguish between those families who have been poor for many generations (victims of what Aponte, 1987, calls structural poverty), poor intermittently or temporarily (as students or while divorced but before remarriage), or recently poor because of loss (such as unemployment or the death of the major wage earner). It also helps to be aware that some poor people, including those who are chronically unemployed, share middle-class values (regarding such things as work and education) while others embrace more survival-based values of the working class as a result of their life experiences. Some lead lives that are a series of crises, and others have forged family and social networks that are resourceful and workable. Above all, any efforts to equate poverty with psychological deviance first must take into account the harsh and confining social conditions usually associated with being poor.

Therapy and Social Justice

Many therapists concerned with the impact of gender, race, ethnicity, social class, economic status, sexual orientation, spirituality and religion, disability status, and immigration status have identified the role that therapy could and, from their perspective, should play in the support and deepening of social justice. Social justice can be understood as the fair and equitable distribution of advantages and disadvantages within a society to all people regardless of their status (Toporek, Gerstein, Fouad, Roysicar, & Israel, 2006). For these therapists, concern for multicultural sensitivity is not just an issue of clinical efficacy. Therapists concerned about social justice assert that practitioners need professional competencies to work toward universal access to justice and equity for marginalized individuals and groups. Constantine, Hage, Kindaichi, and Bryant (2007) have identified nine competencies they believe therapists should acquire in training and practice throughout their professional lives:

- An awareness of oppression and social inequities
- Ongoing self-reflection with regard to race, ethnicity, oppression, power, and privilege
- An understanding of the impact of a practitioner's power and privilege on clients, communities, and research participants
- Active questioning and challenging of inappropriate or exploitative intervention practices
- Understand and share knowledge, as appropriate, about indigenous healing practices
- An awareness of ongoing international social injustice
- A conceptualized, implemented, and evaluative mental health intervention program for the multicultural population
- Collaboration with community organizations to provide culturally relevant services
- Advocate for change in the social system

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Therapists concerned with the social justice dimensions of their professional work often strive to appreciate their own privileged status in the community and to ensure that professional efforts not only help clients but the community and society at large.

In this chapter, we have explored how different societal forces, primarily gender and culture, affect our understanding of family functioning and the theory and practice of family therapy. Research (Keeling & Piercy, 2007) indicates that attention to these dimensions of family functioning and therapy has become widespread and relatively common not only in the United States but around the world. The researchers surveyed 20 marriage and family therapists from 15 countries to see how therapists from different locations address the intersection of gender, power, and culture in therapy. The authors report the widespread application of what they term a "careful balance" they observed in participant-therapists working with clients. This careful balance includes a respect for cultural values and practices and the promotion of equitable gender relationships, and it was seen consistently across cultures.

SUMMARY

Culture, gender, and socioeconomic status are key interrelated factors in shaping lives. Cultural diversity is an important part of American life, and family therapists have widened their focus from the family to include larger sociocultural contexts that influence behavior. A multicultural emphasis urges therapists to be more culturally sensitive before undertaking assessments, forming judgments, or initiating interventions with families whose backgrounds are different from theirs. Otherwise, therapists risk misdiagnosing or mislabeling unfamiliar family patterns as abnormal. Gaining greater awareness of their own culturally based values, assumptions, and beliefs should help therapists work more effectively with ethnic families. A culturally specific emphasis asserts the importance of learning about culturally based family patterns of specific groups.

In regard to gender, men and women are reared with different expectations, experiences, attitudes, goals, and opportunities, and these differences influence later culturally prescribed role patterns in family relationships. Family therapists have only recently begun to fully recognize the impact of these early patterns on current family life. Feminists contend that psychological research and clinical practice have been filled with outdated patriarchal assumptions and offer a male-biased perspective of sex roles and gender-defined functions within a family. They reject certain cybernetic concepts such as circular causality because such concepts fail to acknowledge differences in power and control between men and women, in effect blaming the victim for her victimization. The entry of women across all socioeconomic statuses in large numbers into the workforce has also helped break some long-held stereotypic views regarding the distribution of work and family responsibilities between husband and wife. Gender-sensitive therapy is directed at empowering clients, male and female, to move beyond prescribed sex roles based on biological status to ones in which they can exercise choice.

Social class considerations also influence family lifestyles. Living in poverty, whether temporarily or as part of poverty patterns extending over generations, may erode family structure and create underorganized families. In poor families, life cycle progression is sometimes accelerated by teenage pregnancy, which limits educational or financial security and future marital stability.

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Many therapists today assert a link between the professional values they hold regarding the important considerations of culture and gender in clinical work and the broader values of social justice. They connect clinical practice and the values of social equity and human rights in the community and throughout society as a whole.

RECOMMENDED READINGS

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4

Systems Theory and Systemic Thinking

LEARNING OBJECTIVES

- LO 1 Describe potential problems with using only the scientific method to explain family functioning
- LO 2 Explain systemic functioning using a paradigm or descriptive model
- LO 3 Discuss some characteristics of a family system
- LO 4 Apply systemic thinking to family therapy

Family therapy is informed by **systems theory** and **systemic thinking** in order to fully understand and provide psychotherapy to couples and families (Stanton & Welsh, 2012). A systemic approach stands in contrast to the individualistic thinking typical of most people raised in Western society who were educated in the context of the Cartesian scientific method espoused by Rene Descartes in 1738 (Capra, 2002).

LO 1 Extending Beyond the Scientific Method

The scientific method begins with a questioning mind that does not accept anything as true unless there is clear evidence of its truth and proceeds to break any problem under investigation into pieces in order to understand the components of the problem and tries to solve it. The reconnection of the pieces proceeds from those easiest to understand to those most complex without considering any natural connection between the parts and concludes when thorough questioning ensures nothing was left out of the solution. This method led to major scientific discoveries and the solution of many problems in medicine, food production, and industry. Most of us in the western hemisphere were educated to think according to this method, and we now do so without even realizing we are doing so. However, as this method became the standard way of thinking in Western societies, it resulted in extreme individualism (loss of the natural relationship between parts of the whole), reductionism (trying to understand complex problems by looking at parts of them apart from the context around

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them, resulting in solutions that do not work in real life), linear thinking (trying to understand problems by simple cause–effect explanations that ignore multiple reflexive influences), and extreme objectivism (the idea that knowledge can only come through this scientific method; anything subjective is disregarded; Stanton, 2009).

Most of us do not think about how we think—we simply think, not recognizing that we are using rules about thinking to govern our thought processes. We adopt the **epistemology** of our time without knowing it. An epistemology is a set of thinking rules used by groups of people to define reality or "how we know what we know" (Auerswald, 1990; Stanton, 2009). Our epistemology determines the information we consider—or fail to consider—and the way we organize that information. So, for each of us, "reality" is something we construct based on what our rules say is real and true. For example, some people think feelings are not objective reality, so they disregard them. We see this in couples therapy when one partner shares feelings and the other wants to focus on the "facts." Systems theory challenges family therapists to consider new ways of thinking so that we might effectively understand and help families.

Family therapy grew out of a movement that saw the scientific method as only one way to understand problems. These scientists started looking at the whole again, focusing on the interaction of the parts through communication and other characteristics of systems. They found that families are organized wholes with members living in continuous, interactive, patterned relationships with one another that extend over time and space. A change in any one component inevitably changes any other related components. Beyond the relationships of its constituent members, the family itself is continuously and bidirectionally linked to larger systems. The interplay between families and those social systems tells us a great deal about the level of family functioning. For these early family therapists, systems concepts became a useful *language* for conceptualizing a family's interactive process.

In this chapter we present a systemic framework—or **paradigm**—for understanding the reciprocal interaction between the parts of a system that includes the family system. This will help you think about what you include or exclude when you think about families. We describe several key characteristics of systems, and we try to help you shift from understanding concepts alone to really thinking systemically as a family therapist. We explore the need for family therapists to help families manage their interactions across multiple settings (school, healthcare). Finally, we note some critiques of systems theory and suggest ways contemporary systems theory responds to the concerns.

LO 2 Seeing the System

A systemic perspective greatly broadens the context for understanding family functioning by attending to the numerous social systems with which it functions. Such a view addresses the multiple systems in which families are embedded. In this multidimensional view, attention is directed beyond the family to "external" factors that may be influencing family functioning (Robbins, Mayorga, & Szapocznik, 2003). Beyond helping families improve their coping skills, clinicians with this outlook help empower them to make more effective use of available social and community services. No longer restricted to the consultation room, services may be delivered at places more convenient to the family: in schools, homes, community agencies, and elsewhere.

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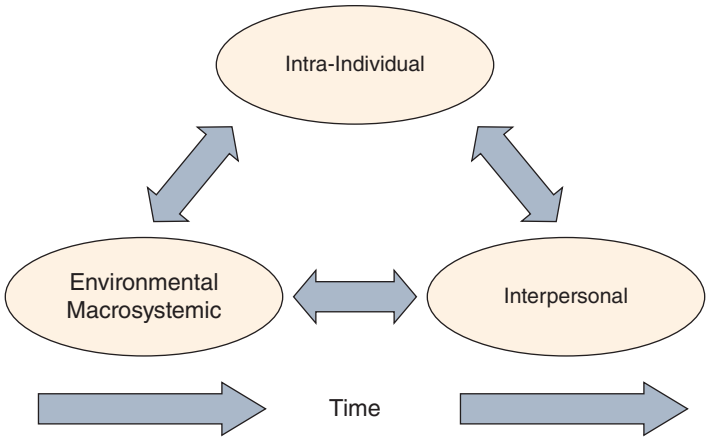


FIGURE 4.1 A systemic paradigm

Source: Stanton (2009).

A variety of models have been introduced to facilitate system conceptualization. They all attempt to demonstrate the complex, interactive, reciprocal nature of systems. Unlike the traditional American business organizational chart that flows from top to bottom, they are often circular and dynamic to illustrate that information, power, and influences flow in many directions simultaneously. One model (see Figure 4.1) notes the dynamic reciprocity between individual factors, interpersonal factors, and environmental or macrosystemic factors over time (Stanton, 2009). Individual factors include such things as personality, psychobiology, gender, age, ethnicity, sexual identity, attachment, cognitive process and intelligence, beliefs, values, and more. Interpersonal factors include family development, family life cycle, family diversity, couple relations, parent–child relations, family strengths, social network relations, and so on. Contextual factors include politics, culture, healthcare, religion and religious organizations, media, national ideology, socioeconomic conditions, physical environment, and more (Stanton & Welsh, 2011). The model provides a basic mental construct for the family therapist to consider in assessment, treatment planning, and intervention.

In such models, individuals and families are nested within multiple but independent social systems that influence how they behave. Bronfenbrenner (1986, Bronfenbrenner & Morris, 2006) proposes a theory of social ecology in which five levels of influence exist, each level containing and influencing the prior level. Thus, the individual is embedded in his or her family system, which is embedded in a neighborhood or religious community, which in turn is part of an ethnic group or social class, and so forth. Depicted on an ecomap (see Figure 4.2), the *microsystem level* refers to the person and his or her immediate system, the *mesosystem* to the relationships in which members of his or her microsystem take part, the *exosystem* to the larger systems that affect the individual, the *macrosystem*, the broad social and cultural forces that have the most widespread influence on the individual, and the *chronosystem*, the evolution of interaction among environments over time.

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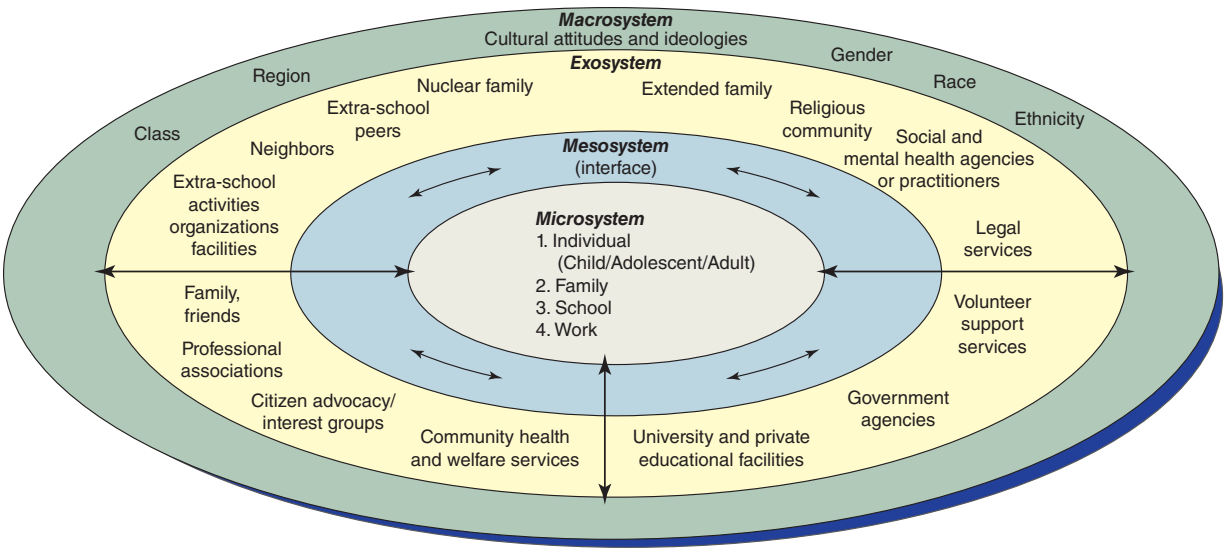


FIGURE 4.2 **An ecomap depicting the multiple contexts that influence a person's self-identity and behavior**

Source: Based on Knoff (1986)

Rather than viewing the family as an isolated, encapsulated system, the systemically oriented therapist is able to intervene at any level to improve family functioning. As Robbins, Mayorga, and Szapocznik (2003) illustrate, problems may be addressed to improve the relationship among family members (microsystem level), to improve a partner's relationship with extended family members or community organization (mesosystem level), to work on a behavior-problem child's parent's connection to Alcoholics Anonymous (exosystem), or by the therapist serving on a committee to develop treatment practices for victims or perpetrators of domestic violence (macrosystem). Maintaining an ecological focus widens the lens to encourage the development of integrated interventions based on ever-broadening social contexts. Social media influences are an important emerging mesosystemic influence in today's families (see Box 4.1).

LO 3 Some Characteristics of a Family System

Organization and Wholeness

The concepts of **organization** and **wholeness** are keys to understanding how systems operate. If a system represents a set of units that stand in some consistent relationship to one another, then we can infer that the system is organized around those relationships. Further, we can say that the parts or elements of the system interact with each other in a predictable, "organized" fashion. Similarly, we can assume that the elements, once combined, produce an entity—a whole—that is greater than the sum of its parts. It follows that no system can be adequately

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BOX 4.1 EVIDENCE-BASED PRACTICE

How Digital Media and Social Networking Are Affecting Families

With the increased use of digital technology and social media, families are learning to interact within the broader context of technology as part of the system in which they reside. Bronfenbrenner (see Figure 4.2) identified media as an important mesosystemic factor influencing and interacting with families. Our children, unlike their parents' generation, are not only consuming content but producing it for the world to see. The shift from information being shared within the family system has shifted to a broader context of "**living out loud**" online. Broadcasting feelings and photos via social media sites, coupled with the instant need for feedback and connection, has presented profound changes in family dynamics, blurred roles and communication.

Communication via Technology

In many respects, the use of technology has made connection and interaction easier for families, as they can check in with each other and communicate from anywhere, anytime. Divorced families or parents on business trips can connect for short periods, increasing communication and connection within the family system. On the flip side, content that was traditionally assigned for one person to see is now public for all and available to a wider audience. It may be through a post or "brag" that family members discover "secrets" or recognize a **digital cry for help**. Hashtags, vague or implicit comments/images, as well as identification with certain sites and groups give families insight into the inner thoughts and lives of their family members. If an individual is struggling in "real space," it is likely that they are carrying over these challenges or addictions (body image, self-harm, gambling, difficulty with friendship, etc.) into their online lives through online chat groups, how-to videos, and sites dedicated to furthering or stopping the behavior.

With the ease of accessibility through mobile devices, relationships are shifting. Some argue we are alone together (Sherry Turkle, 2011) and disconnected, while others contend that we are more connected than ever (Danah Boyd, 2014). What is clear is that we are **digitally tethered** to our devices and to each other. Without context and visual feedback, many conversations lose their context, and misunderstandings transpire, causing fights, cutoffs, and splitting between family members. **Geolocation-based services** can ease anxiety but at the same time create an unhealthy relationship that follows the child into college and beyond. The need for fast responses also spurs insecurity when someone does not respond immediately. Sending multiple texts in succession, often referred to as **textual harassment**, happens in both parent–child and romantic relationships and can be viewed as smothering or a form of abuse.

Anonymity

In the past decade, we have seen a shift from **real name culture** to a **culture of anonymity**. Without a face on the other side of the screen and apps that promise to self-destruct and erase, self-regulation decreases, and individuals are more likely to say or do things online that they would not do face to face. Anonymity may contribute to increased use of online pornography or hook-up sites. This can create suspicion, jealousy, and anger in relationships when it is discovered. **Sexting**, sending explicit or nude images, has created challenges to individuals and their families that are permanent and can lead to family conflict, police intervention, and possible **suicide**. Reference this article if you want more information on why kids sext: http://m.theatlantic.com/magazine/archive/2014/11/why-kids-sext/380798/

understood or fully explained once it has been broken down into its component parts and that no element within the system can ever be understood in isolation, since it never functions independently.

A family, like a human body, is a system in which the components are organized into a whole that transcends the sum of its separate parts. When we speak of the Sanchez family,

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for example, we are discussing a complex and recognizable entity—not simply the aggregate of Mr. Sanchez plus Mrs. Sanchez plus the Sanchez children.[1] Understanding the dynamic relationships among the components (family members) is far more illuminating than simply summing up those components. The relationships among the family members are complex, and factions, alliances, coalitions, and tensions exist. Causality within the family system is circular and multidirectional.

As Leslie (1988) observes, because of the system's wholeness, the movement of each component influences the whole and is explained, in part, by movement in related parts of the system. Focusing on the functioning of one element (member) becomes secondary to understanding the connections or relationships among family members and the overall organization of the system. As an illustration, Leslie notes that a family with two children does not simply add a new member when a baby is born; instead, the family becomes a new entity with accompanying changes in family interactive patterns.

Should a 2-year-old start to engage in hostile outbursts, linear explanations might attribute the new behavior to jealousy or infer the toddler is reacting to the loss of his mother's undivided attention, since she now must devote a great deal of attention to the newborn baby. A systems perspective, on the other hand, might look at how the family has reorganized after the new birth. Perhaps in reorganizing around the infant, the mother has assumed primary care of the infant and the father the major responsibility for the older children, while the older son has been designated a helper to his mother with the newborn. The toddler may have lost his customary role in the family. From this vantage point, his hostile behavior may be signaling the family that their reorganization is inadequate or perhaps incomplete in meeting the needs of all its members. To examine the motives of the toddler alone without addressing the system's interactive patterns would be to miss the point that the system requires alteration (Leslie, 1988). In the same way, it is imperative that the therapist address broader issues—the parent who may be giving up work to remain at home with the children, the other parent who may work longer hours away from home in order to compensate for the income loss, the grandparents who may become involved in caring for the children, the availability of adequate child care, and so on. Adopting a systems view calls for more than viewing the family constellation in isolation.

Family Rules and Patterns

Systems theory posits that a family is a rule-oriented entity. The interaction of family members typically follows organized, established patterns based on the family structure; these patterns enable each person to learn what is permitted or expected of him or her as well as of others in family transactions. Usually unstated, such rules characterize, regulate, and help stabilize how—and how well—families function as a unit. They underlie family traditions and reveal family values, help set up family roles consistent with these values, and in the process provide dependability to relationships within the family system. Rules frequently are carried over from previous generations and often have a powerful cultural component. See Box 4.2 for a clinical note about family rules.

[1]In some ethnic groups, there is no such thing as a "nuclear family," since family refers to an entire network of aunts, uncles, cousins, and grandparents (Hines et al., 1999). They are apt to live in close proximity, if not in the same house.

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BOX 4.2 CLINICAL NOTE

Family Rules and Family Dysfunction

When rules are appropriate for the persons involved and not too rigid, modifications can be made based on their subsequent experiences together. If rules are flexible and responsive to new information and carried out while tending to the needs of both, the couple is able to develop a functional division of labor that is intended to help them pursue the sort of life they wish to lead in the future. If, on the other hand, rules are too rigidly defined and fail to take the needs or specific skills of each participant into account, conflict between the couple is likely to follow, leading to family dysfunction.

Don Jackson (1965a), a pioneer in family therapy, first observed these patterns. He noted that partners in a marriage face multiple challenges as potential collaborators in wage earning, housekeeping, socializing, lovemaking, and parenting. Early in the relationship, they begin to define the rights and duties of each spouse. Such determinations often reflect culturally linked sex roles, but variations are frequent. Jackson adopted the still-helpful concept of **marital quid pro quo** to describe a relationship with well-formulated rules in which each partner gives something and receives something else in return.

Jackson (1965b) also hypothesized that a **redundancy principle** operates in family communication, so a family interacts in repetitive behavioral sequences. Instead of using the full range of possible behavior open to them, members typically settle on redundant patterns when dealing with one another. Jackson maintained that these patterns—rather than individual needs, drives, or personality traits—determine the interactive sequences between family members. Some rules may be negotiable, while others are not. Rigid families may have too many rules, chaotic families too few. All members also learn the family's **metarules** (literally, the rules about the rules), which typically take the form of unstated family directives offering principles for interpreting rules, enforcing rules, and changing rules.

Some rules are stated overtly—such as: "Children allow parents to speak without interruption"; "Children hang up their clothes"; "Parents decide on bedtime"; "Females do the cooking and cleaning chores"; "Dad clears the dinner dishes"; "Younger children go to bed earlier than older ones"; or "Our family does not marry outside our religion."[2]

Most family rules, however, are covert and unstated. They are inferences that family members draw from the repetitive patterns in the relationships they observe at home—for example, "Father is distant due to his frequent absences, so approach Mother if you have a problem"; "Both parents are tired and unavailable, so don't come to them with problems"; "We don't have crybabies in our family"; and "Stay away from their room on Sunday morning; they like

[2]A small child visiting a friend for the first time may be bewildered by observing new and unrecognizable family rules. Parents may greet each other with a kiss, not quarrel over the dinner table, or include children in the conversation. The visiting child is sometimes startled to learn that, according to the rules of the host family, it is not necessary to finish all the food on your plate before you are allowed to have dessert.

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BOX 4.3 THINKING LIKE A CLINICIAN

Family Rules

Rules and patterns help each member learn what is permitted and expected in family transactions. Rules regulate and stabilize family functioning. Consider each member of your family in the present, and indicate in the space provided any spoken and unspoken rules relevant to each. Some examples include, "Teenage sons should excel at math"; "Teenage daughters should excel in language arts"; "Firstborn sons should enter their father's business"; and "The youngest child is less responsible than older children." How do you think these roles help and hinder the stability and growth of your family?

Mother	
Father	
Sister	
Sister	
Sister	
Brother	
Brother	
Brother	
You	

to be alone." Children learn and perpetuate these rules. In a well-functioning family, rules are clearly communicated to help maintain order and stability while at the same time allowing for adjustment to changing circumstances.

Virginia Satir (1972), another pioneer in family therapy, also focused on communication patterns as she tried to help a family recognize its unwritten rules that caused hard feelings. For example, some families forbid discussion of certain topics (mother's drinking problem or father's unexplained absence from home certain nights or brother's inability to read or sister's sexual promiscuity) and consequently fail to take realistic steps to alleviate problems. Other families forbid overt expressions of anger or irritation with each other ("Stop! The children will hear us"; "If you can't say something nice to one another, don't say anything at all"). Still others foster dependence ("Never trust anyone but your mother or father") or enmeshment ("Keep family matters within the family") and thus handicap children as they attempt to deal with the outside world.

Satir argued that dysfunctional families follow dysfunctional rules. Consistent with that view, she attempted to help such families become aware of those unwritten rules that retard growth and maturity. Once identified, she believed the family could revise or discard rules that are outmoded, inappropriate, or irrelevant in order to improve the individual self-esteem of members as well as overall family functioning. See Box 4.3: Thinking Like a Clinician to explore the rules of your family.

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Family Homeostasis or Adaptation?

Homeostasis was a cybernetic concept applied to the family by early family theorists. The idea was that families self-regulate to maintain stability and resist change. Although the result is a steady state, the process is hardly static. To the contrary, a constantly fluctuating interaction of equilibrating and disequilibrating forces occurs. Early family theorists and researchers applied this cybernetic concept to an upset or threatened family system that initiates homeostatic mechanisms in order to reestablish equilibrium. In their initial formulations—groundbreaking for their time (although more controversial today)—researchers saw homeostasis as a way for a family to resist change by returning to its pre-threatened steady state. Most family therapists today adopt a living systems approach that moves beyond cybernetics to argue that helping families return to previous balanced states shortchanges them by failing to credit them with the resiliency and resourcefulness to adapt to a more highly functioning level.

What happens, then, when a family must change or modify its rules? How adaptive or flexible are the metarules for changing established or habitual patterns in a particular family? As children grow up, they usually put pressure on the family to redefine its relationships. Many adolescents expect to be given money to spend as they wish, to make their own decisions about a suitable bedtime, to listen to music that may be repellent to their parents' ears, to play computer games for unlimited amounts of time, to pursue interests other than those traditionally cared about in the family. They may challenge the family's values, customs, and norms; they insist on being treated as equals. All this causes disequilibrium in the family system.

In most cases, a system tends to maintain itself within preferred and familiar ranges. A demand for deviation or change that is too great, too sudden, or too far beyond the system's threshold of tolerance is likely to meet with counterdeviation responses. In poorly functioning families, demands for even the most necessary or modest changes may be met with increased rigidity as the family stubbornly attempts to retain familiar rules.

Family stability is actually rooted in change. That is, to the degree that a family is functional, it is able to promote appropriate adaptability while preserving a sense of order and sameness. This may be called dynamic equilibrium. For example, a well-functioning couple dealing with parenthood for the first time may strengthen their partnership and intimacy as the family expands to accommodate the new arrival. On the other hand, a less well-functioning couple may grow apart after the birth of the child, with one or the other (or both) feeling neglected, angry, and resentful.

Well-functioning families are resilient and able to achieve change without forfeiting long-term stability. An immigrant family, established in their home country but forced to migrate due to war or other social or political events, may face numerous dislocations (new jobs, new language, even a new sense of freedom) but still create a stronger bond than before as they deal with the changing situation.

Feedback, Information, and Control

Feedback refers to *reinserting into a system the results of its past performance as a method of controlling the system, thereby increasing the system's likelihood of survival*. **Feedback loops** are circular mechanisms whose purpose is to introduce information about a system's output

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back to its input in order to alter, correct, and ultimately govern the system's functioning and ensure its viability. Feedback loops help mitigate against excessive fluctuations, thus serving to maintain and extend the life of the system. As a simple example of a feedback loop, think of a person entering a room in which she smells gas. A moment before the air smelled fresh, and now it doesn't. She takes action by going to the stove and shutting off the gas and opening the window. These events and actions restore the system to a normal state. Feedback loops in families occur constantly and in far greater number. They occur both negatively and positively.

Negative feedback, or *attenuating* feedback loops, helps to maintain the system's steady state. New information is fed back into the system and triggers changes that serve to put the system back "on track." **Positive feedback**, or *amplifying* feedback loops, are about changing the system. New information entering the system leads to further change by augmenting or accelerating the initial deviation.

Systems require both negative and positive feedback—the former to maintain the status quo and the latter to accommodate changing conditions. For example, as children in a family grow into adolescence, they are likely to demand greater independence and self-direction, temporarily destabilizing the family system through their insistence on rule changes. Adaptive or enabling families typically attempt to deal with change by renegotiating teenage privileges and responsibilities and receiving feedback information regarding how easily and appropriately the changes are handled. Positive feedback mechanisms are operating here as the family adapts to change by modifying its structure, and the system's stability is regained. See Box 4.4 Clinical Note for an illustration of the operation of positive and negative feedback.

In a less functional manner, a family whose repertoire is limited to negative feedback may be inflexible, stifling, and resistant to dealing with changing circumstances. For example, parents may continue to treat the teenager as a child by refusing to acknowledge his or her growing maturity. In a similarly dysfunctional manner, positive feedback, helping change or modify a system, may reach runaway proportions without the stability provided by negative feedback, forcing the system beyond its coping limits to the point of exhaustion or self-destruction; the adolescent does not know how to handle new freedoms and rebelliously defies all family rules. Every family faces life cycle transitions that require adaptation.

Within a marriage, feedback helps maintain equilibrium, as disturbing or annoying patterns are adjusted and new, stabilizing patterns evolve. A misunderstanding can be corrected and minimized (attenuating deviation) or escalated (amplifying deviation). In the latter case, an argument may get out of control, becoming increasingly vicious, ugly, or even violent, reaching the point where neither spouse can (or no longer wants to) control the consequences. However, the conflict may also be resolved through positive feedback as the couple strives for a new level of understanding and behavior.

At times, it may be advantageous to propel a family with stagnating or otherwise untenable behavior patterns to new levels of functioning. In these cases, the therapist may seize the opportunity of disequilibrium to promote discontinuity and the restoration of family homeostasis at a new, more satisfactory level for all.

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BOX 4.4 CLINICAL NOTE

Negative and Positive Feedback Loops

Goldenberg and Goldenberg (2002) illustrate the operation of negative and positive feedback loops in the case of a remarried couple. In the first situation, there is attenuation, or negative feedback:

HUSBAND: I'm upset at the way you talked to that man at the party tonight, especially the way you seemed to be hanging on every word he said.

WIFE: Don't be silly! You're the one I care about. He said he had just come back from a trip you and I had talked about going on, and I was interested in what he had to tell me about the place.

HUSBAND: OK. But please don't do it again without telling me. You know I'm touchy on the subject because of what Gina [ex-wife] used to do at parties with other men that drove me crazy.

WIFE: Sorry. I hadn't thought about that. I'll try to remember next time. In the meantime, you try to remember that you're married to me now, and I don't want you to be jealous.

In a less blissful situation, instead of the previous attenuation, there is amplification, or positive feedback. Remember, positive doesn't necessarily mean good.

HUSBAND: I'm upset at the way you talked to that man at the party tonight, especially the way you seemed to be hanging on every word he said.

WIFE: One thing I don't appreciate is your spying on me.

HUSBAND: Spying? That's a funny word to use. You must be getting paranoid in your old age. Or maybe you have something to hide.

WIFE: As a matter of fact, I was talking to him about a trip he took that we had talked about, but I don't suppose you'd believe that. Talk about paranoid!

HUSBAND: I give up on women! You're no different from Gina, and I suppose all other women.

WIFE: With an attitude like that, I'm starting to see why Gina walked out on you.

Positive feedback, while destabilizing, may also be beneficial if it does not get out of control. Consider a third scenario. Here, the couple expands and deepens their relationship by nondefensively sharing their feelings and reexamining the rules of their relationship.

HUSBAND: I'm upset at the way you talked to that man at the party tonight, especially the way you seemed to be hanging on every word he said. Can you help me understand what was going on?

WIFE: He said he had just come back from a trip you and I had talked about going on, and I was interested in what he had to tell me about the place. Maybe I should have called you over and included you in our conversation.

HUSBAND: No need to invite me. From now on, I will come over so I'll know what's happening.

WIFE: I'd like that. Keeping in close contact with you at a party always makes me feel good.

Information processing is fundamental to the operation of any system. If it is faulty, the system is likely to malfunction. The exchange of information within a family and between the family and the outside world helps maintain functioning. According to Bateson's (1972) elegant definition, information is "a difference that makes a difference." By this he means new (or different) information that effects change within the system. A word, a gesture, a smile, a scowl—these are differences or changes in the environment comparable to a temperature drop as environmental input. These differences in turn make a difference when the receiver of the new information alters his or her perceptions of the environment and modifies subsequent behavior.

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Subsystems and Suprasystems

A system, as we have seen, is organized into a more or less stable set of relationships. It functions in certain characteristic ways; it is continuously in the process of evolution as it seeks new steady states. **Subsystems** are those parts of the overall system assigned to carry out particular functions or processes within the system as a whole. Each system exists as part of a larger **suprasystem** and contains smaller systems and subsystems.

A family commonly contains a number of coexisting subsystems. The husband and wife dyad constitutes a subsystem of the family as a whole; so do the mother–child, father–child, and child–child dyads. In a family, subsystems can be formed by generation (parents), by gender (mothers and daughters), by interest (intellectual pursuits), or by function (parental caretakers); see Minuchin (1974). Within each subsystem, different levels of power are exercised, different skills learned, and different responsibilities assigned. For example, the oldest child may have power within the sibling subsystem but must cede that power when interacting with his or her parents.

Because each family member belongs to several subsystems simultaneously, a person enters into different complementary relationships with other members. For example, a woman can be a wife, mother, daughter, younger sister, older sister, niece, granddaughter, and so on, simultaneously. Membership in subsystems also changes over time. Today, a woman might be a wife, mother, and sister. In 20 years, she might be a grandmother herself after having lost her own mother. Within each subsystem, she plays a different role and can be expected to engage in different transactional patterns. Consider this example: While giving her younger sister advice about finding a job, a woman is told by her husband to get off the telephone and hurry up with dinner. She decides how to deal with his demand. Some moments later, she remembers not to feel hurt when the children refuse to eat what she has prepared. She even responds diplomatically when her mother, a dinner guest, gives her advice on how to improve the food she has prepared.

The most enduring subsystems are the *executive, parental*, and *sibling* subsystems (Hindman, Riggs, & Hook, 2013). The executive husband–wife dyad is basic; any dysfunction in this subsystem reverberates throughout the family as children are scapegoated or co-opted into alliances with one parent against the other whenever the parents engage in conflict. The spousal subsystem teaches the children about male–female intimacy and commitment by providing a model of marital interaction. How the marital partners accommodate one another's needs, negotiate differences, make decisions together, manage conflict, meet each other's sexual and dependency needs, plan the future together, and so on help influence the effectiveness of relationships among all family members. A viable spousal subsystem, one in which the marital partners have worked out a fulfilling relationship with one another, provides both spouses with the experience of intimacy, support, mutual growth, and an opportunity for personal development.

The parental subsystem (which may include grandparents or older children assigned parental roles) has the major responsibility for proper child rearing, nurturance, guidance, limit setting, and discipline. Through interaction with parents, children learn to deal with

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authority and power dynamics while strengthening their own capacity for decision making and self-direction. Problems within this subsystem, such as serious intergenerational conflicts involving rebelliousness, symptomatic children, or runaways, often reflect underlying family instability and disorganization. In some families, parents share parental authority and responsibility with grandparents, or in other cases with relatives, neighborhood friends, or paid help.

The sibling set represents a child's first peer group. Sibling relationships are typically the longest-lasting connections we make, extending over the life span (Hindman, Riggs, & Hook, 2013). Through participation in this subsystem, a child develops patterns of negotiation, cooperation, competition, mutual support, and later, attachment to friends. Interpersonal skills honed here influence later school or workplace relationships. The influence of this subsystem on overall family functioning depends to a large extent on the viability of all family subsystems. Spousal, parental, and sibling subsystems stand in an overall dynamic relationship, each simultaneously influencing and being influenced by one another.

Other subsystems, most of them less durable than those just outlined, exist in all families. Father–daughter, mother–son, father–oldest son, and mother–youngest child transitional alliances are common. Their protracted duration, however, especially if the alliance negatively affects family functioning, may signal difficulties within the spousal subsystem, alerting the family therapist to the potential instability of the family system.

Boundaries

A **boundary** is a metaphoric line of demarcation that separates an individual, a subsystem, or a system from outside surroundings. Boundaries help define the individual autonomy of a subsystem's separate members, as well as helping differentiate subsystems from one another. Within a family system, boundaries determine who is an insider and who remains outside. The family boundary may act as a gatekeeper, controlling information flow into and out of the system ("We don't care if your friend's parents allow her to stay out until 2:00 a.m.; in our family, your curfew is 12:00 a.m."; "Whatever you hear at home, you are expected to keep private and not discuss with outsiders").

Within a family itself, boundaries distinguish between subsystems, helping define the separate subunits of the overall system and the quality of their interactive processes. Minuchin (1974) contends that such divisions must be sufficiently well defined to allow subsystem members to carry out their tasks without undue interference, while at the same time open enough to permit contact between members of the subsystem and others. For example, a mother defines the boundaries of the parental subsystem when she tells her 15-year-old son, the oldest of three children: "It's not up to you to decide whether your sisters are old enough to stay up to watch that TV program. Your father and I will decide that." However, she temporarily redefines that boundary to include the oldest child within the parental subsystem when she announces, "I want all of you children to listen to your older brother while your father and I are away from home tomorrow evening." Or she may invite grandparents to join the parental subsystem for one evening only, asking them to check on how the children are getting along or to advise the oldest son on necessary action in case of an emergency.

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These examples underscore the idea that the *clarity* of the subsystem boundaries is far more significant in the effectiveness of family functioning than the composition of the family subsystems. While the parent–child subsystem may be flexible enough to include the oldest child, or a grandmother may be pressed into service when both parents are unavailable, the lines of authority and responsibility must remain clear. In most middle-class European-American families, a grandmother who interferes with her daughter's management of the children in ways that undermine the parent–child subsystem (and perhaps the spousal subsystem in the process) is overstepping her authority by crossing family boundary lines. Among poor African-American families, however, active grandparent participation is more likely than not to be the norm, as grandparents help provide care for grandchildren, adult children, and other elderly kin (Hines, 2011).

An important issue here involves the *permeability* of the boundaries, since boundaries vary in how easily they permit information to flow to and from the environment. Not only must the boundaries within families be clearly drawn, but the *rules* must be apparent to all. If boundaries are too blurred or too rigid, they invite confusion or inflexibility, increasing the family's risk of instability and dysfunction.

Open and Closed Systems

A system in continuous interaction with the outside is considered an **open system**, while one whose boundaries are not easily crossed is considered a **closed system**. Open systems do more than adapt passively to their surroundings; their social transactions are bidirectional. They initiate activities that permit an exchange with the community because their boundaries are permeable. Closed systems, on the other hand, have impermeable boundaries. Thus, they fail to interact with the outside environment, lack feedback corrective mechanisms, become isolated, and resist change.

An example of such a closed system is a type of religious cult that closes out the world beyond its borders, specifically to halt the flow of information from the outside world and in that way to control the behavior of its members. Similarly, totalitarian countries that do not permit foreign newspapers, radio or television, or access to the Internet also represent systems deliberately closed to control citizens' behavior.

In family terms, no system is fully open or closed; if it were totally open, no boundaries would exist between it and the outside world, and it would cease to exist as a separate entity; if totally closed, there would be no exchanges with the outside environment, and it would die. Rather, systems exist along a continuum according to the flexibility or rigidity of their boundaries. Families that function effectively develop a balance between openness and closeness, tuned to the outside world to achieve appropriate change and adaptation while resisting changes that threaten the survival of the system. Such a system tends not only to survive but to thrive by being open to new experiences and to altering or discarding interactive patterns that are no longer usable. This is called **negentropy**, or a tendency toward maximum order. Such families increase their chances of becoming more highly organized and developing resources to repair minor or temporary breakdowns in efficiency (Nichols & Everett, 1986). An immigrant family that immediately begins learning the customs and

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BOX 4.5 CASE STUDY

An Immigrant Family Faces an Intergenerational Conflict

Indira and Sanjay Singh were a sister and brother who came from India to the United States with their parents when they were still of preschool age. Their parents had brought them with the hope that the children's lives would be better than theirs, since neither of the parents had had much education or opportunity in their native land. The parents worked very hard, 7 days a week, in a small clothing store they owned, just managing to make a living; and the children were expected to help out as early as 6 or 7 years of age, just as the parents had done with their own parents. Both children were taught to be compliant with adults, to respect their parents' wishes, and to engage in social activities primarily with family or extended family members. Friends from school were discouraged, and Indira and Sanjay, now 17 and 14, respectively, were expected to go places only with each other, never alone or with friends. Television was tolerated but monitored by the parents; for example, the children were not allowed to view scenes of people kissing, which was also not permitted in Indian cinema. When the children objected, the parents reminded them that they were being disrespectful and that if their "insolent" behavior continued, the parents would move them all back to India no matter what the sacrifice to the family.

Loyalty, respect, and family obligation were essential parts of the family code. As in other Indian families they knew, extended family ties were stressed, arranged marriages were the norm, and children were expected to obey their parents, especially their father. The parents did not understand why the children wanted to associate with strangers when family members were available. To what class or caste did these strangers belong? What would happen to her father's plans for her marriage if Indira got into trouble or developed a bad reputation as a result of being in bad company? When Indira asked to go to a party with her high school friends, the parents refused, asking instead why she hadn't proposed helping out in the store so they could get some rest. Despite her protests that she did help but also wanted to have some fun, the parents threw up their hands in despair and told the children how miserable their ungrateful behavior had made their parents.

A teacher who knew something of Indian culture, observing Indira's distress, talked to her about the problems of biculturalism and suggested that such culture conflict was not uncommon between first and second generations in a new country. The teacher suggested family counseling, which the parents first refused to do, expressing shame that intervention by a stranger would be necessary. After the children visited a counselor alone for two sessions, the parents reluctantly came in, and together all four began to deal with the differences between countries and to understand cultural expectations.

(Goldenberg & Goldenberg, 2002, pp. 20–21)

language of the adopted land and encourages its children to adapt in a similar manner can be considered to be acting as an open system. See the case study presented in Box 4.5, in which a working-class family from India immigrates to the United States, experiencing the shift from an open system to an insular one until they find ways to adjust to the present environment.

The lack of such exchanges in relatively closed systems decreases their competence to deal with stress. They are apt to seal themselves off from all but necessary exchanges with the outside world; they maintain strict control on who and what is admitted into the home, screening

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visitors, restricting computer use, preventing contact with social agencies or uncensored reading matter or television programs, and thus are destined for eventual dysfunction because of insufficient input. Such closed systems run the risk of **entropy**; they are prone to eventual disorganization, particularly under prolonged stress.

For example, recent immigrants or ethnic groups that live in relative isolation, communicating only among their own ethnic group, suspicious of outsiders, and fostering dependence on the family, hold on to tradition and avoid change, acting as relatively closed systems. Parent–child relationships in such families may encounter problems due in part to culture conflict that may lead to the development of an entropic family.

Families and Larger Systems

All families interact with and are influenced by one or more of society's larger systems—healthcare, church, welfare, probation, schools, the legal system. Low-income families, families with special-needs children, drug abusers, families with members in trouble with the law, families with schizophrenic members, and immigrant families in particular are apt to find themselves caught up in dependence on and/or conflict with social and community agencies. Family interventions may involve a *case management* approach, which typically includes counseling and family advocacy to link them to available community resources and services (medical care, job training, legal services) and monitors their progress.

Home-based services, an extension of a well-established social service tradition, typically are directed at building and strengthening relationships between the family and the available resources of the community, as part of interventions focused on repairing adolescent or family dysfunction (Tuerk, McCart, & Henggeler, 2012). Collaboration is encouraged between the family, galvanizing its strengths, and community caregivers, who work in partnership to address the needs of the family. In-home therapy is typically short term and intensive and usually focuses on difficult-to-reach, multiproblem families—substance-abusing adolescents and their families, teenage mothers, families in which abuse and neglect have occurred, families with severe psychiatric disorders. These at-risk populations are especially vulnerable to breakdown and in need of social services; in-home therapy, conducted in the comfort of familiar surroundings, may be less threatening than entering the community to seek help and may lead to more favorable outcomes (Gresl, Fox, & Fleischmann, 2014).

Family–School Interventions

The delivery of family services within a school setting is an example of the interlocking nature of systems. Not only is a child a part of a family that has its own unique structure and relationship patterns, but the family itself is embedded in its culture, ethnic group, socioeconomic status, and social history. The child is also a member of a school classroom with its own structure and interactive processes; that classroom, in turn, is located within a matrix of a larger school organization. The two major systems in the child's life, home and school, interface and form a new larger system with its own characteristics, objectives, priorities, and

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regularities; moreover, home and school systems may deal with one another in complementary or antagonistic ways.[3]

The school may often be the first to detect a child's emotional or behavioral problem, perhaps reflecting at-home family conflict. In the cases of many low-income, immigrant, or otherwise closed families, who have difficulty accessing mainstream agencies, school-based family services may open the gates to needed psychological, medical, or other social services (Hong, 2006). The family, the school, and the community are all part of this ecosystem (Stormshak, Fosco, & Dishion, 2010).

The family consultant called upon to help assess and treat a schoolchild's behavioral problem (truancy, dropout, low level of commitment, violence, drug use) needs to adopt a systemic approach, taking into account the interaction of the two systems (home and school) before attempting to sort out whether the child is having difficulties in one or both and deciding how best to proceed (Carlson, Funk, & Nguyen, 2009). He or she must not only remain aware of the child and the family system but also be familiar with the culture of the school, school law regarding children with special needs, how this school reaches decisions, the role of the school board, and so on (Fine, 1995).

Rotheram (1989) offers the following vignette illustrating one type of problem arising in the interface between family and school:

> An angry parent calls the school, complaining that a seventh-grade teacher has given too much homework and is ruining the family's time together over the weekend, asking too much of a young girl. The teacher is righteously indignant and counters that the parents are encouraging dependence and passivity in their child. She refuses to decrease homework. The next week, the daughter makes a suicide attempt, and the family wants to sue the school. (p. 347)

The liaison-consultant called upon to intervene may be a member of the school system, a therapist brought in by the family, or a social services agency representative. Lusterman (1988) urges "mapping the ecosystem"—evaluating both the school and family before deciding whom to include (child, teachers, school counselors, parents, grandparents, and so on) in the treatment plan. In his view, it is necessary from the outset to make clear that the therapist's task is not advocacy for one group or the other but rather helping create conditions for change. A systems perspective facilitates the process; if it is carried out successfully, neither party is targeted as causing the presenting problem, and the interactive process between participants becomes the focus of the joint meetings.

Several promising school-related intervention programs, carefully researched and evidence based, have been developed, illustrating the emerging social-ecological viewpoint. For example, *multisystemic therapy* (Henggeler, Sheldow, & Lee, 2009) is a family-based treatment program directed at chronic behavioral and emotional problems in adolescents. School-related difficulties are conceptualized as the result of a reciprocal interaction between the schoolchild and the major social systems in which he or she is embedded—family, peers, school, and the neighboring community (Henggeler & Cunningham, 2006). Assessment helps pinpoint the characteristics

[3]Families and school personnel may agree on the child's problem (e.g., a pervasive developmental delay), particularly if their cultural norms are similar. In other cases, they may disagree; the school may perceive a behavioral problem (e.g., hyperactivity) that the family does not agree is problematic, or the family may report a child's behavior as troublesome (interrupting others when they are speaking) that the school does not find a particular bother. Families and teachers may misperceive each other's intentions and goals because of cultural differences (Rotheram, 1989).

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of the schoolchild's ecology (called "fit factors") that are contributing to the maintenance of the problem behavior. How much of the school problem is associated with characteristics of the *child* (low motivation, learning disability, etc.), the *family* (ineffective monitoring, parental problems interfering with effective parenting), *peers* (drug use, support for truancy), the *school* (poor classroom-management practices), the *school-family link* (low trust of each other), and the *community* (criminal subculture that does not value academic success)? Identified strengths, discovered during the assessment, are applied in the subsequent interventions.

The EcoFIT is another family–school model with strong research support. It is family centered, assessment driven, addresses social interactions that encompass child problems, focuses on parents' motivation to change, operates within a health maintenance framework, and is based on a developmental-ecological model that includes culture and context in service delivery (Dishion & Stormshak, 2009). This program has schools establish a family resource center and make home visits to parents to engage them. One key goal is facilitation of family utilization of community resources that fit the family's need.

Family–Healthcare Interventions

Another example of interlocking systems is the relationship between families and healthcare. A systemic healthcare framework recognizes the dynamic interactions involved in individual health-illness, including relationships between a patient and significant others—such as family members, friends, and others—and the relationship with a healthcare team of physicians, specialists, family therapists, and other healthcare professionals (McDaniel, Doherty, & Hepworth, 2014). Medical family therapy, an integrated approach to care, aims at increasing self-efficacy and meaningful communication for everyone involved (patient, significant others, and the healthcare team). Family therapists may conduct brief interventions, crisis counseling, or intensive therapy for patients and families while also facilitating healthcare team interaction with patients and families, coaching physicians, providing in-service education for professionals and health programs for patients and families, and conducting program evaluation (McDaniel, Doherty, & Hepworth, 2014).

Family Interventions with Other Populations

Substance abuse and chronic mental illness. These two conditions often involve the intersection of family therapy and community agencies. Models have been developed that help families identify resources and support. For example, several systemic approaches to the treatment of substance abuse have been created that demonstrate evidence for effectiveness, including behavioral couples therapy (O'Farrell & Schein, 2011), brief strategic family therapy (Robbins, Szapocznik, & Horigan, 2009), functional family therapy (Sexton, 2011), multidimensional family therapy (Liddle, 2009), and multisystemic therapy (Henggeler, Sheldow, & Lee, 2009). Stanton (2009) demonstrates how systemic understandings of motivational interviewing, self-help programs, and relapse prevention may be integrated into family treatment.

Marsh and Lefley (2009) describe the social service agency deficits that create significant stressors for the families of those with serious mental illness. There are several types of family-focused treatment, including family psychoeducation, family education, family consultation, family support and advocacy groups, and family therapy. Families need their own treatment, at times, for the challenges they face and help in serving the many roles they must

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fulfill around the treatment of the family member with serious mental illness. They suggest that recovery may be defined as "the process in which people are able to live, work, learn, and participate in their communities" (p. 743) and note that it is possible today.

Systemic Problems. Finally, in some cases, it is incumbent upon family therapists to look beyond the dysfunctional family itself to a broader view of social systems around the family. Otherwise, therapists arrive at "solutions" for the family that, no matter how therapeutically elegant, are short sighted because they fail to consider cultural, political, and institutional issues. For instance, the power of organizations in which families are embedded must be understood, lest the frequent inflexibility of agencies such as psychiatric hospitals, isolating patients from their families, undo any therapeutic gain. In the case of long-standing poverty, the relationship with public agencies may extend over generations. Problems may develop between such families and the agencies as well as between different public agencies. In the case of wife battering presented in Box 4.6, confusion results from conflicting perceptions by the various professionals attempting to help.

BOX 4.6 CASE STUDY

Using an Ecomap in Family Assessment and Therapy

A family who had initially sought the aid of a family therapist for their son Billy's aggressive behavior revealed over the course of therapy that Jim, the father, had been physically abusive to his wife, Cathy. Cathy also disclosed to the therapist that when she was a child and young adolescent, her father had sexually abused her. The referring family physician knew only of the problems with Billy. By the time they consulted a family therapist, the Lee family had become involved with five larger systems: Jim in a local hospital group for men who batter their wives; Cathy in a program for women who have experienced sexual abuse; Jim and Cathy together in a church counseling program for family violence; Cathy in a women's shelter counseling group; and the entire family in family therapy.

When the family therapist invited the various participants to meet together and coordinate their efforts, differences in approach and fundamental beliefs among the various helpers turned out to be significant. For example, while Jim's group sought the causes of violence within him and from his past experiences, urging a long-term group program, the family therapist took a systemic approach, recommended a short-term approach, and attempted to locate the violence in the context of the couple's ongoing interactions. By contrast, Cathy felt the women's shelter counselors blamed Jim exclusively and thought he was the only one who needed treatment.

Because competing definitions of the problem and approaches to a solution surfaced in this macrosystem, a consultant was needed to help untangle the family member–helper coalitions that had developed. Conflict between specialized "helping" systems may, in many cases such as this one, contribute to or enlarge the very problems the helping systems were created to fix or alleviate (Imber-Black, Roberts, & Whiting, 2003). In this case, the consultant highlighted their differences to the helpers, pointing out the impact of these differences on how the couple interacted. Stressing the macrosystem level, she designed an intervention that made the boundaries between helpers clearer and less rigid. At the same time, couple–helper boundaries were clarified and thus became less diffuse and confusing. The restructuring allowed the couple themselves to determine the amount and source of help they needed on a weekly basis.

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LO 4 Systemic Thinking in Family Therapy Practice

Systemic thinking is the foundation for the practice of family therapy. It informs essential features of the therapeutic process, such as the creation and maintenance of the therapeutic alliance, family assessment and case conceptualization, the understanding of change in family therapy, and the selection and delivery of effective interventions (Stanton & Welsh, 2012). For example, family therapy requires the therapist to establish an alliance with multiple individuals at once (Friedlander, Escudero, & Heatherington, 2006). This requires the therapist to recognize and manage how multiple individuals interact and are impacted by the evolving alliance, since each person may have different opinions of her or his alliance with the therapist, as well as perceptions of the therapeutic alliance with other family members (Knobloch-Fedders, Pinsof, & Mann, 2007). The therapist must see the system and comprehend complexity to manage this aspect of therapy. Box 4.7 Thinking Like a Clinician explains important systemic thinking habits.

BOX 4.7 THINKING LIKE A CLINICIAN

Systemic Thinking Habits

Understanding key systemic principles is important, but it is more important that family therapists learn to habitually think systemically. This is a comprehensive cognitive reorientation to challenge nonsystemic mental models, use systemic paradigms to organize thinking, and operationalize systemic concepts into therapeutic problem solving (Stanton & Welsh, 2012). This moves systems theory away from abstract theory or reified knowledge or reductionistic techniques to focus on problem origination, problem continuation, and change in treatment (Stanton & Welsh, 2011). Our list of 10 systemic thinking habits is adapted from Sweeney (n.d.), Stanton and Welsh (2012), and Benson (2007).

Challenge mental models. Family therapists adopt ways of thinking that extend beyond the limitation of common patterns in Western society (typically, the Cartesian model espoused by Descartes in 1637 that divides problems into parts) to embrace other ways of thinking, such as more holistic, systemic, metaphorical, and narrative thinking. They choose the mode most suited to the problem at hand.

See the system. Family therapists who see the system shift their focus from the parts alone to the whole with all its parts. They see networks of relationship and recognize feedback processes as they listen to clients. Many adopt a framework, like the ecomap or the individual-interpersonal-macrosystemic diagram, to help them see all the reciprocal elements of the system.

Comprehend complexity. Family therapists avoid the temptation to simplify their understanding of a problem or the means to resolve that problem. Simple explanations give way to inclusion of multiple factors and contextual influences. For example, the unemployment of a family member in therapy may not be assumed to be solely an issue of personal motivation; it may include individual issues, but they may be joined by interpersonal factors (such as schedule limitations due to child care), community issues (like the closing of a major local employer), or even the global economy (recession or depression). Complexity recognizes that families may function at the edge of chaos as they experience dynamic change, and treatment must include the relevant influences.

Recognize reciprocity. Family therapists avoid linear thinking (single cause–effect pathways) in understanding complex problems and recognize causal webs (Plate, 2010). Reciprocity is the

(Continued)

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concurrent and mutually interdependent interface between individuals (Capra, 2002). For example, parent–child relations are interactive, not linear from parent to child; this is why different children have very different experiences with the same parent. Family therapists need to learn to recognize and "map" reciprocity because it does not come naturally (Sweeney & Sterman, 2007).

Conceptualize change. Family therapists understand that systems can destabilize when faced with challenges and the existing family structures and patterns no longer work effectively. Rather than return them to their prior state, contemporary family therapy seeks to facilitate positive self-reorganization by looking for "leverage points"—the "places in the system where a small change could lead to a large shift in behavior" (Meadows, 2008, p. 145).

Observe patterns and trends. Family therapists know how to identify the underlying commonalities that occur as patterns of interaction and behavior between family members. These are called homologies, and we must not be deceived by the "cover story" of surface features and miss the underlying processes (Sweeney & Sterman, 2007). For example, a couple may focus on sexual problems or financial disagreements, but the therapist will note the pattern of interaction that cuts across both (such as power dynamics or personality interplay).

Consider unintended consequences. Family therapists recognize that the variety of factors that interact in complex systems may result in unintended consequences when trying to solve problems. Such awareness can help the therapist and family consider the variables and recognize potential unintended outcomes, discussing options to maximize the best result. Therapy that only focuses on solving a single problem without considering long-term consequences may result in what Senge (2006) calls "fixes that fail" because they do not last or result in other problems (p. 399).

Embrace ambiguity. Family therapists develop appreciation for ambiguity because they learn that contemporary views of systems understand they are not entirely predictable and absolute because of multideterminancy (Beitel, Ferrer, & Cecero, 2004). Constructivist or narrative approaches understand that the story may evolve or change as families try to make sense of their experience. Ambiguity allows for novel experiences and change.

Shift perspective. Family therapists reject the Cartesian notion of objective external observation to determine reality. They value different types of analysis (subjective as well as objective; Capra, 2002) and multiple perspectives (e.g., considering equally the perspectives of all family members involved in therapy; Pinsof & Chambers, 2009). Family therapists know how to take the perspective of each person and demonstrate accurate empathy for each (Stanton & Welsh, 2012).

Factor in time. Family therapists understand that systems demonstrate past, present, and future dynamic influences concurrently (Capra, 2002). For this reason, they consider at least three generations of the family when addressing current presenting issues, often using a genogram to do so (McGoldrick, Gerson, & Petry, 2008).

Assessment should also reflect systemic thinking. As illustrated in Figure 4.3, **ecomaps** are useful paper-and-pencil assessment devices for diagramming a family's connection to larger social systems. Frequently used by social workers and others to map out and coordinate the helping services a family is receiving (Compton, Galaway, & Cournoyer, 2005), an ecomap is a drawing of the family's social environment, illustrating its simultaneous connections to different agencies. A family receiving child welfare services, for example, might be in contact with the court system, medical services, church, neighbors, police, attorneys, the school

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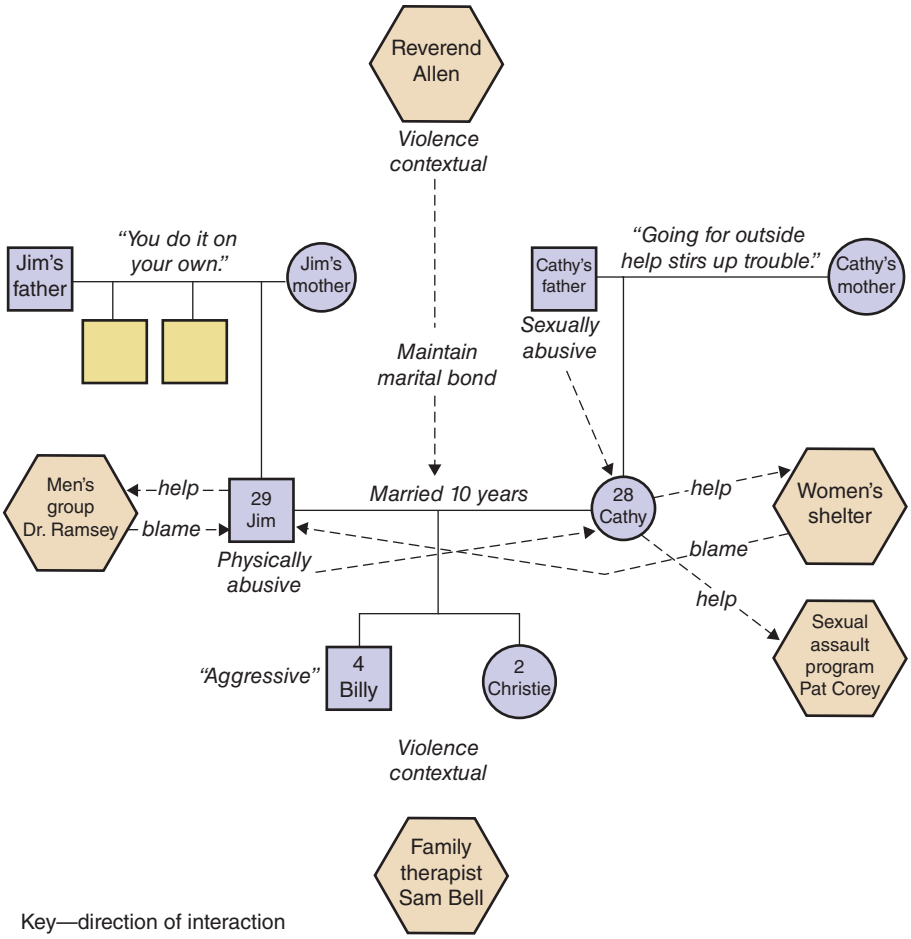


FIGURE 4.3 Conflicting perceptions and interactions in the Lee family case in Box 4.6

Source: Imber-Black (1988), p. 117

system, foster parents, and various childcare agencies; the ecomap offers a "snapshot" of these relationships at any particular time.

These interlocking programs, if not coordinated, may at times work at cross purposes and result in conflict between specialized helping systems. Ecomaps help organize and clarify both the stresses and supports inherent in the family's environment. Ecomaps enable the consultant to call upon as many people as possible in the family's network to coordinate the most workable solutions to the family's current predicament (Gilgun, 2005).

Critiques of Systems Theory

Several challenges have emerged regarding systems theory. At the outset, however, we need to note that many of "these critiques may reflect more on older ideas related to systems that distorted, reified, or simplified dynamic systems ideas in a manner that eliminated the theoretical space to modify and adapt the ideas to the reality of the lived experience" because

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"these [older] models were based more on cybernetic ideas and inanimate systems than on dynamic living systems. Contemporary variations on systemic thinking move away from that rigidity" (Stanton & Welsh, 2011, p. 22). Contemporary systems theory and thinking are much more complex than the deterministic circular causality models of the past that were based on a positivist understanding of behavior. Those models emphasized homeostasis and avoidance of change; new models emphasize dynamic equilibrium and constant change with comparisons to chaos theory (Wadsworth, 2008). Old models were often more mechanistic and positivistic; new models eschew nonliving ideas about systems and embrace perspective and narrative interpretation (Capra, 2002). Lebow (2005) notes increased inclusion of individual problems within systemic context in new theoretical models and more complex and variable interactive causal influences among components of a system. Simply stated, contemporary dynamic systems theory moved away from some of the elements that caused criticism in the past.

For instance, one critique came from feminist family therapists, who insisted that power within families is typically asymmetrical. They argued that within society at large, different people have differing degrees of power in altering an undesirable situation. Luepnitz (1988) suggested that cyberneticists and general system theorists fail to take power differentials (particularly between men and women) into account in their homeostatic formulations. While the less powerful may influence the more powerful, the difference between influence and legitimate power is often substantial. A related argument focused on intimate partner violence and the "standard systemic couples therapy approach to violence" that appeared to blame the victim by its emphasis on reciprocal interaction (Goldner, 1998, p. 264). Goldner, a feminist leader in the Gender and Violence Project at the Ackerman Institute, stated, "To argue that partners mutually participate in an interactional process does not mean they are mutually responsible for it, or for its catastrophic outcome" (Goldner, 1998, p. 264). These arguments make sense, but they are based on old ideas no longer held by most systems thinkers (Lebow, 2005).

Finally, some postmodernists have been particularly rejecting of the systems metaphor. They contend that what we believe to be reality is inevitably subjective and that rather than discover objective facts, we can offer only subjective perceptions of events (Becvar, 2003). They critique therapists who believe they can objectively and impartially diagnose families or that they can identify flaws in a family's structure in concrete fashion. Some criticize systems theorists for reifying concepts—as though families actually possess constructs (rules, feedback, homeostasis) rather than simply using systems constructs as linguistic tools with which to describe and understand families. On the other hand, it might be noted that contemporary systems models include communication and cognition as part of system functioning; "The organizing activity of living systems, at all levels of life, is mental activity" (Capra, 2002, p. 34). Constructivist and narrative models of psychotherapy need not be understood as antithetical to dynamic, living systems ideas that embrace human agency in development, socially constructing reality through interaction with one's entire systemic surround (Stanton, 2009). Living systems models resist reduction to reification or techniques, answering the critique.

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SUMMARY

Systems theory provides the theoretical underpinnings for much of current family therapy theory and practice. It is important for family therapists to see the system, using an organizing framework or paradigm to include the relevant systemic factors in treatment.

The concepts of organization and wholeness emphasize that a system operates as an organized whole that is greater than the sum of its parts and that such a system cannot be adequately understood if broken down into its component parts. A family represents a complex relationship system in which causality is complex and multidimensional. Family rules, for the most part unstated but understood by family members, help stabilize and regulate family functioning. Change is common in families as they face life cycle adjustments and continue across time. When changes are called for, negative as well as positive feedback loops may facilitate change and help restore equilibrium, in the latter case by promoting discontinuity and the achievement of homeostasis at a new level.

Subsystems carry out specific family functions. Particularly significant are the spousal, parental, and sibling subsystems. Boundaries help separate systems, as well as subsystems within the overall system, from one another. Their clarity and permeability are more germane to family functioning than is their membership composition. Families vary in the extent to which they are open systems; relatively closed systems run the risk of entropy or decay and disorganization.

Schools, healthcare, substance abuse treatment, and severe mental illness programs represent an interlocking of systems, in which interventions at various levels can offer a coordinated and successful approach to changing problem behavior. On the other hand, the unbending rules of some institutions may negate any therapeutic gain. Although these systems are often effective in solving problems, confusion may result from competing definitions of the family problem and conflicting solutions offered by different helpers. Ecomaps offer useful visual devices for clarifying the family's relations with interlocking programs to improve coordination among agencies.

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5

Origins and Growth of Family Therapy

LEARNING OBJECTIVES

- LO 1 Explain key developments in the historical roots of family therapy
- LO 2 Describe how marital and sex counseling played a role in the origins of family therapy
- LO 3 Discuss how the child guidance movement and group therapy influenced the emergence of family therapy
- LO 4 Explain at least one trend in each decade of the progressive development of family therapy

In Part I, we established a family relationship framework for viewing and understanding behavior before offering a life cycle or multigenerational outlook for today's families. We next emphasized the importance of gender, culture, and ethnicity to family functioning. Finally, we explored some of the fundamental concepts of systems theory that bind together individuals, their families, and the greater community.

We begin Part II by examining the evolution of family therapy. We look at some scientific and clinical developments that occurred mostly during the 1950s that gave birth to the field and go on to describe the remarkable growth of family therapy as a discipline from then until now. This record of events provides the foundation for current practices. It provides the context for your emerging identity as a family therapist. Along the way, we will introduce important players in family therapy and describe the sociopolitical context in which their ideas blossomed. We end this part with an examination of contemporary professional issues and ethical practices.

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LO 1 Historical Roots of Family Therapy

Most authorities point to the decade following World War II as the period when researchers and then practitioners first turned their attention to the family's role in creating and maintaining psychological disturbance in family members. The sudden reuniting of families in the aftermath of the war created numerous problems (social, interpersonal, cultural, situational) for which the public sought solutions from mental health specialists. Accustomed to working with individuals, these professionals were now expected to work effectively with an array of problems within the family.

In general, psychotherapy became more accessible to people from a broader range of social and educational backgrounds than had been the case before the war. Practitioners from many disciplines—psychiatrists, clinical psychologists, social workers, marriage counselors, pastoral counselors—began to help. The definition of problems considered amenable to psychotherapy, previously dealt with by extended family members and institutions such as the church, expanded to include marital discord, separation and divorce, delinquency, problems with in-laws, and various forms of emotional disturbance not requiring hospitalization. Although most clinicians continued to offer individual treatment only, others began to look at family relationships and the transactions between members that needed modification if individual well-being was to be achieved.

The Macy Foundation Conferences, begun during wartime and continued in peacetime, provided some fundamental postulates of systems theory that were later to prove so central to family therapy formulations. Gregory Bateson deserves recognition for seeing the relevance of such concepts as feedback loops to the social and behavioral sciences and ultimately to how human interactive systems work.

In addition to the gradual acceptance of systems theory by many clinicians, four other seemingly independent scientific and clinical developments during the decade following World War II helped set the stage for the emergence of family therapy:

- The investigation of the family's role in the development of schizophrenia in one of its members
- The evolution of the fields of marital and premarital counseling
- The growth of the child guidance movement
- Advances in group dynamics and group therapy

Studies of Schizophrenia and the Family

First, family environment was investigated to see if family dynamics might account for different forms of adult psychopathology. In particular, researchers considered the role a pathogenic family environment plays in the development of **schizophrenia**.

Fromm-Reichmann and the Schizophrenogenic Mother

Following the then prevalent view that the mother's child-rearing behavior established her developing child's emotional stability, some researchers attempted to reconstruct the early mother–child relationships of adult schizophrenics. Maternal rejection was postulated by Frieda Fromm-Reichmann (1948) for the development of male schizophrenia. In a widely quoted

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paper at the time, this prominent psychoanalyst, known for her work with schizophrenics, introduced the term **schizophrenogenic mother** to denote a domineering, cold, rejecting, possessive, guilt-producing person who, in combination with a passive, detached, and ineffectual father, causes her male offspring to feel confused and inadequate and ultimately to become schizophrenic (a linear cause-and-effect relationship between pathogenic parents and schizophrenia).

Although Fromm-Reichmann emphasized the destructive nature of such parenting, she nevertheless viewed schizophrenia as an intrapsychic disorder, residing within the individual patient. She did not suggest treating the family together but instead saw the clinician's role as freeing the patient from the parents' noxious influences. Fromm-Reichmann's theorizing evolved over nearly three decades of work at Chestnut Lodge mental hospital. Through that work, she came to appreciate, in contrast with the prevailing views of the time, that no patient, however disturbed, was beyond the reach of psychotherapy, including schizophrenics (Hornstein, 2000).

These initial efforts to link schizophrenia to family life were ultimately disavowed. Researchers today no longer look for a culpable, pathologizing parent and a victimized child but more commonly search for biological or genetic markers in trying to understand the disorder's origins. Nevertheless, the concept of the schizophrenogenic mother remains historically important in the evolution of family therapy, because it directed attention to dysfunctional interactions occurring within a family context and shared by all family members. Family communication difficulties and disturbances in the expression of affect are once again the focus of schizophrenia research today, although precisely how these interactive patterns arise or affect the vulnerable person at risk remains elusive.

Bateson and the Double Bind

During the 1950s, a major impetus for family research in schizophrenia came from Gregory Bateson in Palo Alto, California; Theodore Lidz at Yale; and Murray Bowen (and later Lyman Wynne) at the National Institute of Mental Health. Working independently at first, they did not become fully aware of each other's research until late in the decade.

In 1952, Bateson—then affiliated with the Palo Alto Veterans Administration Hospital—received a Rockefeller Foundation grant to study communication patterns and paradoxes. Soon he recruited Jay Haley, then a graduate student studying communication; John Weakland, a former chemical engineer with training in cultural anthropology; and William Fry, a psychiatrist. Together they examined various communication patterns in humans and animals alike, especially possible contradictions between *levels* of messages—what is communicated and how it is qualified (or in some cases contradicted) by messages from that same person at another level of communication. What ultimately proved most intriguing to this group was the manner and frequency with which schizophrenics sent conflicting and contradictory feedback messages at one and the same time.

In 1954, with a 2-year grant from the Macy Foundation to study schizophrenic communication patterns further, Bateson enlisted Don Jackson, a psychiatrist experienced in working with schizophrenics. Interested in developing an interactional theory around the sequence of exchanges between family members, the research group began to study the possible link between pathological communication patterns within a family and the emergence and maintenance of schizophrenic behavior in a family member.

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Using some of the emerging cybernetic concepts Bateson brought to the project, the researchers hypothesized that the family, when upset and threatened, seeks a homeostatic state through feedback mechanisms that monitor the family's behavior in an effort to achieve balance and stability. Perhaps, they speculated, the appearance of schizophrenic symptoms in a family member interrupted parental conflict when it occurred and instead united the adversaries in their parental concerns for their child, returning the system to its former level of equilibrium.

Although this description of schizophrenic symptoms is viewed now as an oversimplification, these researchers, by attending to family communication sequences, were beginning to *redefine schizophrenia as an interpersonal phenomenon*; in so doing, they challenged the long-held psychodynamic view of schizophrenia as an intrapsychic disorder that subsequently damaged interpersonal relationships. More specifically, they hypothesized that the family might have shaped the strange and irrational behavior of a schizophrenic by means of its contradictory and thus impossible communication requirements.

Eager to publish their preliminary results, Bateson, Jackson, Haley, and Weakland (Fry was in the armed services at the time) issued a landmark paper (1956) introducing the double-bind concept to account for the development of schizophrenia in a family member. A double-bind situation occurs when an individual (often a child) receives repeated conflicting injunctions from the same person (say, an adult) with whom the child has an important ongoing relationship. In their exchange, a primary negative injunction by the adult ("don't do that or you will be punished") is followed by a *conflicting* secondary injunction at a more abstract level (a gesture such as a hug, demanding compliance), again with the threat of punishment if the child disobeys. As a tertiary injunction, the adult demands a response but forbids the child to comment on the contradiction, thus forbidding escape from the confusing situation. The child, perceiving the threat to his or her survival, feels compelled to make some response but feels doomed to failure no matter what response he or she chooses. Repeated often enough, any part of the sequence can set off upset, panic, or rage in the trapped recipient. Note particularly that the child is faced with more than conflicting messages (where he or she might choose to obey one and disregard the other). In a double-bind situation, the key is in the two conflicting *levels* of messages.

The paper by Bateson and associates reports the following poignant example:

> A young man who had fairly well recovered from an acute schizophrenic episode was visited in the hospital by his mother. He was glad to see her and impulsively put his arm around her shoulders, whereupon she stiffened. He withdrew his arm and she asked, "Don't you love me anymore?" He then blushed, and she said, "Dear, you must not be so easily embarrassed and afraid of your feelings." (p. 259)

Note the sequence of the mother's underlying messages: "Don't touch me" ("Go away"); "Don't trust your feelings in regard to how I respond" ("Come closer"); "Don't challenge the contradictions in my behavior"; "You can't survive without my love"; "You're wrong and at fault no matter how you interpret my messages." The authors report that the distressed patient promptly became violent and assaultive when he returned to the ward.

When a person is confronted by expressions of love and hate, with an invitation to approach and an injunction to stay away issued by the same important figure, Bateson's

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group hypothesized that he or she is forced into an impossible situation of trying to discriminate correctly between the contradictory messages. Unable to form a satisfactory response (and especially in the case of a child, unable to escape) and unable to comment on the dilemma without being punished further, the person becomes confused and suspicious that all messages have concealed meanings. It becomes impossible for the person to understand what people really mean or how to communicate or relate to others. Response leads to rejection, and failure to respond leads to the loss of potential love—the classic "damned if you do and damned if you don't" situation. For example, if a parent then denies sending simultaneous contradictory levels of messages, this only adds to the child's confusion. Once the pattern is established, these researchers hypothesized, only a hint of the original sequence is enough to set off a panic or rage reaction and, for schizophrenics, may lead to gradual withdrawal from the world of relationships.

Bateson and his colleagues suggested that the typical result of repeated and prolonged exposure to this kind of impossible situation is that the child learns to escape hurt and punishment by responding with equally incongruent messages. As a means of self-protection, he or she learns to deal with all relationships in this distorted manner and finally loses the ability to understand the true meaning of his or her own or others' communications, believing every message contains a concealed meaning. At this point, the child begins to manifest schizophrenic behavior. Although double-bind communications later proved *not* to be the cause of schizophrenia, the historical importance of this landmark research is its focus on *schizophrenia as a prototype of the consequences of failure in a family's communication system*.

The double-bind hypothesis opposed the established outlook of the psychiatric community. By attending to relationships, it challenged the orthodox position that the schizophrenic's problems stemmed from the inner workings of his or her mind, the prevalent psychodynamic view of the time. Not surprisingly, the double-bind idea stimulated much controversy. Particularly troublesome to later critics was its gender bias and linear outlook—the idea that double-bind communication from parents, especially mother toward child, caused schizophrenia. Further research made it clear that double binding occurs at one time or another in most families, without such serious pathological consequences as schizophrenia. Schizophrenia is now seen as a debilitating brain disorder, although one in which communication difficulties and reduced social functioning between family members are often present.

Lidz: Marital Schism and Marital Skew

At about the same time, Theodore Lidz on the East Coast (at Johns Hopkins University and later at Yale) began publishing his findings on the family's role in schizophrenic development of one or more of its children.

A psychiatrist trained in psychoanalysis, Lidz nevertheless rejected the notion advanced by Fromm-Reichmann and others that adult schizophrenics were suffering from maternal rejection. He argued that a family-oriented perspective could contribute to a needed overhauling of psychoanalytic theory (Lidz, 1992). Particularly refuting the singling out of rejecting mothers by calling attention to the father's possibly destructive role, Lidz, Cornelison, Fleck, and Terry (1957a) described five patterns of *pathological fathering* of schizophrenics: rigid and domineering, hostile, paranoid, of little or no consequence at home, passive and submissive.

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To these researchers, carrying out longitudinal studies of families with hospitalized schizophrenic members, schizophrenia was a "deficiency disease" resulting from the failure of both parents to play supportive and complementary roles with one another. Lidz and his associates (1957b) described two patterns of chronic marital discord that are particularly characteristic of families of schizophrenics (although each may exist in "normal" families to a lesser extent). **Marital schism** refers to a disharmonious situation in which each parent, preoccupied with his or her own problems, fails to create a satisfactory role in the family that is compatible with and reciprocal to the other spouse's role. Each parent undermines the worth of the other, especially to the children, and they seem to compete for loyalty, affection, sympathy, and support of the children. Each parent may fear that a particular child (or children) will grow up behaving like the other parent. Threats of separation or divorce are common; it is usual in such families for the father to become ostracized, a virtual nonentity if he remains in the home.

In **marital skew**, which the researchers also observed in families with schizophrenic offspring, the marriage is not threatened, but mutually destructive patterns nevertheless exist. The serious psychological disturbance of one parent (such as psychosis) usually dominates this type of home. The other parent, often dependent and weak, accepts the situation and goes so far as to imply to the children that the home situation is normal. Such a denial of what they are actually living through may lead to further distortions of reality by the children. Lidz and associates (1957b) concluded that male schizophrenics usually come from skewed families in which there is a dominant, emotionally disturbed mother, impervious to the needs of other family members but nevertheless intrusive in her child's life. At the same time, a skewed family usually has a father who can neither counter the mother's child-rearing practices nor provide an adequate male role model.

Lidz searched for family dysfunction (inflexible family role, faulty parental models) as the locus of pathology in schizophrenics. Although gender-sensitive family therapists have criticized his efforts as emphasizing unbalanced, stereotypic sex roles—fathers should be more forceful, mothers more selfless—he nevertheless pointed the way to the detrimental effects of growing up in a strife-torn family that splits the child's loyalties.

Bowen, Wynne, and NIMH Studies

First at the Menninger Foundation in Topeka, Kansas, in the early 1950s and later at the National Institute of Mental Health (NIMH) near Washington, DC, Murray Bowen, a psychiatrist, broke new ground in the study of schizophrenia. In a dramatic experiment at NIMH, Bowen arranged for mothers to move into cottages on clinic grounds near their hospitalized, schizophrenic children for several months. He was especially interested in identifying unresolved symbiotic mother–child interactions. As he later reported (Bowen, 1960), families of schizophrenics often demonstrate interaction patterns resembling Lidz's findings about marital schism.

Bowen termed the striking emotional distance between parents in such a situation *emotional divorce*. He described relationships of this kind as vacillating between periods of overcloseness and overdistance. Eventually the relationship becomes fixed at a point of

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sufficient emotional distance to avoid anxiety; they settle for "peace at any price." One area of joint activity—and, commonly, conflicting views—is the rearing of their children, particularly of children who show signs of psychological disturbance. It is as if the parents maintain contact with each other (and therefore a semblance of emotional equilibrium) by keeping the disturbed child helpless and needy. Thus, adolescence, the period in which the child usually strives for a measure of autonomy, becomes especially stormy and stressful. This is typically the time when schizophrenic behavior first appears.

Bowen proposed the intriguing notion that schizophrenia is a process that spans at least three generations before it manifests in the behavior of a family member. He suggested that one or both parents of a schizophrenic are troubled, immature individuals who, having experienced serious emotional conflict with their own parents, are now subjecting their offspring to similar conflict situations. According to Bowen, that child, ultimately less well functioning than his parents, seeks out a marital partner with a comparable upbringing and level of psychological disability, especially with respect to individuation. The couple's child, who in turn is even more vulnerable to dysfunction, passes the deficit on to the next generation, and so on, finally leading to a schizophrenic individual.

When Bowen moved on to Georgetown Medical School in 1956 to found a family therapy training program, he was succeeded as head of the family studies section at NIMH by Lyman Wynne. Wynne, trained in both psychiatry and the social sciences, focused his research on the blurred, ambiguous, and confused communication patterns in families with schizophrenic members. In a series of papers over the next decade (Wynne, Ryckoff, Day, & Hirsch, 1958; Wynne & Singer, 1963), he and his colleagues addressed the social organization of such families, searching for ways in which their communication patterns could be differentiated from those observed in more normal families. For example, observing the families' recurrent unreal, fragmented, and irrational style of communication, these researchers hypothesized that such a family pattern contributes to the schizophrenic member's tendency to interpret events occurring around him or her in blurred or distorted ways. In turn, such confusion or occasional bafflement increases the schizophrenic's social and interpersonal vulnerability, both within and outside the family.

Wynne, a productive researcher and teacher, left NIMH in 1972 but continued his research at the University of Rochester, in New York, where he helped organize a family therapy training program. His emphasis on how disordered styles of communication—what he terms *communication deviance*—are transmitted in schizophrenic families provides an interactional vehicle for understanding the development of a thought disorder, the defining characteristic of young schizophrenic adults. See Box 5.1 to understand the terms Bowen and his team coined in working with these families.

Analyzing the foregoing history, Seeman (2009) interprets the shift in the understanding of schizophrenia and the family from a feminist perspective. She suggests that the work of Bateson, Lidz, Fleck, and Cornelison, and Wynne, while offering new insights, maintained a then prevailing view of the mother as a damaging cause of illness. She also notes that, in time, fathers joined mothers as involved in the illness of their children through the hostility, critical comments, and over-involvement they conveyed to them. Rather than

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BOX 5.1 EVIDENCE-BASED PRACTICE

How Disturbed Families Deal with Emotions

One of the major contributions by Wynne and his colleagues was the observation that schizophrenic families deal with emotions, both positive and negative, in false and unreal ways. Wynne termed these patterns *pseudomutuality* and *pseudohostility*. He labeled as a *rubber fence* the shifting boundaries surrounding these families, allowing some outside information to be introduced but others to be deemed unacceptable and kept out.

Wynne offered the term **pseudomutuality**—giving the appearance of a mutual, open, and understanding relationship without really having one—to describe how such families cover up conflict and conceal an underlying distance and lack of intimacy between their members. Pseudomutuality is a shared family maneuver designed to defend all the members against separation from one another as well as to avoid pervasive feelings of meaninglessness and emptiness in their lives. One family member typically is designated the "identified patient," permitting the perpetuation of the myth by others that they themselves are normal. A person who grows up in a pseudomutual family setting fails to develop a strong sense of personal identity, since the predominant family theme is fitting together, even at the expense of developing separate identities. Indeed, the effort to cultivate a separate sense of self is viewed as a threat to family unity. This lack of identity handicaps the person from engaging in successful interactions outside the family and makes involvement within his or her own family system all important.

Families with **pseudohostility** maintain a relationship by engaging in continuous superficial bickering, masking their deeper need for tenderness and affection. Doing so serves to cover up their need for intimacy, which they have trouble dealing with directly, and impairs gaining a realistic sense of their relationship. Pseudohostility in families represents an effort to disguise underlying chronic conflict and destructive alignments within the family.

Wynne labeled the resistance to outside influences in a pseudomutual family a **rubber** fence, a changeable situation in which the specific boundaries of the family may shift, as though made of rubber, allowing in certain acceptable information but unpredictably or arbitrarily closing in order to keep unacceptable information out. Here the rules are in a state of continuous flux, as the family attempts to minimize threatening contact with the outside world.

being causes of illness, they were seen as being responsible for psychotic relapses. Seeman concludes that our current judgment of parents of schizophrenic children is more benign in viewing them as co-victims of the illness who suffer along with their children because of the burden of caring for them.

All studies described thus far were cross-sectional in design, involving families in which schizophrenia had been diagnosed in a member, usually a young adult, often long before the research was carried out. A common underlying assumption was that disturbances in family relationships are the major cause of mental disorders in general and that perhaps distinctive patterns of family dynamics can be discovered for each form of psychopathology. Unfortunately, as Goldstein (1988) observed, the major barrier to testing such assumptions is that families were studied long after the major mental disorder such as schizophrenia had affected the family system.

Despite these deficits in research design, considerable enthusiasm was aroused by this new field of clinical inquiry into the baffling etiology of schizophrenia. A group of

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schizophrenia/family researchers met for the first time at the 1957 national convention of the American Orthopsychiatric Association. The cross-fertilization of ideas culminated in *Intensive Family Therapy* (Boszormenyi-Nagy & Framo, 1965), a report by 15 authorities on their research with schizophrenics and their families. The clinical investigations initiated a decade earlier laid the groundwork for the emerging field of family therapy.

LO 2 Marriage and Premarriage Counseling

The fields of marriage and premarriage counseling, precursors of family therapy, are based on the concept that psychological disturbances arise as much from conflicts between persons as from conflict within a person. Focusing on some of the unique problems of this special form of coupling, early marital counselors (gynecologists and other physicians, lawyers, social workers, psychologists, and college professors who were family-life specialists), viewed as "experts," attempted to provide answers for people with sexual and other marital difficulties (Broderick & Schrader, 1991). Clergy were especially prominent in offering formal premarital counseling, often as part of an optional or mandatory preparation program before a wedding (Stahmann & Hiebert, 1997).

If we assume that people have always been ready to advise or seek advice from others, informal marriage counseling has certainly existed for as long as the institution of marriage has. On the other hand, formal counseling by a professional marriage counselor probably began somewhat more than 70 years ago in the United States, when the physicians Abraham and Hannah Stone opened the Marriage Consultation Center in New York in 1929. A year later, Paul Popenoe (a biologist specializing in human heredity) founded the American Institute of Family Relations in Los Angeles, offering premarital guidance as well as aid in promoting marital adjustment. Family educator Emily Mudd started the Marriage Council of Philadelphia in 1932 and later wrote what is thought to be the first textbook in the field (Mudd, 1951). In 1941, largely through Mudd's prodding, the American Association of Marriage Counselors (AAMC) was formed. The AAMC brought together various professionals, primarily physicians, but also others concerned with the new interdisciplinary field of marriage counseling. This organization led the way in developing standards for training and practice, certifying marriage counseling centers, and establishing a professional code of ethics (Broderick & Schrader, 1991).

Similarly, the first documented premarital intervention program was offered by Ernest Groves (later to be first president of AAMC) in 1924 in a family life preparation course at Boston University. Through the mid-1950s, the small quantity of pertinent literature available often focused on such individually oriented topics as physical examinations by physicians as part of premarital counseling efforts. Assistance from clergy was apt to be spiritual, educational, and informational, with an intrapsychic and religious orientation rather than attending to the interpersonal relationship. If relationship problems were addressed at all, they were seen as a by-product of a problem within one or both of the prospective newlyweds (Stahmann & Hiebert, 1997). Rutledge's survey of AAMC members in 1966 found very few professionals performing premarital counseling.

By the mid-1960s, it was still possible to characterize marriage counseling (and premarriage counseling) as a set of practices in search of a theory (Manus, 1966). No breakthrough

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BOX 5.2 CLINICAL NOTE

Social Workers and Family Therapy

Social workers are the unheralded pioneers of what later became the field of family therapy. From the founding of the first citywide charity organization in 1877 in Buffalo, New York, social workers have been at the forefront of delivering services to needy families. *Family casework* is an integral part of social work preparation; and the Family Service Associations of America, beginning in 1911, have been composed of social work agencies specializing in the treatment of marital and family problems. Broderick and Schrader (1991) suggest a case could be made that both marriage counseling and family therapy had their origins within the broader field of social casework. Beginning with Virginia Satir, many leading family therapists have come from a social work background (as mentioned throughout this text).

research was being carried out, no dominant theories had emerged, no major figure had gained recognition. The AAMC published no journal of its own. If practitioners published at all, they apparently preferred to submit articles to journals of their own professions. By the 1970s, however, the situation began to change. Among others, Olson (1970) urged an integration of marriage counseling and the emerging field of family therapy, since both focus on the marital relationship and not simply on individuals in the relationship. In 1970, the AAMC, bowing to increased interest by its members in family therapy, changed its name to the American Association of Marriage and Family Counselors. In 1978, it became the present American Association for Marriage and Family Therapy. In 1975, the organization launched the *Journal of Marriage and Family Counseling* (renamed the *Journal of Marital and Family Therapy* in 1979). By then, as Broderick and Schrader (1991) observe, marriage counseling (and by implication premarriage counseling) had "become so merged with the more dynamic family therapy movement that it had all but lost its separate sense of identity" (p. 15).

The history of sex counseling parallels that of marriage counseling, and the two disciplines had many of the same practitioners. Moving to become a separate specialty, the American Association of Sex Educators and Counselors was formed in 1967 and set up standards and granted certificates for qualified sex therapists. Since 1970, two journals, the *Journal of Sex and Marital Therapy* and the *Journal of Sex Education and Therapy*, have disseminated information in this therapeutic movement.

What exactly was marital therapy at that time? Not considered to be as deeply probing, intensive, or as prolonged as psychotherapy, marital therapy tended to be a short-term attempt at repairing a damaged relationship. By and large, it dealt with here-and-now issues rather than those from the past. Unlike psychotherapy, which presumably probed inner meanings, marriage counseling addressed reality issues and offered guidance to troubled couples in order to facilitate their conscious decision-making processes. Early premarital counseling, which tended to be even less attentive to relationship issues or why this couple chose one another, was content to help the pair prepare for marriage by becoming aware of any neurotic individual problems that might cause later hardships.

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BOX 5.3 CLINICAL NOTE

Motivation in Couples Therapy

Two persons seeking couples therapy rarely arrive with the same degree of motivation or identical agendas. When therapeutic progress is at a standstill for no discernible reason, the therapist might consider that one partner already has made the decision to separate. He or she may go through the motions for a while to give the appearance of making the effort to reconcile but in reality is preparing to leave his or her spouse.

Couples entering premarital therapy may have done so as a checkup on the viability of their relationship before marrying or due to fear that some underlying conflict remains unresolved and may lead to a further deterioration of their relationship once married. In some cases, premarital therapy was mandated by religious groups to which they belong. When one or the other (or both) has been divorced, particularly if there are children from a previous marriage, such caution is pertinent (Goldenberg & Goldenberg, 2002).

Most people who seek help for their marriage are attempting to cope with a crisis (such as infidelity, threat of divorce, disagreements regarding child rearing, money problems, sexual incompatibilities, ineffective communication patterns, conflicts over power and control) that has caused an imbalance in the family equilibrium. Each partner enters marital therapy with different experiences and expectations and with different degrees of commitment to the marriage. At least one of the partners is usually invested in staying married or they would not seek professional help, but the strength of the determination to stay together may vary greatly between them.

As marital counseling began to focus on the couple's troubled relationship, **conjoint** therapy, in which a couple works with the same therapist together in the same room and at the same time, replaced earlier efforts to counsel each partner separately. Once again, we see how the stage was being set for the profession of family therapy.

LO 3 The Child Guidance Movement

Two additional streams of thought and clinical development deserve mention for their influences in the evolution of family therapy. The *child guidance movement*, emerging early in the 20th century, was based on the assumption that if emotional problems did indeed begin in childhood—as Freud and others were arguing—then early identification and treatment of children could prevent later psychopathology.

Alfred Adler, an early associate of Freud's, was especially cognizant of the key role early family experiences played in determining later adult behavior. Adler helped found the child guidance movement in Vienna in the early 1900s, and while he did not work therapeutically with entire families, he did influence one of his disciples, Rudolf Dreikurs, who later emigrated to the United States, to expand child guidance centers into family counseling centers (Lowe, 1982). In 1924, the American Orthopsychiatric Association, devoted to the prevention of emotional disorders in children, was organized. Although child guidance clinics remained few in number until after

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World War II, they now exist in almost every city in the United States. They provide major settings for identifying and treating childhood psychological disorders and are valuable in involving parents and attending to the larger social systems from which the presenting problem evolved.

Early treatment programs were team efforts, organized around a psychiatrist (psychotherapy), a psychologist (educational and remedial programs), and a social worker (casework with parents and outside agencies). It was standard procedure (and still is in traditional clinics) for a parent to visit the clinic regularly for treatment, usually seeing a different therapist from the one working with her child. This collaborative approach has now evolved into conjoint therapy sessions in most clinics, involving both parents as well as siblings of the identified patient. Rather than viewing the child as the identified patient with intrapsychic problems or the parents as the source of the child's difficulties, today's outlook focuses on pathology among all the family participants. Child guidance clinics continue to function on the principle of early intervention in a child's family's emotional problems in order to avert the later development of more serious disabilities.

LO 4 Group Dynamics and Group Therapy

Group dynamics and the behavior of small groups served as models of family functioning for some early family therapists such as John Bell (1961). For these therapists, family therapy was a special subset of *group therapy*, except the participants were not strangers. These practitioners took the position that families are essentially natural groups, and that the therapist's task was to promote interaction, facilitate communication, clarify the group process, and interpret interpersonal dynamics—as any group therapy leader would do. Bell called his approach **family group therapy**.

Group therapy has been practiced in one form or another since the beginning of the 20th century, but the impetus for its major expansion came from the need for clinical services during and immediately after World War II. The earliest use of the group process in psychotherapy can be credited to the Austrian psychiatrist Jacob Moreno, who, around 1910, combined dramatic and therapeutic techniques to create **psychodrama**. Moreno, whose psychodramatic techniques are still used today (Landy, 2007), recreated in the therapeutic process the various interpersonal situations that may have led to the patient's psychological difficulties. Moreno, in the role of therapist/director, used a stage on which the patient could act out his or her significant life events in front of an audience. In these psychodramas, various people (frequently, but not necessarily, other patients) represented key persons ("auxiliary egos") in the patient's life. At certain junctures, the director might instruct the patient to reverse roles with one of the players so the patient could gain a greater awareness of how another person saw him or her. The exploration of a family's interpersonal give and take and the resolution of its conflicts through psychodrama made this model a natural fit for many family therapists.

Stimulated largely by the theories developed by British psychoanalysts Wilfred Bion and Melanie Klein, considerable interest in group processes developed during the 1930s at the Tavistock Institute in London. Several psychoanalysts began experimenting with group intervention techniques (Bion, 1961). In particular, they emphasized dealing with current problems rather than searching for past causes and explanations or reconstructing possibly traumatic early experiences. Samuel Slavson, an engineer by training, began to do group work at the Jewish Board of Guardians in New York City at the same time. He created the activity-group

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therapy technique, in which a group setting encourages disturbed children or adolescents to interact, thereby acting out their conflicts, impulses, and typical behavior patterns (Slavson, 1964). Slavson based his approach on concepts derived from psychoanalysis, group work, and progressive education. In 1943, the American Group Psychotherapy Association was formed, largely through Slavson's efforts.

In the 1960s, inspired by the emergence of various personal growth centers around the United States—particularly the Esalen Institute in Big Sur, California—the **encounter group** (part of the human potential movement) made a dramatic impact on the therapy scene and attracted large numbers of people, mostly from the upper middle class. Today, that enthusiasm has waned, although traditional group therapies (Yalom & Leszcz, 2005) and, to a lesser extent, encounter groups, continue to exist side by side.

Fundamental to the practice of group therapy is the principle that a small group can act as a carrier of change and strongly influence those who choose to be considered its members. A therapy group is a meaningful and real unit in and of itself, more than a collection of strangers, more than the sum of its parts. Another way of putting it is that the group is a collection of positions and roles and not of individuals (Back, 1974). The Tavistock version of group therapy is a good illustration: The group is treated as if it were a disturbed patient who is hurting because certain functions are not being carried out successfully. In a Tavistock group, the leader helps the group function in a more balanced, coordinated, and mutually reinforcing way so the group can accomplish productive work more efficiently. The implications for group therapy with a dysfunctional family are obvious. Table 5.1 summarizes some unique advantages of group therapy.

TABLE 5.1 Some special advantages of group therapy over individual therapy

Principle	Elaboration
Resembles everyday reality more closely	Therapist sees patient interacting with others rather than hearing about it from the patient and possibly getting a biased or distorted picture; adds another informational dimension regarding his or her customary way of dealing with people.
Reduces social isolation	Patient learns that he or she is not unique by listening to others; thus he or she may be encouraged to give up feelings of isolation and self-consciousness.
Greater feelings of support and caring from others	Group cohesiveness ("we-ness") leads to increased trust; self-acceptance is likely to increase when patient is bolstered by acceptance by strangers.
Imitation of successful coping styles	New group members have the opportunity to observe older members and their successful adaptational skills.
Greater exchange of feelings through feedback	Group situation demands expression of feelings, both positive and negative, directed at other members who evoke love, frustration, tears, or rage; patient thus gains relief while also learning from responses of others that intense affect does not destroy anyone, as he or she may have feared or fantasized.
Increases self-esteem through helping others	Patient has the opportunity to reciprocate help, to offer others empathy, warmth, acceptance, support, and genuineness, thereby increasing his or her own feelings of self-worth.
Greater insight	Patients become more attuned to understanding human motives and behavior, in themselves and in others.

Source: Goldenberg (1983).

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LO 5 The Evolution of Family Therapy

We have suggested that early studies in schizophrenia and the family, early marriage and family counseling, the child guidance movement, and group dynamics and group therapy have all contributed to the development of family therapy by illustrating how problems experienced by individuals can be understood and addressed within the groups of which they are part. This section traces the development of family therapy as a distinct field.

From Family Research to Family Treatment (1950s)

Most of the surveys of the family therapy movement (Broderick & Schrader, 1991; Goldenberg & Goldenberg, 1983; Guerin, 1976) agree it was founded in the 1950s as the theories and approaches we have been describing seemed to coalesce. Those ideas, to be sure, pertained more to clinical research than to clinical practice. Observation of the family—particularly one with a symptomatic member—could be justified only if it was presented as a research strategy because of the prevailing sanction of confidentiality against a therapist's contact with anyone in the family other than her or his own patient.

Family therapy therefore owes its legitimacy to the following facts: (a) it was carried out for scientifically defensible research purposes and (b) the "research" was being done on clinical problems such as schizophrenia that did not respond well to the established psychotherapies of that time (Segal & Bavelas, 1983). As Wynne (1983) notes, all early schizophrenia initiatives were initially research motivated and research oriented. Wynne's own work at NIMH with schizophrenics was based on the use of therapy as a source of experimental data. The apparent success of the family research helped give the stamp of approval to the development of therapeutic techniques.

Who actually deserves credit for first adopting a family therapy approach with client families? Certainly, no single person—although Nathan Ackerman, a child psychoanalyst in the child guidance movement, is generally credited with having written the first paper dealing specifically with treating an entire family (Ackerman, 1937). In contrast to the coordinated approach practiced by most child guidance clinics, in which parent and child were seen by separate but collaborating therapists, Ackerman began seeing entire families together at least a decade before other therapists joined him in this approach.

John Bell, an academic psychologist at Clark University in Worcester, Massachusetts, was another major architect of family therapy. Bell (1975) recalled that a casual remark overheard while he was visiting the Tavistock clinic in London in 1951—to the effect that John Bowlby, a prominent psychoanalyst, was experimenting with group therapy with entire families—stimulated his interest in applying the technique to treat behavior problems in children. Bell incorrectly assumed that Bowlby was treating the entire family, but Bowlby only occasionally held a family conference as an adjunct to working with the problem child. Based on this misinformation, Bell began to think through the technical implications of meeting with an entire family on a regular basis. Then a case gave him the opportunity to try out this method in therapy. Bell's description of his work was not widely disseminated until a decade later (Bell, 1961). That groundbreaking monograph, along with Ackerman's 1958 text, is often thought to represent the founding of family therapy as practiced today. Unlike

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John Bell, Ed.D.

most of their colleagues in the 1950s, both Bell and Ackerman worked with nonschizophrenic families.

As noted previously, Don Jackson deserves recognition as a family therapy pioneer, introducing an influential, if still rudimentary, set of descriptive constructs for comprehending family communication patterns (family rules, homeostasis, the redundancy principle) and initiating conjoint treatment to help overcome noxious family interactive patterns. Along with other members of the Palo Alto group, particularly seminal thinkers Jay Haley and John Weakland, Jackson helped develop innovative ways to influence a family's relationship context in order to produce change. (Bateson, a founder of the field but himself not a therapist, was less concerned with the application of the clinical ideas his group had generated than he was with the philosophy underlying those ideas.)

A list of family therapy trailblazers must also include Murray Bowen, for his theoretical proposals and his innovative technique of hospitalizing families with a schizophrenic member in order to study mother–child symbiotic influences.

Carl Whitaker was another early leader in the field. Whitaker began working with families at Oak Ridge, Tennessee, the site of the secret government plant manufacturing the first atomic bomb during World War II. Whitaker, a gynecologist, was not a psychiatrist, and his innovative and often idiosyncratic techniques perhaps reflect his unorthodox training. He used a co-therapist and included intergenerational family members in a patient's therapy. He displayed a highly active style in working with patients.

By organizing a series of family therapy conferences devoted to the treatment of schizophrenia—including a celebrated 1955 event at Sea Island, Georgia—Whitaker was able to bring together many leaders of the emerging family therapy field (including John Rosen and Albert Scheflen from Philadelphia as well as Bateson and Jackson). The conferences, in which schizophrenics and their families were interviewed while being observed behind a one-way mirror, led to the publication of an early text on the psychotherapy of chronic schizophrenic patients (Whitaker, 1958). The use of a one-way mirror lifted the secrecy from the therapeutic process. Introduced into family therapy by Charles Fulweiler, the mirrors allowed others to observe families in psychotherapy, often producing insights into their interactive patterns. Slovik and Griffith (1992) consider the introduction of this observational technique a landmark in the history of family therapy, providing, as it did, clinical confirmation of such concepts as circular causality.

By 1957, the family movement had surfaced nationally (Guerin, 1976) as family researchers and clinicians in various parts of the country began to learn of each other's work. Ackerman, having organized and chaired the first meeting on family diagnosis and treatment at the 1955 American Orthopsychiatric Association, had moved to New York and in 1957 established the Family Mental Health Clinic of Jewish Family Services. In that same year, Ivan Boszormenyi-Nagy, having emigrated earlier from Hungary, joined the Eastern Pennsylvania Psychiatric Institute (EPPI) in Philadelphia to conduct research on schizophrenia. Boszormenyi-Nagy assembled a distinguished group of family-oriented researchers and clinicians and made Philadelphia a major early center for family therapy.

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By 1959, Don Jackson, remaining a consultant on the Bateson project, had founded the Mental Research Institute (MRI) in Palo Alto; Virginia Satir, Jay Haley, John Weakland, Paul Watzlawick, Arthur Bodin, and Richard Fisch would soon join the staff. A year later, Ackerman created the Family Institute in New York (renamed the Ackerman Institute for Family Therapy after his death in 1971). Representing the East and West coasts, both institutes played embryonic roles in the evolution of the family therapy field.

The Rush to Practice (1960s)

Several significant developments in the 1960s indicated that the field of family therapy was gathering momentum. In 1962, Ackerman and Jackson founded the first—and still the most influential—journal in the field, *Family Process*, with Jay Haley as its editor. From its beginnings, the journal enabled researchers and practitioners alike to exchange ideas and identify with the field. In addition, several important national conferences were organized. A meeting in 1964 dealt with the application of systems theory to understanding dysfunctional families (Zuk & Boszormenyi-Nagy, 1967); in 1967, a conference organized by psychologist James Framo was held to stimulate and maintain an ongoing dialogue among family researchers, theorists, and family therapists (Framo, 1972).

Family therapy, gaining professional respectability, became a recognized topic at most psychiatric and psychological meetings. As Bowen (1976) later recalled, therapists were eager to present their newly minted intervention techniques with whole families. In nearly all cases, this "rush to practice" precluded the development of procedures adequately grounded in research or based on sound conceptual formulations. In their clinical zeal—Bowen refers to it as "therapeutic evangelism"—many therapists attempted solutions to family dilemmas using concepts borrowed from individual psychotherapy.

One notable exception to the emphasis on practice over theory and research during this period was Minuchin's Wiltwyck School Project, a pioneering study of urban slum families (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). Minuchin subsequently developed appropriate clinical techniques for successful intervention with male juvenile delinquents, many of whom were Puerto Ricans or African Americans from New York City. From this landmark study of poor, unstable families, largely without fathers or durable father figures, Minuchin developed an approach he called *structural family therapy* that was pragmatic and oriented toward problem resolution, always mindful of the social context in which the family problems emerged and were maintained.

By 1965, Minuchin was director of the Philadelphia Child Guidance Clinic, originally in the heart of the African-American ghetto, where he focused on intervention techniques with low-income families. His staff included Braulio Montalvo and Bernice Rosman from Wiltwyck, and in 1967 he invited Jay Haley (who, together with John Weakland, had joined the MRI in Palo Alto at the close of the Bateson project)[1] to join them. The Philadelphia center was soon transformed from a traditional child guidance clinic into a large family-oriented

[1]The Bateson group had officially disbanded in 1962. Bateson, trained in ethnology and more interested in theoretical ideas regarding communication than in their clinical application to troubled families, moved on to the Oceanic Institute in Hawaii in order to observe patterns of communication among dolphins.

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treatment and training center. By the late 1960s, the Philadelphia group was working with psychosomatic families (with particular attention to families of anorexia nervosa patients), applying Minuchin's earlier concepts of boundaries and the interplay of a family's subsystems to psychosomatic problems.

During this highly productive period, the 1964 publication of *Conjoint Family Therapy* by Virginia Satir, then at MRI, did much to popularize the family approach, as did Satir's highly emotional and colorful demonstrations at professional meetings and workshops in many parts of the world. Toward the end of the decade, the character of the work at the MRI began to change. Satir left to become the director of training at Esalen Institute, a humanistically oriented growth center at Big Sur, California. Haley moved to Philadelphia, and Jackson unexpectedly died in 1968. Although the MRI has continued to focus on family interactional patterns (particularly communication), the brief therapy project, begun in 1967, became its major thrust.

Behavioral family therapy first appeared in the late 1960s. Initially individually focused, often involving amelioration for discrete problems of young children, the techniques relied heavily on learning theory at first. Interventions with families were likely to be derived from empirical studies, and therapeutic procedures were continuously assessed for effectiveness. Consequently, the behavioral approach with families depended less on charismatic leaders or innovative therapists and more on a clinician–researcher collaboration (Falloon, 1991). Nevertheless, interdisciplinary leaders did emerge—psychologist Gerald Patterson, psychiatrist Robert Liberman, and social worker Richard Stuart.

During the 1960s, developments in family therapy arose outside the United States. At the psychoanalytically oriented Institute of Family Therapy in London, Robin Skynner contributed a brief version of psychodynamic family therapy (Skynner, 1981). The British psychiatrist John Howells (1975) instituted family diagnosis as a necessary step in planning interventions. In West Germany, Helm Stierlin (1974) called attention to patterns of separation in adolescence and related them to family characteristics. In Italy, Mara Selvini-Palazzoli (1978), trained in child psychoanalysis but discouraged by her results with anorectic children, was attracted to the new epistemology proposed by Bateson and the Palo Alto group. Shifting to a systems approach that stressed circularity, she was more successful with resistant cases. In 1967, Selvini-Palazzoli, together with colleagues Luigi Boscolo, Guiliana Prata, and Gianfranco Cecchin, formed the Institute for Family Studies in Milan; the institute would eventually have a worldwide impact on the field of family therapy—particularly with its use of "long" brief therapy, in which therapy sessions were held at monthly intervals for up to a year.

Innovative Techniques and Self-Examination (1970s)

For the most part, technique continued to outdistance theory and research in family therapy well into the 1970s. The early part of the decade saw much enthusiasm and a proliferation of family therapy approaches in various parts of the United States:

- In Vermont, treating several families with hospitalized schizophrenic members in groups, in a procedure called **multiple family therapy** (Laqueur, 1976)

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- In Galveston, Texas, bringing families together for an intensive, crisis-focused 2-day period of continuing interaction with a team of mental health professionals, in **multiple impact therapy** (Macgregor, Ritchie, Serrano, & Schuster, 1964)
- In Philadelphia, working in the home with an extended family group including friends, neighbors, and employers, in **network therapy** (Speck & Attneave, 1973)
- In Colorado, treating a family on an outpatient basis in **family crisis therapy** instead of hospitalizing a disturbed, scapegoated family member (Langsley, Pittman, Machotka, & Flomenhaft, 1968)

Behavioral therapists increasingly focused on issues related to family matters, such as teaching parents "behavior-management skills" to facilitate effective child rearing (Patterson, 1971) and proposing therapeutic strategies for working with marital discord (Jacobson & Martin, 1976) and family dysfunction (Liberman, 1970). The newly available technology of videotape allowed family therapists to tape sessions either for immediate playback to the family, for later study by the therapist, or for training (Alger, 1976).

In the 1970s, having come of age and with students and professionals alike now seeking training, the field of family therapy engaged in its first efforts at self-examination. The so-called GAP report (Group for the Advancement of Psychiatry, 1970) presented the results of a survey of practicing family therapists who were asked to rank the major figures in the field according to their influence at that time. The practitioners placed the major figures in this order: Satir, Ackerman, Jackson, Haley, Bowen, Wynne, Bateson, Bell, Boszormenyi-Nagy.

In another effort to bring order and self-awareness to the developing field, Beels and Ferber (1969) observed leading therapists conducting family sessions and studied videotapes and films of their work with families. Beels and Ferber distinguished two types of family therapists based on the therapist's relationship to the family: **conductors** and **reactors**. Conductor therapists are active, aggressive, and colorful leaders who place themselves in the center of the family. They are likely to initiate rather than respond, to propound ideas vigorously, to make their value systems explicit. Reactors are less theatrical personalities, more subtle and indirect. They observe and clarify the family process, responding to what the family presents, negotiating differences among family members.

Beels and Ferber (1969) contended that each type of therapist is effective in directing and controlling the family sessions and in providing family members with possible new ways of relating to each other; the conductors are more direct in their methods but not necessarily more successful in helping create a new family experience as the basis for changing its members' interactive behavior patterns.

Further self-examination focused on outcome effectiveness research. Wells and Dezen (1978) found after surveying the outcome literature that most family therapy theorists, including some major figures in the field, "have never submitted their methods to empirical testing and, indeed, seem oblivious to such a need" (p. 266). By the end of the decade, there had been some improvement (Gurman & Kniskern, 1981), but the effectiveness of family therapy still required continuing and systematic evaluation.

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Perhaps the most far-reaching impact on the field came from the feminist critique of then-current family therapy systemic ideas and therapeutic techniques. As we noted in Chapter 3, since the mid-1970s, a growing number of family therapists, beginning with Hare-Mustin (1978), have argued that family therapy, both as conceptualized and practiced, showed bias in favor of values typically considered masculine—such as autonomy, independence, and control—while devaluing those nurturant and relationship values more customarily associated with females. Moreover, they maintained that developmental schemas typically adopted by family therapists are based on male development and are assumed to be applicable to women as well. By adopting these schemas, as Slovik and Griffith (1992) point out, therapists tend to devalue qualities such as dependency and caretaking normally linked to women. Moreover, by being insensitive to such issues as gender roles and wife battering, they were, in many cases inadvertently, reinforcing patriarchal attitudes as well as masculine and feminine stereotypes.

The family therapy pioneers, all of whom were men (with the exception of Satir), were brought to task for failing to pay sufficient attention to the social and political context in which family members live. Even the venerated Bateson came under fire from feminists. In particular, they contended that his disregard of power and control differences between participants in any transaction, in favor of such cybernetic notions as reciprocity and circularity, assumed a lack of unilateral control by any one participant because the system was in a continuous state of flux. While feminists recognize the circular nature of transactions within a family, they argued that Bateson's formulation is oversimplified in its implication of equal responsibility (and equal blame), particularly in failing to acknowledge the crucial role of power differentiation (men and women; adults and children) in any ongoing relationship.

The feminist critique shook most family therapists out of their growing complacency by insisting that they examine their built-in gender biases regarding fixed male and female roles within a family and society at large. Just as they would later have to deal with developing greater diversity awareness and multiculturalism, so then they were being urged to consider gender-related issues within a family, power differences between husbands and wives, and the individual needs of clients for harmonious family functioning. Perhaps most disturbing of all, family therapists were being directed to examine their own values, attitudes, and beliefs and to confront sexist views that could prove detrimental to helping all family members, male as well as female, feel empowered.

Professionalization, Multiculturalism, and a New Epistemology (1980s)

In the 1980s, a number of signs documented the phenomenal growth of the family therapy field. Whereas barely a decade earlier the field had one professional journal of its own, *Family Process*, there were now approximately two dozen family therapy journals, half of them published in English. Once, family therapy centers could be counted on the fingers of one hand; now, in what many consider the golden age of family therapy, more than 300 freestanding family therapy institutes existed in the United States alone. (There are fewer such centers devoted exclusively to family therapy today.)

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Several organizations now represented the interests of family therapists. In addition to the interdisciplinary American Orthopsychiatric Association (where Ackerman first brought together practitioners interested in family research and treatment), the major groups are as follows:

- The American Association for Marriage and Family Therapy (AAMFT) grew from fewer than 1,000 members in 1970 to more than 7,500 by 1979, to 16,000 by 1989, and more than 24,000 by 2010. The AAMFT has the authority to accredit marriage and family therapy training programs, to develop standards for issuing certificates to qualified persons as approved supervisors, to publish a code of ethics for its members, and to actively pursue state licensing and certification for marital and family therapists.
- The American Family Therapy Association (now called the American Family Therapy Academy) was founded in 1977. This smaller interest group of approximately 700 members (2014) is concerned exclusively with family therapy clinical and research issues as distinct from marriage counseling or marital therapy.
- The International Association of Marriage and Family Counselors (IAMFC), a division of the American Counseling Association, grew from slightly more than 100 members when it was founded in 1989 to almost 8,000 members in 1996. The IAMFC conducts educational programs and helps develop training standards for marriage and family counseling programs.
- The Division of Family Psychology of the American Psychological Association was established in 1986. Today, Division 43 is called the Society for Couple and Family Psychology. Family psychology offers a broader perspective than the clinical emphasis of family therapy, paying special attention to relationship networks within marriage and the family. By the close of the 1990s, membership in the Division of Family Psychology was approximately 1,700.
- The American Board of Professional Psychology, a board of specialties recognizing postdoctoral competence in the applied areas of psychology, in the late 1980s added family psychology as a certifiable specialty. That constituent board is now known as the American Board of Couple and Family Psychology.
- The International Family Therapy Association (IFTA), made up of therapists, theorists, researchers, trainers, and other professionals working with families, was organized in 1987 and now has more than 500 members from 40 countries around the globe. IFTA conferences, held in various countries, allow for the first-hand exchange of ideas. The organization publishes a semiannual newsletter, the *International Connection*, announcing conferences and offering family therapy articles.

Family therapy became an international phenomenon in the 1980s, with active training programs and congresses in Canada, England, Israel, Holland, Italy, Australia, Germany, and elsewhere. The 1985 Heidelberg conference marked the 10th anniversary of the Department

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of Basic Psychoanalytic Research and Family Therapy of Heidelberg University in Germany (then West Germany) with some 2,000 participants from 25 countries (Stierlin, Simon, & Schmidt, 1987). In 1987, an east–west family therapy conference of over 2,500 people from all over the world took place in Prague, the Czech Republic (then Czechoslovakia), followed in 1989 by a similar event in Budapest, Hungary.

Competing models of family therapy, usually associated with one of the field's founders, proliferated in the 1980s (Piercy & Sprenkle, 1990). Although each relied on systems theory, differing perspectives led to the establishment of rival "schools" in the field. Nevertheless, the cross-fertilization of ideas continued through workshops and the videotapes of master family therapists of various persuasions.

Many family therapists broadened the scope of their theories and practices during the 1980s to include collaboration with related disciplines such as medicine. **Medical family therapy** emerged as a subspecialty, and the journal *Family Systems Medicine* (now renamed *Families, Systems & Health*) was founded. Doherty and Baird (1983)—the former a psychologist and the latter a physician—published a landmark book, *Family Therapy and Family Medicine*, in which they argued for the application of a systems approach to treating illness in which both disciplines cooperatively act as providers for patients with a variety of medical conditions. Wynne, Shields, and Sirkin (1992) reminded therapists that illness was more than a personal experience; it was transactional and communicative with fellow family members. As these researchers observed, families typically are deeply troubled and burdened by the presence of a member with a serious physical illness.

In addition, psychoeducational programs for families of schizophrenia were introduced in the 1980s (Anderson, Reiss, & Hogarty, 1986), taking the position that they were dealing with a biological disorder, that families should not be blamed, and that the entire family would profit from help in learning to cope with the disease. Lucksted and colleagues (2012) note that family psychoeducation (see Chapter 15) has emerged as an underutilized treatment for schizophrenia, bipolar disorder, and other disorders. According to these authors, randomized trials have demonstrated that family psychoeducation (1) reduces relapse rates, (2) improves patient functioning, and (3) improves family dynamics. Interventions include empathic engagement, education, ongoing support, clinical resources during periods of stress, social networking enhancement, and enhanced problem-solving and communication skills.

The feminist challenge continued to influence both theory and practice into the 1980s, joined by the recognition that we live in a pluralistic society, and no "one size fits all" solution is appropriate to all client families. Falicov (1983) led the way in presenting a cultural perspective to family therapy practice. Her work was particularly illuminating in working with Latino families. McGoldrick, Pearce, and Giordano (1982) edited a useful book in which experts from various cultural backgrounds offered insights into working with specific ethnic groups. Boyd-Franklin (1989) presented a systems approach for dealing with African-American families in therapy.

Integration, Eclecticism, and the Impact of Constructionism (1990s)

While differences in philosophy about the nature of families and how best to intervene continued to exist between family therapists throughout the 1990s, "schools" became less

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mutually exclusive. A clear trend emerged toward integration of family therapy models (e.g., psychodynamic, cognitive-behavioral, family systems) into a comprehensive approach (Wachtel, 1997). Therapists continued to view families from different perspectives, but there was greater overlap and frequent borrowing from one another, as the clinical problem demands, even if such borrowing of technique or concept may not always be theoretically justifiable. Such pragmatic eclecticism has been criticized by those who argue for more thorough integration or metatheorizing (Kroos, 2012). Broderick and Schrader (1991) note that the field was moving away from narrowly trained specialists. Instead, most therapists were being exposed to an overview of the entire field, developing skills as what these authors call "relational therapists" (not to be confused with relational psychoanalysts—see Chapter 7). More than combining models, integrative efforts aim for a more holistic or comprehensive way of assessing and intervening with families.

At the same time, the need for a quicker return to functioning and the restrictions on practice imposed by **managed care** (see Chapter 6) led to a search for brief techniques. The Mental Research Institute (MRI) in Palo Alto and the Brief Therapy Center in Milwaukee are major examples of places that developed different workable brief therapy procedures. Within that decade, managed care, developed by insurance companies to hold down healthcare costs, greatly influenced the practice of family therapy (by delineating eligibility for services, number and frequency of sessions, fees, length of treatment, etc.).

By the mid-1990s, constructionists had forced family therapists to reexamine not only some cherished systemic theoretical assumptions but also how to most effectively intervene with troubled families (see Greene et al., 1996, for an example from social work). Constructionists believe objectivity is impossible and that the therapist, presumably an outside observer of a family, in actuality participates in constructing what is observed. Their view helped move the thinking of many family therapists away from theoretical certainties and toward a greater respect for differences in outlook and viewpoints between themselves and individuals within families and between families with different gender, cultural, ethnic, or experiential backgrounds. Multiple narratives by different family members, all equally true, were recognized as part of all family functioning, with no one person (therapist included) perceiving an objective universe. Therapeutically, it meant shifting to a greater collaboration between therapist and family members, all of whom had something to contribute about the current difficulties (see Chapter 1).

Assessing a family now called for taking class, ethnicity, and gender roles into account. As Fraenkel (2005) puts it, "thoughtful therapists, sensitive to the mandates of multiculturalism, feminism, economic differences, and so forth, adopted a not-knowing, exploratory, collaborative stance, turning to families as co-experts in solving their problems" (p. 37). In this approach, which stresses a nonpathological orientation to the therapeutic process, all therapists can do is help family members understand and reassess the assumptions and meanings each participant has constructed about a common family problem.

The therapist does not try to change the family's structure, nor is he or she able to change the social conditions that help determine family functioning. Rather, change occurs as a result of a family reexamining its belief systems. Therapists can help by introducing information

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BOX 5.4 THERAPEUTIC ENCOUNTER

Advancing a New Epistemology

One event that had far-reaching consequences for the family therapy field for a decade was the publication of a single issue of *Family Process* early in the 1980s. In it, three sets of family therapists (Allman, 1982; Dell, 1982; Keeney & Sprenkle, 1982) raised important epistemological questions regarding the theoretical foundation, research models, and clinical practice of family therapy. All were critical of the field's rush to put forth new techniques without first rethinking some of the cybernetic notions taken for granted by most family therapists. Dell, for example, objected to the term *homeostasis* as an "imperfectly defined explanatory notion" because it implied a process that returned a system to its previous state and as such prevented change.

Arguing for what has become known as the *new epistemology*, Keeney and Sprenkle (1982) challenged the field to look beyond its narrow pragmatic approaches (exemplified by designing and carrying out interventions to overcome a family's specific presenting problem) to a broader consideration of overall family functioning. The pragmatic approach, they maintained, had led the field astray, leading to searching for more and better how-to-do-it methods and "packageable" techniques but at the expense of more fully appreciating the context in which families live. In their view, the pragmatic focus on symptom reduction (behavioral and strategic techniques are examples) limits the vision of what really troubles families and how best to help them find solutions. Moreover, pragmatic views, influenced by early cybernetic notions, place the observer outside the phenomenon being observed, in effect equating families with machines and paying insufficient attention to family interaction and context. This erroneously supports a linear notion that such an outsider may unilaterally manipulate and control the observed system.

Both Keeney and Sprenkle (1982) and Allman (1982) urged consideration of the *aesthetic* (patterned) dimensions of family therapy. Allman in particular believes the artistry of family therapy is revealed in the therapist's ability to grasp the unifying patterns connecting family members and, if stuck in one pattern they wish to change, to help them rearrange the connecting patterns in order to create new meanings in their lives.

To illustrate the difference between treatment methods reflecting cybernetic concepts and those based on the new epistemology, Keeney and Sprenkle (1982) offer the case of a woman who complains of severe anxiety attacks. The pragmatically oriented therapist might contract with her to engage in a therapeutic effort aimed specifically at alleviating the anxiety symptom. Success could then be evaluated empirically by quantitatively comparing the occurrence of the symptom before and after treatment. An aesthetically oriented therapist would be more concerned with the larger gestalt of family interactive patterns, of which the symptom is but one part. The pragmatic therapist might actually acknowledge that the larger gestalt must change but would contend that change would follow from symptom removal. The aesthetic therapist, on the other hand, does not argue with the pragmatist's technical considerations but does not consider them to be primary. In the aesthetic view, instead of being an outside change agent, a therapist's presence should help create a new context—a new "family"—so that new behavior may emerge.

By drawing attention to the act of observing what is being observed and by becoming part of the system thus created, the new epistemological challenge led to the idea of second-order cybernetics, a view that was to gain prominence in the subsequent decade.

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intended to change patterns, but, from this viewpoint, cannot predict or design the exact nature of any subsequent changes. Family therapy, from this new perspective, becomes the collaborative creation of a context in which family members share their constructions of reality with one another in the hope that the new information thus obtained will facilitate changes in perceptions among the members. As new meaning is co-constructed in conversation, new options and possibilities emerge (Anderson, 2009).

This clinical effort to make family therapy more focused on creating meanings through language rather than on behavioral sequences or family interactive patterns was led by Paul Watzlawick (1984), Michael White (1989), and Lynn Hoffman (1990), as well as Harlene Anderson and Harry Goolishian (1988). Tom Andersen (1987), a Norwegian psychiatrist, employs an egalitarian technique he calls a *reflecting team*, in which a clinical team first watches a family and therapist behind a one-way mirror, then reverses roles and holds an open forum regarding what they have just seen while the family observes their discussion behind the one-way mirror. The idea is to offer various new perceptions to the family and for them to select those that appear to them to be meaningful and useful. The therapist team reflections are meant to stimulate new conversations within the family and ultimately, for each family member, to provoke greater understanding of oneself, one's surroundings, and one's relationships (Andersen, 1993).

In addition to gender and culture, family therapists are paying closer attention to spiritual and religious resources in the lives of their clients (Walsh, 2009). Spirituality and religion play important roles in all cultures as people seek a sense of purpose, meaning, and morality in their daily existence. In family assessment as well as therapeutic interventions, spiritual values, related or not to formal religious institutions, may be central in the lives of many families and may act as major determinants of family attitudes and beliefs.

Ecological Context, Multisystemic Intervention, and Evidence-Based Practice (2000s)

Many contemporary theorists and practitioners argue that every client is more than a member of a single group who can be summarized under a single label such as gay, elderly, divorced, Latino, or Black (Sexton, Weeks, & Robbins, 2003). Rather, each of us is a "multicultural person" who identifies with multiple groups with specific values and particular sets of experiences. They urge therapists to attend to both their client's and their own "ecological niche"—locating individuals and families in terms of race, class, religion, sexual orientation, occupation, migration experiences, nationality, and ethnicity.

Family therapy is broadening the meaning of context, moving beyond examining relationships within a family to add an ecosystemic view concerned with social systems in which families function in order to more fully understand the current diversity of family experiences. In order to do so, many family therapists are moving outside the consultation room and into the community, and they are taking their view of systems within systems with them into outside social agencies and organizations. For example, medical family therapy attempts to coordinate the dynamic relationships among patients, families, and healthcare providers (Ruddy & McDaniel, 2013). This is especially important under the Affordable Care Act.

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An additional challenge calls for better informing clinical practice with relevant research in evidence-based practice (Wike et al., 2014). Toward this end, researchers have begun to develop empirically supported psychological interventions, when feasible, in an effort to advance the scientific basis for clinical assessments and treatment. The goal of evidence-based practices goes beyond merely proving that family therapy works to address what change mechanisms most effectively lead to positive outcomes, with what client populations or sets of clinical problems, under what circumstances, and in what settings (Sexton & Kelley, 2010). All are useful for therapy planning with a specific family. The overall goal here is to improve the quality and cost effectiveness of such interventions and to enhance accountability by practitioners (APA, 2005).

The Core Competency Movement (2000–present)

The core competency movement emerged in renewed form in the 2000s as a way to define the knowledge, skills, and attitudes needed for responsible practice in healthcare disciplines (Kaslow, 2004). The field of family therapy lagged behind other fields in this process but has built upon those fields to create its own competency standards (Miller, Todahl, & Platt, 2010). There are many reasons for establishing core competencies, but most center on ensuring the quality and focus of education and training programs, demonstrating competence for ethical provision of specific therapeutic services, and qualification for reimbursement by insurance companies and government agencies or programs. See Box 5.5 for information on core competencies established by various family therapy organizations.

Today, numerous psychotherapists are competing in the marketplace of consumers looking for help. What distinguishes one from the other? It is important that therapists who offer couples and family therapy demonstrate that they have the competencies—gained by education, training, and experience—to do so (Patterson, 2009). Consumers can have a clearer sense of whom to approach for help with their problems. Practitioners can confidently offer specialties designed to help specific populations. Competencies also help a field develop more professional influence in society.

The achievement of competence in family therapy is developmental, accomplished through a process of growth over time. It begins with education and continues in applied training venues under supervision (Nelson et al., 2007; Nelson & Graves, 2011). Miller, Todahl, and Platt (2010) specify steps in the process:

1. Learn the core information of their field.
2. Experience the ongoing evaluation of their absorption of the material, with testing aimed at assessing overall retention.
3. Apply academic knowledge to the professional field. In family therapy, this means the application of coursework to clinical practice.
4. Undergo a period of mentorship and supervision that provides a source of direct observation, evaluation, and feedback.
5. Experience a "capstone" event that demonstrates overall professional ability.

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BOX 5.5 EVIDENCE-BASED PRACTICE

Core Competencies in Practicing Family Therapy

Various professional groups related to family therapy have developed competency standards.

AAMFT

The **AAMFT Marriage and Family Therapy** Core Competencies Task Force (AAMFT, 2004) identified six domains specific to family therapy competence:

- *Admission to treatment* (interactions with clients before establishing a therapeutic contract)
- *Clinical assessment and diagnosis* (identifying issues to be addressed in therapy)
- *Treatment planning and case management* (directing the course of treatment)
- *Therapeutic interventions* (activities to ameliorate the identified clinical issues)
- *Legal issues, ethics, and standards* (awareness of current statutes, regulations, values, and mores related to family therapy)
- *Research and program evaluation* (knowledge of systematic analysis of therapy and how to assess its effectiveness)

Six subdomains spell out what five processes are involved in acquiring the core competencies: conceptual skills, perceptual skills, executive skills, evaluative skills, and professional skills (Northey, 2005).

Couple and Family Psychology

Competencies for **couple and family psychologists** are defined in a book by Stanton and Welsh (2011). They describe the conceptual and scientific foundations needed for competence and then specify functional competencies (case conceptualization, assessment, intervention, consultation, family forensic psychology, supervision, and teaching) and foundational competencies (ethical and legal, diversity, interpersonal interaction, and professional identity). These were adopted by the American Board of Family Psychology (a division of the American Board of Professional Psychology) as measures to evaluate competency before issuing board certification in couple and family psychology. In this voluntary program, specific education, training, and experience with couples and families are required before candidates are eligible for certification. Candidates must demonstrate competence by providing descriptions of their work with a specific case and pass a rigorous oral examination in couple and family psychology.

CACREP

The Council for Accreditation of Counseling and Related Educational Programs (**CACREP**) accredits programs with a specialty in Marriage, Couple, and Family Counseling. The proposed 2016 standards require evidence of student development in Foundations (such as the history; theories and models; principles of wellness, education, and advocacy; assessment and case conceptualization from a systems perspective), Contextual Dimensions (such as counseling roles and settings; family assessment processes and instruments; diagnostic processes; human sexuality; aging and intergenerational influences; crisis and trauma; addiction; interpersonal violence; unemployment and socioeconomic status; career and gender; cultural factors, ethical and legal issues; practice and management issues), and Practice (systems theories for conceptualization and implementation of treatment; intervention strategies and techniques; fostering family wellness), all in the specific context of marriage, couple, and family counseling (CACREP, 2014).

While the successful completion of these steps is no guarantee of any given individual's ability to practice successfully, they go a long way toward ensuring that most practitioners do indeed achieve this goal. Use Box 5.6: Thinking Like a Clinician to evaluate your evolving competencies.

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BOX 5.6 THINKING LIKE A CLINICIAN

Developing Core Competencies

Use the following items to understand your core competency requirements to become a family therapist.

1. Which courses in your program are required? Why do you think they are required?	
2. Describe your required supervision experience. Identify three goals you hope to achieve in supervision.	
3. Identify the requirements for clinical experience that you need to graduate.	
4. Does your state require a license for you to practice? If so, go online and find the training requirements for licensure. Identify important goals you will need to reach.	
5. What organizations can you join to help support the efforts of the family therapy profession?	

SUMMARY

Five seemingly independent scientific and clinical developments together set the stage for the emergence of family therapy: *systems theory*, exploring how relationships among parts of a system make up an integrated whole; *schizophrenia research*, helping establish the role of the dysfunctional family in schizophrenia and setting the stage for studying interaction patterns in other kinds of families; *marital and premarital counseling*, bringing couples into conjoint treatment to resolve interpersonal conflicts rather than treating the participants separately; the *child guidance movement*, focusing on intervention with entire families; and *group dynamics* and *group therapy*, employing small-group processes for therapeutic gain and providing a model for therapy with whole families.

Stimulated by the research-oriented study of families with schizophrenic members, the family therapy movement gained momentum and national visibility in the 1950s. However, technique continued to outpace theory and research well into the 1970s. Innovative therapeutic techniques were introduced, including behavioral approaches to family-related problems. By then, the field was growing at a rapid rate, and a number of efforts aimed at self-awareness and self-evaluation were undertaken. Most noteworthy was the feminist critique of family therapy, challenging family therapy tenets that reinforced sexist views and stereotypical sex roles.

In the 1980s, marital therapy and family therapy became an all-but-unified field. Practitioners from a variety of disciplines made "family therapist" their primary professional identification when joining interdisciplinary organizations. A new epistemology, challenging the early cybernetic notions, gained

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attention. Medical family therapy was introduced, increasing collaborative efforts with physicians. Psychoeducational programs, especially with schizophrenics and their families, gained prominence, as did efforts to develop cultural competence in working with diverse ethnic groups.

The trend, begun in earnest in the 1990s, was away from strict adherence to "schools" of family therapy and toward integration. Today the constructionist paradigm concerns itself more with helping families examine their belief systems than with intervening in order to change their underlying structure or behavior patterns. At the same time, managed care has imposed limitations on the customary ways of practicing family therapy. Today's family therapists are paying closer attention to gender and cultural issues and to ecosystemic analyses as well as spiritual and religious considerations in the lives of their clients. Researchers, practitioners, consumers, and insurance company payers are seeking evidence-supported interventions in an effort to improve the quality and cost effectiveness of clinical services. These efforts are mirrored by the ongoing examination and revision of core competencies that ensure trainees and practitioners remain fully able to practice their profession. The establishment of core competencies also helps a field gain and deepen professional status and influence.

RECOMMENDED READINGS

Ackerman, N. W. (1958). *The Psychodynamics of Family Life*. New York: Basic Books.

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6

Professional Issues and Ethical Practices

LEARNING OBJECTIVES

- LO 1 Explain preparation for licensure and the importance of licensure for those who practice family therapy
- LO 2 Describe the managed-care system and how it influences the provision of family therapy
- LO 3 Define malpractice and discuss three specific types of malpractice in family therapy
- LO 4 Explain the purpose of professional organization ethics codes and discuss two ethical issues common in family therapy

In this chapter, we focus on the everyday issues of contemporary clinical practice, especially the following: (1) how to ensure the highest possible quality of professional competence at the least cost to society and (2) how to remain alert to ethical standards, particularly as practice shifts from the individual client to the family system as a whole.

Professional Issues

Therapists of all backgrounds face similar professional issues involving licensing and certification, the evaluation of work by peers, and interacting with managed-care organizations. This chapter introduces important aspects of each area. We hope this brief survey will stimulate curiosity about professional ethics, as there is not a day in clinical practice when ethical questions do not arise.

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LO 1 The License to Practice

Statutes in each state in the United States and in all Canadian provinces regulate professional practice (e.g., medicine, law, psychology, clinical social work, etc.). Many licensed professionals provide family therapy. Since 1970, there has been a concerted effort to set legal standards for credentialing marital and family therapists (MFTs). Licensure has become synonymous with professionalism (Wilcoxon, Remley, & Gladding, 2011), and reimbursements from health plans for providing clinical services are paid only to licensed providers. Several important premises support efforts at licensure (Corey, Corey, Callanan, & Corey, 2015). To summarize, licensure provides the following advantages:

- Protects the public by establishing minimum standards of service and holding professionals accountable if they do not measure up
- Helps consumers choose practitioners more judiciously
- Increases the likelihood that practitioners will be competent
- Makes mental health services more affordable, since clients going to licensed practitioners may be partly reimbursed by insurance companies
- Allows the profession to define itself and its activities more clearly, thus becoming more independent

Possessing a license, of course, does not ensure competency. Licenses are generic in that they do not specify what client problems the licensee is competent to work with nor what techniques he or she is trained to use. In the case of working with families, for example, a practitioner may be trained to work with individuals while lacking the experience or skills for family interventions. Ethically, that person should seek additional training and supervision before undertaking clinical work in a new modality (Patterson, 2009). In practice, however, the therapist accustomed to working with individuals may sometimes erroneously convince himself or herself of competence to provide family therapy without the necessary education, training, and awareness of new developments in the family field.

An individual seeking professional status to provide marital and family therapy may earn a graduate and/or professional degree from a university or obtain professional preparation at a center offering specialized training in marital and family therapy. A person who follows the academic route and has obtained the requisite training supervision in a program accredited by the appropriate professional association (APA, AAMFT, NASW, or CACREP) may seek either **licensing** or **certification** (according to the law governing practice in a particular state or province).

State licensing law, more restrictive than certification, regulates who may practice (e.g., licensed psychologist, licensed MFT, licensed clinical social worker, licensed professional counselor) by defining educational and experience criteria, administering qualifying examinations, and stating the conditions under which a license may be revoked (terminating the right to practice). A license restricts who may use the title (say, MFT or LCSW) and who may engage in practice (as a family therapist; Sweeney, 1995).

State certification law, a weaker and less comprehensive form of regulation, simply certifies who has the right to use a particular professional title. Such a law does not govern practice

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or define permissible activities but simply guarantees that the title (e.g., "psychologist") will be used only by people who meet the standards established by the law. Certification laws set up criteria for issuing and revoking certificates, monitoring practice, at least regarding use of the title. Less desirable than licensing, state certification may represent what advocates of a particular discipline are able to achieve in the state legislature, often because of opposition from other mental health occupations.

Regulatory boards and legislatures in many states have mandated the successful completion of specific **continuing education** (CE) courses (e.g., child abuse, human sexuality, chemical dependency, supervisory competence), plus requiring a minimum number of CE hours (attending lectures, conferences, workshops, local and national conventions) as a condition of renewing a license or certificate. These mandates are an effort to ensure that practitioners remain current in theory and practice, so they can offer the most up-to-date services (Nagy, 2005) and retrain if they wish to change areas of practice. Family therapists are most likely to attend annual meetings of the American Association for Marital and Family Therapy (AAMFT), the American Family Therapy Academy (AFTA), the Psychotherapy Networker Symposium, and the multidisciplinary American Orthopsychiatric Association (AOA) meetings, in addition to conventions of the major organizations (American Psychological Association, National Association of Social Workers, American Counseling Association).

After a slow start, licensing of MFTs proceeded swiftly in the United States. One reason for the lag in licensure was that some psychotherapy professions initially opposed an independent profession of marital and family therapy, seeing it as but a subspecialty of psychotherapy. However, MFTs argued that they are a separate profession and that university preparation in a mental health field generally does not sufficiently emphasize work with couples and families. Indeed, graduates of most programs should seek additional education and training in couple and family therapy if they wish to practice in the field. The subject remains controversial, touching on such professional issues as eligibility for third-party payments from health insurance plans to cover the treatment of marital or family dysfunction. Clearly, practitioners educated to work with individual clients need further training before working with families. On the other hand, some family therapists may lack the education and training to treat individuals.

Marriage and family therapy practice is now regulated in all 50 states plus the District of Columbia (West, Hinton, Grames, & Adams, 2013), and two Canadian provinces have regulatory bills. Requirements may vary between states, although all require that those licensed or certified as marriage and family therapists meet certain educational and clinical experience criteria, usually comparable to the standards for Clinical Membership in AAMFT. There were more than 50,000 licensed or certified MFTs in the United States and Canada in 2015, and their interests are represented by AAMFT (AAMFT, 2015).

Peer Review

Monitoring, examining, or assessing the work of one's colleagues or having one's own work reviewed by one or more colleagues is hardly new for anyone who has completed a training

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program in any of the disciplines involved in couple and family therapy. By the time someone has become a professional, she or he typically has presented work samples in numerous case conferences, as well as having been videotaped or observed through a one-way mirror working with families. No doubt, supervisors and classmates have dissected cases while in training. Having become a professional, a therapist may seek further consultation when therapeutic issues arise, in dealing with otherwise difficult or sticky clinical procedures, or whenever upcoming ethical decisions need scrutiny. Therapists in private practice often seek such self-regulating **peer review** and peer support by belonging to peer-consultation groups, in which they deal with problematic cases, discuss ethical and legal issues that arise, and exchange experiences to counter feelings of loneliness that are an inevitable part of functioning as a sole practitioner. Professional participation in a community of colleagues both sustains one's professional health or competence and contributes to the positive functioning of other therapists (Johnson & Freeman, 2014).

Peer review is also characteristic of publishing research in journals as a means to ensure the validity, meaning, and value of the work to the profession. Before accepting articles for publication, editors will ask professionals to evaluate them. Articles will be accepted or rejected based on the collective view of the reviewers. Typically, researchers provide in journal articles their hypothesis, the methodology they use to explore the hypothesis, the results, a discussion of the results, recommendations for further research, and conclusions. This process is designed to ensure that the profession receives the most valuable and properly researched information. It is generally viewed as an ethical responsibility for professionals to remain current by reading professional journals.

The journal-review process is itself subject to ethical evaluation. Brock, Whiting, Matern, and Fife (2009) note that the integrity of research in marriage and family therapy is threatened by a reported increase in the fabrication, falsification, and plagiarism occurring in research across all the sciences. These researchers claim that MFT professionals lag behind researchers from other disciplines in taking responsibility for the veracity of its research literature. They recommend that authors of published research state in writing that their data are valid, and they reveal any conflicts of interest that could possibly have influenced their hypotheses, methodology, and conclusions. They also suggest that the ethical code for the profession be expanded to include integrity training as part of a person's training and ongoing professional experience.

LO 2 Managed Care and Professional Practice

Managed care is the dominant economic force in healthcare delivery in the United States. It has a profound impact on the way therapists and clients interact. Managed care has forced psychotherapists to change professional billing practice from insurance carriers ("third-party payors") on a fee-for-service delivery basis to managed care. Employers, who pay the major portion of healthcare bills for their employees, want to control escalating costs (Wilcoxon, Remley, & Gladding, 2013). The Affordable Care Act is not fully understood, but the law requires coverage of behavioral health, which includes mental health and substance-abuse services. Family therapists who are educated and trained to work with covered issues in a

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systemic fashion with demonstrated effectiveness could benefit from the Act (Loewy, 2013). As of 2015, information on the subject can be found at www.HealthCare.gov/coverage/mental-health-substance-abuse-coverage.

Managed-care organizations contract with employers, insurance companies, or union trusts to administer and finance their health benefit programs. Increasingly, employers who offer health benefits have opted for managed-care programs—prepaid health insurance coverage in which, in addition to employer contributions, a fixed monthly fee is collected from each member enrolled who has voluntarily chosen to participate in a particular medical (including mental health) plan as a subscriber. Although marital and family therapy often is not covered by managed care, it may be if it can be shown that overall healthcare costs decrease or the client can be treated in a cost-effective manner in couple or family therapy (Crane & Christenson, 2012).

Managed care creates contracts between a therapist (usually referred to as a *provider*) or a group of therapists, and a *health maintenance organization* (HMO), a type of managed-care system. In exchange for being admitted into the provider network and agreeing to accept referrals by being part of the HMO roster, the professional agrees under contract to provide services for a previously negotiated fee (usually significantly lower than the customary rates of fee-for-service providers in the community) and to abide by the managed-care organization's explicit provisions. Managed-care groups believe that by monitoring practitioner decisions and insisting on time-limited interventions, they are increasing provider accountability and ensuring efficient and effective treatment. Critics argue that the quality of care is frequently sacrificed by organizational decisions based primarily on financial rather than clinical considerations (MacCluskie & Ingersoll, 2001).

In an attempt at cost containment, managed-care plans typically call for preauthorization before the therapist may begin treatment and further authorization after a previously approved number of sessions (with annual and lifetime cost caps). Typically, only a limited number of sessions per designated period are approved, and the client's choice of therapist is restricted to providers on the managed-care roster. Managed-care programs may limit services and require use of treatment manuals for short-term interventions.

Managed mental healthcare programs usually include a fixed number of mental health practitioners (individually or as part of a provider network); others are excluded when the panel of providers is full—a particular problem for newly licensed practitioners attempting to enter the field. Referrals are made to providers within defined geographic areas; in many plans, the practitioner must be available for emergencies on a 24-hour basis.

Whether a client can be seen, for how many visits, at what fee, covering what services, for what problems or conditions—all are negotiated with the managed-care organization. Peer reviewers or case managers (usually but not always professionals) act as "gatekeepers," carrying out *utilization reviews*, the conclusions of which often conflict with the practitioner's ideas about how best to manage the case. Such utilization reviews, ostensibly directed at determining the necessity and appropriateness of the practitioner's services, occur at regular intervals throughout treatment. They may thus represent an implicit threat of termination of benefits before the practitioner believes the client or family is

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ready to stop treatment. Justifying the continuation of treatment for an additional number of sessions often requires considerable supporting documentation or lengthy telephone conversations with a managed-care reviewer (Davis & Meier, 2001). It is the therapist's responsibility to explain why services are necessary and to account for procedures carried out; the lengthy paperwork and frequent reimbursement conflicts with reviewers are often a source of stress and potential burnout for clinicians with heavy managed-care caseloads (Rupert & Baird, 2004).

Many practitioners become frustrated with managed-care organizations because of the amount of paperwork required, the low fees received, and time spent arguing for payment. As a result, some opt out of the network. These therapists require that their clients pay them directly at an agreed-upon rate that can be negotiated and to assume their own responsibility in working with the managed-care or other insurance organization to possibly arrange for some coverage. Indeed, some organizations do offer subscribers some reimbursement for sessions with out-of-network providers, but the amount is generally less than it would be if the subscriber used an in-network provider.

Managed-care plans support short-term, directive, problem-solving therapy aimed at returning clients to previous levels of functioning (rather than optimal functioning; see Cummings, O'Donohue, & Cummings, 2011). These plans limit treatment to whatever it takes to return clients to a functional level as soon as possible but nothing more. A secondary goal is to prevent recurrence of the presenting symptoms. Just how much treatment is enough remains debatable, argued between case managers and therapists.

Most managed-care organizations require subscribers to sign an information release form, permitting their therapist to disclose private information ordinarily kept confidential. Thus, while the therapist traditionally seeks to protect the clients' privacy, as an HMO provider, he or she is called upon to share information—diagnosis, types of services provided, duration of treatment—that compromises all previously determined ideas regarding **confidentiality**. Because therapists can no longer assure clients of confidentiality, clients may withhold vital information from the therapist or, in more extreme cases, refuse to seek treatment when needed (Acuff et al., 1999).

The current challenge involves training therapists in time-limited interventions and engaging family therapists in outcome research that measures clinical effectiveness and cost effectiveness (Crane & Christenson, 2012). Managed care requires therapists to reexamine their professional ethics, rethink how best to allocate professional resources, account for what they do with clients, and develop short-term effective interventions.

LO 3 Legal Liability

Every practitioner is exposed to the possibility of financial liability—the possibility that the therapist intentionally or unintentionally harmed a client in some specific manner and consequently may be financially accountable. While such suits are still relatively rare, there remains the possibility, especially in an increasingly litigious society, that clients may file a legal malpractice suit against a therapist for one or more of the following reasons: breach of confidentiality, sexual misconduct, negligence, breach of contract (regarding such items as

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BOX 6.1 EVIDENCE-BASED PRACTICE

The Movement toward Evidence-Based Practice

One positive result of managed care's effort to require brief but efficient therapeutic intervention has been the need to develop techniques and procedures of proven effectiveness with specific sets of client problems. Although researchers in medicine, psychology, and other health-related professions focused on the problem of establishing a scientific base for clinical practice for decades, it came into prominence in the 1990s, in part due to the pressures exerted by managed-care programs. Chambless and her associates (1996, 1998) first provided criteria for identifying empirically validated treatments for psychological disorders. Greeted enthusiastically by some as the best demonstration of the scientist-practitioner model long advocated in clinical psychology and as the most ethical way to practice, it also had its detractors, who criticized any reliance on standardized treatment manuals as simplistic and mechanistic. Opponents also decried its early exclusive focus on specific treatment techniques as opposed to common factors, such as the therapeutic relationship, that account for much of the variance in outcomes across various disorders and its initial lack of attention to ethnic, race, or cultural factors (APA, 2005).

Evidence-based practice in psychology addresses "what works for whom" (Roth & Fonagy, 2005). That is, what specific clinical interventions have been shown through research to be most effective with what specific problems or diagnoses (Deegear & Lawson, 2003)? As Norcross (2011) observes, such interventions are most likely to be effective if they attend to the client's specific problems but also the client's strengths, personality characteristics, and sociocultural context. Such variables as age, gender identity, race, religious beliefs, and sexual orientation must also be taken into account, further complicating the task. The development of evidence-based treatments calls for therapists to be up-to-date on research findings, as these treatment methods may well represent the future trend in individual and family therapy.

fees, promised availability), failure to protect clients from a dangerous person's conduct, or even for exercising undue influence over a patient. Bringing such charges into civil court, the client or family may sue for compensatory damages (compensating them for their loss) as well as punitive damages (punishing the therapist for reckless, wanton, or heinous behavior); see Wilcoxin, Remley, and Gladding (2013).

Malpractice, either deliberately or through ineptitude or carelessness, is the most likely form of alleged wrongful behavior to produce client litigation. Here the therapist is accused of failing to render professional services or exercise the degree of skill ordinarily expected of other professionals in a similar situation (Corey, Corey, & Callanan, 2015). That is, professional negligence is said to have occurred; the claim is that the therapist departed from usual practices or did not exercise sufficient care in carrying out her or his responsibilities. (One important note: Practitioners are not expected always to make correct judgments or predict the future, but they are expected to possess and exercise the knowledge, skills, and standards of care common to members of their profession.)

If therapists are sued for malpractice, they will be judged in terms of actions appropriate to other therapists with similar qualifications and duties. However, even if a suit fails and the therapist is exonerated, he or she has inevitably invested considerable time and money and experienced considerable distress in mounting a defense.

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Common types of malpractice suits include the following (Pope & Vasquez, 2010):

- Failure to obtain or document **informed consent** (including failure to discuss significant risks, benefits, and alternative procedures) prior to commencing treatment
- Misdiagnosis
- Practicing outside one's area of competence
- Negligent or improper treatment
- Abandonment of a client
- Physical contact or sexual relations with a client
- Failure to prevent dangerous clients from harming themselves or others
- Failure to consult another practitioner or refer a client
- Failure to adequately supervise students or assistants

One common ground for a malpractice suit is sexual contact (Pope & Vasquez, 2010), and many states have now declared such activity to be a felony. As attorneys Stromberg and Dellinger (1993, p. 8) note, "for therapists who have engaged in sexual intimacies with patients, a *finding of liability against the therapist is highly likely*" (italics theirs). All mental health professional ethics codes prohibit sexual contact with clients (ACA, APA, NASW, AAMFT; Welfel, 2013). Any initial consent by the patient is not a defense, since it is assumed that the client may be experiencing emotional distress, feel low self-esteem, and thus be in a position of greater vulnerability to sexual exploitation than under normal circumstances. A history of emotional or sexual abuse may increase vulnerability and compound the subsequent damage inflicted (Pope & Vasquez, 2010).

Under such circumstances, the courts reason that refusing the overtures of an unscrupulous therapist, whose motives the client wants to trust, may be difficult—especially if the therapist labels such advances as "therapeutic" for relieving the client's problems (Welfel, 2013). Such clients are likely to experience impaired ability to trust, confused roles and boundaries, emotional lability, suppressed rage, ambivalence, increased suicide risk, and cognitive problems (Pope & Vasquez, 2010). If the therapist is found guilty by the court, the likelihood of a suspended or lost license is substantial, as is the probability of losing a malpractice suit with major financial consequences (Welfel, 2013).



BOX 6.2 CLINICAL NOTE

Avoiding Malpractice

Ways of avoiding a malpractice suit include keeping accurate and complete records of treatment plans, following informed-consent procedures, protecting confidentiality of client records to the extent possible, consulting with colleagues when in doubt, operating within the area in which one was trained or studied later in order to maintain a level of competency, taking professional responsibilities seriously and not abandoning a difficult or frustrating case, making referrals when appropriate, and making certain that clients will be seen in emergency situations when the therapist is away.

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Beyond lawsuits for sexual misconduct, claims of malpractice are likely to involve participating in nonsexual dual or multiple relationships (such as going into a business venture with a client) or performing incorrect treatment (incompetence in choosing a treatment plan; see Pope & Vasquez, 2010). Failure to prevent suicide by a client and breaches in confidentiality are also frequent causes for malpractice suits (Welfel, 2013). Assessing the risk of suicide typically involves inquiring about previous suicide attempts, about thoughts or impulses regarding killing oneself, prior incidents of self-harm, the development of a specific suicide plan, or a family history of attempted or completed suicides (Baerger, 2001).

In general, for a malpractice suit to succeed, four elements must be present: (a) a professional relationship existed so that the therapist incurred a legal duty to care; (b) there is a demonstrable standard of care that was breached when the practitioner performed below that standard; (c) the plaintiff suffered harm or injury, physical or psychological; and (d) the professional's breach of duty due to negligence or injurious actions was the direct cause of the harm done to the plaintiff. The plaintiff must prove all four elements exist in order to win the malpractice litigation (Shapiro & Smith, 2011). Corey, Corey, and Callanan (2015) offer this example: In the case of suicide, could a practitioner have foreseen the suicide risk (based on a comprehensive risk assessment and documented findings), and did he or she take reasonable care or precautions, again well documented, to prevent the self-destructive act? Liability arises if the therapist failed to act so as to prevent the suicide or did something that contributed to the suicide attempt.

Professional liability insurance is necessary for all family therapists (unless the organization for which they work carries malpractice insurance covering them). Most professional organizations, such as the APA, the NASW, and the AAMFT, offer group professional liability (malpractice) insurance for purchase by their members.

Therapists are also called into court to be witnesses in cases that involve clients. In these instances, the therapist is not the target of a suit but a participant providing testimony in support of someone else's suit. Marriage and family therapists might, for example, be called to court by divorcing parents suing each other for child custody to testify about a child's home environment, the quality of her or his emotional development, the emotional stability of one or the other parent, and on various custody practices. In some of these instances, the therapist may face having to reveal confidential information. Woody (2007) notes four typical scenarios that might involve a therapist in court proceedings:

- To report abuse
- As a court-ordered witness testifying about relevant legal issues before the court
- As an expert witness to offer professional opinion, based on knowledge of behavioral science research and typical professional recommendations
- As a child custody evaluator

These situations may lead to ethical considerations on the part of the therapist. The first instance—to report abuse—does not generally raise ethical issues, as the law explicitly commands the therapist to report abuse. Sometimes an ethical issue arises in the other cases as, for example, when a therapist who had been called to court as a "fact witness" to provide general information about research or typical professional practice is also asked to provide opinions

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about a case. There might be a tension between providing facts on the one hand and personal professional opinion on the other. As Woody (2000) advises, when the therapist has to decide "whether or not to issue an opinion about an ultimate legal question, the mental health practitioner should consider the empirical research that in fact exists; and without a substantial amount of research directly applicable to the question, the mental health practitioner should readily admit that his or her opinion, although steeped in knowledge about human behavior in general, would not be an expert opinion" (p. 129).

As a general guideline, it is best when the therapist states a position regarding his or her willingness to go to court prior to beginning therapy with a couple contemplating divorce or anticipating a child custody conflict. A therapist who is forthright about not choosing sides in a possible court battle or competent as a forensic expert to appear in court allows the couple to choose another therapist before starting treatment if they so desire. Should they decide to remain, establishing such neutrality at the beginning of the relationship may keep later conflict to a minimum.

Maintaining Ethical Standards

Beyond legal regulation through licensing or certification, professions rely on self-regulation through a variety of procedures—state-mandated continuing education as prerequisite for license renewal, peer review, consultation with colleagues, and so forth—to monitor the professional activities of their members. Codes of ethics offer standards whose potential violation may provoke both informal and formal discipline (Wilcoxon, Remley, & Gladding, 2013). The former involves peer pressure exerted upon violators through consultations regarding questionable practices; the latter may involve censure by professional associations, in some cases barring violators from continued membership.

LO 4 Professional Codes of Ethics

Every major organization devoted to providing psychotherapy has its own code of ethics to guide professional practices and uphold professional standards (e.g., AAMFT, 2015; APA, 2010; NASW, 2008). These codes are periodically updated as community standards and technologies evolve (such as electronic records or therapy offered over the Internet). Beyond those codes, governmental regulatory agencies, state licensing boards, specialty organizations, and local professional associations offer their own guiding principles for acceptable professional conduct. The national organizations also publish recommendations for working with specific populations (e.g., guidance on cultural diversity, on gay and lesbian clients, on accurate record keeping). Each organization typically has an ethics committee to monitor the conduct of its members, protects the public from unethical practices, and considers alleged violations of its code by one of its members.

Should an ethics committee, in response to a colleague or client complaint, determine that a practitioner has violated the code of ethics of the profession, a range of sanctions may be imposed. Generally, the degree of seriousness of the violation is the major determinant of the level of sanction an ethics committee might impose. Code violations range from behavior reflecting poor judgment compared with prevailing standards but without malicious intent (e.g., advertising infractions; inappropriate public statements), which calls for educative resolutions, to those cases

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where substantial harm to others has resulted from the practitioner's behavior, and that person is not prone to rehabilitation (defrauding insurance carriers; sexual exploitation), which calls for expulsion from the professional organization. Ethics committees may be lenient toward a nonmalevolent first offender, ordering an educative solution; that same offense, committed repeatedly by an experienced but recalcitrant practitioner, would be met with more severe sanctions.

Ethical codes define standards of conduct subscribed to by members of the profession, aiding members in their decision making with clients whenever possible areas of conflict arise. Members pledge to abide by a set of ethical standards that helps reassure the public that they will demonstrate sensible and responsible behavior (Woody & Woody, 2001). The codes do not cover all situations but offer general guidelines for responsible behavior. As Fisher (2012) notes, the competency and judgment gained through education, training, supervision, experience, and consultation with colleagues represents the linchpin for fulfilling one's ethical responsibilities.

Table 6.1 provides an overview of the major sections of the ethics codes of four major professional organizations related to family therapy for your comparison.

Ethical Issues in Couples and Family Therapy

Some unique and complex ethical issues arise as therapy shifts from an individual focus to one that involves a couple and family system. For example, to whom and for whom does the therapist have primary loyalty and responsibility? The identified patient? The separate family

TABLE 6.1 Overview of organizational ethics codes

AAMFT	ACA	APA	NASW
Preamble	Preamble & Purpose	Preamble & General Principles	Preamble, Purpose, Ethical Principles
Responsibility to Clients	The Counseling Relationship	Resolving Ethical Issues	Ethical Responsibilities to Clients
Confidentiality	Confidentiality and Privacy	Competence	Ethical Responsibilities to Colleagues
Professional Competence and Integrity	Professional Responsibility	Human Relations	Ethical Responsibilities in Practice Settings
Responsibility to Students and Supervisees	Relationships with Other Professionals	Privacy & Confidentiality	Ethical Responsibilities as Professionals
Research and Publication	Evaluation, Assessment, and Interpretation	Advertising and Other Public Statements	Ethical Responsibilities to the Social Work Profession
Technology-Assisted Professional Services	Supervision, Training, and Teaching	Record Keeping and Fees	Ethical Responsibilities to the Broader Society
Professional Evaluations	Research and Publication	Education and Training	
Financial Arrangements	Distance Counseling, Technology, and Social Media	Research and Publication	
Advertising	Resolving Ethical Issues	Assessment	
		Therapy	

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members as individuals? The entire family? Only those members who choose to attend family sessions? Suppose different family members have conflicting goals or conflicting self-interests. Is the primary goal one of increasing family harmony or maximizing individual fulfillment (Wilcoxon, Remley, & Gladding, 2013)?

To address the multiple interests of family members, Wilcoxon and colleagues (2013) suggest the therapist focus treatment on the family system rather than acting as an advocate of any one member or group of members. At the same time, these authors urge therapists to assist families in negotiating among the values they collectively wish to conserve, modify, or reject in the interest of fairness and family harmony.

Most family therapists struggle at one time or another with the ethical dilemma of family needs versus individual needs. More than academic hairsplitting is involved here. Early feminist thinking represented by Hare-Mustin (1980, p. 935) warned that "family therapy may be dangerous to your health"; that is, the changes that most benefited the entire family were not always in the best interests of each of its members. Hare-Mustin was especially concerned that therapists might influence female family members to subjugate their individual rights for the sake of family needs, further perpetuating society's oppressive gender roles. Margolin (1982) too was concerned that family therapists might endorse—and thus perpetuate—some familiar sexist myths concerning women: that remaining in a marriage is usually best for women, that a woman's career deserves less attention than her husband's, that child rearing is a mother's sole responsibility, and in general that a husband's needs are more significant than a wife's. Now three decades after these warnings, one would hope that family therapists have become more gender sensitive and informed and are better trained from the start to address gender issues.

Ethical issues may also arise in working with families from ethnic backgrounds whose values would appear to conflict with those articulated by the profession. Cole (2008, p. 425) asks, "[H]ow do therapists deal with the dialectic between doing what they are trained to do in their profession versus doing what is culturally appropriate and potentially most beneficial for clients?" She offers the example of a Latino family who, deeply valuing family connections, asks the therapist to their home for dinner and to meet extended family members. Professional ethics, she notes, would strongly caution against accepting the invitation, but to decline would be to risk losing the clients' trust and damaging the relationship with them. She offers as a possible solution the notion that since the therapist–client relationship is a value of paramount importance in all therapy relationships, this clinical and theoretical dimension should be included in any conceptualization of multicultural competency. She also suggests that therapists maintain a respectful curiosity and a professional openness and receptivity to cultural difference. And finally, her view is to allow the client's worldview to have greater influence on our interpretations and constructions of our ethics and theory.

Family therapists inevitably engage in an active valuing process with families, whether intentionally or not. Wilcoxon and colleagues begin their text on ethical issues in marriage and family therapy with a chapter on values as the context for therapy (2013). They maintain that family therapists take value positions continually in their thinking as well as in their interventions with families. As the authors put it, values permeate ethical decision making throughout life and become our life context. For therapists, as for everyone else, values are the cherished beliefs and preferences that guide human decisions.

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Because specific therapist values (attitudes toward divorce, extramarital affairs, nontraditional lifestyles, cross-cultural issues, gender-defined roles in the family or society at large) may be enormously influential in the process of marital or family therapy—guiding decision making—therapists must examine their own attitudes closely. The danger here is that the therapist might be biased against families whose attitudes, culture, and sexual orientation differ from his or her own or might side with one family member (say, a father) against the behavior and stated attitudes of other members (an adolescent), not by situation but by identification with being a parent. In another scenario, a family therapist—deliberately or unwittingly, consciously or unconsciously—may attempt to sustain a failing marriage when one or both partners wish to divorce.

Whether the family therapist's values are such that he or she chooses to be responsible to the individual as opposed to, say, the marriage may have significant consequences. To cite a common problem described by Bodin (1983), suppose a husband is contemplating divorcing his wife, an action his wife opposes. The husband may feel his individual happiness is so compromised by remaining in the marriage that he hopes the therapist attaches greater importance to individual well-being than to maintaining some abstraction called the "family system." The wife, on the other hand, hopes the therapist gives higher priority to collective well-being, helping individuals adjust their expectations for the sake of remaining together. Many therapists caught in such a situation take the position that a strife-torn marriage all but guarantees unhappiness for everyone, including the children. Others argue that the stress and uncertainty of separation and divorce may do damage to the children, and thus the maintenance of family life, imperfect as it is, is preferable to the breakup of the family. As Bodin observes, the therapist's position may have a profound impact not only on the rapport established with the various family members but also on the therapist's formulation of the problems, goals, and plans for treatment.

How should therapists deal with family secrets? Should parental secrets (e.g., sexual problems) be aired before the children or be brought up in a separate couple's session? How should an extramarital affair—hidden from the spouse but revealed to the therapist in an individual session—be handled by the therapist? What about family secrets—incest between the father and teenage daughter or inferred physical abuse of the wife or young children or child neglect? Here the therapist has legal responsibilities that supersede confidentiality; he or she must report the suspicion of abuse or neglect to the police or child welfare authorities, even in the absence of proof. In such a situation, the therapist must carefully observe family interactions, formulate an ethical course of action, and take steps to ensure the safety and well-being of family members. See Box 6.3 for a case example of a therapist dealing with information that needed to be reported.

Undertaking therapeutic work with a family, then, poses a variety of complications with respect to the therapist's professional responsibilities. The help offered to one family member may temporarily deprive or disturb another, especially in a rigid family system. A preference for one or the other spouse implies favoritism and, potentially, the loss of necessary impartiality. Margolin (1982) makes the following observation:

> Attempting to balance one's therapeutic responsibilities toward individual family members and toward the family as a whole involves intricate judgments. Since neither of these responsibilities cancels out the importance of the other, the family therapist cannot afford blind pursuit of either extreme, that is, always doing what is in each individual's best interests or always maintaining the stance as family advocate. (p. 790)

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Confidentiality

When a client enters a professional relationship with a therapist, the latter takes on the ethical responsibility of safeguarding the former from revealing what was discussed during the therapeutic relationship. Confidentiality, protecting the client from unauthorized disclosures of personal information by the therapist without prior client consent, has long been a hallmark of individual psychotherapy. Its rationale is based on encouraging clients to develop the trust necessary for them to make full disclosures without fear of exposure outside the consultation room.

In marital and family therapy, some therapists take the position that they must ensure that information given to them in confidence by a family member will be treated as it would be



BOX 6.3 CASE STUDY

A Therapist Reports Parental Abuse

Ned, Alice, and their four children all appeared to be living a happy, upper-middle-class life in a large western city. Ned was a successful attorney, a partner in a national firm, and Alice, a stay-at-home mom, was busy raising their children, ages 4 to 10, and actively involving herself in their school activities. Beneath the surface impression, however, the couple was engaged in an ongoing destructive interaction with one another that permeated the entire family system.

The most obvious sign of disturbance, and the ostensible reason they contacted a family therapist, was the difficulty both parents were having with Brandon, their oldest son, whom they described over the telephone as "obstinate and defiant." The therapist asked to see all six family members, and they agreed to participate. The parents signed an informed-consent form, which included the therapist's obligation to report a case of child abuse, should that be discovered.

Initially undisclosing for several sessions, the children ultimately began describing the daily battles at home, especially between Alice and Brandon. Soon Ned chimed in, backing up what the children had reported and indicating he had been afraid to bring it up because he feared his wife's wrath. One particularly egregious event, all five agreed, involved Alice locking the boy out of the house, in the winter cold, for 4 hours because he refused to take a bath. That event, according to Alice, represented her desperation after a series of conflicts over Brandon's "misbehavior." When the therapist asked Ned where he was during the melee, all he could reveal was that he was frightened and withdrew to his study.

The therapist believed both parents were involved in child abuse, Alice through her rage and Ned through neglect. She told the couple she would have to report it to Children's Protective Services, which enraged Alice but was accepted by Ned. After consulting the therapist, that agency recommended anger management and a parent training class for Alice. Ned also was ordered to take these classes, since his suppressed anger seemed to have led to his withdrawal and ineffective parenting.

Ned and Alice acknowledged that there was abuse in the family and that their unexamined life as a couple required scrutiny. They agreed that the therapist had been tough on them but that she was fair and impartial and that they would continue to see her as a couple to try to deal with their long-brewing issues. Together, the three worked on how the family system sustained the abuse and needed change.

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BOX 6.4 CLINICAL NOTE

Computer Technology and Confidentiality

The increasingly common use of computers to store case notes, psychological test results, and patient financial records makes those records vulnerable to theft, duplication, or loss of privacy when others have access to the files and thus calls for extraordinary efforts to protect confidentiality (Sampson, Kolodinsky, & Greeno, 1997). The exchange of information regarding clients through e-mail, text messages, facsimile machines, voice mail, answering machines, cell phones, and so on runs similar risks.

In most clinic or hospital situations today, where computers are networked, data that can be retrieved by a variety of viewers are often coded (e.g., Clarence Jones, Social Security number 123-45-6789, becomes J6789), and files backed up separately. Pseudonyms may replace actual names. Encryption reduces the risk of unauthorized access to e-mail communications (Welfel, 2013).

The national Health Insurance Portability and Accountability Act (HIPAA) represents an effort by congress to protect the security and confidentiality of health information transmitted by practitioners over electronic networks to managed-care agencies. The HIPAA, requiring therapist compliance, is primarily directed at protecting patient privacy by requiring the patient's permission to release personal data. In addition, for security purposes, the law mandates that the therapist perform a risk analysis of his or her practice by documenting that computer systems are secure and accessible only to authorized persons. As part of that analysis, each practitioner must review routine practices to prevent unintended or inappropriate disclosures through breaches in security when transmitting confidential information in electronic form for healthcare claims.

in individual therapy and thus not be divulged to a spouse or other family member (although the therapist may encourage the individual to share his or her secret in a subsequent conjoint session). Other therapists, in an effort to avoid an alliance with a family member, refuse to see any member separately, in effect insisting that secrets be brought out into the open to the marital partner or family in sessions together. Still other therapists, if they individually see—or talk to by telephone or receive a written message from—a family member tell the informant beforehand that whatever is divulged may be communicated to the others if in the therapist's judgment it would benefit the couple or family. Whatever the procedure, it is essential to ethical practice that the therapist makes his or her stand on all aspects of confidentiality clear to each family member from the outset of therapy.

Confidentiality is intended to ensure the right to privacy, and a therapist is ethically obligated to refrain from revealing private client information obtained in therapy unless given client authorization to do so. However, there are exceptions in which confidentiality can be breached (Corey, Corey, & Callanan, 2015):

- When mandated by law, as in reporting child abuse, incest, child neglect, or elder abuse
- When necessary to protect clients from harming themselves or when they pose a danger to others

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BOX 6.5 CLINICAL NOTE

Limits of Confidentiality

Confidentiality represents a clinical responsibility that must be maintained unless circumstances demand disclosure to protect the welfare of a client or the public at large. Those extenuating circumstances include the following situations:

- When a client gives informed consent for disclosure
- When a therapist is acting in a court-appointed capacity
- When there is a risk of suicide or some other life-threatening emergency
- When a client initiates litigation against the therapist
- When a client's mental health is introduced as part of a civil action
- When a child under the age of 16 is the victim of a crime
- When a child requires psychiatric hospitalization
- When a client expresses intent to commit a crime that will endanger society or another person (duty to warn)
- When a client is deemed to be dangerous to him- or herself
- When required for third-party billing authorized by the client
- When required for properly utilized fee-collection services

Source: Falvey (2002), p. 93.

- When the family therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy
- When a waiver has previously been obtained in writing

If the therapist should use material about a family in teaching, writing, or lecturing, he or she is obligated to preserve the clients' anonymity. As we observed earlier in this chapter, the increased use of third-party payors for therapeutic services often calls for disclosure of personal information to an insurance company or managed-care organization. This loss of privacy may become a therapeutic issue—clients holding back information—when peer reviews or utilization reviews of therapeutic procedures require therapists to inform clients that some information may be revealed (Miller, 1996). Box 6.5 presents a list compiled by Falvey (2002) regarding the limits of confidentiality.

The duties of protecting clients from harming themselves and protecting others from potentially dangerous clients are especially important professional responsibilities (Ahia, 2012). In the former, therapists must intervene—call in family members and/or the police or get the client to a hospital emergency room—if they believe a client is seriously considering suicide. A therapist who determines that there is clear and imminent danger to someone the client vows to harm must take personal action and inform the responsible authorities; the therapist also has a *duty to warn* and protect the intended victim, because the courts have ruled (*Tarasoff* decision) that "the rights of clients to privacy end where the public peril begins" (Welfel, 2013, p. 130). Adopted in California in 1976, the ruling has become a national standard of practice (Falvey, 2002).

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However, in practice it often poses a serious dilemma for therapists—how to determine when a client is sufficiently dangerous to an identifiable victim (not just letting off steam about someone) that reasonable steps to warn that person must be taken, thus breaching confidentiality (Bersoff, 2014). While no therapist is expected to make perfect predictions of calculable danger, care is necessary in making the assessment of risk to a potential victim; good written records should be kept, and discussions with supervisors, consultants, or even attorneys are advisable (Monahan, 1993). Some states protect therapists from malpractice lawsuits for breaching confidentiality if they can establish having acted in good faith to protect third parties (Welfel, 2013).

Similarly, mandatory reporting laws, while they differ from state to state, all require therapists to disclose suspicions of incest or child abuse to the proper child protective agency. A therapist is held liable for failing to do so if he or she has reason to suspect (or a child discloses) abuse or neglect. Once again, states provide immunity from civil lawsuit for reporting suspected abusers. Sometimes problems arise because the therapist has previously failed to inform clients of this limitation on confidentiality (Nicolai & Scott, 1994), and sometimes therapists, in violation of the law, choose not to report suspected abusers for what they consider to be therapeutic reasons (Kalichman & Craig, 1991). The limits of confidentiality should be spelled out by the therapist at the start of therapy, lest family members agree to proceed while operating under wrong assumptions.

Informed Consent

Matters of informed consent and the right to refuse treatment have become critical ethical issues in the practice of marital and family therapy. Most family therapists agree that before families enter therapy, they must be adequately informed concerning the nature of the process they are about to undertake (Haas & Malouf, 2005). The purposes of the sessions, typical procedures, risks of possible negative outcomes (divorce, job changes), possible benefits, costs, what behavior to expect from the therapist, the limits of confidentiality, information provided to third-party payors, the conditions that might precipitate a referral to another therapist or agency, available alternative treatments—these issues all require explanation at the outset, before each client agrees to participate. Many clinicians ask their clients to sign an informed consent form to ensure that clients understand and agree to these various requirements. Two principles are operating here (Welfel, 2013)—full disclosure by the therapist so the client can decide whether to proceed and free consent (deciding to engage in an activity without coercion or pressure). In some cases, therapists provide written documents ("Patient's Rights and Responsibilities") to accompany their oral presentations, to be read, signed, and retained for future reference.

How should a therapist deal with family members who refuse treatment? Doherty and Boss (1991) focus on the issue of *coercion* regarding reluctant adults or children, as in the case in which therapists insist that all members attend before family therapy can get under way. Willing members are thus in a position of being coerced by denying them access to treatment unless they successfully persuade the others to participate. They suggest that a therapist with such a policy would do well to have a list of competent referral sources to which the family members willing to take part might go for help.

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Children present another thorny issue. Family therapists need to inform children, at the child's level of understanding, what is likely to transpire in family therapy and then ask for their consent to participate. Consent should also be obtained before videotaping, audiotaping, or observing families behind a one-way mirror. The issue of informed consent is important and aligns with concerns for patient and consumer rights.

The advent of **e-therapy**, therapy that involves the use of the Internet or SMS texting, has implications for informed consent. For some, the question of whether to even use the Internet for therapy is an ethical question; those who do must address related matters involving informed consent. Initial research indicates some effectiveness with telemental health services, and family therapists are just beginning to use various forms of e-communication as part of therapy (Hertlein, Blumer, & Smith, 2014). To limit one's liability and to protect the client, e-therapy providers are advised to disclose both the possible risks and benefits and engage with the client in an active dialogue about both (Recupero & Rainey, 2005). A thorough and informed consent procedure enables the client to make an educated decision about whether to engage in e-therapy. The procedure should include a discussion of the therapeutic risks and benefits, the security risks regarding online confidentiality, and, for the therapist, any licensure limits, such as providing services to clients in another state.

Questions of the confidentiality of online therapy increasingly are extending to the growing networks of digital medical record keeping (Richards, 2009). Mental health practitioners who work as part of a multidisciplinary team in institutional settings may be expected to maintain their notes within an electronic system. Clearly, the system immediately broadens the limits of what ethically constitutes confidentiality, since people other than the therapist and the client have access to the client's file. On the one hand, confidentiality as it has previously been understood and practiced by therapists may seem compromised by allowing this type of access; but on the other hand, since some treatment protocols increasingly appreciate the prospect of enhanced positive outcomes from working in a team (Atwood, 2000), such access may be warranted.

Privileged Communication

Privileged communication offers clients even more protection from forced disclosure of private matters discussed with their therapist than does confidentiality. A legal right to privacy, privileged communication protects a client from having prior confidences revealed by a therapist from the witness stand during court proceedings without his or her prior consent (Glosoff, Herlihy, Herlihy, & Spence, 1997). Thus, therapists cannot be forced to produce client records in court, or in general to answer questions about private matters revealed to them by clients, without client permission. However, since the privilege belongs to the client, the client's waiving that privilege of privacy leaves the therapist with no legal grounds for withholding the information.

All states have some form of therapist–client privilege statute, although the specific details vary by state. The issue, however, is less clear in couple or family therapy; indeed, these therapeutic activities are not subject to privileged communication in many states (Corey, Corey, & Callanan, 2015), and clients and therapists alike need to be informed of their state's laws

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regarding both confidentiality and privileged communication at the start of treatment. One sticky problem is, exactly who is the client: the individual, the couple, the family? In the case of a divorcing pair, suppose one spouse seeks testimony from the therapist while the other does not wish the information revealed?

Generally speaking, the therapist, careful about protecting client privacy, should always demand permission in the form of a written release from a client before revealing any information to others. In the case of suspected child or elder abuse, however, the law mandates that therapists report their suspicions, and the rules regarding privileged communication do not apply.

Maintaining Professional Competence

Whether a novice or widely experienced in working with couples and families, all therapists need periodic upgrading of their clinical skills. Continuing education is required to keep abreast of new developments in the field, for example, neuroscience (Celano, 2013), and multicultural approaches to therapy (Rober & DeHaene, 2014), and new populations served (undocumented immigrants, substance abusers, the homeless). Belonging to professional organizations, attending lectures at local and national conventions, taking workshops, consulting with colleagues, keeping up with family therapy clinical and research literature—all are part of the lifelong learning needed to remain a competent professional.

Exceeding the bounds of one's competence and experience in assessing and treating marital or family problems is considered unethical. Therefore, therapists must know the boundaries of their own competence and refer to fellow professionals those clients who require services beyond the therapist's professional training or experience. Reaching a prolonged therapeutic impasse with a family should also alert a therapist that a reassessment is in order and that a referral or a consultation with a peer who has expertise in the particular troublesome area might help move the therapeutic process forward.



BOX 6.6 CLINICAL NOTE

Termination of Therapy

Evidence-based practice has helped clarify best practices based on empirical research. What happens, however, when there is insufficient empirical evidence with which to identify and justify a specific protocol? Rappleyea and colleagues (2009) have asked, for example, how to ethically terminate therapy when there is scant empirically based information with which to establish best practices.

All therapeutic relations move toward termination, yet, as the authors note, there is little research on the topic, especially in the marriage and family literature. Further, the authors caution that in the current environment of evidence-based practice and increased malpractice litigation, therapists need to consider this important aspect of therapy. After searching the literature across a range of mental health fields, the authors note that there is no universal agreement about how to handle terminations, whether initiated by the client or by the therapist.

Developing a professional attitude that includes ethical thinking about every aspect of professional activity can help individual therapists address how to handle problems for which there are as yet no established standards for practice.

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Clients with whom therapists experience serious and irresolvable conflicts in values should also be directed to other therapists competent to deal with their problems. Even highly experienced family therapists seek the input of a consultant for purposes of verifying diagnostic impressions or confirming therapeutic strategies. In addition, psychiatric consultants may be called upon for medication evaluation (e.g., antidepressant drugs) or to hospitalize a client if the family therapist lacks hospital privileges or has not dealt with hospitalization in his or her training.

In this chapter, we have addressed some of the key areas of ethics and professional issues. We have only scratched the surface, as conditions emerge every day that require these considerations. Box 6.7: Thinking Like a Clinician offers some ethical dilemmas that therapists routinely face. Think about these and others that occur to you as a way to enhance your awareness of what constitutes an ethical and professional career.



BOX 6.7 THINKING LIKE A CLINICIAN

Ethical and Professional Dilemmas

Read each of the following scenarios and consider the ethical and professional issues raised by each. What is your view of the problem posed? What actions, if any, would you take in response?

- A couple you have been seeing for 6 months has recently lost their insurance coverage. You have a good relationship, and you feel that they are making good progress. They say that they can afford only a quarter of your fee. Your practice has been slumping recently, and you are also pressed for money.
- A teenager in a family you are working with refuses to continue treatment but has expressed a willingness to participate via online audio and video linkup. After thinking about it, you don't think this is a good idea for defendable clinical reasons, but nothing you or the other family members can do changes the teen's mind. It's either online or nothing.
- A representative from a managed-care organization tells you that you have taken too many sessions for what the company views as adequate for handling the presenting problem. You, of course, disagree. You know that without coverage, your client cannot afford treatment.
- The attorney representing the wife in a child custody fight has summoned you to court. You had worked with the husband, wife, and children for 8 months before the divorce, and privately you believe that although the husband abuses alcohol without, in your view, being alcoholic, he would be the better primary custodian. He seems to you more attentive and caring toward the children and better able to hold a well-paying job than the wife. The wife's attorney makes it clear to you that she will ask you under oath about the husband's drinking behaviors.
- The teenage son in a family you are treating calls you on the phone to ask to see you separately from the rest of the family. You feel that this request represents an important development in the treatment of the family, and you are inclined to agree. As you are thinking about this, he says that he doesn't want you to tell the rest of the family about the meeting because he is terrified of their reaction, especially the father's, if they find out that he has revealed a secret about them. Against your better judgment, you agree. When you meet in person, he tells you that his father has been sexually molesting him. As you probe, it becomes very clear to you that the young man very likely is lying even though he insists the claim is true.

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SUMMARY

Professional practice in marital and family therapy is regulated by legal statutes (licensing or certification) and self-regulated by ethical codes, peer review, continuing education, and consultation. Core competencies in the practice of family therapy are identified in various mental health disciplines. Every state in the United States and some Canadian provinces currently license marriage and family therapists as qualified healthcare providers. Managed-care organizations, dedicated to containing costs and insisting on therapist accountability, increasingly are administering and financing the delivery of mental health services in the United States. One consequence is that therapists who are managed-care providers can no longer ensure strict confidentiality, since most contracts call for subscribers to grant permission for therapists to disclose requested information to case managers.

All therapists have legal and ethical responsibilities to maintain high levels of professional competence. The ethical code of professional organizations, defining standards of conduct for members of the profession, offers guidance in identifying clinical situations in which the therapist must make ethical decisions and offers principles on which those decisions can best be based. New technology has called for new efforts to protect privacy, and the Health Insurance Portability and Accountability Act offers safeguards for ensuring confidentiality. Family therapists frequently must deal with the ethical dilemma involved in concerning themselves with individual needs versus family needs.

Preserving confidentiality of a client's disclosures, providing clients with informed consent (e.g., about the limits of confidentiality) before commencing treatment, and assuring clients of their legal protection through privileged communication are common ethical concerns aimed at protecting client privacy.

RECOMMENDED READINGS

Corey, G., Corey, M. S., & Callanan, P. (2015). *Issues and ethics in the helping professions* (9th ed.). Pacific Grove, CA: Brooks/Cole.

Pope, K. S., & Vasquez, M. J. T. (2010). *Ethics in psychotherapy and counseling: A practical guide for psychologists* (4th ed.). San Francisco: Jossey-Bass.

Welfel, E. R. (2013). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (5th ed.). Belmont, CA: Brooks/Cole.

Wilcoxon, S. A., Remley, T. P., & Gladding, S. T. (2013). *Ethical, legal, and professional issues in the practice of marriage and family therapy* (updated 5th ed.). Boston: Pearson.

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7

Psychodynamic Models



LEARNING OBJECTIVES

- LO 1 Explain the role of theory as the foundation for various approaches to family therapy
- LO 2 Trace the history of psychodynamic family therapy, noting the impact of three pioneers
- LO 3 Describe an early attempt to integrate psychodynamic theory and family therapy
- LO 4 Explain two key concepts from Ackerman's model or an object relations approach to family therapy
- LO 5 Compare and contrast self psychology and intersubjectivity

Introduction to the Established Schools of Family Therapy

Family therapists view the family through the lens of systems theory, recognizing the importance of individual, interpersonal, and environmental factors for understanding human behavior (Stanton, 2009). Across the next several chapters, we examine six established models of family therapy. Each school of thought makes assumptions about the nature and origin of psychological dysfunction, as they differ in understanding family patterns and in their strategies for therapeutic intervention.

Yet the trend today is toward eclecticism and integration in family therapy (see Box 7.1 Clinical Note). Prochaska and Norcross (2014) contend that the modal orientation of family therapists today is eclecticism/integration. They note that the *psychotherapy integration movement* is rapidly accelerating for individual as well as family therapists, as psychotherapy has matured and the "ideological cold war" between theoretical systems has abated. In this postmodern age that emphasizes that all knowledge is relative and subjective, there is less attention to the idea of a single model, universally applicable to all client problems and appropriate for all families regardless of cultural background or family type. The wide variety of family configurations, including single parents, same-sex couples, remarried families, and culturally diverse groups reinforces the idea that no single theory or set of interventions is likely to fit all equally well. Today's family therapists, including many who identify primarily with a particular school, are apt to be less doctrinaire in practice than their theoretical differences suggest, incorporating contributions from "rival" schools (sometimes unwittingly) in their treatment approaches when appropriate, in order to achieve optimal results.

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BOX 7.1 CLINICAL NOTE

Eclecticism and Integration in Current Family Practice

Eclecticism and *integration* are related but not interchangeable notions. The former refers to the selection of concepts or intervention techniques from various theoretical sources, usually based on the experiences of a clinician that a specific approach works with a certain set of presenting problems. Thus, eclecticism is usually pragmatic and case based.

Integration represents a paradigm shift and calls for an extensive combining of discrete parts of theories and treatment processes into a higher-level model that crosses theoretical boundaries and uses intervention techniques in a unified fashion. Lebow (2014) contends that there is a trend toward integration in the practice of many family therapists yet recognizes the tension in the field between those who advocate for specific treatment models and those who actively practice integration. Lebow (2014, p. 29) notes four types of integration: *theoretical integration* (metatheoretical models, such as multisystemic therapy), *technical eclecticism* (shifts away from theory to focus on effective interventions and defined procedures for particular presenting problems), *common factors* (focuses on therapeutic attributes that contribute to positive treatment outcomes in a variety of models; Davis, Lebow, & Sprenkle, 2012), and *assimilation* (the absorption of other models into a host model, essentially using the other models to achieve a particular outcome without modifying the basic orientation of the host model).

While the unmodified practice of a single form of family therapy is less common, and therapists today are likely to selectively borrow concepts and techniques that cross theoretical boundaries, there nevertheless are important distinguishing theoretical constructs between the various traditional schools of family therapy. A therapist's theory helps organize what information to seek and how to go about seeking it, how to formulate a therapeutic plan, make interventions, and understand what transpires (see Box 7.2 Clinical Note). But no single theory can explain and predict all the behavior patterns observed or provide a treatment rationale for all behavioral, intrapsychic, or interpersonal problems.

In the six chapters in Part III, we look at the classical approaches to family theory and therapy and show how current adherents understand and practice within the approaches:

- **Psychodynamic** models emphasize insight, motivation, unconscious conflict, early infant–caregiver attachments, unconscious intrapsychic object relations and, more recently, actual relationships and their impact on inner experience.
- **Transgenerational** models accent how current family patterns, alliances, and boundaries are embedded in unresolved issues from the families of origin.
- **Experiential-humanistic** models address emotional engagement, self-growth, and self-determination through present-day experience, encounter, confrontation, intuition, spontaneity, and action.
- **Structural** models emphasize the context of the family and use spatial and organizational metaphors to describe problems and identify solutions.

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- **Strategic** models privilege directive or task-oriented interventions over understanding the meaning of symptoms. The Milan systemic model questions family belief systems including thoughts and the meanings attached to behaviors.
- **Behavioral** and **cognitive** models emphasize skills and behavioral change.

As you will see, some of these models share ideas and goals, while others offer distinctly different understandings of family therapy. While these models have been in place for decades, each has evolved to present fresh ways of understanding and practicing family therapy. Theories associated with psychoanalysis, for example, have changed in such profound ways that today's psychoanalysts look little like their theoretical forbearers.

Later, in Part IV (Chapters 13–15), we present more recent theories and therapeutic techniques that challenge these older models, such as solution-focused and narrative therapy, largely influenced by the postmodern proposition that people invent rather than discover reality. Such considerations deconstruct the field's notions of objectivity and therapeutic certainty regarding what causes family dysfunction and how best to help families get back on track. We also include psychoeducational approaches to family therapy, which shift our thinking of what causes problems, symptoms, or disabilities in individual family members away from the family as the source of the difficulties to therapeutic efforts directed at maximizing the functioning of families.

LO 1 The Place of Theory

The theoretical foundation of the field of family therapy must be strong, lest it become merely a set of clever, empirically derived intervention techniques. Important and seemingly effective as some of these techniques may be, they require the kind of rationale or justification that only a coherent, unified theory can provide. Patterson (1997) argues that a clear theoretical position provides the structural underpinnings for assessment and treatment planning to occur. He maintains that a therapist must accurately identify the major theoretical orientation from which he or she operates before utilizing congruent intervention methods within it.

There is considerable controversy over whether an integrated supertheory is ever likely to emerge. As Grunebaum (1997) points out, there are too many inherent incompatibilities in the central theoretical constructs of the major theories for such a conceptual integration to occur. Different schools of family therapy make different assumptions about human nature, have different goals, and use different criteria for evaluating what constitutes a successful outcome



BOX 7.2 CLINICAL NOTE

Learning to Use a Specific Model

In learning to do family therapy, it helps to begin by following the theory and techniques of a specific model. Further experience in alternative models is likely to expand the therapist's repertoire, helping avoid simplistic adherence to one model without understanding the pros and cons of other models, as he or she eventually chooses a way of working that is consistent with that person's personality, value system, and clinical experiences.

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(Liddle, 1982). Brown (2010) draws a useful distinction relevant to the debate between integration versus eclecticism when he suggests that teaching family therapy from a meta-theoretical perspective avoids inadvertently advocating a specific eclectic approach based on the particular sequence of theories presented. Keep this caution in mind as you read about each approach. You might find it helpful to consider each with an open mind. All theories, of course, are hypotheses offered in the hope of shedding light or providing fresh perspectives on the causes of family dysfunction. They are never, in and of themselves, true or false; rather, some are more useful than others, particularly in generating research hypotheses that can be verified through testing. All of these theories are tentative; all are expendable in the sense that useful theories lead to new ways of looking at behavior and result in new sets of theoretical proposals.

At this stage in the development of family therapy, we need to examine the usefulness of the contributions that have already been made to our understanding of family development and functioning. Some models came from the research laboratory, others from the consultation room of a clinician working with families. With contemporary advances in neuroscience, some clinically derived theories, such as psychodynamic therapy, are gaining support from controlled scientific experimentation (Solms & Turbull, 2002). In evaluating each of the models presented in this and subsequent chapters, keep in mind the following criteria of a sound theory:

- Is it *comprehensive* ? Does it deal with understanding family functioning and avoid being oversimplified? Is it generalizable to all families as they behave in all situations (not, e.g., only to White middle-class families or only to the ways families behave in special psychotherapeutic situations)?
- Is it *parsimonious* ? Does it make as few assumptions as necessary to account for the phenomena under study? If two competing theoretical systems both predict the same behavior, is the theory chosen the one with fewer assumptions?
- Is it *verifiable* ? Does it generate predictions about behavior that can be confirmed when the relevant empirical data have been collected?
- Is it *precise* ? Does it define concepts explicitly and relate them to each other and to data (avoiding relying solely on figurative, metaphorical, or analogical language)?
- Is it *empirically valid* ? Do systematic empirical tests of the predictions made by the theory confirm the theory?
- Is it *stimulating* ? Does it provoke response and further investigation to enhance the theory or even to demonstrate its inadequacies?

LO 2 Psychodynamic Models: Some Historical Considerations

Psychoanalysis, both as a collection of theories and a form of practice, deserves recognition for playing the central role in establishing and defining the nature of psychotherapy (Sander, 1998). Traditionally, psychoanalysis focused on treating neurotic individuals by examining

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and reconstructing childhood conflicts generated by the colliding forces of inner drives and external experiences. Shortly before World War II, a large number of European psychoanalytic clinicians and theorists (including Erik Erikson, Heinz Kohut, and Erich Fromm), came to the United States to escape the Nazi regime. With their arrival, psychoanalysis began to gain greater acceptance. Many of family therapy's pioneers—Ackerman, Bowen, Lidz, Jackson, Minuchin, Wynne, Boszormenyi-Nagy—(all men, incidentally), were psychoanalytically trained. Some, such as Jackson and Minuchin, moved far from their psychoanalytic roots toward systems thinking, while others (Bowen, Lidz, and Wynne) produced theories that reflected some of their original training.

Freud's Impact on Family Therapy

Sigmund Freud, founder of psychoanalysis at the turn of the 20th century, was aware of the impact of family relationships on the individual's character formation, particularly in the development of symptomatic behavior. For example, in his famous case of Little Hans, a 5-year-old boy who refused to go out into the street for fear that a horse might bite him, Freud hypothesized that Hans was displacing anxiety associated with his Oedipus complex. That is, Freud believed Hans unconsciously desired his mother sexually but felt competitive with and hostile toward his father, as well as fearful of his father's reaction to his hostility. Hans had witnessed a horse falling down in the street, and Freud speculated that he unconsciously associated the scene with his father, since he wanted his father hurt, too. According to Freud, Hans unconsciously changed his intense fear of castration by his father into a phobic symptom about being bitten by the horse, which Hans had previously seen as innocuous. Substituting the horse for his father, Hans was able to turn an internal danger into an external one by displacing it onto a substitute object.

Historically, the case of Little Hans has conceptual as well as technical significance. Conceptually, it enabled Freud to elaborate on his earlier formulations regarding psychosexual development in children and the use of **defense mechanisms** (such as displacement) as **ego** functions that people unconsciously use to protect themselves from overwhelming anxiety. Note, however, that Freud chose not to work with either the child or the family but encouraged Hans's father, a physician, to treat his own son under Freud's supervision. Ultimately, Hans was relieved of his phobic symptom.

From this and similar examples from among Freud's published papers, it is clear that Freud recognized that the family provided the early environment—or context—in which neurotic fears and anxieties developed. Freud argued that psychoanalysts were "obliged to pay as much attention. . . to purely human and social circumstances of our patients as to the somatic data and the symptoms of the disorder. Above all, our interest will be directed toward their family circumstances" (Freud, 1959, pp. 25–26). However, his therapeutic efforts concentrated on the family of origin as the client unconsciously internalized it and later remembered it during analysis and not how his current family functioned.

Freud's theories and techniques stress intrapsychic restructuring rather than restructuring interpersonal or transactional phenomena within a family. Freud's opposition to working with

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more than one family member at a time became virtually an unquestioned doctrine among psychoanalysts (Broderick & Schrader, 1991). In fact, as Bowen (1975) notes, psychoanalytic isolation of the therapist–patient relationship and the related concern that contact with the patient's relatives would "contaminate" the therapist may have retarded earlier growth of the family therapy movement. Bowen reported that some hospitals had one therapist deal with the patient's intrapsychic processes while another handled practical matters and administrative procedures, and a social worker talked to relatives; failure to respect these boundaries was considered "inept psychotherapy." Later, this principle began to be questioned—more often for research than for clinical purposes—and family members began to be seen therapeutically as a group.

Early psychoanalytic theory was significant in the subsequent development of family therapy. While the parameters of the clinical experience were later expanded by many family therapy practitioners to include family members, clinicians from various theoretical perspectives to this day still consider important Freud's emphasis on unconscious conflict, resistance, and transference and countertransference (Kernberg, 2001).

Adler and Sullivan: Contributing Pioneers

Another psychoanalytic influence on family therapy is the work of Alfred Adler, an early associate of Freud's in Vienna. Adler helped found the child guidance movement in the early 1900s. As a physician, Adler began to specialize in neurology and psychiatry, especially in treating childhood disorders. Adler was one of the first invited by Freud to join the Vienna Psychoanalytic Society, which he did in 1902. Although initially he published psychoanalytically oriented articles, Adler eventually diverged from psychoanalytic theory, emphasizing the importance of social (including family) factors as opposed to Freud's **drive theory** (Sharf, 2012). Adler particularly challenged Freud's lack of attention to social elements in personality formation. Instead, he insisted that an individual's conscious personal and social goals as well as subsequent goal-directed behavior could be fully understood only by comprehending the environment or social context, especially the family, in which that behavior originated and was displayed. Adlerian concepts such as sibling rivalry, family constellation, birth order, and style of life attest to Adler's awareness of the key role of family experiences in influencing adult behavior. His holistic view of the person as unpartitionable is applicable to the systems outlook of family therapists.

The goal of Adlerian family therapy is to promote changes in both individuals and the family as a whole (Carlson, Sperry, & Lewis, 2005). While specific goals will differ from family to family, basic principles include the promotion of a new understanding and insight about purposes, goals, and behaviors; the enhancement of skills and knowledge in such areas as communication, problem solving, and conflict resolution; the increase of social interests and positive connections with others; and the encouragement of commitment to ongoing growth and change. This last concept—encouragement—is particularly important in working with families (Carlson & Yang, in Carlson, Sperry, & Lewis, 2005, p. 200) as a means to "promote changes in both individuals and the family as a whole." Encouragement as a technique used

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by the therapist helps family members in therapy together challenge misdirected goals while focusing on realistic possibilities. Table 7.1 summarizes techniques used by Adlerian therapists in working with families.

Adler's direct family therapy connection can be seen today in such psychoeducational efforts as marriage enrichment programs and parent education (Dinkmeyer, McKay, & Dinkmeyer, 1997) and the integration of Adlerian concepts with some of the major approaches in family therapy by scholar-practitioners (Bitter & Main, 2011). Some critics (Slavik & Carlson, 2006) maintain that Adlerian therapy still places too great an emphasis on the self rather than on the self in relation to the larger culture.

Another important theorist, American psychiatrist Harry Stack Sullivan, was psychoanalytically trained but was also influenced by sociology and social psychology. Beginning in the late 1920s, he stressed the role of interpersonal relationships, within the family and with outsiders, in personality development. Sullivan (1953) argued that people are essentially products of their social interactions; to understand how people function, he urged the study of their "relatively enduring patterns of recurrent interpersonal situations" (p. 110). These patterns of interaction within a family significantly influenced a person's personality as well as relationships both within and beyond the family (Corsini & Wedding, 2014). Sullivan emphasized

TABLE 7.1 Techniques of Adlerian family therapy

Technique	Purpose
Family constellation	Information obtained about: • birth order of all family members • siblings • relationships to and between parents • the family climate • additional parental models • physical conditions • academic achievement • sexuality and gender • social development in childhood
Early recollections	Each member is asked to share eight memories from early childhood, each of which is analyzed according to theme and developmental maturity.
Typical day	Family members are each asked to describe in detail events in a complete typical day.
Encouragement	Techniques are used to convey respect and equality among family members.
Paradoxical intention	The therapist assigns the presenting problem or symptom as a homework assignment.
Family council	Family meetings are held on a regular basis in which all members participate in the discussion of issues. Each person's views are taken into consideration.
Use of logical consequences	Parents are taught how to use natural and logical consequences with their children without arguing or criticizing them.
Confrontation	Therapist points out mistaken personal logic.

Source: Adapted from Carlson, Sperry, and Lewis (2005).

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the crucial nature of the early mother–child dyad, arguing that these formative experiences lead to viewing parts of oneself as "good me," "bad me," and "not me"—concepts that, as we shall later see, are consistent with object relations theory.

Sullivan (1940) described his way of engaging patients as acting as a *participant observer*, anticipating by several decades the second-order cybernetic idea of the therapist as part of the ongoing therapeutic system. This is a significant departure from Freudian psychoanalysis in that it replaces transference/countertransference analysis with attention to what a person is doing with others in the here and now. The participant observer is not objective (i.e., a blank screen onto which clients transfer their inner psychic dynamics); instead, the therapist/participant observer recognizes the impact of her or his own subjective experience during therapy (Skelton et al., 2006, p. 247). This recognition aligns with most contemporary approaches to psychodynamic theory that view the meeting and understanding of multiple subjectivities as foundational to the therapeutic experience.

Don Jackson and Murray Bowen, both of whom were to become outstanding figures in family therapy, trained under Sullivan and his colleague Frieda Fromm-Reichmann. Sullivan's notion of redundant family interactive patterns clearly influenced Jackson's work. Bowen's theories pertaining to individual pathology emerging from a faulty multigenerational family system can be traced to Sullivan's influence. Sullivan also exerted considerable influence on contemporary relational psychoanalysis (Mitchell, 2000).

The Psychodynamic Outlook

For the remainder of this chapter, we show how psychodynamic concepts and clinical practices have informed family therapy and cover the following five psychoanalytic perspectives on therapy:

- The classical psychoanalytic drive theories first introduced by Sigmund Freud
- Object relations theory, a revision of earlier psychoanalytic formulations with an emphasis on the human motivation to be in relationships
- The self psychology theory of Heinz Kohut, which rejects classical drive theory and replaces it with a relational conceptualization of personality formation
- The theory of intersubjectivity, which posits that psychological phenomena occur within an intersubjective field constituted of the subjective worlds of child and caregiver or of patient and analyst
- The relational psychoanalytic theory, a contemporary approach that links the influence on personality development of internalized object relations, self states, and interpersonal or social relations (Skelton et al., p. 393)

Classical Psychoanalytic Theory

Freud's psychoanalytic theories focus on what he believed were biologically determined forces, or *drives*, within a person as the basis for understanding motivation, conflicts, and symptomatology. That is, drives motivate behavior by means of bodily demands that take the form of unconscious wishes and impulses seeking satisfaction. Freud contended that each drive has

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four components: an aim (say, the release of sexual or aggressive tension), a source (in the case of hunger, for example, the bodily need for nourishment), an impetus (the pressure or urgency of the drive), and an object (the person or thing or condition that will satisfy the drive: food, sexual intercourse, etc.). An object choice, then, as first articulated by Freud, might be a significant person or anything that is a target of another person's feelings or drives (St. Clair & Wigren, 2004). It is important here to note that it is not the real object or person, per se, nor how that object or person behaves in real life, that is at issue, but rather the *fantasies about the object the perceiver experiences*. So falling in love with another person, according to Freud, primarily involves investing energy in one's inner thoughts or mental representations of that special person.

While classical psychoanalysis is less frequently practiced today, attention by some analysts working with couples or families is still given to core concepts of classical analysis. Sander (2004), for example, points out how infantile sexuality and aggressiveness powerfully influence the interpersonal lives of family members. He argues for adding to the Oedipal myth the myth of Pygmalion and Galatea as a powerful expression of an individual's desire to change the psychic dynamics of others—that is, to use unconscious fantasy to create others in one's own image. Relationships are affected by the compliant or resistant response of others to these wishes.

A trio of Freudian concepts remains important to any psychodynamic approach to individual or family therapy: transference, countertransference, and resistance. In short, **transference** refers to a client's unconscious "transfer" of feelings, wishes, and reactions related to important people from childhood (usually the parents) onto the therapist. **Countertransference** refers to the therapist's unconscious experiences that emerge during the analytic process; these may interfere with the therapist's ability to positively interact with the client (although once understood by the analyst, countertransference experiences offer important clues about either the patient's inner world or the heretofore unconscious dynamics between analyst and patient). And **resistance** refers to any unconscious impediment experienced by the client (or, countertransferentially, the analyst) to the unfolding of the therapy. For Freud, the analysis of the transference after lifting resistances to understanding it or overcoming countertransference obstacles was a primary goal of psychoanalysis. Psychoanalytically oriented family therapists also incorporate these concepts into their work (Scharff, 2003). For them, **interpretation** of the resistances and transferences of individual family members or the family as a whole—that is, making them conscious through language—will lead to psychic healing.

Most of the family therapy pioneers were psychoanalytically trained, and in their initial zeal to adopt systems thinking, they seemed to dismiss individually focused psychoanalytic ideas as antiquated and, in the linking of adult pathology to childhood developmental conflicts, hopelessly linear. Later, however, many family therapists advocated a more integrated view, urging that systems thinkers not neglect the individual family member's personal conflicts and motivation (Nichols, 1987). Mary-Joan Gerson (2010), a relational psychoanalyst and systems family therapist, argues for a foreground–background dialectic between psychoanalysis and systems theory. Sometimes during a session, one theory and practice takes

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precedence over the other and vice versa. Today, many Freudian ideas about the needs and conflicts of individual family members are being revisited alongside family relationship patterns and community life.

LO 3 Early Approaches to Integrating Psychodynamic Theory with Family Systems Theory

As family therapy moved beyond early mechanistic cybernetic formulations, and as there were renewed attempts to include individual experiences and outlooks in a comprehensive understanding of family functioning, there has been a revival of interest in psychodynamic postulations. The new look, however, is relationship based and seeks not only to discover how the inner lives and conflicts of family members interlock but also how the binding together affects disturbances in family members.

Bentovim (1998) and Slipp (1984) attempted to integrate psychodynamic and family systems concepts. Bentovim, a British family therapist, presents a model called focal family therapy. This approach is developmentally oriented and looks for family disturbances, especially traumatic events to family members that have led to intrapsychic and interpersonal disturbance within the family. Samuel Slipp (1984) sees psychoanalysis and family therapy as potentially complementary and both involved in the genesis and maintenance of psychopathology. He attends to any significant childhood development of the participants while addressing ongoing family interaction using the framework of object relations theory. Both individual and family diagnoses are part of Slipp's treatment plan in his effort to integrate psychoanalytic and systems concepts and therapeutic methods.

Nichols (1987) argues for the restoration of individual dynamics into psychodynamic family therapy, because individual family members remain separate flesh-and-blood persons with unique experiences, private hopes, outlooks, expectations, and potentials. At times, people may react as individuals. Psychoanalytically oriented therapists who accept Nichols's holistic view—what he calls *interactional psychodynamics*—are urged to remain attentive to the circular nature of personal and family dynamics.

As we present various family approaches that reflect a psychodynamic perspective, keep in mind that each one simultaneously addresses two levels of understanding and intervention: the motives, fantasies, unconscious conflicts, and repressed memories of each family member and the complex world of family interaction and family dynamics.

LO 4 Psychoanalysis and Family Dynamics: Ackerman's Foundational Approach

Nathan Ackerman, a psychoanalytically trained child psychiatrist in the child guidance movement, is generally credited with adapting psychoanalytic formulations to the study of the family. In what may have been the first paper specifically to deal with family therapy, Ackerman emphasized the influence of the family as a dynamic *psychosocial unit*. The constant interaction between the biologically driven, inner-conflicted person (a psychoanalytic concept), the family, and the social environment (a person-systems concept) preoccupied him

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for more than three decades, as he applied an intrapsychic vocabulary to family diagnosis and treatment—as described in a paper published shortly after his death (Ackerman, 1972):

> Over a period of some thirty-five years, I have extended my orientation to the problems of behavior, step-by-step, from the inner life of the person, to the person within family, to the family within community, and most recently, to the social community itself. (p. 449)



Nathan Ackerman, M. D.

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In contrast to the approach practiced by most child guidance clinics, in which parent (usually mother) and child were seen by separate but collaborating therapists, Ackerman, head of the Child Guidance Clinic at the Menninger Clinic in Kansas, experimented with seeing whole families together for both diagnostic and therapeutic purposes. As part of his effort to obtain a complete picture of family functioning, Ackerman had members of his staff make home visits with client families (Guerin, 1976).

By the 1950s, Ackerman had moved explicitly into family therapy. In New York City in 1960, he opened the Family Institute, soon to become the leading family therapy training and treatment center on the East Coast. Ackerman remained throughout his long career a boldly direct, provocative, confrontational therapist, who, true to his psychoanalytic background, never lost sight of the individual family member's needs and longings.

Ackerman (1970), regarded by some as the "grandfather of family therapy," saw the family as a system of interacting personalities; each individual is an important subsystem within the family, just as the family is a subsystem within the community. Family functioning receives input from several sources: the unique personality of each member, the dynamics of family role adaptations, the family's commitment to a set of human values, and the behavior of the family as a social unit. At the individual level, the process of symptom formation may be understood in terms of intrapsychic conflict, an unconscious defense against anxiety aroused by the conflict, and the resulting development of a neurotic symptom (a classical psychoanalytic explanation). At the family level, the symptom is viewed as part of a recurring, predictable interactional pattern intended to assure equilibrium for the individual but actually impairing family functioning by producing distortions in family role relationships. In family terms, an individual's symptom becomes a unit of interpersonal behavior reflected within a context of shared family conflict, anxiety, and defenses. Conceptualizing behavior in this way, Ackerman was beginning to build a bridge between psychoanalytic theory and the then-emerging systems theories.

A "failure of **complementarity**," to use Ackerman's terms, occurs when change and growth within the system become constricted. Roles become rigid, narrowly defined, or stereotyped—or shift rapidly, causing confusion. According to Ackerman (1966), the family in which this occurs must be helped to "accommodate to new experiences, to cultivate new levels of complementarity in family role relationships" (p. 90). Flexibility and adaptability of roles are essential, allowing for maturing children to gain appropriate autonomy.

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Should the conflict between members become chronic, the family is at risk of reorganization into competing factions. The process begins when one individual—often noticeably different from the others—becomes the family scapegoat. As that individual is singled out and punished for causing family disunity, various realignments of roles follow within the family. One member becomes "persecutor," while another may take the role of "healer" or "rescuer" of the "victim" of such "prejudicial scapegoating." Families are thus split into factions, and different members may even play different roles at different times, depending upon what Ackerman considers the shared unconscious processes going on within the family at any particular time. Typically, observed Ackerman, such family alliances and interpersonal conflicts begin with a failure of complementarity within the marital dyad; the family is precluded from functioning as a cooperative, supportive, integrated whole. In such cases, Ackerman shifted a family's concern from the scapegoated person's behavior to the basic disorder of the marital relationship.

In an early paper, Ackerman (1956) presented a conceptual model of interlocking pathology in family relationships. Noting the impact of the family environment on the development of childhood disorders, he was one of the first to see the constant interchange of unconscious processes taking place between family members as they are bound together in a particular interpersonal pattern. Accordingly, any single member's behavior can be a symptomatic reflection of confusion and distortion occurring in the entire family. With notions such as "interlocking pathology," Ackerman was able to wed psychoanalytic concepts of intrapsychic dynamics to the psychosocial dynamics of family life. See Box 7.3 for an example of Ackerman's intervention style.

Unaffected and deceptively casual in manner, Ackerman used office interviews and home visits to obtain a firsthand diagnostic impression of the dynamic relationships among family



BOX 7.3 THERAPEUTIC ENCOUNTER

Ackerman's Active, Challenging Interventions: A Clinical Vignette

To watch Ackerman on film or videotape is to see an honest, warm, straightforward, provocative, charismatic person at work in the very midst of the family, challenging a prejudice, coming to the aid of a scapegoated child, helping expose a family myth or hypocrisy, vigorously supplying the emotional ingredients necessary to galvanize a previously subdued family. No topic is taboo or off limits, no family rules so sacred they cannot be broken, nothing so shameful as to be unmentionable.

The following brief excerpt is from a therapy session with a family whose crisis was brought on when the 11-year-old daughter threatened to stab her 16-year-old brother and both parents with a kitchen knife. The explosive attack was precipitated by the girl's discovery of a conspiracy among the family members to say that her dog had died when in reality the mother had taken him to the dog pound. Members of the family indulge in many small lies, then cover up and deny their feelings. Note how Ackerman will have none of this charade. He reveals his own feelings in order to cut through the denial and open up the family encounter. The left-hand column is the verbatim account; the right-hand column is Ackerman's analysis of what is taking place.

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TRANSCRIPT	COMMENTS
DR. A: Bill, you heaved a sigh as you sat down tonight.	Therapist instantly fastens on a piece of nonverbal behavior, the father's sigh.
FATHER: Just physical, not mental.	
DR. A: Who are you kidding?	Therapist challenges father's evasive response.
FATHER: I'm kidding no one.	
DR. A: Hmmm . . .	Therapist registers disbelief, a further pressure for a more honest response.
FATHER: Really not . . . Really physical. I'm tired because I put in a full day today.	
DR. A: Well, I'm very tired every day, and when I sigh it's never purely physical.	An example of therapist's use of his own emotions to counter an insincere denial.
FATHER: Really?	
DR. A: What's the matter?	
FATHER: Nothing. Really!	
DR. A: Well, your own son doesn't believe that.	Therapist now exploits son's gesture, a knowing grin, to penetrate father's denial and evoke a deeper sharing of feelings.
FATHER: Well, I mean nothing . . . nothing could cause me to sigh especially today or tonight.	
DR. A: Well, maybe it isn't so special, but . . . How about it, John?	Therapist stirs son to unmask father.
SON: I wouldn't know.	Now son wipes grin off his face and turns evasive, like father.
DR. A: You wouldn't know? How come all of a sudden you put on a poker face? A moment ago you were grinning very knowingly.	Therapist counters by challenging son, who took pot shot from sidelines and then backed away.
SON: I really wouldn't know.	
DR. A: You . . . Do you know anything about your pop?	
SON: Yeah.	
DR. A: What do you know about him?	
SON: Well, I don't know, except that I know some stuff.	
DR. A: Well, let's hear.	

Source: Ackerman (1966), pp. 3–4.

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members. Ackerman believed the family therapist's principal job is to be a catalyst who moves into the "living space" of the family, stirs up interaction, helps the family have a meaningful emotional exchange, and at the same time nurtures and encourages the members to understand themselves better through their contact with the therapist. Hearty, confident, freewheeling, unafraid to be himself or to disclose his own feelings, he was apt to bring out these same qualities in the family. By "tickling the defenses" (gently provoking participants to openly and honestly express what they feel), he caught members off guard and exposed their self-justifying rationalizations. Soon the family was dealing with sex, aggression, dependency, and family secrets—the issues it had previously avoided as too threatening and dangerous. Ackerman was always interested in how people define their own roles ("What does it mean to you to be a father?") and what they expect from other family members ("How would you like your daughter to react to this situation?"). When all members delineate their roles clearly, family interactions proceed more smoothly, he maintained. Members can rework alignments, engage in new family transactions, and cultivate new levels of complementarity in their role relationships.

Ackerman remained staunchly psychodynamic in outlook; his death in 1971 removed one of the major proponents of this viewpoint in family therapy. A collection of his published papers with commentary by the editors (Bloch & Simon, 1982), called *The Strength of Family Therapy*, attests to his trailblazing efforts as well as his broad range of interests (child psychoanalysis, group therapy, social and cultural issues, marriage, and more). He was among the first to demonstrate his work with families before a professional audience, breaking the traditional psychoanalytic code of secrecy about what really went on during therapeutic sessions.

Despite Ackerman's importance in the early years of family therapy, few therapists today would say their approach follows Ackerman's style. He did not leave behind any defined theory of family processes or guidelines for clinical interventions. The Family Institute (renamed the Ackerman Institute in his memory), while acknowledging his pioneering efforts, does not operate from a psychodynamic perspective today. While many therapists continue to be interested in the "psychodynamics of family life" and use classical psychoanalytic concepts, the psychodynamic view is currently best expressed by the psychoanalytic theory termed object relations, to which we now turn.

Object Relations Theory

Object relations' combined attention to individual drives (motives), the development of a sense of self (wishes, fears, internal conflicts), and unconscious relationship seeking helps explain the revived interest in psychoanalytic formulations by some family therapists. They are rediscovering the value of basic psychodynamic concepts that draw attention to the inner lives and conflicts of individual family members.

Object relations theory views the infant's experiences in relationship to the mother or primary caregiver as the main determinant of adult personality formation. According to this theory, the infant's need for attachment to the mother is the foundation for the development of the self—the unique psychic organization that creates a person's sense of identity (Scharff & Scharff, 2005). Bowlby (1969) considers issues of attachment and loss to be central to functioning in humans and all higher mammals; he argues that how people resolve these issues determines

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personality development and possible psychopathology. Most contemporary psychoanalysts place great emphasis on early attachment experience and its impact on subsequent development.

While Freud used the term *object* in relation to instinctual drives, other theorists have expanded it to refer to internal, largely unconscious views a person has of an individual (or a part or aspect of an individual) from past experiences in childhood that shaped his or her current relationships with others (St. Clair & Wigren, 2004). So an individual interacts not only with the actual other person but also with this subjective, internalized representation of the other, likely a distorted version of some actual person from the past.

The theoretical work of Melanie Klein, a British psychoanalyst who emigrated from Vienna in 1926, provided much of the foundation of object relations theory. Her insights into the preverbal, inner world of the child's object relations are often considered the start of the movement. Klein focused on the infant's innate or instinctual makeup as containing elements of love as well as hate. Because the infant's inner life, beginning at birth, involves a world of fantasy, he or she first experiences objects, such as the mother, through fantasies. The infant filters real-life experiences through such prior fantasies. Working directly with children—in contrast to Freud, whose theories about childhood came from the recollections of neurotic adult patients—Klein was able to delve into the fantasies of young clients and to expand previous psychoanalytic formulations to cover the earliest phases of life. Freud saw drives as originally objectless; Klein argued that drives (urges, instincts) are relational and inherently directed at objects (St. Clair & Wigren, 2004).

Following Klein's lead, object relations theory was developed further by members of the British Middle School (Michael Balint, Ronald Fairbairn, Harry Guntrip, and Donald Winnicott), so named because it attempted to maintain a balance between classical psychoanalysts and the followers of Klein, in order that the British Psychoanalytic Society avoid splitting into rival factions (Slipp, 1988). In general they hold that an infant's primary need is attachment to a caring, nurturing caregiver, in contrast to Freud's idea that the infant's basic struggle is in coming to terms with sexual and aggressive impulses aimed at acquiring gratification from a parent (J. S. Scharff, 1989).

W. R. D. Fairbairn (1952), a psychiatrist in Edinburgh, Scotland, who worked therapeutically with **schizoid** adults, followed Klein's work but rejected her acceptance of Freud's drive motivation in favor of purely psychological explanations. His innovative theory of personality development was based strictly on the consideration of object relations, and those objects inevitably are people (Grotstein & Rinsley, 1994).

Fairbairn maintained that because the infant experiences different sets of encounters with a mother—sometimes nurturing, sometimes frustrating—and cannot control the circumstances or leave the relationship, she or he creates a fantasy world to help reconcile the discrepant experiences. In this mediating process, called **splitting** by Fairbairn, the child within the first year of life internalizes an image of the mother into a good object (the satisfying and loving mother) and a bad object (the inaccessible and frustrating mother). The former becomes an idealized object and allows the child to feel loved, the latter a rejecting object that leads to anger, a feeling of being unloved, and a longing to regain that love. Part of mother is loved, another part hated; because she is not seen yet as a whole person, one or the other part

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dominates at different times. Most children are able to integrate the two images by the second year of life. However, the degree to which a person resolves this conflict provides the basis for how well he or she develops satisfying human relationships later in life. If unresolved, the splitting is likely to lead to labile feelings as an adult as a result of a tendency to view people (or the same person at different times) as "all good" or "all bad." Note that object relations psychoanalysts are concerned with the internalized representations of distorted external object relationships. This is important because it argues for keeping the therapeutic focus on the patient's inner world rather than on her or his relationships with actual people, an important difference from some family therapy theories and more contemporary psychoanalytic theories.

To illustrate the concept of splitting, and to demonstrate how classical psychoanalytic and object relations therapists might deal with a familiar "case," St. Clair and Wigren (2004) offer the case of Cinderella in Box 7.4. Note how the latter therapists view the problem in terms of developmental arrest, while the former look for structural conflicts.

To Fairbairn, these internalized split objects become part of one's personality structure: good-object **introjects** (imprints of parents or other significant figures) remain as pleasing unconscious memories, bad-object introjects cause intrapsychic distress. Psychological representations of these introjects unconsciously influence future relationships, since current experiences are interpreted through the filter of one's inner object world of good-bad images. As a result, the person may grow up with distorted expectations of others, unconsciously forcing intimates into fitting the internal role models. These distortions are an inevitable feature of everyone's life; the capacity to challenge reality in well-enough versus poor terms distinguishes normative from dysfunctional experience. The earlier the split (e.g., from an early loss of a parent), the more likely it is that the person will yearn to merge with loved ones so that they become a part of him or her. Or he or she may also yearn for independence and separation, a



BOX 7.4 THERAPEUTIC ENCOUNTER

The Cinderella Story: A Case of Splitting?

Let us suppose that Cinderella and the prince got married. But marital problems have arisen, and she seeks the help of a therapist. A traditional Freudian might investigate Cinderella's repression of her sexual instincts and unresolved oedipal feelings she had for her parents. This therapist or analyst would analyze Cinderella's problems in terms of defenses and conflicts between the structures of the ego and the id.

A therapist working with an object relations perspective would note that Cinderella suffered early psychological deprivation from the loss of her mother. Possibly this loss caused Cinderella to make use of the psychological defense mechanism of splitting, by which she idealized some women (such as her fairy godmother) and saw other women as "all bad" (her stepsisters and stepmother). She idealized the prince, knowing him for only a short time. A marriage based on such distorted inner images of herself and others is bound to run into problems, as she sooner or later must deal with the prince as a real person with human flaws. In object relations theory, the issue would center on the discrepancy between Cinderella's inner world and the persons and situations of the actual world (St. Clair & Wigren, 2004, p. 3).

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normal part of growing up, although too much distance may lead to feelings of loneliness and depression.

British psychologist Henry Dicks (1967), at the Family Psychiatric Unit of the Tavistock Clinic in London, expanded Fairbairn's conceptualizations by proposing that marriages were inevitably influenced by each spouse's infantile experiences. To Dicks, one basis for mate selection was that the potential partner's personality unconsciously matched split-off aspects of oneself. That is, while two people make conscious marital choices based upon many factors, including emotional compatibility, physical and intellectual attraction, background similarities, and so forth, Dicks believed that unconscious motives were also operating; as Scharff and Scharff (2008) observe, at the unconscious level, they seek an "extraordinary fit, of which they are unaware" (p. 169). Each one thus hopes for integration of the lost introjects by finding them in the other.

Dicks suggested that in a troubled marriage, each partner relates to the other in terms of unconscious needs; each partner perceives the other to a degree as an internalized object, and together they function as a joint personality. In this way, each partner attempts to rediscover, through the other, the lost aspects of his or her primary object relations that had split off earlier in life. This is achieved through the operation of the defense mechanism elaborated by Melanie Klein of **projective identification**, an interactive mental process in which marital partners unconsciously defend against anxiety by projecting or externalizing certain split-off or unwanted parts of themselves onto their partners, who in turn are unconsciously manipulated to behave in accordance with this projection.

An example of projective identification is when a person who feels herself (and wants other people to know her) to be thoughtful and kind believes that a perfect stranger is cruel. Her own cruel impulses that don't conform to her preferred self-impression are projected onto the stranger. This may happen in therapy: for example, the patient believes that the therapist is being selfish by insisting that she be paid on time. Less common is the projection of a cherished part of oneself onto someone else for safekeeping from retained bad objects. Consequently, each person attempts to reestablish contact with missing or repudiated parts of themselves.

To put it succinctly, object relations theorists believe we relate to people in the present partly on the basis of expectations formed by early relationship experiences (Nichols, 1987). People respond to others based largely on their resemblance to internalized objects from the past rather than how these others may truly behave. Thus, a family member may distort the meaning or implication of another member's statement or action, perhaps misreading or overreacting because of unconscious, emotion-laden, inner images developed early in life with parents or other important caretaker figures. To resolve current problems with others, it becomes necessary to explore, expose, and repair those faulty unconscious object relationships internalized since infancy.

Family therapists are especially interested in how this plays out in marital relations. According to the object relations view, the two individuals joined by marriage each bring to the relationship a separate and unique psychological heritage. Each carries a personal history, a unique personality, and a set of hidden, internalized objects into all subsequent transactions with one another. Inevitably, the dyadic relationship resembles the parent–child relationships

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the partners experienced in their families of origin. As Meissner (1978) observes, "The capacity to successfully function as a spouse is largely a consequence of the spouse's childhood relationships to his (or her) own parents" (p. 26). The relative success that marital partners achieve and the manner in which they approach and accomplish developmental tasks throughout the life cycle are largely determined by the extent to which they are free from excessive negative attachments to the past.

In addition, the partners' unresolved intrapsychic problems also are passed along to their children, who eventually bring psychic disturbances into their own marriages. Object relations therapists contend that only by gaining insight into and thus freedom from such burdensome attachments to the past can individuals—or couples—learn to develop adult-to-adult relationships in the present with members of their families of origin.

Object Relations Therapy

Braverman (1993) notes how an individual's therapy can be enhanced by exploring the objects projected by the client onto more people than just the person of the therapist. A psychoanalytically oriented systems therapist, she argues, would want to help the client understand how members of one's family of procreation hold each other's unexamined projections as part of the family's self-corrective feedback system. Slipp (1988) suggests that the object relations perspective also reminds family therapists that individuals may bring serious personal emotional problems into a relationship and that pathology need not exist mysteriously only in the transactions between people.

We present two approaches using object relations theory in family therapy. First, however, we note an important concept used by object relations therapists when working with individuals or families: the holding environment. **Holding environment**, a phrase attributed to D. W. Winnicott, refers to the safe and nurturing environment provided by the mother to her infant that supports good-enough psychological development. The term also refers to a comparable environment that the therapist seeks to create for the patient. In this "shared holding" space, the child (or individual or family) may interact with the therapist for the sake of growth and/or healing. Although the concept originated in object relations theory, it is accepted by most other contemporary psychoanalytic perspectives.

Object Relations and Family-of-Origin Therapy (Framo)

James Framo (1981) stressed the relationship between the intrapsychic and the interpersonal, offering an amalgam of psychodynamic and systems concepts. One of the few psychologists in the early family therapy movement, he was affiliated first with the Eastern Pennsylvania Psychiatric Institute (EPPI) in Philadelphia then had an academic career at Temple University. For the last 20 years of his long career, ending in his death in 2001, Framo was a teacher and practitioner in San Diego. Among the founders of the family therapy movement, Framo is particularly celebrated for his advocacy of couples groups.

Maintaining an understanding of an individual's intrapsychic world, Framo nevertheless believed psychoanalytic theory had not paid sufficient attention to the social context of a person's life, particularly the early crucial role played by family relationships in shaping individual

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behavior. Framo refused to polarize the intrapsychic and the interactional, maintaining that both are essential to understanding the dynamic aspects of family life. As he pointed out in the introduction to a collection of his papers (Framo, 1982), his orientation to marital and family theory and therapy emphasized "the psychology of intimate relationships, the interlocking of multi-person motivational systems, the relationship between the intrapsychic and the transactional, and the hidden transgenerational and historical forces that exercise their powerful influences on current intimate relationships" (p. ix).



James Framo, Ph.D.

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Framo developed a set of intervention techniques that helped couples in marital therapy deal with unresolved issues each partner brings to the marriage from his or her family of origin. Framo believed that these intrapsychic conflicts continue to be acted out or replicated with current intimates, such as a spouse or children. Indeed, Framo (1981) contended that efforts at the interpersonal resolution of inner conflict (e.g., harshly criticizing a spouse for failing to live up to one's wildly inappropriate expectations) are at the very heart of the kinds of distress found in troubled couples and families.

Extrapolating from Fairbairn's proposals regarding splitting, Framo (1976) theorized that a young child who interprets parental behavior as rejection, desertion, or persecution is in a dilemma; the child cannot give up or change the sought-after object (the parents). Typically, the ensuing frustration is dealt with by internalizing aspects of the "loved-hated" parents in order to control the objects in the child's inner world. According to Framo, the most powerful obstacle to change is people's attachments to their parental introjects. The more psychologically painful the early life experience, the greater the investment in internal objects, the more an adult will engage in an unconscious effort to make all close relationships fit the internal role models.

Framo drew from Fairbairn and Dicks to posit that people *usually do not select the partner they want; they get the one that they need*. Each is drawn to someone who recreates the childhood dream of unconditional love, but also is enough like the bad inner object to allow old hatreds to be projected. According to Framo (1992, p. 115), "one's current intimates, one's spouse and children, are, in part, stand-ins for old images, the embodiments of long-buried introjects."

One major source of marital disharmony results from projective identification—spouses who project disowned aspects of themselves onto their mates and then attack them. Similarly, children may be assigned inappropriate family roles based on parental introjects. Such roles may even be chosen for them before they are born (e.g., conceiving a baby in the belief that the offspring will save a shaky marriage).

Therapeutically, Framo began by treating the entire family, especially when the presenting problem involved the children. However, symptomatic behavior in a child may simply be a means of deflecting attention from a more basic marital conflict. Once the child's role as identified patient is made clear and the child is **detriangulated** from the parents, Framo typically dismissed the children and worked with the marital dyad.

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Framo's unique contribution to family therapy technique was his process of guiding a couple through several treatment stages: conjoint therapy; couples group therapy; and, finally, family-of-origin (intergenerational) conferences. The couples group, added soon after beginning treatment, allowed Framo to use many of the positive aspects of group therapy, especially therapeutic feedback from other couples, to assist his therapeutic efforts. It may be more enlightening and potent for a couple to see its own interaction patterns acted out by another couple than to hear a therapist merely comment on the same behavior. To Framo, the group experience also reduced the individual's resistance to the next stage of treatment, which involved bringing family-of-origin members together.

In a daring therapeutic maneuver, Framo (1992) involved each individual (without the partner present) in sessions with his or her family of origin (parents, brothers, and sisters). Here, Framo provided an opportunity to clear up past misunderstandings or sources of chronic dissatisfaction directly with family members. In some cases, misinterpretations based upon childhood misperceptions could be straightened out. Clients were encouraged to present their views, perhaps not aired before, but the session was not intended to be an opportunity for indictment, blame, recrimination, or condemnation.

Often conducted with a co-therapist, family-of-origin sessions were usually divided into two 2-hour sessions with a break in between (varying from several hours to an overnight interruption). There were two major goals—to discover what issues or agendas from the family of origin might be projected onto the current family and to have a corrective experience with parents and siblings. Framo cogently reasoned that if adults were able to go back and deal directly with both past and present issues with their original families—in a sense, to come to terms with parents before they die—then they would be liberated to make reconstructive changes in their present marriage or family life. Usually held toward the end of therapy, family-of-origin conferences enabled individuals to gain insight into the inappropriateness of old attachments, rid themselves of "ghosts," and respond to spouses and children as individuals in their own right—not as figures on whom they project unresolved issues and introjects from the past.

As Framo (1992) warned, family-of-origin therapy may not change people's lives drastically, nor is it likely to fulfill all fantasies of what clients might get from parents and siblings. However, it often has a restorative function, reconnecting family members to one another, allowing participants to see one another as real people and not simply in their family-assigned roles. Old rifts may be healed by more accurate readings of one another's intentions, or perhaps as past events are reinterpreted from an adult perspective. The encounter provides a forum for forgiveness, compromise, acceptance, and resolution.

Object Relations Family Therapy (Scharff and Scharff)

An object relations approach that includes many concepts from psychoanalysis comes from the collaboration of David Scharff and Jill Savege Scharff, husband and wife psychiatrists affiliated for many years with the Washington School of Psychiatry, now at their own institute—the International Psychotherapy Institute.

In the Scharffs' therapeutic approach, unconscious themes expressed in dreams and fantasies are evoked and investigated, family histories are explored as they relate to current

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relationships, interpretations are made to the family, insight is sought, and transference and countertransference feelings are explored in an effort to arrive at greater understanding and growth. The Scharffs attempt to aid the couple in overcoming resistance in order to become aware of repressed impulses, feelings, or ideas. Unlike individual psychoanalysis, however, the focus is on the family as a nexus of relationships functioning in ways that support or obstruct the progress of the family or any of its separate members as they proceed through the developmental stages of family life (Scharff & Scharff, 1987, 2008). Marriage is seen as similar to each partner's earlier child–mother relationship in that, as adults, each seeks a permanent attachment to a caring figure. In the case shown in Box 7.5, both partners view the maternal image as powerful.



BOX 7.5 CASE STUDY

Object Relations Therapy with a Distressed Couple

A shy, timid man always felt inferior because, although he was tall and handsome, he was not athletic, didn't have many friends, and could never get a date for the prom. He met a small but assertive, opinionated, athletic woman who was his company's softball coach. He saw in her qualities that he would have liked to have in himself. She felt much less attractive than he was, but she enjoyed a challenge and invited him out on a date. She soon recognized that he had problems with self-esteem. She disavowed them in the same way that she pushed past her own vulnerabilities. It turned out that they were attracted to each other physically and felt happy together and sexually fulfilled, but they stayed together for unconscious reasons. Both shared the unconscious assumption that the woman was more important, stronger, and more dependable than the man. In his close-knit, Old World immigrant family, the man continued to revere the mother, even though he wanted distance from the old-fashioned family culture. The woman was close to her mother, a modern, divorced, professionally achieving woman, and she had been deeply hurt by her father's abandonment. In marriage, the man found another woman to adore and serve, and the woman found a father who would stay with her.

Then she became pregnant, and their sex life stopped. He thought that his male role was to stay out of the way so she could carry out her supremely maternal function. She felt that he had abandoned her now that she was to have a child, just as her father had done to her mother. The more passive and withdrawn he became, the more she overfunctioned, recreating with her daughter the exclusive relationship she had with her mother and hating her husband for abandoning her emotionally as her father had done. All her rage at her father came out in relation to her husband. Envious of the exclusive attention given to the baby, he felt inferior and unworthy of love, and his self-esteem plummeted.

The projective identificatory system, in which the strong woman was admired and which was the basis for their bond during courtship, became a divisive force in the child-rearing years of their marriage. In object relations couple therapy, the couple learned about this basic assumption and how disabling it had been. The husband and wife reviewed their family histories and let go of the working models they had developed in their families of origin. They freed each other to create a more equal appreciation of mother and father, traditional and contemporary lifestyles, and male and female contributions to their marriage and family.

Source: Scharff and Scharff (2003), pp. 68–69.

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Historical analyses of current individual and relationship difficulties are central components of this technique, since it is assumed that intrapsychic and interpersonal levels are in continuing interaction. Helping family members become conscious of how they internalized objects from the past and how these objects intrude on current relationships is an indispensable part of providing understanding and instigating change.

According to the Scharffs, interpretation by the therapist in order to provide insight is essential. While they oppose the blank-screen stance of classical psychoanalysts, they do adopt a neutral stance of involved impartiality, helping provide a shared holding environment,[1] thus creating a therapeutic climate allowing each family member to project onto the therapist his or her own unfinished problems from the past. In contrast to the view that the therapist inevitably becomes a part of the family system—the Scharffs believe they are able to remain outside the family system, and in a position to offer comments on what is happening to them as well as on what they observe taking place within the family.

That is, the Scharffs make use of the transference, which they view broadly as occurring between family members, between each family member and the therapist, and between the family as a group and the therapist. This is an essential part of treatment, since the therapist's neutrality evokes in the therapeutic sessions an "object hunger"—a replay of infantile relating with caretakers in the family of origin. At the same time, the therapist experiences countertransference in responding to the family struggles, unconsciously evoking his or her own internal struggles from the past. If sufficiently worked through in previous personal analysis and training, and with supervision, this shared venture of object relations may evoke greater empathy from the therapist with family vulnerabilities and struggles. As David Scharff (1989) points out, in this way, object relations therapists allow themselves to "be the substrate for a newly emerging understanding, which they then feed back to the family in the form of interpretation" (p. 424).

In forming a therapeutic alliance with a family, the Scharffs create a nurturing climate in which family members can rediscover lost parts of the family as well as their individual selves. This holding environment is a key element, as the therapist offers empathy and a safe environment while attending to the psychological processes each participant is experiencing separately as well as with one another and with the therapist. Each partner is encouraged to examine his or her early nurturing or caring experiences and how images retained from those experiences affect the couple's current marital relationship and their view of the therapist. The therapist assesses the family's shared object relations, their stage of psychosexual development, and use of various mechanisms of defense against anxiety. Observing family interaction, encouraging members to express their own viewpoints as well as observe the views of one another, obtaining a history of internalized objects from each member, feeding back

[1]Holding environment is an important concept in Scharff and Scharff's therapeutic approach. First used by British pediatrician Donald Winnicott (1965), a member of the British Middle School of object relations theorists, to describe the needs of an infant to avoid feeling abandoned or annihilated, successful holding experiences result from being raised in a nurturing home climate and lead to feeling whole, real, effective, with self-esteem.

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therapist observations and interpretations—these are all ways of joining the family. Later, helping family members work through chronic interaction patterns and defensive projective identifications is necessary if they are to change patterns and learn to deal with one another in a here-and-now fashion attuned to current realities rather than unconscious object relations from the past (D. Scharff, 1989).

Successful treatment is measured not by symptom relief in the identified patient but by the family's increased self-understanding and its improved capacity to master developmental stress. A fundamental goal is for the family to support one another's needs for attachment, individuation, and growth. See Box 7.6: Thinking Like a Clinician for an exercise in working with a family from an object relations perspective.



BOX 7.6 THINKING LIKE A CLINICIAN

Family Therapy and Object Relations

The Hansons have come for treatment. Richard Hanson strikes you as a quiet man who holds back a lot of what is on his mind. His wife Alice seems more dynamic, perhaps dominating. She is an assistant bank manager. Their children, Doug and Max, are in their mid-teens. Doug speaks confidently and with emotional resonance, whereas Max appears more cautious. The presenting problem is that in recent months Max's grades have fallen significantly. When his parents have asked him about what might be wrong, he says only, "What's the point? I can't do anything right anyway." Because he previously received As and Bs, this attitude baffles the parents.

You have learned in previous sessions that Alice is very anxious about money. Richard, a lawyer, hasn't worked in more than 7 months, and their nest egg is almost gone. At times, you have sensed that Alice is both very frightened about not having enough money and quite angry at Richard, who seems to have given up looking for work after having been rejected by one firm after another.

After reading the dialogue below, answer the questions that follow.

ALICE: Max received another D today. This time on a social studies project that I know he did almost no work on. I'm at the end of my rope about this. He wants to get into a good college, and if this continues, he won't, and he'll have no one but himself to blame.

MAX: Oh, Mom.

ALICE: I'm serious. You're digging your own grave with this behavior of yours. It would be one thing if you had always been a mediocre student—then we'd just accept the situation for what it would be—but you are a smart kid, and you're ruining your record over goodness knows what trouble you refuse to talk to us about.

MAX: I do too talk.

ALICE: No, you don't! What do you think we're doing here? We are here to give you whatever you need to deal with whatever is bothering you.

DOUG: Will you leave Max alone! Maybe the problem isn't with him but with you.

ALICE: Doug, that kind of talk doesn't help, so kindly keep your opinions about what is wrong with me to yourself.

DOUG: Oh, that's good: I should keep my feelings to myself in a shrink's office! Makes a lot of sense, Mom. You want to control everything—even my thoughts!

ALICE (with agitation): I do *not* want to control your thoughts. It's just that your father and I are paying a lot of money for us to be here, and I want to use the time profitably.

(A sense of tension grows in the office. The therapist notices that Richard remains silent but appears anxious.)

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THERAPIST: Alice, you seem very concerned about money. It's an important issue, I know. How do you feel today about money matters?

ALICE: Of course I am worried. I can't sleep over money troubles. We never seem to have enough. In fact, for all my life, even when I was a little girl, there never was enough. My father was an architect who somehow never managed to keep any clients. I am so upset about this. History is repeating itself. I am no better off now than I was when I was young. I have never figured out how to have enough money. Ironic I work in a bank, no? My father never earned enough. Richard doesn't earn enough. I don't, and now it looks like Max will follow in our illustrious footsteps. What is wrong with us?

THERAPIST: So you see a pattern involving your father, Richard, and yourself. Can you tell me more about that?

ALICE: Oh, terrific. You're thinking I married my father.

THERAPIST: I am not thinking anything yet. I was just wondering if you noticed anything else about this pattern.

ALICE: Only that we're all a bunch of losers.

THERAPIST: I notice that Richard hasn't said anything and the boys very little.

1. How has the therapist contributed to maintaining a holding environment?
2. Identify and describe object relations that might characterize Alice's intrapsychic experience.
3. Identify an example of a resistance in the dialogue.
4. How might Alice's phrase, "Oh, terrific. You're thinking I married my father," be considered a resistance rather than an example of self-awareness?

Kohut and Self Psychology

Heinz Kohut (1971, 1977), an American psychiatrist born and educated in Vienna, was responsible for another major development in psychoanalysis. Kohut's disavowal of drive theory represents a more radical departure from Freudian theory than the original object relations theorists, many of whom retained it in their reformulations. Based on his work in analyzing patients with **narcissistic personality disorders**—patients Freud considered unanalyzable because they were unable to engage in a relationship (or establish a transference) with the analyst—Kohut developed what he termed **self psychology**, a theory of psychoanalysis that emphasizes the relationship between the self (the person's personality core or center of initiatives) and outside objects as the defining organizational principle of human life. Kohut believed that changing family lifestyles and new family forms required reexamination of Freudian theory. From his viewpoint, conflict within the person (and between people) arises early in life from a compromised sense of self rather than from instinctual conflict. Kohut focused specifically on how early relationships, especially with the caretaker mother, are crucial in forming the child's later sense of self and in affecting how well that person can make and sustain relationships later in life.

Kohut contends that initially the infant does not experience its parents as separate persons or objects but instead experiences them narcissistically as selfobjects. **Selfobject** refers to a sense of oneself in relation to an other that is needed for the sustenance or enhancement of the

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self (Skelton et al., 2006, p. 423). A selfobject is neither self nor object but the self-sustaining psychic function that takes place within a self in its relationship to others (objects) who by their presence help sustain and support the self's sense of itself. The concept can be clarified by example. An infant experiences her mother's breast as something simultaneously part of herself and as something alien depending on her needs at any given moment. Perhaps when very hungry and feeding, the available breast is experienced as something undifferentiated from the self, whereas when the infant is full, the breast might be experienced as somehow other than self—at least until hunger returns. Kohut insisted that throughout life, our self needs *require* a selfobject, and so from birth on we unconsciously seek and form selfobject relationships.

In therapy, the selfobject is analyzed by exploring the selfobject transference, which is co-created by both the client and the analyst. In Kohutian terms, the selfobject transference is the transference formed by patient within which current narcissistic needs are experienced and explored vis-a-vis the therapist. Unlike the Freudian transference, which is intended to be "worked through," the selfobject transference is to be understood so that developmental needs can be met and goals achieved. Developmentally, Kohut maintains that the infant does not yet have a self, even if the parents think otherwise. That core self begins to emerge from interactions with and responses from selfobjects. Ideally, young children start to develop a core cohesive self when they experience two qualities from their attentive parents—empathy (validating how they feel) and idealization of parents (being proud to have good parents and to be part of them). As a result of internalizing parental appreciation, the child forms an autonomous self, characterized by self-acceptance and self-esteem. Such children are said by Kohut to have their needs *mirrored* by their parents and the idealization met by satisfying interaction with parents who themselves feel self-esteem. Children whose parents fail to demonstrate sufficient appreciation or themselves have little self-esteem continue to crave admiring attention throughout life.

Narcissism, then, is ever present, especially among infants and young children, and represents a stage of development. It is not a pathological condition of self-absorption but a necessary motivating organizer of development in which love of self precedes love for others. All adults continue to have narcissistic needs they wish to fulfill and continue to need the mirroring of the self by selfobjects throughout life (St. Clair & Wigren, 2004). As Kohut (1971) notes, even as adults, seeking a connection with someone who is unresponsive or indifferent often makes us feel empty, unloved, with lowered self-esteem, and filled with narcissistic rage. By exploring "self needs" by analyzing the selfobject transference, the therapist helps the client mitigate these unpalatable "self states."

Kohut (1971) contended that patients with narcissistic personality disorders are experiencing a defect in the structure of the self, not having successfully completed the integration of the grandiose self (what the child wants or believes he or she deserves) and idealized object (what the idealized parents want him or her to do) into a reality-oriented self. It is the job of the self psychologist to help the client complete this integration. Kohut found that those who grow up feeling insufficiently admired or attended to will seek such acceptance in exaggerated

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narcissistic cravings. To the narcissistic adult, then, a selfobject is a person relatively more undifferentiated from oneself who serves the needs of the self. He or she sees everyone as an extension of self and as existing to serve the self. Within a marriage, he or she may continue to search for the idealized partner—determined to be in control, rageful if not—forever seeking merger with the unconditional availability of the mirroring selfobject or idealized object (St. Clair & Wigren, 2004).

The therapist often finds the necessary empathy to help narcissistic clients by remembering the great pain and deprivation that led to this self state. A person whose selfobject has helped her or him successfully bridge inner self states and the object world can be said to have integrated narcissistic and object needs. In this instance, narcissism is mitigated by an appreciation of others. Such a person, with healthy narcissism with which to take care of inner needs, also appreciates the existence and needs of others.

For analysis to be effective, according to Kohut, the reactivation of the original developmental tendencies must take place with the therapist. Persons with disorders of the self must be both mirrored and permitted to idealize the authentic, empathetic therapist so that both self and other may be appreciated. The term **mirroring** denotes the acceptance (even celebration) by one person (parent or therapist) of another person's narcissistic self such that the person being mirrored may experience self-acceptance. In therapy, the therapist can begin to develop within the patient mirroring or idealizing transference. In the former, the client's self is affirmed, and through the latter, the client can reinforce that affirmation by appreciating via idealization the specialness of the other. Once transference is established, therapist interpretations provide the patient with insights into how to negotiate self needs with the needs of others within the mutuality of a maturing relationship. Box 7.7 illustrates such a therapeutic situation.



BOX 7.7 THERAPEUTIC ENCOUNTER

Cinderella Revisited: A Case of a Self Disorder?

In Box 7.4, St. Clair and Wigren (2004) illustrated the use of object relations therapy in the case of Cinderella, described as representing a case of splitting. The same authors differentiate an object relations view from the self psychology of Kohut with the following:

> A therapist or analyst working within the framework of self psychology would attend to the experience that Cinderella had of herself in therapy as this experience is manifested in the transference to the therapist. Analysis of her transference might reveal an impoverished self that needed a powerful and idealized object. Cinderella's search for such an object reflects her lack of self-esteem and her need to be affirmed by such an idealized object, whether in the form of the fairy godmother, the prince, or the therapist. She needed to fuse with the idealized prince out of hope for a feeling of well-being. Out of touch with her own inner emptiness and angry feelings, Cinderella might either idealize her therapist or view the therapist the way she viewed her stepmother. (p. 3)

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LO 5 Intersubjective Psychoanalysis

Intersubjective theory originated in the United States during the 1990s and is associated with the work of Robert D. Stolorow, Bernard Brandchaft, and George E. Atwood (Atwood & Stolorow, 2014; Stolorow, Brandchaft, & Atwood, 1994, 2000). Intersubjectivity is sometimes considered synonymous with self psychology, but while the two theories share some key ideas, there are important differences between them. Both reject the concept of drives in favor of an emphasis on relationships; both feature the analyst's use of empathy and introspection as a guiding principle of the therapy (Trop, 1994), as well as the co-construction of the client–therapist relationship.

Intersubjectivity departs from the self-psychological assumption that analyst and patient are separate psychic entities even while appreciating the importance and inevitability of the patient's selfobject and selfobject transferences. Whereas the traditional self psychologist will eventually interpret the patient's selfobject transferences with the goal of helping him gain an enhanced sense of an independent self that can relate to others, the intersubjective analyst appreciates that every interaction, whether between child and parent or client and therapist, takes form within an **intersubjective field** (Skelton et al., 2006, p. 249). The intersubjective field (or matrix) represents a dynamic psychological system made up of the reciprocally interacting and differently organized subjective worlds of parent and child (or client and therapist).

Within the intersubjective field, two subjectivities meet and engage with each other. The recurrent patterns of intersubjective transaction between the two (say the child and the mother or the client and the analyst) result in the establishment of **organizing principles** that unconsciously pattern subsequent experiences (Skelton et al., 2006, p. 342). Intersubjective psychoanalytic therapy seeks to investigate and illuminate these previously established organizing patterns and establish the possibility of new ones.

Leone (2008) integrates these basic intersubjective concepts within couple therapy. She illustrates how selfobject needs, unconscious organizing principles, and learned relational patterns can be used to conceptualize couples' difficulties. She elaborates a treatment approach that involves (a) listening from within each partner's subjective perspective; (b) establishing a therapeutic dialogue through which each partner's selfobject needs, ways of organizing experience, and patterns of relating can be empathically illuminated and transformed; and (c) facilitating new relational experiences with the therapist and eventually between the partners themselves.

Livingston (2004) adds that the intersubjective model, with its emphasis on a person's subjective/affective experiences and on the experience of increasing vulnerability during therapy, invites the processing of previously unexpressed painful affect for couples. As one partner speaks about a painful concern, for example, the other may react with a self-protective response. The therapist continually strives to be attuned to each partner's shifting self/affective states as they emerge during a session. The therapist legitimizes each partner's fears and desires and at the same time reminds each that their respective responses triggered protective or impatient reactions in the other. With the support of the therapist's

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sustained empathy, each partner may develop an increased capacity for affect regulation and a strengthened psychic structure. Healing is seen as the outcome of processing intersubjective differences and ruptures that occur during therapy and the resulting deepening of intimacy of both partners.

Relational Psychoanalysis

From its inception, psychoanalysis has been concerned with human relatedness (Mitchell, 2000), although the focus during analysis or therapy remained on the patient and his or her inner world. However, some theorists and practitioners took a divergent path, most notably in Europe the Hungarian psychoanalyst and one-time confident of Freud, Sandor Ferenczi, and in the United States, Harry Stack Sullivan. Ferenczi thought differently than Freud and even went so far as to experiment in mutual analyses, whereby the patient and the analyst analyzed each other. This approach to the analytic experience was so renegade that it contributed to the end of Ferenczi's friendship with Freud. As a result, his idea of the mutuality of the psychoanalytic relationship went underground for decades.

In the United States, Harry Stack Sullivan and others wrote about the impact of the external world on a developing psyche. Without entirely abandoning drive theory, these early "interpersonalists" tended to address the relationship between outside events and personal relationships and a patient's inner world. But again, traditionalists of the time rejected this shift in emphasis, and these ideas remained marginalized for years.

Today some theorists who appreciate the mutual relationship of therapist and patient in the therapeutic encounter refer to this as **two-person psychology** (Wachtel, 2010). Greenberg and Mitchell first coined the term *relational* in their efforts to synthesize British object relations with the interpersonalists (Greenberg & Mitchell, 1983). This two-person psychology takes place within the largely unconscious intersubjective field noted by the intersubjectivists. Relational psychoanalysis involves the mutual impact of external, interpersonal, or social relations, internal relations among persons, varied self-states, and object relations (Skelton, 2006). Within this intersubjective field, the older concept of analyst as outside authority gives way to one in which both analyst and patient are equals who participate equally. They experience a "meeting of the minds," resulting in a unique "co-constructed" psychic experience that can lead to healing (Aron, 1996) for both. An analysis, then, becomes not the analyst's encounter of the patient's theoretically separate psyche so much as the occasion for two minds to meet and mutually influence each other in unique and manifold conscious and unconscious ways.

Whereas most analysts today do not go as far as Ferenczi in engaging in mutual analysis, relational analysts do include selective self-disclosure in their approach to technique. Presumably, the analyst, having already been analyzed, is more likely than the patient to become aware of the resulting unconscious constructions that emerge during the therapeutic work and can help make those constructions available to both parties by giving them language. Very often these mutual interactions require that the analyst divulge personal information to the patient. For most of the history of psychoanalytic technique, the analyst was advised to remain neutral—to be a **blank screen**—so as to allow the patient's transference

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to unfold with relative freedom. To divulge personal information was regarded as a countertransference error that unconsciously and unhelpfully gratified the patient's infantile wishes.

Relational psychoanalysis rejects the blank screen metaphor as reflecting a naive assumption that the analyst could ever be truly separate. Under the right circumstances, for example, an experienced relational therapist might say to a narcissistic client something like, "You know when you go on and on about yourself, I feel left out and unimportant to you. I wonder if that is how your wife feels when she tells you how lonely she feels." As in every therapeutic intervention, there is always some risk (in this case, the therapist should be aware that the statement is in the service of the therapy rather than a sadistic impulse of her own). In this example, a client who does value his therapist might benefit from learning that he has had an impact on her and that something within him needs to be examined. The relationship between the two in the here and now in which both parties are sharing how they feel would be seen as central to the client's growth.

According to Perlman and Frankel (2009, p. 108), a "cornerstone of all relational theory is the premise that human beings are born with a primary need for relatedness and communication with other human beings." The self is shaped through our interactions with others. This is an important point of contact with systems theory. Gerson (2010) takes this understanding of analysis into her work as a family therapist. Although she acknowledges the transference-countertransference dimensions of couple or family work, she leaves behind the traditional dyadic nature of these forces and posits a more circular one. Rather than exploring individual histories and opening hidden fantasies, as she might when working with an individual, in couples work she strives to disrupt circular—that is, repetitive—dynamically constituted problems by taking a more playful and less interpretive position. Whereas the Scharffs argue for a more traditional separation of therapist from clients, Gerson uses herself to hold the couple's dynamic processes and "plays" with them in ways that may be tolerably disruptive to old patterns. From a relational perspective, she appreciates that her work with couples is indeed co-created, but she doesn't use this awareness to enhance individual introspection. Rather, by placing her analytic knowledge in the background and moving her systems knowledge to the foreground, she interacts more directly and playfully (through the use of metaphor, visual imagery, dramatic enactments, and so on).

For more than 100 years, psychoanalytic theory and practice have changed in far-reaching ways. No longer just concerned with the inner life of the patient as the sole target of inquiry, psychoanalytic theory embraces the patient, the world in which the patient was born and developed, the patient's current family and significant relationships, as well as the patient's relationship with the therapist. Although conceptualized in many ways, relationships now stand at the center of the work for most psychoanalysts. This increased emphasis opens new ways of applying analysis to couple and family therapy. Despite all this change, however, psychoanalysis remains devoted to unconscious process, a careful and patient listening to the client's associations, attention to the dialectic between fantasy and reality, a concern with the patient's feelings toward the analyst (transference), and the psychological resistances that a patient experiences when facing uncomfortable thoughts or feelings (Mitchell & Aron, 1999).

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Postscript: Attachment Theory and Neuroscience

Psychoanalysis, like any other theory or set of theories, is not an isolated epistemology. In the postmodern world, its theories inform and are informed by other theories. Of particular importance for psychoanalysis today are attachment theory and new developments in neuroscience (Prior & Glaser, 2006).

Attachment refers to the early emotional bond that develops (or fails to develop adequately) between infants and their caregivers. According to John Bowlby (1969), infants develop a secure attachment when certain core needs in the developmental process are met. When secure, the infant who becomes frightened or feels threatened (a normal occurrence) will reach out to the caregiver (usually but not necessarily the mother) for responsiveness, comfort, and protection, confident that its needs will be met. On the other hand, those infants who experience rejection or indifference when feeling in jeopardy are likely to internalize insecure or anxious attachment relationships. For the latter group, separation from the persons with whom they have formed an attachment can lead to the emotional distress seen in infant separation anxiety.

Mary Ainsworth and her associates (1978) continued to describe the complex interactive process by which mother and child communicate. Rather than being passive recipients, babies cry, smile, fuss, gaze, grasp, babble, reach, and so forth, and so actively participate in the mother–infant relationship for survival and pleasure. According to Ainsworth's research, most infants who form *secure attachments* become upset if their mother leaves but are easily calmed when she returns. Others, less fortunate, display an *anxious-ambivalent attachment*, loudly protesting their mother's departure and not being particularly comforted by her return. A third group demonstrates *anxious avoidant attachment*, seeking little connection to the mother, showing no distress when she leaves, and often rejecting offers of comfort. Subsequently, Main and Solomon (1986) identified another type of attachment, termed *disorganized-disorientated*, a category that recognizes that some children manifest behavior that does not fit the original insecure categories but still appear insecure. The attachment style of the caregiver profoundly influences the attachment style each person eventually develops (Scharff & Scharff, 2003). Early infant experiences with maternal unavailability (due to illness, death, high stress levels, trauma, abuse, etc.) frequently leads to impaired relationships later in life. Additional research by Main has suggested how parents' attachment styles tend to get passed on to their children (Main, Goldwyn, & Hesse, 2003).

A premise of attachment theory that relates to couples therapy is that in their personal relationships, people tend to maintain the type of attachment relationship to which they are accustomed. O'Gorman (2012) demonstrates how attachment theory and systems theory share some common elements to mutual benefit. Table 7.2 outlines attachment styles and how a person evincing the style tends to relate to others, including a therapist.

Attachment styles or patterns, object relations, and self states have also been explored from the perspective of neuroscience, extending those conceptualizations. Schore (2003a, 2003b), for example, has shown how hyperaroused self states are due to the hyperactivation of the hypothalamic-pituitary adrenal (HPA) axis. This finding has impact on our understanding of how couples and families interact, as these neurological conditions would

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TABLE 7.2 Exploring attachment styles

Attachment Style	Behavior toward Significant Other
Secure	• Reach out for support (trusting it will be given) • Communicate self-revealingly • Less likely to be verbally aggressive or to withdraw in therapy during problem solving
Anxious	• Watchful and hypervigilant • Express jealousy, concerns about abandonment • Acting coercively or threateningly
Avoidant	• Act distantly

Source: Adapted from Gerson (2010)

have to be accounted for in stressful family dynamics. Schore and Schore (2014) point to early relational experiences that impact right-brain maturation, impacting all subsequent social-emotional cuing and stress regulation, leading them to develop regulation theory and affect regulation therapy. Schore and Schore (2014) present contemporary attachment theory as "the most complex theory of the development of the brain-mind-body available to science" (p. 181) because of the neurological and biological means through which attachment relationships develop. For example, affect management is imprinted as the mother-caregiver both "down-regulates" negative emotional states and "up-regulates" positive affect, shaping the child's right-brain development (p. 184). Goldstein and Thau (2004) show how this brain functioning affects working with couples. In their clinical work, they encourage awareness of states of arousal, which in turn facilitates attention to verbal and nonverbal cues that can be acknowledged as expectable and processed. Mentalization, "a form of imaginative mental activity about others or oneself, namely, perceiving and interpreting human behavior in terms of intentional mental states" (Bevington et al., 2013), and mentalization-based therapies that promote positive interpersonal relations draw upon attachment theory and affective neuroscience.

SUMMARY

Current trends favor eclecticism and integration in family therapy, as therapists borrow concepts and techniques that cross theoretical boundaries. However, distinguishing theoretical constructs remain between traditional schools, and controversy remains regarding the possibility of ever creating an integrated supertheory of family therapy.

The psychodynamic viewpoint originally focused on drive theory and the interplay of opposing forces within an individual. While treatment based on this model appears to be exclusively concerned with the personality of the single individual patient, the role of family context in personality formation is an essential element of the theory.

Nathan Ackerman, a family therapy pioneer, attempted to integrate psychoanalytic theory (with its intrapsychic orientation) and systems theory (emphasizing interpersonal relationships). He viewed family dysfunction as a failure in role complementarity between members and as the product of persistent

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unresolved conflict (within and between individuals in a family) and prejudicial scapegoating. His therapeutic efforts were aimed at disentangling such interlocking pathologies.

The psychoanalytic position today is largely based on more relationally oriented perspectives that include object relations theory, self psychology, intersubjectivity, and relational psychoanalysis. The emphasis of object relations therapists is on the infant's primary need for attachment to a caring person, and the analysis of those internalized psychic representations—objects—that continue to seek satisfaction in adult relationships.

Framo and Scharff and Scharff provide two examples of object relations therapeutic approaches. Framo believed that insoluble intrapsychic conflict, derived from the family of origin, is perpetuated in projections onto current intimates such as a spouse or children. He focused on working through and removing these introjects; his process included couples alone, then in a couples' group, and separate sessions with each partner and the members of his or her family of origin.

Scharff and Scharff use a psychoanalytic therapeutic approach to create a holding environment, evoke unconscious material, make interpretations, and provide insight, relying on transference and countertransference to help families learn how past internalized objects intrude on current family relationships. The goal is for family members to support one another's needs for attachment, individuation, and personal growth.

Kohut's work with self psychology focused on early infant relations with a caretaker mother, particularly the view of the mother as an extension of the child (a selfobject). Kohut emphasized the development of a core self, mirrored by parents, as well as the idealization of parents; he viewed both processes as essential to forming an autonomous self.

At the forefront of today's psychoanalytic-psychodynamic theories are intersubjectivity and relational psychoanalysis. Moving beyond intrapsychic experience, these theories include the impact of actual relationships on the development of personality. Intersubjectivity extends the self–other relationship of self psychology to one that sees core relationships as mutually informing within an intersubjective field of unconscious and conscious interactions that lead to the establishment of organizing principles that shape the participants' way of experiencing and understanding their inner and outer lives.

Relational psychoanalysts note the impact of external interpersonal or social relations and internal relations among a person's varied self-states and object relations. Both intersubjective and relational analysts eschew one-person psychology in favor of a two-person model. While intersubjectivists rely on self-psychological theories and techniques such as mirroring and idealization, relationalists argue that these techniques limit access to feelings and thoughts that one might find difficult or impossible to mirror. In their efforts to explore the interpersonal dynamics between themselves and their clients, they may selectively employ self-disclosure. By including the ongoing impact of others on personality, contemporary analytic theory becomes closer to similar emphases by family therapists.

Attachment theory explores the impact of early infant–caregiver interactions on the capacity of individuals to relate with others. Secure, anxious, avoidant, and disorganized attachment styles result from varied attachment experiences. Attachment informs the development of internal object relations. Neuroscience supports various attachment conditions.

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8

Transgenerational Models

LEARNING OBJECTIVES

- LO 1 Discuss the move from individual parts of the family to a focus on the whole family
- LO 2 Explain Bowen's eight interlocking concepts
- LO 3 Describe the eight forces that shape family functioning
- LO 4 Explain how one's level of differentiation effects your functioning in the world
- LO 5 Discuss the concept of triangulation
- LO 6 Understand how emotional cutoff effects individuals

Transgenerational approaches offer a psychoanalytically influenced historical perspective to current family problems by attending to family relational patterns over decades. Advocates of this view believe current family patterns are embedded in unresolved issues in the families of origin. That is not to say that earlier generations cause the problems of current families but rather that when problems remain unsettled, they persist and repeat across generations. How today's family members form attachments, manage intimacy, deal with power, resolve conflict, and so on may mirror earlier family patterns. Unresolved issues in families of origin may show up in symptomatic behavior patterns in later generations.

A number of pioneering family therapists—Murray Bowen, Ivan Boszormenyi-Nagy, James Framo, Carl Whitaker—incorporated generational issues in their work with families. As we noted earlier, Framo typically brought each partner's family members in for family-of-origin sessions in which current differences were discussed, and Whitaker invited extended family members such as grandparents as "consultants" to ongoing family sessions. However, we have chosen to place both Framo and Whitaker elsewhere in the text—Framo with the object relations therapies and Whitaker with the experiential therapies—because their efforts are also strongly influenced by these other outlooks and procedures. The remainder of this chapter focuses on the multigenerational views of Murray Bowen and Ivan Boszormenyi-Nagy.

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LO 1 Bowen's Family Theory

A key figure in the development of family therapy was Murray Bowen, who remained, until his death in 1990, its major theoretician. By turning first to Bowen's work, we present a theory that represents the intellectual scaffolding upon which much of mainstream family therapy is built. Bowen, the developer of **family systems theory**, conceptualized the family as an emotional unit, a network of interlocking relationships, best understood when analyzed within a multigenerational or historical framework.

Bowen's theoretical and therapeutic contributions bridge psychodynamically oriented approaches that emphasize the significance of past family relationships on an individual on the one hand and systems approaches that focus on the family unit as it is presently constituted and currently interacting on the other. His therapeutic stance with couples was disciplined and unruffled but engaged. He was careful not to become triangulated within the couple's emotional interaction (see his ideas on triangulation later in the chapter). By attending to the processes of their interactions and not the content, Bowen hoped to help the partners hear each other out without deafening passions, accusations, or blame and to learn what each must do to reduce anxiety and build their relationship.

Unlike many of his fellow pioneers in family therapy who struggled at first to stretch classical psychoanalytic theory to fit family life, Bowen recognized early on that most psychoanalytic concepts were too individually derived and not readily translatable into the language of the family. Rather than attempt to adapt such concepts as *unconscious motivations* to family interactive patterns, Bowen offered another view. He believed that the driving force underlying all human behavior came from the submerged ebb and flow of family life, the simultaneous push and pull between family members for both distance and togetherness (Wylie, 1990b). *This attempt to balance two life forces—family togetherness and individual autonomy—was for Bowen the core issue for all humans*. Successfully balanced, such persons are able to maintain intimacy with loved ones while differentiating themselves sufficiently as individuals.

Since his early clinical work with schizophrenics and their families at the Menninger Clinic as well as at the National Institute for Mental Health (NIMH), Bowen stressed the importance of theory for research, teaching, and psychotherapy. He was concerned with the field's lack of a coherent and comprehensive theory of either family development or therapeutic intervention and its all-too-tenuous connections between theory and practice. In particular, Bowen (1978) decried efforts to dismiss theory in favor of an intuitive "seat-of-the-pants" approach, which he considered especially stressful for a novice therapist coping with an intensely emotional, problem-laden family.

Bowen's professional interest in the family began early in his career when he trained as a psychiatrist and remained on the staff at the Menninger Clinic. Under the leadership of Karl Menninger, innovative psychoanalytic approaches were being tried in treating hospitalized persons suffering from severe psychiatric illnesses. Intrigued by the family relationships of inpatients, especially schizophrenics, Bowen became particularly interested in researching the possible transgenerational impact of a mother–child **symbiosis**, or intense enmeshment, in the development and maintenance of schizophrenia. Extrapolating from the psychoanalytic concept that schizophrenia might result from an unresolved symbiotic attachment to the

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mother, herself immature and in need of the child to fulfill her own emotional needs, Bowen began studying the emotional *fusion* between schizophrenic patients and their mothers. In 1951, in order to view their relationship close up, he organized a research project in which mothers and their schizophrenic children resided together in cottages on the Menninger grounds for several months at a time.

In 1954, Bowen was eager to put his new ideas regarding family dynamics into clinical practice. However, stifled by what he saw as the prevailing emphasis on conventional individual psychiatry at the Menninger Clinic, he moved his professional research activities to the NIMH in Bethesda, Maryland. Soon, in what was a radical idea for its time, Bowen had entire families with schizophrenic members living for months at a time in the hospital research wards, where he and his associates were able to observe ongoing family interaction. Here Bowen discovered that the emotional intensity of the mother–child interaction was even more powerful than he had suspected (Kerr, 2003). More important, the emotional intensity seemed to characterize relationships throughout the family,[1] not merely those between mother and child. Fathers and siblings also were found to play key roles in fostering and perpetuating family problems (Hargrove, 2009). Bowen recognized that these additional relations took the form of triangular alliances that were continually formed and dissolved among differing sets of family members.

The reciprocal functioning of all the individual members within the family became so apparent that Bowen expanded his earlier mother–child symbiosis concepts to viewing the entire family as an unbalanced emotional unit made up of members unable to separate or successfully differentiate themselves from one another. Although he did not adopt a cybernetic epistemology per se, nor was he interested especially in directly changing a family's ongoing interactive patterns, Bowen had moved from concentrating on the separate parts of the family (the patient with the "disease") to a focus on the whole family.



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Murray Bowen, M.D.

Then he began to direct his attention to what he called the family emotional system—a kind of family guidance system shaped by evolution that governs its behavior. The conceptual shift proved to be a turning point in his thinking, as Bowen increasingly viewed human emotional functioning as part of a *natural system* that followed the same laws that govern other systems in nature, such as the laws of gravity. Bowen began to study human emotional functioning in a more rigorously scientific way. In so doing, Bowen was beginning to formulate nothing less than a new theory of human behavior.

Family systems theory (sometimes referred to as *natural systems theory* to differentiate it from cybernetically based family systems theories) is derived from the biological view of the human family as one type of living system. As Friedman (1991) points out, the theory is

[1]Bowen's early observations of the emotional intensity of families with schizophrenic members have been confirmed by research on the role of expressed emotions such as anger and hostility on the course of the schizophrenic disorder. Studies of schizophrenics following hospital release indicate that lowering expressed emotion in the family is a major way of reducing relapse (Miklowitz, 1995).

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not fundamentally about families but about life (or what Bowen referred to as the "human phenomenon"), and it attempts to account for humanity's relationship to other natural systems. As Wylie (1990b, p. 26) explains, Bowen "considered family therapy a by-product of the vast theory of human behavior that he believed it was his real mission to develop." According to the theory, the human family is seen as appearing due to an evolutionary process in nature. Thus, like all living systems (ant colonies, the tides, the solar system), humans and the human family are guided by processes common in nature. In particular, the theory concerns itself with a special kind of natural system—the family's emotional system (Kerr, 2003).

When the NIMH project ended in 1959, Bowen moved to the Department of Psychiatry at Georgetown University in Washington, DC, because the university was a place more conducive to his theoretical bent. He remained there for 31 years, until the end of his career. Working in an outpatient setting, and with families many of whom had less severe problems than schizophrenia, Bowen continued to formulate a comprehensive family systems theory that could be applied to processes occurring in all families, functional as well as dysfunctional. At the same time, he proposed a method of therapy based on a solid theoretical foundation. Developing a training program in family therapy while continually refining the concepts he first developed in the 1960s, he published *Family Therapy in Clinical Practice* in 1978, detailing his theoretical formulations and offering therapeutic techniques consistent with that theory. In 1977, Bowen became the first president of the newly formed American Family Therapy Association, an organization he helped found to pursue interests in research and theory.

LO 2 Eight Interlocking Theoretical Concepts

Bowen's theory of the family as an emotional relationship system consists of eight interlocking concepts. Six address emotional processes taking place in the nuclear and extended families; two concepts—emotional cutoff and societal regression—speak to the emotional processes across generations in a family and in society. All eight constructs are interlocking, so none is fully understandable apart from the others (Kerr, 2003).

The eight concepts are tied together by the underlying premise that *chronic anxiety* is omnipresent in life. While it may manifest itself differently, and with different degrees of intensity depending on specific family situations and differing cultural considerations, chronic anxiety is an inevitable part of nature. Bowen viewed chronic anxiety as a biological phenomenon that humans have in common with all forms of life (Friedman, 1991). From this natural systems perspective, past generations transmit chronic anxiety, which impacts family members as they balance togetherness and individual self-differentiation.

Anxiety is the sense of arousal in an organism when it perceives a real or imagined threat. In humans, anxiety stimulates the emotional system, overriding the cognitive system and leading to behavior that is automatic or uncontrolled (Kerr, 2003). Anxiety is inevitably aroused as families struggle to balance the pressures toward togetherness as well as toward individuation. If greater togetherness prevails, imbalance results and the family moves toward increased emotional functioning and less individual autonomy, leading the person to experience increased chronic anxiety.

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Consider the case of a high school senior who comes from a working-class family in which a sense of togetherness prevails over an appreciation of the individuality of its members. She has just been accepted to a college in another state and has been offered a scholarship. As the family has only limited financial means, the scholarship represents a major opportunity. In a family such as this, the other members might subtly or explicitly pressure the young woman not to take this chance. Let's say that part of her wants to go while a part of her understands (because of the submerged ebb and flow of family dynamics) that she shouldn't go. The chance exists that the family demands for togetherness could keep this young woman feeling anxious, from finding herself as an individual and achieving important life goals. Chronic anxiety, then, represents the underlying basis of all symptomatology; its only antidote is resolution through differentiation (see next section), the process by which an individual learns to chart his or her own direction rather than perpetually following the guidelines of family and others.

LO 3 According to Family Systems Theory, Eight Forces Shape Family Functioning:

1. Differentiation of self
2. Triangles
3. Nuclear family emotional system
4. Family projection process
5. Emotional cutoff
6. Multigenerational transmission process
7. Sibling position
8. Societal regression

LO 4 Differentiation of Self

The cornerstone of the Bowen family systems theory is the notion of forces within the family that lead to individuality and the opposing forces that make for togetherness. Both intrapsychic and interpersonal issues are involved here. In the former, the person must, in the face of anxiety, develop the ability to separate feelings from thinking and to choose whether to be guided in a particular instant by intellect or emotion. In the latter, he or she must be able to experience intimacy with others but separate as an autonomous individual from being caught up in any emotional upheaval sweeping the family. The well-differentiated person is able to balance thinking and feeling (adhering to personal convictions while expressing individual emotions) and at the same time retain objectivity and flexibility (remaining independent of the family's emotional pressures).

Differentiation of self, says Bowen, reflects the extent to which a person is able to distinguish between the intellectual process and the feeling process of what he or she is experiencing. Differentiation of self is demonstrated by the degree to which a person can think, plan, and follow his or her own values or convictions, particularly around anxiety-provoking issues, without having behavior automatically driven by the emotional cues from others.

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BOX 8.1 CLINICAL NOTE

A Feminist Challenge

Some feminists such as Hare-Mustin (1978) and Lerner (1986) dispute Bowen's contentions regarding the differentiation of self. They argue that what Bowen seems to value here are qualities—being autonomous, relying on reason above emotion, being goal directed—for which men are socialized, while simultaneously devaluing those qualities—relatedness, caring for others, nurturing—for which women typically are socialized. However, Bowenians McGoldrick and Carter (2001) maintain that by distinguishing between thinking and feeling, Bowen was addressing the need for controlling one's emotional reactivity in order to control behavior and think about how we choose to respond and was not arguing for the suppression of authentic or appropriate emotional expression.

One way people can demonstrate (especially to therapists) their degree of relative differentiation is through speaking in I-statements (reflective of I-positions), that is, statements that verbalize the degree of separation an individual feels vis-à-vis others.

The degree to which one separates emotionally from parents in growing up is key to differentiation. In extreme cases, the attachment becomes a symbiosis in which parents and child cannot survive without one another. Such unresolved emotional attachment is equivalent to a high degree of undifferentiation in a person and in a family (Papero, 1995). (In other cultures, particularly those that focus on family togetherness, individuality and differentiation may be expressed differently.)

The ideal here is not to be emotionally detached or fiercely objective or without feelings, but rather to strive for balance, achieving self-definition but not at the expense of losing the capacity for spontaneous emotional expression. Individuals should not be driven by feelings they do not understand. As Hargrove (2009) notes, "The person who balances emotional reactivity and thinking without regard to the family's emotional process is thought to be functioning at a higher level of differentiation of self" (p. 290).

As Papero (1990, p. 48) summarizes, "To the degree that one can thoughtfully guide personal behavior in accordance with well-defined principles in spite of intense anxiety in the family, he or she displays a level or degree of differentiation." For example, suppose our high school student mentioned previously chooses to go to college. After living away, she goes home at midyear to attend her sister's wedding. Amid the tensions that typically occur around such an event, to what degree is she drawn into family feuds, conflicts, coalitions, or emotional turmoil? Her differentiation can be gauged by the degree to which she is able to remain sufficiently involved to enjoy the pleasures of this family event while sufficiently separated so as not to be drawn into the family emotional system.

Individuals with the greatest **fusion** between their thoughts and feelings (e.g., schizophrenics dealing with their families) function most poorly; they are likely to be at the mercy of automatic or involuntary emotional reactions and tend to become dysfunctional even under low levels of anxiety. Unable to differentiate thought from feeling, such persons have trouble differentiating themselves from others and merge easily with whatever emotions dominate or sweep through the family. Highly fused persons, with few firmly held positions

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of their own, are apt to remain emotionally "stuck" throughout their lives in the position they occupied in their families of origin (Bowen, 1978).

Bowen (1966) early on introduced the concept of **undifferentiated family ego mass**, a term derived from psychoanalysis. The term conveys the idea of a family emotionally "stuck together," one in which "a conglomerate emotional oneness . . . exists in all levels of intensity" (p. 171). The classic example of the symbiotic relationship between mother and child may represent the most intense version of this concept (in such families, a father's detachment may be the least intense). The degree to which any one member is involved in the family from moment to moment depends on that person's basic level of involvement in the family ego mass. Sometimes the emotional closeness can be so intense that family members feel they know each other's feelings, thoughts, fantasies, and dreams. This intimacy may lead to uncomfortable "overcloseness" and ultimately to a phase of mutual rejection between members. So emotional tensions in a family system shift over time (sometimes slowly, sometimes rapidly) in a series of alliances and splits.

Bowen later recast the term *undifferentiated family ego mass* into systems language as *fusion-differentiation*. Both terms underscore the transgenerational view that maturity and self-actualization demand that an individual become free of unresolved emotional attachments to his or her family of origin. To illustrate his point, Bowen (1966) proposed a theoretical scale (not an actual psychometric instrument) for evaluating an individual's differentiation level. As noted in Figure 8.1, the greater the degree of undifferentiation (no sense of self or a weak or unstable personal identity), the greater the emotional fusion into a common self with others (the undifferentiated family ego mass). A person with a strong sense of self ("These are my opinions . . . This is who I am . . . This is what I will do, but not this") expresses convictions and clearly defined beliefs. Such a person is said to be expressing a *solid self*. He or she does not compromise that self for the sake of marital bliss, to please parents, or to achieve family harmony.

People at the low end of the scale are those whose emotions and intellect are so fused that their lives are dominated by the feelings of those around them. As a consequence, they feel anxious and are easily stressed into dysfunction. Fearful and emotionally needy, they sacrifice their individuality in order to ensure acceptance from others. They are expressing an undifferentiated *pseudo self*, which they may deceive themselves into thinking is real but which is composed of the opinions and values of others. Those far fewer individuals at the high end are emotionally mature. They can think, feel, and take actions on their own despite external pressures to fall in line. Because their intellectual or rational functioning remains relatively (although not completely) dominant during stressful periods, they are more certain of who they are and what they believe, freer to make judgments independent of any emotional turmoil around them. In the midrange are persons with relative degrees of fusion or differentiation. Note that *the scale eliminates the need for the concept of normality*. It is possible for people at the low end of the scale to keep their lives in emotional equilibrium and stay free of symptoms, thus appearing "normal." However, they are more vulnerable to stress and, under stress, may develop symptoms from which they recover far more slowly than those at the high end of the scale.

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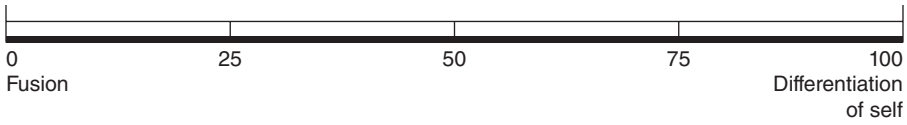


FIGURE 8.1 Bowen's theoretical differentiation-of-self scale distinguishes people according to the degree of fusion or differentiation between their emotional and intellectual functioning

- **Those at the lower level (0–25) are emotionally fused to the family and others, and lead lives in which their thinking is submerged and their feelings dominate.**
- **Those in the 25–50 range are still guided by their emotional system and the reactions of others; goal-directed behavior is present but carried out in order to seek the approval of others.**
- **In the 50–75 range, thinking is sufficiently developed so as not to be dominated by feeling when stress occurs, and there is a reasonably developed sense of self.**
- **Those rare people functioning between 75 and 100 routinely separate their thinking from their feelings; they base decisions on the former but are free to lose themselves in the intimacy of a close relationship. Bowen (1978) considers someone at 75 to have a very high level of differentiation.**
- **Those over 60 constitute a small percentage of society.**

To summarize:

- Below 50 (low differentiation): tries to please others; supports others and seeks support; dependent; lacks capacity for autonomy; primary need for security; avoids conflict; little ability to independently reach decisions or solve problems.
- 51–75 (midrange differentiation): definite beliefs and values but tends to be overconcerned with the opinions of others; may make decisions based on emotional reactivity, especially whether significant others will disapprove.
- 76–100 (high differentiation): clear values and beliefs; goal directed; flexible; secure; autonomous; can tolerate conflict and stress; well-defined sense of solid self and less pseudo self (Roberto, 1992).

A person's level of differentiation also relates to the person's relative independence from others outside the family group. A moderate to high level of differentiation permits interaction with others without fear of fusion (losing one's sense of self in the relationship). While all relationships ranging from poorly to well-differentiated ones are in a state of dynamic equilibrium, the flexibility in that balance decreases as differentiation decreases. Figure 8.2 illustrates the varying degrees to which a person's functioning can be influenced by the relationship process.

Bowen family systems theory assumes that an instinctively rooted life force in every human propels the developing child to grow up to be an emotionally separate person, able to think, feel, and act as an individual. At the same time, a corresponding life force propels the child and family to remain emotionally connected. Because of these counterbalancing forces, no one ever achieves complete emotional separation from the family of origin. There are considerable differences in the amount of separation each of us accomplishes, including differences between siblings in the degree to which they emotionally separate from the family.

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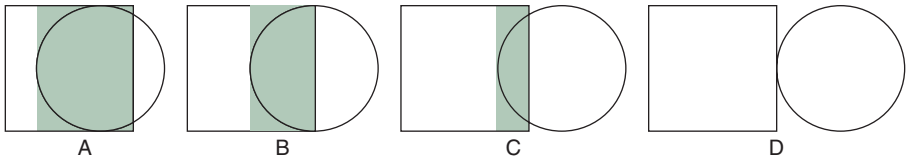


FIGURE 8.2 Relationship A is one where the functioning of each person is almost completely determined by the relationship process. The degree to which individual functioning is either enhanced or undermined by the relationship is indicated by the shaded area. The clear area indicates the capacity for self-determined functioning while in a relationship. Relationships B and C are progressively better differentiated. Individual functioning, therefore, is less likely to be enhanced or undermined by the relationship process. Relationship D is theoretical for the human. It represents two people who can be actively involved in a relationship yet remain self-determined

Source: Kerr and Bowen (1988), p. 71.

The latter is due to characteristics of the different parental relationships established with each child, which we elaborate on later in this section.

LO 5 Triangles

Bowen family systems theory also emphasizes the emotional tension within an individual or in that person's relationships. For example, the greater the fusion in a couple, the more difficult it is to find a stable balance satisfying to both. One way to defuse such an anxious two-person relationship, according to Bowen (1978), is to triangulate—draw in a significant family member to form a three-person interaction. Triangulation is a common way that two-person systems under stress attempt to achieve stability (Hargrove, 2009).

Think of a couple in therapy that are considering divorce. After weeks of hostility and mutual blaming, the therapist invited the couple to bring in their 16-year-old son and asks the young man, "What do you think of your parents getting a divorce?" The young man, looking very sad, says, "Finally, someone has asked me for my opinion." Each parent looks at each other and realizes that in their fused state of rage and anxiety, they have both neglected their son. They both take deep breaths and for the first time start talking more honestly about all their thoughts and feelings. As this example suggests, the basic building block in a family's emotional or relational system is the **triangle**. During periods when anxiety is low and external conditions are calm, the dyad or two-person system may engage in a comfortable back-and-forth exchange of feelings. However, the stability of this situation is threatened if one or both participants get upset or anxious, either because of internal stress or from stress external to the pair. When a certain moderate anxiety level is reached, one or both partners often will involve a vulnerable third person.

Let's continue the example of the divorcing couple and their son by suggesting that throughout their lives together, the son has often played the role of his parents' referee. A few weeks of family therapy go by, and the son tells his parents and the therapist that he feels that his father's frequent absences from home due to his sales job are the cause of his parents'

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problems. The father becomes defensive and angry, and the mother becomes anxious. She now turns to the therapist and says, "That is one of the most important problems between us. He's never home. Certainly you see how painful this has been for me." Now the mother, perhaps with the son's collusion, wants to create a new triangle, this time with the therapist. The therapeutic goal is for the clients to view themselves as individual, differentiated selves as well as family members. However, if the therapist (as the third person in the triangle) loses emotional contact with the other two, the twosome will proceed to triangulate with someone else.

Bowen (1976) refers to the triangle as the smallest stable relationship system. By definition, a two-person system is unstable and forms a three-person system under stress as each partner creates a triangle in order to reduce the tension in their relationship. When anxiety is so great that the three-person triangle can no longer contain the tension, the distress may spread to others (as when the family in our example tried to triangulate with the therapist). As more people become involved, the system may become a series of *interlocking triangles*, in some cases heightening the very problem the triangulations sought to resolve. For example, a distraught mother's request for help from her husband in dealing with their daughter is met with withdrawal by the father. As the mother–daughter conflict escalates, she communicates her distress to a son, who proceeds to get into conflict with his sister for upsetting their mother. What began as a mother–daughter conflict has now erupted into interlocking conflicts—between mother and daughter, brother and sister, and mother and father. Thus, triangles extend and interlock into ever-larger groups as tension increases (Kerr, 2003). Sometimes such triangulation can reach beyond the family, ultimately encompassing social agencies or the courts.

Generally speaking, the higher the degree of family fusion, the more intense and insistent the triangulating efforts will be. The least-well-differentiated person in the family is particularly vulnerable to being drawn in to reduce tension. Often this person winds up being the identified patient. The higher a family member's degree of differentiation, the better that person will manage anxiety without creating triangles (Papero, 1995). Beyond seeking relief of discomfort, the family relies on triangles to help maintain an optimum level of closeness and distance between members while permitting them the greatest freedom from anxiety. Perhaps in our example, the father and mother might discuss the prospect of divorce with their son.

Kerr and Bowen (1988; Kerr, 2003) point out that triangulation has at least four possible outcomes: (a) a stable twosome can be destabilized by the addition of a third person (e.g., the birth of a child brings conflict to a harmonious marriage); (b) a stable twosome can be destabilized by the removal of a third person (a child leaves home and thus is no longer available to be triangulated into parental conflict); (c) an unstable twosome can be stabilized by the addition of a third person (a conflictual marriage becomes more harmonious after the birth of a child); and (d) an unstable twosome can be stabilized by the removal of a third person (conflict is reduced by getting a third person, say a mother-in-law who has consistently taken sides, out of the picture).

In another familiar example, conflict between siblings quickly attracts a parent's attention. Let us assume that the parent has positive feelings toward both children. If the parent can control his or her emotional responsiveness and manage not to take sides while staying in contact with both children, the emotional intensity between the siblings will diminish.

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As McGoldrick and Carter (2001) observe, involvement in triangles and interlocking triangles represents a key mechanism whereby patterns of relating to one another are transmitted over generations in a family.

Nuclear Family Emotional System

Bowen (1978) contends that people choose mates with levels of differentiation equivalent to their own. The relatively undifferentiated person will be attracted to a person who is equally fused to his or her family of origin. These poorly differentiated people, now married, likely will become highly fused and produce a family with the same characteristics. Bowen indicates that the resulting **nuclear family emotional system** will be unstable and will seek to reduce tension and maintain stability. The greater the nuclear family's fusion, the increased likelihood of anxiety and potential instability, and the greater the family's propensity to seek resolution through fighting, distancing, exploiting the compromised functioning of one partner, or banding together over concern for a child (Kerr, 1981).

Kerr and Bowen (1988) note three possible symptomatic patterns in a nuclear family when partners are intensely fused. The greater the level of fusion in the marital dyad, the more frequently are these mechanisms likely to occur. Similarly, in a family with a high level of chronic anxiety, these mechanisms are at work continuously, their intensity or frequency changing in response to acute anxiety being experienced at the moment (Papero, 1990). Each pattern described here is intensified by anxiety and, when the intensity reaches a sufficient level, results in a particular form of symptom development. The person (or relationship) who manifests the symptom is largely determined by the patterns of emotional functioning that predominate in a family system. The three patterns are as follows:

1. *Physical or emotional dysfunction in a spouse*, sometimes chronic, an alternative to dealing directly with family conflict; the anxiety generated by the undifferentiated functioning of every family member is absorbed disproportionately by a symptomatic parent.

2. *Overt, chronic, unresolved marital conflict*, in which cycles of emotional distance and over closeness occur; both the negative feelings during conflict and the positive feelings for one another during close periods are likely to be equally intense in roller-coaster fashion; the family anxiety is being absorbed by the husband and wife.

3. *Psychological impairment in a child*, enabling the parents to focus on the child and ignore or deny their own lack of differentiation; as the child becomes the focal point of the family problem, the intensity of the parental relationship is diminished. Thus the family anxiety is absorbed in the child's impaired functioning; the lower a child's level of differentiation, the greater his or her vulnerability to increases in family anxiety and dysfunction. Furthermore, dysfunction in one spouse may take the form of an *overadequate-underadequate reciprocity*, in which one partner takes on most or even all family responsibilities (earning a living, caring for the children, cooking, shopping, arranging a social life, and so on) while the other plays the counterpart role of being under-responsible (can't drive without anxiety, can't choose clothes, can't have friends to the house). Fused together, the two pseudo selves develop an arrangement in which one partner increasingly underfunctions while the other

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takes up the slack by assuming responsibility for them both. When the tilt gets too great, according to Singleton (1982), the one giving up more pseudo self for the sake of family harmony becomes vulnerable to physical or emotional dysfunction.

In some cases, this pattern intertwines with marital conflict, as when the underadequate one complains of dominance, inconsiderateness, and so forth from the spouse. The overadequate one is more comfortable with the arrangement until the underadequate one complains or becomes so inadequate as to cause difficulties for the overadequate one. This problem is likely to be seen by the unsophisticated eye as belonging to the unhappy underadequate spouse rather than as a relationship problem for which both need help.

Almost any family will have one child who is more vulnerable to fusion than the others and thus likely to be triangulated into parental conflict. Any significant increase in parental anxiety triggers this child's dysfunctional behavior (in school, at home, or both), leading to even greater anxieties in the parent. In turn, the child's behavior becomes increasingly impaired, sometimes turning into a lifelong pattern of poor functioning.

The nuclear family emotional system is a multigenerational concept. Family systems theorists believe individuals tend to repeat in their marital choices and other significant relationships the patterns of relating learned in their families of origin and to pass along similar patterns to their children. The only effective way to resolve current family problems is to change the individual's interactions with his or her family of origin. As that person changes, others in emotional contact with him or her will make compensatory changes (McGoldrick & Carter, 2001). As differentiation proceeds, all become less overreactive to the emotional forces sweeping through the family.

Family Projection Process

Parents do not respond in the same way to each child in a family, despite any claims to the contrary. That is, they pass on their level of differentiation to the children in an uneven fashion: some emerge with a higher level than their parents, some with a lower level, and others with a more or less identical level (Papero, 1995). In particular, those children more exposed to parental immaturity tend to develop greater fusion to the family than their more fortunate siblings and have greater difficulty separating smoothly from their parents. Responding to their mother's anxiety, they remain more vulnerable to emotional stresses within the family and consequently live lives more governed by emotional upheavals than do their brothers or sisters.

The fusion-prone, focused-on child is the one most sensitive to incipient signs of instability and other disturbances within the family. Bowen (1976) believed that poorly differentiated parents, themselves immature, select as the object of their attention the most infantile of all their children, regardless of his or her birth order in the family. This child receives the parents' own low levels of differentiation and becomes that way him- or herself. Bowen calls this transmission experience the **family projection process**. In many cases, this child is physically or mentally handicapped or psychologically unprotected in some fashion and pays the price by becoming poorly self-differentiated.

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The intensity of the family projection process is related to two factors: the degree of immaturity or undifferentiation of the parents and the level of stress or anxiety the family experiences. In a triangulating scenario described by Singleton (1982), the child responds anxiously to the mother's anxiety as principal caretaker. The mother becomes alarmed at what she perceives as the child's problem and becomes overprotective. Thus, a cycle is established in which the mother infantilizes the child, who in turn becomes demanding and impaired. The third leg of the triangle is supplied by the father, who is frightened by his wife's anxiety and by needing to calm her but, without dealing with the issues, plays a supportive role in her dealings with the child. As collaborators, the parents have now stabilized their relationship around a "disturbed" child and in the process perpetuated the family triangle. That person will be less able to function autonomously in the future.

LO 6 Emotional Cutoff

Children less involved in the projection process are apt to emerge with a greater ability to withstand fusion, to separate thinking and feeling. Those who are more involved try various strategies to separate upon reaching adulthood, or even before. They may attempt to insulate themselves from the family by geographic separation (moving to another state), through the use of psychological barriers (cease talking to parents), or by the self-deception that they are free of family ties because actual contact has been broken off. This latter experience was charmingly portrayed in the 2002 romantic comedy *My Big Fat Greek Wedding*, in which a Greek-American woman falls in love with a non-Greek man. The overly close family can't tolerate this relationship and at first fights to stop it. The movie is about the young woman's experience in separating. In time, everyone seems to come together in mutual respect. However, during the last scene, the bride's parents give the newly married couple a new house as a wedding gift, which is, of course, right next door to theirs. While cultural issues certainly play a role here, we witness a situation in which psychological gains of separation might be seen to have been mitigated by lingering family dynamics of overinvolvement.

Bowen (1976) considers such supposed freedom an **emotional cutoff**—a flight of extreme emotional distancing in order to break emotional ties—and not true emancipation. In Bowen's formulation, cutting oneself off emotionally from one's family of origin often represents a desperate effort to deal with unresolved fusion with one or both parents—a way of managing the unresolved emotional attachment to them. More likely than not, the person attempting the cutoff tends to deny to himself or herself that many unresolved conflicts remain with family-of-origin members. Kerr (1981) contends that emotional cutoff *reflects* a problem (underlying fusion between generations), *solves* a problem (reducing anxiety associated with making contact), and *creates* a problem (isolating people who might benefit from closer contact). As McGoldrick and Carter (2001) note, cutting off a relationship by physical or emotional distance does not end the emotional process but actually intensifies it. Cut off from siblings or parents, those individuals are apt to form new relationships (with a spouse or children) that are all the more intense and that may lead to further distancing and cutoffs from those new relationships.

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Cutoffs occur most often in families in which there is a high level of anxiety and emotional dependence (Bowen, 1978). As both factors increase and greater family cohesiveness is expected, conflicts between family members may be disguised and hidden. Should the fusion-demanding situation reach an unbearable stage, some members may seek greater distance, emotionally, socially, perhaps physically, for self-preservation. When a family member insists on communication, it is apt to be superficial, inauthentic, and brief (short visits or phone calls during which only impersonal topics are discussed).

Bowen insisted that adults must resolve their emotional attachments to their families of origin. In a revealing paper (1972), he openly described his personal struggles to differentiate from his own family of origin. Without differentiation, Bowen argued, family therapists may unknowingly be triangulated into conflicts in their client families (much as they were as children in their own families), perhaps overidentifying with one family member or projecting onto another their own unresolved family conflicts. Family therapists need to ensure that unfinished business from their past does not intrude on current dealings with client families.

Multigenerational Transmission Process

In perhaps his most intriguing formulation, Bowen (1976) proposed the concept of a **multigenerational transmission process**, in which severe dysfunction is conceptualized as the result of chronic anxiety transmitted over several generations. Two earlier concepts are crucial here: (1) the selection of a spouse with a similar differentiation level and (2) the family projection process that results in lower levels of self-differentiation for the targeted offspring, who is often particularly sensitive to parental emotional patterns. By contrast, children less involved in parental overfocusing can develop a higher level of differentiation than their parents (Roberto, 1992). So a single multigenerational family may create individuals at various points of differentiation (Kerr, 2003).



BOX 8.2 THERAPEUTIC ENCOUNTER

Bowen's Self-Differentiation from His Family of Origin

Bowen's self-revealing article "Toward a Differentiation of Self in One's Family" (1972) was published under an anonymous authorship because Bowen was describing real people whose anonymity he wished to protect. Actually, the entire process of achieving greater self-differentiation from his family of origin represents a deliberate effort by Bowen to confront entrenched and complex patterns of family interaction.

Given an opportunity to return home for the funeral of a distant relative, Bowen decided to apply his newly formulated ideas about fusion, triangles, and so on, at a time when family members were experiencing anxiety and thus might be more open to change. Purposely provoking a response by raising old family emotional issues, he managed to remain detached and undefensive, to calm his family's anxieties, and in the process to differentiate himself once and for all. Wylie (1990b) reports Bowen's exhilaration about successfully carrying out the visit without becoming triangulated or fused into the family's emotional system. Bowen's self-differentiation efforts have sometimes been compared to Freud's self-analysis. Therapists training to practice Bowen's techniques work on differentiating themselves from their families of origin, much as candidates wishing to become psychoanalysts have a training analysis (Titelman, 1987).

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Assume for a moment that the least-well-differentiated members of two families marry—as Bowen's theory would predict—and that at least one of their children, due to the projection process, will have an even lower differentiation level than theirs, which in turn increases his or her anxiety. The eventual marriage of this person—again, to someone with a similarly poor differentiation of self—passes along the reduced level of differentiation to the members of the next generation, who in turn pass it along to the next, and so on. As each generation produces individuals with progressively poorer differentiation ("weak links"), those people are increasingly vulnerable to anxiety and fusion and, as noted, to spousal dysfunction, marital conflict, or child impairment. If the parents focus their anxiety on the most vulnerable offspring, that poorly differentiated person will grow up having a difficult time managing emotional reactions and maintaining autonomy.

Although the process may slow down or remain static over a generation or two—it may take as many as 8 or 10 generations—ultimately, a level of impairment is reached that is consistent with dysfunction (Papero, 1990). If the family encounters severe stress and anxiety, however, serious dysfunction may develop in an earlier generation. In some less stressful cases or under favorable life circumstances, poorly differentiated people may keep their relationship system in relatively symptom-free equilibrium for several generations longer. This process may be reversed, of course, should someone in this lineage marry a person considerably higher on the differentiation-of-self scale. However, as noted earlier, Bowen contended that most persons choose mates at more or less their own level of differentiation.

Sibling Position

Bowen credits Toman's (1961, 1993) research on the relationship between birth order and personality with clarifying his own thinking regarding the influence of **sibling position** in the nuclear family emotional process. Toman hypothesized that children develop certain fixed personality characteristics based on their birth order in the family. He offered 10 basic personality sibling profiles (such as older brother, younger sister; younger brother, older sister; only child; twins), suggesting that the more closely a marriage duplicates one's sibling place in childhood, the better will be its chance of success. Thus, a first-born would do well to marry a second-born, for example. He further maintained that, in general, the chances for a successful marriage are increased for persons who grew up with siblings of the opposite sex rather than with same-sex siblings only.

Bowen realized that interactive patterns between marital partners may be related to the position of each partner in his or her family of origin, since birth order frequently predicts certain roles and functions within one's family emotional system. Thus, an oldest child who marries a youngest may expect to take responsibility, make decisions, and so on. That person's mate also expects this behavior based on his or her experiences as the youngest in the family. Two youngest children who marry may both feel overburdened by responsibility and decision making. The marriage of two oldest children may be overly competitive because each spouse is accustomed to being in charge (Kerr, 1981). Note, however, that it is a person's *functional* position in the family system, not necessarily the actual order of birth, that shapes future expectations and behavior.

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BOX 8.3 FAMILY DIVERSITY

Bowen and diversity

Although Bowen tried to remain current in dealing with society's influences on family life, his efforts many years ago did not anticipate the current interest in how gender, race, ethnicity, sexual orientation, and so forth affect attitudes, beliefs, behavior patterns, and the transmission of family values over generations. As we emphasize throughout this text, those factors are at the forefront of contemporary family psychology and family therapy.

Societal Regression

In the final, least well developed of his theoretical formulations, **societal regression**, Bowen argued that society, like the family, contains within it opposing forces toward undifferentiation and toward individuation. Under chronic stress (population growth, depletion of natural resources) and an anxious social climate, there emerges an emphasis on short-term solutions based on self-interest rather than community interest (Kerr, 2003).

It was Bowen's (1978) pessimistic view that society's functional level of differentiation had decreased over the last several decades, leading Kerr (2003) to the conclusion that the percentage of undifferentiated and low-functioning individuals is higher. Kerr (2003) predicts a reversal when the distress of ill-formed "easy" solutions compels more people to act in thoughtful and responsible ways.

Empirical Support for Bowen's Theories

How valid are Bowen's theories? For many years his theories, while certainly influential, lacked empirical support. In recent years, however, studies have been conducted to address this question. Skowron and Friedlander (1998) developed a self-report instrument, the Differentiation of Self Inventory, subsequently revised (2003), that focuses on intrapersonal and interpersonal factors. In a preliminary study, adults with scores reflecting less emotional reactivity and less fusion showed lower chronic anxiety and greater marital satisfaction. Jankowski and Hooper (2012) subsequently found support for the measure of differentiation of self in research and clinical assessment, especially when focused on use of the Emotional Cutoff and Emotional Reactivity subscales together.

Bartle-Haring, Glade, and Vira (2005) hypothesized that clients with higher levels of differentiation would improve more quickly in therapy than clients with lower levels of differentiation. The results showed variation in the initial levels of psychological symptoms and that differentiation was a significant predictor of this variance.

Differentiation levels sometimes are used to assess other aspects of individual or family functioning. Klever (2009) studied the impact of differentiation of self on goal direction and effectiveness and emotional maturity. The study examined 50 developing nuclear families over 5 years. Couples with higher-functioning nuclear families, when compared with couples with lower-functioning families, placed more emphasis on family goals, had more balance between family and personal goals, and pursued more goals over the 5 years. Quantitative analysis supported the hypothesis that goal effectiveness and emotional maturity influenced variation

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in nuclear family functioning. And couples' goal effectiveness and emotional maturity were associated with nuclear family functioning more strongly than individual goal effectiveness and emotional maturity were associated with individual functioning. Priest (2013) found that differentiation is an important factor in the interaction between a history of family violence and subsequent generalized anxiety disorder and romantic relationship distress.

Peleg (2008) studied the relationship between differentiation of self and marital satisfaction in various stages of married life were studied. Marital satisfaction was found to be inversely correlated with emotional cutoff, so that lower cutoff was associated with greater satisfaction. In other words, more differentiation related to marital satisfaction.

Faber (2004) also examined couples from a Bowenian perspective, noting that many couples who marry for the second time are plagued with anxiety that stems from unresolved issues in their previous marriages. By acknowledging the influence of their previous marriage on their current one, couples were better able to work through anxiety, raise the level of differentiation, maintain an I-position, and become less emotionally reactive.

Questions about the applicability of Bowen theory to diverse populations are beginning to be researched. Kim and colleagues (2014) found higher differentiation in older South Koreans than younger, as well as that higher differentiation in that group is associated with enhanced family satisfaction, healthier family functioning, and more positive family communication. In another study, Kim, Edwards, Sweeney, and Wetchler (2012) found that differentiation was related to satisfaction in Asian-White American international couples.

Identity development of young adults was studied in terms of achieved levels of differentiation of self (Allain, 2009). In this case, difficulties in identity development and differentiation from family of origin were shown to predict higher levels of distress, difficulties in coping, and maladjustment to stressful situations. College students in the study who were shown to have higher levels of differentiation of self from their families of origin were further shown to be more likely to perceive themselves as better able to solve problems encountered in daily living. Similarly, Hollander empirically assessed hypothesized relations between variables associated with psychological constructs of attachment, psychosocial maturity, and differentiation of self in a sample of emerging adults. Associations were found among these constructs: anxiety, avoidance, I-position, reactivity, emotional cut off, identity, and the capacity to experience intimacy. Significant associations were found between attachment, psychosocial maturity, and differentiation of self, with intimacy predicting emotional cutoff and identity predicting cut off and I-position. Attachment also predicted differentiation of self, with anxiety predicting all differentiation variables and avoidance predicting emotional reactivity and cutoff. Finally, associations between anxiety and cutoff and between avoidance and cutoff were mediated by psychosocial identity and intimacy, and associations between anxiety and I-position were mediated by identity.

Toward the other end of the life span, Kim-Appel, Appel, Newman, and Parr (2007) explored Bowen's theory with respect to individuals 62 years of age or older. Specifically, they tested the effectiveness of Bowen's theory of differentiation as a predictor of psychological distress in individuals from this age cohort. They considered emotional reactivity, I-position, emotional cutoff, and fusion with others and demonstrated that there is a positive relationship

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between differentiation levels as understood from the perspective of these further constructs and psychological symptom status for this group.

Finally, Kruse (2007) studied the relationship between self differentiation and levels of truth, shame, and guilt in intimate relationships. The four components (or subscales) of differentiation—emotional reactivity, emotional cutoff, fusion with others, and I-position—were examined in relation to trust, shame, and guilt. Kruse posited that individuals with higher levels of differentiation would have lower levels of shame and guilt.

In each of these studies, significant evidence is presented in support of Bowen's key ideas. We turn now to Bowenian clinical practice.

Bowen Family Systems Therapy

Family systems therapy occurs in stages. Adopting a neutral and objective role in order to remain untriangled into the family, the therapist first attempts to assess the family's emotional system, past and present, through a series of evaluation interviews and measurement techniques before intervening therapeutically. Therapeutic goals for changing the relational system include helping family members manage their anxiety, helping them detriangulate from three-person systems, and most important, aiding each family member to increase his or her basic differentiation of self. See Box 8.4: Thinking Like a Clinician.

The Evaluation Interview

The appraisal of a symptomatic family begins with the initial telephone contact. Kerr and Bowen (1988) caution the therapist against being drawn into the family emotional system by overresponding to the caller's forceful, charming, or theatrical presentation of the family's problem. Throughout the subsequent therapy, the therapist must guard against becoming incorporated into the family's problem, taking sides in disputes, or becoming overly sympathetic with one member or angry at another. "The most important work is done by the patient in relationship to his or her family and not to the therapist" (Hargrove, 2009, p. 293). A therapist who becomes fused with the family's emotional system, triangulated into their conflicts, or engulfed by their anxiety, can have a divisive influence on family functioning and fail to promote further differentiation among family members. While the family must become convinced that the therapist cares and remains interested in them, the therapist must resist their efforts to get him or her overinvolved emotionally. As Friedman (1991, p. 151) advises,

> if you, as a therapist, allow a couple to create a triangle with you, but take care not to get caught up in the emotional process of that triangle either by overfunctioning or being emotionally reactive, *then, by trying to remain a nonanxious presence in that triangle, you can induce a change in the relationship of the other two that would not occur if they said the same things in your absence*. (author's emphasis)

Objectivity, as opposed to emotional reactivity, should characterize the therapist's behavior. It is important to stay connected to all participants without taking sides. Bowen believed that the more a therapist has worked on becoming differentiated from his or her own family of origin, the more the therapist can remain detached and objective. As Friedman (1991) points out, it is the therapist's presence—engaging without being reactive, stimulating without

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BOX 8.4 THINKING LIKE A CLINICIAN

Detriangulation and Differentiation

Bill and Diego have been living together for 10 years. Diego has always been the sole breadwinner, does the housework, arranges the couple's social life, pays the bills, and so forth. Bill stays at home, watches television, checks Facebook, and walks the dog.

Diego comes home one day with a panicked expression and tells Bill that he's lost his job. Very gently, he asks Bill to think about getting a job while he also looks for one. Bill immediately starts complaining. The 10-year system between them has suddenly been disrupted. Diego becomes very hurt and angry at Bill. After weeks of barely talking to each other, Diego talks Bill into going together to a couple therapist.

During their fourth session, Bill turns to you and says, "Can you believe that Diego wants me to get a job? *Can you?* I don't have nearly his education or skills. Does he expect I can get any kind of job that's worth my time?"

Diego interrupts and says, "I feel like I have been taken advantage of for years. And I've put up with it until now. Everything was fine until I lost my job. But now that I need help, all I get from my partner is complaints."

1. Identify the underadequate and the overadequate partner.
2. What is Bill doing when he asks you about Diego's request that he look for work?
3. How would you assess Diego's degree of differentiation? Bill's?
4. What would you expect the respective families of origin were like in terms of closeness and distance?
5. How do you feel as you "listen" to each man? Do you feel yourself siding with one or the other? If so, what might that suggest about your role in the session?
6. What intervention might you try to help?

rescuing, teaching a way of thinking rather than using any specific behavior or therapeutic intervention technique—that is the ultimate agent of change.

Family evaluation interviews are carried out with any combination of family members: a parent, husband and wife, the nuclear family, perhaps including extended family members. Since Bowen viewed family therapy as a way of conceptualizing a problem rather than as a process that requires a certain number of people to attend the sessions, he was content to work with one family member, especially if that person was motivated to work on self-differentiation from his or her family of origin. In fact, according to Kerr and Bowen (1988), while conjoint sessions are generally useful, at times seeing people together may impede the progress of one or the other. Instead, they argue, if one parent can increase his or her basic level of differentiation, the functioning of the other parent as well as the children will inevitably improve.

Family evaluation interviews begin with a history of the presenting problem, focusing especially on the symptoms (physical, emotional, social) and their impact on the symptomatic person or relationship. If more than one person is present, the therapist is interested in each member's perception of what created and what sustains the problem for which they seek relief, why they seek such help now, and what each hopes to get from the experience. Through a series of such process questions, the therapist attempts to assess the pattern of emotional

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functioning as well as the intensity of the emotional process in the nuclear family of the symptomatic person.

What is the relationship system like in this family? What are the current stressors? How well differentiated are the family members? What is the family's adaptive level? How stable is the family, and how (and how successfully) does it handle anxiety? What triangles exist? Are emotional cutoffs operating? The initial interview, which may extend over several sessions, seeks information to assess the degree of family dysfunction associated with the presenting symptoms, which may appear in one or more family members.

Consistent with a transgenerational outlook, Bowenians are particularly interested in the historical pattern of family emotional functioning, the family's anxiety levels at varying stages of its life, and the amount of stress experienced in the past compared with current functioning. Of special interest too is whether one spouse's functioning has improved significantly—and the other spouse's has declined significantly—over the course of their relationship. By probing the history of the symptoms in each family member, therapists search for clues as to where the various pressures on the family have been expressed and how effectively the family has adapted to stress since its inception. At this point in the evaluation, the focus has begun to expand beyond the symptomatic person to an examination of the relationship network of the nuclear family. See Box 8.5 for an example of how history can affect the quality of a marriage.

The final part of the evaluation interview attempts to understand the nuclear family in the context of the maternal and paternal extended family systems. The therapist is interested in multigenerational patterns of fusion, the nature of the nuclear family's relationship with the extended families, and the degree of emotional cutoff of each spouse. Parallels in relationship patterns between the husband and wife and his or her parents may offer important clues of poor differentiation from the families of origin. The therapist's goal is to develop a road map of the family's emotional system, since each nuclear family is believed to embody the emotional processes and patterns of preceding generations.

The Genogram

Since Bowen believed multigenerational patterns and influences are crucial determinants of nuclear family functioning, he developed a graphic way of investigating the genesis of the presenting problem by diagramming the family over at least three generations in a family genogram. Worked out with the family in early sessions, it provides a useful tool for therapist and family members alike to examine the nuclear and extended family structure and emotional processes and patterns in the system (Platt & Skowron, 2013).

Figure 8.3 offers a partial set of commonly used genogram symbols. Together, the symbols provide a visual picture of a family tree: who the members are, what their names are, ages, sibling positions, marital status, divorces, adoptions, and so on, typically extending back at least three generations for both partners. When relevant, additional information such as religious affiliation, work histories, ethnic origins, geographic locations, socioeconomic status, noteworthy health issues, and significant life events may be included. Platt and Skowron (2013) present an interview protocol for genogram construction consistent

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BOX 8.5 CASE STUDY

Ghosts from the Holocaust

Martin and Rachel began therapy at Rachel's insistence. It was either therapy or the marriage was over. The couple had been married for 3 years. Although during their dating and early marriage Martin was communicative and attentive, he had become morose, silent, and withdrawn. The couple were Israeli and had moved together to New York to start a new business. They had one child, a boy.

As the therapy progressed, it became clear that Martin was a deeply anxious man. He worried about his death and the deaths of his wife and child. He revealed that he hated both his parents, especially his mother, who dominated him whenever they were together. Martin's father, when a boy, survived a Nazi concentration camp, and his mother, while not herself imprisoned, had lost most of her family to the Holocaust. Both of Rachel's parents, while not directly involved in the Holocaust, had lost many family members to the genocide. As the therapy continued, the couple came to see how their relationship had similarities to that of Martin's parents. Silence reigned. There was little communication between them. Although Martin expressed that he could see that he was like his parents and that he was terrified that his relationship with Rachel would be like theirs, he couldn't see how anything could change.

The therapist noticed that whenever Martin did start to talk about his feelings, Rachel would jump in and say that he wasn't thinking about her, only of himself. She often pressed the therapist to validate her observations and feelings. At one such moment, the therapist, not allowing himself to be triangulated, simply stated, "You seem to need me to approve of your views about Martin." Rachel responded that she could see this and started to weep. No one, she said, ever did confirm her right to her feelings and now, in her marriage, Martin seemed to be off in space somewhere, leaving her feeling even more alone.

Martin said, in a surprising moment, "Imagine how alone my father must have felt at Dachau [the Nazi concentration camp]. Why would he ever want to speak after seeing what he saw? I once asked him about it, and all he did was turn away. That's all he ever did with me: turn away. I guess the Nazis got me, too." The therapist suggested that something about the generation that preceded them had indeed been transmitted into Martin and Rachel.

Over several more sessions, the couple noticed how deeply the consequences of their parents' trauma had affected them. Martin noted how clinging and narcissistic his mother was and wondered if that had to do with her fear of his dying. While there were times he couldn't stand being with his mother, he could see that the fear of death must haunt her, and he felt sorry for her.

The therapist asked Martin and Rachel about how ghosts might haunt them. Martin turned to Rachel and said that he wanted to be done with ghosts and that he certainly didn't want to have anything to do with passing them on to their son. In time, the couple could see that talking with each other was a way to exorcise the traumatizing ghosts of their past. Their therapy lasted until they felt comfortable enough being on their own. As the therapist said during their last session, "The ghosts may still be flying around somewhere, and every now and then you may feel them, but the work you've done is to separate yourselves from their reach. By feeling yourselves as a couple, you separate yourself in a good way from a past that would otherwise be disabling."

with Bowen theory. Cook and Poulsen (2011) suggest using client photographs to enrich genograms and elicit emotion in couple therapy. More than just a concise pictorial depiction of the family, the genogram may suggest certain emotional patterns in each partner's family of origin, thus providing data for assessing each spouse's degree of fusion to extended families and to one another.

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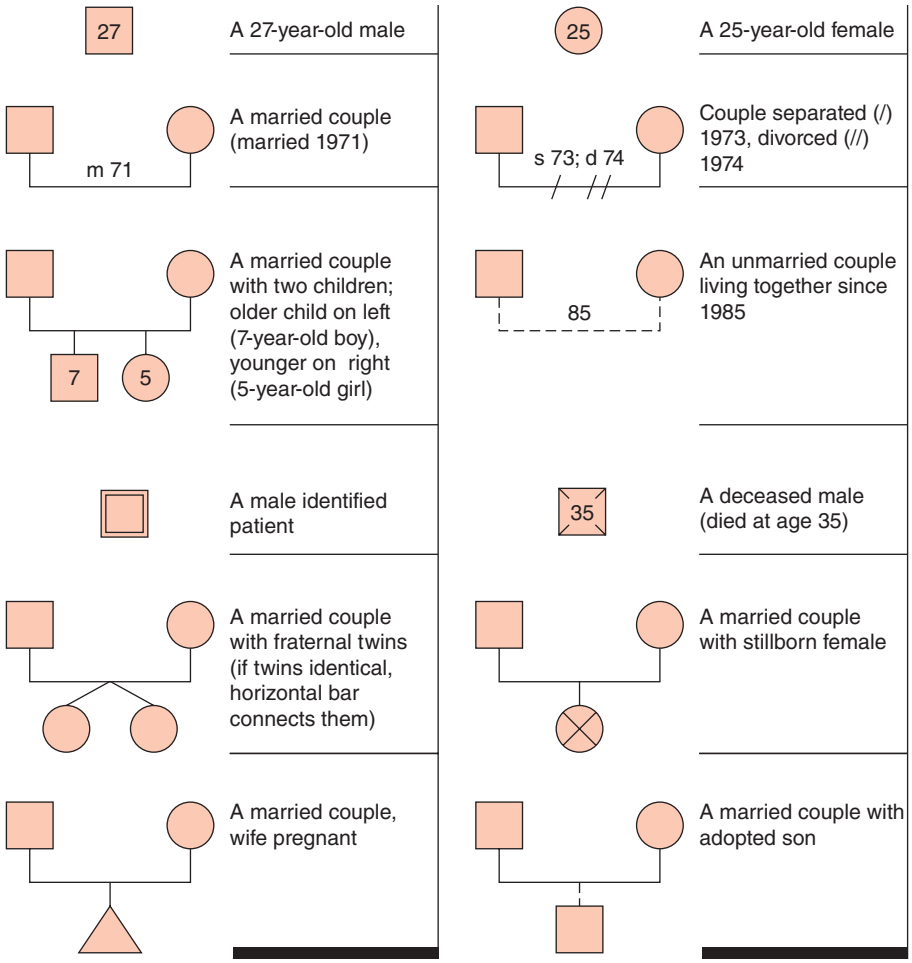


FIGURE 8.3 A partial set of commonly agreed-upon genogram symbols

Source: Based on McGoldrick et al., (2008)

McGoldrick, Gerson, and Petry (2008), strongly transgenerational in outlook, suggest that family patterns tend to repeat themselves; what happens in one generation will often occur in the next, as the same unresolved emotional issues are replayed from generation to generation. Their text contains numerous computer-generated genograms of multigenerational processes in 32 notable families, ranging from those of Sigmund Freud to Bill Clinton, Thomas Jefferson to the Roosevelts, and celebrities from the entertainment world.

Therapeutic Goals

Bowen family systems therapy, no matter the presenting clinical problem, is governed by two basic goals: (a) management of anxiety and relief from symptoms and (b) an increase in each participant's level of differentiation in order to improve adaptiveness (Kerr & Bowen, 1988). Generally speaking, the family needs to accomplish the former goal before the latter can be undertaken. Ultimately, overreactive emotional interactions with the extended family must be changed, leading to greater self-differentiation for nuclear family members. Box 8.6 illustrates

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BOX 8.6 CLINICAL NOTE

Constructing a Genogram in Family Therapy

Genograms often give families their first inkling of intergenerational family relationship patterns. Even the most intense, quarrelsome families often quiet down during the construction of a genogram. Goldenberg and Goldenberg (2002) offer this example:

> A family contacted a counselor in 1988 because their son, Ivan, was having school difficulties, disrupting class activity, and generally being inattentive. The genogram revealed that his mother, Loretta, had been adopted after her adoptive parents had tried unsuccessfully to have a daughter after three sons. She married early, at 20, soon after the death of her adoptive mother. Steve, a middle child whose parents divorced when he was a preteenager, lived in a single-parent household with his mother and two sisters until he married Loretta. Steve and Loretta started their own family before either was 25, perhaps in an effort to create some stability in contrast to what either had known growing up.
>
> The fact that they now have four children (one died in childbirth) suggests a strong involvement in family life, especially because the children's ages are spread over more than 10 years. Are the parents being overprotective, perhaps to compensate for what they felt deprived of as youngsters? What has been the effect of Loretta's pregnancies over the last several years on the other children? To what extent does Ivan feel he is being displaced as the youngest child by the birth of Bianca? (p. 59)

Note how many hypotheses spring from the genogram to be explored with the family. Fusion-differentiation in the family of origin, the nuclear family emotional system, emotional cutoffs by parents, sibling positions, and many of Bowen's concepts are possibly relevant to Ivan's presenting symptoms. When evaluation interview data are put into schematic form in a family genogram, therapist and family together are better able to comprehend the underlying emotional processes connecting generations. In a sense, the family genogram is never completed, as information uncovered during the course of therapy sheds new light on basic patterns of emotional reactivity in both the nuclear and extended families. Major turning points (such as the unexpected death of a key family member) may start a series of family problems that reverberate across generations (Papero, 1990). Genograms are a way of collecting information that makes sense to the family and connects them to the therapeutic exploratory process.

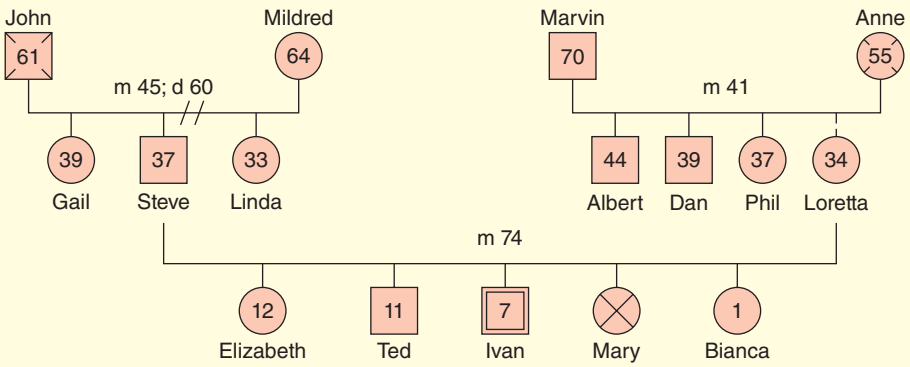


FIGURE 8.4 Genogram of three generations of a family
Source: Goldenberg and Goldenberg (2002), p. 61

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the use of genograms in psychotherapy. In marital conflict, for example, the therapist tracks the emotional process between the spouses and then *shifts* the emphasis from the *marital* level to the *self* level as each partner differentiates from the spouse. In the process, equal attention is paid to historical ways in which previous generations have created family patterns as well as current manifestations of those patterns throughout the family system (Aylmer, 1986). In the case presented in Box 8.7, a rural couple in conflict must deal with their deteriorating economic situation. However, instilled roles, traditions, and values from their families of origin are sources of anxiety as they consider options. Family cohesion is at stake.

Bowen's standard method of family therapy was to work with two adults and himself. Even when the identified patient was a symptomatic child, Bowen asked parents to accept the premise that the basic problem was between the two of them—the family's emotional system—so the identified patient was not the source of the problem. Bowen might never see the child (Hargrove, 2009). As Kerr (1981) explains, "A theoretical system that thinks in terms of family, with a therapeutic method that works toward improvement of the family system, is 'family' regardless of the number of people in the sessions" (p. 232).



BOX 8.7 CASE STUDY

A Farming Couple Faces a Dilemma

Martha and her husband, Jacob, were at great odds. Tradition in their farm families held that women should not work but instead should rear children. Jacob prided himself on providing adequately for his family, even with the small parcel of land that was his share of their family farm. But the tobacco crop had not done well this year, and they were having great difficulty even keeping their children clothed. Both Martha's and Jacob's parents volunteered to help financially to see them through poor times. Martha's pride was too great to accept handouts, and having been reared with a strong work ethic, she accepted a job as a clerk in a bookstore at the town shopping mall without consulting Jacob. Jacob took her action as a personal affront. Both sets of parents were so distraught that they were barely speaking to Martha. In fact, Jacob's parents were so disturbed they refused to look after the children for the few hours after school before Martha returned from work. They firmly believed the children would suffer. They saw the role of women as remaining in the home, rearing children, keeping the house, and helping with the farm as needed.

Referred by a new friend at her job, Martha came willingly to conjoint marital therapy. Jacob came with much reluctance. There was a very cold tension between them. Jacob preferred not to reveal their family problems to an outsider. Martha believed this was their only chance to bring the family back together. In efforts to build a therapeutic alliance and create an atmosphere in which it was safe to reveal feelings, the therapist acknowledged Jacob's hesitations to come to therapy and validated his reasons for reluctance; likewise, the therapist reflected understanding of Martha's belief that therapy was their only hope of reuniting the family.

The next task of therapy was to explore the differences between the couple. Guided by the therapist in a very structured mirroring dialogue that helped the couple feel safe with each other, Jacob admitted he blamed the group of farm women, of which Martha was a member, for influencing her decision to go to work. He saw her involvement as disloyal to him and disrespectful of what he was trying to do for the family. Martha argued that it was only the desperate financial

(Continued)

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situation that had propelled her to go against Jacob's will. Eventually she disclosed that she was not satisfied with staying home and had often yearned for work outside the home.

Using the genogram as a tool, the therapist explored family-of-origin issues with the couple. Jacob revealed the shame he felt for not sufficiently providing for the family and the resentment he harbored toward his father for giving up so much of their family land for development rather than preserving it for succeeding generations. With improved communication, the couple became more accepting of each other, and Jacob began to acknowledge how Martha's income benefited the family.

Next, the couple was coached in talking to their respective families. They felt the need to convince their families that employment for Martha was best for their family. The therapist guided them in presenting their newly found common perspective to both families. As Jacob's parents began to see their son as a willing participant in the new arrangement and to realize that he was even proud of Martha's work, they were able to discuss the guilt they had been feeling for not having more land to give Jacob and began to become less protective of him. Martha's family was less accepting but nevertheless acknowledged the couple's right to make their own decision.

Source: Shellenberger and Hoffman (1995), pp. 464–465.

Back Home Visits

To help remove an adult client from a highly charged emotional triangle with parents, solo visits to the family of origin may be arranged. Typically, these structured visits are prepared for beforehand by telephone or letter, in which the client makes known those issues causing personal distress. The client is instructed to maintain an "observer" stance as much as possible at first, monitoring distressing emotional and behavioral patterns while retaining a sense of separateness despite surrounding tensions and anxiety. Later, the now more self-directed client can decline getting caught up in old patterns and negotiate for more functional and supportive relationships (Roberto, 1992).

Because Bowen was particularly concerned that his clients develop the ability to differentiate themselves from their families of origin, the focus of much of his work was on extended families. In this respect, Bowen resembled Framo (1981), although Bowen sent clients home for frequent visits (and self-observations) after coaching them in their differentiating efforts, while Framo brought members of the families of origin into the final phases of therapy with his clients. Going home again, for Bowen, was directed at greater self-differentiation from one another—not at confrontation, the settlements of old scores, or the reconciliation of long-standing differences. Reestablishing emotional connectedness with the family of origin—especially when rigid and previously impenetrable boundaries have been built up—is a critical step in reducing a client's residual anxiety due to emotional cutoff, in detriangulating from members of that family, and in ultimately achieving self-differentiation, free of crippling entanglements from the past or present.

Family Therapist as Coach

Bowen presented himself as a researcher helping the family members become objective researchers into their own ways of functioning. The term he preferred was coach (having moved during his career, in his own words, "from 'couch' to 'coach' ")—an active expert who calmly

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BOX 8.8 CLINICAL NOTE

Using "I-statements" in Family Therapy

Learning to make "I-statements" ("I'm upset at what you're doing now") rather than accusations ("Why do you enjoy picking fights?") is apt to lead to a more honest exchange than blaming the other person. When both partners take responsibility for their feelings and express them directly, the chances of resolving conflict are greatly improved.

assists family members, through low-key direct questions, in defining and clarifying their emotional responsiveness to one another. In the process, family members were encouraged to listen, think about their situation, control their emotional reactivity, and learn to express self-defining *I-positions*. When the coach has taught them successfully, often by modeling I-positions, the individual family members are responsible for the actual work of changing. Their self-differentiation, the basic goal of the therapy, must come from them and not the therapist, and it must be achieved on the basis of a rational understanding of the family's emotional networks and transmission processes.

Bowen (1976) took the position that the successful addition of a significant other (a friend, teacher, clergyman) to an anxious or disturbed relationship system can modify all relationships within the family. The family therapist can play this role as long as she or he manages to stay in nonanxious emotional contact with the two most significant family members (usually the parents) and remains uninvested in (or detriangulated from) the family conflict—maintaining what Aylmer (1986) calls a *detached-involved position*. If the therapist can maintain that stance—despite pressures to be triangulated into the conflict—Bowenians believe tension between the couple will subside, the fusion between them will slowly resolve, and other family members will feel the positive repercussions in their own lives, including the likelihood of achieving greater self-differentiation.

Family systems therapists may choose one partner, usually the one more mature and better differentiated, and focus on that individual for a period of time. This person is assumed to be the member of the family most capable of breaking through the old emotionally entangling patterns of interaction. When that person succeeds in taking an "I-stand," the others will shortly be forced into changing, subsequently moving off in their own directions. A stormy period may follow before a new equilibrium is reached, but the former pathological ties are broken, and each person has achieved a greater sense of individuality.

Doing family therapy by *coaching* individual family members to change themselves in the context of their nuclear and parental family systems (McGoldrick & Carter, 2001) has become a prominent part of Bowen family systems therapy. After defining the crisis that brought the family into therapy, the individual member is tutored to define himself or herself in both the family and the family of origin. By guiding that person to avoid triangles and getting embroiled in family emotional processes, the coach is helping change his or her emotional functioning in the family, eventually helping change the entire system. Genograms sometimes help define that person's role in the system. Process questioning also helps clarify for the client his or her role in the family's emotional life. Successful coaching helps the individual

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BOX 8.9 FAMILY DIVERSITY

Coaching for Family Reentry

Cheryl, a 30-year-old African-American social worker who had not seen her father for many years, spent several sessions describing her current marital and in-law conflicts, which had led her to seek help. She had not corresponded with her father since he left the family to live with a girlfriend years before. She had had a distant relationship with her mother since she left home at 17 to live with an aunt and attend college. She considered her mother "hopeless" for having stayed so long with her father, who was cold and critical, and then with a boyfriend, whom she was still supporting. She saw both parents as irrelevant to her current life and problems.

After discussing the striking patterns of marital conflict, in-law problems, and emotional cutoffs on her genogram, she was encouraged to undertake a coaching process to explore her role in her family of origin as a way to gain more flexibility for her marriage. She explored the cutoff with her parents and became aware with the coach that her issue with her mother was much less intense than the one with her father. As her first move of reentry, she decided to write a letter to her father in which she referred briefly and regretfully to their cutoff and then went on in a low-key way to express interest in his life, his wife, and young son (whom she had never met) and to bring him up-to-date about her life. To her mother, for whom she realized she had fewer conflictual feelings, she wrote in more depth about her life and proposed to visit her in the near future.

Source: McGoldrick and Carter (2001), p. 289.

reenter the system by developing authentic emotionally engaged relationships with other family members rather than repeating old, dysfunctional family patterns. McGoldrick and Carter (2001) describe the process as follows:

> The basic idea of coaching is that, if you can change the part you play in your family and hold it despite the family's reaction while keeping in emotional contact with family members, you maximize the likelihood (not a guarantee!) that they will eventually change to accommodate your change. (p. 291)

Box 8.9 illustrates a coaching procedure with a young African-American woman.

A Controlled, Cerebral Approach

Bowen family therapy sessions tend to be controlled and cerebral. Each partner talks to the therapist rather than talking directly to the other. Confrontation between the partners is avoided to minimize emotional reactivity between them. Instead, what each partner is thinking is externalized in the presence of the other. Interpretations are avoided. Calm questioning defuses emotion and forces the partners to think about the issues causing their difficulties. Rather than allowing partners to blame each other or ignore their differences in a rush of intimacy, Bowenians insist that each partner focus on the part he or she plays in the relationship problems.

Contemporary Bowenian Theorists

Several advocates of Bowen's theoretical ideas and their clinical applications have advanced the model over time. Michael Kerr (Kerr, 2003; Kerr & Bowen, 1988) and Daniel Papero (1990,

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BOX 8.10 **CLINICAL NOTE**

Treatment Technique: Have Partners Speak to the Therapist'

The technique of having each partner in a marital conflict speak directly to the therapist is used when the therapist wishes to de-escalate the level of emotional intensity taking place between the partners when they attempt to address one another directly.

2000), along with faculty at the Georgetown Family Center in Washington, DC, are well-known contemporary proponents of Bowen's theory and practice. Edwin Friedman (1991), a rabbi trained by Bowen, applied family systems theory to pastoral counseling before he died in 1996. Philip Guerin, an early student of Bowen, founded the Center for Family Learning in New York and devised interventions tailored to the intensity and duration of the marital conflict (Guerin, Fay, Burden, & Kautto, 1987) and family relationship triangles (Guerin, Fogarty, Fay, & Kautto, 1996). Peter Titelman (2010) in Massachusetts focuses on the clinical utility of Bowen theory. Betty Carter (a founder and director of the Family Institute of Westchester in New York until her death in 2012) and Monica McGoldrick (2010), director of the Multicultural Family Institute in New Jersey, applied Bowen theory to multigenerational work on family life cycles (with Garcia-Preto). Carter and McGoldrick (2001) paid close attention to the powerful influences of culture, class, gender, and sexual orientation on family patterns. Elizabeth Skowron, at the University of Oregon, has been influential in the assessment of individuation (2004).

Contextual Therapy

Ivan Boszormenyi-Nagy was the primary pioneer of contextual therapy. A psychiatrist with psychoanalytic training who immigrated to the United States from Hungary in 1948, he founded the Eastern Pennsylvania Psychiatric Institute (EPPI) in Philadelphia in 1957 as a research center for studying schizophrenia (James Framo, Geraldine Spark, Gerald Zuk, and David Rubenstein were early associates). After a long series of unsuccessful attempts to find biochemical clues to explain the etiology of the disorder, Boszormenyi-Nagy and his colleagues focused on the behavioral and psychological aspects of schizophrenia, ultimately turning to transgenerational issues within the family. When the EPPI closed in 1980 due to the loss of state funding, the researchers continued to refine contextual theories at nearby Hahnemann University Medical School.

Relational Ethics

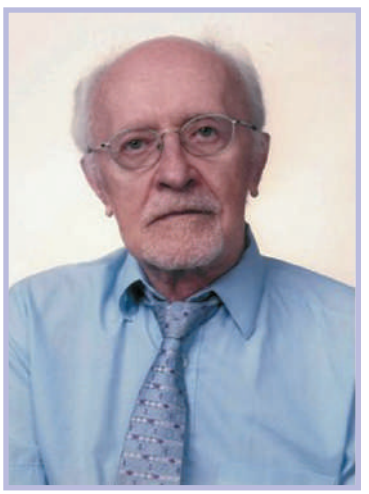
Contextual therapy, as elaborated in a collection of papers spanning 30 years by Boszormenyi-Nagy (1987), is heavily influenced by Fairbairn's (1952) object relations theory, existential philosophy, and Sullivan's interpersonal psychiatry (1953), to which he added an *ethical perspective*—trust, loyalty, transgenerational indebtedness, and entitlements, as well as fairness in relationships between family members. Boszormenyi-Nagy believes that the burdens for today's families are complex, and a comprehensive picture of their functioning must go beyond a simple appreciation of the interactional sequences occurring between members.

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What also demands attention is the impact of both intrapsychic and intergenerational issues within families, especially each member's subjective sense of claims, rights, and obligations in relation to one another. To function effectively, family members must be held ethically accountable for their behavior with one another and must learn to balance *entitlement* (what one is due or has come to merit) and *indebtedness* (what one owes to whom). This balance provides the relational foundation or context for all potential relationships (Ducommun-Nagy & Schwoeri, 2003).

A core concept in contextual theory, **relational ethics** focuses attention on the long-term, oscillating balance of fairness among members within a family, whereby the welfare interests of each participant are taken into account by the others. Relational ethics encompasses both individual psychology (what transpires within the person) and systems characteristics (roles, power alignments, and communication sequences within the family). A marital couple, for example, must develop a symmetrical give-and-take, balancing rights and responsibilities, merits and obligations, toward one another, in order to maintain and continue to build their relationship. When the needs of the partners conflict, which is inevitable in any relationship, they must be able, openly and honestly, to negotiate differences that maintain overall fairness. Fairness, decency, consideration of every family member's needs, loyalty, equality, reciprocity, caring, accountability—these together help determine the direction, form, and freedom of action within a family (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). Symptoms may appear when trustworthiness and caring within a family break down. Destructive entitlements may occur when an injured person pursues amends from an innocent third person. For example, injured parents can put unfair demands on a child, expecting the child to act as a mature adult—called parentification—then that child goes on to put unfair demands on his or her own children. Constructive entitlements recognize that there is an inherent reward in giving, despite the response (Ducommun-Nagy & Schwoeri, 2003).

To contextual therapists, the patterns of relating within a family that are passed on from generation to generation are keys to understanding individual as well as family functioning. *Trust* is the fundamental property of relationships, and it can be depleted or restored depending on the capacity of family members to act upon a sense of loyalty and indebtedness in their give-and-take with one another. Instead of focusing on symptomatic behavior or family pathology, the contextual therapist attends to relational resources as leverage for change; relationships are viewed as trustworthy to the extent that they permit dialogue among family members regarding issues of valid claims and mutual obligations.



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Ivan Boszormenyi-Nagy, M.D.

Boszormenyi-Nagy joined initially with Geraldine Spark, a psychiatric social worker with a psychoanalytic background and experience in child guidance centers. Together the pair (Boszormenyi-Nagy & Spark, 1973) advanced a theory based upon **invisible loyalty** within a family, in which children unconsciously take on responsibilities to aid their parents, often to their own detriment (e.g., become a failure to confirm parental forecasts).

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Family Ledger, Legacies, Debts, and Entitlements

In addition, Boszormenyi-Nagy and Spark proposed a set of therapeutic techniques designed to uncover and resolve family "obligations" and "debts" incurred over time, using the metaphor of a **family ledger** on which these "accounts" are kept. This multigenerational accounting system tracks what has been given and who, psychologically speaking, still owes what to whom.

They also introduced such new terms as *family legacy*, expectations handed down from previous generations concerning what is expected, say, of men and women, and family loyalty, referring to allegiances in children based on parental fairness in order to emphasize that family members inevitably acquire a set of expectations and responsibilities toward each other. Fair and equitable parental behavior engenders loyalty in the children; unfair demands or an exaggerated sense of obligation may produce invisible loyalties in which the child unconsciously continues, endlessly, to pay off a debt to parents, frequently to his or her own disadvantage as it takes priority over all other concerns.

Figuratively speaking, each person has a sense of unsettled accounts, how much he or she has invested in relationships within the family, and whether there has been a fair balance between what has been given and received. While this is hardly a strict bookkeeping system and seldom if ever perfectly balanced, confronting and redressing imbalances is viewed as essential if a family is to stay vital and avoid stagnation. Ulrich (1983) cites a temporary imbalance: A wife works at an unsatisfying job so her husband can finish law school—but with the expectation that what she has invested in the common fund will eventually be replaced for their mutual enrichment. Obligations may be rooted in past generations and need not be consciously recognized or acknowledged to influence the behavior of family members in the present. See Box 8.11: Case Study for an example of how a therapist uses the metaphor of the ledger in a clinical situation.

Boszormenyi-Nagy and Krasner (1986) argue that traditional interventions, either individually or family focused, consistently ignore family balances due, either owed or deserved, especially intergenerational ones. Yet people, in or out of therapy, constantly raise such questions as "What do I owe, and to whom?" "What do I deserve, and from whom?" "What relationships do I need and want?" "What relationships am I obliged to retain, whether or not I need or want them?"

Whenever injustices occur, there is the expectation of some later repayment or restitution. Problems in relationships develop when justice comes too slowly or in an amount too small to satisfy the other person. From this perspective, dysfunctional behavior in any individual cannot be fully understood without looking at the history of the problem, the family ledger, and examining unsettled or unredressed accounts. A symptom that develops might represent an accumulation of feelings of injustice that has grown too large.

The family legacy, then, dictates debts and entitlement. One son may be slated to be successful ("We expect you'll be good at anything you try"), another to become a failure ("We don't think you'll ever amount to much"). A son may be entitled to approval, the daughter only to shame. Because of such family imperatives, as Boszormenyi-Nagy and Ulrich (1981)

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BOX 8.11 CASE STUDY

Taking a Relationship into Account

Jim is a wealthy and successful business executive and an attractive man of about 50. He came to treatment toward the end of his second marriage. He quickly mentioned to the therapist that his marriage was ending because he and his wife hadn't had sex in years and that, from his perspective, she was controlling and distant. He also mentioned that he had been having affairs for several years and was presently seeing Mira, with whom he was head over heels in love. He added that he had several female friends in different cities whom he'd date whenever he was in town. The therapist had a sense that Jim was very anxious and lonely.

As the months passed, the relationship with Mira grew hostile, and Jim, now divorced from his wife, felt he had to leave her. His anxiety at being alone increased.

During one session, Jim mentioned that as a boy, his job was to attend the opera with his mother as her "date," because Jim's father didn't enjoy going. As the therapist listened, it became clear that this "request" of Jim's mother was more of a requirement. She felt entitled to his attending these performances with her; he had no choice but to agree. Jim was about 14 when the opera attendances first started. He felt terribly embarrassed when he saw all the other women with their husbands or mature dates. He mentioned to the therapist that he felt his mother required a limitless amount of his attention. He said that she was always taking from him and that he received nothing back that he needed from her. The therapist asked this successful executive, "What kind of deal was this? Would you accept those terms today?" Jim smiled and said that he wouldn't. The therapist noted, "Perhaps those accounts can be closed out. After all, there is no point in throwing good money after bad."

Although there was more work to do, Jim later acknowledged that seeing how the "ledger" wasn't in his favor helped him start separating from his mother. He went on to see how her demands had influenced his choice in women, and he began to better tolerate being on his own.

point out, the children are ethically bound to accommodate their lives somehow to their legacies. Ulrich (1983) gives the following graphic example:

> A son whose familial legacy is one of mistrust among family members, angrily confronts his wife every time she spends any money without his prior approval. He is convinced, and he tries to convince her, that her untrustworthy, spendthrift behavior is going to bankrupt them. (p. 193)

In fact, the wife, who works full time as well as tending to their child, contributes to the family's solvency. If her response to his anger is fear—a legacy she carries from her own family—she may hide her purchases. His discovery of such concealment reinforces his mistrust; his subsequent anger strengthens her fears. Together their legacies have had a corrosive effect on their marriage. In ledger terms, he is still making payments to his mother's injunction that a wife is not to be trusted. By "overpaying" his mother, he is robbing his wife. She, in turn, may be paying off similar debts. Contextual therapy would direct them to reassess all their relationships, pay off legitimate filial debts, and free themselves from oppressive obligations.

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Besides Boszormenyi-Nagy, leading exponents of this view include psychologist David Ulrich (1998) in Connecticut, as well as psychiatrist Catherine Ducommun-Nagy (2003), wife of the founder, at the Institute for Contextual Growth in Pennsylvania.

Therapeutic Goals

While the reduction of stress is an important goal in this, as in all therapies, the fundamental goal of contextual therapy is the improvement in the family members' capacity for relatedness, rebalancing the give-and-take and emotional ledgers between family members. Thus, contextual therapists help families reopen the often conflicting claims of who owes what to whom; some of these claims may have lain dormant for generations. *Multidirected partiality* is the therapeutic process in which the position of each person is considered in turn with fairness and impartiality (Ducommun-Nagy & Schwoeri, 2003). Once the claims are addressed, the therapist aids family members in taking reparative steps to regain a balance and restore fairness and trust in their relationships (Ulrich, 1998). Well-functioning families are characterized by their ability to negotiate imbalances and maintain a sense of fairness and accountability in their interactions.

Contextual therapists do not focus on pathology but rather attend to the family's relational resources (Ducommun-Nagy, 1999). That is, they help each family member explore the possibility of earning entitlements from others by appropriate giving to them. Advocates of this view insist that individual autonomy cannot be achieved without a genuine consideration of others. Clients are encouraged to consider the interests of others as ultimately benefiting both giver and receiver.

The Ethical Connection

The ethical dimension gives contextual therapy its uniqueness. Insisting that they are not moralizing or taking a judgmental position, practitioners of this approach contend that they offer a realistic strategy for preventing individual and relational imbalance and eventual breakdown. They argue that effective therapeutic intervention must be grounded in the therapist's conviction that trustworthiness is a necessary condition for reworking legacy assessments and allowing family members to feel they are entitled to more satisfying relationships. Practitioners of contextual therapy maintain that families cannot be fully understood without an explicit awareness of family loyalty—who is bound to whom, what is expected of all family members, how loyalty is expressed, what happens when loyalty accounts are uneven ("We were there for you when you were growing up, and now we, your aging parents, are entitled to help from you").

Contextual therapy helps rebalance the obligations kept in the invisible family ledger by identifying imbalances, directing efforts at settling old family accounts (e.g., mothers and daughters "stuck" in lifelong conflict), "exonerating" alleged culprits, or transforming unproductive patterns of relating that may have existed throughout the family over many past generations. The major therapeutic thrust is to establish or restore trustworthiness and relational integrity in family relationships. Parental behavior may be reassessed (and forgiven) in light of its roots in the past. In the example in Box 8.12, a therapist helps a family split by dissension and conflicting loyalties learn fairer and more ethically responsible ways of dealing with one another.

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BOX 8.12 CASE STUDY

A Contextual Therapist Elicits a Family's Relational Resources

Mr. and Mrs. Jones were seeking help for their marriage. The presenting problem had to do with Mrs. Jones's angry outbursts at her husband and mother. An intelligent and compulsively neat person, Mrs. Jones was resentful of the fact that her mother had humiliated and frustrated her. Their relationship, she claimed, was characterized by mistrust and manipulation. She handled her rage through long-distance calls to her parents that inevitably resulted in tortuous arguments with her mother, or else she ignored her parents for prolonged periods of time.

His wife's hostile outbursts rendered Mr. Jones helpless. A hardworking, meticulously responsible salesman, he was deeply discouraged and never knew what he would face when he came home from work. On some occasions, Mrs. Jones would try to ruin the garden equipment that he so highly prized. On other occasions, she would throw out his favorite books. On the other hand, there were times when their marriage seemed to be all right. For example, they could function as a team whenever members of their extended family were in real need. During their brief respite, they could enjoy each other and reported that their sexual relations were good.

However, the couple was often at war over their only child. Sheila, age 12, was chronically caught between them and lived in constant jeopardy of being split in her loyalties to them. Mrs. Jones would greet her husband at the door with complaints about their daughter. He resented being cast into the unfair role of referee and retaliated by forming a subversive alliance with Sheila. In therapy sessions, the couple finally consented to hear each other out. Together the three family members began to work toward fairer ways of relating.

Mr. and Mrs. Jones and Sheila seemed comforted by the therapist's capacity to elicit the justifications of each of their sides (multidirected partiality). Yet Mrs. Jones was openly annoyed at any attempts to offer fair consideration to her mother. In the interim, things went better for the family. Until now, Mrs. Jones had lacked the security to look for a job commensurate with her intelligence and ability. For a long time she had invested her energies in compulsive housekeeping. Suddenly, she found a job that she liked.

Immediately, tensions eased as her world widened and opened up. Mr. Jones learned to distance himself from his wife when she regressed into outbursts of anger. Mrs. Jones began to exchange letters with her mother and managed some pleasant visits with both her parents.

On occasion, some of the vindictiveness previously channeled toward her parents was now transferred to the therapist. At one point, Mrs. Jones refused to accompany her husband to their therapy session, arguing that the therapist "didn't care" about her. Two weeks later, though, she left an emergency message with the answering service: Her mother had died suddenly, unexpectedly. Overcome by the intensity of her emotions, she expressed profound gratitude. What would have happened to her, she wondered, if the therapist had not enabled her to find a way to her mother? What if she had failed to repair their relationship before it was too late?

Source: Boszormenyi-Nagy and Krasner (1986), pp. 45–46.

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SUMMARY

Bowen family systems theory has a transgenerational outlook based on a natural systems perspective in which human behavior is seen as the result of an evolutionary process and as one type of living system. Bowen conceptualized the family as an emotional relationship system and offered eight interlocking concepts to explain the emotional processes taking place in the nuclear and extended families over generations: differentiation of self, triangles, the nuclear family emotional system, the family projection process, emotional cutoff, multigenerational transmission process, sibling position, and societal regression. Chronic anxiety is seen as an inevitable part of nature, transmitted from previous generations as families attempt to balance togetherness and differentiation.

Family evaluation interviews stress objectivity and neutrality, as therapists make an effort to remain outside and not triangled into the family's emotional network. Genograms offer helpful pictorial depictions of the family's relationship system over at least three generations. Therapeutically, Bowenians work with marital partners in a calm and carefully detriangulated way, attempting to resolve the fusion between them; their goals are to reduce anxiety and resolve symptoms and ultimately to maximize each person's self-differentiation within the nuclear family system—and from the family of origin. Coaching individual family members to redefine themselves and detriangulate from parents is a prominent part of contemporary practice.

Contextual family therapy, developed primarily by Ivan Boszormenyi-Nagy, focuses on relational ethics and transgenerational legacies, exploring how influences from the past have a bearing on present-day functioning in all members. In this view, families have invisible loyalties—obligations rooted in past generations—and unsettled accounts that must be balanced. Contextual therapy attempts to rebuild responsible, trustworthy behavior, taking into account the entitlements of all concerned. Its goal is to help dysfunctional families rebalance the give-and-take and emotional ledgers between members and develop a sense of fairness, trust, and accountability in interactions with one another.

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9

Experiential Models

LEARNING OBJECTIVES

- LO 1 Discuss the importance of the therapist as real and authentic
- LO 2 Clarify the significance of depathologizing human behavior
- LO 3 Explain the family mission as S-EFT sees it
- LO 4 Describe Satir's three factors that influence human development
- LO 5 Justify how Virginia Satir's legacy is related to emotionally focused therapy
- LO 6 Explain the support for the effectiveness of emotionally focused therapy

Experience, encounter, confrontation, intuition, process, growth, existence, spontaneity, action, here-and-now—this is the vocabulary of experiential family therapists. These therapists tend to minimize theory (and especially theorizing) as a therapeutic hindrance and argue that change resides in a *nonrational therapeutic experience* that establishes the conditions for personal growth and unblocks family interaction. They are not particularly interested in intellectual reflection or insight into the origins of problems. It is the relationship between the family and an involved therapist in a therapeutic process that catalyzes the growth of individual family members as well as the family system as a whole.

Experiential family therapy is an outgrowth of **phenomenological** techniques (Gestalt therapy, psychodrama, Rogerian client-centered therapy, the encounter group movement) that were popular in the individual therapy approaches of the freewheeling 1960s. Phenomenological psychotherapy is concerned with the experience or subjectivity of an individual's (or family's) unique life circumstances. Expanding experiences, unblocking suppressed impulses and feelings, developing greater sensitivity, gaining greater access to one's self, learning to recognize and express emotions, achieving intimacy with a partner—these are some of the phenomenological **humanistic** goals for experientialists.

Early advocates aimed at personal fulfillment, in contrast to the then-prominent psychoanalytic goal of resolving childhood-formed neuroses. Less systemic in their thinking than most other first-generation family therapists, and definitely out of step with cognitively based and social constructionist approaches such as solution-focused therapy

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and narrative therapy, the experiential family therapists focused attention on "in-the-moment" emotionality. This view suffered a serious setback with the passing of two of its illustrious leaders, Carl Whitaker and Virginia Satir.

Today, a new experiential wave is represented by, among others, Susan Johnson and Leslie Greenberg, whose **emotionally focused therapy (EFT)** with couple and family applications emphasizes emotional engagement between family members and partners, identifying feelings that define the quality of their relationship, and helping create secure attachment bonds. This approach is more accepting of theory than its experiential forebears while continuing to emphasize client awareness of inner experiences over intellectual understanding. In research particularly conspicuous because of its rarity among experiential therapists, they (Greenberg, 2014; Johnson & Bradley, 2009) spell out replicable procedures and evaluate the effectiveness of their therapeutic undertakings.

LO 1 A Shared Philosophical Commitment

Experiential interventions are, by definition, uniquely fitted to the individual client or family by a personally involved therapist. Each approach in this chapter engages families in different ways, although they share certain philosophical tenets. All emphasize choice, free will, and the human capacity for self-determination and self-fulfillment, thus accentuating the client's goals over any outcomes predetermined by the therapist. Disordered or dysfunctional behavior is viewed, especially by the early experientialists, as a failure in the growth process, a deficiency in actualizing one's capabilities and possibilities. Because each person (or family) is unique, each must become aware of and reach his or her (or its) potential, discovering in the process the solutions to current problems.

Psychotherapy with individuals or families is an interpersonal encounter in which therapist and client(s) strive to be real and authentic. Acquiring sensitivity, accessing feelings and their expression, and learning to be spontaneous and creative (by engaging in nonrational experiencing) are typical avenues clients take to arrive at their goals. If the intervention succeeds, it should facilitate growth for both clients and therapists.

The primacy of emotional experience over rational thought and especially intellectualization is underscored in each of the approaches. Human growth potential and the importance of the therapeutic alliance are stressed. Therapists are active, often self-disclosing, and likely to use various evocative procedures to help clients get closer to their feelings, sensations, fantasies, and inner experiences. Sensitivity to one's here-and-now, ongoing life experiences is encouraged throughout therapy; denying impulses and suppressing affect is viewed as dysfunctional and growth retarding. In the case of emotionally focused approaches, empathic attunement and responsivity to others are stressed so that each person feels understood. Helping family members overcome constricted emotional expressions that prevent empathic responses is the key skill to be mastered.

Experiential family therapists attempt to expand their own experiences, often having to deal with their own vulnerabilities in the process (which, when appropriate, they are likely to share with clients). Their interventions attempt to be spontaneous, challenging, and personalized (therefore often idiosyncratic) as they help clients gain self-awareness (of their

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thoughts, feelings, body messages), self-responsibility, and personal growth. The experiential family therapist seeks to enrich a family's experiences and enlarge the possibilities for each family member to realize his or her unique and extraordinary potential.

The Experiential Model

Experiential family practitioners tailor their approach to the unique conflicts and behavior patterns of each family with whom they work. The work of some experiential therapists such as Carl Whitaker (1976) clearly reflects the psychodynamic orientation of their training,[1] though they are careful, as far as possible, not to impose any preconceived theoretical suppositions or techniques upon families. Others, such as Kempler (1981), evidence their training in Gestalt therapy. Virginia Satir, a warm, intuitive, highly empathic therapist, utilized her humanistic outlook and creative techniques to draw out the positive growth potential in each family member with whom she worked.

David Kantor, Fred Duhl, and Bunny Duhl, represent other early influential experiential family therapists. They cofounded the Boston Family Institute in 1969 and developed expressive techniques, such as **family sculpting**, a nonverbal communication method whereby a family member can physically place other members in a spatial relationship with one another, symbolizing his or her perception of the family members' differences in power or degrees of intimacy with one another (Duhl, Kantor, & Duhl, 1973).

Carl Whitaker and Symbolic-Experiential Family Therapy

Symbolic-experiential family therapy (S-EFT), pioneered by Carl Whitaker, is a multigenerational approach that uses therapy to address both individual and family relational patterns (see Box 9.1). Oriented toward personal growth and family connectedness, the therapist assumes a pivotal role in helping family members dislodge rigid and repetitive ways of interacting by substituting more spontaneous and flexible ways of accepting and dealing with their impulses. Several generations of a family are typically included in the therapeutic process, since practitioners of S-EFT consider the influence of extended families, past and present, to be omnipresent in the family's unverbalized *symbolic* experiences. Why symbolic? Keith and Whitaker (1982) explain it this way:

> We presume it is experience, not education that changes families. The main function of the cerebral cortex is inhibition. Thus, most of our experience goes on outside of our consciousness. We gain best access to it symbolically. For us "symbolic" implies that some thing or some process has more than one meaning. While education can be immensely helpful, the covert process of the family is the one that contains the most power for potential changing. (p. 43)

[1]Whitaker's training in child psychiatry and his original orientation with individual patients was influenced by Otto Rank, an early associate of Freud's who emphasized allying himself with the patient's search for growth and providing a "here and now" therapeutic experience. British object relations theorist Melanie Klein's insistence that psychopathology represents the patient's efforts toward self-healing was another important early influence on Whitaker's conceptualizations (Neill & Kniskern, 1982).

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BOX 9.1 CLINICAL NOTE

Symbolic-Experiential Therapy's Distinguishing Features

- A pragmatic, nontheoretical approach to psychotherapy
- A steadfast effort to depathologize human experience
- The replacement of preplanned therapeutic technique with the therapist's spontaneous creativity
- An emphasis on emotional experience and affectively engaging families
- A commitment to client self-access, self-fulfillment, expanded experiences, and family cohesiveness
- The use of self by the therapist (drawing upon images, fantasies, and personal metaphors from one's own life)
- The use of symbolic, nonverbal methods or play
- The use of co-therapy

To understand how symbolic-experiential family therapy evolved, we must trace the career of Carl Whitaker, an unconventional, colorful, and iconoclastic psychiatrist who, right up until his death in 1995, was the epitome of an experiential family therapist. He first made his national influence felt with his innovative and often radical work in individual psychotherapy, especially his trailblazing efforts to redefine a schizophrenic's symptoms as signs that an individual was "stuck" in the process of growth (rather than suffering from a deteriorative condition) and was attempting to apply "creative" solutions to vexing interpersonal problems. Coauthor of a landmark book, *The Roots of Psychotherapy* (Whitaker & Malone, 1953), Whitaker was an early champion for the active therapist, pushing for growth and integration in his patients and not simply offering insight or understanding to facilitate their "adjustment" to society. In his work with schizophrenics, Whitaker took the audacious position, never before espoused in family therapy, that each participant in therapy is to some degree simultaneously patient and therapist to the other (a similar view for one-on-one therapy was first espoused by psychoanalyst Sandor Ferenczi in the 1920s but was stifled by the psychoanalytic establishment of the time). Both invest emotion in the process, both are vulnerable, both regress, both grow as individuals as a result of the experience. Both expose themselves to the risks of change. Each takes responsibility for his or her own maturing process, but not for one another. The therapist must be committed to personal growth if he or she is to catalyze growth in others.

The Use of Co-Therapy with Schizophrenics

Raised in relative isolation in rural upstate New York, and perhaps less bound by customary social convention than most people, Whitaker early on pursued an unorthodox career path. Trained as an obstetrician/gynecologist in the early 1940s, Whitaker found himself interested in the psychological aspects of that field. In an unconventional move, he spent his final year of training at a psychiatric hospital, working largely with schizophrenic patients. He received further training at the Louisville Child Guidance Clinic and at the nearby Ormsby Village, a residential treatment center for delinquent adolescents. There he learned to develop here-and-now techniques for reaching patients ordinarily resistant to more customary forms of psychiatric intervention (Neill & Kniskern, 1982).

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As the United States entered World War II in 1941, Whitaker, a civilian, was called upon to treat patients in Tennessee at Oak Ridge Hospital, a closed community located where the secret U.S. atomic bomb was being assembled. Perhaps because of the heavy workload (Whitaker is said to have treated 12 patients per day in half-hour, back-to-back sessions), or perhaps because he believed he lacked sufficient experience with adult patients, or perhaps because he wished to share his intense personal involvement in the therapeutic process, Whitaker began working with colleagues such as John Warkentin as part of a **co-therapy** team. Following the war, he was asked to establish and chair the psychiatry department at the medical school at Emory University in Atlanta, Georgia. There, together with associates such as Warkentin (who possessed a doctorate in psychophysiology but with additional training as a child therapist) and later Thomas Malone (trained in psychoanalytic work with adults), Whitaker continued his earlier unconventional co-therapy treatment of schizophrenics. The technique allowed one therapist to serve as an observer while the other engaged the client more directly.

As Whitaker pursued his unorthodox approach to treating schizophrenics, he became increasingly aware of the key role played by the family in the disorder. As he later put it, he became intrigued with the idea that "there is no such thing as a person, that a person is merely the fragment of a family" and, in typical Whitaker provocative style, that "marriage is not really a combination of two persons; rather it is the product of two families who send out a scapegoat to reproduce themselves" (Whitaker & Ryan, 1989, p. 116).

Whitaker began to conceptualize schizophrenia as both an intrapsychic and interpersonal dilemma and to treat his schizophrenic patients along with their families. The multiple-therapist team—an extension of Whitaker's earlier reliance on co-therapy—was an innovation that helped prevent a single therapist from becoming entangled in what Whitaker found to be a powerful, enmeshing family system, as well as modeling desirable interpersonal behavior for the entire family (for example, disagreeing in front of the family, but in a constructive manner).

The Symbolic Aspects of Family Therapy

By the mid-1960s, Whitaker had resigned from Emory University to form the Atlanta Psychiatric Clinic, a private practice group. In 1965, now defining himself as a family therapist, Whitaker moved to the University of Wisconsin School of Medicine in Madison and began—first with August Napier, a psychologist now in practice in Atlanta, and later with David Keith, a child psychiatrist now in Syracuse—to elaborate his ideas about effectively engaging a variety of families, not simply those with psychotic members (Keith & Whitaker, 1982; Napier & Whitaker, 1978). Moreover, Whitaker was starting to pay closer attention to what he personally was experiencing in the treatment process; he saw the potential for using that awareness to press for changes in his patients at the same time that he himself continued to benefit by investing in the therapeutic encounter.

Symbolic-experiential family therapists insist that both real and symbolic curative factors operate in therapy. They liken the symbolic aspect of therapy to the infrastructure of a city; while not apparent on the surface, what runs underneath the streets and buildings is what permits life on the surface to go on (Whitaker & Bumberry, 1988). Reflecting a psychodynamic influence, these therapists believe our personal subterranean worlds are dominated by the flow of impulses and evolving symbols, even if not always conscious;

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indeed, they believe it is these "emotional infrastructures" that ensure the flow of our impulse life. Since they contend that the meaning we give to external reality is determined by this internal reality, it follows that helping expand the symbolic inner worlds of families can aid in their leading fuller, richer lives.

The Therapist's Use of Self

Symbolic-experiential family therapists attempt to understand a family's complex world of impulses and symbols by identifying and voicing similar underlying impulses and symbols within themselves. Not willing to settle for material from the surface world of thinking and reasoning, they probe into the covert world beneath the surface words, trying to sense the far more important symbolic meanings of what transpires between themselves and the client family. By showing ease with accepting and voicing their own impulses and fantasies, they help family members become more comfortable in recognizing, expressing, and accepting theirs. The growth and development of individual members, according to S-EFT, is stimulated when members feel themselves to be a part of an integrated family. Once they experience this sense of security and belongingness, they can later feel free ("unstuck") enough to psychologically separate from the family and develop autonomy as unique individuals.

LO 2 Normalizing Human Behavior

Throughout therapy, advocates of S-EFT listen, observe, stay in immediate touch with what they are experiencing, and actively intervene to repair damage without being concerned over *why* the breakdown occurred. They make an effort to depathologize human experience; dysfunction is viewed in both its structural and process aspects.

Structurally, perhaps disorganized or impermeable family boundaries have resulted in nonfunctional subsystem operations, destructive coalitions, role rigidity, and separation between generations. Process difficulties may have led to a breakdown in negotiation between family members to resolve conflict, the loss of intimacy or attachment or trust, as individual relationship needs remain unmet. In general, these therapists assume that symptoms develop when dysfunctional structures and processes persist over time and interfere with the family's ability to carry out its life tasks (Roberto, 1991).

In these therapists' view, "psychopathology" arises from the same mechanisms that produce "normal" behavior. Consequently, following Whitaker's lead, they are not afraid to encourage "craziness" (unconventional, childlike, socially unacceptable behavior) in family members or, for that matter, in themselves, believing that new outlooks and creative solutions typically follow as the family is freed to stretch and grow. Through his sometimes quirky and irrepressible "right-brain" style, Whitaker was often able to help sensitize the family to its own unconscious or symbolic life.

For practitioners of S-EFT, the focus of therapy is the process—what occurs during the family session—and how each participant (therapist included) experiences feelings, exposes vulnerabilities, and shares uncensored thoughts. Whenever an individual or family system



Carl Whitaker, M.D.

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seeks to grow, the therapist (or co-therapists) can take advantage of this inherent drive toward fulfillment and maturity to engage that person or group in an existential encounter free from the usual social restraints and the role playing that customarily characterize doctor–patient or therapist–client relationships. The encounter is intended to shake up old ways of feeling and behaving and thus to provide an unsettling experience to reactivate the seemingly dormant but innate process of growth.

LO 3 Establishing Therapeutic Goals

The family therapist's mission, as S-EFT sees it, is to help the three-generational family (family-of-origin and current family) to simultaneously maintain a sense of togetherness along with a sense of healthy separation and autonomy. Family roles, while largely determined by generation, should remain flexible, and members should be encouraged to explore, and on occasion even exchange, family roles. Healthy families, according to Whitaker and Keith (1981), develop an "as if" structure that permits latitude in role playing, often allowing each family member to try on new roles and gain new perspectives:[2]

> For example, the 6-year-old son says to daddy, "Can I serve the meat tonight?" and daddy says, "Sure, you sit over on this chair and serve the meat and potatoes and I'll sit over in your place and complain." (p. 190)

In S-EFT, this exchange is an opportunity to develop healthy, straight-talking communication, in which all family members are able to look at themselves and grow both as individuals and as a family. Consistent with this experiential perspective, Whitaker viewed family health as an ongoing process of *becoming*, in which each member is encouraged to explore a full range of family roles in order to develop maximum autonomy. Growth as a goal takes precedence over achieving stability or specific planned solutions, and symbolic-experiential therapists may terminate therapy still leaving the family uncertain about future direction but with better tools for finding their own way.

The Therapeutic Process

Symbolic-experiential family therapy sets itself the goal of encouraging individuation and personal integrity of all family members at the same time that it helps the family members evolve a greater sense of family belonging. Rather than attend to symptoms in an identified patient, here the family therapist immediately engages the entire family, forcing it as a group to examine the basis of their existence as a family unit.

In Whitaker's colorful description of the therapeutic process, "the journey of family therapy begins with a blind date and ends with an empty nest" (Whitaker & Bumberry, 1988, p. 53). In its initial stages, the therapist must deal with the inevitable *battle for structure*, as the

[2]Whitaker's notion of an "as if" structure denotes the playful interactions that can occur during a therapy session; this meaning is very different from the psychoanalytic concept of the same name that references patients who did not develop a normal Oedipus complex and therefore validate their existence through identification (mimicry) with others.

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family sizes up the therapist and his or her intentions and attempts to impose its own definition of the upcoming relationship: what's wrong with the family, who's to blame, who requires treatment, how the therapist should proceed. In S-EFT, therapists insist on controlling the structure, from the first telephone contact onward, so therapy begins on a productive note and the therapist does not compromise his or her own needs, beliefs, or standards. If the therapist loses this initial struggle, the family will then bring into therapy the identical behavioral patterns that are likely creating their current problems. See Box 9.2 for an example of how Whitaker worked with families.

In the process, the therapist is establishing an "I" position with the family, stimulating them, ultimately, to piece together an identifiable "we" position as a family. For example, by insisting on his own autonomy, Whitaker was telling the family that he is interested in his own growth as a result of their experience together and that they need not be concerned about protecting him. Real caring, for Whitaker, requires distance, partially achieved by caring for himself and not only for his client family. Whitaker and Bumberry (1988) emphasize dealing with the family on a symbolic level in a "metaposition"—establishing what each can expect from the other. Whitaker, who frequently used sports analogies, saw himself as a coach. He was not interested in playing on the team, only in helping it play more effectively. By stepping in to play first base, he argued, he would be indicating he did not think much of their first baseman, a destructive message. Instead, as coach, he encouraged them to develop their own resources. The therapist, who starts out in an all-powerful position, eventually becomes a facilitator and resource person as the family increasingly takes the initiative for how it wishes to change (Keith, 2000).

If the therapist must win the battle for structure, the family must be victorious in the *battle for initiative* (Napier & Whitaker, 1978). Just as the battle for structure defines the integrity of the therapist, so the battle for initiative defines the integrity of the family. They are in charge of their lives and responsible for decisions about the direction they wish to go. Any initiative for change must not only come from the family but also be actively supported by its members. These therapists shun responsibility for changing a family and especially for seeking family leadership.

Practitioners of S-EFT insist the family convene with all members present, underscoring their sense of a family unit and that the whole family is the client. The family is encouraged to probe relationships—in Whitaker's words, "to ante up"—despite attempts to identify specific members as the problem. Rather than comfort or reassure, the therapist is outspoken and takes risks, shaking up entrenched family patterns. Keith (1998) suggests an initial goal of increasing family anxiety ("It's really much worse than you think") to force family members to take more responsibility for the pattern they created.

In Whitaker's view (1977), then, family therapy occurs in stages:

1. *A pretreatment or engagement phase* in which the entire nuclear family is expected to participate; the therapist or co-therapists establish that they are in charge during the sessions but that the family must make its own life decisions outside these office visits (the latter is intended to convey the message that a therapist does not have better ideas for how family members should run their lives than they themselves do).

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BOX 9.2 THERAPEUTIC ENCOUNTER

Working with Symbolic-Experiential Family Therapy

The Stein family came to therapy because they recognized that life together seemed to be, as the son put it, "drifting away." The 16-year-old boy said, "We don't talk to each other much, don't eat together, and haven't had a vacation together in years." The mother was quiet but nodded her head in agreement. The father, a very successful businessman, said nothing and gave away nothing of whatever he might have been feeling. A daughter did not attend the first session but came to subsequent ones. She spoke about how much her brother teased her. She was overweight, had bad skin, and did not do as well as the young man at school.

One day, the father arrived late. The rest of the family had assembled, and the session began without him. When he showed up 15 minutes late, he took his seat, glanced at his watch, and looked out the window. The therapist noticed this "performance" and said, "It doesn't look like you want to be here."

The father, looking annoyed, said, "Frankly, I don't. I've been coming here now for a couple of months, and there is no change. And you know, I've been thinking that you are so much younger than I am that there isn't anything I can learn from you. Maybe we need a therapist with more experience."

The therapist said, "Well, I may be younger than you are, but I can teach you one thing. How about some manners?" The father was stunned as the therapist continued. "You didn't apologize to us for being late. And come to think of it, Ellen, you also never apologized to us for not attending the first session. What, does lateness and rudeness run in the family? We need to be here on time. We need to tell each other if we have to be late or can't make it."

"I don't need to do anything, and I don't owe you anything. And neither does Ellen. I'm paying the bill, and if I want to come late, I will."

"True enough that you pay the bill, but that doesn't make you any less rude."

"I thought therapists were supposed to keep their mouths shut and interpret our dreams. You're kind of a jerk, aren't you?"

"It takes one to know one. So how about Jerk Number 1 helps Jerk Number 2 to figure out why his family is falling apart? What's in it for anyone to connect with you when you can't even own your own stuff and say you're sorry for being late? What's in it for Ellen to come to our session at all if she thinks you won't even show up? I hate when people stand me up. How about you?"

The father softened. "Yes, that is irritating when people are late for an appointment with me or stand me up." The therapist looked at the son and mother. The boy was smiling and the mother seemed anxious. Everyone was quiet for a few minutes.

The therapist's acknowledgment that he himself had been a "jerk" got the father's attention. The discussion continued in a way that allowed the father to realize that being a jerk (or whatever that symbolized to him) was less of a problem—because anyone can have a testy moment—than the unwillingness to speak about what was on his mind and to consider the emotional needs of his family. The therapist and family came to understand that being a jerk was, for the father, all about his fear that his children didn't really care for him. Being confronted by the therapist helped the father see how his anger and isolated feelings kept him from connecting with his wife and children.

2. *A middle phase* in which increased involvement between both therapists and the family develops; care is taken by the therapist not to be absorbed by the family system; symptoms are seen and relabeled for the family as efforts toward growth; and the family is incited to change by means of confrontation, exaggeration, anecdote, or absurdity.

3. *A late phase* in which increased flexibility in the family necessitates only minimal intervention from the therapist or therapy team.

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4. *A separation phase* in which the therapists and family part, but with the acknowledgment of mutual interdependence and loss. In the final phase, the family uses more and more of its own resources and assumes increased responsibility for its way of living. With separation—the "empty nest"—there is joy mingled with a sense of loss.[3]

Symbolic-experiential change-producing interventions have a covert, implicit quality. Symptoms are rarely attacked directly. Insight seems to follow rather than precede changes in feelings and behavior. History taking is occasionally important but not routine; in any case, it cannot impede this approach's major therapeutic thrust—forming a close and personal alliance with the family as a whole and providing an experience that is symbolic to the family but does not reinforce its distress (Keith & Whitaker, 1982). What the family therapist has most to offer, Whitaker believed, is his or her personal maturity; the stage of the therapist's personal development influences the kind of support or assistance he or she gives to the family. Whitaker maintained that the therapist who does not benefit, therapeutically, from his or her work has little to give, therapeutically, to client families. The use of co-therapists enables both therapists to join, have fun together, disagree, or even quarrel with each other, and perhaps to go off on different tangents—one acting "crazy" and the other providing stability—modeling spontaneous and productive interaction.

Toward Evidence for Symbolic-Experiential Family Therapy

S-EFT has been criticized for the lack of research evidence of its clinical efficacy. Mitten and Connell (2004), inductively identified a conceptual framework from Whitaker's stages of family therapy, providing a set of six variables that can be researched:

- Generating an interpersonal set that eliminates the notion of an identified patient to a model that shifts anxiety equally among all members of the family
- Creating a suprasystem
- Stimulating a symbolic context
- Activating stress within the system
- Creating symbolic experiences
- Moving out of the system

We'll take a closer look at each aspect. The generation of an interpersonal set acknowledges that Whitaker did not speak of an identified patient. Instead, he accessed the family's symbolic infrastructure by identifying the affectively loaded issue and relevant themes of family life. The identified patient is replaced by a set (the family), with all members seen as experiencing anxiety. This redistribution of anxiety and involvement in the family dynamics helps the family experience itself as a whole. This "whole" constitutes a "suprasystem" that Whitaker, as therapist, would seek to join yet not be fully part of. The therapist repeatedly joins and

[3]Napier and Whitaker (1978) provide an intriguing full account of family therapy with the Brice family (two parents; a suicidal, runaway teenager; an adolescent son; and a 6-year-old daughter) in their book *The Family Crucible*.

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distances herself from the family. She stimulates movement in various ways and then backs out, functioning as a catalyst for change.

An important therapeutic intervention is the stimulation by the therapist of symbolic content. The authors note that when Whitaker sensed his connection with the family, he shifted from the real to the symbolic by listening "through" what was being said rather than "to" it. Following an analytic concept, Whitaker accessed the symbolic world of the family to facilitate "primary process" relating. An example offered by the authors is the withdrawn or isolated father (reality) who is called by family members the "hermit" (symbolic designation). Now the family can play with the symbolic concept of hermit.

Once these steps are accomplished, the therapist intentionally activates stress within the family; increasing anxiety prompts change. For example, if the therapist says to the isolated hermit father, "You are not desperate enough to change," the father's anxiety will likely increase and with it the need to change his relationship with the family. Or the therapist may create a symbolic experience, perhaps by amplifying the roles that the family members have assumed. The therapist might respond to the wife of the "hermit," who says, "Yes, my husband often seems like he's on another planet," by saying something to the husband like, "Boy, I can see how at times I'd want to be on Mars too if I had to be with the rest of the family." The point, of course, is not to reinforce the father-husband's isolation but to say something so jarring that it will prompt more feeling and talking. Perhaps the father will become angry with the therapist for the comment; in which case, the therapist might respond, "That doesn't sound so isolated to me." Of crucial importance here is that the intervention emerges from the therapist's authentic emotional self and that it is offered in such a way as to resonate with the emotional environment in the office. Otherwise, the therapist may risk being sadistic or plain rude.

The last variable identified by Mitten and Connell is moving out. The therapist removes herself from the family system having created live in-the-moment experiences along with symbolic representations of them that have shifted the respective awarenesses of family members. The hermit learns about his need to isolate as well as his need for contact. The wife and children appreciate that the father-husband needs some time alone even as they can now remind him that they miss their hermit when he's away too long. See Box 9.3: Thinking Like a Clinician for experience in thinking like an S-EFT therapist.

Research on experiential therapy has extended recently to focus on "noticings"—therapist practices that focus attention on the here-and-now by attending to a "client's verbal or nonverbal affectual stance," indicating the relative impact of facilitating, shifting, or disrupting therapist behavior (Muntigl & Horvath, 2014, p. 89). In addition, experientialists are investigating client emotional productivity (CEP), an evaluation of the type of client experience of emotion in treatment that advances progress toward experiential therapy goals. The construct includes emotional activation, emotion type (primary or secondary; adaptive or maladaptive), and manner of processing (productive or not), and initial research suggests that CEP predicts reduction of depressive symptoms in experiential therapy for depression (Auszra, Greenberg, & Herrmann, 2013).

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BOX 9.3 THINKING LIKE A CLINICIAN

S-EFT

The Mercer family comes to therapy with you because the parents are concerned that their adopted 16-year-old daughter Emily doesn't seem to want to interact with the family as the others do. The mother (who strikes you as controlling) says that her daughter "acts out" by staying out past her curfew. The father (who seems loving but timid) admits that he misses the way he and Emily used to interact ("We had such fun together," he says with a wistful smile), and now he finds it hard to want to spend any time with her at all. Emily doesn't say a word and keeps her iPod on as the others talk. Her brother (also somewhat timid) doesn't say much beyond that he thinks it's cool that the family is in therapy together, to which Emily smirks and says, "Yes, I am the stranger in this perfect family," to which the mother replies, "No, you are not a stranger, but you're often the bull and we're the china shop."

Using the above scenario and the six variables of S-EFT listed and described on page 249, indicate in the space provided at the right of each question any thoughts you may have or interventions you might make as an S-EFT therapist. Use a separate sheet or your word processor if you need additional space for your responses. HINT: As you write your responses and create your clinical scenarios, pay close attention to your own feelings. How can your feelings help you with your interventions?

1. What are your thoughts about the identified patient, Emily?	
2. How might you help the family realize that all together, they are the "patient"?	
3. How might you use symbolic language to help the family members understand important aspects of themselves both as individuals and as a family unit?	
4. Invent a scenario in which you might meaningfully activate stress within the family system.	
5. Develop a scenario to show how you can help the family use its symbols to have a meaningful emotional experience in support of growth.	
6. Invent a scenario that would indicate growth/change had been achieved in the Mercer family.	

Gestalt Family Therapy (Kempler)

The family therapy approaches in this chapter are all, to a greater or lesser extent, *existential*. More an orientation to understanding human behavior than a formal school of psychotherapy, existentially influenced therapies seek to enter and comprehend the world as it is being experienced by individual family members as well as the family as a functioning whole. The therapies share an emphasis on the meaning the patient gives to existence, to *being*. Because people define themselves through their current choices and decisions, action in the

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BOX 9.4 THERAPEUTIC ENCOUNTER

Whitaker: The Person of the Therapist

Throughout his work with individuals and families, Whitaker stressed his personal need to "stay alive" as a human being and as a therapist. He frequently asserted that "nothing worth knowing can be taught," insisting that the therapist must uncover his or her own belief system and symbolic world and then use that self (rather than specific therapeutic techniques) to grow and help families do the same. He offered a loosely formulated set of rules for therapists that still seem applicable today (Whitaker, 1976, p. 164):

1. Relegate every significant other to second place.
2. Learn how to love. Flirt with any infant available. Unconditional positive regard probably isn't present after the baby is 3 years old.
3. Develop a reverence for your own impulses, and be suspicious of your behavior sequences.
4. Enjoy your mate more than your kids, and be childish with your mate.
5. Fracture role structures at will and repeatedly.
6. Learn to retreat and advance from every position that you take.
7. Guard your impotence as one of your most valuable weapons.
8. Build long-term relations so you can be free to hate safely.
9. Face the fact that you must grow until you die. Develop a sense of the benign absurdity of life—yours and those around you—and thus learn to transcend the world of experience. If we can abandon our missionary zeal, we have less chance of being eaten by cannibals.
10. Develop your primary process living. Evolve a joint craziness with someone you are safe with. Structure a professional cuddle group so you won't abuse your mate with the garbage left over from the day's work.
11. As Plato said, "practice dying."

These "rules" urge therapists to be sure to take care of their own needs in the process of caring for others. They need to open themselves up to others, allowing themselves to love without insisting on perfection in their love object. Whitaker urged therapists to abandon rigid rules because they inhibit growth and to try to remain flexible and available for new experiences without insisting on always knowing the right answer. Strong relationships, says Whitaker, are worth cultivating, and once developed can endure angry conflict. Let go; you can't fix everything!

Learn to play—both at home and at work—and live every day to its fullest measure!

present, not reflection on the past, is the key to understanding for the existentialist. Even the future—what people choose to become—has more influence than issues and conflicts associated with the past. In existential therapies, clients are urged to examine and take responsibility for their lives. Unconscious material may be brought forth but is not automatically assumed to be any more meaningful than the conscious data of life.

Psychotherapy in this framework is an *encounter* between two or more persons who are constantly developing, evolving, and fulfilling their inner potential. Technique is de-emphasized to preclude one person seeing the other as an object to be analyzed. In contrast to the common therapeutic belief that understanding stems from technique,

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existentialist therapists believe that technique follows understanding. Formal and conventional doctor–patient roles are replaced by a more egalitarian and open arrangement in which each participant opens his or her world to the other as an existential partner. The emphasis is on presence; in a real, immediate, ongoing relationship between two or more persons, each tries to understand and experience as far as possible the being of the other(s).

If existentialism is concerned with how humans experience their immediate existence, Gestalt psychology focuses on how they perceive it. Frederick (Fritz) Perls is generally credited with launching the Gestalt therapy movement in the United States. For Perls (1969), who worked with individuals, change is facilitated when the client's thoughts and feelings become congruent; the client achieves greater self-awareness in order to become more self-directed, more centered, more congruous. By removing entrenched intellectualized thinking patterns, the client could break through to his or her emotionally rooted inner experiences. (Perls enjoyed putting it this way: Lose your mind and come to your senses.) Extrapolating from the individual focus, Gestalt family therapists focus attention on the immediate—"What people say, how they say it, what happens when it is said, how it corresponds with what they are doing, and what they are attempting to achieve" (Kempler, 1982, p. 141). Here the goal is to bring discordant elements (within oneself or between family members) into a self-disclosing confrontation and ultimate resolution.

Gestalt family therapy, popularized in the 1970s and 1980s, appears dated today, but we include it as a forerunner of contemporary models because: (1) it encourages open and honest expression of all emotions (hopes, fears, wishes, anxieties), a precursor of today's therapeutic approaches aimed at achieving authenticity and connection to others; (2) it emphasizes individual growth and the development of the Self, within family systems, again a contemporary view; and (3) it rests heavily on therapist modeling of desired behavior, being a genuine person, and utilizing the therapist's personality to effect change, a part of many current collaborative procedures.

Leading Figure: Walter Kempler

The most prominent Gestalt family therapist is Walter Kempler, whose techniques stem from his adaptation of the individual work of Perls, with whom he studied. Kempler, a physician, returned for a psychiatric residency at the UCLA Neuropsychiatric Institute in the late 1950s. Later, he established the Kempler Institute for the Development of the Family in Southern California. Kempler traveled extensively until his retirement, especially in the Scandinavian countries, lecturing and demonstrating his prodding, confrontational interventions with family members. Antitheoretical, like Whitaker, Kempler's therapeutic efforts aimed at helping clients expand their awareness, take responsibility for their actions, and gain a sense of autonomy and authenticity. Again like Whitaker, Kempler contends that the family holds the key to the personal development of its members.

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BOX 9.5 CLINICAL NOTE

A Gestalt Family Therapy Credo

Kempler (1981, p. 38) insists that an effective therapeutic encounter meet the following four demands:

1. A clear knowledge of "who I am" at any given moment. This requires a dynamic awareness of what I need from moment to moment.
2. A sensitive cognition or appraisal of the people I am with and the context of our encounter.
3. The development and utilization of my manipulating skills to extract, as effectively as I am capable, what I need from the encounter.
4. The capability of finishing an encounter.

The Therapeutic Encounter

Employing a personally interactive way of working with families, **Gestalt family therapy** blends some of the principles and procedures of family and Gestalt therapies in order to help people reach beyond their customary self-deceptive games, defenses, and facades. To do so, the therapist relies on the forthright expression of what he or she is experiencing to assist clients to become aware of and release previously unrecognized or bottled-up feelings.

Kempler's (1981) therapeutic efforts are provocative, highly personal, uncompromisingly honest, and powerful. He presses for self-disclosure by family members, expecting that the wish or need to resolve their problems or improve relationships will give them the courage to expose their vulnerabilities. He actively and directly insists that everyone, himself included, become more intensely aware of what they are doing or saying or feeling. Like the mechanic who would rather listen to a troublesome engine than hear a description of it, Kempler first starts up a family conversation:

TRANSCRIPT	COMMENTS
MOTHER: Our 15-year-old son Jim has been making a lot of trouble for us lately.	The healthier the family, the more readily they talk to each other. For instance, should Jim respond immediately to his mother's charge with "That's not true!" it would indicate that he has both self-confidence and the hope of being heard. Let's assume Jim doesn't leap in.
THERAPIST (TO JIM EVOCATIVELY): Do you agree that the number one problem in this family is that you are a troublemaker?	
JIM: Not really.	
THERAPIST: Tell her what you think is.	
JIM: It's no use.	
THERAPIST (TO MOTHER): Do you have anything to say to his hopelessness?	

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TRANSCRIPT	COMMENTS
MOTHER: I think we've said all there is to say.	Family members are often reluctant to engage one another, particularly initially. The therapist perseveres by offering himself, if necessary.
THERAPIST (TO JIM): I'd like to know what you think is the problem, Jim.	The battle lines often have both parents on one side. It is better when it is a free-for-all.
JIM: They are too rigid.	
THERAPIST: Both of them identical?	
JIM: Mother more than Father.	
THERAPIST: Then, maybe you can get some help from him.	
JIM: He's too weak. He always gives in to her.	
THERAPIST (TO FATHER): Do you agree with him?	
FATHER: Of course not.	
THERAPIST: You didn't tell him.	

Source: Kempler (1974, pp. 27–28).

Kempler is interested in what each person wants and from whom, expressed in the most specific terms possible. Participants are forced to talk to each other, in face-to-face, encounter-group-like fashion. If a wife complains to Kempler that her husband lacks understanding or sensitivity, Kempler directs her to tell that to her husband, not to the therapist, and to be specific in her complaint. If she argues that it will do no good, Kempler insists she tell *that* to her husband. If she then breaks down, admits her feelings of hopelessness, and begins to cry—all without provoking a response from her husband—Kempler will point out his silence and invite him to answer her. From the initial interview through the subsequent sessions, the focus remains the immediate present. Self-disclosure and open, honest exchanges with others are basic ground rules for family members to follow if they are to untangle a family problem or overcome an impasse.

Gestalt family therapists attempt to help each family member achieve maximum individuation at the same time that they promote more vital relationships among the various members. After family members explore how their awareness is blocked, the therapist then channels the increased awareness so that they may engage in more productive and fulfilling processes with one another (Kaplan & Kaplan, 1978).

The Gestalt therapist facilitates self-exploration, risk taking, and spontaneity. Since such undertakings are all but impossible if an individual or family fears that self-discovery could be harmful, it is essential that the therapist provide an unchecked and unequivocal model for self-disclosure. To strike the familiar pose as a benevolent and accepting therapist only plays into the client's fantasies that disapproval is dangerous, according to Kempler (1982). By contrast, Kempler is emotionally intense, assertive, genuine, challenging, sometimes brutally (if

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refreshingly) frank; in short, he expresses whatever he is feeling at the moment in the hope of making an impact on the family.

Kempler's demand for a complete and honest emotional encounter with and between family members reflects his Gestalt heritage. Although far less popular today than in the heyday of encounter groups and sensitivity training decades ago, this technique offers a useful counterweight to a strong focus on cognitive analyses and behavior change. No holds are barred, no feelings stifled. The therapist is a real person who knows who she is, what her needs are, and what she is experiencing from moment to moment during the shared therapeutic encounter with the family. At the same time, she insists that all participants search for, uncover, and express what they are experiencing *now*, since to Gestaltists, *nothing exists except in the now*. She urges clients to stay with the experience as it is happening until they recognize and "own" what they are feeling from moment to moment, because it is in the now that people are or are not growing, are or are not enhancing their coping abilities, are or are not in touch with themselves and with reality.

The Human Validation Process Model (Satir)

The human validation process model, experiential in nature, emphasizes the collaborative efforts of therapist and family members to achieve family "wellness" by releasing the potential viewed as inherent in every family (Satir & Bitter, 2000). Clear, congruent communication is critical to maintain a balanced and nurturing family system, and building self-esteem is considered essential if all members are to thrive as individuals and as part of a functional system. Especially important to this model—as in all experiential approaches—is the personal involvement of a caring therapist who demonstrates, often through self-disclosure, his or her own honest and spontaneous feelings. The therapist encourages family members to develop a process for directly expressing emotions, learning to change embedded rules that discourage or in some cases prohibit dealing with one another at a feeling level.

Leading Figure: Virginia Satir

Virginia Satir's central place in the history of the family therapy movement has been noted earlier in this book. In the 1950s, among the founding parents of the family therapy movement, Satir was in the unique position of being both a woman and a social worker among predominantly white male psychiatrists. Actually, she probably preceded most of her male counterparts in working with families, reportedly having seen her first family in therapy in 1951 and having offered the first training program ever in family therapy in 1955 at the Illinois State Psychiatric Institute (Satir, 1982). It was several years later that she read of a group engaging in family research efforts in Palo Alto, California (Bateson, Jackson, Haley, & Weakland, 1956); having contacted them, she was invited by Jackson to help him start what became the Mental Research Institute (MRI). More interested in training than in research, Satir soon set about demonstrating her techniques with families, culminating in the first published description of conjoint family therapy (Satir, 1964), truly a groundbreaking text for therapists and students alike.

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Over a 30-year span, until her death in 1988, Satir continued to be a prolific writer. She is especially celebrated for her inspiring family therapy demonstrations around the world. Although linked to the communication approach because of her early MRI affiliation, Satir's work during the 1960s at Esalen, a growth center, encouraged her to add a humanistic framework and emphasize a number of growth-enhancing techniques (sensory awareness, dance, massage, group encounter techniques) to evoke feelings and clarify family communication patterns. In her later writing, Satir (1986) identified her approach as a **human validation process model** in which the therapist and family join forces to stimulate an inherent health-promoting process in the family. Open communication and emotional experiencing were the mechanisms that helped achieve that end, as family members, following the therapist's lead, learned to take the risk of expressing feelings openly, congruently, and without defensiveness.

Virginia Satir was a charismatic leader, truly an original, and no discussion of experiential family therapy would be complete without paying homage to her vision. She presented herself to families as a dynamic, nurturing, folksy, genuine person, with a belief in the goodness of people and in the "healing power of love" (Satir & Baldwin, 1983). While the latter made her appear simplistic and Pollyannaish to critics, she was revered by followers and profoundly touched those families with whom she worked. The "love" she practiced with clients and that she postulated as a necessary condition for actualizing one's capabilities was based on her assumptions about what best facilitates change.



satirglobal.org/Virginia Satir

Virginia Satir, M.S.W.

Satir assumed people want to be whole, authentic, sensitive, and genuine with one another. Thus, she looked for and found in people signs of their healthy *intentions*, even when these were embedded in unhealthy behavior (Lawrence, 1999). Symptomatic behavior, for Satir, was "adaptive attempts gone awry" rather than fixed characteristics of the person (Waters & Lawrence, 1993). Summaries of her philosophical assumptions and therapeutic techniques can be found in Woods and Martin (1984), Brothers (1991), Andreas (1991), Satir, Banmen, Gerber, and Gomori (1991), and Satir and Bitter (2000).

Symptoms and Family Balance

Satir concerned herself with the family as a balanced system. In particular, she wanted to determine the "price" each part of the system "pays" to keep the overall unit balanced. That is, she viewed any symptom in an individual member as signaling a blockage in growth and as having a homeostatic connection to a family system that to keep its balance requires blockage and distortion of growth in some form in all of its members.

A presenting symptom in a family member gave Satir (1982) the initial clues for "unraveling the net of distorted, ignored, denied, projected, unnourished, and untapped parts of each person so that they can connect with their ability to cope functionally, healthily, and joyously" (p. 41).

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LO 4 Individual Growth and Development

Satir believed that all humans strive toward growth and development and that each of us possesses all the resources we need for fulfilling our potential, if only we can gain access to these resources and learn to nourish them. She pointed to three factors that influence human development: (a) unchangeable genetic endowment, determining our physical, emotional, and temperamental potential; (b) longitudinal influences, the result of learning acquired in the process of growth; and (c) the constant mind–body interaction.

Longitudinal influences—the sum of learning since birth—are especially significant. Satir emphasized the child's experiences of the *primary survival triad* (father, mother, child) as the essential source of self-identity. Adult self-worth or self-esteem evolves from the relative proportion of constructive to destructive interaction experiences arising from this triad. The child also learns to decipher parental messages; discrepancies between words, tone, touch, and looks help shape future adult communication patterns.

Another factor in individual growth is the *mind, body, feeling triad*. Body parts may take on metaphoric meaning, with each having a positive or negative value attached to it by its owner. Some are liked, others disliked, some need awakening. In what Satir called a therapeutic *parts party*, clients are encouraged to become aware of these parts and learn to use them "in an harmonious and integrated manner" (Satir & Baldwin, 1983, p. 258).

Building self-esteem, promoting self-worth, expanding awareness, exposing and correcting discrepancies in how the family communicates—these were the issues Satir tackled as she attempted to help each member of the family develop "wellness" and become as "whole" as possible. The extent to which they could identify and practice new possibilities determined their chances to integrate change into their family life.

BOX 9.6 CLINICAL NOTE

Satir's Eight Aspects of the Self

Satir (1986) contended that the self—the core of every person—consists of eight separate but interacting elements or levels, which together exert a constant influence on a person's well-being. Satir searched for the varying degrees of strength in each of these parts of the person. In tapping an individual's nourishing potentials, she attempted to work at one or more of the following levels:

1. *Physical* (the body)
2. *Intellectual* (thoughts, logic, processing of facts, left-brain activity)
3. *Emotional* (feelings, intuition, right-brain activity)
4. *Sensual* (sound, sight, touch, taste, smell)
5. *Interactional* (I–Thou communication between oneself and others)
6. *Contextual* (colors, sound, light, temperature, movement, space, time)
7. *Nutritional* (solids and fluids ingested to furnish energy)
8. *Spiritual* (one's relationship to life's meaning, the soul, life force)

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Family Roles and Communication Styles

Satir contended that the way the family communicates reflects the feelings of self-worth of its members. Dysfunctional communication (indirect, unclear, incomplete, unclarified, inaccurate, distorted, inappropriate) characterizes a dysfunctional family system. One of Satir's lasting contributions is her simple—but far from simplistic—classification of styles of communication, especially apparent in dealing with stress. She argued that under stressful conditions, a person in a relationship communicates in one of five ways (Satir, 1972). These styles are expressed through body position and body language as much as through verbal behavior. The *placater* acts weak, tentative, self-effacing, and always agrees, apologizes, and tries to please. The *blamer* dominates, invariably finds fault with others, and self-righteously accuses. The *super-reasonable* person adopts a rigid stance, remains detached, robot-like, calm, cool, maintaining intellectual control while making certain not to become emotionally involved. The *irrelevant* person distracts others and seems unable to relate to anything going on, afraid to offend or hurt others by taking a position on an issue. Only the *congruent communicator* seems real, genuinely expressive, sending straight (not double-binding or confusing) messages in their appropriate context.

Various combinations of these styles exist in most families. For example, take the case of a blaming wife, a blaming husband, and a placating child triad: "It's the school, they don't teach anything anymore"; "It's the child down the street, that's where she's learned those bad words"; "It's the way you've raised her, she's just like you"; "I'll try to do better, Daddy. You're absolutely right. I'll stop watching TV tomorrow, go to the library. . . . Leave the dishes, and I'll do them tomorrow after school." In a blamer/super-reasonable couple, the wife might complain bitterly: "We hardly ever make love anymore; don't you have any feelings for me?" The husband might respond coldly: "Of course I do or I wouldn't be married to you. Perhaps we define the word *love* differently." In the case of a conversation between a super-reasonable parent ("Let's discuss precisely why you seem to be having difficulties with your math problems tonight") and the irrelevant child ("It's time for my television program now"), nothing gets settled or resolved; the tension is maintained if not increased. Table 9.1 illustrates Satir's four-stance model of dysfunctional family communication. Only the congruent person maintains self-esteem under stress, making certain that his or her inner feelings are matched by clear and direct outer communication and behavior (Satir & Bitter, 2000).

Satir maintained that these roles are essentially poses that keep distressed people from exposing their true feelings because they lack the self-esteem that would allow them to be themselves. Placaters are afraid to risk disapproval if they speak up or disagree or act in any way independent of a parent or spouse. Blamers also feel endangered and react by attacking in order to cover up feeling empty, unworthy, and unloved themselves. Super-reasonable people feel safe only at a distance and rely on their intellect to keep from acknowledging that they too have feelings and are vulnerable. Irrelevant people (often the youngest child in a family) gain approval only by acting cute and harmless. Satir, a warm, caring, nurturing person—but also capable of being fearlessly direct—inevitably tried to facilitate straight talk between family members, encouraging them to be congruent in their communications, matching words to feelings to body stance, without qualification.

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TABLE 9.1 Four dysfunctional communication stances adopted under stress (SATIR)

Category	Caricature	Typical Verbal Expression	Body Posture	Inner Feeling
Placater	Service	"Whatever you want is okay. I'm just here to make you happy."	Grateful, boot- licking, begging, self-flagellating	"I am like a nothing. Without you, I am dead. I am worthless."
Blamer	Power	"You never do anything right. What is the matter with you?"	Finger pointing, loud, tyrannical, enraged	__"I am lonely and unsuccessful."
Super-reasonable	Intellect	"If one were to observe carefully, one might notice the work-worn hands of someone present here."	Monotone voice, stiff, machine-like, computer-like	"I feel vulnerable."
Irrelevant	Spontaneity	Words unrelated to what others are saying. For example, in midst of family dispute: "What are we having for dinner?"	In constant movement, constant chatter, distracting	"Nobody cares. There is no place for me."

Source: Based on Bandler, Grinder, and Satir (1976).

The "Threat and Reward" and "Seed" Models

In her workshops, Satir often presented two contrasting views of the world, which she labeled the "Threat and Reward" model and the "Seed" model. Relationships in the former suppose a hierarchy in which some people define rules for others to follow without question. The hierarchy is based on roles that powerful individuals hold on to for life. While those on top are not necessarily malevolent, their behavior helps create individuals who feel weak and have low self-esteem. Conformity is expected in the Threat and Reward model, whether based on gender or lower-status positions in society. The cost of nonconformity is guilt, fear, or rejection. Resentment and hostile feelings also are common, and for some people feelings of hopelessness may be present.

In the Seed model, *personhood* rather than role determines identity, and every person is born with a potential that may be fulfilled. While roles exist, they define relationships only within certain contexts and are not based on permanent status or role differences. In the Seed model, change is viewed as an ongoing life process and an opportunity for growth. Satir was a strong advocate of the Seed model, insisting that given the proper conditions of nurture, children, like seedlings, can develop into healthy adults.

Family Assessment and Intervention

Satir tried to help people feel good about themselves, often as a result of her own boundless, optimistic approach to life. She was less concerned with conducting a formal assessment or zeroing in on the specific content of presenting problems than she was with getting to work clarifying and improving family communication. Her diagnostic understanding of the family came out of her developing relationship with each of its members. She tended to work with families in terms of their members' day-to-day functioning and their emotional experiences with each other. She taught people congruent ways of communicating by helping restore the use of their

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senses and the ability to get in touch with and accept what they were really feeling. Thus, she helped individuals and families build their sense of self-worth; she opened up possibilities for making choices and bringing about changes in relationships (Bandler, Grinder, & Satir, 1976).

Because Satir believed human beings have within them all the resources they need in order to flourish, she directed her interventions at helping families gain access to their nourishing potentials—and then learn to use them. This is a growth-producing approach in which she encouraged people to take whatever risks were necessary in taking charge of their own lives. Early in the therapy process, Satir would present herself as a teacher introducing the family to a new language, helping them understand their communication "discrepancies," blocking the kinds of repetitive sequences that end with members falling into the incongruent family communication styles discussed earlier.

Satir's primary talent was as a therapist and trainer rather than a theory builder or researcher. She aimed at accessibility in her writing style, consistent with her desire for clear and direct communication, although her concepts (self-esteem, family pain, family health) often lacked precision. She was a vigorous, nurturing, compassionate, down-to-earth, and perceptive person who engaged a family authoritatively from the first session onward. She spoke simply and directly, kept up a running account of what she was doing with the family, tried to pass along her communication skills to family members, and then arranged encounters between members according to the rules she had taught them.

In an example (in Box 9.7) from her early, if somewhat dated work (Satir, 1967), the parents and their children, Johnny (age 10) and Patty (age 7), are being seen together. Johnny, the identified patient, is having behavior problems at school. Satir wants to clarify what ideas each member has about what to expect from therapy and why each is there. Note how she tries to help the family members (a) recognize individual differences among them by having each member speak for himself or herself; (b) accept disagreements and differing perceptions of the same situation; and most important, (c) say what they see, think, and feel in order to bring disagreements out into the open.

In this brief excerpt, we also see Satir's effort to build self-esteem in each family member and to emphasize that each person is unique and has the right to express his or her own views without another person (e.g., a parent) answering for him or her. She lets the family know her goals, thus enabling them to know what to expect as they work together. Warm and caring herself, with a strong set of humanistic values, Satir stressed the role of intimacy in family relationships as a vehicle for growth among all family members. A healthy family, to Satir, is a group in which members can ask for what they need, needs are met, and individuality is allowed to flourish. Dysfunctional families do not permit individuality, and their members fail to develop a sense of self-worth. If parental messages to one another or to their children are incongruent or confusing, then family communication across generations tends to be similarly unclear or confounded. Parents with low self-esteem communicate poorly and contribute to feelings of low self-esteem in their children.

In an early technique, Satir initiated a family's treatment by compiling a **family life fact chronology** to understand the history of the family's development by depicting key elements

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BOX 9.7 THERAPEUTIC ENCOUNTER

Satir Clarifies Family Communication

PATTY: Mother said we were going to talk about family problems.

THERAPIST: What about Dad? Did he tell you the same thing?

PATTY: No.

THERAPIST: What did Dad say?

PATTY: He said we were going for a ride.

THERAPIST: I see. So you got some information from Mother and some information from Dad. What about you, Johnny. Where did you get your information?

JOHNNY: I don't remember.

THERAPIST: You don't remember who told you?

MOTHER: I don't think I said anything to him, come to think of it. He wasn't around at the time, I guess.

THERAPIST: How about you, Dad? Did you say anything to Johnny?

FATHER: No, I thought Mary had told him.

THERAPIST: (to Johnny) Well, then, how could you remember if nothing was said?

JOHNNY: Patty said we were going to see a lady about the family.

THERAPIST: I see. So you got your information from your sister, whereas Patty got a clear message from both Mother and Dad. (Shortly, she asks the parents what they remember saying.)

THERAPIST: How about that, Mother? Were you and Dad able to work this out together—what you would tell the children?

MOTHER: Well, you know, I think this is one of our problems. He does things with them and I do another.

FATHER: I think this is a pretty unimportant thing to worry about.

THERAPIST: Of course it is, in one sense. But then we can use it, you know, to see how messages get across in the family. One of the things we work on in families is how family members communicate—how clearly they get their messages across. We will have to see how Mother and Dad can get together so that Johnny and Patty can get a clear message.

(Later, she explains to the children why the family is there.)

THERAPIST: Well, then. I'll tell you why Mother and Dad have come here. They have come here because they were unhappy about how things were going in the family and they want to work out ways so that everyone can get more pleasure from family life. (Satir, 1967, pp. 143–145). See Satir and Baldwin (1983) for a transcript of one of Satir's demonstrations, including an explanation of her techniques and interventions.

in its evolution, beginning with the birth of the oldest grandparents. Her goal was to force family members to think about characteristic family patterns and especially about the relevant concepts that had formed the basis for their developing relationships.

Family Reconstruction

Another innovation developed by Satir, **family reconstruction** guides clients to unlock dysfunctional patterns stemming from their families of origin. The technique blends elements of Gestalt therapy, guided fantasy, hypnosis, psychodrama, role playing, and family sculpting (as noted earlier, physically molding family members into characteristic poses representing one family member's view of family relationships at a particular moment—say, after the death of a grandmother). The idea is to shed outgrown family rules and dislodge early

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misconceptions. Used in family and group therapy (Nerin, 1986), family reconstruction takes family members through certain fixed stages of their lives. By reenacting their family's multigenerational drama, members have an opportunity to reclaim their roots and perhaps view old perceptions in a new light, thereby changing entrenched perceptions, feelings, and beliefs (Nerin, 1989).

Family reconstruction has three goals: (a) to reveal to family members the source of their old learning, (b) to enable them to develop a more realistic picture of the personhood of their parents, and (c) to pave the way for members to find their own personhood. The technique is said to be especially useful for dealing with family issues when there is little or no access to the real family of origin.

Within a group setting, usually with enough members so that separate actors can portray each family member, the client (called the Explorer) elicits others to play key roles in the history of the Explorer's extended family across at least three generations. The therapist, acting as Guide, leads the Explorer by asking questions to work through lingering family conflicts (e.g., "healing" a relationship between him and his mother) in an effort to reconstruct the past mysteries of his or her life, come away with a new understanding of past events, and as a result become free to maximize his or her potential.

Satir is quoted (Nerin, 1989, p. 55) as saying,

> When one views human life as sacred, as I do, family reconstruction becomes a spiritual as well as a cognitive experience to free human energy from the shackles of the past, thus paving the way for the evolvement of being more fully human.

The Avanta Network

For the last decade of her life, Satir's influence waned in the family therapy movement, probably because of conflict with other leaders and her interest in changing larger systems. She moved away from the mainstream of the family therapy movement.[4] While continuing to travel around the world as a kind of roving emissary of humanistic family therapy, Satir was persuaded to try to supply a systematic rationale for her interventions so that her style could be learned by others and not be merely her unique technique. With two colleagues who analyzed and devised a model of Satir's linguistic style with families (Bandler, Grinder, & Satir, 1976), she identified the key elements in her approach: challenging the built-in expectations in the family's existing communication patterns; helping the family members work together to understand what they want in terms of change; preparing the family for

[4]One event hastening Satir's departure—according to Pittman (1989), who was present—occurred in Venezuela in 1974, at a meeting of board members of the influential journal *Family Process*. In a heated debate with Salvador Minuchin regarding the future direction of family therapy, Minuchin criticized what he regarded as Satir's evangelical approach, insisting that more than the healing power of love was involved in repairing dysfunction within a family. Satir argued otherwise, calling on her colleagues to join her crusade for nothing less than the salvation of humankind through family therapy. When it became clear to all assembled that Minuchin's position represented the direction in which the field was headed, Satir, dissatisfied with its limited mission, directed her efforts away from mainstream family therapy and focused her energies on the Avanta Network and similar organizations.

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a new growth experience; helping the members learn a new family process for coping; and providing the tools they will need to continue the change process after therapy. Most important, these researchers' linguistic analysis indicated that Satir taught the actual skills necessary to communicate differently as a family. Having learned these skills, family members presumably would be able to cope more creatively and effectively with any new problem or crisis.

Having developed a worldwide following, Satir turned her attention to larger systems. In 1977, as an outgrowth of her humanistic orientation, she formed the Avanta Network (*avante* is Italian for "moving ahead"; thus, Avanta referred to "going beyond"), a nonprofit organization for training others in her therapeutic outlook and procedure, today known as the Virginia Satir Global Network (Haber, 2011).

LO 5 Satir's Legacy

Satir's contributions—an insistence on the importance of open and direct communication, her effort to help clients build self-esteem, her belief in the resiliency of every family—were essential to family therapy's early development and a needed balance to rival approaches less concerned with emotion. Despite Satir's enormous influence on the field—she was judged during her lifetime to be one of the best family therapy teachers in the world (Braverman, 1986)—her artistically intuitive way of working with families has a dwindling number of followers today. Possibly this is because many perceive her interventions to be more a manifestation of her personality and inventiveness—thus hard to learn—than a systematic set of therapeutic procedures based on theory.

However, Brubacher (2006) suggests connections between Satir's model and emotion-focused therapy, a therapeutic approach that is solidly grounded in explicit theory, relationship principles, and therapeutic skills and processes. In addition, Cheung (1997) suggests that Satir's emphasis on the importance of language, her belief that people have the potential to change and make their own choices, and her view of the therapist as participant-facilitator may represent an early influence consistent with social construction theories. In Cheung's view, family reconstruction resembles a narrative approach that reexamines beliefs and reconstructs meanings past experiences.

Emotionally Focused Therapy

The most well-known contemporary experiential family therapy model integrates a focus on the Self with a systems outlook, presenting a model grounded in explicit theory and supported by effectiveness research. Emotionally focused therapy (EFT) views couples and families in both intrapsychic and interactional terms, helping them gain access to what is emotionally significant for each person. At the same time, it helps them examine what guides their experiences and actions and assists their explorations through the ongoing transactions occurring in the close, personal therapist–client(s) relationship.

EFT practitioners' focus is on the process between people, not what is inherent in each person. Each person learns to examine how his or her interactions with others set off cues that

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maintain distress and dysfunction in the relationship. The emphasis is on helping clients explore their moment-to-moment inner experiences and relationship events, especially the rigid patterns that block *emotional engagement*. The therapist is a facilitator, helping clients explore experiences, rather than the expert who knows *what* the client is experiencing (Greenberg, Rice, & Elliott, 1996). Greenberg (2014) views the therapist as an "emotion coach" helping clients work through feelings rather than control or avoid them.

Leading Figures: Johnson and Greenberg

Susan Johnson (Johnson & Bradley, 2009), a Canadian psychologist at the University of Ottawa, is also director of the Center for Emotionally Focused Therapy and the Ottawa Couple and Family Institute. Les Greenberg (2014), a psychologist at York University in Toronto, Canada, is the director of that university's Psychotherapy Research Center. Together, the two are the originators and main proponents of emotionally focused therapy (EFT), with couple (EFCT), and family therapy (EFFT) versions, considered to be among the best empirically supported interventions currently available.

A Brief, Integrative Approach

This short-term (8–10 sessions) experiential approach is an outgrowth of humanistic therapy, especially the client-centered procedures of Carl Rogers (creating a safe therapeutic environment and modeling active *empathic* understanding), and Fritz Perls's Gestalt therapy (directing clients toward greater awareness by engaging in resolution-enhancing *affective processes*). Add to this mix Satir's emphasis on *congruent communication* and closeness in the therapist–client relationship, as well as an adaptation of Bowlby's contribution of *attachment theory* directed at adult love relationships.

EFT practitioners believe that humans have an inherent tendency to maximize our capabilities, to actualize ourselves. We organize what we see and give it meaning, filtered through our current emotional states and the ways in which we organize our experiences. If couples and families can be helped to change their negative emotional patterns, to bond to one another with positive, caring emotion, and learn to restructure their relationship so that they become more attuned and responsive to each other, then therapeutic changes can occur.



Courtesy of Susan Johnson

Susan Johnson, Ed.D.

The Change Process

There are three stages in the EFT change process (Johnson & Bradley, 2009, pp. 405–412): "Stage I: De-escalation of negative cycles and stabilization" (assessing and creating an understanding of interpersonal patterns and foundational attachment-related affect); "Stage II: Creation of new stances and patterns of interaction that foster open responsiveness and more secure bonding" ("withdrawer re-engagement and blamer softening"), allowing attachment needs to surface and be met in a "transforming emotional connection"; and "Stage III: Consolidation/integration" (addressing issues in light of new patterns).

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BOX 9.8 CLINICAL NOTE

Outlining the EFCT Change Process

Greenberg and Johnson (1986, p. 261) illustrate the change process in this way:

1. An individual perceives himself or herself differently by bringing into focal awareness experiences not previously dominant in this person's view of self. For example, "I see and accept my vulnerability."
2. The spouse, upon witnessing the partner's new affective expressions, perceives the partner in a new way. For example, "I see your need for caring and contact rather than your hostility."
3. The individual's personal reorganization leads to different behavior in the interaction with the spouse. For example, "I now ask you for reassurance from a position of vulnerability."
4. The spouse's new perception of the partner leads to different responses. For example, "I comfort you rather than withdraw."
5. As a function of their partner's new behaviors, individuals come to see themselves in a new way. For example, "Since I can fulfill your needs, I see myself as valuable and necessary to you."

Put simply by Wetchler and Piercy (1996, p. 87), "as Mary begins to see John's withdrawal as a fear of being emotionally hurt and John understands that her anger is due to her fear of being abandoned by him, they will begin to talk differently to each other and develop a more stable bond."

Skills for enhancing empathic exploration and understanding of one another are taught, and EFT exercises aid individuals in recognizing and identifying their own and others' internal cognitive, emotional, and bodily processes. Brubacher (2006) suggests that what Satir was able to achieve intuitively, such as seemingly magically unearthing positive intentions and resources in presenting problems, EFT does systematically in a step-by-step series of therapeutic tasks, in manual form, to facilitate emotional change.

Specifically, EFT helps clients restructure habitual negative interactive patterns (attacking-withdrawing, pursuing-distancing) that have created emotional removal or remoteness or have led to attack-attack engagement. In distressed relationships, these patterns become rigid and laden with affect, curtailing closeness or trust and precluding the evolution of new patterns or responses. The EFT therapist tries to modify the key emotional experiences of both partners, the positions they take in this relationship dance, and the relationship events that define the quality of their attachment in order for them to build secure emotional bonds (Johnson & Bradley, 2009).

Attachment Theory and Adult Relatedness

Attachment theory[5] (Bowlby, 1969; Meyer, Jones, Rorer, & Maxwell, 2015) explains how adult relationships become troubled and dysfunctional. Everyone needs the predictable emotional accessibility and responsiveness of significant others in order to experience personal

[5]The concept of attachment is used somewhat differently here than in object relations theory. Acknowledging that early attachment bonds provide the model for later adult relationships, emotionally focused therapists view all humans as needing security and protection; in distressed relationships, these essentially healthy attachment needs are thwarted due to the couple's rigid pattern of interaction. EFCT tries to help partners in close relationships create secure attachment bonds (Johnson, 2003).

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BOX 9.9 CLINICAL NOTE

Attachment Injuries May Result in Rage

A rageful spouse who declares he or she has been betrayed by a mate is likely experiencing a powerful attachment injury. The partner, attending a significant family event such as a birthday party or funeral, was seen as emotionally unavailable, unresponsive, or inattentive at a key moment when support or other signs of caring were urgently needed. If unresolved, the injured partner is likely to bring the incident up repeatedly, sometimes over many years, as a symbolic example of the other's untrustworthiness and lack of caring.

security, a sense of trust and safety, and self-confidence. If not, there is no emotional engagement, and the person is left feeling disconnected, frustrated, angry, depressed, and detached. Under such conditions of despair, destructive interactive patterns are almost sure to follow.

As Johnson (2003) observes:

> . . . when one partner fails to respond at times when the other partner's attachment needs become urgent, these events will have a momentous and disproportional negative impact on the affective tone of the relationship and its level of satisfaction. Conversely, when partners are able to respond at such times, this will potentiate the connection between them. (p. 266)

Marital distress, for example, signals the failure of an attachment relationship to provide security, protection, or closeness, resulting in anxiety and a sense of vulnerability in one or both partners. Couples may hide their *primary emotions* (their real feelings, such as fear of rejection) and in their place display defensive or coercive emotions (*secondary, reactive emotions* such as expressing anger or blaming when afraid), leading to *negative interactions* in which each partner fears revealing his or her primary emotions. Repeated over time, this pattern builds fears of trusting one's partner enough to exhibit honest primary emotions, which in turn become buried even further. EFCT therapists use the therapeutic relationship to help the couple access and reprocess the primary emotions underlying their interactional positions, enhance their emotional bond, and change their negative interactional sequences toward increased attachment security.

Nelson (2005) notes that EFCT is based on an attachment view of romantic love and integrates elements of both intrapsychic and interpersonal theories of relationships. The therapist focuses on emotions as reflective of attachment needs by forming a safe therapeutic alliance from which to understand and expand the emotional bases of each partner's experience before then helping each interact with the others differently.

LO 6 Effectiveness Evidence for EFT

An increasing number of research studies demonstrate the effectiveness of EFT in various clinical situations and populations, such as marital distress (Wood, Crane, Schaalje, & Law, 2005); marital satisfaction (Dalgleish et al., 2014); marital functioning and patient experience of empathic care in couples where one partner is facing end-stage cancer (McLean et al., 2013); forgiveness in couple relations (Menesses & Greenberg, 2014); depression (Dessaulles, Johnson, & Denton, 2003, compared EFCT with pharmacotherapy in the treatment of major depression and found

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BOX 9.10 CLINICAL NOTE

Steps in the EFT Treatment Manual

Johnson and Greenberg (1995) offer a step-by-step treatment process for EFT so others can replicate the therapy process:

1. Delineating conflict issues in the core struggle
2. Identifying the negative interaction cycle
3. Accessing the unacknowledged feelings underlying interactional positions
4. Reframing the problem in terms of underlying feelings, attachment needs, and negative cycles
5. Promoting identification with disowned needs and aspects of self, and integrating these into relationship interactions
6. Promoting acceptance of partner's experiences and new interaction patterns
7. Facilitating the expression of needs and wants and creating emotional engagement
8. Establishing the emergence of new solutions
9. Consolidating new positions

the treatments to be equally effective in symptom reduction); and, couple satisfaction when one partner was a survivor of childhood sexual abuse (MacIntosh & Johnson, 2008, found that about one-half of the couples reported clinically significant increases in mean relationship satisfaction and in decreases in trauma symptoms; trauma symptoms such as affect dysregulation and hypervigilance were identified to play a role in the challenges that survivors experienced in fully engaging in EFCT therapy). In addition, single-case studies suggest initial support for EFT in the treatment of PTSD (Greenman & Johnson, 2012), chronic illness (Chawla & Kafescioglu, 2012), and generalized anxiety disorder (Priest, 2013).

These combined efforts—operationalizing therapeutic intervention procedures, supported by research demonstrating successful outcomes—augur well for the revitalization of the experiential approach to family therapy.

SUMMARY

Experiential family therapists use the immediacy of the therapeutic encounter with family members to help catalyze the family's natural drive toward growth and the fulfillment of individual members' potentials. Early experiential efforts were essentially nontheoretical and nonhistorical, stressing action over insight or interpretation, primarily by providing a growth-enhancing experience through family–therapist interactions. Attention to moment-by-moment emotional experiences remains a defining feature of this form of family therapy.

The major practitioners of the experiential approach have been Carl Whitaker, Walter Kempler, and Virginia Satir. Whitaker stressed both intrapsychic and interpersonal barriers to development and maturity. His family therapy approach, often involving a co-therapist, capitalized on both the real and symbolic experiences that arise from the therapeutic process and was aimed at bringing personal growth. Claiming that his interventions were largely controlled by his unconscious, he sought a growth-producing experience for himself, believing

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that a therapist who does not personally benefit, therapeutically speaking, from the encounter has little to give to client families.

Kempler, a practitioner of Gestalt family therapy, is adamant in dealing only with the *now*—the moment-to-moment immediacy shared by the therapist and the family members. Like most Gestalt therapists, Kempler guides individuals to reach beyond their customary self-deceptive games, defenses, and facades. Uncompromisingly honest himself, he challenges all family members to explore how their self-awareness is blocked and to channel their increased awareness into more productive and fulfilling relationships with each other.

The most celebrated humanistic family therapist was Virginia Satir. Her demonstrations with families were known around the world. Her approach to families combined her early interest in clarifying communication "discrepancies" between family members with humanistically oriented efforts to build self-esteem and self-worth in all the members. Believing that human beings have within themselves the resources they need in order to flourish, Satir viewed her task as one of helping people gain access to their nourishing potentials and teaching people to use them effectively.

Experiential family therapy today is best represented by emotionally focused therapy (EFT), with couple (EFCT), and family therapy (EFFT) versions, developed by Leslie Greenberg and Susan Johnson. Systemic with client-centered and Gestalt principles, this approach aids couples and families to change negative interactive patterns at the same time that they build secure emotional bonds. Attachment theory provided its theoretical base. Therapeutic procedures are offered in a step-by-step treatment program that is easy to emulate, and data-based outcome studies have demonstrated its clinical effectiveness.

RECOMMENDED READINGS

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10

The Structural Model

LEARNING OBJECTIVES

- LO 1 Discuss boundaries, alignments and coalitions in transactional patterns and how they determine family structure.
- LO 2 Compare the use of insight to action in structural family therapy.
- LO 3 Explain how family mapping explicates structural family therapy.
- LO 4 Describe how enactments contribute to change in structural family therapy.

Many of the basic concepts of the **structural approach** to family therapy are already familiar to the reader: family rules, roles, coalitions, subsystems, boundaries, wholeness, organization. The very fact that these constructs are part of the everyday vocabulary of family therapy underscores the historical prominence of this model. Its clearly articulated theory of family organization and guidelines for applying that theory offered by Minuchin and his associates (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Lee, & Simon, 2006; Minuchin & Nichols, 1993; Minuchin, Rosman, & Baker, 1978) ensured that a legion of systems-oriented family therapists would adopt the structural viewpoint. Indeed, in the 1970s, the carefully crafted structural view for working with a family first helped popularize family therapy to many professionals and the public alike.

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The Structural Outlook

The uniqueness of structural family therapy is its use of *spatial and organizational metaphors*, both in describing problems and identifying solutions and in its insistence on *active therapist direction* (Colapinto, 1991). The model's major thesis divides into three parts:

- Individual symptoms are rooted in the context of family transaction patterns.
- Family organization or structure must change before symptoms are relieved.
- The therapist must provide a directive leadership role in changing the structure or context in which the symptom is embedded.

Salvador Minuchin and his supervisees (Minuchin, Lee, & Simon, 2006) describe the major determinants of structural theory:

- The *wholeness* of the family system
- The influence of the family's *hierarchical* organization
- The interdependent functioning of its *subsystems*

The family's underlying organizational structure and its flexibility in responding to changing conditions throughout the family life cycle help govern the appearance of functional or dysfunctional patterns. Minuchin (1984) views families as going through their life cycles seeking to maintain a delicate balance between stability and change. The more functional the family, Minuchin suggests, the more open to change and structure modification during periods of family transition, as new conditions demand.

The primary role of structural therapists is the facilitation of organizational changes in the dysfunctional family, assuming that individual behavioral changes and symptom reduction will follow as the context for the family's transactions changes. When the family's structure is transformed, the positions of its members are altered, and each person experiences change. As an instrument of change, the therapist actively engages the whole family to introduce challenges[1] that force adaptive changes, supporting and coaching family members as they attempt to cope with the consequences (Colapinto, 1991).

Leading Figure: Salvador Minuchin

Raised in Argentina of European immigrant parents, Salvador Minuchin practiced pediatrics following his medical training. When Israel declared itself a state in 1948, Minuchin, guided by his sense of social purpose, volunteered his services to Israel as an army doctor for 18 months. After subsequent training as a child psychiatrist in the United States, partly under the tutelage of Nathan Ackerman, Minuchin returned to Israel in 1952 to work with children displaced from the Holocaust and with Jewish immigrants to Israel.

[1]One famous challenging technique is the "stroke and kick," a restructuring maneuver in which the therapist first says something positive and reinforcing (e.g., saying to a substance abuser working at recovery, "You're doing a good job of trying to deal with your problem," and then turning to his wife, whom the husband has neglected, and asking her, "How does it feel to be without a husband this last 6 months?").

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photo supplied by Salvador Minuchin

Salvador Minuchin, M.D.

In 1954 Minuchin returned to the United States to begin psychoanalytic training at the William Alanson White Institute (where Sullivan's interpersonal psychiatry ideas held sway), eventually becoming the intake psychiatrist at the Wiltwyck School, a residential school for delinquent adolescents outside New York City. Inspired by an article by Don Jackson in 1959, Minuchin began to look beyond the individual children to examine and analyze their family predicaments. He worked primarily with low-income African-American and Puerto Rican adolescents from New York's inner city. Minuchin and his therapeutic team began developing a theory and a special set of intervention techniques in response to the multiple problems arising from the disconnected and underorganized structures of the families they encountered. Increasingly, he turned to a sociological analysis of social context—how the experience of living in poverty affected family functioning. Minuchin and his coworkers developed therapeutic ways to change family context rather than focusing on personality or behavioral problems.

Finding that long-term, interpretive psychoanalytic techniques were ineffective with this population, Minuchin and associates devised many brief, direct, concrete, action-oriented, and problem-solving interventions to effect context change by restructuring the family. (Nathan Ackerman's influences regarding interlocking pathology and his provocative, charismatic presence with families are clear here.) Minuchin's 8 years at Wiltwyck, during which he developed many highly original and action-oriented techniques for working with disadvantaged families, were described in *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) and earned Minuchin widespread recognition (Simon, 1984). The Wiltwyck focus on family reorganization and effective hierarchy among family members laid the cornerstone for structural family therapy.

In 1965, wanting to test his techniques with a wider cross-section of families, including both working-class and middle-class populations, Minuchin took on the directorship of the Philadelphia Child Guidance Center. To assist with training, he brought along social worker Braulio Montalvo from Wiltwyck and recruited Jay Haley from Palo Alto. Originally a small clinic with a staff of 10 serving the African-American population, the Philadelphia Child Guidance Clinic blossomed under Minuchin's boldly imaginative leadership as it grew into the largest facility of its kind ever established, with an elaborate modern complex, close to 300 people on its staff, and affiliation with Children's Hospital on the campus of the University of Pennsylvania. It was the first clinic in the United States where poor urban families represented a majority of the clients served. In 1974, Minuchin published the widely read *Families and Family Therapy*, an elaboration of ideas concerning change in families through structural family therapy.

After stepping down as director of the Philadelphia Child Guidance Center in 1975 and as director of training there in 1981, Minuchin spent most of his professional time teaching, consulting, supervising, writing, and demonstrating his dramatic techniques in front of professional audiences around the world. In 1981, he founded and, until 1996, led a small institute called Family Studies (now renamed the Minuchin Center for the Family) in New York City, offering consultative services to community organizations, particularly those dealing

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BOX 10.1 FAMILY DIVERSITY

Structural Family Therapy with Diverse Families

From the early days at Wiltwyck, where Minuchin developed his approach while working with low-income Puerto Rican and African-American families from New York City, to his time as director of the Philadelphia Child Guidance Center, where initially most of the families that utilized clinic services were African American or Latino, often on welfare, structural family therapy was shaped and adapted to meet the needs of those diverse families across ethnic and socioeconomic status. Recently, while focusing on family organization, Minuchin notes the radical change to a "broader and more complex conception of possibilities for each gender, but also an increase in the diversity of family patterns" (Minuchin, Reiter, & Borda, 2014, p. 50).

Case study research demonstrates the applicability and evidence for the use of structural family therapy with various diverse populations. Becerra and Michael-Makri (2012) discuss how it can be used with Mexican and Mexican-American families in conjunction with cultural factors like familism and marianismo, even when the family has complicating issues like child disability. Kim (2003) demonstrates its use in addressing family members' struggles with acculturation.

with poor families (Minuchin, Colapinto, & Minuchin, 2007). Minuchin has now retired to Florida but continues to lecture around the world.

Other Leading Figures in Structural Theory

Over the years, Minuchin surrounded himself with clinicians from various disciplines who themselves have contributed significantly to shaping structural family theory and therapy. Psychiatrist Charles Fishman (1993), social worker Harry Aponte (2009), and psychologist Marion Lindblad-Goldberg (Lindblad-Goldberg, Dore, & Stern, 1998), all of Philadelphia, have contributed to advancing the structural viewpoint through offering family therapy training, typically with economically needy families.

Marianne Walters, a social worker in Washington, DC, is best known for the groundbreaking work she and her associates (Walters, Carter, Papp, & Silverstein, 1988) produced as part of the long-running Women's Project, employing the lens of gender to examine family relationships. Psychiatrist Jorge Colapinto (2000) is Coordinator of Training and Consultation at the Minuchin Center. The original Philadelphia Child Guidance Center, having trained thousands of family therapists, closed a decade ago and has been replaced by a more modest Philadelphia Child and Family Guidance Training Center, still structurally oriented, under Lindblad-Goldberg's direction.

Psychosomatic Families

At the Philadelphia Child Guidance Clinic, Minuchin turned his attention to the role of family context in psychosomatic conditions, especially such urgent medical problems as diabetes and anorexia. More specifically, no medical explanations could be found for the unusually large number of diabetic children who required emergency hospitalization for acidosis (a depletion of alkali in the body), nor would they respond to individual psychotherapy

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directed at helping them deal with stress. As Minuchin and his coworkers began to accumulate research and clinical data and to redefine the problem in family terms, successful interventions involving the entire family became possible. Later research expanded to include asthmatic children with severe, recurrent attacks as well as anorectic children; the additional data confirmed for Minuchin that the locus of pathology was in the context of the family and not simply in the afflicted individual.

As noted in *Psychosomatic Families* (Minuchin, Rosman, & Baker, 1978), families of children who manifest severe psychosomatic symptoms are characterized by transactional problems that encourage somatization. *Enmeshment* is common, *subsystems* function poorly, and *boundaries* between family members are too diffuse to allow individual autonomy. A psychosomatic family was found to be overprotective, inhibiting the child from developing a sense of independence, competence, or interest in activities outside the safety of the family. The physiologically vulnerable child, in turn, feels great responsibility for protecting the family. The manifestation of symptoms typically occurs when stress overloads the family's already dysfunctional coping mechanisms. Thus, the symptoms are regarded as having a regulating effect on the family system, the sick child acting as a family conflict defuser by diverting family attention from more basic but less easily resolved family conflicts.

Unlike the underorganized, often single-parent, family population at Wiltwyck, at the Philadelphia Child Guidance Center, there were primarily middle-class, intact families that often appeared to be too tightly organized. Interventions had to be modified to first destructure the family's rigid patterns and then restructure them to permit greater flexibility. Therapeutic efforts were directed at changing the structure of relationships within the family, helping the family develop clearer boundaries, learning to negotiate for desired changes, and dealing more directly with hidden, underlying conflicts. According to Colapinto (1991), the Minuchin team's family-focused success in treating anorexia nervosa—which, unlike diabetes or asthma, has no physiological basis—drew many family therapists to the structural model.

LO 1 Structural Family Theory

Minuchin (1974) describes his viewpoint as follows:

> In essence, the structural approach to families is based on the concept that a family is more than the individual biopsychodynamics of its members. Family members relate according to certain arrangements, which govern their transactions. These arrangements, though usually not explicitly stated or even recognized, form a whole—the structure of the family. The reality of the structure is of a different order from the reality of the individual members. (p. 89)

Like most systems theorists, structuralists are interested in how the components of a system interact, how balance or homeostasis is achieved, how family feedback mechanisms operate, how dysfunctional communication patterns develop, and so forth. Consistent with Minuchin's background in child psychiatry, he influenced his associates to observe too how families cope with developmental tasks and make adaptive changes during periods of transition. Structuralists pay attention to family transactional patterns because these offer clues to the family's structure, the permeability of the family's subsystem boundaries, and the existence

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of alignments or coalitions—all of which ultimately affect the family's ability to achieve a delicate balance between stability and change. Before an individual's symptoms can be reduced or extinguished, according to this model, structural changes must first occur within the family.

Family Structure

Families need some form of internal organization that dictates how, when, and to whom to relate. The subsequent transactional patterns make up the structure of the family (Colapinto, 1991). Put another way, a family's structure is the covert set of functional demands or codes that organizes the way family members interact with one another (Minuchin, 1974). The structure represents the sum of the *operational rules* the family has evolved for carrying out its important functions. It provides a framework for understanding those consistent, repetitive, and enduring patterns that reveal how a particular family organizes itself in order to maintain its stability or, under new conditions, to seek adaptive alternatives. Once established, such patterns are self-perpetuating and resistant to change until changing circumstances cause tensions and imbalance within the system.

For example, an interactive routine may evolve in a family whereby the young son refuses to comply with his mother's pleading to clean up his room but will submit to his father's request without hesitation. Repeated over time and in a variety of situations, a basic family structure may emerge in which the father is seen in the family as the ultimate authority and the mother as possessing insufficient power or clout to be obeyed.

Subsequent transactional patterns are likely to reflect this now-established blueprint, combining into more or less constant relationships (Umbarger, 1983) and regulating the family's day-to-day functioning. However, structure is not static or fixed. On the contrary, certain temporary structures (a mother–son coalition in which the father is kept in the dark, say, about erratic school attendance or a bad grade) may occur but not persist beyond a brief arrangement and thus must be considered to be dynamic. The structural therapist watches for repeatable family processes in action during therapy sessions in order to detect problematic or ineffective patterns that need restructuring.

A family's transactional patterns regulate the behavior of its members and are maintained by two sets of constraints: *generic* or universal rules and *idiosyncratic* or individualized rules (Minuchin, 1974). For example, structuralists contend that it is a universal rule that well-functioning families should be hierarchically organized, with the parents exercising more authority and power than the children and the older children having more responsibilities as well as more privileges than their younger siblings.

In addition, *complementarity* of functions is universal—the husband and wife, for example, operate as a team and accept their interdependency. The degree to which the needs and abilities of both spouses dovetail and reciprocal role relations provide satisfaction are key factors in harmonious family functioning. In some cases, family balance is achieved by family members being assigned complementary roles or functions (good child–bad child; tender mother–tough father). Complementarity takes the form of teamwork in well-functioning families. Idiosyncratic constraints apply to specific families and involve mutual presumptions regarding family member behavior toward one another. While the origin of

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certain expectations may no longer be clear, buried in years of implicit and explicit negotiations, their pattern of mutual accommodation and functional effectiveness is maintained (Minuchin, 1974).

Some feminists take exception to Minuchin's insistence on family hierarchies, claiming that they run the risk of reinforcing sex-role stereotypes. Luepnitz (1988) argues that Minuchin bases many of his ideas regarding family organization on the work of the influential functional sociologist Talcott Parsons (Parsons & Bales, 1955), who saw normal family life neatly organized according to gender roles, family functions, and hierarchical power. Parsons maintained that adaptation to society requires that husbands perform an "instrumental" role (e.g., making managerial decisions) in the family and that wives perform "expressive" roles (caring for the family's emotional needs). Hare-Mustin, as quoted by Simon (1984), believes Minuchin himself models the male executive functions while working with families, in effect demanding that the father resume control of the family and exert leadership much as Minuchin leads and directs the therapeutic session.

Colapinto (1991) contends that Minuchin does not hold the stereotypic division of instrumental versus expressive as an ideal but rather believes all families need *some* kind of structure, *some* form of hierarchy, and *some* differentiation between subsystems. A family will try to maintain preferred patterns—its present structure—as long as possible. While alternate patterns may be considered, any deviation from established rules that goes too far too fast will be met with resistance as the family seeks to reestablish equilibrium. On the other hand, the family must be able to adapt to changing circumstances (a child grows into a young adult; mother goes to work outside the home; grandmother comes to live with them). It must have a sufficient range of patterns (including alternatives to call upon whenever necessary) and must be flexible enough to mobilize these new patterns in the face of impending change if members are to continue as a family.

Family Subsystems

As we pointed out in Chapter 4, families organize themselves into coexisting subsystems, often arranged in hierarchical order. Typically, subsystem divisions are made according to gender (male/female), generation (parents/children), common interests (intellectual/social), or function (who is responsible for what chores). Other possibilities (older children vs. younger; parents vs. teenagers) spring up in most families. All families contain a number of coexisting but separate subsystems.

Subsystems are components of a family's structure. They exist to carry out various family tasks necessary for the functioning of the overall family system. Each member may belong to several subgroups at the same time, and families are capable of organizing themselves into a limitless number of such units. Each person may have a differing level of power within different subgroups, may play different roles, may exercise different skills, and may engage in different interactions with members of other subsystems within the family. Complementarity of roles (Ackerman's influence again) is a key here—as Minuchin (1974) points out, a child has to act like a son so his father can act like a father, but he may take on executive powers when he is alone with his younger brother.

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Subsystems are defined by interpersonal *boundaries* and rules for membership; in effect, they regulate the amount of contact with other subsystems. Such boundaries determine who participates and what roles those participants will have in dealing with one another and with outsiders who are not included in the subsystem. They may be temporary alliances (mother and daughter go shopping together on Saturday afternoon) and may have rules concerning exclusion (fathers and brothers are unwelcome). Or they may be more enduring (based on generational differences in roles and interests between parents and children), with clearly defined boundaries separating the two generations (one watches public television documentaries, the other spends hours on Facebook and Twitter). Subsystem organization within a family provides valuable training in developing a sense of self in the process of honing interpersonal skills at different levels.

The spousal, parental, and sibling subsystems are the most prominent and important subsystems in the family. The strength and durability of the *spousal subsystem* in particular offers a key regarding family stability. How spouses learn to negotiate differences and accommodate to one another's needs and develop complementary roles impacts the likelihood of family stability and flexibility to adapt to changing circumstances.

While the arrival of children forces the couple to transform their system to become a *parental subsystem* grappling with new responsibilities, complementarity of roles remains essential as the couple negotiates differences in parenting attitudes and styles. Accommodations to one another's perspectives are apt to be renegotiated as children grow and require different parental responses at different stages of their lives. It is crucial that, whatever the demands of child rearing and the evolution of an effective parental subsystem, the parents work to maintain and strengthen their spousal subsystem, which is fundamental to family well-being.

The *sibling subsystem* offers the first experience of being part of a peer group and learning to support, cooperate, and protect (as well as compete, fight, and negotiate differences). The sibling subsystem deals with the parental subsystem to work out relationship changes commensurate with the developmental changes they are going through. In a well-functioning family, all three subsystems operate in an integrated way to protect the differentiation and integrity of the family system. When the integrated family structure is flexible enough to meet ongoing family developmental challenges, we may consider the family functional. When the family cannot adjust to changing circumstances, we consider it dysfunctional. From the structural perspective, family dysfunction generally involves boundary issues such as enmeshment, disengagement, alignments, power, and coalitions.

Family Dysfunction

Rosenberg (1983) summarizes the structural position: "when a family runs into difficulty, one can assume that it is operating within a dysfunctional structure" (p. 160). This may happen when the family hits a snag entering a life cycle stage, such as the birth of a child, children leaving for college, or retirement. Perhaps the family members have become enmeshed, or, at the other end of the continuum, perhaps they are disengaged. Dysfunction suggests that the covert rules that govern family transactions have become, if only temporarily, ineffective and require renegotiation.

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In the Wiltwyck families (Minuchin et al., 1967), typically burdened by severe external stressors brought about by poverty, five dysfunctional family structures were differentiated: (a) enmeshed families, (b) disengaged families, (c) families with a peripheral male, (d) families with noninvolved parents, and (e) families with juvenile parents. A sense of feeling overwhelmed and helpless was common to these families, often led by single mothers, who struggled to control or guide their delinquent children.

Just as the social context as stressor was apparent in the Wiltwyck population, so the inadequate internal responses to stress—the other component of the dysfunctional equation—played a key role for the Philadelphia working-class and middle-class families suffering from psychosomatic disorders (Colapinto, 1991). Here the problem stemmed from inflexibility, particularly the family's inability to modify those transactional patterns that had ceased to satisfy the needs of family members. For example, a couple that negotiated a complementary relationship before the arrival of children that did not allow for much open conflict failed to adapt readily to becoming parents because there was conflict regarding the new roles of mother and father. Or parents accustomed to dealing with young children were unable to adapt to growing teenagers who now demanded more autonomy. Fear of departing from established patterns led to rigid repetition of failed patterns.

Disengagement or enmeshment—avoiding contact with one another or continuous bickering—are both directed at circumventing change, thus failing to achieve conflict resolution. Overprotection of the sick child by the entire family helped cover up underlying family conflicts and tended to discourage the development of a sense of competence, maturity, or self-reliance on the part of the symptomatic child.

Minuchin (1974) reserves the label of *pathological* for those families who, when faced with a stressful situation, increase the rigidity of their transactional patterns and boundaries, thus preventing any further exploration of alternatives. Normal families, in contrast, preserve family continuity and permit family restructuring.

Boundary Permeability

The specific composition of a subsystem is not as important as the clarity of its boundaries. Boundaries in a family vary in their **permeability**, and that degree of accessibility helps determine the nature and frequency of contact between family members. *Clearly defined boundaries* between subsystems help maintain separateness and at the same time emphasize belongingness to the overall family system. In an ideal arrangement, the clarity enhances the family's overall well-being by providing support and easy access for communication and negotiation between subsystems while simultaneously encouraging independence and the freedom to experiment by the members of the separate subsystems.

Excessively *rigid or inflexible boundaries* lead to impermeable barriers between subsystems. In this case, the parents and children—the generational hierarchy—are separate and distinct; the members of neither subsystem are willing or able to enter into the other's world. With parents and children unable to alter or cross subsystem boundaries when necessary, autonomy may be maintained, but nurturance, involvement, and the easy exchange

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of affection with one another are typically missing. While the child in such a family may gain a sense of independence, it may come at the price of feeling isolated from others and unsupported during critical times.

Diffuse boundaries are excessively blurred and indistinct, so easily intruded upon by other family members. Here, parents are too accessible, and contact with their children may take the form of hovering and the invasion of privacy. Children run the risk of becoming too involved with their parents, in the process failing to develop independence or to learn the skills for developing relationships outside the family. Because there is no clear generational hierarchy, adults and children may exchange roles easily, and a member's sense of self or personal identity becomes hard to establish for later adulthood. Here children may feel supported and cared for by parents, but it is often at the expense of feeling free to take independent (and possibly disapproved-of) actions.

In a well-functioning family, clear boundaries give each member a sense of "I-ness" along with a group sense of "we" or "us." Each member retains his or her individuality but not at the expense of losing the feeling of belonging to a family. Most family systems fall somewhere along the continuum between **enmeshment** (diffuse boundaries) and **disengagement** (rigid boundaries; Minuchin et al., 1967), although they may contain enmeshed or disengaged subsystems. Minuchin and Nichols (1993) describe a familiar if troubled family pattern in which a disengaged father is preoccupied with work and neglectful of his wife and children, and an enmeshed mother is overinvolved with her children, her closeness to them serving as a substitute for closeness in the marriage.

Enmeshment refers to an extreme form of proximity and intensity in family interactions in which members are overconcerned and overinvolved in each other's lives. The family's lack of differentiation between subsystems makes separation from the family an act of betrayal. Belonging to the family dominates all experiences at the expense of each member's self-development. Whatever is happening to one family member reverberates throughout the system: a child sneezes, his sister runs for the tissues, his mother reaches for the thermometer, and his father becomes anxious about sickness in the family.

Subsystem boundaries in enmeshed families are poorly differentiated, weak, and easily crossed. Children may act like parents, and parental control may be ineffective. Excessive togetherness leads to a lack of separateness; members, overly alert and responsive to signs of distress, intrude on each other's thoughts and feelings. Members of enmeshed families place too high a value on family cohesiveness, so they yield autonomy and have little inclination to explore and master problems outside the safety of the family. As we indicated earlier, enmeshment is common in psychosomatic families.

At the other extreme, members of disengaged families function separately and autonomously but with little sense of family loyalty. Interpersonal distance is great, the members frequently lacking the capacity to be interdependent or to request support from others when needed. Communication is strained and guarded, and the family's protective functions are limited. When an individual is under stress, the enmeshed family responds with excessive speed and intensity, while the disengaged family hardly seems to look up, offer emotional

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support, or respond at all. As Minuchin (1974) illustrates, the parents in an enmeshed family may become enormously upset if a child does not eat dessert, while in a disengaged family they may be unconcerned about the child's hatred of school.

Alignments, Power, and Coalitions

While boundaries are defined by how a family is organized, **alignments** are defined by the way family members unite or oppose one another in carrying out a family activity.

Power in a family has to do with both authority (who is the decision maker) and responsibility (who carries out the decision). Thus, alignments refer to the emotional or psychological connections family members make with one another. Power, on the other hand, speaks to the relative influence of each family member on an operation's outcome.

Aponte and Van Deusin (1981) believe that every instance of a family transaction makes a statement about boundaries, alignments, and power. As noted, the boundaries of a subsystem are the rules defining who participates and what roles they will play in the transactions or operations necessary to carry out a particular function. (For example, should the sex education of young children be carried out by father, mother, older siblings, or be a shared responsibility? Or should the task be left to the schools?) Alignments refer to how supportive or unsupportive of one another the players are in carrying out an operation. (For example, does father agree or disagree with his wife's disciplinary actions with the children?) Power is seldom absolute but is related to the context or situation. (For example, the mother may have considerable influence on her adolescent daughter's behavior at home but minimal influence over the daughter's social contacts outside the home.) Power is also related to the way family members actively or passively combine forces. (For example, the mother's authority depends on her husband's support and backing as well as on the acquiescence of her children.)



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Mealtime rituals often provide an opportunity for open communication, helping ensure boundary permeability between generations.

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In this simulated scene, a mother's whispered secret strengthens her alliance with one child but may have an undermining effect on overall family functioning.

Structuralists consider certain alignments dysfunctional. In what Minuchin (1974) calls **triangulation**, each parent demands the child ally with him or her against the other parent. Whenever the child does side with one parent, however, the other views the alignment as an attack or betrayal, putting the child in a no-win situation. Every movement the child makes causes one or the other parent to feel ganged up on and assailed. Because the parents fail to work out the problems, a third person is brought in (similar to Bowen's concept of triangles) and becomes part of the interaction.

Coalitions (Minuchin, Rosman, & Baker, 1978) are alliances between specific family members against a third member. A *stable coalition* is a fixed and inflexible union (such as mother and son) that becomes a dominant part of the family's everyday functioning. A *detouring coalition* is one in which the pair hold a third family member responsible for their difficulties with one another, decreasing their relational stress.

Alignments, power, boundaries, and coalitions are interrelated phenomena in a family system. Power often results from alignments between members and can be an important determinant of functional or dysfunctional living. Structuralists believe that the power from a strong parental alignment is beneficial to child rearing and limit setting. On the other hand, coalitions between a parent and a child against the other parent can have an undermining effect on family functioning. Detouring, while it may give the impression of family harmony, may often be destructive to maintaining clear boundaries.

Structuralists believe that to achieve a desired outcome in the family, there must be

- *Clearly defined generational boundaries* so that parents together form a subsystem with executive power
- *Alignments between the parents* on key issues, such as discipline
- *Rules related to power and authority*, indicating which of the parents will prevail if they disagree and whether they can carry out their wishes when they do agree

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Note that strong generational boundaries also prohibit interference from grandparents as much as they prevent children from taking over parenting functions. Alignments must function properly or individuals will cross generational boundaries—go to Grandmother for permission if Mother says no—to get what they want.

Structural Family Therapy

The structural approach has made two particularly noteworthy contributions to family therapy practice, according to Aponte and DiCesare (2000): (a) demonstrating that poor families, including those living in chaotic environments, can benefit from family therapy, and (b) examining a family's structure, including those families that have become fragmented or underorganized, can be a powerful means for treating family dysfunction. The model recognizes the influence of social factors in family functioning and in working within the community's larger systems.

LO 2 Therapeutic Goals

Because structuralists view symptoms in a family member as emerging from and being maintained by a family structure unable to adapt to changing environmental or developmental demands, they reach their therapeutic goal when the family has restructured itself and freed its members to relate to one another in nonpathological patterns. Changing a family's structure calls for changing its rules for dealing with one another, and that in turn involves changing the system's rigid or diffuse boundaries to achieve greater boundary clarity (Prochaska & Norcross, 2014).

Structural therapeutic efforts are geared to the present and are based on the principle of action preceding understanding. The major therapeutic thrust of structural family therapy is to actively and directly challenge the family's patterns of interaction, forcing the members to look beyond the symptoms of the identified patient to view all their behavior in the context of family structures. They aim to help the family change its stereotyped interactive patterns and redefine its relationships, aiding members to better deal with the stresses in their lives (Colapinto, 2000). In a marital relationship, for example, one partner's behavior might be yoked to the other's (Minuchin & Nichols, 1998). Their actions are codetermined and subject to reciprocal forces that support or polarize the relationship. The structural therapist's task is to disentangle the pair from their automatic yoked reactions, helping each partner discover his or her individuality, power, and responsibility. For example, changes in the relative positions of family members may be in order, such as more proximity between husband and wife or more distance between mother and son.

Hierarchical relationships in which the parents customarily exercise authority may be redefined and made more flexible in some cases and reinforced in others. Alignments and coalitions may be explored, embedded conflicts acknowledged, alternative rules considered. To use an example offered by Colapinto (1982), a mother may be urged to abstain from intervening automatically whenever the interaction between her husband and son reaches a certain pitch, while father and son may be encouraged not to automatically abort an

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argument just because it upsets Mom. For structuralists, the most effective way to alter dysfunctional behavior and eliminate symptoms is to change the family's transactional patterns that maintain them.

Although they are not always so neatly separated in practice, the therapeutic efforts of structuralists typically follow this order:

1. Joining and accommodating
2. Assessing family interactions
3. Monitoring family dysfunctional sets
4. Restructuring transactional patterns

Joining and Accommodating

In an attempt to help family members who may be suspicious or fearful of being challenged or blamed to feel more comfortable, structuralists typically begin by adjusting to the family's affective style. With a constricted family, the therapist tries not to be too demonstrative; with an expansive family, he or she is more open and uses expressive movements. The therapist greets each member by name and encourages him or her to participate but does not insist on a response or confront silent or resistant members. The therapist shows respect for the family hierarchy by asking first for the parents' observations. (If the children are addressed first, the parents may feel the therapist is blaming them for family problems, and they will likely reject future therapist efforts as biased.) Nonthreatening, friendly, ready to help without being pushy, the structural therapist is at the same time adapting to the family organization, assimilating the family's language patterns, interactive style, and commonly used terms—and gaining a sense of family patterns and structures.

As a therapist, Minuchin (1974) describes himself as acting like a distant relative, **joining** a family system and respectfully **accommodating** to its style. As the therapist begins to understand family themes and family myths, to sense a member's pain at being excluded or scapegoated, to distinguish which persons have open communication pathways between them and which closed, he or she is beginning to obtain a picture of the family hierarchical structure, subsystems operations, boundaries, coalitions, and so on.

Mimesis (Greek for "copy") refers to the process of joining the family by imitating the manner, style, affective range, or content of its communications in order to solidify the therapeutic alliance with them. The therapist might tell of personal experiences ("I have an uncle like that") or mimic a family member's behavior (taking off his coat, sitting in a particular position, playing with the baby). These efforts are sometimes spontaneous, sometimes planned; whatever the case, they often have the effect of increasing kinship with the family and building trust as the therapist becomes part of the system.

Joining lets the family know that the therapist, a nonpermanent but concerned member, understands and is working with them in a common search for alternate ways of dealing with family problems. In the process, the structural therapist is encouraging the family to feel secure enough to explore other, more effective ways of interacting and solving problems

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together. Acknowledging their areas of pain or stress, the therapist lets family members know that he or she will respond to them with sensitivity and that it is safe for them to confront the distressing previously avoided issues.

The therapist might make *confirming statements* regarding what is positive about each member. This technique builds self-esteem and may allow other family members to see that person in a new light. Another type of confirming statement occurs when the therapist describes an obviously negative characteristic in one family member while at the same time "absolving" that individual of responsibility for the behavior. One effect may be for that person to rebel or begin to seek changes against being controlled by the other person. Minuchin and Fishman (1981) give the following illustrations:

> To a child, the therapist might say: "You seem to be quite childish. How did your parents manage to keep you so young?" To an adult, the therapist could say: "You act very dependent on your spouse. What does she do to keep you incompetent?" (p. 34)

Through this technique, the person feels recognized in a problem area without feeling criticized or guilty or to blame about it. As a result, that individual more readily acknowledges the dysfunctional behavior rather than denying it or becoming defensive. By identifying the dysfunction as interpersonal, the family is being prepared to think of their transactions in circular rather than linear terms and to attend to the complementarity of family relations. In this simple, nonpathologizing way, the therapist also subtly is suggesting that the participants are capable of (structural) change if they work together to reprogram how they deal with one another.

LO 3 Assessing Family Interactions

Assessment overlaps with joining the family. From the start, structuralists assess a family by attending to its organizational structure and ongoing transaction patterns and by noting the social context in which any dysfunctional behavior has manifested itself. Their ultimate concerns in any family appraisal are the family's hierarchical organization, the ability of its subsystems to carry out their functions, the family's possible alignments and coalitions, the permeability of its current boundaries, and its pliability or rigidity in meeting the needs of individual members as circumstances command. Structuralists focus on how flexibly the family adapts to developmental changes as well as unexpected situational crises and how readily and effectively family members join together to resolve conflict.

The overall thrust of assessment, from the initial session onward, is to evaluate the family's ability to change obsolete or no-longer-workable interactive patterns into ones more consistent with ongoing family development. But the major purpose of the early assessment is to develop a *road map* for entering the family—adjusting to its customary style of dealing with problems—and once inside, planning restructuring interventions.

Immediately—sometimes before meeting the family, based on intake form information—the therapist forms hypotheses about the family's structural arrangement. Use Box 10.2: Thinking Like a Clinician to gain practice at assessing families.

These early hunches, subject to refinement and revision, help guide early probing into the family's organization. What part of the system appears to be underfunctioning? Why, and

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BOX 10.2 THINKING LIKE A CLINICIAN

Assessing a Family

Read the following description of a family, and follow the prompts that follow to assess its functionality/dysfunctionality.

The Lomax family has come to you for therapy. Over the phone, Mrs. Linda Lomax indicated that her family is in crisis because her husband, William, a traveling salesman, admitted to having an affair while out of town on business. Their two sons, Brent and Harry, are in their late teens. Linda mentioned that neither son does well at school and that her husband doesn't realize the seriousness of their poor academic performance. In fact, he seems to think they have very bright futures ahead of them even though neither one of them has a job, and both stay home "dreaming."

As the family settles into their seats for their first session, you notice that William seems distant. You wonder if he is depressed. The wife seems oddly upbeat and chipper. She looks at her husband with great tenderness and explains that despite William's long hours on the job, the family has been struggling financially. She adds that though they are only a single mortgage payment away from owning their house, they just don't have the money to pay it.

Suddenly, William brightens and says, "So let's get the show on the road, Doc. What do we need to tell you? My boys here can tell you that we're a tight family and that soon we're going to be rolling in money. I am getting tired of traveling and have asked the office for a position here in town. The boys were going to take me out last night to celebrate, but they didn't make it to the restaurant. It's OK, though, I didn't mind them standing me up. They are busy making deals. School is for losers. My sons are winners!" You notice Brent look away, and Harry seems on the verge of tears. Linda sits smiling with her hands folded on her lap. Harry looks toward her and reaches for her hand. He says very quietly, "Momma has suffered more than all of us combined." To which William says angrily, "What do you mean she suffers? Nobody suffers here, except me, having to travel all over the place at my age to keep a roof over your heads!"

Harry presses his mother's hands and apologizes to his father. You see Brent looks furious.

1. Describe the family hierarchy.	
2. Identify possible subsystems and assess their ability to carry out functions.	
3. Do you notice any potential alignments and coalitions? If yes, describe them.	
4. Assess the boundaries among family members.	
5. What current circumstances in the family are members facing?	
6. Assess the relative pliability or rigidity of the family to meet the needs both of individuals and of the family as a whole.	

how badly, has the system broken down? Why now? Which family interactive patterns seem especially problematic? What latent adaptive structures can the family call upon from their past efforts to cope with crises? These and similar questions are likely to occur to the structural therapist experiencing the family's transactions as he or she begins to form a tentative diagnosis of family functioning.

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One technique is to direct the family's attention to the their current organization, which they diagram in graphic form in order to map out relationship patterns within the family. Just as Bowenian family systems therapists utilize genograms to chart family relationships over generations, structuralists use family diagramming to depict a family's *current* transactional patterns.

Structuralists use a simple pictorial device called a *structural map* to formulate hypotheses about those areas in which the family functions well and other areas in which dysfunction may be occurring. **Family mapping** helps provide an organizing schema for understanding complex family interactive patterns—especially which particular subsystem is involved in perpetuating a problem—and as such may be invaluable in therapeutic planning. As Minuchin and Fishman (1981) point out:

> The family map indicates the position of family members vis-à-vis one another. It reveals coalitions, affiliations, explicit and implicit conflicts, and the ways family members group themselves in conflict resolution. It identifies family members who operate as detourers of conflict and family members who function as switchboards. The map charts the nurturers, healers, and scapegoaters. Its delineation of the boundaries between subsystems indicates what movement there is and suggests possible areas of strength or dysfunction. (p. 69)

Figure 10.1 illustrates some common symbols structuralists use to delineate the clarity of family boundaries (clear, diffuse, rigid), subsystem operations, and family transactional styles. Figure 10.2 offers two examples of the use of structural mapping in depicting family conflict. The upper figure exemplifies a familiar detouring coalition within a family in which parents cope with relationship conflict by directing the problem they are having onto their child. The lower figure is a notation by a structural therapist of an intergenerational coalition in a family with diffuse mother–child boundaries.

Mapping offers an almost endless number of possible combinations for picturing family boundaries, alliances, affiliations, coalitions, detouring strategies, and so on. For

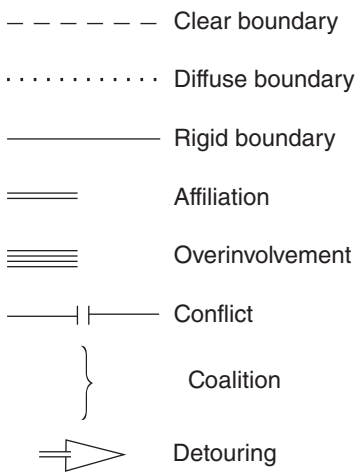


FIGURE 10.1 Minuchin's symbols for family mapping
Source: Minuchin (1974), p. 53

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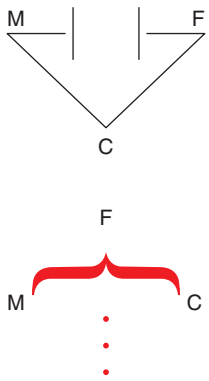


FIGURE 10.2 **The effect of stress on the subsystem boundaries of a family. In the top diagram, a father (F) and mother (M) both stressed at work come home and criticize each other but then detour their conflict by attacking the child (C). In the bottom diagram, the husband criticizes the wife, who seeks a coalition with the child against the father. Note the rigid cross-generational subsystem of mother and child; their coalition has the effect of excluding the father. Minuchin refers to this as a cross-generational dysfunctional pattern.**

Source: Minuchin (1974), p. 61

example, family enmeshment may be illustrated by the symbol of overinvolvement or brackets identifying a coalition of several members against another. Family mapping is a simple shorthand device with two useful purposes: It graphically describes how the family is organized, and it helps the therapist detect the family subunit requiring restructuring (Umbarger, 1983). Figure 10.3 diagrams an overinvolved parent–child bond as well as a family coalition against the other parent. Structural maps are created throughout therapy and are revised or discarded as new family information becomes available.

LO 4 Monitoring Family Dysfunctional Sets

Monitoring and helping modify troubled or problematic transaction patterns is the crux of the structural intervention process. Once structuralists join the family, they begin to probe the family structure, looking for areas of flexibility and possible change. For example, a family has come for therapy because the teenage daughter is shy, withdrawn, and has difficulties in her social life. The therapist may observe how the family enters the therapy room: the girl sits next to her mother, and they move their two chairs close together. When the therapist asks what the problem is, the mother answers, ignoring her daughter's attempts to add her thoughts on the matter. The mother makes comments that suggest she has too intimate a knowledge of her adolescent daughter's personal life—more knowledge than is usual. Soon, the structural therapist makes the first intervention, asking the mother and father to change chairs. Structural therapy has begun: As the father is brought into the picture, the family flexibility is being tested; implying pathology in the mother–daughter dyad, the family's reason for seeking therapy for the teenager is already being reframed or relabeled as a problem with a larger focus.

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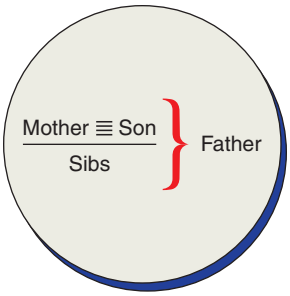


FIGURE 10.3 This diagram shows a closed-family-unit boundary with an overinvolved mother and son comprising the parental subsystem. Between them and the other children is a rigid boundary, yet apparently under enough control so that all are in a coalition against the father.

Source: Umbarger (1983), p. 36

Two structural techniques are operating in this example. **Boundary making** represents an effort to create greater psychological distance between the enmeshed mother and daughter, and, by bringing the marginalized father closer, begins to modify the family's customary transactional patterns. The daughter, in turn, gains a greater chance of developing more independence as the diffuse boundary with her mother begins to be clarified. The strengthened parental subsystem increases the likelihood of greater differentiation between parents and children in the family. At the same time, the therapist is using the technique of **unbalancing**—attempting to change the hierarchical relationship between members of the parental subsystem by having the father take on an expanded role in the family. By seeming to side with the father, the therapist is upsetting the family homeostasis and making an initial move to change preexisting family patterns by first unbalancing and then realigning the system. In boundary making, then, the therapist tries to change the distance between subsystems; in unbalancing, the goal is to change the hierarchical relationships of the members of a subsystem (Minuchin & Fishman, 1981).

Through **tracking**, the structural therapist adopts symbols of the family's life gathered from members' communication (such as life themes, values, significant family events) and deliberately uses them in conversation with the family. The therapist's effort to confirm that he or she values what family members say, without soliciting the information, is also a way of influencing their later transactional patterns. Minuchin (1974) calls this technique "leading by following." Tracking a particular family theme may also reveal clues to the family structure. For example, in working with an enmeshed family, Minuchin noted the father's statement that he disliked closed doors. Minuchin discovered that the children were not permitted to close the doors of their rooms, that a brother slept in his older sister's room, and that the sex lives of the parents were curtailed because their own bedroom door remained open. Later, Minuchin used the metaphor of the doors to help the family clarify its boundaries. So tracking can be a restructuring strategy.

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An **enactment** is a staged effort by the therapist to bring an outside family conflict into the session so that family members can demonstrate how they deal with it. The therapist can observe the conflict sequence and begin mapping a way to modify the members' interaction and create structural changes. Using this technique, the therapist has the players act out their dysfunctional transactions rather than simply describe them (Colapinto, 2000). For example, Rosenberg (1983) recounts a mother complaining that her 2-year-old daughter had tantrums and embarrassed her in front of grandparents, on buses, and in other situations. The daughter remained well behaved during the early sessions despite (or maybe because of) her mother's insistence that she engaged in this awful behavior away from the therapist. During the third or fourth session, when the child asked for gum, Rosenberg saw his chance: He asked the mother not to give her daughter the gum, because lunchtime was approaching.

As the child's whimper turned to crying, to begging, and finally to falling on the floor and undressing herself—and as the mother considered giving in—Rosenberg encouraged the mother to hold firm despite the by-now deafening noise. More than a half hour later, the child came to a whimpering stop. She seemed fine, although both mother and therapist were exhausted. However, the mother had asserted her control during the enactment, thus learning she could be competent and more resolute than she had previously thought. From a structural viewpoint, the child's problematic behavior was redefined in transactional terms; the generational boundaries were reestablished; effective alternative transactional patterns were introduced; the proper hierarchical order was put into place (mother was again in charge); and the daughter, whose tantrums at home ceased shortly thereafter, was comfortable in knowing that her mother could handle her.

Nichols and Fellenberg (2000) identified three phases of an enactment: initiation, facilitation, and closing, each with numerous possible interventions. Further, they ask two clinical questions: (1) what do therapists do to promote the effective use of enactments, and (2) what do they do or fail to do that makes enactments ineffective? Their research indicates that during a successful initiation phase, therapists direct the participants to talk; therapists lean back in their chairs to "remove" themselves from the dialogue; they specify the topic of conversation and physically position participants' chairs to face each other. Successful facilitation includes not interrupting the family members; encouraging participants to talk with each other rather than to the therapist, and, when conversation bogs down, to push the members to explain themselves more fully or to speak more about what they are feeling. The therapist's task during the closing phase is to help the clients gain insight on how to profit from the experience. Their research indicates that successful closings include explaining the problematic dynamic that took place, advising clients how to continue to improve their communication, praising clients for expressing feelings and listening well, and emphasizing the need for continued dialogue.

Davis and Butler (2004) also offer a three-phase model of enactments: initiation, intervention, and evaluation. Their research confirms the efficacy of enactments for:

- Facilitating communications skills
- Redirecting relationship processes or patterns

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- Restructuring relationships
- Facilitating attachment-oriented emotional disclosures
- Assessment

Butler and colleagues identified pitfalls often experienced by beginning therapists in working with enactments (Butler, Davis, & Seedall, 2008). After examining the work of a group of new therapists, they determined that while most were effective with initiating enactments, they struggled more with the facilitation and evaluation phases. They caution that enactments should not be unstructured or free flowing, a situation that might worsen the clinical experience of volatile or emotionally reactive clients.

Structuralists deliberately take on a decisive role with families, since they view the therapist, rather than any techniques, interpretations, or prescriptions, as the ultimate instrument of change (Colapinto, 1991). Therapeutically, they actively challenge the rigid, repetitive transactional patterns by which some families unsuccessfully attempt to organize themselves and cope with stress, and then, by deliberately "unfreezing" these patterns and unbalancing the system, create an opportunity for the family to structurally reorganize.

Here it is important to note that while essentially focused on family transactional patterns, structuralists nevertheless make certain they do not lose track of what is happening to each family member. As Minuchin, Rosman, and Baker (1978) caution, therapists would be committing a serious error by "denying the individual while enthroning the family" (p. 9). That is, while they believe problematic or symptomatic behavior typically arises when families rigidly resist change, they remain aware that certain individuals may bring physical, emotional, behavioral, or learning disabilities to the family situation and that these disabilities must be accommodated in facilitating family restructuring.

Structuralists explore any dysfunctional hierarchical issues within the family since, as they insist, for families to be functional, parents must be in charge of their children, and differentiation should exist between subsystems. Parents together must form and maintain an executive coalition, a parental subsystem; they have the responsibility to care for and protect and help socialize their children. Siblings too must develop a working subsystem of peers by learning to negotiate, cooperate, compete, and develop a sense of belonging. Spouses must also receive support from one another and together develop a marital subsystem for expressing affection, helping each other deal with stress, and dealing with conflict as equals. If there is a major dysfunction within the spousal subsystem, it will likely reverberate throughout the family (Minuchin & Fishman, 1981).

Minuchin (1974) conceives of family pathology as resulting from the development of *dysfunctional sets*, the family reactions, developed in response to stress, repeated without modification whenever there is family conflict. A husband experiencing stress at work comes home and shouts at his wife. The wife counterattacks, escalating the conflict that continues until one partner abandons the field. Both parties know nothing was resolved. Or, a mother verbally attacks an adolescent son, the father takes his side, and the younger children seize the opportunity to join in and pick on their older brother. All family members become

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involved, and various coalitions develop; but the family organization remains the same, and the dysfunctional sets will be repeated in the next trying situation.

Restructuring Transactional Patterns

Structuralists assume that a family seeking treatment is experiencing some stress that has overloaded their adaptive and coping mechanisms, handicapping the optimum functioning of its members in the process. Consequently, the task is to help families rearrange their organization—restructuring the system that governs its transactions—so the family functions more effectively and each family member's growth potential is maximized.

Restructuring involves changes in family rules and realignments, changes in the patterns that support certain undesirable behaviors, and changes in the sequences of interaction. We have noted several techniques structuralists employ to facilitate structural changes—enactments, boundary making, unbalancing. To highlight a particular transaction and get the message across to family members, the therapist may also increase the *intensity* of a remark by heightening its affective component. For example, the therapist might say to parents who consistently disagree about setting rules for their teenage son, "It's essential that you as parents agree about this." Or the therapist might repeat a message to a child who resists growing up: "But how *old* are you?"

One particularly useful technique, **reframing**, changes the original meaning of an event or situation by placing it in a new context in which an equally plausible explanation is possible. The idea is to relabel what occurs in order to provide a more constructive perspective, thereby altering the way the event or situation is viewed. As used by structuralists, reframing relabels the problem as a function of the family structure. Typically, within the context of an enactment, the therapist first redefines a presenting problem. For example, in the case of an adolescent daughter's self-starvation, the anorectic girl is labeled as "stubborn" and not "sick," forcing the family members to reconsider their earlier view that she is ill and thus not responsible for what is occurring.

Giving new meaning to the girl's behavior creates a new context that can ultimately change the family's transactional patterns, perhaps helping modify dysfunctional coalitions or alter poorly working boundaries and subsystems. The fact of the daughter's not eating has not changed, only the *meaning* attributed to that behavior. Not intended to deliberately deceive, reframing rather is used by structuralists and other family therapists (especially strategic therapists) to change family perspectives and ultimately to change family behavior patterns based on the new options and alternatives.

Structural interventions frequently *increase the stress* (another restructuring technique) on the family system, perhaps even creating a family crisis that unbalances family homeostasis. But they also open the way for transformation of the family structure. Now the family has no choice but to face the chronically avoided conflict. In an enmeshed family system, for example, members often believe the family as a whole can neither withstand change nor adapt to it; consequently, the system demands that certain members develop symptoms in order to maintain the dysfunctional homeostasis.

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When the danger level of family stress is approached, the symptom bearer is activated as part of a conflict avoidance maneuver. The family reinforces the continuance of the symptoms that help maintain the system's balance and status quo. It is the structural therapist's job to make everyone aware, often through reframing, that the problem belongs to the family, not an individual; that the implementation of new functional sets must replace the habitual repetition of the dysfunctional ones; and that the family, having located and identified the problem, together can resolve the underlying conflict by making the necessary structural modifications.

The therapeutic tactics employed by structuralists are often dramatic and at times theatrical. Like stage directors, they set up a situation, create a scenario for enactment, assign roles and tasks to the family, and then observe the family in action (Colapinto, 2000). For example, in treating an anorectic adolescent, Minuchin arranges to meet the family at lunch for the first session (Minuchin, Rosman, & Baker, 1978). He creates such an enactment deliberately, to foster a crisis around eating and to experience what the family members are experiencing. He observes the parents pleading, demanding, cajoling, becoming desperate, and feeling defeated.

He watches the adolescent girl demonstrate hopelessness and helplessness, pathetically asserting through her refusal to eat that she has always given in to her parents at the expense of herself but will do so no longer. While the daughter has been labeled as the problem, Minuchin reframes the situation to help the family see that the symptoms of anorexia nervosa are a response to family dysfunction, not simply the adolescent's defiant behavior. All the family members are locked into a futile pattern of interaction that has become the center of their lives. Each member has a stake in maintaining the disorder.

Continuing the example of the anorectic girl, the structural therapist shows the family how the syndrome plays an important role in maintaining its homeostasis. Structural family therapy helps each person in the family recognize the syndrome and take responsibility for contributing to it. By creating a family crisis, Minuchin forces the family to change the system, substituting more functional interactions.

Typical of Minuchin's directive, unyielding, crisis-provoking approach is his insistence in this case that the parents force the emaciated girl to eat. They coax, cajole, threaten, yell, and finally stuff food down her throat until their daughter collapses in tears. Minuchin believes she will now eat. As he later explains it:

> The anorectic is obsessed with her hopelessness, inadequacy, wickedness, ugliness. I incite an interpersonal conflict that makes her stop thinking about how terrible she is and start thinking about what bastards her parents are. At that demonstration, I said to the parents, "Make her eat," and when they did she had to deal with them as people. Previously, the parents had been saying "We control you because we love you." In the position I put them in, they were finally saying "God damn it, you eat!" That freed her. She could then eat or not eat; she could be angry at them as clearly delineated figures. (Malcolm, 1978, p. 78)

With this approach, Minuchin illustrates that the anorectic symptom is embedded in the faulty family organization. Changing that organization may eliminate the potentially fatal symptom. As family members begin to experience themselves and each other

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differently, the stage is set for new transactional patterns to emerge. New patterns aid the identified patient along with the family as a whole. As inappropriate or constricting rules are replaced and family members are released from stereotyped positions and functions, the symptom is no longer needed to maintain family homeostasis, and it becomes psychologically unnecessary (Colapinto, 1982). Future symptom development should be less likely as the opportunity is increased for all members, and the family as a whole, to enhance their growth potential.

A study by Fishman (2006) reviews and confirms the effectiveness of structural family therapy for the treatment of anorexia nervosa. From Fishman's perspective, family therapy is the treatment of choice for this condition. He also presents the key concepts of crisis induction, enactment, and therapeutic intensity—derived from Minuchin's approach—as the demonstrated means for treating this disorder. These techniques can act as a summary of the overall structural approach to therapy.

1. Crisis Induction: The therapist induces a crisis and anxiety into the family system to force a sense of immediacy to overcome inertia. It is designed to transform rigid systems that lead psychosomatic families into symptomatic patterns.

2. Enactment: The therapist encourages family members to deal directly with each other in session, thus permitting the therapist to observe and modify their interactions. Problematic behavioral sequences are treated through enactments by examining established roles and encouraging the adaptation of new ones that are based on more functional ways of acting. Minuchin's well-known "lunch session" described previously is an example of such an enactment. It is key that the therapist maintain therapeutic distance from the family so that the roles and behaviors can be observed, clarified, and modified.

3. Therapeutic Intensity: The therapist maintains a situation (through the enactment) of prolonged intense affect, repeated interventions, and pressure. The enactment is also followed with specific behavioral protocols such as, in the case of a lunch session treatment for anorexia, targeted weight gains.

The treatment of anorexia is a striking example of the application of structural therapy in practice. In Box 10.3, we offer a detailed case concerning the triangulation that occurs when a child from a former marriage comes to live with a newly married couple. Note particularly how the therapist employs various structural family therapy techniques (family mapping, reframing, reestablishing boundaries, strengthening the spousal subsystem) in helping the family alter its previously destructive path.

Structural family therapy has been used in conjunction with other therapeutic approaches. Family-directed structural therapy, for example, is based on the traditional concepts of structured family therapy but adds aspects of a strengths-based approach and group-work theory (McLendon, McLendon, & Hatch, 2012). This approach is time limited and goal oriented. It identifies the strengths of family members and finds concrete skills to develop both inside and outside of sessions. Use Box 10.4: Thinking Like a Clinician to deepen your understanding of structural family therapy techniques.

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BOX 10.3 CASE STUDY

Structural Therapy with a Divided Stepfamily

Joyce and David Oliver had been married only 8 months when they contacted a family counselor as a last resort. Both partners were in their late 20s: Joyce, never married, had established a career in business; David, previously married, had been divorced for about a year when he met Joyce at a ski resort. They had a great time together, and, after seeing each other daily for several months when they returned to the city, decided to marry. David had spoken briefly of Kiri, his 4-year-old daughter who lived with his ex-wife in another state, but Joyce did not see the child as having much to do with her, since Kiri lived with her mother. Joyce had met her future stepdaughter only once before the wedding ceremony.

The family problems began shortly after the wedding when Rhonda, David's ex-wife, announced that she was having some personal problems—including some with Kiri—and was sending her to live with David and Joyce. For David, who took his parental responsibilities very seriously, this was a welcome opportunity to see Kiri daily and take an active part in her upbringing. At last he would have the perfect family he had always dreamed of, the perfect harmony that he had failed to achieve in his previous marriage. Joyce, having no experience with children, wasn't sure what to expect, but she was eager to share parental responsibilities if it made her new husband happy.

Unfortunately, David's dreams failed to materialize, in no small part due to his own behavior—as well as Kiri's. She was not an easy child to live with, having been suddenly whisked away from an overclose mother. Confused and frightened, Kiri clung to her father, quickly becoming overattached to him and excluding her stepmother. David, in turn feeling guilty over his child's obvious upset, became very attached to Kiri—so much so that Joyce sometimes felt he preferred the child's company to hers. Instead of learning to live with her new husband, Joyce soon felt she was saddled with an instant family in which she felt like an outsider in her own home. David called Kiri daily before leaving work to see if she needed him to bring anything home. When his wife objected and complained of feeling "frozen out," David defended himself by saying he was merely acting like any concerned parent would, adding that Joyce's jealousy forced him to do even more for Kiri than he might have if Joyce had done more.

At night David put Kiri to bed; if he stayed more than the 10 minutes he had promised Joyce, she became depressed, withdrew, and did not talk to him the rest of that evening. According to David, Joyce was a spoiled child herself, being competitive with a 4-year-old; he was losing respect for her. During their joint sessions with a family counselor, he spoke of being raised by a widowed mother as an only child and how central to his life was the feeling of family closeness. Joyce, on the other hand, insisted that David did not allow her to develop a relationship with Kiri, expecting her to instantly love someone because he did but doing nothing to instill in Kiri that they had to reorganize the family to include all three of them. She herself had been raised by a divorced mother in a relatively disengaged family in which all three children lived relatively separate lives.

The conflict between them had reached the boiling point by the time the couple contacted the counselor. David labeled his wife a "wicked stepmother," whom he threatened to leave unless she "corrected her behavior." She, in turn, accused her husband of having a "romance" with his daughter, strongly implying that there might be more to the father–daughter relationship than was evident. Neither was willing to listen to what the counselor was saying, each apparently eager to win his favor and favorable judgment regarding who was right. Joyce would hear of nothing short of sending Kiri back to her mother; David insisted he would not be given an ultimatum regarding how to deal with his own child. While the counseling was in its early stages, Rhonda announced that she had gotten remarried to a man named Mel, and she was pregnant.

The counselor began by indicating he was not there to judge who was right but to help David and Joyce gain some tools for understanding what was happening to them. It was clear that both were miserable, and Kiri undoubtedly was also. If

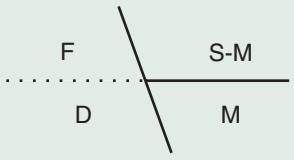
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the couple continued this way, they would almost certainly get divorced—an unfortunate circumstance for both of them, since their marriage had not had a chance.

To reduce the white heat between the couple so that counseling might proceed, the counselor attempted two early interventions. One was to reduce the tension by asking them to describe their own histories of child rearing. The information would be useful later and for the moment would help each spouse begin to grasp that they had come into parenting with different experiences and expectations. As another initial intervention ploy, the counselor asked whether they would be willing to listen to what the other had to say without condemning it, getting defensive, or resorting to name calling. The counselor thus appealed to their rational selves; since each spouse was anxious not to be labeled the difficult or unreasonable one, the two agreed.

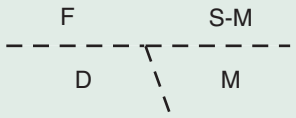
Each spouse proceeded to discuss his or her view of child rearing. They had clear disagreements based on their own different experiences, and the counselor helped each of them to listen and try to understand. Joyce's rejecting behavior toward Kiri was reframed by the counselor as inexperience rather than wickedness; David's overinvolvement was reframed as eagerness to be a good father. Joyce acknowledged that she could learn from David, since she had known little parental attention and affection growing up, but she insisted that he try to be less critical of her if he really wanted her to make the effort. David acknowledged he might be overdoing the parenting, since he had not had a father of his own at home as a model. The counselor helped him understand that fathers who obtain custody often have unrealistic expectations of how a stepmother should behave. In this case, David was willing to relinquish some parenting chores as he became convinced Joyce was willing to try. He was encouraged to avoid any coalitions with Kiri against Joyce.

The next phase of the counseling dealt with reestablishing boundaries. The counselor explained that stepfamily blending does not come automatically or instantly but only through a gradual rearrangement of the new family's structure. It was agreed that David would allow Joyce to do more of the parenting in the best way she saw fit—even if it differed from his way. He would explain to Kiri that although Rhonda was still her mother, Joyce would be taking over the day-to-day job, with his approval, when Kiri lived with them. That is, Kiri was told that Joyce was not replacing her biological mother, only supplementing her. Kiri could visit her mother whenever it could be arranged—something Kiri expressed an interest in doing, especially after her half sister was born. Together, David and Joyce told Kiri that she was a member of two households; she could feel free to move between the two without loyalty conflicts.



Precounseling

The diffuse boundary between father and daughter indicates they have formed an overinvolved or enmeshed relationship; the stepmother is isolated and excluded, as is the absent biological mother.



Postcounseling

A restructuring has occurred, and a clear boundary now exists between the united parents and the daughter, as well as between the daughter and her biological mother.

FIGURE 10.4 Pre- and postcounseling structural mapping of the oliver family

(Continued)

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David and Joyce had their own loyalty issues to resolve. As he came to understand that he had given his daughter his first loyalty—primarily out of guilt over the impact on Kiri of his failed marriage—David recognized that he was contributing to the diminution of his current marital relationship. Joyce recognized that because she felt in a secondary position, she struggled against the child excessively, forcing David to defend Kiri; thus she, too, contributed to the deteriorating marriage. The counselor helped the pair untangle these difficulties, focusing them on working to strengthen their separate identity as a couple and their primary loyalty to each other. They were encouraged to spend more time alone as a couple, sharing activities that did not include Kiri. As this occurred, the couple's bond grew; differences between them, although still present, began to be negotiated more openly rather than through a father–daughter-versus-stepmother conflict. New rules and happier solutions followed as David, Joyce, and Kiri began to develop their own traditions and to define themselves as a family.

Note the counselor's goals in this case:

1. Reduce the accusations and blame fixing between the adults.
2. Reframe or relabel the behavior each finds objectionable in the other as well intentioned, thereby diffusing some of the self-righteous rage and indignation.
3. Appeal to each adult's wish to be seen as reasonable and fair in hearing out the spouse's contentions.
4. Define the problem as a systems one to which each member, including the child, is contributing.
5. Strengthen the spousal subsystem, encouraging their loyalty to each other and their common purpose and family identity.
6. Consolidate parental authority and unity in regard to the child without her experiencing loss of her biological mother.
7. Help reduce loyalty conflicts for the child and adults.
8. Keep the remarried system an open system with permeable boundaries, so that the child not only derives a sense of security from the home where she lives but also retains membership in her other household.
9. Help the family members tolerate differences among themselves or from some ideal intact family model.
10. Encourage the development of new rules, behavior patterns, and family traditions.

Source: Goldenberg & Goldenberg (2002), pp. 195–198

Research on the Effectiveness of Structural Family Therapy

Research provides support for the effectiveness of structural family therapy with various populations and problems. For example, structural approaches may benefit families with acute childhood illnesses like leukemia by enhancing coping skills and mental state (Meng, Mei, & Wu, 2003), mothers' and their children's depressive and anxiety symptomology (Weaver et al., 2013), grandparents experiencing life-cycle grief and loss as they assume the primary caregiver role with grandchildren (Lever & Wilson, 2005), and foster-care families (Lewis, 2011). Other research demonstrates the validity of concepts like triangulation in resolving adolescent externalizing problems (Etkin, Ross, Cummings, & Davies, 2014) or pornography addiction (Ford, Durtschi, & Franklin, 2012).

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BOX 10.4 THINKING LIKE A CLINICIAN

Monitoring Dysfunctional Sets

Before reading the following, review the material about the Lomax family in Box 10.2: Thinking Like a Clinician. Then respond to the following prompts to monitor family dysfunctional sets.

You have been seeing the Lomax family for 2 months. During that time you have had success in having them see their systems in a new way. Linda, especially, has seen how difficult it has been for her to separate herself from her family in a way that better allows for her needs to be met. During this session, Brent drops a bombshell: He plans to leave home.

The family is silent. William is obviously fuming. Linda is smiling as though nothing is wrong. Harry fidgets, and Brent is sitting with a defiant expression.

"Well, Cowboy, tell the doc about your new plans," says William.

"Now, William, Brent doesn't have to do anything he doesn't want to," says Linda, looking to you.

"Quiet!" shouts William, and then turning to Brent says again, "Tell the doc about your ridiculous cowboy dreams."

As Brent straightens up in his chair he says, "I went in with a friend on a ranch in Wyoming. He owns 70% and I have 30."

"Stupid arithmetic if you ask me," says William. "He'll always be your boss. And where did you get the money?"

Ignoring his father, he turns instead to his mother and says, "I may be stupid about this—nothing more than a dreaming cowboy—but I gotta get out. I can't stand it here anymore. We've been coming here for 2 months, and we never get to the bottom of anything. It's impossible. We don't even know if Dad is still seeing his girlfriend."

"Quiet about that!" yells William.

"I don't want to be quiet anymore. I'm getting out. And Harry is coming with me. He dropped out of school before we met you to come here." He points to his younger brother, who is in tears. Linda is visibly shocked. William slumps in his chair.

The family is silent.

1. What dysfunctional sets do you see in this transactional pattern?	
2. What do you notice about how the family entered your office?	
3. How might you employ boundary making in this session?	
4. How might you unbalance the family hierarchy? Why might you want to do this?	
5. What element of the family communication might you want to track? Why? How might you use this technique to help the family?	
6. Think of an enactment that you might use to see how the family might get past their silence at the end of this transactional pattern. What would you say?	
7. What complication, if any, does the age of the children pose?	

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SUMMARY

The structural approach in family therapy is primarily associated with Salvador Minuchin and his colleagues, first at the Wiltwyck School and later at the Philadelphia Child Guidance Center. Systems-based, structural family theory focuses on the active, organized wholeness of the family unit and the ways in which the family organizes itself through its transactional patterns. In particular, the family's subsystems, boundaries, alignments, and coalitions are studied in an effort to understand its structure. Dysfunctional structures point to the covert rules governing family transactions that have become inoperative or in need of renegotiation.

Structural family therapy is geared to present-day transactions and gives higher priority to action than to insight or understanding. All behavior, including symptoms in the identified patient, is viewed within the context of family structure. Structural interventions are active, carefully calculated, even manipulative efforts to alter rigid, outmoded, or unworkable structures. To achieve such changes, families are helped to renegotiate outmoded rules and to seek greater boundary clarity.

By joining the family and accommodating to its style, structuralists gain a foothold to assess the members' way of dealing with problems and with each other, ultimately helping them change dysfunctional sets and rearrange or realign the family organization. Family mapping provides a simple observational technique for charting the family's ongoing transactional patterns.

Enactments (having the family demonstrate typical conflict situations in the therapy session), *boundary making* (realigning inappropriate or outdated boundaries), *unbalancing* (supporting one member to interfere with family homeostasis), and *reframing* (the therapist's relabeling or redefining a problem as a function of the family's structure) are therapeutic techniques frequently used to bring about a transformation of the family structure. The ultimate goal is to restructure the family's transactional rules by developing more appropriate boundaries between subsystems and strengthening the family's hierarchical order. A final case study illustrates some structural techniques.

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11

Strategic Models



LEARNING OBJECTIVES

- LO 1 Discuss paradoxical techniques and how they attempt to change behavior
- LO 2 Explain the contribution of the Milan Group to family therapy theory
- LO 3 Describe the affect of circular questioning on family members
- LO 4 Discuss the effectiveness of strategic therapy

Strategic therapies offer active and straightforward therapeutic interventions aimed at reducing or eliminating the presenting family problems or behavioral symptoms. Less focused on the meaning of the symptom or its origins, strategists typically issue a series of directives or tasks to the family. These aim to change repetitive interactive sequences that lead to cross-generational conflict, sometimes without the cooperation of family members or their awareness that they are being manipulated into doing so. Two strengths of strategic family therapy are its insistent attention to removing the disturbing symptom or dysfunctional behavioral sequence by continuously tracking the family's patterns of interpersonal exchanges and its use of assignments of tasks to achieve therapeutic ends.

Strategic therapies derive from the Palo Alto research group projects of 1952–1962 on family communication. Gregory Bateson, Don Jackson, Jay Haley, John Weakland, Paul Watzlawick, and their associates all influenced strategic therapy. Feedback loops, the redundancy principle, double binds, family rules, marital quid pro quo, and family homeostasis are all a part of this theoretical model. These concepts and techniques have become so characteristic of family therapy that students today might assume they were always known. They were not; they are part of communication theory, which emerged when Bateson and his colleagues set out to study communication patterns in families with schizophrenic members.

This chapter presents the main concepts and clinical techniques associated with the strategic school. It concludes by looking at a related approach—the Milan Systemic Model—that introduced postmodern (i.e., nonlinear) ideas to the strategic perspective.

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The Communications Outlook

Communication theorists concern themselves with how verbal and nonverbal messages are exchanged within a family. They pay attention to *what* is occurring rather than *why* it is occurring—to the ongoing *process* between people within a system and the ways in which they interact, define, and redefine their relationships, and not to drawing inferences about each participant's inner conflicts. Communication patterns—the manner in which information is exchanged within a family; the precision, clarity, or ambiguity of the transmission; and the behavioral or pragmatic effect of the communication, as much as the *content* of what is communicated—help determine those relationships.

In shifting the locus of pathology from the individual to the social context, these family therapy pioneers were not denying that intrapsychic mechanisms influence individual functioning. Instead, they were giving greater credence to the power of family rules to govern interactive behavior. To them, a breakdown in individual or family functioning follows from a breakdown in rules. Feedback loops revealed a great deal about how family members communicated with one another, how they went about resolving conflict, and what chain of command existed within their ranks. To this day, the strategic therapist's primary way of viewing problems is to attend to the family's *sequence of interactions* and its *hierarchy of interactions* (Keim, 1998).

Communication theorists argue that a circular interaction continues between people because each participant imposes her or his own **punctuation** on what is being communicated; that is, each believes that what she or he says is caused by what the other person says. In a sense, such punctuations between family members resemble the dialogue of children quarreling: "You started it!" ("I'm only reacting to what you did.") "No, you started it first!" and so on. As Weakland (1976) contends, it is meaningless to search for a starting point in a conflict between two people because a complex, repetitive interaction, is not a simple, linear, cause-and-effect situation with a clear beginning and end. Often, each person in a communication holds the other responsible for his or her own reactions.

The communications perspective has undergone considerable revision since its inception. For example, the view of redundant patterns of communication within the family as offering clues to family dysfunction was a conceptual leap forward that became central to the emerging field. Also, the early view of the therapist as an authoritative expert strategically directing—manipulating—families to change has largely been replaced by a collaborating therapist or coach without fixed ideas of how the family should change.

We present four perspectives on the strategic model: (1) the original Mental Research Institute (MRI) interactional view, (2) the brief therapy principles and therapeutic procedures that characterize current MRI activities, (3) the strategic therapy refinements advanced primarily by Jay Haley and Cloé Madanes, and (4) the strategic-related efforts developed in Milan, Italy, by Mara Selvini-Palazzoli and her associates.

The Strategic Outlook

Efficiency and technical parsimony are the hallmark of all these models. They are change oriented and brief in duration. All four perspectives view families in nonpathological terms. All involve active therapists who tailor their strategies or interventions specifically to a family's

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presenting complaint and terminate therapy as soon as that complaint is resolved. They are less concerned with promoting personal growth or working through any underlying family emotional issues or teaching families specific problem-solving skills (Rohrbaugh & Shoham, 2015). The family receives help for what they came for, without the therapist speculating on whether other, as yet unidentified, problem areas might still exist or that further therapy might be beneficial.

While there are noteworthy differences in the four approaches, we group them together because all represent, in varying degrees of refinement, elaborations on the theme that clients determine what the problem is and *therapists are responsible for change*.

MRI Interactional Family Therapy

Don Jackson

Founded by Don Jackson in 1959, initially with a small staff consisting of Virginia Satir and Jules Riskin, the Mental Research Institute in Palo Alto at first existed side by side with the Bateson Project. In 1962, Haley, Weakland, and, briefly, Bateson himself, joined the MRI as research associates. Also at MRI were psychologists Paul Watzlawick and Arthur Bodin and psychiatrist Richard Fisch. Other prominent family therapists discussed elsewhere in this text such as John Bell, Carlos Sluzki, Cloé Madanes, and Steve de Shazer have been affiliated with this outstanding training center at one time or another.

Developing a Communication Paradigm

The theoretical groundwork for the interactional approach of the MRI was based largely on general systems theory, cybernetics, and information theory. These researchers zeroed in on the family interaction sequences in all families to understand how faulty communication patterns might lead to family dysfunction. Watzlawick, Beavin, and Jackson's (1967) *Pragmatics of Human Communication* is considered the classic pioneering text in communication. It encourages the simultaneous study of *semantics* (the clarity of meaning between what is said and received), *syntax* (the pattern as well as manner or style in which information is transmitted), and *pragmatics* (the behavioral effects or consequences of communication), using a series of axioms regarding interpersonal communication:

- *All behavior is communication at some level*. Just as one cannot *not* behave, so one cannot not communicate. The wife who complains in utter frustration that her husband "refuses to communicate" with her but instead stares at the television all evening is responding too literally to his failure to talk to her. On a nonverbal level, she is receiving a loud and clear message that he is rejecting her, withdrawing from her, may be angry or bored with her, wants distance from her, and so on.
- *Communication may occur simultaneously at many levels*. In addition to the content of what is said, gesture, body language, tone of voice, posture, and intensity are all part of communication. In some cases, the message at one level contradicts one at another level. People can say one thing and mean another. They can modify, reinforce, or contradict what they have just said. In other words, they are both communicating ("How are you?") and at another level communicating about their communications ("I do

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not really expect you to answer, nor do I especially want to know the answer"). All communication occurs on at least two levels—the surface or content level and a second level called **metacommunication**, which qualifies what is said on the first level. Problems may arise when a message at the first level ("Nice to see you") is contradicted by a facial expression or voice tone that communicates another message ("How can I get away from this boring person?") at the second level.

- *Every communication has a content (report) and a relationship (command) aspect*. Every communication does more than convey information. It also defines the relationship between communicants. For example, the husband who announces "I'm hungry" is offering information but also, more important, he may be telling his wife that he expects her to prepare dinner, thus making a statement of his perceived rights in the relationship. The way his wife responds tells him whether she accepts his *definition of the relationship* or wants to engage in a process to redefine it ("It's your turn to make the dinner tonight" or "Let's go out to a restaurant tonight" or "I'm not hungry yet").
- *Relationships are defined by command messages*. These messages stabilize relationships and define family rules in order to preserve family homeostasis. In a family, when a teenager announces she is pregnant or parents decide to get a divorce or a handicapped child is born or a family member becomes schizophrenic, it has an effect similar to flinging open a window when the house has been warmed to the desired temperature. The family goes to work to reestablish its balance.
- *Relationships may be described as symmetrical or complementary*. In a relationship based on equality, the interactive pattern is **symmetrical**; participants mirror each other's behavior: if A boasts, B boasts more grandly, causing A to boast still further, and so on in this game of one-upmanship. **Complementary** relationships are based on inequality and the maximization of differences. Typically, one partner (traditionally the male) takes the "one-up" position, and the other (traditionally the female) assumes the submissive "one-down" position. However, despite appearances, the positions may not be an indication of the partners' relative strength or weakness or power to influence the relationship.
- *Symmetrical relationships risk becoming competitive*. Each partner's actions influence the reactions of the other in a spiraling effect called **symmetrical escalation**. Quarrels may get out of hand and become increasingly vicious as a nasty jibe is met with a nastier retort, which prompts the first person to become even more mean, and so on. Neither partner is willing to back down nor to concede a point. (In a Woody Allen movie, a bickering couple say something like this: "The Atlantic is the best ocean"; "You're crazy—the Pacific is a much better ocean"; "You're the one who's crazy and doesn't know what he's talking about"; and so on.) Clearly, the content of the argument is meaningless; it's the power struggle that is notable and defines the relationship.
- *Complementary communication inevitably involves one person who assumes a superior position and another who assumes an inferior one* (a bossy wife, a submissive husband, or vice versa). One partner's behavior complements the other's. If A is assertive, B becomes submissive, encouraging A to greater assertiveness, and so on.

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- *Each person punctuates a sequence of events in which he or she is engaged in different ways*. Such punctuations organize behavioral events taking place into each participant's view of cause and effect and thus are vital to ongoing interactions.
- *Problems develop and are maintained within the context of redundant interactive patterns and recursive feedback loops*. Haley, who had been a graduate student in communication when first recruited for the Bateson project, underscored the struggle for power and control in every relationship that is inherent in the messages that sender and receiver exchange. Who defines the relationship? Will that person attempt to turn it into a symmetrical or complementary one? Who decides who decides? Observe a couple discussing how to allocate expenditures or what television program to watch or who will answer the telephone, balance the checkbook, go to the refrigerator to get a snack, or pick up the dirty socks and underwear from the bedroom floor, and in each of these see if you do not learn a great deal about how the partners define their relationship.

LO1 Paradoxical Communication

Communication theorists accent that there is no such thing as a simple message. People continually send and receive a multiplicity of verbal and nonverbal messages, and every message may be qualified or modified by another message on another level of abstraction (Weakland, 1976). Not infrequently, the receiver can become confused by contradictions between what is said and what is expressed in tone or gesture.

A double-bind message is a particularly destructive form of **paradoxical injunction**. A double-bind message occurs when one person, especially someone in a powerful position, issues an injunction to another that simultaneously contains two levels of messages or demands that are logically inconsistent and contradictory, producing a paradoxical situation for the recipient. In addition, the recipient is unable to avoid the incongruity or to comment on the impossibility of meeting its requirements, resulting in confusion.

Paradoxical injunctions are forms of communication that must be obeyed but that must be disobeyed to be obeyed! Two conditions must exist: (a) the participants must have a close complementary relationship and (b) the recipient of the injunction cannot sidestep or otherwise avoid responding to the communication or metacommunication.

Consider the following injunction from a person in a position of authority:

IGNORE THESE INSTRUCTIONS

To comply with the instructions, a person must *not* follow instructions, since one message denies or negates the other ("I order you to disobey me"). Unable to discriminate which order or level of message to respond to, the recipient nevertheless must respond. He or she is thus caught in a bind, called upon to make a response but doomed to failure with whatever response is chosen. Although initially speculated to be the type of paradox that might be responsible for schizophrenia in a child who repeatedly receives such double-bind communications, it is now assumed that double binding, while damaging, may exist at varying times

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and with varying consequences in all families.[1] Admittedly a linear construct, the double-bind concept (Bateson, Jackson, Haley, & Weakland, 1956) was groundbreaking and provided new language and assumptions regarding relationships reflected in communication patterns to account for symptomatic behavior.

Therapeutic Assumptions

Led primarily by the innovative thinking of Paul Watzlawick (Watzlawick, 1978, 1984; Watzlawick, Weakland, & Fisch, 1974), the MRI therapeutic model emphasizes the irony that the solutions people use in attempting to alleviate a problem often contribute to the problem's maintenance or even to its worsening. That is, people are not being difficult or resistant to change but rather are "stuck" in repeating inappropriate and nonworkable solutions. In this view, problems may arise from some ordinary life transition such as the birth of an infant or an older child going off to school for the first time. Most families handle such transitions with relative ease, although occasionally a difficulty turns into a more serious problem if mishandled or allowed to remain unresolved. Ultimately the original difficulty escalates into a problem "whose eventual size and nature may have little apparent similarity to the original difficulty" (Fisch, Weakland, & Segal, 1982, p. 14). For example, when a family is in turmoil because a 16-year-old daughter had sex with her boyfriend, the parents react to her as they did when she was 12 by telling her to be home by 9:00 p.m., and the girl resists and stays out until 1:00 a.m., to which the parents react with stiffer penalties more appropriate for a younger girl, and so on. Screaming matches ensue, and one night the daughter comes home very late and very drunk. Clearly, the problem is escalating even as every member of the family is suffering more and more.

A pragmatic, therapist-directed approach breaks into the family's repetitive and negative cycle. The MRI therapist wants to know what makes the behavior persist and what he or she must do to change it (Watzlawick, Weakland, & Fisch, 1974) but not what in the past caused it or how the family needs insight or restructuring.

First, the therapist must carefully delineate the problem in clear and concrete terms. In the example of the sexually active daughter, the therapist might articulate the problem in this way: "Holly feels she is in love and that sex is an appropriate expression of that love, and as her parents you feel she is too young to engage in sexual activity. You also feel that she proves her immaturity by her drinking behaviors." Next, solutions previously attempted by the family must be scrutinized. The therapist now defines, as precisely and concretely as necessary, what change is sought before implementing a strategy or therapeutic plan for achieving change (Watzlawick, 1978). The therapist might suggest that the family is having a difficult time appreciating that Holly is getting older and that her needs today are not the same as they were just 2 or 3 years ago. And Holly might be asked to consider how her behavior affects her parents in their obvious concern for her. As a rule, the interactional therapist seeks ways to change outmoded family rules, reveal hidden personal agendas, and modify or attempt to extinguish paradoxical communication patterns (see Box 11.1 for an example of implementing small changes).

[1]The double-bind situation is no longer believed to be the cause of schizophrenia, although it remains a historically significant formulation in that it drew attention to the possible role of family communication patterns in developing and maintaining family dysfunction. The double-bind concept is currently used loosely to refer to a variety of interactive communication patterns whose messages leave the receiver confused.

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BOX 11.1 CASE STUDY

Treating an Alcoholic Symptom

In the following case, the therapist asks the patient to make what seems to be a small alteration in how he handles his drinking problem. Seeing it as a minor adjustment, he accepts the directive easily, not aware that he is beginning the process of modifying his "solution" to the problem. Therapy is concluded when the presenting symptom is eliminated or the presenting problem resolved, despite the fact that other problems remain.

Don was a 38-year-old high school teacher who had seen the therapist 10 years earlier with indecisions over a career. This time, his anxious call for an appointment alerted the therapist that some crisis had occurred, and when Don appeared in her office the next day, he was agitated and distraught. He told her how he had embarrassed himself and his wife and teenage children at a family wedding. Ordinarily a meek, mild-mannered person, he drank too much and got into a physical fight with a stranger. He reported that his family was angry with him, that he was determined to quit drinking, and he was ready to start working on the problem now.

The therapist recommended a self-help, 12-step AA program, but Don insisted he could conquer the problem on his own. The therapist was skeptical, however, and encouraged him at least to enlist the support of his older brother who had quit drinking and to talk to him as a "sponsor" every day.

After several sessions of weekly therapy, Don suffered a relapse when his wife, Gwen, invited him to stop for a drink on their way home after he had picked her up at the airport. Gwen also had a drinking problem, which she claimed was under control, and by now it was clear to the therapist that drinking was a core part of their relationship. When Gwen was asked to attend the therapy sessions with Don, she resisted, explaining that he was the one with the uncontrollable problem.

The therapist's initial efforts to provide insight into the connection between the use of alcohol and their relationship did not seem to help or lead to change. Deciding to concentrate on the presenting symptom—Don's drinking—the therapist suggested that he make a small change: to drink only when he was with Gwen and at no other time. Since she was going on a business trip and he had sole responsibility for caring for the children, he had earlier decided he would not drink during her absence, so he agreed to the directive.

Later, he told the therapist that her assignment was not hard to comply with and that he had not had drinks with the other teachers after school on Friday as had been the group's custom. He was even more gratified by realizing he had voluntary control over when he drank. He did continue drinking with Gwen when she returned, as he had been directed to do, but recognized there needed to be more to their relationship than being drinking buddies. They began to discuss their relationship—for the first time in years—and Gwen decided to seek help for her drinking. When Don called the therapist 6 months later, he seemed proud to report that the drinking was under better control and that he and his wife and children had become closer.

First-Order and Second-Order Changes

One especially useful set of concepts introduced by Watzlawick, Weakland, and Fisch (1974) concerns the level of change sought by the therapist. **First-order changes** are superficial behavioral changes within a system that do not change the structure of the system itself. These changes are apt to be linear and little more than cosmetic or simply a reflection of a family's good intentions—for example, the therapist might suggest to Holly and her family that they agree to end all screaming at each other. First-order changes are likely to be short lived. Even if the symptom is removed—the couple tries to control their quarreling—the underlying systemic rules governing the interaction between them have not changed, and the cease-fire is likely to be violated sooner or later.

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Second-order changes require a fundamental revision of the system's structure and function. Here the therapist moves beyond merely helping to remove the symptom, but strives to help the family alter its systemic interaction pattern and reorganize the system so that it reaches a different level of functioning. If the therapy is successful, the old rules are discarded as obsolete and the family will attempt to reconstitute itself in a new way. According to Watzlawick (1978), therapy must accomplish second-order changes rather than mere first-order changes. An example of a second-order change for Holly and her family might involve having a frank discussion about sex, sexually transmitted disease, the prospects of pregnancy, Holly's feelings toward her boyfriend, and what it would be like for the parents to treat Holly more as an adult. One goal would be to change the parents' assumption about Holly's developing thoughts and feelings as she matures.

Some researchers view second-order change as a key aspect of any effective therapeutic approach, strategic or otherwise. Second-order change has been extended to understand changes in both educational and business environments; the concept is important for family therapists who are employed in these work areas (Fraser & Solovey, 2007).

The Therapeutic Double Bind

Interactional therapists (and strategic therapists in general) argue that it is their responsibility as outsiders to provide the family with an experience that will enable the members to change their rules and metarules. Families must examine their patterns of communication (including report and command functions) and the context for communication.

While focusing on the presenting problem and helping the family develop clear and concise goals, strategists often try to induce change by offering explicit or implicit directives—therapeutic tasks aimed at extinguishing ineffective interactional sequences. These are maneuvers designed to subtly gain control over the presenting symptoms and force families to attempt different solutions. To the family, these directives appear to fly in the face of common sense. The purpose of such paradoxical approaches is to jar or interrupt established but ineffective patterns of interaction by indirect means. Since second-order change is the goal, the therapist attempts to circumvent family resistance to altering the interactive patterns that maintain the problematic behavior.

An alternative to the pathological double bind is the **therapeutic double bind**, a general term that describes a variety of paradoxical techniques used to change entrenched family patterns. Where a pathological double bind places an individual in a no-win predicament, a therapeutic double bind is intended to force a person, couple, or family into a no-lose situation. For example, a depressed person is directed by the therapist not to be in such a hurry to give up the depression, although the individual is expecting to be helped to change. In effect, the therapist's directive is to change by remaining the same. The person is caught in a trap: If the directive not to do anything is defied and the individual tries to lift the depression, he or she learns to acquire control of the symptom, and this constitutes desired therapeutic change; if the person complies and does not attempt to change, he or she acknowledges a voluntary exercise of control over the symptoms. The person can no longer claim to be behaving symptomatically through no fault of his or her own. Either way, the person gains control over the symptom instead of being controlled by it.

In a form of therapeutic double bind called **prescribing the symptom**, strategic therapists try to produce a runaway system by urging or coaching the client to engage in or practice his or her

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symptoms, at least for the present time. A family is instructed to continue or even to exaggerate what it is already doing (e.g., a mother and daughter who continually fight might be directed to have a fight on a regular basis, say every evening for 15 minutes immediately after dinner). Since the family has come in desperation for help from the therapist (who seems to have high qualifications and experience) and since the directive not to change appears easy to follow because the symptomatic behavior (the fighting) is occurring anyway, the family attempts to comply.

The therapist, asked to help them change, appears to be asking for no change at all. Such an assignment, however, undermines family members' fearful resistance to anticipated efforts to get them to change by rendering such opposition unnecessary. The therapist is actually on the way toward outwitting any resistance to change. At the same time, the therapist is challenging the function or purpose of the symptom, suggesting the family behaves that way because it serves to maintain family balance. In our example, confronted with the repugnant task of fighting on a regular basis, thereby exercising voluntary control over a previously uncontrolled situation, the mother and daughter resist the directive and begin to interact in a different manner. The unstated rules by which they operated before may become clearer to them, as does the notion that their quarreling does not "just happen" involuntarily but can be brought under voluntary control.[2] Since their interactive pattern no longer serves the family function of providing balance, the entire family must seek new ways of interacting with one another.

Another form of therapeutic double bind, **relabeling** (changing the label attached to a person or problem from negative to positive) attempts to alter the meaning of a situation by altering its conceptual and/or emotional context in such a way that the situation is perceived differently. Language is used to alter the interpretation of what has occurred, inviting the possibility of a new response to the behavior. The situation remains unchanged; but the meaning attributed to it, and thus its consequences, are altered.

The classic example comes from Mark Twain's Tom Sawyer, who relabeled as pleasurable the drudgery of whitewashing a fence and then asked other boys to pay for the privilege of helping him. Relabeling typically emphasizes the positive ("Mother's not being overprotective; she merely is trying to be helpful") and helps the family redefine disturbing behavior in more



BOX 11.2 THINKING LIKE A CLINICIAN

Relabeling

Relabeling works best when there is an aspect of truth in the directive. Thus, "What you call your wife's nagging is merely her wishing to have things put away so the two of you will have a neater home to enjoy."

[2]Maurizio Andolfi (1979), director of the Family Therapy Institute in Rome, Italy, is particularly adept at unbalancing rigid family systems, often through effective use of "prescribing the symptom." In a family in which an anorectic adolescent girl controls family communication and defines all relations, Andolfi will forbid the girl to eat during a lunch session when the therapist and family eat together normally. Since her symptom (not eating) is now involuntary, the family can no longer use its typically incongruent message, "Eat, but don't eat." The prescription interrupts the family game based on the daughter's eating problem and helps expose the rules of the anorectic family system.

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sympathetic or optimistic terms. Relabeling provides a new framework for looking at interaction; as the rules by which the family operates become more explicit, the family members become aware that old patterns are not necessarily unchangeable. The goal of relabeling, like that of the other therapeutic double-bind techniques, is to change family relationships and interactions.

MRI Brief Family Therapy

Brief family therapy as practiced at the MRI is a time-limited (usually no more than 10 sessions), pragmatic, nonhistorical, step-by-step strategic approach based on the notion that most human problems develop through the mishandling of normal difficulties in life. In the MRI view, the attempted "solutions" imposed by families become the problem, as people persist in maintaining self-defeating "more of the same" attempts at problem resolution. From the MRI behavioral perspective, *the client's complaint is the problem, not a symptom of an underlying disorder*, as psychodynamic approaches might theorize.

The time limitations of this approach force clients to specifically define their current problem ("We believe our teenage boy is using drugs") rather than speak in generalities ("We're having family problems"). The therapist is interested in how, exactly, this problem affects every participant's life and why they are seeking help just now (rather than earlier or later).

Once the strategically oriented brief therapist obtains a clear picture of the specific problem as well as the current interactive behavior that maintains it, she devises a plan for changing the aspects of the system that perpetuate the problem (Segal, 1987). By restraining families from repeating unworkable solutions and altering the system, the therapist can help them break out of their dysfunctional cycle of behavior.

Three Types of Misguided Solutions

From the MRI perspective, there are three misguided solutions that lead to bigger problems: (a) some action is necessary but not taken (e.g., the family attempts a solution by denying there is a problem—the roof is not leaking, sister is not pregnant, money is no problem even though father has lost his job); (b) an action is taken when it is unnecessary (e.g., newlyweds separate soon after the wedding ceremony because their marriage is not as ideal as each partner fantasized it would be); (c) action is taken at the wrong level (e.g., marital conflicts or parent–child conflicts are dealt with by "common sense" or first-order changes, such as each party agreeing to try harder next time, when revisions in the family system—second-order changes—are necessary). The third type is probably most common, since people with problems attempt to deal with them in a manner consistent with their existing frame of reference. Repeated failures only lead to bewilderment, frustration, and intensification of the same responses.

MRI Brief Therapy in Action

Brief therapy sets up a powerful expectation of change. At the same time, the therapists tend to "think small," to be satisfied with minor but progressive changes. They urge their clients to "go slow" and to be skeptical of dramatic, sudden progress. This restraining paradoxical technique is actually designed to promote rapid change as the family is provoked to prove the

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therapist wrong in his or her caution and pessimism. In general, therapists do not engage client resistance to change, neither confronting the family nor offering interpretations to which the members might react negatively or defensively. Brief therapy aims to avoid power struggles with the family while it reshapes the members' perspectives on current problems and on their previous attempts to overcome difficulties.

MRI brief therapists do not insist that all family members attend sessions; they are content to deal only with those members motivated enough to do so. An important aspect of their work is first to collect data on previously failed solutions so as not to repeat them. They then set up specific goals of treatment, formulating a case plan and implementing interventions whenever there is an opportunity to interrupt earlier repetitive attempted solutions that merely serve to perpetuate the problem (Segal, 1991).

The MRI brief therapy program is a team effort. Although each family is assigned a primary therapist who conducts the interviews, other team members may watch from behind the one-way mirror and telephone the therapist with advice, feedback, and suggestions while treatment is in progress—all efforts directed at speeding up a change in family interactive patterns. In special cases (e.g., a therapist–family impasse), one of the team members may enter the room and address the primary therapist or the clients, perhaps siding with the client to increase the likelihood that forthcoming directives from the observer will be implemented. Families are not screened prior to treatment and are taken into the program on a first-come, first-served basis. Team discussions precede and follow each session after the initial family contact. Telephone follow-ups, in which each family receiving treatment at the center is asked by a team member other than the primary therapist to evaluate change in the presenting problem, take place 3 months and 12 months after the last interview.

The systemic nature of both problem formation and problem resolution, with its recursive feedback loops and circular causality metaphors, is basic to MRI thinking and therapeutic endeavors. Schlanger and Anger-Diaz (1999), directors of the Latino Brief Therapy Center at the MRI, outline the following steps in their brief therapy approach in response to the client's initial phone call:

- Defining the problem
- Identifying the attempted solutions
- Determining the position of the client
- Designing an intervention
- Selling the intervention to the client
- Assigning homework
- Doing a homework follow-up
- Terminating

The case description in Box 11.3 illustrates the effectiveness of the MRI brief therapy approach. The therapy team helps a wife revise her earlier self-defeating solutions to a problem and institute second-order changes in her interactions with a resistant husband. Use Box 11.3: Therapeutic Encounter to develop your own skills in strategic therapy.

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BOX 11.3 THERAPEUTIC ENCOUNTER

Strategically Designing a Novel Solution for a Chronic Problem

The author (Segal) and Dr. Fritz Hoebel studied and treated 10 families in which the husbands had suffered a major heart attack but were still continuing to engage in high-risk behaviors: poor diet, smoking, lack of exercise, and excessive consumption of alcohol. All these families were referred by cardiologists or by the staff of a cardiac rehabilitation program, who had given up on these individuals, fearing they were on a suicide course. In all 10 cases, the identified heart patient would have nothing to do with any further treatment or rehabilitation efforts.

Rather than wasting a lot of time and energy trying to convince the patient to come for treatment, we worked with their spouses. Using a five-session limit, we focused our attention on the way the wives had attempted to reduce their husbands' high-risk behavior—our aim was to change the system (i.e., the husband's behavior)—by getting the wives to change their attempted solutions. In most cases the wives struggled, argued, and nagged their men to change, so our primary effort was getting the wives to back off from this position. In one case that worked particularly well, on our instructions, the wife returned home and told her husband that she had been doing a lot of thinking about him.

She said she had decided that he had a right to live out the rest of his life in his own style, no matter how short that might be. Her primary concern now was herself and the children and how they would be provided for when he died. She then insisted that her husband go over all the life insurance and estate planning, instructing her how to handle things after his death. She also called life insurance agencies and asked whether there was any way her husband's life insurance could be increased. As instructed, she told them to call back at times she knew she would not be home but her husband would be there to take the calls. Within 2 weeks after she had begun to deal with him this way, the husband had resumed his participation in the cardiac rehabilitation exercise program and was watching his diet.

Source: Segal (1982), pp. 286–287

Strategic Family Therapy (Haley and Madanes)

If the original MRI communication/interaction approach drew the greatest attention from family therapy professionals in the 1960s, and Minuchin's structural model was the most consistently studied and emulated in the 1970s, then it is fair to say that the various strategic approaches took center stage in the 1980s (and that social constructionist and narrative approaches gained ascendance in the 1990s and into the present century). As we've noted, the main characteristic of the strategic approach is that the therapist takes responsibility for devising a strategy for solving the client's presenting problem.

The Haley–Madanes strategic approach defines a presenting problem in such a way that it can be solved. Goals eliminating the specific problem are clearly set, and therapy is carefully planned, in stages, to achieve these goals. Problems are defined as involving at least two and most likely three people, allowing for an examination of problematic family structures (broken hierarchical rules, cross-generational coalitions) and dysfunctional behavior. The intervention shifts the family organization so that the presenting problem or symptom no longer serves its previous function in the family. Change occurs not through insight and understanding but as the family carries out directives issued by the therapist. See Box 11.4 for an opportunity to practice your skills in Strategic Family Therapy.

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BOX 11.4 THINKING LIKE A CLINICIAN

Strategic Family Therapy

The Beyers family has come for therapy. Bill and Maria are the parents, and Veronica and Justine are their two teenage daughters, ages 16 and 14, respectively.

BILL: I guess we've come to see you because we fight all the time. We don't have any good times together anymore.

MARIA: (interrupting) Baloney! We're in trouble because we don't have any money. Period. Bill refuses to get a job even though he has an MBA. We should be well off. Instead, we live off of the money my father left us—and that's going fast. If Bill would just develop a little backbone and get a job, we'd all be fine.

(You notice that Bill withdraws, and Veronica rolls her eyes as her mother talks.)

MARIA: I make what little money we earn, and to do it I have to work 10 hours a day. When I get home, no one has done a thing to help the family. Bill is playing computer games like a 12-year-old, and the girls are text messaging everyone in creation. The other night I refused to cook dinner and took myself out to a restaurant. They could all starve as far as I am concerned. Of course, I don't want things to be like this, but what am I supposed to do, give in every single day of my life? Frankly, I am married to a coward, and the girls are spoiled brats. No one cares about me at all.

BILL: That's not true, Maria. We all care about you very much.

MARIA: Yeah, well, talk is cheap. Prove it. Go get a job.

BILL: I am trying, but in this market there isn't much out there. You know I send out my resume to someone practically every day.

VERONICA: I am so tired of listening to this same old battle. Mom says Dad's a wuss, and Dad tries to calm her down. (Turning to her parents): Why don't you get a divorce already? You obviously don't love each other anymore.

MARIA: See what I mean? She is such a brat. Of course I love Bill. We're just going through a tough time.

VERONICA: Yeah, for about a century.

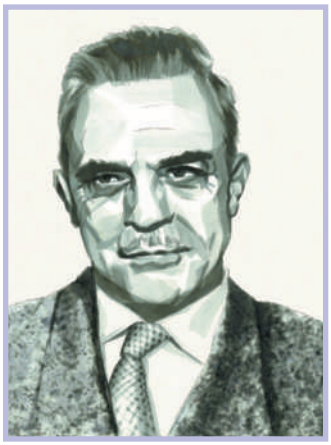
(You notice that Justine has remained silent throughout.)

1. Clarify the specific nature of the Beyers's problem.	
2. What interactive behavior maintains the problem you identified?	
3. Identify any misguided solutions that the family itself proposes to solve its own problems.	
4. Identify a goal of treatment. Create a case plan.	
5. What is one therapeutic double bind you might offer to disrupt established patterns?	
6. What homework might you assign to the family for the next session?	

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Jay Haley, John Weakland, Milton Erickson

The career of Jay Haley plays an important part in the development of the strategic approach to family therapy. Haley was a key member of Bateson's schizophrenia research project in the 1950s and helped develop the double-bind concept. Where Bateson was interested in the concept's theoretical significance, Haley (1963) saw its clinical application. He took the position that implicit in every interpersonal transaction is a struggle for control of the *definition* of the relationship. He viewed symptomatic behavior in one partner as a maladaptive control strategy, warning that the therapist must maintain control of the therapy relationship, lest the client gain control and perpetuate her or his difficulties in order to "continue to govern by symptomatic methods" (Haley, 1963, p. 19).



Ullstein bild/Getty Images

Milton Erickson, M.D.

Haley, along with Weakland, became interested in understanding the communication occurring between hypnotist and subject and attended workshops on that subject led by Milton Erickson. Intrigued by Erickson's metaphoric therapeutic style for issuing indirect suggestions through hypnosis, Haley and Weakland visited Erickson regularly in Phoenix over several years. Erickson's influence on many of the underlying assumptions and subsequent therapeutic techniques of strategic therapy is great. Haley (1973, 1976) actually credits his mentor as the inventor of the general approach of strategic family therapy.

Erickson's therapy was brief, active, directive, and carefully planned. Taking responsibility for change, he tailored a novel approach for each case, typically looking for the person's area of resourcefulness and putting it to work (Hoffman, 2002). His use of hypnotic techniques, typically focused on symptom removal, required the therapist to assume full charge of the treatment and to issue directives (however subtle or indirect) as a way of gaining leverage for eliminating the troublesome symptom. Joining with patients, believing in their inherent wisdom to help themselves once shown how, and gaining their trust, Erickson used indirect suggestions to encourage them to break out of their old behavior patterns and, in the process, abandon their presenting symptom. Erickson argued that an effective therapist must be a strategist who approaches each new client with a specific therapeutic plan, sometimes a simple directive or a paradox, fitted to that individual and intended to solve his or her problem. Erickson's unorthodox but artful stratagems, extraordinary feats of observation, and seemingly uncanny ability to tap unrecognized and previously untapped resources in his clients (usually individuals rather than families) have been chronicled by Haley (1973) and Zeig (1980). Jeffrey Zeig has continued Erickson's legacy, founding and directing the Milton H. Erickson Foundation in Phoenix, dedicated to promoting and advancing Erickson's ideas by offering training programs in hypnosis and psychotherapy worldwide.

Noted for his creative and unconventional hypnotic techniques, Erickson was particularly skilled at "bypassing client resistance" through the use of *paradoxical directives*. He was able to persuade patients to hold on to a symptom (by not fighting it or insisting the client work at giving it up) and then subtly introduce directions to induce change. Thus he was able to avoid direct confrontation with the symptom, a tactic likely to have been met with resistance, and

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to use the client's own momentum to force symptom abandonment. This technique, developed so that the hypnotic subject would not experience a loss of control to the hypnotist, later became the basis for many of Haley's strategic interventions in working with families. The family's fear of relinquishing control to the therapist often makes it resistant to change. By not directly confronting such resistance, the therapist lessens the fears of family members that they will be required to do things against their will. Once they feel safe, the therapist jumpstarts the change process, and people begin to call upon their own resources to attempt new ways of thinking and behaving.

Haley was also influenced by his long association (1967–1973) with Salvador Minuchin and Braulio Montalvo at the Philadelphia Child Guidance Center. Mitrani and Perez (2003) actually classify Haley's position as a structural-strategic approach. Minuchin himself points out that there are obvious similarities between the structural and strategic outlooks (Simon, 1984). Haley's concern with maintaining family generational hierarchies and avoiding disabling coalitions[3] (joint action by two family members against a third) allies him with the structural group, while his interest in paradoxical directives and other unobtrusive ways of managing resistance identifies him with the strategic focus.

By 1975, Haley and Cloé Madanes (then his wife who had trained at the MRI before moving on to the Philadelphia Child Guidance Clinic) together formed the Family Therapy Institute of Washington, DC, a highly respected training program for family therapists. Haley, a prolific writer, wrote three influential works: *Problem-Solving Therapy* (1976) describes strategies for changing the way a family is organized; *Ordeal Therapy* (1984) presents the premise that if a client is maneuvered into a position where he or she finds it more distressful to maintain a symptom than to give it up, the client will abandon the symptom; and *Directive Family Therapy* (2007), cowritten with Madeleine Richeport–Haley, summarizes his key ideas and provides examples of effective clinical intervention.

The Meaning of Symptoms

Although the generally accepted view at the time was that symptoms were by definition involuntary and maladaptive, Haley early on took the position that a symptom is a strategy that is adaptive to a current social situation for controlling a relationship when all other strategies have failed. All participants are caught up in the repetitive sequence that keeps the process going. The symptomatic person simply denies any intent to control by claiming the symptom is involuntary. ("It's not that I am rejecting you. It's my headache that keeps me from wanting sex with you tonight.") Thus, symptoms often control another person indirectly, and this oblique way of communicating through symptom formation may serve a function for the overall family system.

Power and control are at the very core of Haley's thinking about family functioning. Jockeying for control occurs in all families and in every relationship between two or more people.

[3]As Mitrani and Perez (2003) observe, coalitions are detrimental to family functioning because they detour conflict and do not allow relationships to develop fully among the three participants. If Julia and Samantha have a conflict they cannot manage directly, and Emily aligns herself with one against the other, the original two do not have an opportunity to work out their problem, and their relationship does not develop.

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BOX 11.5 THINKING LIKE A CLINICIAN

Symptoms: Voluntary or Involuntary Efforts at Control?

Haley cites the case of a woman who insists her husband be home every night because she suffers anxiety attacks if left alone. She does not recognize her demand as a means of controlling his behavior but explains it as a function of her anxiety attacks, over which she presumably has no control. The husband faces a dilemma; he cannot acknowledge that she is controlling his behavior (the anxiety attacks are at fault for that), but he cannot refuse to let her control his behavior (after all, she has anxiety attacks).

By acting helpless, the wife gains considerable power and control over the relationship. Without offering insight or otherwise sharing the view that symptoms are under the client's control, the strategist seeks to change the situation—perhaps help the couple redistribute power and responsibilities—so that the symptom is no longer necessary.

Most couples develop direct means of dealing with issues of control. According to Haley, people who present symptoms are resorting to subtle, indirect methods. It is his contention that control struggles in a relationship are inevitable. One cannot *not* try to define a relationship or attempt to control an outcome. Haley considers the maneuver pathological only if one or both participants deny trying to control the other's behavior and/or exhibit symptomatic behavior in the process of doing so.

All strategists contend that communication defines the nature of the relationship between partners. If a husband is willing to discuss only the weather when he and his wife are together in the evening, he may be defining the relationship as one in which they talk only about conventional or impersonal matters. If the wife refuses to comment on tomorrow's forecast but instead expresses the idea that they seem distant from each other this evening, she is attempting to redefine the relationship on more personal and intimate terms. *Their conflict is not a struggle to control another person but a struggle to control the definition of the relationship*. As we have noted, in some marriages, a partner's symptoms (e.g., anxiety attacks, phobias, depressions, heavy drinking) control what takes place between the partners—where they go, what they do together, whether one can leave the other's side for any length of time, and so on. Strategists thus *define symptoms as interpersonal events*, as tactics used by one person to deal with another. In their view, the therapist's goal is to maneuver the client into developing other ways of defining relationships so that the symptomatic methods will be abandoned.

Triangles, Sequences, and Hierarchies

In the Haley–Madanes approach, problems involve the interaction of at least three parties (with a coalition of a minimum of two against at least one other). While larger numbers may exist in a family, they argue that the triangle is the preferred way of describing family interaction (Keim, 1999). Presented with a case of marital conflict, the strategic therapist will not view it as an issue between spouses; rather, he or she will look at the effect of others (children, in-laws, work associates) on the couple.

Strategic therapists also track interactional sequences of events, which are likely to be circular. Keim (1999) cites the case of shoplifting by a teenager as more than an individual

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BOX 11.6 THINKING LIKE A CLINICIAN

Even-Handed Alliances

Therapists need to be evenhanded and not be tempted to form coalitions with family members low in the family hierarchy (e.g., overprotecting children or the identified patient) against those with higher authority or power.

act. It is a sequence of events involving peers and parents. Rather than treating the individual offender, strategists change the relevant interactional sequence of the presenting problem, helping the family replace painful or escalating sequences between members with a calmer and more conciliating sequence.

Hierarchy within a family, so central to Minuchin's structural ideas, is incorporated into strategic thinking. See box 11.6 for one application of hierarchy in family therapy. Without viewing a client family's hierarchical structure as functional or dysfunctional, strategists want to know what roles each member plays and whether problems arise because people are unhappy with their roles. As Keim (1999) illustrates, a child who is functioning as an adult within a family is not a problem in and of itself, according to strategic thinking; but the child's role becomes a problem if unhappiness develops in the family because he or she is assuming the adult role. Strategic therapists are especially attuned to oppositional behavior that may develop in a family when assigned or ascribed roles are uncomfortable or no longer fit and conflictual communication and behavioral sequences follow.

Developing Therapeutic Strategies

The emphasis in strategic therapy, according to Madanes (1981), is not on devising a therapeutic method applicable to all cases but rather on designing a unique strategy for each specific presenting problem. The focus throughout is on artfully alleviating the presenting problem, not exploring its roots or buried meanings. Haley–Madanes strategic therapy is likely to be short term, limited to specific problems and tailored to solutions.

Criticized for his manipulative style, Haley (1963) points out that therapists and patients continually maneuver with each other in all forms of family treatment. Family members, fearful of change, may try to manipulate, deceive, exclude, or subdue a therapist in order to maintain the homeostatic balance they have achieved, even if it is at the expense of symptomatic behavior in one of their members. They do so not to torment a therapist but because they are clinging to what they believe is the only solution to their problem. The strategic therapist, therefore, must take an authoritative stance. Haley (1976) sees his task as taking responsibility for changing the family organization and resolving the problem that brought the family to see him. He is highly directive, giving the family members precise instructions and insisting that they be followed.

For example, Haley cites the case (1976) of a grandmother siding with her grandchild (age 10) against the mother. He saw the mother and child together, instructing the child to irritate the grandmother and telling the mother to defend her daughter against the grandmother. This

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task forced a collaboration between mother and daughter and helped detach the daughter from her grandmother, creating a more appropriate hierarchical structure.

This example illustrates how strategists typically cast problems in triadic terms (in this case, child, mother, grandmother), focusing on the effects of their directives on the behavioral sequences that follow between the participants. As active, take-charge therapists, their aim is to issue directives that alter dysfunctional sequences. Typically, as in this example, those sequences revolve around one's family hierarchy, since a family's confused hierarchical setup is often thought to be the root of symptomatic behavior in a family member. Haley advocates that therapists intervene when they see the need to do so (rather than when the family requests therapist input), comment openly about the family's efforts to influence or control them, give directions and assign tasks, and assume temporary leadership of the family group. Strategic therapists attempt to avoid getting enticed into coalitions within the family; however, they may develop a coalition with one or more members to overcome an impasse but quickly disengage before becoming entangled with one or another family faction.

Another strategic tactic is to emphasize the positive, usually by relabeling previously defined dysfunctional behavior as reasonable and understandable. In one often-quoted example, allegedly attributed to Haley, he boldly (and at first glance, outrageously) told a wife whose husband had chased after her with an ax that the man was simply trying to get close to her. Here, Haley was following a principle of communication theory described earlier—namely, that all communication occurs at two levels and that the message at the second level (metacommunication) qualifies what takes place on the surface level.

What Haley was communicating by the relabeling, and what the wife also sensed, was that the husband indeed did want to connect with her, but his rage got in the way of doing so in any constructive manner. (In everyday exchanges, a remark made by a sender in normal conversation can be taken as a joke or an attack, as praise or as blame, depending on the context in which the receiver places it.) By addressing the metamessage—he wanted to get close—Haley freed them to think and therefore behave differently.

The Initial Interview

Haley (1976) contends that the first interview, which he insists the whole family attend, sets the stage for the entire course of therapy. Proceeding systematically through stages, strategists negotiate with the family to decide what specific problem requires attention, then formulate a plan of action to change the family's dysfunctional sequences or faulty hierarchy in order to eliminate the problem. Typically, in the opening *brief social stage*, strategists create a cooperative and relaxed atmosphere while observing family interaction and trying to get all members to participate, thus indicating all are involved (not merely the identified patient) and should have a voice in the therapy.

Next, in this highly structured process, Haley-influenced strategists shift to the *problem stage*, getting down to the business of why the family is there (e.g., to solve what specific presenting problem?). They pose such questions as "Why do you seek help now? What would each of you like to change? Quickly or slowly? Do you wish to realize what is happening or just to change? Are you willing to make sacrifices to change?" (Haley, 1988). In this

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information-gathering phase, in which all members are urged to participate in defining the presenting problem, conversation is directed at the therapist, who displays an interest but does not interpret the thoughts and feelings being expressed.

The *interactional stage*, during which the family discusses the problem aloud with one another in the presence of the therapist, permits the therapist to observe any dysfunctional communication sequences, coalitions, problematic hierarchies, conflicts between any duos, and so forth, thereby offering clues about future therapeutic interventions.

The fourth segment, the *goal-setting stage*, gives the therapist and family together an opportunity to precisely determine the presenting problem they wish to solve or eliminate. This phase results in a contract that clearly defines goals, allowing all participants to measure change or gauge the success of their efforts as therapy progresses.

In the final or *task-setting stage*, the strategic therapist ends the initial interview with the first set of simple homework assignments or directives, beginning the process of changing sequences of interaction within the family. If the initial interview is successful, family members feel comfortable with the therapist and committed to working together for change (Haley, 1976).

The Use of Directives

Directives, or assignments of tasks to be performed outside of the therapeutic session, play a key role in strategic family therapy and are given for several reasons: (a) to get people to behave differently so they will have different subjective experiences; (b) to intensify the therapeutic relationship by involving the therapist in the family's actions between sessions; and (c) to gather information, by their reactions, as to how the family members respond to the suggested changes. Advice, direct suggestions, coaching, homework, even assignments of ordeal-like behavior to be followed if a symptom appears are examples of straightforward directives by the therapist aimed at changing an unworkable system and achieving problem solution. They are typically prepared with care, tailored to the family's style, and issued in a precise manner, with the expectation that the family will report back at the next session about carrying out the task.

As Madanes (1991, p. 397) emphasizes, "The directive is to strategic therapy what the interpretation is to psychoanalysis. It is the basic tool of the approach." In some cases, strategists issue a straightforward directive (simultaneously a report and a command) to family members to take specific action (e.g., instructing a mother to stop intruding when the father and son try to talk to each other) because they want or expect them to follow it in order for them to change their behavior toward one another. However, asking someone to stop engaging in certain behavior is a difficult directive to enforce; its success depends upon the status of the therapist giving the instruction, the severity or chronicity of the behavior, how often the directive is repeated, and especially the willingness of family members to cooperate with the therapist in accomplishing the task.

Frequently, the direct approach is unsuccessful. (If direct suggestion were successful, the chances are great that the family would have followed advice from friends and not come to a therapist's office.) Another kind of task assignment, more indirect, is one by which the therapist attempts to influence clients to take some action without directly asking them to do so. Often couching the task in paradoxical form (see Table 11.1), the strategic therapist hopes to

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TABLE 11.1 Common examples of paradoxical interventions

Reframing	"He checks on your whereabouts several times a day not because he's jealous but because he's thinking about you all the time."
Relabeling	"Your wife is being helpful by reminding you about unfinished tasks around the house because she wants to make a nice home for you."
Prescribing the symptom	"Practice quarreling with each other as soon as you wake up."
Restraining	"Don't do anything about the problem this week so we can see how really bad it is."
Offering prescriptions	"Keep a list of everything that might worry you during the day, and set aside an hour every night to go over them and become a competent worrier."
Offering descriptions	"The two of you, as a married couple, are to be commended for avoiding confronting your differences. It would be too risky to change things now."
Predicting a relapse	"The two of you got along better this week, but you're probably going to have a major blowup soon."
Declaring hopelessness	"You're probably right. There's nothing you can do. It would be a disservice to you to allow you to continue therapy."

Source: Seltzer (1986); Weeks and L'Abate (1982).

provoke the family to rebel or resist him or her so that they give up the symptom. Assignment of paradoxical tasks can be directed at individual family members, at pairs of people, or at the family system (Weeks & L'Abate, 1982).

Paradoxical directives should be used with relative infrequence, as when a client is in crisis or especially resistant to change. They commonly take one of two forms—*prescriptive* or *descriptive*. Prescriptive paradoxes ask the client(s) to do something, while descriptive paradoxes relabel in a positive manner something already being done.

As Wachtel and Wachtel (1986) illustrate the former, a client seeking help for procrastination is asked not to try to accomplish more in the coming week between sessions but rather to record the various ways he wastes time each day and how long each takes. The changing set or perhaps the unpleasant task often leads to a reduction of procrastination. The client may report that there was little to write down the previous week because he got his work done. If a list is made, the client will often gain greater awareness of his self-defeating behavior or perhaps learn that he is less a procrastinator than overdemanding or expecting too much from himself. We offered an example of a descriptive paradox earlier when Haley relabeled the ax-wielding of the husband as a loving act.

As used by strategists, a paradoxical directive asks clients to *refrain from change*, and is designed to provoke defiance in the recipient. The client is told to continue to do what he or she came to therapy to get over doing (i.e., to continue having the symptom). The therapist is trying indirectly to get the client or family to decide that they won't do what they have now been directed to do. Confused, the family members perceive that through the assignment of such a task, the therapist is asking them not to change at the same time that the therapist has declared the intention of helping them change.

For example, an intelligent son, failing in school, is told to continue to fail so that his less well-educated father can feel good about himself. If the boy conforms to the directive, he

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admits control and acknowledges how his behavior contributes to family secondary gain (an advantage or benefit, such as reassuring the father, that arises due to an illness or appearance of a symptom). If he rebels against the directive to continue to fail, he gives up the symptom. This paradoxical prescription subtly reveals the secondary gain that the patient's symptomatic behavior (poor grades) provides for the family, covertly suggesting change is both possible and desirable.

Paradoxical interventions[4] represent a particularly ingenious way of maneuvering a person or family into abandoning dysfunctional behavior. Similar to "prescribing the symptom," this technique is particularly appropriate for strategists because they assume that families who come for help are also frightened and therefore resistant to the help being offered. If not careful, Andolfi (1979) warns, the therapist can easily get entangled in the family's contradictory logic of "help me change, but without changing anything." The strategic paradoxical approach, aimed at families who defy compliance-based interventions and based on putting clients in a double bind, encompasses several stages.

First, the therapist attempts to set up a relationship with the family in which change is expected. Second, the problem to be corrected is clearly defined. Third, the goals are clearly stated. In the fourth stage, the therapist must offer a concrete plan; it is helpful if a rationale can be included that makes the paradoxical task seem reasonable. In the fifth stage, the current authority on the problem (such as a physician or a parent) is disqualified as not handling the situation the right way; in the sixth stage, the therapist issues the directive. In the seventh and last stage, the therapist observes the response and continues to encourage the usual problem behavior in order to maintain the paradox.

It is of utmost importance for the therapist using a paradoxical intervention that prescribes the symptom to carefully encourage the member(s) with the behavior to be changed to continue that behavior unchanged—a domineering wife to continue to run everything in the family; a daughter refusing to attend school to stay home; an adolescent boy masturbating in public to continue doing so but to keep a chart of how often, what days he enjoyed it most, and so on. Strategists might tell a couple who always fight unproductively to go home and fight for 3 hours. The issue becomes one of control. The domineering wife no longer runs everything if the therapist is telling her what to do, and if she resists his directive, she will become less domineering in relation to her husband. Similarly, strategists assume in the other cases that the symptom presented, originally a way of gaining an advantage, will be resolved if

[4]This approach is employed by many family therapists, especially in dealing with defiant or resistant families. A paradoxical injunction (e.g., "Be spontaneous") is a prototype of a double-bind situation. To command someone to be spontaneous demands behavior that cannot be spontaneous because it is commanded. Thus, with seeming innocence, the sender is trapping the receiver into a situation in which compliance also entails rule violation (Watzlawick, Weakland, & Fisch, 1974). The receiver is faced with two conflicting levels of messages, is bewildered, and cannot respond effectively. The family is told, in effect, "Disobey me." Thus, the family told not to change in effect defies the therapist's injunction; the family begins to change to prove the therapist wrong in assuming it could not change. If the therapist allows himself or herself to be put down as wrong and even suggests that the change is very likely to be temporary and a relapse probable, the family will resist relapse and continue to change to prove the therapist wrong again. It is essential that the therapist never claim credit for helping the family—indeed, the therapist remains puzzled by the change—in order to preclude the family's need to be disobedient in the form of a relapse.

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the symptom now places the person at a disadvantage. In the case of the couple, strategists expect them to stop fighting; people do not like to make themselves miserable because someone else tells them to do so.

Should the individual or family follow instructions and continue the problematic or symptomatic behavior, the therapist has been given the power and control to make the symptom occur at his or her direction. Should the individual or family resist the paradoxical intervention, the symptomatic behavior is, in the process, given up (and, again, the therapist retains power and control). Strategic therapists devote a great deal of time to devising *nonharmful*, if sometimes seemingly absurd, paradoxical tasks appropriate to the problem of the person desiring to change or get rid of a disturbing symptom.

In another form of prescriptive directive called *ordeal therapy* (Haley, 1984), once again based on the work of Erickson, the strategic therapist will instruct a client to carry out an unpleasant chore (e.g., rising in the middle of the night to wax the kitchen floor) whenever the symptom appears during the day, thus making the distress of the consequences a greater hardship than the distress of the original symptom. By selecting a harmless or mildly noxious task, but one consistent with a client's desires (say, keeping a spotless house) yet like an ordeal in its execution, Haley again tries to make it more difficult for the client to have the problem or symptom than to give it up. Ordeal therapy calls for a clear statement of the problem or symptom to be addressed and a commitment to change on the part of the client even if suffering is required, as well as a promised willingness to follow a therapist's directive regardless of its logic or relevance to the presenting problem.

There are three major steps in designing a paradox, according to Papp (1983): *redefining, prescribing*, and *restraining*. Redefining is intended to change the family's perception of the symptom. Behavior that maintains the symptom is defined as benignly motivated, loving gestures the family employs to preserve its stability. Anger is relabeled as caring, suffering as self-sacrifice, distancing as a way of reinforcing closeness. Instead of trying to change the system directly, the therapist appears to be supporting it, respecting the emotional logic upon which it runs.

Next, the wording of the prescription ("Practice being depressed"; "Continue being rebellious against your parents") must be brief, concise, and unacceptable (in order for the family to recoil at the instruction), but the therapist must appear sincere by offering a convincing rationale for the prescription. Later, when the family members press for change, the therapist attempts to regulate the pace of change by urging restraint, pointing out to them what new difficulties might arise. At the same time, the therapist seems to be cautiously allowing the family to change despite these anticipated difficulties.

Restraining strategies ("go slow") are efforts to emphasize that the system's homeostatic balance is in danger if improvement occurs too rapidly. If the directive is presented with a creditable rationale ("Change takes time and must proceed step by step; otherwise there is danger of relapse if too much change occurs too fast"), the client is likely to go along with it. The tactic is intended to prepare clients for change, to acknowledge their reluctance to change, and to solidify change once it begins (Shoham, Rohrbaugh, & Cleary, 2008). "Go slow" messages, according to Fisch et al. (1982), provide the additional benefit of reducing the client's sense of urgency about finding new solutions. Such messages have the

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added effect of normalizing relapse should it occur, without the family becoming demoralized or giving up trying.

Haley (1976) inquired, in a case of a young, middle-class couple concerned that their young child soiled his pants, what the consequences would be if he began to go to the toilet normally. (This move suggested that Haley could help them with the problem but would rather not until he was sure of the positive consequences to the entire family.) When the couple returned the next week and indicated that they could think of no adverse consequences, the therapist suggested some possibilities: For example, could the mother tolerate being successful with her child? This effort to challenge the mother's involvement with her child and reframe her behavior contained messages at several levels: (a) Haley thought she could tolerate success; (b) he was benevolently concerned, so he wanted to make sure she could tolerate it; and (c) the mother would find the suggestion of not tolerating success to be unacceptable. No mother is likely to think she cannot be successful with her own child, as Haley well knew. Thus provoked (the father was similarly confronted), both parents became highly motivated to solve their problem to prove they could tolerate being normal; the boy's problematic behavior ceased.

LO 2 The Milan Systemic Model

Made up originally of adherents of the strategic school, particularly the early MRI model, the Milan group in Italy extended strategic theory and practice into a postmodern paradigm. In short, the work of this group shifted the focus of treatment away from the observation of interactive sequences and patterns toward questioning family belief systems. Families were helped to become aware of repetitive belief and behavioral patterns and to see themselves within a relational context (i.e., from the perspective of fellow family members) in order to examine various perspectives with which to address problems.

History and Leaders

This model was first presented by a group of family therapists from Milan, Italy, led by Mara Selvini-Palazzoli. The Milan group's model was conceptually and methodologically aligned with Bateson's ideas about circular epistemology (MacKinnon, 1983). Characterized by a systematic search for differences—in behavior, in relationships, in how various family members perceive and construe an event—and by efforts to uncover the connections that link family members and keep the system in homeostatic balance, the approach has come to be known as **systemic family therapy**.

Joining Selvini-Palazzoli in the late 1960s were eight fellow psychiatrists—including Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata. At first they treated families of severely disturbed children, many of whom were suffering from anorexia nervosa. To improve on the perceived limitations of psychoanalysis, the team turned to the work of the Palo Alto group, particularly to the book *Pragmatics of Human Communication* (Watzlawick, Beavin, & Jackson, 1967).



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Mara Selvini-Palazzoli, M.D.

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By 1971, the four formed the Milan Center for the Study of the Family in order to work more exclusively with family systems. Watzlawick was their major consultant in the early years, but over time the group developed their own theory and set of strategic intervention techniques (Boscolo, Cecchin, Hoffman, & Penn, 1987). They introduced a team approach to treatment and techniques such as *positive connotation*, designed to overcome therapeutic impasses and change stalemated family interactive sequences.

Their first comprehensive model came in the book *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction* (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). After a decade together, the four separated into two autonomous groups (Selvini-Palazzoli and Prata; Boscolo and Cecchin) each pursuing differing emphases in thinking and practice although retaining similar systemic outlooks.

Key Concepts: Paradoxes, Counterparadoxes, Positive Connotations, and Rituals

Although the Milan school has lost much of its influence in present-day family practice, several of its key concepts remain valuable; these include paradoxes, counterparadoxes, positive connotations, and rituals.

The Milan team began by *prescribing no change* in symptomatic behavior. They adapted the MRI technique of paradoxical intervention to their own systemic formulations that all of the family's attitudinal and behavioral patterns were moves designed to perpetuate the family game and thus could not be confronted or challenged head on. Through the use of therapeutic **counterparadoxes**—essentially therapeutic double binds—the family was warned against premature change, allowing the members to feel more acceptable and unblamed for how they were, as the team attempted to discover and counter the family's paradoxical patterns to disrupt repetitive, unproductive games.

Positive connotation reframes the family's problem-maintaining behavior so that symptoms are seen as positive or good because they help maintain the system's balance and thus facilitate family cohesion and well-being. Instead of being considered "bad" or "sick" or "out of control," a symptomatic child, for example, is considered to be *well intentioned* and to be *behaving volitionally*. Note that it is not the symptomatic behavior (say, refusing to go to school) that is connoted to be positive, but rather the intent behind that behavior (family cohesion or harmony). The symptomatic behavior is now viewed by the family as voluntary, greatly enhancing the possibilities for change.

Rituals address aspects of family relationships that the therapist or team hypothesizes as significant for family functioning regarding the current difficulty. Generally, they are ceremonial acts proposed by the therapist as temporary experiments. The therapist does not insist that the ritual be carried out but indicates that it may be useful. Take the case of parents who are inconsistent or competitive with one another in attempting to maintain behavioral control of a disruptive child. A ritual might be suggested in which Mother takes full charge of discipline on odd days (with father observing and taking exact notes on the ensuing mother–child interaction), and Father takes charge on even days (with mother playing the counter-role). Each parent is directed to carry out the assigned roles for a certain number of days and to

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behave "spontaneously" for the remaining days of the week. Carrying out the ritual clarifies differences in approach for the parents and provides greater awareness of how their differences can cause confusion in their child. It highlights the importance of two-parent consistency as a goal if the child is to achieve the comfort level necessary to abandon the disruptive behavior.

Structured Family Sessions

The classic Milan therapeutic interview format was divided into five segments: the presession, the session, the intersession, the intervention, and the postsession. Family therapy began with the initial telephone call from the family. A team member talked to the caller at length, recording relevant information. Intake issues were taken to the entire team in the presession to propose tentative *hypotheses* regarding the family's presenting problem.

Team conferences occurred before each session, as the group met to review the previous session and plan strategies for the upcoming one. These tactics affirmed the Milan belief that the family and therapist(s) are part of one system. During the session itself, a major break in the family interview (the intersession) occurred as the observer team had an active discussion with the therapist outside the family's hearing, during which hypotheses were validated or modified; the therapist then returned to offer the team's intervention (usually a prescription or ritual) to the family. The team's postsession discussion focused on an analysis of the family's reaction to the intervention and gave the therapists a chance to plan for the following session (Boscolo, Cecchin, Hoffman, & Penn, 1987).

LO 3 An Evolving Model: Hypothesizing, Neutrality, and Circular Questioning

The landmark paper, "Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session" (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980), introduced three new intervention strategies—hypothesizing, circularity, and neutrality—that are central to post-Milan technical innovations.

Hypothesizing, a continual interactive process of speculating and making assumptions about the family situation, guides the systemic interview. It is not true or false but rather a starting point, open to revision or abandonment by the family as well as the therapist as new data accumulate. The technique allows the therapist to search for new information, identify the connecting patterns that sustain family behavior, and speculate on how each participant in the family contributes to systemic functioning. See Box 11.7 for an example of forming an hypothesis about a symptom in family therapy.

Hypotheses formulated by the team typically are systemic or relational statements that link all family members and establish a circular structure regarding family rules and interactive behaviors. They help the team organize information from the family and begin to comprehend why the symptomatic behavior manifested itself in this family at this time. Hypotheses are constructed to elicit a picture of how the family organizes around the symptom or presenting problem. As Burbatti and Formenti (1988) contend, *the goal of therapeutic hypotheses is change, not truth*.

Another systemicist therapeutic stance—**neutrality**—means the therapist is interested in and accepts without challenge each member's unique *perception* of the problem. No one

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BOX 11.7 THERAPEUTIC ENCOUNTER

An Anorectic Adolescent and the Family Game

Consider the following hypothesis about how the symptom of anorexia might provide a clue about the family game:

A 13-year-old girl whose mother has recently returned to work goes on a diet to lose her "baby fat" and continues food refusal to the point of developing symptoms of anorexia. These symptoms and the resulting danger to the girl's health require that her mother leave her newly acquired job and become active in monitoring her daughter's eating habits. The father, who is 9 years older than the mother, encourages his wife in this diligent detective-like behavior.

When viewed within the context of this family's relationship pattern, the child's self-destructive behavior can be seen as an ingenious attempt, covertly supported by the father, to keep her mother dependent and tied into the role of wife and mother. Alternately it can be seen as supporting the mother's ambivalence regarding obtaining employment and her need to pull the father closer to home with worries. Finally, as Selvini-Palazzoli (1986) recently argued, the child's behavior may represent the culmination of concerted efforts among all family members to prove that competition leads nowhere.

Source: Gelcer, McCabe, and Smith-Resnick (1990), pp. 52–53.

family member's view is seen as more correct than that of any other. Thus, each family member may continually experience the therapist as being allied with one or another member as that person's views are elicited but never as allied with any one participant. To Milan therapists, neutrality refers to efforts to remain allied with all family members, avoiding getting caught up in family coalitions or alliances.

Circular questioning involves asking each family member questions that address a difference or define a relationship between two other members of the family. These differences are intended to reveal the multiple perspectives of different family members and to expose recursive family patterns. The therapist maps the interconnections among family members, assuming that asking questions about differences in perception is the most effective way of creating such a map (Campbell, Draper, & Crutchley, 1991). Asking a child to compare his mother's and father's reactions to his sister's refusal to eat or to rate each one's anger on a 10-point scale or to hypothesize what would happen if they divorced—these are all relatively benign ways to compel people to focus on differences. So each family member is continually exposed to feedback from others throughout therapy. As Selvini-Palazzoli, Boscolo, Cecchin, and Prata (1980) define it in their paper:

> By circularity, we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about differences and change. (p. 3)

A Post-Milan Systemic Epistemology

Boscolo and Cecchin continued to elaborate the systemic ideas first presented in the hypothesis-neutrality-circularity paper. Departing from strategic interviewing techniques,

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they developed a post-Milan collaborative therapeutic intervention style based on the interviewing process itself, particularly the use of circular questioning. By listening to the differing views of the same situation presented by various family members, each participant is helped to see his or her own behavior in a relational context rather than from a linear or narrow self-centered perspective. Their model aligns with contemporary constructivist and narrative approaches. Indeed, Boscolo and Cecchin claim that therapists do not have the answers but, together with the family, can co-construct or co-evolve new ways of looking at the family system, deconstructing old family assumptions and creating the possibility of new narratives or versions of reality that are less saturated with past problems or past failed solutions.



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Luigi Boscolo, M.D.

Reflexive Questioning

Karl Tomm (1987a, 1987b, 1988) adds "strategizing" to the original set of Milan techniques, calling for continuous "interventive interviewing." More than simply seeking workable interventions, Tomm (1987a) urges therapists to attend closely to the interviewing process, especially their own intentionality, adopting an orientation in which everything an interviewer does and says and does not do or say could be therapeutic, nontherapeutic, or countertherapeutic.

Tomm (1987b) refers to *reflexive questions*, which are designed to help families reflect on the meaning they extract from their current perceptions, actions, and belief systems, stimulating them to consider alternative constructive cognitions and behavior. Tomm differentiates eight groups of reflexive questions:

1. *Future-oriented questions* (designed to open up consideration of alternate behavior in the future) ("If the two of you got along better in the future, what would happen that isn't happening now?")
2. *Observer-perspective questions* (help people become self-observers) ("How do you feel when your wife and teenage son get into a quarrel?")
3. *Unexpected counterchange questions* (opening up possibilities of choices not previously considered by altering the context in which the behavior is viewed) ("What does it feel like when the two of you are not fighting?")
4. *Embedded suggestion questions* (therapist points in a useful direction) ("What would happen if you told her when you felt hurt or angry instead of withdrawing?")
5. *Normative-comparison questions* (suggesting problem is not abnormal) ("Have any of your friends recently dealt with the last child leaving home so that they would understand what you are going through now?")
6. *Distinction-clarifying questions* (separating the components of a behavior pattern) ("Which would be more important to you—showing your boss's ignorance or helping him so that the project can be successfully completed?")

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7. *Questions introducing hypotheses* (using tentative therapeutic hypotheses to generalize to outside behavior with others) ("You know how you become silent when you think your husband is angry with you? What would happen if next time you told him how you felt?")
8. *Process-interrupting questions* (creating a sudden shift in the therapeutic session) ("You just seemed to get quiet and upset, and I wonder if you thought I was siding with your wife?")

These questions permit strategic interventive interviewing through questions intended to help families break free of their current fixed ideas and achieve new meaning as they go about reorganizing their behavior.

As Tomm moved toward a social constructionist/narrative view (Collins & Tomm, 2009), he helped individuals and families bring out their *healthy interpersonal patterns (HIPS)* and replace *pathologizing interpersonal patterns (PIPS)*. To Tomm, it is the interaction pattern (e.g., domination and control vs. submission and compliance) that is contaminated in PIPS, not the persons who drifted into the habitual pattern. If HIPS open up space (welcoming others into one's life and nurturing the relationship), then PIPS close off growth, promote defensiveness, and cutoff relatedness. See Box 11.8: Thinking Like a Clinician to explore further HIPS, PIPS, and reflexive questioning.



BOX 11.8 THINKING LIKE A CLINICIAN

Exploring Interpersonal Patterns

Read the following clinical material. Indicate in the space provided three or more reflective questions. What attitudes do you bring to the picture, and how might they affect the family? Do you think they might be therapeutic, nontherapeutic, or countertherapeutic? Answer the questions that follow the dialogue.

Lisa and Cathy have been together for 15 years. Lisa is a veterinarian, and Cathy teaches part time at a nursery school. They share a home in an affluent neighborhood. They have always been financially comfortable. However, lately finances have become a problem. Unaccustomed to having to budget their money, they have been quarreling. Neither seems to understand the other's perspective. Fights about money have opened up other long-simmering issues between them.

LISA: I have always made more money than Cathy, and it has never been a problem. We shared everything and never worried about who made more than whom. Cathy seems to resent me when I tell her that we have to cut back.

CATHY: I understand that your practice isn't as successful now as it always was, but it will get better again. We have plenty of money saved, so I don't get the urgency. This just feels typically controlling of you. You have a problem, and I have to toe the line. (To the therapist): She is so controlling, and I am sick of it. You know, without telling me, she canceled our vacation.

LISA: No I didn't. I just canceled what we were going to do. I canceled our trip to Egypt and Greece, but I had no intention of canceling our vacation. I just wanted to plan a less expensive one. I had every intention of including you in the planning of where we could go instead.

CATHY: And you don't see the problem in that?

LISA: No, I put down the deposit on the trip, so I just canceled it.

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CATHY (IRONICALLY): So much for sharing everything.

LISA: Well, maybe we haven't shared everything. You always seem to like what I provide. You know, it's always been that way with you. I give and you take.

CATHY (ANGRY): Like I don't provide you with anything! You're crazy. Even though I don't earn what you do, I contribute a great deal to our relationship. I certainly hope that the stress of the situation is causing you to be so insulting, because if I thought you actually meant that I don't contribute, I'd be very hurt and very angry.

LISA (SOFTLY): Yes, you do contribute. I'm sorry. But through all the months that my business has been doing badly, you have not once asked me how I am feeling about it. And that's pretty typical, too. All you do is ask me what I am doing to improve it. Makes it sound like you care more about my income than about me.

CATHY: Of course I don't.

LISA: Then why haven't you asked? I feel like your employee.

CATHY: Well, you know, you haven't asked me how I feel about our situation. All you do is come home, drink I don't know how many glasses of white wine, and go to bed. You might as well be in Greece for all the time we spend together.

LISA: Here we go again. (To the therapist): Now she's going to tell you how I am never around. All I do is work. And how I love my work more than I love her. I am so bored with this. How do you think I made the money that I did?

CATHY: Give it a rest. I know you love your work more than you love me. I accepted that years ago. (To the therapist): Imagine loving a gerbil more than you love your partner of 15 years. What is wrong with me that I've been putting up with this for so long? I must have no self-esteem or something.

LISA: Or maybe you just don't mind being supported by someone who has a real job.

CATHY: If you say that again, I will walk out of this office.

LISA: Look, we're not getting anywhere. (To the therapist): Our fighting has gotten very bad lately. It's like this almost every day. I love Cathy very much, and I don't want to fight anymore. I know she loves me, too. I just don't know how to put together again the pieces of our lives. We can't let our relationship be dependent on changes in the stock market, for goodness' sake.

1. Identify the maladaptive interpersonal patterns shown in this dialogue.
2. Identify the healthy interpersonal patterns shown in this dialogue.
3. Review the questions you came up with and any other reactions you had while "listening," and create an intervention that might help Cathy and Lisa identify and seek alternatives to the maladaptive patterns you have identified.

LO 4 Effectiveness of Strategic Approaches

Is strategic therapy effective? Many advocates of this approach rely heavily on anecdotal case reports. In early studies (Watzlawick et al., 1974), a telephone follow-up at regular intervals after ending therapy found favorable results: 40% claimed complete symptom relief, 32% considerable relief, 28% no long-term help. Stanton and Todd (1982) offered a well-designed, controlled study in which structural-strategic techniques were employed for treating families with an adult member who engaged in heroin addiction; positive results were found in follow-ups. Stanton and Shadish (1997), in a comprehensive survey, found that structural-strategic family therapy produced more favorable outcomes than nonfamily-based interventions.

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BOX 11.9 CLINICAL NOTE

A Humanistic Set of Strategies?

Two approaches are less provoking or authoritarian forms of strategic family therapy. Madanes's (1981, 1984) pretend techniques are paradoxical but less confrontational than Haley's. Based on playfulness, humor, and fantasy, these gentler approaches have a therapist suggest, for example, that a symptomatic child (say, one who is a periodic bed wetter or has recurring stomachaches) "pretend" to have a symptom at this moment and that the parents "pretend" to help. In effect, the therapist is subtly asking the clients to voluntarily control behavior (by turning it on and off) that they regard as uncontrollable.

Today, strategic family therapists have moved away from power and control over families to a collaborative role in post-Milan systemic therapy (Rhodes, 2013). Keim (1999) demonstrates the effectiveness of this approach with families in which oppositional behavior in children or adolescents is the presenting problem. Calling it the "soft side" of hierarchy, Keim directs parents to retain authority while avoiding power struggles in the family. Parents are helped to create a more satisfying system of positive and negative consequences with their children. Children, feeling better understood, are helped to achieve an emotional state of safety to discuss their problems within the family.

The strategic approach has been shown to be an effective way to reduce avoidance symptoms resulting from posttraumatic stress disorder (Sautter et al., 2009). Powell and Ladd (2010) have shown the efficacy of strategic/structural family therapy for mediating the aggressive tendencies in adolescents leading to bullying behavior. They note that this therapy helps decrease the negative communication patterns within the family as well as increase their conflict resolution techniques.

One related clinical model with substantial research support is brief strategic family therapy (BSFT). It incorporates elements of both strategic and structural family therapy under the goal of changing "the patterns of family interactions that allow or encourage problematic adolescent behavior" (Szapocznik et al., 2015, p. 122). Across 40 years of research, BSFT has demonstrated efficacy in lowering adolescent problem behavior and substance abuse and enhancing family functioning; success in engaging and retaining families in therapy; effectiveness in community settings; and improving adolescent and family outcomes (Szapocznik et al., 2015). Initially focused on Hispanic families, the approach is effective with African-American and White-American families as well (Robbins, Feaster, Horigan, Rohrbaugh, et al., 2011).

SUMMARY

Communication theories emerged from the Mental Research Institute in Palo Alto in the 1950s to impact the family therapy field by recasting human problems as interactional and situational (tied to a set of circumstances that maintains them). This epistemology by Bateson, Jackson, and others laid the foundation for the original interactive therapeutic approach, now conceived as strategic family therapy. It is known for using therapeutic double binds or paradoxical techniques to change family rules and relationship patterns.

Paradoxes—contradictions that follow correct deductions from consistent premises—are used

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therapeutically to direct an individual or family not to change in a context that carries with it the expectation of change. The procedure promotes change no matter which action—compliance or resistance—is undertaken. "Prescribing the symptom" is a paradoxical technique for undermining resistance to change by rendering it unnecessary.

The interactional view of the MRI is today best exemplified by its Brief Therapy Center activities. Here, the flawed or misguided solutions attempted by families are considered to be the problem, and interventions are directed at treating those previously failed solutions by offering novel, therapist-designed directives.

Haley and Madanes offer a related version of strategic family therapy. Their approach is characterized by carefully planned tactics and directives for solving a family's presenting problems. Haley in particular uses straightforward directives or task assignments as well as indirect paradoxical interventions; the latter force the willing abandonment of dysfunctional behavior as the family defies the directive not to change.

Madanes employs paradoxical principles in the form of "pretend" techniques, nonconfrontational interventions directed at achieving change without inviting resistance. Strategic therapists now take a softer, more soothing approach, as in the case of working with families in which there is oppositional behavior in children or adolescents.

The Milan team practices systemic family therapy, an outlook based on Bateson's circular epistemology. Their approach included many innovative interviewing techniques aimed at counteracting sustained and entrenched family games. Initially emphasizing paradoxical therapeutic measures, the Milan approach later introduced hypothesizing, circular questioning, and therapist neutrality as guidelines for conducting sessions, helping each family member become exposed to information about the perceptions of the other members, and interrupting destructive family interactive patterns. Positive connotations and the use of prescribed rituals are other Milan therapeutic trademarks.

Boscolo and Cecchin have been influential in stimulating interest in second-order cybernetic ideas, developing a post-Milan view that has influenced postmodern therapy. Tomm elaborated on the thinking of Boscolo and Cecchin, cataloguing sets of circular questions aimed at encouraging families to reflect on the meaning of their life patterns in an effort to trigger families to consider new cognitive and behavioral options.

The notion that the therapist as observer is part of what is being observed—and thus is inescapably a part of the system to which he or she is offering therapy—redefines the therapist as someone who, like the other participants, has a particular perspective but not a truly objective view of the family or what's best for it. One consequence of this thinking is to take "truth" away from the therapist and make goal setting a participatory process that therapist and family members engage in together.

RECOMMENDED READINGS

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12

Behavioral and Cognitive-Behavioral Models

LEARNING OBJECTIVES

- LO 1 Describe how behavioral family therapists attempt to bring the scientific method to bear on the therapeutic process
- LO 2 Explain how principles of social learning theory and social exchange theory are applied to family therapy
- LO 3 Identify some characteristics of stable marriages
- LO 4 Explain how functional family therapists view behavior as they attempt to integrate systems, behavioral and cognitive theory in families
- LO 5 Describe some feminist critiques of sex therapy

Behavioral and cognitive-behavioral psychotherapeutic models have been applied to family therapy only in the last 30 or so years. Therapeutic behavioral methods with individuals, however, go back to the 1960s, when a movement began to bring the scientific method to bear upon the psychotherapeutic process. **Cognitive** therapies, applied to families, were an expansion of behavioral approaches to couples in conflict (Dattilio, 2010).

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LO 1 Behavioral Therapy and Family Systems

Early efforts to modify behavior involved the application of learning theory and other experimentally based principles to changing undesired client behavior. In initial formulations, family members when considered at all were assumed to be a part of the client's natural environment. In seeking ways to extinguish the client's problematic or maladaptive behavior, the therapist observed the manner in which family members stimulated or aroused that behavior in the client. While it was assumed that modifying an individual's deviant behavior necessitated changing the behavior of key family members, therapeutic intervention directed at the family as a whole was rarely attempted.

Leading Figures

Three pioneers in behavior therapy came from related disciplines—social worker Richard Stuart (1969), psychologist Gerald Patterson (1971), and psychiatrist Robert Liberman (1970). They addressed specific behavioral problems in families (poor communication between spouses, acting-out behavior in children and adolescents), identified in a family assessment process, not comprehensive family dynamics (Sanders & Dadds, 1993). Limiting their therapeutic efforts to observable behavior, without inferring intrapsychic or interpersonal causality, these therapists attempted to extinguish or otherwise manipulate certain targeted behaviors by means of reinforcements. **Reinforcements** are the consequences immediately following and contingent upon a given behavior.

As Falloon (1991) illustrates, they assumed a child's deviant behavioral patterns resulted at least in part from the reinforcement provided by other family members. Therapeutic efforts were individually focused, but the behavior therapist simultaneously instructed key family members on how best to change or modify their behavior so they would not sustain the client's deviant behavior. Patterson (Forgatch & Patterson, 2010) developed **behavioral parent training** that clinically adapted learning principles from the laboratory to modify the behavior of a multiple-problem child as well as the reinforcing responses of his parents. Patterson's sessions often occurred in the clients' homes.

Adopting a Family Framework

Behavior therapists working with couples or families kept the role as teacher, coach, or model, as well as intervention procedures directed at imparting skills (like problem solving or communication) involving the mutual exchange of positive behavior, thus altering earlier maladaptive patterns. Liberman (1970) and Stuart (1969), working independently, were early proponents of **behavioral couples therapy**. Based on **operant conditioning**, it relied on the Skinnerian principle that certain voluntarily emitted responses can be strengthened by selectively rewarding or reinforcing those responses, so that in the future they will occur more frequently than other responses that have not been rewarded.

Liberman, at UCLA, also pioneered a psychoeducational approach to working with families with mentally disordered members. Stuart, working primarily with distressed couples, offered a **contingency contract**, a written schedule describing the terms for the exchange of mutually reinforcing behaviors between individuals in a family, aimed at reducing undesired

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or problematic behavioral exchanges. Other early behavioral therapists, such as Joseph Wolpe (1958), advanced a set of desensitization techniques based upon the earlier **classical conditioning** laboratory studies of Ivan Pavlov and John Watson. Box 12.1 lists the major assumptions of behavior therapy.

The Rise of Cognitive-Behavioral Therapy with Families

By the late 1970s some behaviorists began to acknowledge that cognitive factors (attitudes, thoughts, beliefs, attributions, expectations) also influence behavior, introducing an auxiliary cognitive component to supplement the main behavioral treatment, especially with couples in conflict. Since that breakthrough, **cognitive-behavioral therapy**, emphasizing the importance of cognitive and behavior interactions among family members, has been embraced by many family therapists, in no small part because of its empirically supported, research-based effectiveness (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Today, cognitive-behavior couples therapy has been the focus of more controlled outcome studies than any other therapeutic modality (Dattilio & Epstein, 2005).



BOX 12.1 CLINICAL NOTE

Ten Underlying Assumptions of Behavioral Therapy

1. All behavior, normal and abnormal, is acquired and maintained in identical ways (i.e., according to the same principles of learning).
2. Behavior disorders represent learned maladaptive patterns that need not presume some inferred underlying cause or unseen motive.
3. Maladaptive behavior, such as symptoms, is itself the disorder rather than a manifestation of a more basic underlying disorder or disease process.
4. It is not essential to discover the exact situation or set of circumstances in which the disorder was learned; these circumstances are usually irretrievable anyway. Rather, the focus should be on assessing the current determinants that support and maintain the undesired behavior.
5. Maladaptive behavior, having been learned, can be extinguished (i.e., unlearned) and replaced by new learned behavior patterns.
6. Treatment involves the application of the experimental findings of scientific psychology, with an emphasis on developing a methodology that is precisely specified, objectively evaluated, and easily replicated.
7. Assessment is an ongoing part of treatment, as the effectiveness of treatment is continuously evaluated and specific intervention techniques are individually tailored to specific problems.
8. Behavioral therapy concentrates on "here-and-now" problems, rather than uncovering or attempting to reconstruct the past. The therapist is interested in helping the client identify and change current environmental stimuli that reinforce the undesired behavior in order to alter the client's behavior.
9. Treatment outcomes are evaluated in terms of measurable changes.
10. Research on specific therapeutic techniques is continuously carried out by behavioral therapists.

Source: Goldenberg (1983), p. 221.

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Leading Figures: Ellis and Beck Applied to Families

Albert Ellis, a New York psychologist, and Aaron Beck, a psychiatrist in Philadelphia, are generally considered to have offered the earliest cognitive slants on intimate couple relationships. According to Ellis's (2014) A-B-C theory of dysfunctional behavior, it is not the activating events (A) of people's lives that have disturbing consequences (C), but the unrealistic interpretation they give to the events, or the irrational beliefs (B) about what has taken place that cause them trouble. For example, a partner might have unrealistic expectations about a relationship, "catastrophizing" a commonplace disagreement and making negative evaluations ("I am worthless, a failure") afterward. Ellis suggested it is not the quarrel per se but the exaggerated, illogical, or otherwise flawed interpretation that causes havoc and leads to negative views of oneself or the future of the relationship. He contended that **cognitive restructuring** would help the client modify her perceptions and allow her to produce new self-statements ("It's upsetting that we don't agree, but that doesn't mean I'm a failure as a person or that our marriage is doomed").

Beck's viewpoint is more expansive, attending in greater depth to family interactive patterns. Family relationships, cognitions, emotions, and interactive behavior are all seen as mutually influencing one another; thus, Beck's view is more consistent with the systems perspective (Dattilio, 2001). Beck conducted research with depressed patients, in which he concluded that they felt as they did because they committed characteristic *errors of thinking* (negative thoughts about themselves, the world, the future). Beck (1976) hypothesized that earlier in life, these depressed people had, through various unfortunate personal and interpersonal experiences, acquired negative **schemas** (enduring sets of core beliefs and attitudes about people, relationships, and so on that organize subsequent thoughts and perceptions) that are reactivated when a new situation arises that resembles, in their thinking, conditions similar to those under which the schema was learned. Cognitive distortions follow, leading to a misperception of reality. Beck's therapeutic efforts were then directed at providing patients with experiences, both during therapy sessions and outside the consultation room, that disconfirm negative conclusions (such automatic thoughts as "Our marriage is hopeless"; "I'm to blame") and attempt to alter negative schemas. Beyond changing current distorted beliefs, Beck advocated that therapist and client work together to teach the client new methods he or she can use in the future for evaluating other beliefs, all leading to changing dysfunctional behaviors.

Applying Beck's theory to families, each member's set of schemas includes attributions about why certain events occurred in the family, how the spousal relationship should operate, what types of problems to expect in a marriage, what responsibilities each family member should have, how best to raise children, and similar cognitions about family life (Schwebel & Fine, 1994). These schemata influence how each person thinks, feels, and behaves within the family. Family schemas are shared beliefs about what is occurring within the family and of course are open to errors, distortions, and omissions impacting how family members respond, emotionally and behaviorally, to one another. Therapeutically, the task becomes helping families restructure the family's dysfunctional beliefs and, as a consequence, helping alter their behavioral patterns.

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Many of the initial ideas from Ellis's rational-emotive therapy and Beck's cognitive therapy were considered too simplistic by family therapists when compared to the more complex systems theory then at the height of its popularity, so they received little attention. But over time, due to systems-friendly research on the role of the partners' perceptions, thoughts, and expectations regarding each other's actions, cognitive interventions in marital and family therapy gained a foothold. Today's major figures include Frank Dattilio (2010) at the University of Pennsylvania School of Medicine and Harvard Medical School, Norman Epstein (Epstein & Falconier, 2015) at the University of Maryland, Donald Baucom at the University of North Carolina (Baucom & Boeding, 2013), and Brian Doss at the University of Miami. Cognitive theory and research has made its strongest contribution in marital or couples therapy (Epstein & Falconier, 2015).

The Cognitive-Behavioral Outlook

Cognitive-behaviorists understand personal functioning to be the result of continuous, reciprocal interaction between behavior and its controlling social conditions, emphasizing the importance of *self-regulation* and *self-direction* in altering behavior. Cognitive-behavioral therapy attempts to modify thoughts and actions by influencing an individual's conscious patterns of thoughts. Gambrill (1994) defines behavioral practice as "an empirical approach to personal and social problems in which the selection of assessment and intervention methods is based whenever possible on related research" (p. 32). The unique contribution of this approach, then, lies not in its conceptualizations of psychopathology or adherence to a particular theory or underlying set of principles or even to a unique set of interventions but in its insistence on a rigorous, data-based set of procedures and a regularly monitored scientific methodology.

Although the cognitive-behavioral viewpoint focuses on the identified patient as the person having the problem and in that sense remains linear, some former behaviorally oriented therapists (Alexander, Waldron, Robbins, & Neeb, 2013; Christensen, Doss, & Jacobsen, 2014) accommodate a systems/behavioral/cognitive perspective. Most cognitive-behavioral family therapists today continue to view family interactions as maintained by environmental events preceding and following each member's behavior. These events or contingencies, together with mediating cognitions, are what determine the form as well as the frequency of each family member's behavior (Epstein & Falconier, 2015).

The Key Role of Assessment

Behavioral and cognitive-behavioral family therapists strive for precision in identifying a problem, employ quantification to measure change, and conduct further research to validate their results. They design programs that emphasize a careful assessment of the presenting problem (a **behavioral analysis** of the family's difficulties) and include some direct and pragmatic treatment techniques to alleviate symptoms and teach the family how to improve its skills in communication and self-management (Beck & Weishaar, 2014).

A Behavioral Assessment

Falloon (1991) suggests that a behavioral assessment of family functioning typically occurs at two levels: (1) a **problem analysis** that seeks to pinpoint the specific behavioral deficits

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underlying the problem areas that, if modified, would lead to problem resolution. For instance, in a distraught family in which the presenting problem is a 4-year-old boy's "temper tantrums," the behavioral therapist might want to know exactly what the family means by "tantrums," as well as the frequency and duration of such behavior and (2) a **functional analysis** directed at uncovering the interrelationships between those behavioral deficits and the interpersonal environment in which they are functionally relevant. Continuing the temper tantrum example, the interviewer identifies the specific responses to the behavior by various family members and especially the antecedent and consequent events associated with these outbursts. This gauges the extent of the problem and the environmental factors (such as the presence of a particular family member, a particular cue such as parents announcing bedtime, a particular time and place such as dinnertime at home) that maintain the problematic behavior. Environmental circumstances are crucial, since the behavioral therapist believes that all behavior (desirable and undesirable) is maintained by its consequences.

The therapist is interested not only in altering the environmental conditions that oppose or impede positive family interaction but also in training family members to maintain the improved behavior. The individual or family is not necessarily helped to gain insight into the origin of current problems. Instead, emphasis is placed on the environmental, situational, and social determinants that influence behavior (Kazdin, 2013).

A Cognitive-Behavioral Assessment

Cognitive-behavioral therapists who work with families, by contrast, include a functional analysis of *inner experiences*—thoughts, attitudes, expectations, beliefs. More systemic, they see individuals as interactive participants, interpreting, judging, and influencing each other's behaviors. Typically, they gather such data using three main forms of clinical assessment: self-report questionnaires, individual and joint interviews, and direct behavioral observations of family interaction (Epstein & Baucom, 2002). A typical assessment may start with a joint interview with both partners, listening to how each conceptualizes the presenting problem (Bevilacqua & Dattilio, 2010). As an example of a family self-report, parents complaining about their child's resistance to a bedtime schedule might be asked to keep logs at home, monitoring and recording specific acts and their specific responses ("For the last four nights, our 8-year-old has gone from one of us to the other until his father finally agrees he can stay up past his bedtime and watch the TV program"). In the case of adult relationship problems, tests are employed. Eidelson and Epstein's (1982) Relationship Belief Inventory, for example, assesses unrealistic beliefs about close relationships. Fincham and Bradbury's (1992) Relationship Attribution Measure assesses inferences about the cause of events in a relationship, such as one partner's perceived overcriticalness of the other partner (Dattilio, Epstein, & Baucom, 1998). Individual visits with each partner may review his or her responses to the measures before conjoint sessions commence.

Interview-based data may reveal automatic thoughts/beliefs ("He avoids talking to me at night"), *expectancies* ("I hate to make plans with friends because he's always late"), or *attributions* ("The reason he acts as he does is because he doesn't care about my feelings") as clients report upsetting experiences with one another. Direct observation of couples, for example, might focus on communication skill deficits as they are directed to plan a night out away from the children

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or their inadequate negotiation skills as their failure to compromise escalates conflict. On the other hand, when asked to solve a problem together in the therapist's office, they may discover previously untapped problem-solving skills. Structured tasks (e.g., role playing an adolescent's request for a later curfew) are often used by cognitive-behavioral therapists to check on progress toward desired changes in targeted behaviors (Epstein, Schlesinger, & Dryden, 1988). Box 12.2 offers various types of cognitive distortions frequently found among couples.

Behaviorally Influenced Forms of Family Therapy

The behaviorally oriented family therapist is more likely than many systems-based family therapists to use distinct clinical procedures (such as skills training) and not to insist on participation of the entire family. Sometimes family sessions occur when individual procedures fail or when behavioral observation suggests that family members contribute to the individual's symptomatic behavior. The family is excused after that phase of therapy, and the therapist continues to implement individually oriented procedures.

Extended family members are far less likely to be involved in behavioral therapy. In general, behavioral family therapists view the family as burdened by the patient or perhaps as unwittingly responding in ways that support and maintain his or her problem behavior, while most systems-oriented family therapists assume that family involvement is always present and plays an active part in symptom maintenance (Todd, 1988).



BOX 12.2 CLINICAL NOTE

Some Common Cognitive Distortions among Couples

ARBITRARY INFERENCES: Conclusions drawn in the absence of supporting substantiating evidence. ("She's late returning from work. She must be having an affair.")

SELECTIVE ABSTRACTIONS: Information taken out of context, highlighting certain details and ignoring others. ("He didn't say good morning when we woke up. He must be angry.")

OVERGENERALIZATION: An isolated incident or two is allowed to serve as representative of all similar situations, related or not. ("She turned me down for a date Saturday night. I'll always be rejected.")

MAGNIFICATION AND MINIMIZATION: A case or circumstance is perceived in a greater or lesser light than is appropriate. ("Our checkbook is out of balance. We're financially ruined.")

DICHOTOMOUS THINKING: Experiences are codified as complete successes or complete failures. (A husband asks his wife how his paperhanging job is going. She questions the smoothness of one seam, to which he replies, "I can't do anything right in your eyes.")

MIND READING: Knowing what the other is thinking without asking and, as a consequence, ascribing unworthy intentions to the other. ("I know what's going on in her mind. She's trying to figure out a way to dump me.")

BIASED EXPLANATIONS: A suspicious type of thinking about a partner, especially during times of interpersonal stress, assuming his or her negative intent. ("He's acting real 'lovey-dovey' because later he'll ask me to do something he knows I hate to do.")

Source: Adapted from Bevilacqua and Dattilio (2010).

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As noted earlier, strictly behavioral family therapists tend to adopt a linear rather than the circular outlook on causality held by most system-oriented therapists. For instance, a parent's inappropriate, inconsistent, or otherwise flawed response to a temper tantrum is believed to cause as well as maintain a child's behavioral problem (contrary to the more commonly held systems view among family therapists that the tantrum constitutes an interaction, including an exchange of feedback information, occurring within the family system). Predictably, the behavioral family therapist is likely to aim at changing dyadic interactions (e.g., a mother's way of dealing with her child's having a tantrum) rather than adopting the triadic view more characteristic of systems-oriented family therapists, in which the participants in any exchange are simultaneously reacting to other family transactions (e.g., a mother who feels neglected by her husband and who attends too closely to the slightest whims of her child; a father who resents his wife taking so much attention away from him in order to interact with their son).

While some of the leading behavioral family therapists do view the family as a social system (whose members exercise mutual control over one another's social reinforcement schedules), others remain far from convinced. Gordon and Davidson (1981), for example, acknowledge that in some cases, a strained marital relationship may contribute to the development and/or maintenance of deviant child behavior (or vice versa), but they argue that systems theorists have exaggerated the prevalence of the phenomenon. Their experiences lead them to conclude that deviant child behavior may occur in families with and without marital discord; they state, "the simple presence of marital discord in these families may or may not be causally related to the child's problems" (p. 522).

LO 2 Behavioral Couples Therapy

Early behavioral therapists began to apply the model to couple discord. Robert Liberman and Richard Stuart separately offered straightforward, step-by-step sets of interventions in which operant conditioning principles were applied to distressed marital relationships,

BOX 12.3 CLINICAL NOTE

Some Characteristics of Behavioral Family Therapies

The work of behavioral family therapists (including cognitive-behaviorists) has several characteristics that distinguish it from the approaches taken by the systems-oriented family therapists we have considered:

- A direct focus on observable behavior, such as symptoms, rather than an effort to hypothesize causality interpersonally
- A careful, ongoing assessment of the specific, usually overt behavior to be altered
- A concern with either increasing (accelerating) or decreasing (decelerating) targeted behavior by directly manipulating external contingencies of reinforcement
- A striving to teach and coach communication and problem-solving skills
- An effort to train families to monitor and modify their own reinforcement contingencies
- A standard of empirically evaluating the effects of therapeutic interventions

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Ventura County Reporter

Robert Liberman, M.D.

effectively increasing partner satisfaction and relationship stability in many cases. From its inception, the basic premise of behavioral marital therapy (BMT, now renamed behavioral couples therapy) has been that the behavior of both partners in a marital relationship is shaped, strengthened, weakened, and modified by environmental events, especially those events involving the other spouse (Holtzworth-Munroe & Jacobson, 1991, p. 97).

MANIPULATING THE CONTINGENCIES OF REINFORCEMENT

Liberman (1970) began with a behavioral analysis, asking such questions as "What behaviors would each like to see changed in themselves or their partners?" or "What interpersonal contingencies currently support the problematic behavior?" He then attempted to restructure the reciprocal exchange of rewards between the partners by increasing certain target behaviors and decreasing others by directly manipulating the external contingencies of reinforcement. The couple was expected to monitor and modify their own reinforcement contingencies. Liberman's goals were simple and straightforward and, especially in their early form, focused strictly on behavior change: increase pleasing interactions and decrease aversive interactions.

Stuart (1969) developed a set of therapeutic procedures he called **operant interpersonal therapy**, especially the use of contingency contracting, to try to get couples to maximize the exchange of positive behaviors. He argued that successful marriages could be differentiated from unsuccessful ones by the frequency and range of reciprocal positive reinforcements the partners exchange ("I'll be glad to entertain your parents this weekend if you accompany me to the baseball game [or ballet performance] next month"). Although this technique today is considered by most family therapists to be an oversimplified, heavy-handed, and mechanical approach to a complex marital exchange, Stuart was blending Skinner's operant learning principles with *social exchange theory* (Thibaut & Kelley, 1959). Relationship satisfaction was recast as reward–cost ratios: If missing but potentially rewarding events can be identified and maximized and displeasing events occurring in excess can be identified and minimized, then the reward–cost ratio should increase greatly, and each partner should not only feel more satisfied but also be more willing to provide more rewards for the other partner. Stuart had each partner record the number of instances and the type of caring behavior he or she offers each day. Table 12.1 describes such "caring days" requests.

FROM REINFORCEMENTS TO SKILL BUILDING

Communication/problem-solving training was subsequently added to help couples negotiate conflict resolutions in noncoercive ways, creating positive relationship changes. In some cases, **therapeutic contracts**—written agreements between spouses stipulating specific behavioral changes—were negotiated. Here, each spouse explicitly states the behavior he or she wants increased, avoiding the all-too-familiar marital plea for mind reading: "If you really loved me, you'd know what I want."

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TABLE 12.1 A sample request list for caring days

In *Helping Couples Change*, Stuart (1980) described criteria for the "caring days" technique for building commitment in a faltering marriage: (1) they must be positive ("Please ask how I spent my day" rather than "Don't ignore me so much"); (2) they must be specific ("Come home at 6:00 p.m. for dinner" rather than "Show consideration for your family"); (3) they must be small instances of behavior that can be demonstrated at least once daily ("Please line up the children's bikes along the back wall of the garage when you get home" rather than "Please train the children to keep their bikes in the proper place"); and (4) they must not have been the subject of recent intense conflict (since neither spouse is likely to concede major points at this stage of treatment).

Partner 1	Partner 2
• Don't use the Internet so much when I am home. • Tell me that you love me. • Ask me if you can pick up some items for me when you go to the store. • Let me use the remote for the television. • Give me a massage. • Offer to pick up the kids from school when you're coming home early. • Tell me that you think I am sexy. • Appreciate that I need to spend time with my parents as they get older. • Don't always leave it to me to organize our social life. Come up with a surprise activity for us. • Snuggle with me after we make love. • Remember my birthday and our anniversary. • Appreciate my political views. • Bring me flowers every now and then. • Kiss me before you leave the house.	• Understand that I need some "alone time" every so often. • Ask me if I might like something to eat or drink when you're heading into the kitchen to get something for yourself. • It would be great if we didn't always have to attend romantic movies. Sometimes I'd like to see other kinds of movies with you. • Discipline the kids yourself without always sending them to me. • Experiment with me with our sex life. • Hold me when you see I am upset. • Ask me with interest about my day at work. • Make my favorite dinner. • Do the dishes. • Don't leave your piles of things all over the house.

The agreement developed by Stuart (1980) in Table 12.2 offers each partner a range of constructive choices, any one of which can satisfy their reciprocal obligations. By avoiding the expectation that reciprocation should be forthcoming immediately ("I'll do this if you do that"), a contract increases the likelihood of spontaneous reciprocation. Stated briefly, the interplay of any couple's behavior is often overlooked (Atkins, Dimidjian, & Christensen, 2003).

Critics of BMT charged that some of its assumptions were too simplistic: that both partners will not resist change but will follow the therapist's suggestions; that a focus on overt behavior change is sufficient, without attending to underlying perceptual processes and interpersonal conflicts; that disharmony derives from the same sources, such as insufficient reciprocity, throughout the relationship life cycle; that displeasing behavior, such as anger, should simply be held in check without exploring the covert reasons for conflict; that the couple–therapist relationship can be ignored (Gurman & Knudson, 1978).

Increasingly based on **social learning theory** (learning that occurs due to interaction with other people) as well as behavioral-exchange principles, behavioral couples therapy became less technological and more flexible. Therapists such as Jacobson and Margolin (1979) aimed to reduce problems by teaching couples more effective problem-solving skills in two phases. First is *problem definition*, learning how to state problems in clear, specific, nonblaming ways

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TABLE 12.2 A holistic therapeutic marital contract

It is understood that Jane would like Sam to:	It is also understood that Sam would like Jane to:
wash the dishes; mow the lawn; initiate lovemaking; take responsibility for balancing their checkbooks; invite his business partners for dinner once every 6 or 8 weeks; meet her at his store for lunch at least once a week.	have dinner ready by 6:30 nightly; weed the rose garden; bathe every night and come to bed by 10:30; call him at the office daily; plan an evening out alone for both of them at least once every 2 weeks; offer to drive the children to their soccer practice and swim meets; accompany him on occasional fishing trips.

Source: Stuart (1980), p. 248.

and learning to acknowledge one's own role in creating or perpetuating the problem. During this phase, a partner also learns how to paraphrase the other's view, even if it is inconsistent with one's own. The second phase leads to *problem resolution*. During this phase, couples or family members brainstorm solutions together and learn to negotiate compromises (which later may be put in writing). Rather than the accusatory "You don't love me anymore," the therapists suggest that couples use a more concrete, less provocative, and more self-revealing statement, "When you let a week go by without initiating sex, I feel rejected" (Jacobson & Margolin, 1979, p. 230).

Recognizing that behavior changes will lead to greater marital satisfaction, behavioral couples therapy attempts to change behavior in two ways: (a) by encouraging partners to define the specific behaviors they wish their partners to exhibit, then instructing them in how to increase the frequency of those behaviors and (b) by teaching couples communication and problem-solving skills so that they can produce those changes (Eldridge, Christensen, & Jacobson, 1999).

Broadening the Outlook: The Cognitive Perspective

Proponents of cognitive-behavioral therapy argue that distress and conflict in a relationship are influenced by an interaction of cognitive, behavioral, and affective factors and that a strictly behavioral approach is too linear and does not fully address such complex interplay (Fischer, Baucom, Hahlweg, & Epstein, 2014). They contend that behavior change alone is insufficient to achieve permanent conflict resolution between partners, particularly if that conflict is intense and ongoing. To resolve escalating antagonistic and provocative behavior between them, couples need to acquire skills for recognizing and defining problems clearly, identifying mutually acceptable problem-solving strategies, and implementing these solutions quickly and effectively (Dattilio, 2010).

Cognitive-behavioral family therapy is directed at restructuring distorted beliefs (schemas) learned early in life from the family of origin, cultural traditions, the mass media, and relationship experiences. In turn, these schemas affect automatic thoughts and emotional responses to others (Dattilio & Epstein, 2003). Partners also develop schemas specific to their current relationship. Working with the couple, cognitive therapists try to modify each person's

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BOX 12.4 CLINICAL NOTE

Homework Assignments as Therapeutic Aids

Many couple and family therapists assign tasks to be performed outside the consultation room and then discussed at the following session. Cognitive-behaviorists in particular use such techniques in an effort to keep the therapy session alive during the time between meetings, making therapy a 24-hour experience and part of daily living. Actually changing undesired behavior or thoughts replaces simply talking about doing so during the therapy session or trying to recollect each time what was discussed at the previous session. Bevilacqua and Dattilio (2010) and Schultheis, O'Hanlon, O'Hanlon, and Schultheis (2010) have provided useful brief family therapy homework planners.

Homework assignments may take various forms:

1. Assigned readings (e.g., Markman, Stanley, & Blumberg's *Fighting for Your Marriage*, 2010)
2. Audiotaping and especially videotaping of sessions, to be played back at home for a review of the interactions that occurred during the session
3. Trying out unfamiliar activities together in order to observe the couple's interactions and learn improved ways of dealing with one another
4. Practicing techniques (assertiveness exercises, pleasing behaviors) learned during therapy to alter undesired behavior

unrealistic expectations about what they should expect from the relationship and teach them how to decrease destructive interactions. Distortions in evaluating experiences derived from negative automatic thoughts that flash through one's mind ("I notice her looking at other men whenever we go out; she must be thinking she'd be better off with someone else") are labeled as beliefs that are *arbitrary inferences* in the absence of supporting evidence. Sometimes such automatic thoughts, which couples are taught to monitor, may take the form of *overgeneralizations* (the partner who forgets to do a chore is labeled as "totally undependable"). In other cases, *selective abstractions* may occur ("You're good at finding the one thing I forgot to do, but you never seem to notice the things around here that I do"). By identifying and exposing each partner's underlying schema about themselves, their partner, and the relationship, the therapist helps the couple work together to lessen the distress they are experiencing (Fischer, Baucom, Hahlweg, & Epstein, 2014). Often "homework" assignments are made by the therapist (see box 12.4), focused on decreasing specific negative behaviors by substituting specific positive behaviors each partner stipulates as desirable in the other and reviewing the performance of each partner at the next therapy session (Kazantzis & Dattilio, 2010).

Integrative Couples Therapy

Neil Jacobson (at the University of Washington) and UCLA's Andrew Christensen (Christensen, Doss, & Jacobson, 2014; Jacobson & Christensen, 1996) developed behaviorally based therapeutic strategies to promote more accommodating and collaborative attitudes—"partner acceptance"—in addition to traditional techniques for helping couples attain positive behavior change.

In this eclectic approach, strategic techniques (reframing) and humanistic/experiential techniques (empathic joining of the couple around the problem, self-care) are added to the

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more traditional behavioral methods (use of assessment instruments, therapist modeling, behavioral exchange interventions, communication/problem-solving training) to promote intimacy and understanding in place of anger and blame (Christensen, Doss, & Jacobsen, 2014). These techniques are directed at overcoming each participant's tendency to see the problem between them coming from the other person and subsequently attempting (unsuccessfully) to change that person's behavior where changes are not feasible. Instead, **integrative couples therapy** delineates various procedures to help couples see differences between them as inevitable while helping them foster tolerance concerning perceived negative behaviors in a partner and to accept minor incompatibilities. By acknowledging each other's emotional vulnerabilities and personality differences, they contend that couples have taken a large step toward active acceptance of each other's feelings and actions and have moved away from blaming each other and toward *reconcilable differences*. This therapeutic approach promotes both acceptance and change (Christensen, Doss, & Jacobson, 2014).

Integrative couples therapy retains a traditional behavioral emphasis on the functional analysis and external determinants of behavior, but it is considered part of the **"third wave" of behavioral therapy** because of its additional emphasis on acceptance, affect, and mindfulness (Christensen, Dimidjian, & Martell, 2015). Earlier approaches focused on achieving *change*, because excesses or deficits in the behavior of one partner were considered to be the causes of distress in the other. Therapy was directed at helping couples change the *rules* of their behavior (e.g., the husband learns to kiss his wife upon arriving home because the therapist instructed him to increase positive behaviors leading to the wife's greater satisfaction).

Unfortunately, the underlying *theme of the problem*—for example, that he still "doesn't get it" about being generally more attentive and caring and that she finds that intolerable—isn't addressed. In other cases, the rule-governed behavior feels fake or contrived or insincere, so it backfires and is abandoned. Rule-governed processes may lead to change, argue these therapists, but additional strategies are needed when the couples are unable or unwilling to make the changes the other desires.

Emotional acceptance refers to situations in which behavior change either fails to occur or else occurs but not to the extent the partner would like. Instead of demanding more of what was deemed insufficient (or less of what was excessive), here the partners are urged to alter their reactions to the behavior previously seen as intolerable or unacceptable in their partner. In effect, partners learn to *balance change with acceptance* of those behaviors not open to change. Acceptance may be enhanced in two ways: (a) by experiencing the problem in a new way, say as a common enemy (from joint empathic understanding of the problem or perhaps from detachment from the problem so it becomes less offensive) or (b) by reducing the aversiveness of the partner's actions, either through greater tolerance of those actions or through the increased ability to take care of oneself when confronted with the partner's negative behaviors (Christensen, Dimidjian, & Martell, 2015). The partner may still not like the behavior or wish it were different, but nevertheless learn to consider it a part of the package of appealing and bothersome qualities in their mate. In effect, instead of requiring change of aversive behavior in order to achieve relationship satisfaction, this approach also fosters acceptance of that behavior where change is unattainable (Christensen, Doss, & Jacobson, 2014).

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LO 3 The Gottman Method



John Gottman

John Gottman, Ph.D. & Julie Schwartz Gottman, Ph.D.

John Gottman, a prolific marriage researcher, has been especially active in developing a scientific basis for helping couples in conflict (Gottman, 2011). Professor emeritus at the University of Washington and cofounder (with his wife Julie Schwartz Gottman) of the Gottman Institute in Seattle, he focuses on marital stability and divorce prediction.

Gottman (2011) describes marital interactive processes that discriminate between happily married and unhappily married couples. His work includes both heterosexual and homosexual couples (Gottman et al., 2003). Using video cameras, EKG monitors, galvanometer sensors, and specially designed observational instruments, Gottman and his research team (Gottman, Coan, Carrere, & Swanson, 1998) compared how couples communicate, both verbally and nonverbally, microsecond by microsecond. The researchers studied such indicators as body movements, facial expressions, gestures, even the couple's heart rates during conflict with one another, attempting to identify those behavioral and physiological responses essential to a stable marriage as well as those that predict the couple is headed for divorce (Gottman, 1996).

According to Gottman (2011), and contrary to popular and even professional opinion, it is not anger that predicts divorce but rather four forms of *negativity* that Gottman calls "The Four Horsemen of the Apocalypse"—*criticism* (attacking a spouse's character), *defensiveness* (denying responsibility for certain behavior), *contempt* (insulting, abusive attitudes toward a spouse), and *stonewalling* (a withdrawal and unwillingness to listen to one's partner). In a typical demand-withdrawal transaction, women were found more likely to criticize, while men were likelier than women to stonewall. Using these four variables, Gottman and his associates were able to increase their prediction of marriage dissolution to 85%. In addition, a second *distance and isolation cascade* (emotionally flooding, viewing problems as severe, not wanting to work out problems with a spouse, living parallel lives, and experiencing loneliness) increase the prediction of dissolution to more than 90% (Gottman, Ryan, Carrere, & Erley, 2002). Clearly, it is positive affect that plays a pivotal role in the development of satisfying and lasting relationships.

Gottman (2011, pp. 15–20) identifies eight relationship dysfunctions that predict divorce or a miserable relationship:

- More negativity than positivity—relationships headed for divorce have a ratio of positive to negative emotion of 0.8:1 or less, while enduring couples have a ratio of 5:1
- Escalation of negative affect—criticism, defensiveness, contempt, and stonewalling
- Turning away—attempts to relate are ignored
- Failure of repair attempts—unable to heal wounds from normal relationship conflict
- Negative sentiment override—underlying assumption that partners acts are negative

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- Maintaining vigilance and physiological arousal—a state of agitation perpetuates negative thoughts, hinders processing, and eliminates humor
- Chronic diffuse physiological arousal—generalized response to perceived threat that engenders defensiveness and lessens the ability to resolve differences constructively
- The failure of men to accept influence from their women—rejection of influence through disengagement or intense responses

As Gottman moved from pure research to therapy based on his research (2011), he posited the theory of the "Sound Relationship House" to describe relationships that navigate the challenges of life well (see Figure 12.1). The model includes seven levels. The first three reflect friendship in the relationship: build love maps (a mental understanding of your partner); share fondness and admiration (appreciate your partner's positive qualities); and toward, rather than away (responsiveness and engagement with your partner). Other levels build on the friendship foundation: positive perspective (underlying positivity about the relationship that overcomes potential negatives); manage conflict (gentle, reparative, compromising interaction about normal differences); make life dreams come true (understanding and facilitating our partner's dreams); and create shared meaning (finding shared value in the relationship; pp. 29–37). Subsequently, Gottman (2011) noted that trust is an important metafactor that permeates these levels.

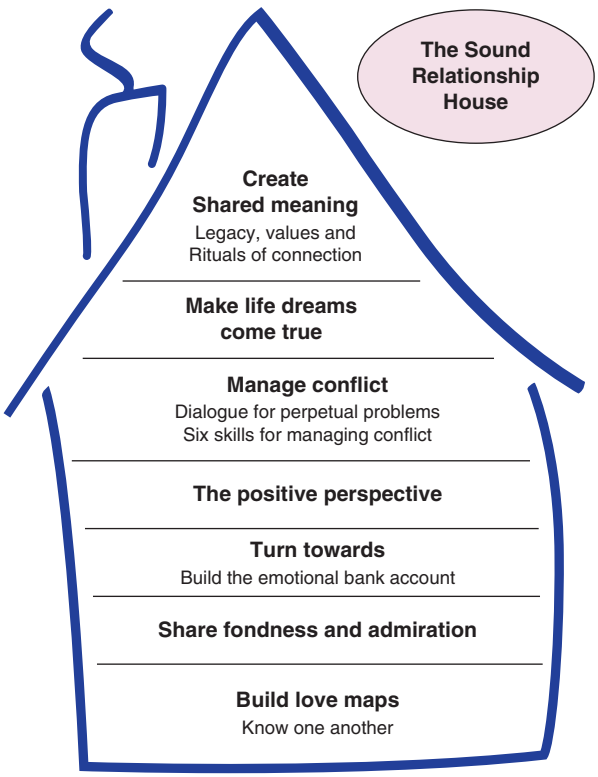


FIGURE 12.1 The sound relationship house
Source: Gottman (2011).

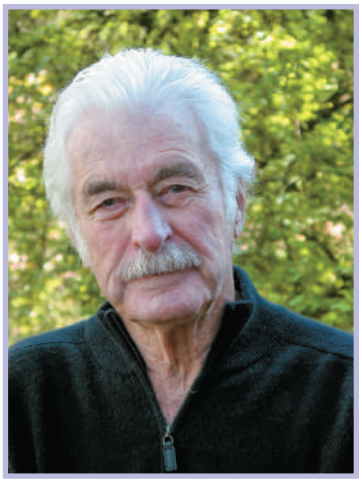
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BOX 12.5 CLINICAL NOTE

Parental Disagreement About Child Treatment

Parents frequently disagree about the child's need for treatment, often providing a clue, to be investigated, regarding marital conflict.

Behavioral Parent Training and Family Management Skills



Research Press

Gerald Patterson, Ph.D.

Most behavioral parent training (BPT) advocates have had as their goal the alteration of the undesirable behavior in the child (bedwetting, temper tantrums, chore completion, compliance with parental requests, hyperactivity, sleep problems, and bedtime fears rather than more global sets of personal or interpersonal problems of children; Dangel, Yu, Slot, & Fashimpar, 1994), accepting the parents' view that the child is the problem. By changing parental responses, the behavioral therapist hopes to produce a corresponding change in the child's behavior. Gerald Patterson, a pioneer in the field of parent training, argues that while out-of-control children are angry, fail in school, lack self-esteem, and have poor relationships with their parents, these factors are secondary by-products of an ongoing process and not the causes of delinquency. Psychologists at the Oregon Social Learning Center, under the direction of Patterson and John Reid, developed a series of treatment programs, based on social learning principles, teaching parents how to reduce and prevent antisocial behavior in children and adolescents (Forgatch & Patterson, 2010).

Parent skills training has many practical features to recommend it. It is cost effective because the treatment plan is standardized. Its focus is on family empowerment. It minimizes the family's reliance on qualified professional therapists. Skills learned with one child may be applicable to his or her siblings should similar conditions arise. Without diminishing parental authority, the training process, if successful, builds competence and a feeling of confidence in parents. It has a preventive aspect. Perhaps most important, parents possess the greatest potential for generating behavior change because they have the greatest control over the significant aspects of the child's environment (Forgatch & Patterson, 2010). The use of parents as trainers makes it easier for children to actually use the new behavior they learn, since they do not have to go through the process of transferring what they have acquired from a therapist to their home situation. Griffith (2010) reports that the approach to behavioral change appears to be effective in reducing rates of problem behavior in children and adolescents.

The initial request for treatment usually comes from parents who are concerned about their child's disturbed (and disturbing) overt and covert antisocial behaviors (see Table 12.3). According to Forgatch and Patterson (2010), a faulty parent–child interaction pattern has probably developed and been maintained through a reciprocal process of *coercion* ("using aversive behavior to control the behavior of another"; p. 161). BPT aims to change this mutually destructive pattern of interaction, usually by training parents to observe and measure the child's problematic behavior and then to apply social learning techniques for accelerating

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TABLE 12.3 Overt and covert antisocial behaviors

Overt Behaviors	Covert Behaviors
"Relatively innocuous aversive behaviors that become increasingly noxious" • Excessive noncompliance • Temper tantrums • Hyperactivity • Hitting • Biting • Fighting • Other direct actions against others	"Develop as a means of avoiding overly harsh parental discipline…buttressed by positive reinforcement from peers and siblings" • Lying • Stealing • Truancy • Fire setting • Animal abuse • Substance use and abuse

Source: Forgatch and Patterson (2010), p. 160.

desirable behavior, decelerating undesirable behavior, and maintaining the cognitive and behavioral changes.

As in all cognitive or behavioral interventions, parent training begins with an extensive assessment procedure including interviews, questionnaires, behavioral checklists, and naturalistic observations of parent–child interactions. This first stage identifies the specific problem behavior along with its antecedent and consequent events. Through this behavioral analysis, the therapist is able to understand the problem more exactly; evaluate the form, frequency, and extent of its impact on the family; and systematically train parents to use social learning principles to replace the targeted behavior with more positive, mutually reinforcing interaction.

Parent Management Training, the Oregon Model (PMTO), is the version of BPT advocated by Patterson (Forgatch & Patterson, 2010). It uses role play to teach parents to be proactive during vulnerable times and situations (e.g., during shopping) by regulating emotion, using positive parenting, and lowering use of coercion. Presumably, many adults come by these skills "naturally," that is, without deliberately following a prescribed program. The intervention sequence begins with a focus on strengths to facilitate change (surprising parents who are highly attentive to the problems in the family); proceeds to teaching parents how to provide good directions (identify a specific desired behavior, calm down, engage the child by addressing her or him by name, state the desired behavior with a "please" added, and remain neutral for 10 seconds); and moves to how to teach behavior by encouragement. Following these foundation skills, the model focuses on limit setting, problem solving, affect regulation, monitoring, school success, and positive engagement (Forgatch & Patterson, 2010). A variety of behavioral practices and reinforcements are built into the learning modules, such as contingent positive reinforcement, incentive charting, contracts, physical rewards, time out, and fines or chores for noncompliance. The model may include a plan for observing a child's behavior to establish a **baseline**, pinpointing the specific behavior the parents wish to change, observing and graphing their own behavior, negotiating a contract with the child, and so on. Figure 12.2 represents a checklist constructed for a boy who displayed a wide range of out-of-control behavior. The parent-child contract, jointly

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Dave's Program						
	M	T	W	T	F	S
Gets to school on time (2)	2					
Does not roam around the room (1)	0					
Does what the teacher tells him (5)	3					
Gets along well with other kids (5)	1					
Completes his homework (5)	2					
Does homework accurately (5)	3					
Behaves OK on the schoolbus (2)	2					
Gets along well with brothers and sisters in evening (3)	0					
Total	13					

1. If Dave gets 25 points, he doesn't have to do any chores that night and he gets to pick all the TV shows for the family to watch.
2. If Dave gets only 15 points, he does not get to watch TV that night.
3. If Dave gets only 10 points, he gets no TV and he also has to do the dishes.
4. If Dave gets only 5 points or less, then he gets no TV, washes the dishes, and is grounded for the next 2 days (home from school at 4:00 and stays in yard).

FIGURE 12.2 A parent–child negotiated contract checklist indicating specific duties to be performed and a point system based on the degree of goal achievement
Source: Patterson (1971).

negotiated, stipulated that the parent would check with the teachers daily to get the necessary information and would regulate the consequences for the child's behavior. These consequences included mild but fair punishment for continued problem behavior, in addition to "payoffs" (such as no dishwashing chores, permission to watch TV) for adaptive behavior. In establishing the contract, the child helps set the "price" in points for each item, sees the results daily (the program is posted in a conspicuous place at home, such as the refrigerator door), and negotiates the backup reinforcers (e.g., TV programs) for the accumulated points.

Contingency Contracts and Other Techniques

Contingency contracting, based on operant conditioning principles, may be a particularly useful "give to get" technique in reducing parent–adolescent problems. The technique is simple and straightforward: a contract is negotiated wherein each participant specifies who is to do what for whom, under which circumstances, times, and places. This usually involves a written agreement that spells out the exchange of positively rewarding behaviors between the relevant parties. Initially offered by Stuart (1969) for couples, the concept is applicable to parent-adolescent conflict where the previous excessive use of aversive controls by parents (nagging, demanding, threatening) has been met by equally unpleasant responses from

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the adolescent. The goal is to acknowledge the power of both sets of participants to reverse this persistent negative exchange through a mutual exchange of positive and cooperative giving of pleasurable behavior (Falloon, 1991). Contingency contracting has also been shown effective in working with young children. In one study (Stover, Dunlap, & Neff, 2008), it was shown to eliminate nocturnal enuresis (bedwetting) in children ages 5 to 7 years old.

Contract negotiations are open and free from coercion. The terms of the contract are expressed in clear and explicit statements. For example, a contract negotiated between parents and an adolescent with poor grades specifies that she will "earn a grade of 'C' or better on her weekly quiz" rather than "do better in school." The second statement is too vague and open to different interpretations by the participants. The more vague definition allows the adolescent to believe she has done better and fulfilled her part of the agreement while the parents believe the gain is insignificant, so the conflict between them over school performance remains unresolved. By the same token, the rewards must be specific ("We will give you $15 toward the purchase of new clothes for each week your quiz grade is 'C' or better") and not general or ambiguous ("We'll be more generous about buying you clothing if you get good grades"). The point here is that each participant must know exactly what is expected of him or her and what may be gained in return.

A contract (Figure 12.3) is an opportunity for success, accomplishment, and reward. However, the desired behavior, such as a "C" grade, must be realistic and within the grasp of the contractor. In addition, each member must accept the idea that rewards are contingent on the performance of responsibilities. Behavioral therapists believe that a family member will exchange maladaptive behavior for adaptive behavior in anticipation of a positive consequence. The teenager's responsibility (i.e., better grades) is the parents' reinforcer, and the parents' responsibility (money) is the teenager's reinforcer. BPT helps a family set up a monitoring or record-keeping system that enables the contractors and the therapist to assess the reciprocal fulfillment of the contract terms. Bonuses are given for consistent fulfillment of the terms, and penalties are imposed for failure to adhere to them. Note that as in all behavioral procedures, the success of treatment can be measured by the extent to which the contract works for all parties. See Box 12.6: Thinking Like a Clinician for experience in working with contingency contracts.

Other BPT techniques include modeling, **shaping** (the reinforcement of successive approximations of the desired behavior until the desired behavior is accomplished), time out, use of tokens, and other operant reinforcement strategies. Contracting may open up communication within a family and help members express for the first time what each would like from the others. In some cases, the contracting process even makes family members aware of wishes or desires they had not previously recognized within themselves. Finally, an important aspect of this approach is its focus on goals and accomplishments by formalizing the expectations of family members into concrete

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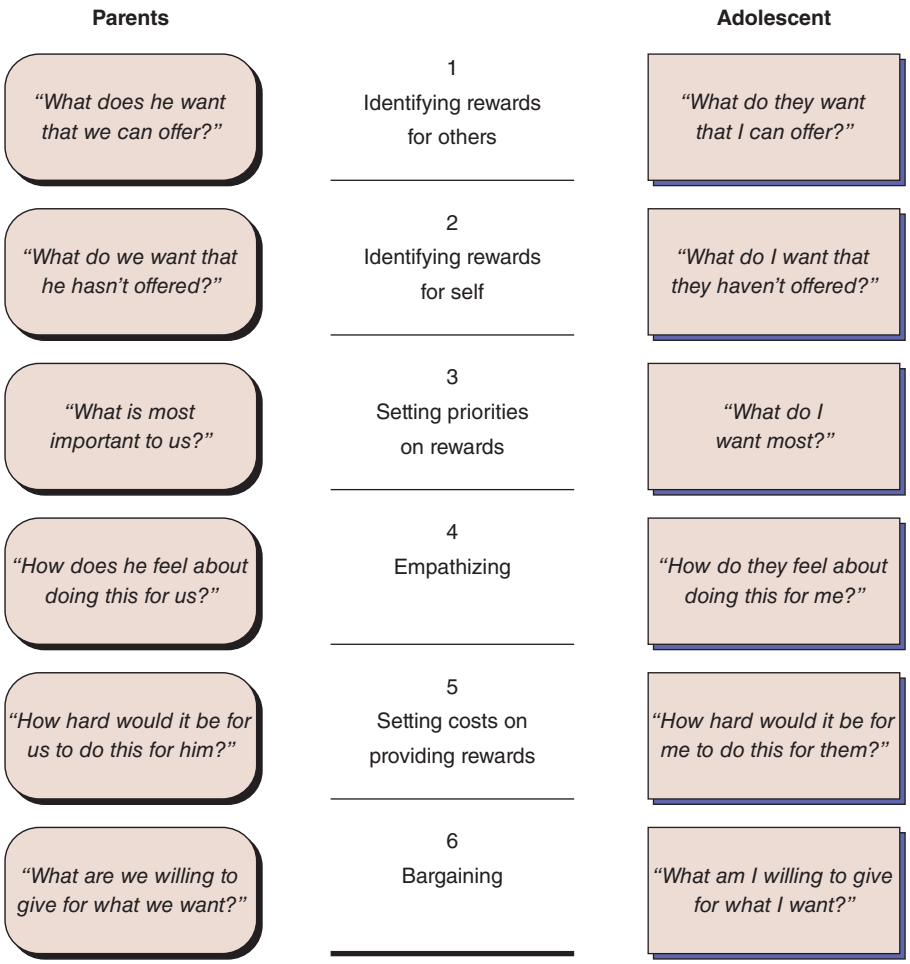


FIGURE 12.3 Steps in negotiating a contingency contract between parents and an adolescent. This is a structured learning experience conducted by the behaviorally oriented family therapist to help family members identify their needs and desires (rewards) for themselves and each other, to set priorities for rewards for self, to empathize with others, to set costs of providing rewards to others, and finally to bargain and compromise.
Source: Weathers and Liberman (1975).

actions. By recognizing achievement, the family develops more positive interaction. Through this process, the behavioral therapist is teaching a way of negotiating that may serve as a model for conflict resolution in other areas of family life.

The next horizon for behavioral parent training is expanding the programs beyond founding organizations into routine practice. Implementation models, such as the one developed by Forgatch, Patterson, and Gewirtz (2013), describe the steps and processes needed to make BPT more widely available. The availability of technology and Internet resources is a major facilitator of program implementation.

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BOX 12.6 THINKING LIKE CLINICIAN

Negotiating a Contingency Contract

The Hernandez family has come to you for help with various issues. Inez Hernandez, the mother, notes that her 16-year-old daughter, Jennifer, has been socializing with a "bad" crowd. She is concerned that Jennifer will get hurt. Inez indicates that over the last 6 months, Jenny's grades have fallen and that on two occasions, Inez smelled alcohol on Jenny's breath after she came home much later than her curfew. Ramón, the father, agrees with his wife and adds that their son, Richie, who is 2 years younger than Jenny, is starting to behave similarly to his sister. Both children deny that they have done anything wrong and say that their parents are hypocrites because while not alcoholics, both parents drink too much, and Ramón, especially, is almost never home. Jenny adds, "Not that I care where he is." Richie says that their parents are ridiculously old fashioned and that their 11:00 p.m. curfew is "stupid" and embarrassing.

After the family has seen you for two sessions, Inez tells you that the school principal has informed her that Jenny regularly cuts classes and has been caught smoking marijuana. She faces suspension unless she improves her behavior. Jenny interrupts and says that it's no big deal since she plans to become a singer and sees no point in learning geometry and social studies. You notice that Richie starts laughing at his sister's dream. Inez says there is no way her daughter will ever be an entertainer and that she has to finish high school with good grades so she can go to college. Ramón nods and then looks at his iPhone when Jenny says sarcastically, "If you spent with us half the time you spend on your iPhone, we'd be a happy family." Her father quickly puts away the device, but you feel that he is anxious for doing so. Richie says that his parents only care about Jenny because she is such a problem and that they pay no attention to him—even though he does get good grades. He wonders what's the point of working hard when he never gets anything for all his effort. He smiles and says that maybe he'll try some weed, too. Inez says to you, "I think you need to tell these kids that if they don't straighten up, they are going to end up in big trouble."

You suggest creating a contract to help everyone get more of what they need while remaining aware of the needs of the other family members. Help the Hernandez family by helping them negotiate a contingency contract. Follow the steps shown below.

1. Jennifer and Inez indicate that they don't know which of their desired rewards matters most. Help them prioritize the desired rewards. What would you say?	
2. How might you express empathy to each family member about the contracted terms? Be specific with respect to the dilemmas that might emerge for each family member.	
3. How might you facilitate bargaining among disagreeing family members?	

Research in Behavioral Couple and Family Therapy

Behavioral couples therapy is arguably the most studied approach in couples' therapy (Sexton, Robbins, Holliman, Mease, & Mayorga, 2003). A large, well-designed clinical comparison of traditional behavioral couples therapy (TBCT) and integrative behavioral couple therapy (IBCT) that tracked participants for 5 years posttherapy found that distressed couples in both models improved in satisfaction, though they operated differently (IBCT focuses immediately on long-term issues, while TBCT focuses first on improving positive interactions). Clinically significant improvement was demonstrated for both models at conclusion of treatment and at

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5-year follow-up, with IBCT showing slightly higher effect (Lebow, Chambers, Christensen, & Johnson, 2012). A review of "third wave" behavioral therapies, in general, finds them to be empirically supported (Kahl, Winter, & Schweiger, 2012).

Demonstrated effectiveness of behaviorally oriented techniques can be a rationale for research funding and insurance reimbursement. For example, behavioral marital therapy (along with emotionally focused therapy) was found cost effective when paid for by the government by reducing the cost of divorce on public finances associated with divorce (Caldwell, Woolley, & Caldwell, 2007). Similar results were found for insurance company payment for behavioral therapy versus the health care costs associated with divorce.

Behavioral couples therapy may be adapted for couples facing the consequences of an extramarital affair, using a forgiveness model with three stages (Gordon, Baucom, & Snyder, 2004). Initial results found that TBCT and IBCT could utilize elements of forgiveness successfully in treating couples for whom an affair occurred, but IBCT would allow the stages below to occur as needed, without an a priori determination that all stages are needed for all couples (Baucom, Gordon, Snyder, Atkins, & Christensen, 2006). The three stages:

Stage 1: Addressing the impact of the affair, defining how each partner can live with the other during such strained circumstances. Partners negotiate issues like whether to sleep in the same bed, eat together, and remain in the same domicile while in treatment. Guidance on self-care is provided. The goal is to stabilize the relationship.

Stage 2: Exploring the context and meaning of the affair. In addition the therapist also helps the partners to evaluate the ongoing effects of the affair.

Stage 3: Moving on. Through the integration of the previously gathered information, consider forgiveness, reassess the relationship, and determine whether there is a future together, helping the partners make an informed decision about how to "move on."

Howard Markman, a psychologist who focuses his longitudinal research with couples on what causes marital distress, has, along with his colleagues, investigated the impact of couples' exchange of negative affect before parenthood on their later marital and family functioning (Markman, Stanley, & Blumberg, 2010). We'll return to this work when we discuss psychoeducational programs for couples and families.

LO 4 Functional Family Therapy

Based on a clearly stated set of principles and strongly supported by research evidence, **functional family therapy**, or FFT (Alexander, Waldron, Robbins & Neeb, 2013; Sexton, 2011), fosters both cognitive and behavioral changes in individuals and their families. The model, which purports to integrate learning theory, systems theory, and cognitive theory, goes beyond most behavioral models by attempting to do more than change overt behavior. FFT posits that clients need help first in understanding the *function* the behavior plays in regulating relationships. FFT has emerged as a clinically relevant, evidence-based intervention used widely to treat adolescent behavioral problems, especially underserved youth with problems with violence, delinquency, and substance abuse (Onedera, 2006).

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Parents in troubled families often blame their difficulties on their child's negative traits (laziness, selfishness, irresponsibility) and feel powerless as they try to effect change. Developed by Alexander and Parsons (1982), functional family therapy aims at creating a nonblaming relationship that seeks to explain the causes of all members' behaviors without imputing motives to anyone (Alexander et al., 2013). By urging adoption of this new perspective, the functional therapist tries to modify the attitudes, assumptions, expectations, labels, and emotions of the entire family. New perceptions and, ultimately, new behaviors are apt to follow these cognitive changes.

To functional family therapists, such as James Alexander at the University of Utah, *all behavior is adaptive*. Rather than being thought of as "good" or "bad," individual behavior is viewed as serving a function, representing an effort to create a specific outcome in relationships. While the interpersonal payoffs or functions for family members may take various forms (a child elicits parental attention by having a tantrum; a teenager creates independence by having himself thrown out of the house; a husband avoids arguments by busying himself at work for long hours into the evening), they are understood as behaviors that serve to define and create patterns of interpersonal relationship related to the problem at hand in two categories: relational connection (a pattern of pulling in or pushing away) and relational hierarchy (one-up, symmetrical, or one-down, characterizing the mix of power and control in the relationship; Alexander et al., 2013, p. 119).

Functional family therapy proceeds in three phases with clinical strategies and therapist skills for accomplishing the goals of each phase (Sexton, 2009, 2011). The initial phase is engagement and motivation, followed by behavior change, then generalization (see Figure 12.4). There are four goals for the first phase: creating an alliance, lowering negativity,

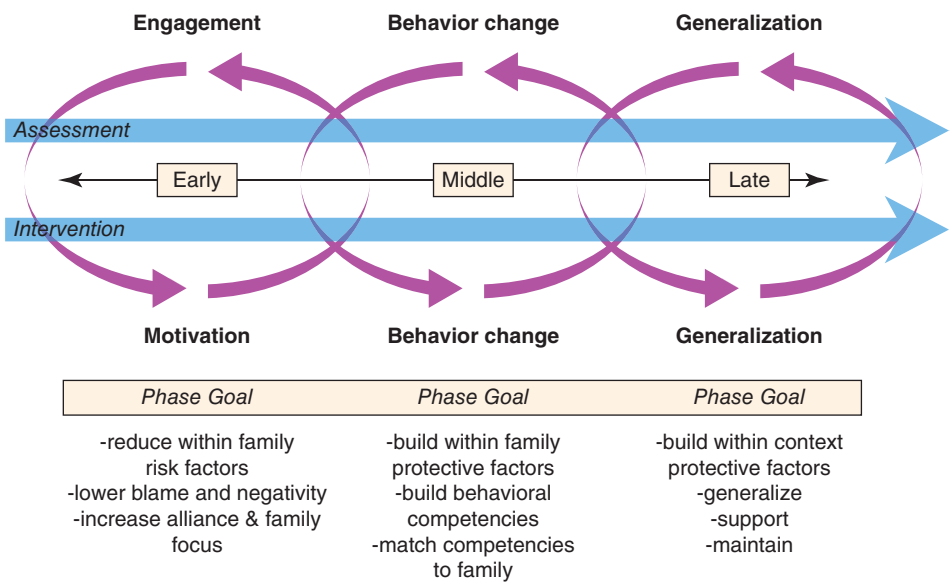


FIGURE 12.4 Phases of functional family therapy.
Source: Sexton (2011).

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reducing blame, and creating a shared perspective on the presenting problem. The therapist is interested in determining the functions served by the behavioral sequences of various family members. Are they creating greater distance, or are they becoming closer through their interpersonal patterns? Family members typically enter therapy with a punitive, blaming explanation for their problems ("My mother bugs me; she still thinks I'm a baby"; "My daughter is a chronic liar, and she creates all the tension in the house"). The therapist's task during this phase of treatment is to change the focus from an individualistic, blaming outlook to one in which all participants understand that together they form a system and share responsibility for family behavior sequences. Working with at-risk adolescents and their families, the therapist uncovers *the risk and protective patterns* characteristic of their interaction. The "problem" behavior is not viewed as the source of the family's troubles; rather, the way the problem behavior is managed within the family relationship system is what creates the difficulty (Sexton, 2011).

The second phase, behavior change, requires enhancing the ability of family members to perform activities related to their risk factors in a way that matches their relationship functions. This involves modifying attitudes, expectations, cognitive sets, and affective reactions to create protective behaviors. FFT therapists do not attempt to change the family's relational experiences. For example, the adolescent may still seek attention, but the earlier means of doing so (getting himself thrown out of the house) is changed. In the case of an at-risk adolescent, FFT changes the *means* (drugs, gang membership) by which the young person attains what he or she seeks, especially if such means hurt others.

Finally, generalization, overlapping with behavior change, extends the changes to new issues and environments to help the family cement the new behavior and avoid relapsing to old patterns of behavior (Sexton, 2009). Community resources are engaged to help the family interact with its community (Sexton, 2011).

Research data indicate that FFT is especially effective in engaging families in the therapeutic process and keeping them in therapy (rates from 78% to 89% compared to the typical high dropout rates), as well as demonstrating a greater reduction in recidivism and harmful activities than probation services (Alexander et al., 2013; Sexton, 2011). For example, Sexton and Turner (2010) found that when the therapist adheres to this treatment model, a 35% reduction in felonies and 30% reduction in violent crimes may occur. Reductions in misdemeanor recidivism were marginal, however. In another study—this one relating to the treatment of alcohol-abusing, runaway adolescents—the efficacy of FFT was compared with home-based (ecological) family therapy and typical services provided at a shelter. Perhaps unsurprising, both therapies were found to be more effective than the services at the shelter. The goal of FFT in this case was to alter dysfunctional family patterns that contribute to the alcohol abuse and runaway behavior. Researchers determined that FFT successfully combined a systemic framework with a behavioral treatment methodology to effect positive change. Baglivio, Jackowski, Greenwald, and Wolff (2014) found that FFT has similar effectiveness to multisystemic therapy with juvenile offenders. Finally, FFT is cost effective, showing large savings in justice system and crime victim costs compared to FFT therapy costs (Sexton, 2009).

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BOX 12.7 FAMILY DIVERSITY

Conducting a Sexual Status Examination

- Dattilio (2010) notes the importance of cultural sensitivity when conducting **cognitive-behavioral family therapy** based on Western values with couples and families from different cultures. Cognitive-behavioral interventions are well suited for adaptation because they are based on the client's automatic thoughts, not ideology, so the therapist may proceed using "a collaborative approach that allows for the individual family's cultural beliefs to inform the treatment goals and process" (p. 185).
- Research on the **Gottman Method** indicates that satisfaction and stability in gay and lesbian relationships are related to similar emotional qualities as he identified in heterosexual relationships (Gottman et al., 2003).
- **Functional family therapy** has been used successfully in "a wide range of multiethnic, multicultural, and geographical contexts" (Sexton, 2009, p. 327). It is administered in at least eight languages (Spanish, English, Arabic, Vietnamese, Chinese, Dutch, Swedish, Haitian Creole) by therapists who are "as diverse as the clients in regard to gender, age, and ethnic origin" (Sexton, 2011, p. 8-2). The core FFT idea of "matching" allows a therapist to evidence factors that align with the culture of the clients (Alexander et al., 2013).

LO 5 Conjoint Sex Therapy

Both behavioral and cognitive-behavioral techniques have been applied to sex therapy, especially in treating many forms of sexual dysfunction in a relatively quick and effective manner (Kleinplatz, 2012). Generally, these interventions are brief and intensive treatment of symptoms, regardless of origin or underlying psychological or emotional causes. Treatment, whether applied to men or women, is apt to be aimed at reducing or eliminating any mechanical problems in sexual performance. In recent years, there has been an increasing medicalization of the field with the introduction of drugs such as Viagra.

However, sexual problems may be a metaphor for the dynamics of a couple's relationship, in which case the therapist focuses on helping them repair their interpersonal struggles. Or sexual problems may be more direct experiences that require sex education, cognitive restructuring, or the learning of behavioral skills (Mason, 1991). More than likely, elements of both are involved, since sexual functioning is increasingly seen as a biopsychosocial phenomenon calling for couple therapy (McCarthy & McDonald, 2009).

The clinician (family therapist and/or sex therapist) must evaluate the psychological, physical, and interpersonal nature of sexual dysfunction while remaining sensitive to the distress, shame, embarrassment, loss of self-worth, or fear of rejection one or both partners may feel because of the dysfunction. Treatment involves a relationship assessment, including the commitment of each partner, their sexual histories and expectations, their ability to communicate feelings about sex and other matters, their ability to negotiate what they want or what gives them pleasure, and their degree of comfort in problem solving together (Walen & Perlmutter, 1988).

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BOX 12.8 THERAPEUTIC ENCOUNTER

Conducting a Sexual Status Examination

An essential part of any evaluation of a couple's sexual problems includes the sexual status examination (Kaplan, 1983) in which the interviewer tries to discover the immediate causes of the presenting problem and the possible parts played by medical or psychological factors. Here the interviewer must help both partners feel comfortable going into detail about their sexual activities before launching into questions about their most recent sexual encounter. When did the experience occur? Where? Under what circumstances? Who initiated the encounter? How did the other person respond? What, if any, problems (e.g., premature ejaculation in a man, a nonorgasmic response in a woman) arose, and how did each participant react? What feelings and thoughts did each have before, during, and after intercourse?

In some cases, it may be instructive to question masturbatory practices, dreams, or fantasies, since these may provide leads to the causes of the couple's problems and aid in developing suitable out-of-session behavioral assignments (Plaut & Donahey, 2003).

According to Kaplan (1979), there are several types of sexual dysfunctions, grouped according to stages of the sexual response cycle: *desire disorders* (ranging from low sexual desire to sexual aversion), *arousal disorders* (difficulty achieving sexual excitement), *orgasm disorders* (premature, delayed, or unpleasant orgasms), *sexual pain disorders* (pain involved in sexual activity), or *problems with sexual frequency* (disparities between partners regarding desired frequency).

Sex therapy emerged with the breakthrough publication by Masters and Johnson (1970) of *Human Sexual Inadequacy*, based on 11 years of clinical research. This monumental study advanced the open discussion of sexual dysfunction and pinpointed specific learning-based remediation plans for such sexual dysfunctions as impotence or premature ejaculation in males and nonorgasmic female responses (previously pejoratively labeled frigidity) and dyspareunia (painful intercourse) in women. Masters and Johnson demonstrated that sexual problems could arise from a variety of prior experiences (or lack of experiences), did not necessarily mean that the symptomatic person was struggling with neurotic conflict, and could be treated successfully (i.e., sexual performance improved) without much attention to underlying causes (Burg & Sprenkle, 1996).

An assumption in the Masters and Johnson (1970) approach that aligns it somewhat with a systems framework is that there is no such thing as an uninvolved partner in a relationship in which some form of sexual inadequacy exists. Innovative for their time, research-oriented gynecologist William Masters and psychologist Virginia Johnson treated couples conjointly to emphasize that inevitably, any dysfunction is partly a relationship problem rather than one that belongs to only one partner.

The Masters and Johnson 2-week residential program began with an extensive assessment; a detailed sexual history was taken from each partner, including chronological sexual experiences and sexually oriented values, attitudes, feelings, and expectations. Next a medical history was taken, and each partner underwent a thorough physical examination. Then the co-therapists and

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BOX 12.9 CLINICAL NOTE

Individual or Conjoint Sexual Status Examinations

While it is sometimes appropriate to conduct a conjoint sexual status examination so both partners hear each other's versions, the situation may at times prove to be too uncomfortable for one or the other, suggesting the procedure to be done separately for each partner. Here the therapist should suggest that the information may need to be revealed at a later joint session for a fuller exploration of the couple's sexual problems.

the marital partners met to review the accrued clinical material and to begin relating individual and marital histories to current sexual difficulties. During the next several days, the therapists concentrated on giving the couple instructions, to be practiced outside the therapy session.

The therapists taught the marital partners *sensate focus*—that is, learning to touch and explore each other's bodies and to discover more about each other's sensate areas but without feeling any pressure for sexual performance or orgasm. Sensate focus exercises are designed to offer both partners pleasure in place of the anxiety previously accompanying a demand for sexual arousal or intercourse, a technique based on classical conditioning procedures for dealing with phobic objects and situations.

According to Masters and Johnson, a primary reason for sexual dysfunction is *performance anxiety*—the participant is critically watching (they refer to it as "spectatoring") his or her own sexual performance instead of abandoning himself or herself to the giving and receiving of erotic pleasure with a partner. Masters and Johnson point out that in order to fully enjoy what is occurring, partners must suspend all such distracting thoughts or anxieties about being evaluated (or evaluating oneself) for sexual performance. Although Masters and Johnson were not cognitive-behaviorists themselves, their treatment involved some therapeutic ingredients (sex education, communication training, behavioral exercises, a focus on symptom remission rather than a search for explanations from the past) that fit comfortably with cognitive-behavioral principles and intervention procedures (Heiman & Verhulst, 1990).

Psychiatrist Helen Singer Kaplan (1974), attempting to integrate a psychodynamic model with Masters and Johnson's behavior model, described a variety of personal and interpersonal causes of couple sexual dysfunction that included sexual ignorance, fear of failure, demand for performance, excessive need to please one's partner, and the failure to communicate openly about sexual feelings and experiences. She identified various intrapsychic conflicts, such as early sexual trauma, guilt and shame, and repressed sexual thoughts and feelings within one or both partners that impede satisfying sexual activity.

Finally, Kaplan cited a third set of psychological determinants of sexual dysfunction—factors arising from the relationship—such as forms of marital discord, lack of trust, power struggles between partners, and efforts to sabotage any pleasure being derived from the sexual experience. In combination or singly, any of these problems or conflicts can lead to distressing sexual symptoms that threaten a marriage by heightening tensions and can even lead to its dissolution.

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Kaplan, a solo therapist, successfully treated couples on an outpatient basis once or twice a week with an integrated set of procedures based on miscellaneous behavioral interventions (systematic desensitization, sensate focus, relaxation techniques), cognitive therapy (cognitive restructuring), psychodynamic psychotherapy, antipanic medication, and family systems interventions. Throughout her "psychosexual therapy," she emphasized the relational or interpersonal nature of the treatment. In her later work, Kaplan (1995) described her efforts to treat sexual desire disorders (inhibited or hypoactive sexual desire), ordinarily the type of sexual problem most resistant to treatment.

Cognitive behavioral sex therapists today employ a number of techniques—sensate focus to reduce performance anxiety and facilitate pleasure, stimulus control to connect comfort and pleasure to sex, sexual skills training to incorporate new behaviors, and cognitive restructuring to modify dysfunctional sexual beliefs (Nobre, 2014). Cognitive-behavioral family therapists provide accurate information about sex, engage sexual desire issues through partner interaction exercises, help couples set positive and reasonable expectations, and address common female and male dysfunctions in a biopsychosocial frame in couple therapy (McCarthy & Breetz, 2010).

As sex therapy has become more "medicalized" (McCarthy & McDonald, 2009), drugs (such as Viagra), penile injections of testosterone, or vacuum devices have been used for improving erectile function, leading to successful sexual intercourse. (Testosterone for women has also been used in treatment.) Critics argue, however, that the sole use of these devices—while they may improve sexual performance—tends to obscure any underlying interpersonal distress that may be a causal or relapse factor in a couple's difficulties (McCarthy & McDonald, 2009). For instance, low relationship satisfaction may mitigate the positive effects of improved female sexual functioning on sexual distress (Stephenson, Rellini, & Meston, 2013). The dropout rate from sex medication is high when expectations are unrealistic and it is not integrated well into couple intimacy (McCarthy & Breetz, 2010). Tiefer (2012) offers a feminist critique to the medicalization of sex therapy, including the downplaying of the relational aspects of the sexual experience and the denial of the power differential between men and women partners. She notes too that the focus on drugs often neglects social, cultural, and economic issues related to sex. She argues for a sex therapy framework that extends beyond techniques to embrace a diversity of goals and values.

Hertlein, Weeks, and Gambescia (2009) note the theoretical fragmentation in sex therapy today due to a divide between couples therapy and sex therapy that begins in training programs and continues in professional societies. They suggest an integrative paradigm for sexual functioning founded on Weeks' **intersystem approach** (a systemic cognitive-affective-behavioral model that recognizes individual biological, medical, and psychological factors as well as the dyadic relationship, family-of-origin influences, and the impact of historical-cultural-religious societal dynamics) but incorporating Sternberg's triangular theory of love, and the theory of interaction proposed by Strong and Clairborn. They believe this model avoids the potential errors of technique-driven, eclectic approaches by positing a systemic theoretical foundation that places sex therapy in its full context.

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Finally, although sex therapy may treat a couple's sexual difficulties, it is no panacea for a marriage that has already failed. In this regard, David Schnarch (2010), diverging from the behavioral viewpoint, integrates couple and sex therapies by focusing on the relational context in conceptualizing sexual problems. In what he calls *crucible therapy*, Schnarch teaches couples how to achieve both greater personal autonomy and sexual intimacy by developing emotionally committed relationships rather than attending exclusively to correcting the presenting symptoms of sexual dysfunction.

Basing the therapy primarily on self-differentiation (including use of a differentiation scale; Schnarch & Regas, 2012), he tries to help couples resolve past individual and interpersonal issues by increasing each partner's sense of both self *and* togetherness in the relationship. According to Schnarch, poorly differentiated persons experience an anxiety-driven pressure for togetherness, thus losing autonomy and placing responsibility for adequate functioning on the other person in the relationship. By contrast, developing a clearly defined sense of oneself allows greater involvement with a partner without the risk of "losing oneself in the process of requiring distancing maneuvers" (Schnarch, 1995, p. 240). For Schnarch, to achieve intimate sex is to celebrate autonomy.

A Constructivist Link

Some cognitive therapists incorporate a constructivist perspective in their work (Mahoney, 2001). Donald Meichenbaum, at the University of Waterloo in Canada, one of the founders of the "cognitive revolution," is extremely influential through his work on stress inoculation and self-instructional training aimed at helping clients teach themselves to overcome previously stressful situations.

His cognitive orientation in treating victims of violence and abuse led Meichenbaum to adopt some narrative constructive ideas (see Chapter 14) after hearing people describe the "stories" of their traumatizing experiences, constructing their personal realities and creating their own representational models of the world. Constructivists argue that reality is invented, a product of the personal meanings each individual creates. From a narrative perspective, the traumatized person constructs stories to explain his or her situations (Meichenbaum, 2014).

To help clients achieve "narrative repair"—change their assumptions and schemas about the world and their ability to manage stress—Meichenbaum (2014) and his colleagues conduct collaborative sessions in which distressed persons learn to develop and accept a reconceptualization of the distress they previously helped co-create. These cognitive-behavioral therapists help clients talk to themselves differently—unfreezing their beliefs, creating new narratives—in order, ultimately, to behave differently.

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SUMMARY

Behavioral models of family therapy attempt to bring the scientific method to bear upon the therapeutic process by developing regularly monitored, data-based intervention procedures. Initially drawing on established principles of human learning, these approaches emphasize the environmental, situational, and social determinants of behavior. Increasingly, most behaviorists have also recognized the influence of cognitive factors in mediating family interactions. Personal functioning is viewed as the result of continuous, reciprocal interaction between behavior and its controlling social conditions. Cognitive-behavioral therapists attempt to increase positive interaction between family members, emphasizing the importance of self-regulation and self-direction in altering behavior.

Currently, cognitive and behavioral approaches are having a significant impact in distinct areas: behavioral couples therapy, behavioral parent training, functional family therapy, and the conjoint treatment of sexual dysfunction. Proper assessment plays a key role in all of these endeavors, which requires identifying the problem, measuring progress, and validating change. Behavioral couples therapy blends principles of social learning theory and social exchange theory, teaching couples how to achieve positive reciprocity so that their relationship will be more pleasing for both partners. Cognitive interventions view stress in a troubled relationship as influenced by the interaction of cognitive, behavioral, and affective factors: cognitive restructuring is directed at changing dysfunctional interactive patterns and distorted belief systems (schemas) as couples acquire skills in problem solving. Partner acceptance is a key factor in integrative couples therapy.

While research indicates that stable marriages may take several forms, the Gottman method indicates unstable marriages are characterized by a high ratio of negative to positive exchanges. Behavioral parent training, largely based on social learning theory, represents an effort to train parents in behavioral principles of child management. Intervention typically attempts to help families develop a new set of reinforcement contingencies in order to begin learning new behaviors. Skills acquisition, contingency contracting, and the learning of behavioral principles play important roles in parent training.

Functional family therapy attempts to integrate systems, behavioral, and cognitive theories in working with families. Viewing all behavior as serving the interpersonal function of creating specific outcomes in behavior sequences, functional family therapists do not try to change these functions but rather try to change the behaviors used to maintain the functions. The technique has been successfully applied to families with adolescents at risk for delinquency, violence, or drug abuse.

Conjoint sex therapy involves both partners in an effort to alleviate problems of sexual dysfunction. First developed by Masters and Johnson and elaborated by Kaplan, the treatment of sexual dysfunction typically uses a variety of explicitly cognitive and behavioral techniques (sensate focus, systematic desensitization, communication training) aimed specifically at remediation of the sexual problem. In recent years, medical interventions have become increasingly popular. While some therapists focus exclusively on the presenting sexual problem, others attempt to integrate marital and sexual therapy by calling attention to the relational context in treating the couple's sexual problems.

An expansion of cognitive therapy has led some clinicians to incorporate a constructivist perspective in their work. Clients who have experienced trauma or abuse are coached to construct new "stories" to explain their conditions or situations, unfreezing hampering beliefs and thereby creating more options in their behavior.

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13

Social Construction Models I: Solution-Focused Therapy and Collaborative Therapy



LEARNING OBJECTIVES

- LO 1 Compare and contrast modernist versus postmodernist perspectives
- LO 2 Explain some assumptions underlying the social constructionist point of view
- LO 3 Describe miracle questions, exception-finding questions, and scaling questions
- LO 4 Explain how a reflecting team works

Postmodern social construction therapies reject the idea that there is an objective truth observable to all. Instead, they focus on the subjective perceptions of the truth or reality that each client presents. Skeptical of the modern scientific assumption that truth is waiting to be uncovered by careful, objective observations and measurements, postmodernists in family therapy contend that multiple views of reality exist and that absolute truth can never be known. This challenge to taken-for-granted assumptions—in religion, the arts, politics, and the sciences—represented a **deconstruction** of fixed ways of thinking and an exploration of new assumptions and development of new constructions. Postmodern ideas in family therapy derive from the work in philosophy and literary criticism by such people as French philosopher Jacques Derrida (the originator of deconstruction), U.S. literary theorist Paul de Man, and poststructuralist historian and social critic Michel Foucault, among others. From a postmodern perspective, everything is open to challenge, including postmodernism itself. The postmodern movement, along with its **constructivist** epistemology—the view that each person constructs a personalized view and interpretation of what they might be experiencing together—has significantly impacted the field of family

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therapy and is at the cutting edge of today's practice. The number of family therapists practicing this type of therapy has grown significantly (Bradley, Bergen, Ginter, Williams, & Scalise, 2010), standing with behavioral and Bowen family systems among the approaches most often practiced in North America.

It is important to note the cultural context in which these postmodern trends emerged, as rapidly changing social and political awareness of multiple lifestyles and perceptions have gained prominence. All attempts at imparting meaning—whether from printed text, Internet posting, social media, or anything else—provide variable conditions and contexts within which sense can be construed. If three different people—one from Paris, another from Hong Kong, and a third from New York—all read the same Internet web page, there would not be absolute agreement among them about its meaning, due in part to how the social and cultural backgrounds of each reader inform each person's understanding.

LO 1 The Postmodern Revolution

To better understand postmodernism, compare it with the earlier modernist perspective. For a modernist, the world is simply out there, available for observation (Gergen, 2001). Although modernists appreciate the endless perspectives one could take in understanding the world (think of Picasso's cubism or Freud's unconscious), the knowability of the world, however challenging, was not a question. Postmodernists, on the other hand, argue that what we call reality is not an exact replica of what is out there but is socially constructed through language. One cannot hope to fully know an elusive truth; one only continually constructs and reconstructs it. As Freedman and Combs (1996) observe:

> A central tenet of the postmodern worldview in which we base our approach to therapy is that beliefs, laws, social customs, habits of dress and diet—all the things that make up the psychological fabric of "reality"—arise through social interaction over time. In other words, people, together, construct their realities as they live them. (p. 23)

Postmodern thinkers emphasize that our beliefs about the world—what constitutes reality—are social inventions, not a reflection or map of the world; they evolve from conversations with other people. Through the interactive process of language (not merely words but gestures, facial expressions, vocal inflections, and silences), people connect and construct their shared views of reality. The development of knowledge, then, is a social and cultural phenomenon, mediated through language, and not determined by an objective condition of reality. The concept of adolescence, for example, was not considered a specific period of human development until recently. Did that period suddenly appear, or did people begin within the last century to sort out their perceptions into types or classes based on chronological ages? Obviously, the latter explanation makes more sense. Recall the discussion in Chapter 2 of adolescence, emerging adulthood, and early adulthood. Whereas in the past, we considered only adolescence and adulthood, we now have additional categories. It is important to realize that we have not just added labels to a static condition of human development. Instead, the experiences of people have changed, and the language with which we describe and understand

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those changes has changed. Indeed, in this case, the back and forth between language and experience reflects how reality and language mutually influence each other in an ongoing process that defies final meaning.

Gergen (2015) calls attention to such modern concepts as "romantic love" or "maternal love" as *invented* social constructions. In our times, "codependent" or "adult child of alcoholics" or "gay" or "straight" or "bipolar" or "borderline" or "normal" also are invented terms—social constructions—that we reify, that is, convert or regard as something concrete. In the postmodern view, each term is simply an invented label that clients and therapists alike bring to therapy. This is a useful, in fact inevitable, way of communicating. But it also can have a dangerous consequence, as de Shazer (1991) maintains, because as therapists, we run the risk of reifying cybernetic concepts (such as homeostasis) and describing families as though families really possess those concepts.

Postmodern thinkers coined the term *constructivism* to emphasize the subjective construction of reality. That is, each of us constructs a sense of the world based on our own previously held dominant beliefs, which in turn largely reflect (but are not identical with) the dominant beliefs of society (meaning making includes idiosyncratic experience and creativity). Those beliefs are kept alive and passed along through stories or *narratives* that we share with one another. Moreover, these narratives help organize and maintain our view of life. People organize their experiences and their memories into self-narratives—personal and family stories, myths about family characteristics or circumstances, reasons for doing or not doing something—to gain a sense of order, continuity, and meaning in their lives. Our identities require the organizing capacities of language. We view the world "through the lens of a succession of stories—not only a personal story, but gender, community, class, and cultural stories" (Parry & Doan, 1994, p. 24).

A postmodern social construction outlook challenges some types of systems thinking, especially the first-order cybernetic type, by examining the assumptions clients make about their problems rather than conceptualizing their difficulties in terms of interactional behavior and feedback loops. Collaboratively helping clients seek new meaning through mutual inquiry replaces the therapist as outside expert. In this view, the therapist walks alongside the clients toward an unknown destination of new meaning and action (Anderson, 2012) rather than directing the couple or family with any preconceived notions. Clients make sense of their world, gain knowledge, attribute meaning to their experiences, and create a sense of their reality through language.

Postmodernist Constructions

Postmodern therapists reject the features central to a modernist, problem-focused, objective orientation to human problems. They do not focus on blocked impulses or unconscious conflicts, flawed family structures, emotional incapacities, distorted cognitions, or dysfunctional personality traits. Nor are they interested in maintaining the conventional barrier between therapist and client. In Gergen's (1993) view, "that sacred distance between objectivity, neutrality, and reason on one side, and subjectivity, bias, and passion on the other" is no longer relevant to psychotherapy (p. ix).

Despite education or expertise, a therapist's prejudgments cannot be considered objective or unbiased and must not determine the goals toward which the family therapy should be directed. Indeed, labeling families as dysfunctional or interventions by the therapist to change

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BOX 13.1 THERAPEUTIC ENCOUNTER

Constructivism and Social Constructionism

Constructivism and social constructionism are related but not identical concepts. Both address the nature of knowing and reject the idea of describing an objective reality. Constructivism, however, is rooted in the biology of cognition—more specifically, in the neurobiology of Humberto Maturana (1978), who emphasized the limitations of our perceptions in ever really knowing what is "out there" because nothing is perceived directly and each person's perceptions are filtered through individual nervous systems. Each of us thus brings different assumptions to the same situation—we construe reality differently—as a result of our own mental and symbolic processes and meaning-making structure.

Social constructionism agrees that none of us sees an objective reality, but it expands this view by focusing on the language system, relationships, and culture we share with others. Our attitudes, beliefs, memories, and emotional reactions arise out of relational experiences. Through language, we inculcate the prepackaged thoughts of our society in the process of socialization, learning to speak in acceptable ways and share the values and ideology of our language system (Becvar, 2000).

Hoffman (2002) illustrates the differences between a traditional objective modernist position, a constructivist view, and a social constructionist view in the following Three Umpires joke: First Umpire (Modernist): "I call 'em as they are"; Second Umpire (Constructivist): "I call 'em as I see 'em"; Third Umpire (Social Constructionist): "There ain't nothing till I (or we) call 'em."

Therapeutically, the clinician with the modernist (sometimes called essentialist) outlook, as an outside observer, might search for an objectively knowable condition—the cause of the problem—and try to fix it. By contrast, in applying either of the other two concepts, clinicians are more collaborative in working with family members; they help families examine and reassess the assumptions their members make about their lives rather than focusing on family interactive patterns. The constructivist, believing the problem to be in the eyes of the beholder, might help the family change the way its members perceive the problem. The social constructionist becomes a part of the system, engaging in collaborative conversation with family members to discover new possibilities that reconstruct the meaning they give to their lives, helping them to dissolve their problems.

the way a family operates run the risk of imposing a conventional or socially sanctioned view of what constitutes a normal or stable or happy family.

The notion of "normality" is particularly thorny. Despite an appreciation of the difficulty in determining what is "normal," modernists tended to assume that a condition called "normality" did exist and could be defined and used as a kind of measure against which experience could be understood. From the postmodern perspective, however, one cannot meaningfully talk about what constitutes socially determined views on normality because all views on these subjects are themselves multiply constructed. Even within social or cultural systems, there is no agreement about what constitutes normality.

Postmodern notions affect the way postmodern therapists understand diversity and culture and their relationship to the family. Therapists with a postmodern, constructivist, or social constructionist outlook (see Box 13.1) argue that preconceived views of what constitutes a functional (or dysfunctional) family are "correct" only to the beholder. Rather than imposing a single standard for determining a family's functional level, consideration of ethnicity, culture, gender, sexual orientation, type of family organization, and so on must also be considered. The personal experiences

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and viewpoints of individual family members must be included and the family's interaction with larger systems (schools, social agencies) addressed. All views of events and relationships are valued equally, irrespective of gender, social class, cultural background, or sexual orientation.

Social constructivists note the importance of cultural diversity on the therapeutic experience itself. By minimizing multicultural influences, modernist therapists ran the risk of judging ethnically unfamiliar families by their own standards of what "objectively" constitutes a functional family life. The postmodern view rejects such so-called objective knowledge, questioning its certainty and universality. Truth, rather than being immutable or absolute, is simply the best-informed understanding for which there exists a high degree of consensus among people. Thus a Western postmodernist might find herself challenged in working with a family from a culture in which patriarchal values dominate family experience. She cannot impose her Western values on their experience, nor should she shy away from recognizing the value of her experiences and values.

Postmodern therapists take a "not knowing" stance (Anderson, 2012) that replaces any predetermined view of how a family should change with a collaborative posture in which all participants examine the belief systems by which the different family members and the therapist view "reality." The therapist follows leads as openings develop rather than imposing some predetermined scheme or framework for uncovering patterns. After each family member has considered his or her own assumptions about the world that form the basis for the *meanings* given to events, the family and therapist come together in a "conversation" to *co-construct* new views of the family's "reality" and develop new options its members might pursue. Instead of concentrating on the origins of problems, the therapist turns, together with family members, to finding workable solutions. In the process, the family may be helped to clarify and revise some of the central themes of its personal narratives or stories about its members.

Here is a good opportunity to compare a familiar modernist concept in psychotherapy with a postmodernist one. In comparison with Anderson's not-knowing stance, consider Freud's so-called "even hovering attention," which describes the nonjudgmental way analysts should listen to their patients' free associations designed to free the participants from familiar meanings and culturally imposed inhibitions. The patient's verbal productions were, however, eventually interpreted within the Freudian schema (itself a construction). Today, postmodern therapists (including psychoanalysts) recognize the shifting contexts that inform the way people understand themselves and their own changing lives.

Postmodern Therapeutic Outlooks

Postmodern-oriented therapists attempt to collaborate with family members as self-creating, independent participants. There is an assumption of a shared expertise among all participants. The therapist is no longer a detached, powerful outside observer or sole expert but rather a partaker, with his or her own set of prior beliefs, ready to play a role with family members in constructing the reality being observed. No longer giving directives as sole expert, the therapist works with the clients to retell and relive stories and to co-construct possible alternative stories or new outcomes. This requires therapist *responsiveness*, sensitive reciprocal adjustments with clients to achieve goals, and *persistence*, sustained focus on exploring new ideas with clients, ideally expressed in "responsive persistence," a commitment to sustained negotiation of

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meaning (Sutherland, Turner, & Dienhart, 2013, p. 472). The therapist engages in dialogue with family members, helping them shake loose from a fixed account of their lives (a story from which they often see no escape) so that they might consider alternatives offering greater promise. A therapist might help a person who struggles with alcohol see that he is more than a person with a drinking problem, for example.

Postmodern therapists are interested in the shared set of premises of reality a family attaches to a problem that perpetuates its behavior. Together, as a unitary therapist–family observer system, therapy becomes a cooperative undertaking in which new meaning and understanding are jointly constructed rather than imposed by the therapist. With new outlooks, family members (and therapists!) develop more empowering stories about themselves and find new ways of coping with their difficulties. Shunning the traditional barriers often erected between therapist and clients, Doherty (1991) encourages therapists to engage in a subjective but liberating dialogue with family members: "Their goal is to enable clients to find new meanings in their life situations and to "restory" their problems in ways that free them from the mesmerizing power of the dominant culture" (p. 38).

Social constructionists (Gergen, 2015) think that the assumptions about reality that we make are not objective mirrors of reality but arise through communication—language and conversation with others—so that any knowledge we have develops out of a social context that has been mitigated by language. More than the mere outward expression of inner thoughts and feelings, language shapes and is shaped by human relationships. If reality is conditional and contextual, then each of us creates reality by observing, making distinctions about these observations, and sharing our perceptions with others through language. As Campbell, Draper, and Crutchley (1991) contend, "language is a process of consensual agreement between people and is, therefore, the basis of one's view of reality" (p. 336).



BOX 13.2 CLINICAL NOTE

Some Characteristics of Social Constructionist Therapies

- *Assumptions about the presenting problems are explored.*
- *The therapist has permission not to be an expert.* Not bringing preconceived ideas to the session, the therapist and the family engage together in mutual inquiry.
- *The client (not the therapist) is the expert in his or her own life.*
- *There is greater acceptance of eclecticism.* Moving beyond employing specific intervention techniques, the therapist can more readily combine techniques (cognitive, systemic, constructivist) or modalities (individual, couple, family).
- *Language is the vehicle used for forming new constructions.*
- *The focus of attention is cognition, not behavior; beliefs shape action, and culture shapes beliefs.*
- *There is increased likelihood to attend to diversity issues.* Not looking for the "truth" of the situation, the therapist can learn about differing views offered by different family members, not promoting his or her own socially acquired prejudices.
- *Clients and therapists alike are empowered by believing their situation is changeable.* The goal is to help clients explore new meanings in their lives.

Source: Adapted from Goldenberg and Goldenberg (1999) and de Shazer (1985).

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LO 2 Social Constructionist Therapies

In this chapter, we offer four social constructionist therapeutic approaches in which the language and meaning given events take precedence for the therapist over attending to behavioral sequences or family interactive patterns. These therapists are intent on engaging families in conversations calculated to facilitate changes in family members' perceptions of their problems, empowering them to restory and actively redirect their lives. These family therapists urge a shift in attention away from an inspection of the origin or the exact nature of a family's presenting problems to an examination of the stories (interpretations, explanations, theories about relationships) family members have told themselves that account for how they have lived their lives. The family that considers itself to be a "winning" family, for example, may have a very difficult time coping with a member who does not live up to expectations. To them, the narrative about being winners may seem unalterable. People often become convinced that their stories are reality or the truth; in effect, they have confused their personal map of the world with the territory the map is intended to represent. This notion that "the map is not the territory" was first proposed by Alfred Korzybski (1942) and was adopted by Bateson (1972) to indicate that the conceptual frame we bring to the analysis or interpretation of a situation is just that—a personal point of reference—not to be confused with the way the situation really is. Many possible explanations or interpretations could be assigned to the identical experience.

Social constructionist therapists are particularly interested in expanding clients' rigid and inflexible views of the world. Members of the "winning" family, for example, might feel great relief if they can rewrite their story to allow for imperfection or defeat. Unspoken resentments or harshly competitive feelings may dissolve once the premise of "winner" is deconstructed. Client views are mirrored in the language they use in constructing their takes on reality. Language—conversation—in turn becomes the therapeutic vehicle for altering old behaviors by considering new explanations leading to new solutions.

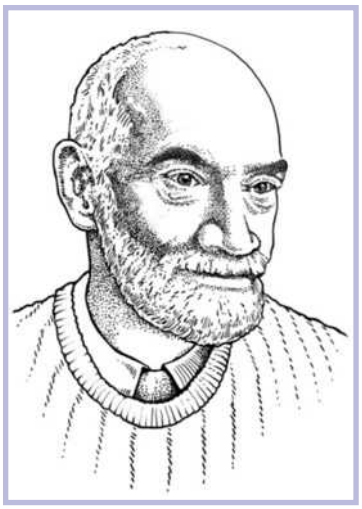
LO 3 Solution-Focused Brief Therapy (SFBT)

Among today's most popular and influential family therapies, solution-focused brief therapy (SFBT) is concerned with change rather than with assessing *why* the family developed its problems. Solution-focused therapists insist that families, right from the start of therapy, join them in *therapeutic conversation* as they examine their troublesome situation. Discouraging families from speculating about why a particular dilemma arose or looking for underlying family pathology, solution-focused therapists listen to the language used as families describe their situations and the conflict resolution they hope to achieve. Led by the therapist but directed by client goals, family members construct possible solutions together to reach those goals. As Berg and de Shazer (1993) put it:

> As the client and therapist talk more and more about the solution they want to construct together, they come to believe in the truth or reality of what they are talking about. This is the way language works, naturally. (p. 9)

Instead of "problem talk" (searching for explanations of client problems by piling "facts" upon "facts" about their troubled lives), these pragmatic, minimalist therapists urge

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Steve de Shazer, M.S.W

"solution talk" (in which therapist and clients discuss solutions they want to construct together). For example, instead of saying to a family in the initial session, "Tell me what problems brought you to see me," the solution-focused therapist might ask, "How can we work together to help you change your situation?" The therapist sets the stage for dialogue, brings forward the expectation that change will take place, and solicits the client's active and collaborative participation in achieving change. See Box 13.3 for a case presentation that illustrates how the therapist initiates change.

If, as social constructivists assert, numerous realities exist, with each reality being arbitrarily and subjectively based on personal constructions or stories of what's out there, then what we agree to call reality is nothing more than consensus about our perspectives shared through language. The solution-based therapist helps families, by means of solution-talk, to come to believe in the truth or reality of what they are talking about

BOX 13.3 THERAPEUTIC ENCOUNTER

A Therapist Initiates a Solution Process

Observe how a therapist sets up an expectation of change with a woman trying to be a perfect mother (de Shazer, 1985). In the process, he helps create in her a corresponding sense of what to expect after the problem or presenting complaint is gone.

Mrs. Baker came to therapy complaining about her approach to her children. She thought she should *completely* stop yelling at them because the yelling did not achieve its aim and just left them frustrated. Trying to find a minimal goal, the therapist asked her, "What sort of thing do you think will happen when you start to take a more calm and reasonable approach to your children?" (p. 35)

Several features are noteworthy in this therapeutic intervention. The phrasing recasts the goal (a calmer and more reasonable approach) as small and more reachable than stopping yelling completely. The implied suggestion is not only that Mrs. Baker should take a calmer and more reasonable approach but also that she will (the use of *when* rather than *if*). The further expectation is that taking a calmer and more reasonable approach will make a difference, sufficient enough for Mrs. Baker to notice (things will happen).

By turning the goal into a small start, the therapist is encouraging the client to proceed with changes she is likely to view as self-generating, minimizing further therapeutic interference. In fact, due to Mrs. Baker's randomizing her approach and permitting herself the solutions of yelling or being calm, depending on the circumstances, the children no longer found her behavior so predictable (and thus able to be ignored); the "causes" of her yelling therefore diminished in both frequency and intensity. Soon her occasional yelling took on a new meaning, signaling to the children when she meant business. Mrs. Baker did not have to stop yelling completely in order to be a perfect mother, as she had believed at the start of therapy, since she now had a solution—she could choose to yell or not to yell, according to the situation and the response of others. de Shazer's technique fully accepts Mrs. Baker (as a yeller) and does not scold her for yelling nor tell her to change by eliminating the yelling. Any continued yelling, when appropriate, is not seen as a sign of resistance but rather as cooperation with the therapy.

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together with the therapist and to construct solutions consistent with those consensually validated perceptions. Workable solutions result from redescriptions of themselves—in effect, the family creates new, empowering stories about themselves. If successful, clients achieve a cognitive change, reconstructing their sense of their own ability to resolve, control, or contain the presenting problem (Shoham, Rohrbaugh, & Patterson, 1995).

De Shazer's (1985, 1988) overall contribution was to provide the family with "skeleton keys"—interventions that work for a variety of locks. Such keys do not necessarily fit a complex lock perfectly; they only need to fit sufficiently well so that a solution evolves. That is, in constructing a solution, the therapist does not need to know about the history of the problem or what maintains the complaint. Nor is the therapist particularly interested in the details of the complaint, preferring to attend instead to developing with the family expectations of change and solution. By limiting the number of sessions (typically 5 to 10), the therapist helps create the expectation of change, making the achievement of goals appear more attainable. (It also endears SFBT to managed-care organizations that continue to pressure therapists to reduce the length of therapy.)

Another theoretical view that sets SFBT apart from the MRI model is the rejection of the idea that clients who come asking for change are at the same time resisting change. Solution-focused therapists contend that clients really do want to be cooperative and to change. They resist interpretations or other interventions from the therapist only if these do not seem to fit. To promote cooperation, the therapist *compliments* clients ("You seem to be really trying to be a good mother under difficult circumstances"), focusing on client strengths or past successes (Seedall, 2009). Once family members sense that the therapist is on their side, he or she is in a position to make suggestions that they try something new that might make them feel better. Typically, therapists encourage *small changes* that, once achieved, lead to further changes ("Marie seemed to like it when you sat and talked to her on Wednesday. Do you think you could try to do the same thing two nights next week?"). See Box 13.4 for an example of expanding change options.



BOX 13.4 THERAPEUTIC ENCOUNTER

Either/Or or Both/And Choices

Solution-focused therapists believe people who focus on problems often give themselves "either/or choices" (e.g., in Box 13.3, to continue yelling or stop yelling completely). Instead, solution-focused therapists construct a "both/and choice" (expecting Mrs. Baker to continue yelling when appropriate and to contain her yelling when she deems it unnecessary). Couples therapists often see clients, each of whom takes an "either/or" position ("I'm right and you're wrong"). Without declaring one the winner, the solution-focused therapist is likely to offer a "both/and" substitute (both have valid positions, and each partner's unwillingness to listen to the other leads to a standoff that is nonfunctional) in order to reexamine the couple's viewpoints (de Shazer, 1985).

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LEADING FIGURES: DE SHAZER, BERG, LIPCHIK, MILLER, AND DE JONG This internationally recognized short-term approach, which takes a nonpathological view of clients and strives to help them find solutions to current, specified problems, comes primarily from the work of social worker Steve de Shazer (1988, 1991, 1994); Insoo Berg (1994); Eve Lipchik (2002); Scott Miller (1994); and Peter De Jong (De Jong & Berg, 2012). The center was co-founded by de Shazer and his wife, Insoo Berg, a native of Korea. He died in 2005, and she passed away in 2007, at which time the rights to the center's training materials were transferred to the Solution Focused Brief Family Association. Lipchik continues to practice in Milwaukee, as does Miller in Chicago.

De Shazer had worked at the Mental Research Institute (MRI) in Palo Alto with John Weakland, so early solution-focused theory was closely identified with the strategic approach. De Shazer (1991, 1994) later turned to the ideas of linguistic philosopher Ludwig Wittgenstein—especially his notions concerning "language games," which are conversations people engage in with one another to determine reality. Today solution-focused therapy is clearly in the social constructionist camp, emphasizing the central role of language in how clients view themselves and their problems. Not surprisingly, SFBT shares with the MRI the notion that dysfunction arises from faulty attempts at problem solution. The family perceives itself as stuck, having run out of ways to deal with the problem (Duncan, Miller, & Sparks, 2003). However, de Shazer and associates part company with strategists by emphasizing that the family has developed a faulty or negative set of constructions; as a result, family members continue to think of the problem using the same language as before, with few new options (Lipchik, 1993).

Solution-focused therapists aid the family in discovering its own creative solutions for becoming "unstuck." In short, while the MRIers try to get clients to change the behavior that hasn't worked, the SFBTers try to get them to change their cognitions in order to open up the possibility of finding new ways to deal with the problem. The MRI model is problem focused; the Milwaukee model is solution focused. The former urges clients to *do* things differently, while the latter urges them to *view* things differently (Shoham, Rohrbaugh, & Patterson, 1995).

The assumption here is that clients already know what they need to do to solve their complaints. The therapist helps them use that knowledge differently. The overall aim of this approach is to help clients start the solution process. *The solution does not need to be matched to the specific problem to be effective*. Actually, solution-focused therapists believe that the *solution process* is similar despite different problems. In describing his approach, de Shazer uses a simple metaphor: The complaints clients bring to the therapist are like locks on doors that could open to a more satisfactory life, if only they could find the key. Often, time is wasted and frustration heightened in trying to discover why the door is locked when the family should be looking for the key.

SFBT therapists take the position with clients that change is inevitable; the only issue is when it will occur. This creates expectations that change will occur as soon as the "key" is found. The therapist might wonder aloud what the client expects to be different after the

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presenting complaint is gone. According to de Shazer, just expecting to get somewhere different, somewhere more satisfactory, creates the expectation of beneficial change in the client and makes it easier to get there. Solution-focused therapists have devised various therapeutic questions to disrupt problem-maintaining behavioral patterns, change outmoded family beliefs, and amplify **exceptions** to behavior previously thought of by clients as unchangeable. Three kinds of questions, often asked during the initial session, are central to the solution-focused approach: (a) "miracle questions"; (b) exception-finding questions; and (c) scaling questions (De Jong & Berg, 2012).

The *miracle question* (de Shazer, 1991) states:

> Suppose that one night there is a miracle and while you were sleeping the problem that brought you to therapy is solved. How would you know? What would be different? What would you notice the next morning that will tell you that there has been a miracle? What will your spouse notice? (p. 113)

Future oriented and intended to illuminate a hypothetical solution, this therapeutic act offers each family member an opportunity to speculate on what their lives will be like when the problem the family brought to therapy (say, marital conflict or struggles between parents and adolescents) is solved. Consideration of a brighter future in which all members change increases its likelihood to occur, and the solution calls for a consideration of how to reach the stated goal offered by the family members themselves. Each family member is also encouraged to reveal differences in his or her behavior that the others will notice. The idea here is for the therapist to invite the client to gradually construct an image of a fulfilling, productive, rewarding future with well-formed goals (De Jong & Berg, 2012). This movement to goals constitutes a "solution" (Fish, 1995). See Box 13.5 for an example of how a therapist implements the miracle question.

Scaling questions—asking clients to quantify their own perception of a situation—are intended to build a positive outlook and to encourage its achievement. First utilized by behavioral therapists, the technique allows the therapist to assess each client's viewpoint and to motivate partners to expand their goals. Consider the following question asked of a client in the first session (Berg & de Shazer, 1993, p. 10):

> How confident are you that you can stick with this? Let's say 10 means you're confident that you're going to carry this out, that a year from now you'll be back and say, "I did what I set out to do." Okay? And 1 means you're going to back down from this. How confident are you, between 10 and 1?

Here the therapist is getting the client to commit to change and, once having done so, to stick to or even improve the forecast. Used at various times during therapy, scaling questions may help couples gauge each other's perceptions of an event (She to therapist: "I thought the way we dealt with the money issue last night was a 7." He: "Well, at least we didn't end up fighting, but I think we have a long way to go, and I would rate it a 4"). The therapist then uses these numbers to motivate or encourage: "What might the two of you do to make a small change, say move it up one point?" Or perhaps the therapist points out that previously they rated themselves at 2 or 3, so what exception

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BOX 13.5 THERAPEUTIC ENCOUNTER

Asking the Miracle Question

In the following excerpt of an interview, Cheryl, a therapist, asks her client, Rosie, what she would notice was different if she woke up the next morning and a miracle had occurred, solving her problems. Rosie is a 23-year-old pregnant high school dropout, with two preschool girls, 2 and 3 years of age, and two older boys at school. She has been a prostitute to supplement welfare payments and believes she may have gotten pregnant this time from unprotected intercourse with a client.

ROSIE (smiling): That's easy; I would have won the lottery—$3 million. *[Notice how Rosie posits an unrealistic miracle and the therapist redirects her to an achievable goal.]*

CHERYL: That would be great, wouldn't it? What else would you notice?

ROSIE: Some nice man would come along who has lots of money and lots of patience with kids, and we'd get married. Or I wouldn't have so many kids, and I would finish high school, and I would have a good job.

CHERYL: OK, that sounds like a *big* miracle. What do you imagine would be the first thing that you would notice that would tell you that this day is different, it's better, a miracle must have happened?

ROSIE: Well, I would get up in the morning before my kids do, make them breakfast, and sit down with them while we all eat together.

CHERYL: If you were to decide to do that—get up before them and make them breakfast—what would they do?

ROSIE: I think maybe they would come and sit down at the table instead of going and turning on the TV.

CHERYL: And how would that be for you?

ROSIE: I'd be happier because we could talk about nice things, not argue over TV. And my babies won't start crying over all the fighting about the TV.

CHERYL: What else? What else will be different when the miracle happens?

Exception-finding questions, used early in therapy (De Jong & Berg, 2012), deconstruct a problem by focusing on exceptions to the rules—times when the adolescent was cooperative, the child did not wet his bed, dinner did not end in a family free-for-all. In this case, the therapist later asks Rosie if there have been times during the previous 2 weeks when the miracle she just described happened, to which the client reports that actually things were different 4 days ago. The therapist helps the client see that she has the skills, and if she managed things differently, changes could occur.

ROSIE: Well, I went to bed about ten the night before and had a good night's sleep. I had food in the house, because I had gone to the store and to the food pantry on Saturday. I had even set the alarm for 6:30 and got up when it rang. I made breakfast and called the kids. The boys ate and got ready for school and left on time. (remembering) One even got some homework out of his backpack and did it—real quick—before he went to school.

CHERYL: (impressed) Rosie, that sounds like a big part of the miracle right there. I'm amazed. How did it happen?

Here the solution-focused therapist encourages the client to build on times she was able to control the problem. A client who complains of *always* being depressed might be directed to pay attention to an "up day" and later to describe what he or she did differently that day. Later, when a depressing day is expected, the therapist directs the client to do something normally done on an up day in order to find a solution. Clients who report vague complaints might be told to observe and report back the next time something happens in their lives that they want to continue to have happen. In the following session, they might be asked what they think they need to do to get those satisfying experiences to continue to happen. As in most solution-focused techniques, the therapist does not teach the client what to do differently or teach her or him new tactics for accomplishing behavioral change. The therapist's interventions tend to be simple and minimal and in most cases are effective in opening doors.

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brought about the improvement? In this way, change is conveyed as continuous and expected.

Solution-focused therapy is largely organized around two activities: creating well-defined goals and developing solutions based on exceptions (De Jong & Berg, 2012). Feedback is offered to families at the end of each solution-building conversational session, and client efforts toward reaching satisfactory solutions are periodically reviewed. Therapy concludes, usually in a few sessions of solution-talk, when the presenting complaint is alleviated, and the client, feeling empowered, reconstructs his or her view of the world.

Before commencing solution-focused conversation, however, therapists attempt to assess the nature of the therapist–client relationship, categorizing clients as *visitors*, *complainants*, or *customers* (de Shazer, 1988). Visitors may be there at someone else's suggestion or demand, do not describe a clear complaint, do not expect change, and do not really want to engage in therapy. (The therapist may respond politely but offer no task or seek no change.) Complainants are willing to describe the perceived basis for their unhappiness but are not currently willing to work on constructing solutions, perhaps waiting for their partner to change first. (Here the therapist is accepting, sometimes suggesting tasks directed at noticing exceptions to the pattern complained about in the partner.) Customers describe their complaints and are prepared to take action to construct a solution. (The therapist here may be more direct in guiding such clients toward solutions.)

While therapists are complimentary and may attempt to engage in solution-focused conversations with all three types of clients, they are more active in helping a customer look for exceptions. However, the therapist–client relationship may change over time, as a visitor or complainant may respond to an assignment or set of questions and become a customer, willing to participate more fully in seeking solutions.

De Castro and Guterman (2008) offer a five-stage protocol for conducting solution-focused therapy. In addition to the cognitive aspects of this approach, these therapists accent the role of empathy in the therapy process. As previously noted, the exceptions are alternatives to problematic contexts. The five stages are:

1. Co-constructing a problem and goal
2. Identifying and amplifying exceptions
3. Assigning tasks
4. Evaluating effectiveness
5. Reevaluating problems and goals

Ramisch, McVicker, and Sahin (2009) offer an interesting example of how the miracle question and scaling might be used to help divorcing couples establish appropriate boundaries with each other and their children. They addressed shifts in power relationships among family members and boundary ambiguity that can emerge during and after parental divorce. The authors used both structural family therapy to assess power relationships within the family and solutions-focused therapy to facilitate change. The therapists redesigned the miracle question

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to build parental confidence and self-efficacy by focusing the solutions on an enhanced sense of power over outcomes and an ability to renegotiate boundaries:

> Imagine that when you leave the session tonight a divorce miracle happens and you both step into a movie set where you see yourselves as characters in a movie about your life after divorce. The movie also includes your children. Even though you are divorced or are currently going through divorce, the directors [of the movie] have mandated that you both still interact with each other and are both involved with raising the children. Imagine what you can see from your character's perspective, how you feel as the character now that the divorce has happened, and what specifically you are saying. How would you be able to tell that this is a movie rather than your real life?

See Box 13.6: Thinking Like a Clinician for practice in working with miracle questions, exception-finding questions, and scaling questions.

Solution-focused therapists aim at initiating new behavior patterns by offering generic *formula tasks* ("Do something different"; "Pay attention to what you do when you overcome the temptation or urge to overeat"), implying that the client can change while simultaneously focusing on the future triumphant moment when success is achieved. Rather than argue with the overeater who complains of *never* being able to control herself, the therapist might instruct her to watch for the exception—noticing times when she does control her urge to eat, thus learning for herself that *never* was a gross overstatement.



BOX 13.6 THINKING LIKE A CLINICIAN

Using an SFBT Perspective in Family Therapy

The Richards family has suffered the loss of a child. Just over a year before seeing you, their 14-year-old daughter, Julie, was killed in a car accident. All the other family members, including Julie's 16-year-old brother, Stevie, were physically unhurt. The entire family complains of exhaustion and depression. Mike Richards, Julie's father, had been driving, and he tells you that despite knowing that the other driver was completely at fault, he cannot shake a profound sense of guilt. He tells you, "I used to be a guy who could see the bright side of just about anything. With this . . . with Julie's death . . . I've closed down. I want to be there for the rest of my family, but I've become a professional mourner." His wife, Jennifer, agrees and adds that Mike's distance makes her feel unbearably alone in this tragedy. "It's like he's there and not there at the same time," she says. Stevie has more or less stopped seeing his friends, and though his grades remain good, his usual excitement at being at school is gone.

Address the following scenarios from an SFBT perspective.

1. What is Mike's current "story"? What compliment might you pay to help him begin to see alternative stories?	
2. Develop a miracle question to help the family in its present circumstances.	
3. What is an exception-finding question you might pose to Jennifer to help her with her relationship with Mike?	
4. Develop a scaling question to help Stevie reexamine his relationship with school.	

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BOX 13.7 EVIDENCE-BASED PRACTICE

Support for SFBT

Franklin, Trepper, McCollum, and Gingerich (2012) summarize SFBT research in a variety of settings and treatment populations (intimate partner violence, substance abuse, adolescents with externalizing behavior problems, or medication compliance with individuals diagnosed as schizophrenic) and conclude that "SFBT has considerable empirical support and has sought to continuously ground itself in research evidence" (p. 411). De Jong and Berg (2012) trace the chronological development of the research support for SFBT concurrent with the evolution of the model, beginning with observational research that generated new treatment strategies to treatment outcome studies that used client feedback during treatment, at the end of treatment, and several months after treatment to gauge their perceptions of goal accomplishment. This progressed to more controlled outcome studies, as reviewed by Gingerich and colleagues (2012), which have become increasingly sophisticated as they compare SFBT to other treatments that are considered evidence based and provide preliminary support for the effectiveness of SFBT.

Process research investigates the change interventions used by a model to determine if they are successful (McKeel, 2012). For example, in one study (Lloyd & Dallos, 2006), the miracle question was used with families who have children with an intellectual disability. They found that conversations that were at first problem oriented with respect to the impact of the disability on the family shifted to conversations about resilience and skills. Other research assesses its efficacy with targeted populations, such as group therapy with Level-1 substance abusers (Smock et al., 2008).

Other researchers are interested in how SFBT might work when integrated with other approaches. In one study (Seedall, 2009), SFBT and couple enactments driven by the therapist were used to affect change in couple treatment. SFBT presupposed client competency, strength, and resiliency in creating exceptions, accomplishing goals, and incorporating new solutions. At the same time, however, he introduced "couple enactments," which are understood as therapist-coached couple (or family) interactions. The rationale for integrating approaches is that enactments operate on attitudinal and behavioral levels and might be of use when the clients are particularly volatile and unable to work in a more solutions-focused way, especially during the initial phases of therapy. From this perspective, the enactments (or direct therapist intervention) are seen as a "conduit" to facilitate movement to solution building.

The Milwaukee group uses one-way mirrors and intercom systems. It is common for the therapist to take a consultation break for 10 minutes or so before the end of the session so the team can develop an intervention message. The first part of that message is likely to compliment what the client(s) is doing already that is useful. Subsequent parts might offer clues about possible solutions, give behavioral homework assignments, or issue team-constructed ideas that will lead to solutions.

While Fish (1995) applauds the "minimalist elegance" of this approach, critics such as Efran and Schenker (1993) find the approach too formulaic and wonder if clients haven't simply learned to go along with their therapist and keep their complaints to themselves. Indeed, there are signs that solution-focused therapists themselves have become less doctrinaire in their insistence on upbeat cognitive discourse, at times allowing client feelings and relationship needs to become a part of the treatment. Lipchik (2002) has been influential in integrating

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emotional issues into the sessions, emphasizing the importance of the client–therapist relationship over reliance on technique alone and using the interpersonal aspects of the therapeutic alliance in "unstuck" cases to reach successful solutions. Lipchik's position echoes that of de Shazer (Trepper, Dolan, McCollum, & Nelson, 2006), who argued toward the untimely end of his life for an evolving approach to understanding SFBT; to expand the model by making it more dynamic, especially with respect to clarifying the role of emotion in SFBT therapy; and to determine alternative outcome research methods to assess the overall effectiveness of SFBT. The relationship between postmodern therapy and research has gained attention by researcher-scholars who argue that the boundaries between them are not necessarily clear (De Haene, 2010). Must we use objective research processes and findings in a postmodern world that disavows objective truth?

Solution-Oriented Possibility Therapy

An offshoot of SFBT, solution-oriented therapy stresses the importance of keeping open for clients the opportunities for change as they search for solutions that work for them. Therapy is a brief, joint undertaking to which both clients and therapist bring expertise. Clients are experts on their own feelings and perceptions and provide the data from which the therapist can construct a workable problem definition, cast in a solution framework. Clients, and not therapists, identify the goals they wish to reach in therapy. The therapist, careful not to impose any single "correct" way for a family to live, is the expert at creating a collaborative solution-oriented dialogue. That conversation is guided by two main principles (O'Hanlon, 1993)—*acknowledgment* (that clients are being heard, validated, and respected) and *possibility* (keeping alive the prospect for change and solution).

According to O'Hanlon (Hoyt, 2001c), one feature that distinguishes SFBT from O'Hanlon's version (which he now refers to as *possibility therapy*) is the latter's validation of the client's emotions (reflecting the early influence of Carl Rogers on O'Hanlon's thinking). In addition, he contends that political, historical, and gender influences on the presenting problem are more likely to be explored in his approach.

LEADING FIGURES: O'HANLON AND WEINER-DAVIS

The solution-oriented approach developed by O'Hanlon and Weiner-Davis (2003) derives its therapeutic rationale primarily from three sources: the ideas advanced earlier by Milton Erickson, the earlier solution-focused brief therapy of de Shazer and colleagues, and the strategic intervention techniques developed at the MRI Brief Therapy Center. Bill O'Hanlon had been a student of Milton Erickson's and was later a translator and elaborator of his mentor's ideas. Michele Weiner-Davis had been affiliated with de Shazer at the Milwaukee Brief Therapy Center. O'Hanlon currently is associated with Possibilities in Santa Fe, New Mexico, where he links solution-oriented therapy with positive psychology. He authored several books on the application of solution-oriented techniques, including a focus on change (O'Hanlon, 2006) and spirituality (O'Hanlon, 2006), and a collection of his papers, *Evolving Possibilities* (O'Hanlon, O'Hanlon, & Bertolino, 1999).

Michele Weiner-Davis, a social worker, practices in Woodstock, Illinois. She has written several books for the general reader offering solution-oriented prescriptions (exceptions,

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miracle questions) and recommendations for marital problems, including *Divorce-Busting* (Weiner-Davis, 1992) and *Divorce Remedy* (Weiner-Davis, 2001).

SOME THEORETICAL ASSUMPTIONS Solution-oriented therapists concur with the constructivist view that there is no single correct view of reality—not the family members' view, not the therapist's view. Therapists therefore rely on the clients to define the goals they wish to reach in treatment. This tactic is based on the assumption that clients have the skills and resources to solve their own problems but have become so focused on the problem and their more-of-the-same unsuccessful solutions that they have lost sight of alternative ways of problem resolution. (The influence of the MRI brief problem-focused approach is clear here.) The therapist's role is to help clients use their inherent skills to find solutions not previously considered or to remind them of what they have done in the past that worked under similar circumstances. Emphasizing hope, encouragement, client strengths, and possibilities, solution-oriented therapists believe they empower clients to improve their lives and, in the process, help create self-fulfilling prophesies of success (O'Hanlon & Weiner-Davis, 2003).

Matthew Selekman (1993) outlines the following seven theoretical assumptions followed by solution-oriented therapists:

1. *Resistance is not a useful concept.* Clients do want to change, and the therapist should approach the family from a position of cooperation rather than figuring out how to control them to overcome their resistance to help.
2. *Change is inevitable.* The therapist emphasizes that it is only a matter of time before change occurs, employing language that underscores possible solutions.
3. *Only a small change is necessary.* Once clients are able to value minimal changes, they are more likely to expect and look forward to even greater changes.
4. *Clients have the strengths and resources to change.* Therapy achieves more positive results by supporting family strengths than by focusing on problems or pathology.
5. *Problems are unsuccessful attempts to resolve difficulties.* It is the family's repeated attempts at solutions that maintain the problem. Families need help to get "unstuck" from more-of-the-same attempts at seeking solutions.
6. *You don't need to know a great deal about the problem in order to solve it.* Exceptions when the problem did not occur can be used by the therapist as building blocks for co-constructing solutions with families without determining precisely why the problem surfaced in the first place.
7. *Multiple perspectives.* There is no final or "correct" way of viewing reality; there are many ways to look at a situation and more than one way to find a solution.

Selekman (2006), a social worker, describes how to work collaboratively with aggressive, violent children and adolescents using this model. Hudson and O'Hanlon (1992) help couples in conflict "rewrite their love stories." When couples struggle, they develop stories about one another that poison their relationship ("You just want to control me"; "You're exactly like your father"; "You care more about the children than you do about me"). Convincing themselves that their view is the "truth," they argue over whose view of reality is the correct one. They typically expect the therapist to judge who is right and who is wrong.

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Without imposing their own stories as explanations for the couple's problems, Hudson and O'Hanlon try to help couples co-construct new interpretations of each other's behavior that allow new options in behavior to follow. Instead of focusing on their partner's troubling behavior, these therapists advocate bypassing blame, replacing destructive stories with action language asking the partner to do something new or different in the future, providing hope for change. "Catching your partner doing something right" is an exception-seeking therapeutic stratagem for finding new perspectives leading to new solutions, incorporating both solution-focused and MRI problem-focused procedures.

STRENGTH is a recent model that integrates solution-oriented and strengths therapy into therapeutic themes: **S**olution focus, **T**rajectory preview, **R**esource development, **E**xceptions analysis, **N**oticing positives, **G**oal setting, **T**enacity review, and **H**uman capacity development (Davidson, 2014). Tambling (2012) applies the solution-oriented approach to treatment of survivors of sexual assault and their partners.

A Collaborative Approach

The collaborative approach is another popular social construction therapeutic model, based on assumptions of a "postmodern tapestry" that emphasizes language and communication in the therapeutic relationship (Anderson, 2009, p. 301). This client–therapist collaborative dialogue approach reflects the ideas of psychologists Harlene Anderson and the late Harry Goolishian. Anderson contends that meaning is created and experienced in dialogue with others and with oneself. Human systems are essentially language- and meaning-generating systems. She observes:

> Knowledge and language are relational and generative, and therefore intrinsically transforming…when engaged in the use of language and in the creation of knowledge one is involved in a living activity (i.e., dialogue with oneself or another) and cannot remain unchanged. (Anderson, 2009, p. 303)

Cheon and Murphy (2007) add that therapists who practice from this perspective strive to "open and make their invisible thoughts visible" and that therapists are conversational partners who accent issues being linguistically constructed in the here-and-now.

Therapy systems are no exceptions. Therapist and client together create meaning with one another as they discuss a "problem." Anderson (1995) typically places "problem" in quotation marks to underscore her belief that there is no such thing as one problem. Rather, there are as many descriptions and explanations of the problem as there are members of the system. Thus, linguistically oriented therapists do not offer a specific set of intervention procedures, nor do they consider themselves objective experts regarding family problems. On the contrary, they actually downplay technique or therapist control and do not claim detached objectivity. Instead, they collaborate with family members in empathic conversations, which generate new meanings, new outlooks, and the dissolution of the problem. While the solution-focused therapies discussed earlier in this chapter propose various intervention techniques (miracle questions, exception-finding questions, and scaling questions), this model is more about attitude than technique or clinical methodology. That attitude is reflected in having egalitarian, purposeful conversations with family members as together they explore their problems and search for understanding and new options within the conversation (Anderson, 2009).

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For these therapists, the essence of therapy is dialogic conversation in which a client and therapist are *conversational partners who together engage in a shared inquiry* unique to each relationship and each conversation. While the client is the expert on his or her own life, the therapist has expertise in and responsibility for facilitating a conversational process, out of which comes the opportunities for change. Conversation, tailored to each family rather than based on any preplanned intervention methodology, involves active, respectful, and responsive listening; immersing oneself in client concerns; and asking conversational questions, all intended to encourage the full telling of the client's current story. The therapist is both a host for the conversation and a guest in the client's life (Anderson, 2009). Together, they engage in a shared or mutual inquiry for new meanings, attitudes, and narratives that change the perspective of both client and therapist.

LEADING FIGURES: GOOLISHIAN, ANDERSON, AND HOFFMAN

A pioneer in family therapy because of his participation in the innovative Multiple Impact Therapy project in the 1960s, in which collaborative collegial efforts were introduced into this brief therapy form, Harry Goolishian became a strategic therapist in the 1970s. Later, stimulated by the work of the Milan group, he began to challenge the applicability of early cybernetic theory to human systems. During the 1980s and early 1990s, his outlook evolved with social constructionism and postmodern thinking into what he called language systems. Goolishian maintained that problems are not fixed entities but are created and deconstructed through language.

Together with his colleague Harlene Anderson, the two viewed therapy as a linguistic process of "dissolving" problems in conversation by co-creating stories that open up new possibilities for clients as well as for the thinking of professionals. Goolishian founded the Galveston Family Institute in 1977, an acclaimed training center for family therapy. Since his death in 1991, the renamed Houston-Galveston Family Institute has been under the direction of Anderson. She continues to tie postmodern thinking to family therapy through an evolution of organizing metaphors for practice (Anderson, 2012).

Lynn Hoffman (1990, 2002) followed a course similar to Goolishian's, beginning as a strategic therapist (having worked with Jay Haley), moving on to a Milan viewpoint (while at the Ackerman Institute), and finally adopting the collaborative, problem-dissolving conversational outlook espoused by Goolishian and Anderson.

A LINGUISTIC PHILOSOPHY

As Hoffman (1990) puts it, *problems are stories that people have agreed to tell themselves*. This is consistent with the postmodern view that the problems people bring to therapy are not so much approximations of the truth as they are life constructions, made up of narratives, metaphors, and the like (Gergen, 1993). The validity of a person's claims is less important than the social utility the stories play in explaining his or her life. Therapy, then, becomes reconstructive, intended to free the client from a particular self-account in order to open the way for adopting alternative accounts—new linguistic spaces—that offer new options for action.



© Moment movies

Harlene Anderson, Ph.D.

Building upon Boscolo and Cecchin's idea that the problem creates a system of meanings, Anderson and Goolishian focused on the meaning system a family organizes around a problem. To them, the problem determines the system (which

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family members are touched by the problem) more than the system determines the problem (the more traditional family therapy view). Deliberately avoiding the expert's interventionist stance of designing therapeutic change in the modernist tradition, therapists in this postmodern collaborative approach view themselves as "learners" (the clients are the "knowers"), conducting therapy from a position of "not knowing." This is not to say that the therapist lacks knowledge or is without therapeutic skills but rather that he or she maintains respectful listening, stays in sync with the unfolding story, and tries not to begin with any set ideas about what should or should not change. Anderson (2007) uses a "story ball" metaphor to describe how clients hand her their life narratives as intertwined threads:

> As they put the ball toward me, and while their hands are still on it, I gently place my hands on it but I do not take it from them. I begin to participate with them in the storytelling, as I slowly look at/listen to the aspect that they are trying to show me … I am curious, I pose questions, I make comments, and I gesture. (p. 47)

This collaborative approach urges therapists to engage family members in "therapeutic conversation" as together they seek understanding and co-constructed meaning, leading to the consideration of new options and new behavioral possibilities. As Anderson and Goolishian (1990) described their outlook:

> We see therapy as a linguistic event that takes place in what we call a therapeutic conversation. The therapeutic conversation involves a mutual search and exploration through dialogue (a two-way exchange, a crisscrossing of ideas) in which new meanings are continually evolving toward the "dis-solving" of the problems and, thus, the dissolving of the therapy system and what we have called the problem-organizing and problem-dis-solving system. Change is the evolution of new meaning through the narratives and stories created in the therapeutic conversation and dialogue. (p. 161)



BOX 13.8 THERAPEUTIC ENCOUNTER

Hermeneutics and Collaborative Therapy

Hermeneutics, derived from the Greek word for *interpretation*, comes from Bible studies and represents an approach to knowledge. It is a process influenced by the beliefs and assumptions of the interpreter. In relationship terms, no one can ever truly understand an event or exchange between people, because each attempt to do so is influenced by what the interpreter brings to the situation (a particular way of looking at people or worldview). All each of us can see is one version of the truth of another person's meaning or intention.

Understanding, then, calls for a continuing open dialogue as people in a relationship try to understand each other's reality. Collaboration is essential in this back-and-forth activity, and there is no one correct interpretation of, say, the client's symptoms or stated problems. In this uncertain realm, the therapist, who may understand the process, is not any more of an expert than the client. The client is actually the expert in his or her own life. The therapy session is of necessity an egalitarian one, and the therapist must put previous assumptions aside and attempt to listen to views he or she may not share while remaining open to any newness in meaning that may emerge.

Language allows us to construct and make sense of what we are experiencing, to help organize and attribute meaning to our stories. But it does not mirror what is—instead, it reveals the meaning the speaker has attributed to the event. As Anderson (2003) observes, the reality we attribute to events, experiences, and people in our lives does not exist in the thing itself but is a socially constructed attribution created within a particular culture and shaped and reshaped by language.

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In therapy, all participants are engaged in a language system coalesced around a "problem"—"something or somebody that someone is worried about and wants to change" (Anderson, 1993, p. 324). That system is made up of those people who wish to "talk" about the problem and may include teachers, members of social agencies, and so forth. Membership in the therapy system is fluid, is determined on a session-to-session basis, and may change as the conversation changes and new units become the focus of therapy (Anderson, Burney, & Levin, 1999).

Family therapy is aimed at "dis-solving" (rather than solving) the problem. The problem, created through language, is dissolved (becomes a nonproblem) through language, as alternative meanings (new co-created stories) of the troublesome thoughts or feelings emerge. Greater self-capability occurs as altered understanding leads to no longer viewing or experiencing the previously distressing matter as a problem. Change, whether in understanding or behavior, follows naturally from the "therapeutic conversation" as new solutions arise, dissolving the problem. The therapeutic goal is reached when a conversation takes place in which the complaint is no longer a part (Hoffman, 2002). See Box 13.9: Thinking Like a Clinician for practice working from a linguistic perspective.



BOX 13.9 THINKING LIKE A CLINICIAN

Using a Linguistic Perspective in Family Therapy

Sean and Shona have come to you for help with a problem the couple says they simply can't solve. They have very little money (in fact, you've agreed to see them at a reduced fee). Sean tells you he is very anxious about money and believes Shona is irresponsible with money. Shona disagrees and tells you she buys only what she thinks of as necessities.

Sean jumps in and says, "Like lunch out with your girlfriends?"

Just as quickly, Shona responds, "We went to an inexpensive place."

Sean counters by saying, "You shouldn't be going out at all until we have the money."

"Oh, great, so I'm supposed to live under a rock until one fine day when we have the money for me to buy a silly hamburger!?"

Soon, the couple is fighting in your office. Working from a linguistic perspective, you invite the couple to talk about money, asking each to discuss what money means to them.

Sean jumps in once again, this time in anger at you, and says, "You don't get it. There is absolutely nothing to say about money. It means what it means. We have exactly forty-three dollars in our checking account. That's what it means. Forty-three dollars and the rent is $1,500.00, and we're already late in paying it. I don't even know what I am doing here since we can't afford you even at discount rates."

When you ask how the couple might earn more money, Sean rages at you for not listening to him. He's working as hard as he possibly can, and so is Shona. He recognizes that she contributes as much as he does and says they are doing the best they can.

1. How might you get Sean to enter into a conversation?	
2. What challenges do you see when people experiencing "concrete" problems (such as the lack of money) find it difficult to see how the problem is constructed?	
3. How might you help Shona open up the conversation?	

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LO 4 The Reflecting Team

One final postmodern approach that also relies heavily on therapy as a conversational and collaborative enterprise comes from Tom Andersen (1993, 1997). Consistent with social constructionist thinking, this approach to therapy strives to be egalitarian. It calls for less of a privileged subject–object dichotomy between therapist and family and thus is less hierarchical than most therapies. In this simple but original technique, a "two-way mirror" has replaced the more traditional "one-way mirror" so that in the course of a therapy session, professionals and families reverse roles and observe one another openly, offering perspectives on the family's issues. This opens up the therapeutic process between team members and family, lowers professional-client barriers, democratizes the undertaking, increases intimacy all around, and lets the client feel all participants are working together to help (not just sitting behind a one-way mirror and judging the client's behavior).

LEADING FIGURE AND THE LISTENING-TO-EACH-OTHER PROCESS

Tom Andersen was a Norwegian psychiatrist originally working from a Milan orientation. He eventually rejected its distancing therapist–client hierarchical system, especially the stance of the therapist as expert. While the earlier Milan interviews halted a family session in order for the therapist to consult with a team of professionals observing through a one-way mirror, Andersen expands on this tactic. In his creative use of reflecting teams, at one or more times during the session, especially during an impasse, the therapist will solicit comments from the professionals behind the mirror, and the family and therapist become the observers as team members have a conversation about the family conversation they have just observed. Without prior knowledge of the family or preplanning strategies, and unencumbered by hypotheses in order to understand the family's own construction of reality, the team members spontaneously present their views based on what they observed during that particular session. Typically, these views are offered as tentative, nonpejorative speculations regarding the problematic issues—with the team members careful not to make pronouncements, offer interpretations, or instruct family members regarding what they should talk about ("I wondered what it meant when . . ."; "I thought about the exchange between . . ."). After the team finishes its reflections, family members have an opportunity to talk about the reflecting team's comments. Shifting between inner and outer dialogue offers two differing perspectives on the same events and stimulates the search for new outlooks. In the process, the family feels heard, uncriticized, and important.

Andersen contended that sharing hypotheses about the family directly with them helps demystify therapy and leads to the use of a common "public language" rather than the hidden "private language" professionals often use when discussing cases (Andersen, 1992). The result is often greater common understanding among all participants, from which new conversations and new perspectives might emerge. Out of this new meaning may come new actions

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and the creation of a new reality for them. Andersen (1995) makes the following observation from his experiences using **reflecting teams**:

> When we finally began to use this mode we were surprised at how easy it was to talk without using nasty or hurtful words. Later it became evident that how we talk depends on the context in which we talk. If we choose to speak about the family without them present, we easily speak "professionally," in a detached manner. If we choose to speak about them in their presence, we naturally use everyday language and speak in a friendly manner. (p. 16)

Andersen (1992) likened the reflecting team approach to a walk into the future. Many roads are possible; some routes lead to dead ends, others to valuable new places. What did the family expect by taking the road they chose? Might there be other routes? Have they considered those? How can they talk to themselves about which routes were taken and which future routes might be best? Stimulated by reflecting team ideas in an egalitarian and collaborative fashion, and free to select those that are deemed useful, family members are encouraged to develop a new dialogue among themselves from which new perceptions emerge that lead to new meanings and ultimately new solutions.

Reflecting team processes have evolved in many creative ways (Anderson & Jensen, 2007). However, there is limited research support for the practice, with only two outcome studies, each with significant design limitations (Willott, Hatton, & Oyebode, 2012).



BOX 13.10 FAMILY DIVERSITY

Using SFBT across cultures

De Jong and Berg (2012) suggest that solution-focused brief therapy (SFBT) is well suited for use across cultures because it respects each client's voice and integrates clients' cultural customs, histories, and relational styles. They note that it has been used successfully with African American, Latino, Native American, and White clients.

Social construction approaches have been adapted for use in various cultures. For instance, Hsu and Wang (2011) integrated the Chinese construct of filial piety into SFBT for the treatment of parent–child conflict, using techniques such as the miracle question to explore possible solutions. Chaudhry and Li (2011) examined the appropriateness of SFBT for Muslim-American families, noting the need for sensitivity to issues of religion, family values, psychotherapy expectations, intrapopulation diversity, and experience of societal hostility. The characteristics of SFBT (positive frame, present focus, empowering, lower expectations of self-disclosure, and short-term focus) suggest that it may be culturally appropriate for Muslim clients, especially when compared to some other approaches.

Similarly, Meyer and Cottone (2013) indicate that SFBT may be appropriate for American Indian families because it accords with the American Indian perspective of continuous and unavoidable change, it focuses on client competence, and it can incorporate culturally valued practices. However, the future-oriented miracle question may need to be adapted to the present focus of American Indians.

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SUMMARY

The postmodern revolution in family therapy challenges cybernetic thinking. In the postmodern view, there is no objectively knowable universe—instead, what we call "reality" is socially constructed. People, together, construct their realities as they live them. Therapists with this view value diversity and contend that what we call reality is mediated through language and is socially and culturally determined from our experiences. Ethnicity, culture, gender, sexual orientation, type of family organization, and so forth must be addressed in determining a family's functioning level.

Both constructivism and social constructionism figure prominently in the therapies influenced by the postmodern revolution. The former, rooted in neurobiology, points to the limitations of our perceptions, based on the assumptions we make about people, while the latter notes that what we call reality is mediated through language and is socially and culturally determined from our experience.

Therapists with a social constructionist view focus on the meaning or shared set of premises or assumptions a family holds regarding a problem. These therapists reject the customary therapist–client hierarchy, engaging families on a more collaborative level without seeking "truth" or "objectivity" or "insight." Clients are encouraged to examine the "stories" they have lived by and to search together with the therapist for new, empowering ways of viewing and resolving their problems.

Reality exists only in the context of each person's set of mental constructs. The postmodern-influenced therapist is interested in engaging families in collaborative dialogues in which language and meaning assigned to events take precedence over behavioral sequences or family interactive patterns. Therapists help clients to find their own new meanings in their lives and to restory their problems and find more workable solutions.

Four examples of social constructionist family therapy are solution-focused brief therapy (de Shazer), solution-oriented therapy (O'Hanlon and Weiner-Davis), the collaborative approach (Goolishian and Anderson), and the reflecting team (Andersen). Solution-focused therapy emphasizes aiding clients in seeking solutions rather than searching for explanations about their miseries. Miracle questions, exception-finding questions, and scaling questions are commonly employed techniques. A related set of procedures, solution-oriented therapy, helps clients use their inherent skills to explore possibilities and develop solutions without imposing therapist explanations or solutions on the problem.

The collaborative approach pays particular attention to meanings generated between people. Therapists and clients become conversational partners engaged in a shared inquiry aimed at dissolving problems by co-creating stories that open up new possibilities. This approach offers no special techniques but rather offers a viewpoint or egalitarian attitude in the search for new options.

The reflecting team technique employs two-way mirrors so that professionals and families can reverse roles and observe one another, offering differing perspectives or tentative speculations on family issues. This opening up of the therapeutic process breaks down professional-client barriers and helps all participants communicate with one another using a shared "public language."

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14

Social Construction Models II: Narrative Therapy

LEARNING OBJECTIVES

- LO 1 Describe how narrative therapists use the concept of deconstruction
- LO 2 Each person's self-narrative provides the principle framework for structuring their experience. Explain how therapists encourage clients to become aware of unrecognized, internalized narratives
- LO 3 Discuss the meaning of problem-saturated stories
- LO 4 Define unique outcomes and explain how they help to change behavior
- LO 5 Justify the use of letters in narrative therapy

Narrative therapy is at the forefront of today's theory and practice of family therapy, signifying that our knowledge of reality is organized and maintained through stories we tell about ourselves and the world we inhabit (Kaslow, 2010). Our stories link life events together in a particular sequence to make sense of how and why we live the lives we do. This ongoing process of weaving together events includes stories about ourselves, our abilities, competencies, actions, relationships, achievements, and failures (Morgan, 2000). Certain dominant stories explain our current actions and impact our future lives.

The stories we tell ourselves about how we act with one another are not *about* our lives but rather *are* our lives (Freedman & Combs, 2000). The reality of our lives is the reality of the stories we tell about them. This idea has powerful consequences for talk therapy. For many family therapists, influenced by this approach, the metaphor of systems (feedback loops, interactive behavior patterns) has been replaced by the metaphors of language, stories, and the way people organize, interpret, and assign meanings to their experiences. Freeman (2011) notes four clusters of the life narrative: (1) the Core Narrated Self (one's internal and external identity); (2) Life Predictions and Expectations (optimism or pessimism for the future); (3) Life Events and Actors (the influence of people and circumstances on the narrative); and (4) Opportunities for Meaning Making and Growth (an aerial view allowing reflection). See Figure 14.1 for the cluster components.

According to narrative therapists, families frequently construct negative, self-defeating, dead-ended narratives about their lives (myths, excuses, negative self-labeling, reasons for feeling overwhelmed or inadequate or defeated, explanations and justifications for why they are unable to do

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things differently). Narrative theory asserts that to achieve change, people need to learn to consider alternate ways of examining the values, assumptions, and meanings of their lives and see how existing stories dominate their views of themselves and their problems. Ultimately, families create and internalize new stories, make new assumptions, open themselves to new possibilities; in short, they rewrite their future story lines and actively change or reshape their lives.

Narrative therapy involves respectful, nonblaming conversations in which clients are the experts in their own lives and assumed to have the skills and competencies needed to construct more positive stories about themselves. New outlooks lead to new ways of assigning meaning to life experiences and, if the process is successful, to new behavior.

Our lives are multistoried and, like the richest stories in literature, filled with ambiguity and differing meanings. What we notice about a new event typically fits into a previously established dominant story. A deconstruction or changed interpretation of an event ("My boss assigned me this task, so he must think I can do it") may replace an old self-negating view ("My boss probably couldn't find anyone else to do it at the last minute"). Once the new interpretation is adopted ("I know I can handle the assignment"), the client may begin to link this new self-confidence to other situations ("I'm going to apply for that promotion" or perhaps, "I'm going to say yes to the next invitation from coworkers to go out after work," instead of, "They ask me to join them, but they don't really want me around"). The new dominant story begins to reshape outlooks, attitudes, and behavior. See Box 14.1 for an example of a dominant story.

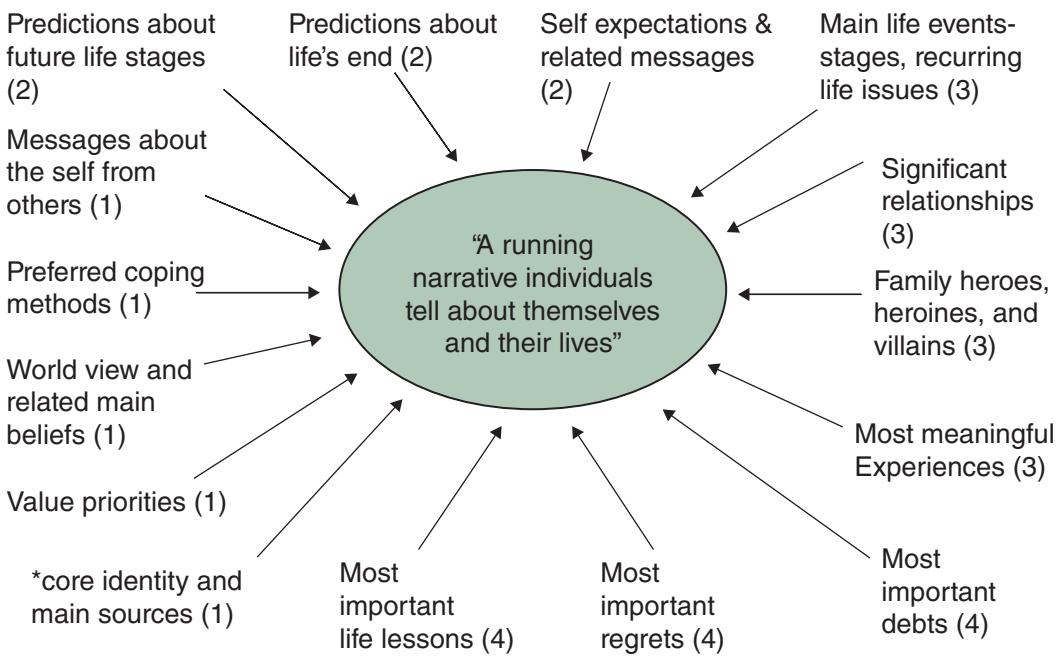


FIGURE 14.1 Components of the life narrative
Source: Freeman (2011), p. 72.

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BOX 14.1 CLINICAL NOTE

A Dominant Story: "I'm a Good Student"

Let's say you feel good about yourself as a student. You remember how your kindergarten teacher praised you for your ability to share and clean up after yourself and how your fifth-grade teacher told you she was proud of you when you turned in that original project. You remember that your high school English teacher went out of his way to talk to your parents at Open House, praising you for doing the reading assignments on time, neatly typing your paper, participating in class discussion. You recall how your parents bragged to friends about your grades, and one year your mother attached a bumper sticker to her car announcing that her son was an honor student at the middle school.

In other words, you have selected and strung together a series of events over time, some perhaps even exaggerated, that form a plot, a dominant story about yourself that is privileged over other stories of your academic history. The plot thickens as you continue to add new examples: the time you won the spelling contest, how quick you are at *Jeopardy* on TV, how you aced the SATs, how you had a choice of colleges.

In telling about your school success to friends, you emphasize these events but somehow neglect to mention that chemistry baffled you, and you still have trouble balancing your checkbook. These things are insignificant in the light of your dominant story—scholastic success. When a new intellectual challenge at work or at home occurs, you believe that of course you can handle it; after all, you are a good student, an overall competent human being. If anyone doubts it, you tell them to ask your mother.

Your brother, 2 years younger, lives by a different dominant story. He remembers his early school years with discomfort, recalling especially how teachers, remembering you, always seemed disappointed in him by comparison. He thought of himself as slow and plodding, rarely experiencing school success. He was diagnosed as dyslexic in second grade and has had difficulty reading all his life. When reminded that as a young child he was a whiz at putting Lego tiles into complex patterns without reading the instructions, he brushes that off as a minor accomplishment. He does the same regarding his hobby of furniture building, even as others praise his ability to work with his hands.

He did graduate from a junior college but hated applying for jobs, especially filling out the applications. After months of searching, he went to work at a sports club, where his main job was distributing towels and other accessories to patrons. When the boss offered him a promotion—a job at the front desk, meeting new customers and persuading them to sign up—your brother became agitated and, not feeling confident enough to explain his apprehension, quit. He was still living by his dominant story of incompetence.

Poststructuralism and Deconstruction

Narrative therapy emerged from poststructuralism and deconstruction (Dickerson, 2014). *Poststructural* thought rejects the structuralist notion that there is a deep structure to all phenomena and that its complexity can be broken down to its elements. To structuralists, behavior is the surface manifestation of deeper elements buried within the individual; these elements can be classified and retrieved so an objective outside expert can interpret those deeper layers to reveal the "truths" about the meanings of the behavior. This type of therapy looks for underlying (deep) causes, proceeds by repairing the flaw, and is not satisfied with simply reducing or eliminating symptoms. Structural ideas (from Freud's intrapsychic structures to family therapy's traditional focus on family structures) characterize much of 20th-century thought in the social sciences.

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Drawing upon the poststructural ideas of cognitive psychologist Jerome Bruner (1986), anthropologist Barbara Meyerhoff (1986), and French political and social philosopher Michel Foucault (1980), narrative therapists such as Michael White (1995) question the static surface/depth dichotomy. They argue that searching for underlying traits or needs or personality attributes relies on artificially imposed "thin" descriptions (e.g., superficial, insubstantial descriptors of internal states such as normal/abnormal or functional/dysfunctional) when we should be looking for "thick" (enriched, intentioned, multistoried) descriptions, shaped in part by personal, historical, political, and cultural forces. Beyond helping clients reauthor alternative stories, narrative therapists thus look to enhance or make more complex the client's descriptions of his or her life and relationships.

Thin and Thick Descriptions

Early in therapy, narrative therapists often hear stories clients tell about themselves that are problem filled and based on *thin descriptions*—an anthropological concept (Geertz, 1973)—often imposed on them by others with definitional power (teachers, doctors, parents, clergy) and incorporated in their self-definitions as established, if oppressive, "truths." Thin descriptions typically are made by politically powerful or influential outside observers studying the lives of other people and are rarely informed by interpretations of those engaged in the actions being studied (White, 1997). Consequently, the observers may not deal with the complexities of life and the personal meaning given those actions by the protagonist. The resulting thin descriptions are likely to lead to thin conclusions (labeling a person as bad, greedy, selfish, lazy) that are superficial and disempowering to the person being observed. To make matters worse, people who are labeled often begin to adopt these outside designations ("Yes, I am a selfish person") as true and real, accepting them as unchangeable, problem-saturated stories about themselves, without examining how they themselves attribute meaning to their own behavior (e.g., a frightened or insecure person who doesn't know how to help). Thin conclusions ("There I go putting myself first again; I'm really a bad person") often lead to failing to remember times when one was generous and helpful to others. Positive characteristics are obscured or hidden by the thin description–inspired story.

Thick descriptions, on the other hand, are elaborately presented and multistoried, not simply labeled by others. They involve the views of the person or people whose lives are being discussed and are usually interwoven with the lives of others. Comprehensive understanding of a person requires a rich, thick description that comes about through the telling and retelling of the preferred stories about one's history and identity. The exploration of subjective experiences—hopes, desires, passions, purposes, fantasies, aspirations, commitments—contributes to thick descriptions of why people behave as they do. White listened for underlying values and commitments that contribute to meaning making, hidden beneath the story, calling them the absent but implicit, allowing more stories with multiple possibilities; this process doesn't remove the problematic stories, but it shifts their meaning when viewed in light of other stories and often makes them feel less significant, since they are "only one strand" of the story (Combs & Freedman, 2012, p. 1038).

In addition to helping clients develop alternate stories and free themselves of problematic stories, narrative therapists facilitate reauthoring conversations to thicken or enrich the description of their lives and relationships. It is important to note that narrative therapists do not help clients replace one story with another, but rather help them view life as multistoried,

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with numerous options available. In place of the one-dimensional view of their lives that a troubled family presents—problem saturated and deficit centered, frozen in time and without a sense of the future—narrative therapists help family members expand their lives by changing their limiting and unsatisfying stories about themselves, each other, and the world. Narrative therapists reject the expert role, that of believing they understand clients better than clients do themselves. They collaborate with clients, honoring the stories and cultural background each client brings to the therapy.

LO 1 Deconstruction

Deconstruction is a term introduced by French theorist Jacques Derrida (1978) in examining texts to indicate they have no single meaning. Many people believe that the term means the disassembling of assumptions that are taken for granted, and to a degree this is true. The term signifies, however, a great deal more.

Derrida (1978, 1998) insisted that deconstruction is *not* a methodology per se and cannot be transformed into one. Instead, deconstruction "takes place." It does not await the deliberation, or conscious intention, of a subject (i.e., an individual person). Deconstruction is not something one does, but it is a quality of language itself that one discovers through the examination of its metaphoric or rhetorical nature. This condition of textuality is not limited to written or spoken language but to the discursive structuring of experience, institutions, reality, and subjectivity. This suggests that nothing outside textuality, or language, can ground meaning absolutely.

Narrative therapists use the concept of deconstruction when they remind clients that the dominance of one meaning or one set of assumptions is an illusion and that it is possible to apply a multitude of meanings or assumptions in understanding the same event or experience. Thus narrative therapists help clients reexamine so-called truths about themselves—imposed by others or by the culture and internalized as given and unchangeable—and construct new narratives. Deconstructing the power of a dominating, problem-saturated narrative can empower clients to deal more competently with new views of reality and lead more satisfying lives. Narrative therapists have to be very sensitive in working with people who might find the absence of grounding reality or authorizing texts a significant cause of anxiety. Think of the person who seems to be seeking above all else someone to tell them how to live their lives! Or think of the feminist client who says she needs feminist discourse as a ground for her own identity experience (indeed, some feminist theorists quarrel with deconstruction over this very point). The deconstructionist would appreciate the nonabsolute nature of this discourse as he or she would any other (including Derridean deconstruction!). As a narrative therapist, one would have to be highly respectful of this client's emotional and intellectual relationship with text (feminism) and identity even as they co-construct alternative narratives.

Deconstruction is a powerful concept in narrative therapy (or other therapeutic models that appreciate the liberating possibilities it suggests) because clients often confuse the language they use about themselves with something they consider to be real and unalterable about themselves. Deconstruction points out that one's reality and the language one uses in engaging with that reality (the reality of one's self) are not mutually authorizing. There is always more to "be" and "say."

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Leading Figures: Michael White, David Epston, and Colleagues

Michael White at the Dulwich Centre in Adelaide, Australia, was the leading figure in narrative therapy until his unfortunate premature death in 2008, having described in great detail a philosophy and set of techniques consistent with helping clients reauthor their lives. A prolific writer (1989, 1991, 1995, 1997, 2000, 2007), White, trained as a social worker, offered workshops throughout the world. Originally drawn to the work of Gregory Bateson—especially Bateson's observations on how people construe and give meaning to the world about them—White later rejected Bateson's cybernetic thinking in favor of a narrative metaphor. He was influenced by the feminist thinking of Cheryl White, his wife, and some ideas from anthropology offered by colleague David Epston at the Family Therapy Centre in Auckland, New Zealand (White & Epston, 1990). White was a caring, dedicated, persistent clinician with a social and political agenda: liberating people from oppressive culturally dominated, problem-saturated stories and empowering them to reauthor their lives to develop more rewarding dominant stories and lead more fulfilling lives.

David Epston (2014; Epston & White, 1992), a social worker/family therapist interested in anthropology and storytelling, introduced narrative metaphor thinking to White. Epston is particularly known for his innovative *therapeutic letters* to families, which are extensions of conversation aimed at reauthoring lives (we return to these letters later in this chapter). He and two colleagues provided a useful set of narrative techniques for working with children and their families (Freeman, Epston, & Lebovits, 1997).

Cheryl White is a social activist, founder of Dulwich Centre Publications in Adelaide (C. White & Denborough, 2014). She edits the *International Journal of Narrative Therapy and Community Work*, a journal devoted to interviews, cases, and recent contributions to narrative theory and practice. David Denborough joins her there. In the United States, Jill Freedman (2014) and Gene Combs (2009) in Illinois; Jeffrey Zimmerman with Victoria Dickerson (1996) and Marie-Nathalie Beaudoin (2011) in the San Francisco Bay area; Kathy Weingarten (1998) in Boston; and Jennifer Andrews and David Clark (Andrews, Clark, & Baird, 1998) in Los Angeles are advocates of the narrative viewpoint. In Canada, Stephen Madigan (2011) is the director of the Vancouver School for Narrative Therapy and presents workshops internationally.



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LO 2 Self-Narratives and Cultural Narratives

Advocates of narrative therapy propose that people, in attempting to make sense of their lives, arrange their experiences of events over time to arrive at a coherent account of themselves and their surroundings. Such self-narratives give each person a sense of continuity and meaning and become the basis for interpreting subsequent experiences.

Each person's own story or self-narrative (how my parents' divorce turned me against marriage; how my mother's alcoholism frightened me about drinking; how my grandmother inspired me by coming to this country penniless and succeeding in business; how my illness as a child made me feel inferior to others) provides the principal framework for structuring those

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experiences. Put succinctly, the stories we develop about our lives shape or constitute our lives. Helping clients become aware of those previously unrecognized but powerful internalized narratives that limit their lives allows them to engage in reauthoring therapeutic conversations that seek to develop alternative life stories (White, 1995). Bear in mind that clients reauthor their lives, aided by therapists, but that narrative therapists do not reauthor people's lives.

Cultural stories underlie, influence, and shape personal narratives (White, 1991), providing *dominant narratives* specifying the customary or preferred ways of behaving within that culture. For example, if a society applauds women who strive for thinness, judges success by body shape and size, and promotes self-surveillance and individualism, then anorexia or bulimia are likely to be common problems. Similarly, male violence and abuse against women can only thrive in a society that endorses male dominance and patriarchy (Morgan, 2000). Beliefs that form the basis for racism, sexism, ageism, class bias, and so forth represent other common toxic cultural narratives. Narrative therapists attempt to engage families in conversations that discover, acknowledge, and support the deconstruction of the cultural beliefs and practices (customs, laws, institutions, language, and so on) that help perpetuate the problem story. See Box 14.2: Family Diversity.

White was influenced by Michel Foucault (1965, 1980), a French intellectual and social critic who wrote extensively about the politics of power. Foucault saw language as an instrument of power. He insisted that certain "stories" about life, perpetuated as objective "truths" by the dominant culture, help maintain a society's power structure and eliminate alternate accounts of the same events (e.g., regarding what constitutes normal sexuality or what behavior should be classified as pathological or how to react to members of a minority community or what it takes to be a "real" man). Those with dominant or expert knowledge (politicians, clergymen, scientists, doctors, therapists), according to Foucault, hold the most power and determine what knowledge is held to be true, right, or proper in society (Combs & Freedman, 2012).

Because oppression is based upon the control of language, Foucault advocated helping people to resist culture's dominant discourses. He urged that certain dominant cultural or institutional narratives be challenged, because following them unquestioningly eliminates the consideration of alternative knowledge or viewpoints and thus may be anathema to free choice or to the best interests of a particular individual or family. Issues of power, privilege, oppression, control, ethics, and social justice were high priorities for White in his therapeutic work. Cultural or institutional discourses often not only constrain or oppress people but also lead to attitudes of entitlement—that Whites are superior to non-Whites, men have the right to dominate women, heterosexuality is normal while homosexuality is not, and so forth. Narrative therapy is at the forefront in challenging such attitudes (Hoffman, 2002). The role of the therapist, the process of therapy, and its goals all show Foucault's influence, and its commitment to social justice and questioning power have drawn many family therapists to the narrative therapy camp.

Therapists with a narrative orientation typically view client stories through a political lens—particularly those stories that oppress people's lives (racism, sexism, gender or class bias, gay bashing). Here they are extending Foucault's analysis of society to the personal or family levels, arguing further that certain internalized narratives (e.g., what it means in our society to be successful or worthwhile in life) often become oppressively self-policing and lead to a self-subjugating narrative of failure for falling short of the arbitrary achievement mark. Moreover,

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BOX 14.2 FAMILY DIVERSITY

Culture and cultural meaning in narrative therapy

Narrative therapy emphasizes the impact of culture and cultural meaning systems on individual and family narrative (Dickerson, 2014). "Problems" are defined by the normative understandings of cultures and subcultures. Power is perpetuated in discourse, and privileged people have more weight in social communication. Change occurs as individuals and families collaboratively identify new meanings and opportunities within the political and social context of life. Consequently, social justice is front and center in narrative approaches (Combs & Freedman, 2012). Narrative therapists recognize that they are liable to perpetuate social injustices that marginalize others, and they actively facilitate a collaborative process that moves away from historical ideas of power and authority vested in "expert" clinicians to an understanding that each person and each family is the expert on her/his/their life. Narrative therapists are not neutral observers; they actively promote social justice.

Narrative therapy has particularly focused on family-centered services in frontline public health practice that involve "culturally responsive, strength-based, collaborative, and accountable partnerships with families" (Madsen, 2014, p. 381). These organizations and services mirror the characteristics of the communities they serve and seek to eliminate healthcare disparities. They empower families, recognizing their expertise regarding their own lives, their community, and their culture; this promotes "voice and choice" and "nothing about us without us" (Madsen, 2014, p. 384). Therapists function like anthropologists, seeking to understand the family's meaning and their microculture.

Narrative therapy has been applied to a variety of diverse contexts, including understanding how aspects of marriage are socially constructed, based on cultural values, and impact intrarelational diversity (Aniciete & Soloski, 2011) and intercultural couples in such areas as societal pressure and divergent role attitudes (Kim, Prouty, & Roberson, 2012), as well as helping sexual-minority couples retell their story as an alternative to their experience of social adversity (Cohn, 2014). It has been used to understand how young Africans faced with high HIV rates think about abstinence in nonstigmatizing discourses (Winskell et al., 2011) and to empower children and families in Uganda for economic development in a manner consistent with their culture (Wakhungu, 2014).

Finally, Akinyela (2014) posits *cultural democracy* as an alternative to multiculturalism, which he believes stresses the incorporation of non-European perspectives into a dominant European therapeutic model. He argues for full dialogue between therapists of all cultures in the continuing evolution of the narrative model.

internalizing these narrow, culturally based, dominant discourses leads to a self-defeating outlook about the future and restricts alternative ways of thinking about and being in life.

A Therapeutic Philosophy

A narrative therapist's efforts are respectfully directed at liberating the client from hopelessness by helping that person recognize the previously subjugated plots and subplots of his or her life. Instead of playing the role of expert and objectively diagnosing someone's motives, needs, drives, ego strengths, or personality characteristics, the narrative therapist is interested in collaborating or consulting with people, giving what they have to say equal privilege, and helping them consider alternative dreams. For example, White explored with a client what a particular belief or act reflects about the client's visions or outlook or dreams. Such a poststructuralist approach is intended to open up conversation about client values, beliefs, and purposes, giving them the

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opportunity to consider a wide range of choices while freed from personal or cultural oppressive demands. To White, any interpretations from the therapist are not "privileged" or honored over the meaning the client gives to his or her own views. The narrative therapist is thus *decentered*—still influential but not at the center of what transpires therapeutically.

For example, the narrative therapist might ask such questions as "What was that experience like for you?" followed by "What effect did it have on your life?" or "Why was this so important to you?" In asking such questions, the therapist is focusing on the person's expressions of his or her experiences of life and the preferred interpretative pathway he or she chooses to give meaning to those experiences. An important therapeutic twin goal here is the deconstruction of domineering self-narratives and the reestablishment of freedom, individually and as a family, from the dominant discourses of the culture. Reauthoring conversations are intended to invigorate clients in understanding what happened in their lives, how it happened, and what it means, leading to a consideration of more positive options to lead their lives more fully.

LO 3 Therapeutic Conversations

Externalizing the Problem

Because many clients internalize problems ("I always manage to get things wrong. I'm hopeless."), White developed *externalizing conversations* to help them place the problem outside themselves and attach new meanings to their experiences. The aim here is to help clients recognize that they and the problem are not the same ("We are not our problems"; Denborough, 2014, p. 25). Then the problem can be understood as socially constructed (a product of a predominant self- or cultural narrative) and changeable.

Externalizations are designed to help separate the person's identity from the problem for which help is sought while helping the client revise his or her relationship with the problem and its restraining influence over his or her life. This therapeutic stratagem is based on the premise that the client is not the problem, and the family is not the problem; the problem is the problem. Consequently, no time is devoted to discovering family patterns or exploring family dynamics, nor to searching for critical events in the past that led to the current situation. Narrative therapists are not concerned with how family interactional patterns affected the presenting problem; on the contrary, they are interested in how the problem affected the family. See Box 14.3 for examples of externalizing language.

Narrative therapists help families "externalize" a restraining problem—in effect, by reframing the problem from an internal deficiency or pathological condition in the individual, couple, or family to an objectified external and unwelcome narrative with a will of its own to dominate their lives. The therapist then encourages the family to unite against that problem. Starting with the family's set of beliefs and use of language in describing the problem (an adolescent daughter's anorexia, a mother's depression, a couple who are bad communicators), the family is encouraged by the therapist's questioning to view the problem as existing outside the family. To effect this viewpoint, it sometimes helps to personify the problem, making it a separate entity (sometimes giving it an agreed-upon name based on the family's description of the problem) rather than an internal characteristic or attribute of the symptomatic person.

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BOX 14.3 CLINICAL NOTE

Practicing Externalizing

Externalizing may not come easily to therapists, who must overcome early training in which they often learn to make "objective" judgments of clients ("he's bipolar"; "she's anorexic"; "depressives act that way") that suggest the problem is within the person.

The person is the problem.	The person is not the problem; the problem is the problem.
He's a bad kid.	*Trouble* is following that kid around.
Lucy is a depressed person.	Lucy says she's been in a *fog of depression* since her mother died.
I'm useless.	The *feeling of uselessness* is strongest when I'm in the classroom.
Bill's schizophrenic.	Bill says the *hostile voices* (of schizophrenia) try to convince him he's worthless.

Source: Adapted from Denborough (2014).

Instead of finding fault with that person for giving the family problems through the appearance of symptoms, the family now looks at the problem as an external entity and is better able to collaborate in altering their way of thinking about developing new options for their lives. This paves the way for reducing self-blame and generating thickly described alternative stories.

When the adolescent identifies herself by saying, "I am anorexic," the therapist might ask, "What was Anorexia's purpose in deceiving you by promising you happiness but bringing you despair?" Or perhaps the mother will be challenged to look at her depression not as some internalized, objective truth about herself but rather as an external burden: "How long has Depression been controlling your life?" The "troubled" young boy might be assisted in externalizing the problem by giving it a name ("How did Mr. Mischief manage to trick you all this time?"). By identifying when Mr. Mischief is most likely to visit, the boy can construct more hopeful ways of outmanuevering Mr. Mischief. Guiding clients to separate themselves from the problem can help them notice other possible choices for individual or family behavior (Denborough, 2014).

Externalizing has great appeal for families who see their inability to rid the symptomatic person of the problem as a reflection of themselves as failures. Or perhaps they have blamed the symptomatic person ("It's Harry's nature to be depressed" or "His constant depression is destroying the family"). Or they transfer the blame from one person to another ("it's not the son's fault, it's his mother's"). Now they are presented with a nonpathological, externalized view of the problem ("Sadness sometimes overtakes Harry"), one in which no one is to blame. Perhaps they begin to realize that the symptomatic person doesn't like the effects of his feelings any more than any other family member does.

Next, they are offered an empowering opportunity to co-construct with the therapist a new narrative that provides an alternate account of their lives. Two related processes are operating here: unraveling the history of the problem that shaped their lives and reconstructing or reauthoring an alternate (previously subjugated) story that was obscured by the dominant story. Externalizing conversations with all family members present enables them to

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separate from the stories they have told themselves about themselves; they can then work as a team on the now-externalized problem they hope to defeat (Payne, 2006).

Employing Therapeutic Questions

Narrative therapy uses questions like an investigative journalist to explore "the *influence* and *operations* of the problem" (Denborough, 2014). White's respectful but persistent questioning typically is directed at *what* the person is experiencing ("What is Self-Consciousness trying to talk you into about yourself?") and *how* the problem is being experienced ("How does Self-Consciousness affect you socially? With women? When you want to ask the boss for a raise?"). To achieve a "rich" or "thick" description, the therapist might ask the client to describe the problematic story—and later, the alternative story—in various ways and in varying situations, often interweaving questions regarding the new story, for example, with the stories of others. Cultural discourses might be questioned in the same way: "How do you think society views aggressive and unaggressive men, and what does that say to you about your self-consciousness?" See Box 14.4 for examples of how therapists help families overcome problem-saturated stories.



BOX 14.4 THERAPEUTIC ENCOUNTER

Overcoming Dominant Problem-Saturated Stories

Narrative therapists join families in exploring the stories—and the meanings they attach to events—that led them to feel defeated. Families typically offer thin descriptions ("Our son, Harry, has been diagnosed with depression") to explain the cause of their despair, allowing little room for noting exceptions to his behavior and likely reflecting a professional's explanation for the family's troubles. This isolates and disempowers Harry, who may feel weak and ashamed for causing problems for the family. A thin description disconnects him from other family members and rules out alternative ways of viewing the situation. Once it is established that Harry is the problem, the cause of everyone's misery, they continue gathering evidence ("He wouldn't get out of bed all day" or "We hate to take Harry places, because there's no telling when he'll become silent or start crying") to support the problem-saturated stories about him.

To combat these attitudes, the narrative therapist initiates conversations to help the family break away from past stories and create preferred alternatives. Externalizing the problem, labeling it as Sadness, the therapist might ask these questions:

"Harry, when was the last time you were able to turn Sadness away?"

"How did you get to that point?"

"What did you tell yourself that was different?"

"What exactly did you do?"

"What does it say about you, Harry, that you could do this?"

"What else was Harry able to do in the past that helps explain how he's standing up to Sadness now?"

"What is it like living with Harry when Sadness no longer runs his life?"

These interventions facilitate an alternate view of the family's life, rediscovering neglected aspects of its members, starving the problem rather than feeding it, and reauthoring their stories to include a new sense of empowerment, depicting enhanced ways of living together and engaging other people in their lives. In effect, problem-saturated stories start to be replaced by stories rooted in history and richly described in detail concerning the future. Later, families no longer blaming themselves or one another are encouraged to engage in behavior consistent with these alternative stories.

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White's approach employs directed questions (unlike Anderson and Goolishian's conversational tone) that encourage families to view the problem as some entity or thing situated outside the family, separate from their identity. Parents with a symptomatic adolescent (say, a teenager who is refusing to attend school) might be asked: How has the problem affected Sean's life? Your life? Your relationships? How has the problem affected you as parents? Your view of yourselves? Your behavior with one another? With your friends? The technique allows the family to distance themselves from the problem, detach from the story that shaped their self-view and dominated their lives, and to create an alternative account.

Narrative therapists believe that families with problems typically offer *problem-saturated stories*, pessimistic and self-defeating narratives about themselves, reflecting their frustration, despair, and powerlessness ("We never know from day to day what mood Harry will be in"). Narrative therapists help families identify previously *subjugated stories* involving success or alternative views by locating "facts" that contradict earlier self-descriptions (times when Harry overcame his sadness and was fun to be around) that they were unable to perceive due to problem-saturated accounts of their family life.

LO 4 Seeking Unique Outcomes

Next, the narrative therapist listens for descriptions of events or experiences that do not fit the problematic story, when the problem's influence was less apparent or nonexistent. These are entryways to reauthoring conversations and alternative story lines (Combs & Freedman, 2012). Or the therapist might ask the family to search for **unique outcomes**—perhaps exceptional events, actions, or thoughts contradicting their dominant problem-saturated story, when the problem did not defeat them. This is similar to solution-focused therapy, as both ask clients to search for exceptions—experiences that contradict a problem-dominated story—and help clients find more empowering alternative stories.

"Can you think of a time when you refused to go along with Sadness's commands?"

"How were you able to trust your own thoughts or desires?"

"What did this tell you about yourself?"

Unique outcomes open doors to exploring alternative narratives—the beginning of a new family story line. They involve any instances or events that do not fit with the dominant story. They may be a plan, action, feeling, statement, quality, desire, dream, thought, belief, ability, or commitment (see Box 14.5). As noted, they may pertain to the past, present, or future. In the following example, a couple caught up in stories that limit the possibility of change in their lives seeks help with marital problems. In the first session, the narrative therapist begins looking for ways that unique outcomes deviate from the dominant discourse about the hopelessness of the couple's situation:

HUSBAND: I kept your phone number for over a year and just got the courage to call.

THERAPIST: What does it say about you that you did it this time?

WIFE: I actually started to dial you several times last year but hung up. It was frightening. But this time, I forced myself to stick with the task until I completed the call.

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THERAPIST: What does this new step tell us? Can you think of any other times when you were scared but went ahead and did what you knew you needed to do?

HUSBAND: One thing that comes to mind is how I hated my job but stayed in it because I couldn't get up the courage to leave and try something new. Finally, I'd had it, and scared or not, I quit, and within a week I found this job I really like.

WIFE: I remember being frightened, too, but encouraged him because we were both miserable and both knew something had to be done.

Co-Constructing Alternative Stories

As clients proceed in this process, it is as though the therapist has helped them escape entrapment in the basement of a multistory building to gain access to the upper floors, where they can enlarge their view and see the horizon that was denied to them in the basement. They no longer feel trapped by their problematic stories—other vistas are more visible. (Some stories, of course, have greater staying power than others, especially if supported by strong cultural beliefs, and they are not easily deconstructed.)

Reporting unique outcomes may strengthen the alternative story. Narrative therapists encourage clients to tell and retell the preferred stories, thickening them by going into detail, interweaving them with the lives and stories of other people. The thickening process keeps clients connected to the new preferred story line and beginning to live out the preferred story



BOX 14.5 THINKING LIKE A CLINICIAN

Unique Outcomes

A plan: Mel planning to go out for a cup of coffee when Anorexia tries to tell her she will get fat and shouldn't go. (past)

An action: Ari ringing a friend when the voice of Depression has tried to isolate him from his friends. (past)

A feeling: Marcy feeling pleased with her exam results when Self-Perfection tried to tell her they weren't good enough. (present)

A statement: Paula giving her opinions in a meeting when Self-Doubt tried to silence her. (past)

A quality: Erin maintaining her care for others in the face of abusive practices in her work environment. (present)

A desire/dream: Dave hoping to share a holiday with his family when his life is free of the influence of alcohol and drugs. (future)

A thought: Xiang thinking "It's not my fault" when Mother Blaming tried to talk her into feeling responsible for her daughter being subject to abuse. (present and past)

A belief: Luz saying, "I believe I will get better from this" when Depression tries to tell him that this is impossible. (present)

An ability: Chris and Leanne laughing together about something their daughter said to them. "Expectations" had on many occasions gotten between them and made it difficult for them to experience joy with parenting. (present)

A commitment: Roberto and Laurie being committed to nonviolent forms of parenting when their own experience had been one of abuse. (past and present)

Source: Morgan (2000), p. 53.

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in place of the problematic one. In some cases, reflecting teams (see Chapter 13) or *outside witness groups* (discussed later) reinforce the alternative narratives. In the following section, we consider other ways of thickening the preferred story.

Therapeutic Ceremonies, Letters, and Leagues

Creating a richer description of the alternative story—as an aid in staying connected to this preferred narrative—calls for a number of supplementary practices employed by narrative therapists. The goal is for life to become more multistoried.

Definitional Ceremonies

Adapting some of the definitional ceremony metaphors of anthropologist Barbara Meyerhoff (1986) for therapeutic purposes, narrative therapists may provide clients with the opportunity to tell (or perform) the stories of their lives before an audience of outside witnesses, drawing attention to how they attribute meaning to their experiences. Then they may call upon observers from the nonjudgmental audience (reflecting team members if the observers are professionals, outside witness group members if they are not) to respond to the stories they have just heard (retelling the stories they just heard). Through this telling and retelling process, many of the plots and alternative stories of people's lives are thickened and linked to their ongoing values and commitments. Options for future action are sometimes introduced as clients hear what about their lives or identities captured the attention and imagination of the audience members. This may lead to retellings of retellings (the client responds to what was told by the outsiders) and retellings of retellings of retellings (by the first set of outside witnesses or a secondary group of witnesses), and so forth. The definitional ceremony (White, 1997) helps authenticate clients' preferred claims about themselves and thicken alternative stories.

Outside witness groups of at least two members may be friends, family members, therapists, or community members—anyone able to observe the reauthoring conversation between therapist and clients and later offer relevant retelling experiences. Morgan (2000) offers the example of a child, subjected to teasing and harassment, meeting with a team of children who experienced similar oppression so they can offer their coping experiences. The outside witness group observes the narrative interview with the child and family from behind a one-way mirror—so as not to intrude on what is taking place—then changes places with the family, which observes as each outside witness retells what he or she has just observed.

In some cases, witnesses may comment on how the conversation between therapist and family affected their thinking about their own lives. Called "decentered sharing" (White, 1997), this technique acknowledges the link between all participants but does so in a way that respects the client family as the center of the retelling. The focus of discussion for the witnesses—typically in the form of questioning each other about what they heard—is likely to concern the alternative stories and unique outcomes they identified in observing the therapist–family interaction and to indicate how what they witnessed resonated with their own life experiences. The aim of such dialogue between witnesses is to build upon each other's stories and to enrich the emerging alternative stories that caught their attention, possibly because

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BOX 14.6 CLINICAL NOTE

Clients Keep Significant Communications

It is not unusual for clients to keep significant letters, newspaper clippings, or saved email and texts pertinent to their personal narrative. Therapists sometimes have the experience of a client pulling out a saved communication to help tell her or his story.

it reflected their own experiences. In typical narrative fashion, witnesses do not presume to know what is right or best for this particular family, nor is it their place to offer opinions about how the telling person should lead his or her life. Neither do they hold up their own lives and actions as models or examples.

Once again swapping places, the clients comment on the retelling by the outside witness group (retellings of the retellings). Finally, everyone involved—therapist, family, witnesses—meets to further reflect on what transpired. The entire process, if successful, helps separate the clients from the problem-saturated stories and helps rebuild their lives around preferred stories of their identity (Morgan, 2000).

Denborough (2014) notes that it is possible to engage remembered or imagined audiences as a client tells and retells a story. Remembered audiences are people who cheered the client on earlier in life; even though they may not be present now, their voices can be summoned by imagining what they might say today to the client's story. The narrative therapist helps the client identify and utilize these voices from the past.

LO 5 Therapeutic Letters

Narrative therapists often use letters sent to clients in therapeutic ways, especially in supplementing and extending therapeutic sessions and keeping clients connected to the emerging alternative story. With the clients' consent, Epston in particular (2009; Epston & White, 1992; White & Epston, 1990) routinely employs therapeutic letters in summarizing sessions, inviting reluctant members to attend future sessions, and addressing the future. This enables the therapist to extend conversations while encouraging family members to record or map out their own individualized view of the sequences of events in their lives over a period of time. Letters may reduce the perception of hierarchy and enhance the therapeutic alliance (Kindsvatter, Nelson, & Desmond, 2009).

Letters, because they can be read and reread days, months, or even years later, have great continuity value; they thicken or enrich an alternative story line and help clients stay immersed in the reauthoring process. Epston and White (1992) estimate that a single letter can be as useful as at least four or five therapy sessions. Epston (2009) recognizes that the letter writing technique must adapt as technology advances. Moules (2009) notes that email letters may be more expedient and interactive than traditional letters (the same could be said for texting) but identifies potential boundary concerns and that therapists must attend to legal and ethical issues in electronic communication; the key issue is maintaining the careful therapeutic nature of any written communication, despite the medium.

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Summary letters based on careful note taking and attuned to discussion during the session that opened up the possibilities for alternatives to the client's problem-saturated stories are sent to the client following each session (Epston, 1994). The client's own words are carefully recalled and included in the summary letter. A reminder of some unique outcomes discussed during the session might also be included.

Epston sends *letters of invitation* to family members reluctant to attend sessions; most are surprised and pleased by his caring about them and their place in the family, and they may begin to attend. *Redundancy letters* note that certain members have taken on duplicate roles in the family (being a father to one's brother) and wish to change them. In a related *discharge letter*, written with a client, another family member is thanked but informed that he or she is no longer needed to play that role. *Letters of prediction*, written at the conclusion of therapy, predict continued success in finding new possibilities.

For Epston, letters are not separate interventions but are organically intertwined with what took place in the consultation room. Whatever their form or medium, letters render lived experiences into narrative form. Consistent with an egalitarian orientation, the narrative therapist's thoughts are out in the open, to be confirmed, amended, or challenged by the family. Taken together, the letters create an ongoing picture of therapist–client collaboration as they seek to co-construct alternative life stories. See Box 14.7: Thinking Like a Clinician for experience in working from a narrative perspective.



BOX 14.7 THINKING LIKE A CLINICIAN

Narrative Therapy

Aaron and Rachel have been married for 10 years. They are very unhappy in their relationship and are considering divorce. They hope that therapy will help them either stay together or gain the strength to part. Though they say they still love each other, circumstances have impacted them. A year ago, they lost a baby during the eighth month of Rachel's pregnancy. Rachel herself nearly died. A doctor then told them that while having another baby was possible, there would be serious health risks to Rachel if she were to become pregnant again. Since then, Aaron feels morose and Rachel feels like a failure: first with the baby and now in her marriage. Both admit to feeling deeply depressed.

AARON: I don't know, I'm just not feeling it anymore. I know it's my fault. I didn't support Rachel after we lost the baby. I just went deeper into my work. I knew then it was wrong, but I couldn't help it. Even now, I know that I should be helping her to feel better about herself, but I can't do it. All I want to do is my work at the office, and when I am not there, my painting at the studio.

RACHEL: I don't need your help to feel better. I'm finally learning that you are not responsible for me. I am. And though I've never felt particularly good about myself, it's not your job to fix me. That's what I can't stand about what's going on between us: It feels to me like you would rather fix something than just be with me.

THERAPIST: What does this new understanding of yourself tell you about your relationship with Aaron?

RACHEL: For years, I think, we colluded with each other in our depression. We would escape

(Continued)

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together and for weeks on end see no one else or do anything but mope around the house feeling sorry for ourselves. We still do this. My own therapist has helped me see this. And I don't want to do this anymore. That's why my therapist referred us to you. I really don't want depression to be the thing that unites Aaron and me.

THERAPIST: Do you agree, Aaron, that depression unites you?

AARON: I guess I do. Yes.

THERAPIST: It's like there is a third person in your relationship. We can call him Mr. Depression. (Aaron and Rachel smile and nod in agreement.) What would the two of you like to say to Mr. Depression?

RACHEL: You remember what the Good Witch of the East said to the Wicked Witch of the West in *The Wizard of Oz* when they were together in Munchkinland? I'd like to tell Mr. Depression "Be off; you have no power here. . . ."

AARON: I don't know. I think Mr. Depression has plenty of power.

RACHEL: Maybe so, but I am very, very tired of talking about how miserable everything is. Look, I am never going to get over losing Fiona, but I don't want the rest of my life to be wrecked because this horrible thing has happened.

AARON: We are permanently guilty.

RACHEL: It saddens me that everything since then is so dark. And we do feel permanently guilty.

THERAPIST: Yes, it was a dark time; but remember, I was just wondering what would happen if someone dumped a bucket of water on Mr. Depression like Dorothy did the Wicked Witch of the West and melted him away. How would life be?

RACHEL: I don't really know. And I am not sure it involves the two of us staying together, but I want *this* (points to herself and Aaron) to change. I would love for the guilt I feel to melt away. I don't think another baby is in the picture. I hate it when people tell me I can always have another.

AARON (QUIETLY): I don't want another baby. I couldn't bear worrying about your health throughout another pregnancy.

THERAPIST: So it seems that you can start seeing something about the future—if not right now exactly what it will hold, then at least what it won't. What do you think?

Write Aaron and Rachel a summary letter. Use as many of their own words as possible to accent new possibilities and emerging narratives. Name any externalized problems that came up during the session. Remind them of any outcomes discovered in the session. Mention in the letter any strengths that you perceive in Aaron and Rachel. Be careful, however, not to draw conclusions about anything not directly discernible from the conversation itself. Remember: They, not you, are the experts of their own lives.

Forming Supportive Leagues

Separating one's identity from an external problem is part of the underlying philosophy of narrative therapy. Typical of this outlook is the development of Anti-Anorexia/Anti-Bulimia Leagues, begun by Epston in New Zealand, that spread to the United States, Canada, and Australia. They are based on the idea that people who have experienced certain problems, such as anorexia and bulimia, have the experience and knowledge about the problem to help one another by sharing their experiences with each other. Through shared experiences, clients can build upon each other's skills to defeat the problem. Offering mutual support, participants can team up and begin changing their relationship to the problem, perhaps reauthoring their lives to cope successfully with food and body image. Members speak of personally painful issues they might otherwise keep to themselves, and then take some social action to bring about greater public awareness. Audiotapes, artwork, letters to one another, periodic meetings, handbooks, public speeches, a newsletter, monitoring of magazine and newspaper ads—all

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represent politically inspired efforts to develop a supportive subculture, a logical extension of narrative therapy's goals of achieving liberation from destructive cultural narratives. The therapist plays an influential but decentered role here; in this community effort all voices are privileged, not just those of professional therapists.

Similar leagues deal specifically with other issues. Fraenkel and Shannon (2009), for example, describe a collaborative group that works with homeless families living in shelters. Narrative-based discussion groups help homeless family members tell the stories of how they became homeless, witnessed by others. Of particular importance is the opportunity to tell one's story without fear of getting into trouble with law officials or social organizations that are currently providing financial or other benefits. The production of group narratives—old and new—helps individuals overcome a sense of isolation and gain hopefulness. As is generally the case in working with narrative therapy, strengths are emphasized so that problems (perhaps externalized) can seem more manageable or solvable. And true to the narrative approach to therapy, homeless individuals are helped to see that their identities are separate from their circumstances of being homeless.



BOX 14.8 EVIDENCE-BASED PRACTICE

Recent Research

Some narrative therapists eschew traditional research verification as contrary to the nature and spirit of the approach, so it is only recently that research has been conducted on the model. "This may be partially explained by narrative therapy practitioners moving away from anything they deemed scientific or methods that attempted to quantify lived experience" (Madigan, 2011, p. 141), resulting in a gap between research and practice.

One way to bridge the gap is through *reflective practice* (Duvall & Béres, 2011). This approach encourages practitioners to reflect on their narrative practices, defining research broadly as the creation of knowledge about the intersection of theories with practice elements to refine practice. This is decidedly not linear or positivist research; it uses treatment videos, field notes, and group journals from therapy debriefing sessions as data for the identification of phenomenological themes and deductive examination. Duvall and Béres (2011) found a storyline structure, the significance of language circulation, and the evolution of pivotal moments in narrative therapy as key ideas in their research. They also note the usefulness of narrative practice in walk-in clinics, therapy with past trauma, addiction therapy, and therapy with men who had evidenced abusive behavior. In the case of men who used abusive behaviors in their families (Béres & Page Nichols, 2010), anger-management strategies were paired with narrative techniques, including the externalization of abusiveness so that the men could gain insight into their behaviors. They identified how they first learned the behaviors, who and what circumstances supported the behaviors, and how the behaviors negatively affected them and the people they care about. Treatment focused on creating new narratives about implementing nonabusive ways of interacting.

Lambie and Milsom (2010) report success in using narrative therapy to support students who were diagnosed in traditional therapy with learning disabilities (working with a diagnosis raises challenges for postmodern practitioners, because a diagnosis imposes a pathological view of human experience on individual narratives, in diametric opposition to the postmodern approach to therapy). The investigators note the use of a

(Continued)

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narrative technique called *mapping* with students who struggle to organize thoughts, to comprehend what they read, or to communicate verbally. Mapping allows the therapist to ask questions that help clients identify the effects of the problem throughout their life. Attention is often given to the impact of these problems on relationships. The questions thicken the narrative about how the learning disability affects relationships with school, parents, and friends. Mapping decenters the dominant story about the disability and identifies client strengths, leading to rich restorying and client empowerment.

Narrative therapy has also been used to help elders struggling with memory loss and the anxiety and depression that often accompany the realization that one's sense of identity is fading from awareness (Young, 2010). Here, people developing dementia are helped to revise their stories and fashion new identities as their personal histories become less accessible to them, emphasizing character traits and thematic patterns in their stories.

Vromans and Schweitzer (2011) studied the use of narrative therapy with adults experiencing major depressive disorder. They found a reduction in depressive symptoms comparable with other treatments, providing initial support for elements of narrative therapy in treatment of depression. Graham (2014) posits the applicability of narrative therapy with video game addictive behaviors. Erbes and colleagues (2014) demonstrated initial support for narrative therapy with military veterans with a diagnosis of PTSD in a pilot study. Ultimately, the clinical effectiveness of narrative therapy may be evidenced as clients show more flexibility and "stop talking about a therapeutic theme, ruminate less, or talk about the topic less frequently or with less emotional intensity" (Meier, 2012, p. 126).

SUMMARY

Narrative therapists focus on helping clients gain access to preferred story lines about their lives and identities in place of previous negative, self-defeating, dead-ended narratives about themselves. With the therapist influential but decentered, the clients are helped to create and internalize new dominant stories, draw new assumptions about themselves, and open themselves up to future possibilities by reauthoring their stories.

The model, now prominent in the field, is based on poststructural thinking that challenges the need for underlying "truths" and repairing underlying structures. Deconstructing old notions and replacing them with multistoried possibilities helps reduce the power of dominating, problem-saturated stories. The therapeutic process calls for attending to and overcoming restrictive self-narratives as well as institutionalized cultural narratives.

To narrative therapists, the client is not the problem; the problem is the problem. Thus therapeutic conversations typically begin by externalizing the problem. In some cases, the problem is given a name, further identifying it as an outside force. Helping families reclaim their lives from the problem, narrative therapy takes the form of questions, often of a deconstructing kind, as the therapist helps clients achieve "thick" descriptions of an alternate story line about their future. Unique outcomes are searched for as possible entryways to developing alternate stories. As clients gain a history of the problem-saturated stories that have dominated their lives, they begin to develop a sense of other options involving more open-ended and feasible stories. Change calls for creating alternative narratives; the process is facilitated by various means for "thickening" or enriching the new story line and connecting to it in future options.

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Definitional ceremonies, using reflecting teams or outside witness groups, help tell and retell the story, helping clients authenticate preferred stories. Therapeutic letters extend the therapeutic sessions and keep clients connected to emerging alternative stories. Community-based leagues, focused on experiences like anorexia/bulimia or homelessness, enable citizens to offer mutual support, build upon each other's skills, and act as a political action group to change destructive media portrayals of their problems.

Narrative therapies do not readily align with modern research methods, but there is initial qualitative and quantitative evidence for the approach.

RECOMMENDED READINGS

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15

Population-Based Family Treatments

LEARNING OBJECTIVES

- LO 1 Discuss the use of family therapy in the treatment of severe mental disorders
- LO 2 Give an example of multiple family therapy
- LO 3 Define medical family therapy
- LO 4 Discuss some family adaptations to chronic illness
- LO 5 What are the main characteristics of psychoeducational family therapy?

Family therapists serve a variety of client populations in a variety of practice settings (psychotherapy offices, clinics, hospitals and medical facilities, schools, businesses, universities; Nutt & Stanton, 2008). The systemic foundation of family therapy and the increasing breadth of therapeutic approaches in the field extend to assist people dealing with many issues or circumstances. We provide an overview of family therapy related to schools and education, individual mental disorders in the family context, primary medical care and the family, gay and lesbian families, relationship psychoeducation, family violence, and divorce and stepparenting.

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Families and Schools

There is a significant interaction between families and schools in the socialization and development of children, termed the home–school relationship (Carlson et al., 2009). This systemic interaction was noted by Bronfenbrenner (1986) as a *mesosystemic* relationship between the primary environments in which a child develops; the quality of the relationship is critical to developmental outcomes. The ecosystem extends to the community in which the family resides, as well as the cultural context, socioeconomic conditions, and other macrosystemic factors (Stormshak, Fosco, & Dishion, 2010).

In the home–school relationship, family influences and academic influences interact in reciprocal fashion. Parenting styles (authoritative, authoritarian, permissive, neglectful) and a variety of parenting practices (behavior monitoring, parent–school engagement, development of learning spaces and conditions) can either facilitate or diminish the quality of the interaction, although specific aspects may vary by family ethnicity (Carlson et al., 2009). Similarly, schools impact the developing child and contribute to the socialization process. However, especially with low-income diverse families who understand their role as the provision of home-based support for the child's education, programs that focus on parental participation in school functions as the main priority may be off target, while programs that assist parents in improving home academic processes (reviewing homework, encouraging reading) may result in better school achievements (Carlson et al., 2009). Practices that improve communication between the school and the home may enhance the interaction (Hiatt-Michael, 2010).

Family therapists who engage the family–school relationship must remember the systemic nature of the interaction and design interventions that pay due attention to the complexity of the relationship. Many school-based programs target problem behaviors by teaching skills to the child but fail to achieve long-term success because they leave the family out of the process. Current best practices are family-centered treatments, including the EcoFIT model that is evidence based, developmental ecological, incorporates assessment, includes the social relationship context of child mental health, focuses on parent change motivation, and adopts a health maintenance perspective (Dishion & Stormshak, 2009). There are a number of family–school interventions with demonstrated support (see table in Carlson et al., 2009); social workers and therapists in school settings are encouraged to use empirically supported interventions (Powers & Swick, 2014).

Families and Mental Disorders

There is a long history of using family therapy for mental disorders, but Nichols (2009) concludes that it is still necessary to reduce professional resistance to genuine biopsychosocial theoretical and practice models. Today, there is substantial evidence for the effectiveness of family therapy with particular disorders, including depression, anxiety, substance abuse, eating disorders, and serious mental illness, as demonstrated next.

Families with Depression and Anxiety

Couple and family therapy for depression and/or anxiety in children, adolescents, and adults has demonstrated effectiveness. Childhood mood disorders often emerge and progress in

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dysfunctional family types; a family history and recurrence of depression is more likely in families that include a depressed child (Kaslow, Mintzer, Meadows, & Grabill, 2005). Environmental elements and genetic factors can create risk for adolescent depression, but family protective elements can reduce the risk or influence teen attitudes and choices that positively impact treatment course and outcomes (Kaslow, Broth, Arnette, & Collins, 2009). Given the prevalence of behavioral and affective symptoms and disorders in the child–adolescent population, interventions that include the family in some fashion (along a continuum from adding a parent to including the full family to including several families in a group) are on the rise (Kaslow, Broth, Smith, & Collins, 2012). A review of evidence for family-based treatments identifies a variety of approaches for depression, bipolar disorder, anxiety disorders, ADHD, oppositional defiant disorder, autism spectrum disorders, and eating disorders, with varying levels of support (Kaslow et al., 2012).

Adult depression is often treated today in the context of couple dynamics and couple therapy. There is evidence to suggest that couple discord may be both a cause and consequence of depression; treatments that address the relationship and the depression result in better outcomes (Whisman, Whiffen, & Whiteford, 2009). Cognitive-behavioral couples therapy (CBCT) targets relationship communication and behaviors to increase closeness, as well as conflict management skills over 15 to 20 therapy sessions plus homework outside the sessions; it includes relapse-prevention strategies and is most effective when depression and couple distress co-occur (Whisman & Beach, 2012). There are also a variety of family stressors, including parenting problems, that correlate with depressive episodes; treatments that focus on the parent–child interaction may help relieve parental depression, enhance parenting skills, and improve child results (Beach & Whisman, 2012).

Families and Substance Abuse

Although substance abuse is frequently considered an individual problem, it often occurs in the family context, and there is strong evidence for systemic treatments that include family members (Stanton, 2009). The CRAFT model (Smith & Meyer, 2004) teaches family members how to encourage substance abusers to enter treatment. Motivational enhancement, an empathic approach that seeks to evoke and reinforce a client's motivation to change, has demonstrated success, especially in regard to substance abuse (Miller & Rose, 2009); it may be adapted for couples therapy (Burke, Vassilev, Kantchelove, & Zweben, 2002), and it is hypothesized that a concerned significant other (partner, family member) may contribute positively to a substance abuser's motivation to change (Stanton, 2009). Relapse prevention is another major intervention for substance abuse. Witkiewitz and Marlatt (2004) present a dynamic systems model of relapse that seeks to capture the complex, nonlinear elements of the process. Stanton (2005) extends the model to enhance recognition of interpersonal factors and social support as key elements in treatment, as family members aid in the identification of high-risk circumstances, join the substance abuser in risky situations as a sober support, enhance coping skills, and enhance self-efficacy for sobriety. Interpersonal conflict can trigger negative emotions and relapse, so it is important for therapy to improve relationship and coping skills.

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Several evidence-based family interventions address adolescent substance abuse and externalizing disorders. Each is systemic, focuses on a complex therapeutic alliance with multiple family members, and targets enhanced understanding between parents and the adolescent; each has research support in carefully designed studies and has been adopted broadly (Lebow, 2014). Functional family therapy (Alexander et al., 2013; Sexton, 2011), multisystemic therapy (Henggeler, Sheidow, & Lee, 2009), multidimensional family therapy (Liddle, 2009), and brief strategic family therapy (Robbins, Szapocznik, & Horigian, 2009) help families with an adolescent abusing substances.

Systemic models of couples therapy are also very effective in treating substance abuse; they engage the addict's partner in treatment and utilize systemic concepts and practices to reduce substance abuse (Stanton, 2005). Behavioral couples therapy has strong support for clinical effectiveness. This model recognizes the "vicious cycle" between relationship dysfunction and substance use problems, with each influencing the other, so it addresses both concurrently in treatment. It uses behavioral interventions, like a *recovery contract* and a *sobriety trust discussion* conducted daily between partners to reinforce abstinence, as well as homework assignments and participation in self-help groups, like Alcoholics Anonymous (Fals-Stewart, Birchler, O'Farrell, & Lam, 2009).

Families and Eating Disorders

A "review of the theoretical justification and current evidence base for the use of family treatments for eating disorders in children and adolescents" finds that "family interventions are the current first-line treatment for adolescent anorexia nervosa and promising for adolescent bulimia nervosa" (Lock, 2011, p. 274). Family therapy approaches for eating disorders are scalable through model dissemination and have initial evidence of effectiveness across settings. The Maudsley Hospital (in London) program for anorexia nervosa has strong evidence for effectiveness. It uses four phases toward the goal of using "the adaptive mechanisms of the family to explore ways in which attempts at dealing with the problem may have become part of the maintaining mechanisms, and the role that the symptoms have gradually taken on in the way that the family functions" (Eisler, 2009, p. 556). Eisler (2009) describes four phases:

Phase 1: Engagement and development of the therapeutic contract: explore perceptions of the eating problem; disinterest in identifying causes; assess severity; medical evaluation; externalize the problem; provide information; engage problem solving with the family.

Phase 2: Helping the family to challenge the symptoms: explore meal time practices; identify needed changes; discuss options used by others.

Phase 3: Exploring issues of individual and family development: as improvement begins, consider the interaction between typical adolescent concerns (self-image, identity, separation) and anorexic behavior; focus on future life without anorexia.

Phase 4: Ending and discussion of future plans: reflection on learning; what to do if eating problems recur.

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LO 1 Families and Serious Mental Illness

Mental illness in a family can be a "ravaging, devastating disease" that disrupts a family and permits little respite (Marsh & Johnson, 1997). In addition to the continuing social stigma and ostracism of people with mental illness such as schizophrenia or bipolar disorder, families with mentally ill members also confront objective and subjective stressors, including challenges accessing treatment, premature treatment discharge or the patient's refusal of treatment, insurance problems and financial difficulties, employment problems, the burden of 24/7 supervision, family conflict, impaired health, and a diminished social life. Grief, chronic sorrow, the loss of dreams and hopes for the affected person, the emotional roller coaster punctuated by periods of relapse and remission, potentially violent or self-destructive behavior, the unpreparedness of families to deal with the challenges, and the scarcity of services—these are the common experiences of families (Marsh & Lefley, 2009). The mother of a mentally ill daughter describes it this way:

> The problems with my daughter were like a black hole inside of me into which everything else had been drawn. My grief and pain were so intense sometimes that I barely got through the day. It felt like a mourning process, as if I were dealing with the loss of the daughter I had loved for 18 years, for whom there was so much potential. (Marsh, 1992, p. 10)

Teaching anguished family members to be "informal case managers," learning how and from whom in the community to obtain mental health, welfare, legal, and medical services is often of great benefit, especially since most families feel helpless and confused when such new roles are thrust upon them (Marsh & Lefley, 2009). The National Alliance for the Mentally Ill (NAMI) is an important source of information, education, and support for professionals, family members, and the general public. Training in daily problem solving and crisis management to handle extreme stress in the family are part of psychoeducational therapy. Simultaneously, therapy intends to ensure that to the extent possible, family members preserve the integrity of their own lives. Therapy brings the family's competencies and resiliency into play for constructive action.

Interest in the family treatment of severe mental disorders has waxed and waned over the years. Today, schizophrenia is viewed as a genetic and/or biologically based disease whose symptoms are best dealt with by using antipsychotic medication. The disorder may arise in well-functioning families as well as those that show a high degree of dysfunction. However, environmental factors within family life do play a role in schizophrenic *relapse rates*. Psychoeducation advocates maintain that helping family members understand the disorder and learn specific coping skills is essential in supplementing medication, reducing family stress, and preventing symptomatic relapse in the schizophrenic member. Families, relieved at not being blamed or shamed for the development of the disorder in one of their members, may be more receptive to integrated treatment programs, thus increasing the likelihood of improved treatment compliance. However, some reject therapy out of denial or the fear of social stigma. Their willingness to collaborate with supportive therapists is increased if they are persuaded that these efforts will delay or reduce in severity any symptomatic relapse.

A noteworthy example of psychoeducationally based family therapy was developed by psychologist Carol Anderson and her colleagues, Douglas Reiss and Gerald Hogarty, at the Western Psychiatric Institute in Pittsburgh (Anderson, Reiss, & Hogarty, 1986). Their initial observation was that recovering hospitalized schizophrenics frequently relapsed when released to the custody of their families. Was the family at fault? Did the patient stop taking prescribed

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medication? Did they need family therapy exploring underlying toxic family dynamics? They discovered that existing interventions intended to head off relapse failed in most cases; the search for causes within family life only aroused guilt and defensiveness, sometimes resulting in failure—or worse, relapse. Moreover, they contended that the encouragement of highly charged emotional exchanges by family therapists might actually be antitherapeutic in the case of schizophrenia. Instead of the customary focus on the family's effect on the schizophrenic, they proposed a turnaround—attending to the impact of the schizophrenic on family life.

Without blaming the family, they went about the business of helping all family members, including the schizophrenic, overcome obstacles to family functioning. They used a matter-of-fact approach, teaching coping skills to families who must attend daily to "the devastating impact of watching one's child deteriorate into someone who is all but a stranger, and a most incapacitated one" (McFarlane, 1991, p. 364). Families were recognized as having experienced severe stress that left them feeling depleted and susceptible to dysfunctional behavior patterns, so they were supported as they learned new empowering techniques to mitigate stress and strain and to reduce the likelihood of relapse.

Similar efforts by other like-minded clinicians/researchers such as Michael Goldstein (1981) and David Miklowitz (2008) at UCLA and Ian Falloon (Falloon et al., 2005) at the University of Southern California are examples of family-focused programs that emerged in response to briefer hospitalization for patients experiencing a major psychosis (schizophrenia or **bipolar disorder**). Because patients are often discharged while only in partial remission from their psychotic symptoms, they and their families must cope with problems connected with reentry into the community. The focus is on the schizophrenic's impact on family functioning, not the other way around.

Psychoeducational programs, highly structured, were designed to fit the bill. "Survival skills workshops" addressed such everyday family concerns as setting limits on the schizophrenic when other members are affected, assigning chores the schizophrenic member is able to perform, and reducing unrealistic expectations. The workshops were coordinated with medication to forestall relapse. Such cost-effective, community-based treatment placed partially remitted patients in closer contact with their family members (Goldstein & Miklowitz, 1995). "There is strong evidence for the clinical, social, family, and economic benefits of family psychoeducation" (Marsh & Lefley, 2009, p. 745). See Box 15.1 for recent research evidence on treatment effectiveness.

Expressed Emotion and Schizophrenia

The theory of **expressed emotion** (EE) suggests that schizophrenia is a thought disorder in which the individual is vulnerable to and highly responsive to stress caused by the expression of intense, negative emotions. Researchers reasoned that when former patients returned home to a stressful, negative, and hypercritical family environment where EE was high, the patients were likely to become aroused and relapse into symptoms. On the other hand, for patients returning to households manifesting low EE, while family members also were concerned about the disturbed (and disturbing) behavior of the schizophrenic, they were not overly anxious in response to the patient's condition, allowing the individual more psychological space (Leff & Vaughn, 1985). Expressed emotion is a validated indicator for relapses of schizophrenia (Cechnicki, Bielańska, Hanuszkiewicz, & Daren, 2013), and the value of reducing EE in families with schizophrenia has

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BOX 15.1 EVIDENCE-BASED PRACTICE

Families with Mental Disorders

Bipolar Disorder and Depression

A review of research in the last 20 years on family psychoeducation for bipolar I disorder found enhanced coping by relatives and decreased family burden from the disorder (Fiorillo et al., 2013); this was followed by a study that found the intervention effective for improving social functioning and reducing family burden (Fiorillo et al., 2015). Psychoeducation, combined with medication, can also be effective for reducing symptoms of depression (Morokuma et al., 2013) in a cost-effective manner (Shimodera et al., 2012).

Schizophrenia

Family psychoeducation programs for families with a member diagnosed with schizophrenia are an established evidence-based practice lowering relapse rates and rehospitalizations, but they are underutilized in contemporary healthcare (Lucksted, McFarlane, Downing, & Dixon, 2012). An earlier meta-analysis concluded that "psychoeducational interventions are essential to schizophrenia treatment" (Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001, p. 73), especially those that combine psychosocial support with medical treatment and last more than 3 months because they reduce relapse by 20%. Subsequent studies confirm and reinforce the validity of evidence-based psychosocial treatment (Sungur et al., 2011). Positive early results of delivering family psychoeducation online may extend the model effectively to more families (Rotondi et al., 2010).

been documented (Atkinson & Coia, 1995). Lowering EE is also linked to reduced relapse rates for various forms of depression and bipolar disorder (Mueser & Glynn, 1995).

Recent research suggests that the EE–relapse relationship may be more complex than originally understood. Research with Mexican American families including a member with serious mental illness found that EE was increasingly connected to relapse as historical enculturation shifted to acculturation to U.S. culture, so culture may influence family factors in the relapse process (Aguilera et al., 2010); a related analysis suggests a curvilinear relationship between EE and relapse, with high levels being toxic but medium levels evidencing some protective effect (Breitborde et al., 2007). Higher education level predicted lower blame attributions in White and Hispanic families but not Black families, further suggesting the need to consider culture and family variables (Duarte, deMamani, Rosales, & Kymalainen, 2008), including the possibility that EE may have been a proxy in early research for the risks related to family caregiver attributions regarding the ill person's agency in the recovery process and the impact that has on recovery or relapse, including aspects of EE (Breitborde, López, & Nuechterlein, 2009).

LO 2 The Therapeutic Process

Family psychoeducation follows one of two formats—working with individual families (Anderson, Reiss, & Hogarty, 1986) or with multiple families simultaneously (McFarlane, 2011). In the former, Anderson and colleagues phase interventions (often resembling structural family therapy because of the emphasis on boundaries, hierarchy, and subsystems), beginning with engaging the family; research indicates that establishing a positive therapeutic alliance with the family improves outcomes (Smerud & Rosenfarb, 2011). Gaining the family's cooperation, they begin survival skills workshops—teaching family members about the prevalence and course of mental illness, its

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biological etiology, current modes of pharmacological and psychosocial treatment, common medications, and prognosis. Patient and family needs are discussed and family coping skills strategized. EE findings are aired here, and basic behavioral guidelines for keeping EE in check are discussed to help take the pressure off the patient to hurry up and behave in a normal manner. Because schizophrenics are usually sensitive to overstimulation, families are urged to respect boundaries, allowing schizophrenics to withdraw whenever necessary. Generational boundaries are also reinforced as parents are urged to form a stronger bond and together remain in charge rather than letting all family decisions be controlled by the patient's needs.

During the subsequent reentry period into the social environment, outpatient sessions (usually weekly) that may go on for a year or more are aimed at achieving stability outside the hospital. Patients may be assigned small tasks and their progress monitored. The therapy team typically uses this period to shift attention to the family structure, which may have changed because of accommodating to the patient's return from the hospital. The final rehabilitation phase consolidates gains and raises the patient's level of functioning.

McFarlane's (2011) multifamily version owes its heritage to multiple family therapy, an early effort (Laqueur, 1976) to treat several families of hospitalized schizophrenic patients together. In its psychoeducational reincarnation, multiple family therapy lecture-and-discussion workshops are held with relatives. Typically, five or six families attend, offering increased social support, usually with sessions over at least 12 months. The U.S. Department of Health and Human Services (SAMHSA) includes McFarlane's model among evidence-based practices and has an implementation tool kit available (SAMHSA, 2009). Box 15.2 presents guidelines for families following a schizophrenic episode.



BOX 15.2 CLINICAL NOTE

Psychoeducational Guidelines for Families and Friends of Schizophrenics

1. *Go slow.* Recovery takes time. Things will get better in their own time.
2. *Keep it cool.* Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down, too.
3. *Give each other space.* Time out is important for everyone. It's okay to reach out. It's okay to say "No."
4. *Set limits.* Everyone needs to know what the rules are. A few good rules keep things clear.
5. *Ignore what you can't change.* Let some things slide. Don't ignore violence.
6. *Keep it simple.* Say what you have to say clearly, calmly, and positively.
7. *Partner with your relative's treatment team.* Understand your relative's goals and the steps outlined in their treatment plan.
8. *Carry on business as usual.* Reestablish family routines as quickly as possible. Stay in touch with family and friends.
9. *Do not use street drugs or alcohol.* They make symptoms worse, can cause relapses, and prevent recovery.
10. *Pick up on early warning signs.* Note changes. Consult with your consumer relative and the treatment team, if possible.
11. *Solve problems step by step.* Make changes gradually. Work on one thing at a time.
12. *Adjust expectations.* Use a personal yardstick. Compare this month to last month rather than to last year or next year.

Source: SAMHSA (2009); Adapted from McFarlane (1991), p. 375

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LO 3 Medical Family Therapy

Medical family therapy (MedFT) is "a form of professional practice that uses the biopsychosocial model and systemic family therapy principles in the collaborative treatment of individuals and families dealing with medical problems" (McDaniel, Doherty, & Hepworth, 2014, p. 9). This model deals with the complex interface between family relationships and family health. It replaces the traditional medical model that focuses exclusively on a sick individual receiving care to one in which the family becomes the cornerstone of the caregiving system, and its ability to cope and adapt are based on family system strengths. From this perspective, psychosocial factors and biological interventions play an important role in healing (Rolland, 2012). There is a journal devoted to medical family therapy called *Families, Systems, and Health*.

Research supports the value of interactive communication between physicians and mental health practitioners in the medical setting (Foy et al., 2010), providing initial support for aspects of the MedFT model. The interactive relationship between health or disease and family functioning is well documented in research, including positive healthcare outcomes from family interventions and demonstrated cross-cultural applicability (Tyndall, Hodgson, Lamson, White, & Knight, 2012). However, further, more sophisticated studies are needed that build upon a shared lexicon of the components of MedFT and establish metrics to determine which aspects of the model achieve desired outcomes; research could include quantitative and qualitative approaches to evaluate clinical, operational, and financial aspects of MedFT (Mendenhall, Pratt, Phelps, & Baird, 2012).

Leading Figures

George Engel (1977), an internist at the University of Rochester School of Medicine, is usually credited as the first to call for an integrated approach to medical problems that he designated the "biopsychosocial approach." Engel argued that the patient and the disease must be understood in context, that families must be involved in medical care, and that all systems must be considered equally. McDaniel, Harkness, and Epstein (2001) suggest the biopsychosocial view emerged as a reaction to the then-prevailing reductionistic, biomedical model for treating medical problems.

To promote family-centered medical care, William Doherty and MacAran Baird (Doherty & Baird, 1983, 1987), a psychologist and family physician, delineated five levels of physician engagement with families: (a) little if any involvement, (b) keeping family members informed of patient treatment, (c) offering support, (d) planning interventions, and (e) providing family therapy.

Psychologists Susan McDaniel in New York, William Doherty in Minnesota, and Jeri Hepworth in Connecticut, all having worked in primary-care medical settings, promote *medical family therapy* (McDaniel, Doherty, & Hepworth, 2014). They call attention to "eco-systemic splits" (p. 5) that hinder healthcare by separating mind and body; individual and family; individual-family and healthcare systems; the clinical, financial, and operational aspects of healthcare; and healthcare and the culture or community. Their book describes new roles for family therapists in a variety of healthcare settings. See Box 15.3 for common adaptations made by families facing chronic illness.

Other leading figures include two psychiatrists who specialize in family medicine: John Rolland (2012), a founder of the Center for Family Health at the University of Chicago and

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BOX 15.3 **CLINICAL NOTE**

LO 4 Common Family Adaptations to Chronic Illness

1. *A change in family roles.* Ill person can no longer fulfill old roles (child care, domestic tasks), and family caregivers must increase time devoted to sick person.
2. *Caregivers stressed and overburdened.* Assistance may not be available, and caregivers may feel guilty about their feelings.
3. *Financial hardship.* Ill person's decrease or loss of earning power, particularly if main breadwinner at height of earning potential.
4. *Accommodations to treatment regimen.* From simple dietary changes to time-consuming trips to doctor and hospital, engaged in willingly or resentfully.
5. *Communication regarding illness.* Differing ideas about what and how much to reveal to patient or others, shame if illness is the possible result of AIDS or chronic mental illness.
6. *Coping with multiple losses.* Loss of functioning, loss of intimacy with ill person, anticipated death of loved one.

Source: Adapted from Ruddy & McDaniel (2003)

developer of a family systems health model that conceptualizes how an illness interacts with components of family functioning over time; and Thomas Campbell, in Rochester, New York, a former student of Engel's, interested in collaborative work involving general systems theory and family healthcare (Campbell & Patterson, 1995).

Collaborative Family Healthcare Association

A number of family therapists, physicians, nurses, and other healthcare workers, primarily working in healthcare facilities, joined together in 1993 to form a coalition now called the Collaborative Family Healthcare Association (McDaniel et al., 2014). Researchers, educators, administrators, healthcare policy makers, social workers, and consumer-group representatives join in the effort to re-vision healthcare. The association seeks to help establish a collaborative, team-based family healthcare paradigm aimed at providing cost-effective, humane, and integrated patient and family services. It provides "education, training, partnering, consultation, research, and advocacy" as well as "a leading-edge conference every year" (CFHA, 2015).

Clinical collaboration between medical providers, family therapists, and other health professionals is the cornerstone of this comprehensive approach for dealing with a variety of medical problems (McDaniel et al., 2014). Today, all professionals work as a team to benefit families coping with the impact on overall family life of chronic illness (diabetes, leukemia, cardiovascular disease), life-threatening conditions (AIDS, anorexia nervosa, infants born prematurely), or impairment and disability (spinal cord injury, blindness or deafness, dementia in the elderly) of one of their members. Family-level interventions for lifestyle changes (quitting smoking, losing weight, healthier diets) are also important.



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BOX 15.4 CLINICAL NOTE

Psychosocial Types of Illness

Moving beyond the standard disease classification based strictly on biological criteria, Rolland (2012) adds a psychosocial dimension. In his "psychosocial typology of illness," he offers the following categories for considering how an illness impacts individuals and families across the life cycle.

Onset: Sudden and acute (a stroke) or gradual and chronic (Alzheimer's Disease). The former calls for family mobilization of crisis-management skills, the latter for long-term planning and role adjustments.

Course: Chronic illnesses may challenge the family in different ways: (1) by getting *progressively worse* (lung cancer), entailing continuing role changes, adaptations to new losses, and increased strain on family caregiving; (2) by *remaining constant* (heart attack) so that after initial recovery, there are ongoing limitations in functioning, and the family needs to make long-term adaptations to change; and (3) by *relapsing* or manifesting *episodic* illnesses (asthma) with alternating periods of freedom from symptoms and flare-ups, so that the family lives with uncertainty and transitions between crisis and noncrisis states.

Outcome: Fatal (metastasized cancer), nonfatal (flu), life-shortening (heart attack), imminent (inoperable brain tumor), or sudden death (hemophilia) are possible, and the family must learn to live with how disease will affect the individual's lifespan. Different family reactions represent different degrees of anticipatory grieving and loss to the family.

Incapacitation: Disability may involve impairment of cognition (Alzheimer's), of sensation (blindness), of movement (paralysis), disfigurement (mastectomy), or social stigma (AIDS; Olkin, 1999). Family must adapt to loss of breadwinner income, role shifts, output of funds for assistance, social isolation from previous reference group.

Rolland's typology assembles onset, course, outcome, and incapacitation into a grid (e.g., emphysema—gradual onset, progressive course, incapacitating, fatal; spinal cord injury—acute onset, remains constant, incapacitating, nonfatal). The course of some diseases is predictable (Alzheimer's), while others progress unevenly and unpredictably (early multiple sclerosis). Rolland's psychoeducational framework highlights the interaction between the illness or disability and the characteristics or qualities of the family (its life cycle stage, its resources or resiliencies, the role of the ill person in the family, the family's belief system about illness, and so on). Family support groups for chronically ill patients and their families are often tailored to a particular type of condition (e.g., leukemia), its course (e.g., progressive or relapsing), or perhaps timed to a critical phase of the disease's manifestations (Steinglass, 1998). Each phase of an illness poses its own psychosocial demands and developmental tasks, calling for significantly different strengths, attitudes, or changes from the family (Rolland, 2003).

Family Therapist–Physician Partnerships

Partnerships between therapist and physician, nurse, pharmacist, or rehabilitation specialist to achieve more comprehensive care call for accepting each other's language, therapeutic assumptions, and working styles, which often are in conflict. Collaboration requires moving past toleration and beyond cooperation to continuing communication toward a joint treatment plan (McDaniel et al., 2014). Physicians are able to educate the therapist about the causes, likely course, and prognosis of a disease, while the therapist can enlighten the

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physician and other caregivers about the patient's experience of illness, perhaps exploring how to minimize patient or family anxiety, help them accept the disease, and enable them to participate in their own healing (McDaniel, 1995). Medical providers help therapists to recognize important biological aspects of a complex presenting problem. By the same token, in working with therapists or social workers, physicians are less apt to overlook the psychosocial levels of a problem or illness. The task of tending to a family's emotional needs, say after major surgery, often falls on the mental health person and leaves the surgeon free to care for the patient's biomedical needs.

Medical family therapists need a working knowledge of the major chronic illnesses and disabilities, as well as major treatments and their emotional sequelae, along with familiarity with the healthcare system. Physicians need to understand and accept the help offered by the family therapist without feeling a loss of sovereignty over patient care. While battles over turf and professional competition often exist, working partnerships offering a holistic, ecosystemic approach to healthcare are increasing in frequency.

Family Therapist–Family Partnerships

Collaborative care strengthens the shaken family system, allowing its members to regain a sense of involvement, control, choice, and power about medical decisions. "A family's beliefs about mastery strongly affect its relationship to an illness and to the health care system" and impact family engagement and treatment adherence (Rolland, 2012, p. 473). Another is to reduce the emotional consequences to the family of an ongoing medical condition by enhancing family communion and connection, in the process perhaps altering the clinical course of the illness. Medical family therapists help families deal with complex conditions and their consequences. The most frequent cases relate to chronic illness (McDaniel et al., 2014); see Box 15.5 for clinical strategies in a medical setting.



BOX 15.5 CLINICAL NOTE

Strategies for Medical Family Therapy

1. Recognize the biological dimension.
2. Elicit the family illness history and meaning.
3. Respect defenses, remove blame, and accept unacceptable feelings.
4. Facilitate communication.
5. Attend to developmental issues.
6. Reinforce the family's nonillness identity.
7. Provide psychoeducation and support.
8. Increase the family's sense of agency.
9. Enhance the family's sense of communion.
10. Maintain an empathic presence with the family.

In addition, medical family therapists need to practice self-care. Dealing with serious illnesses on a daily basis raises existential challenges and is often lonely and stressful for therapists. Developing tolerance for ambiguity and potential losses, managing anxiety regarding medical procedures, and having a consultation group may help avoid burnout.

Source: McDaniel, Doherty, & Hepworth (2014), pp. 35–50, 97–108

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Gay and Lesbian Families

Sexual minority families experience unique stressors, including employment discrimination, bullying of gay and lesbian (GL) children and adolescents, and legal issues related to couple relations and parental custody (Green, 2012). Despite recent changes, the history of gay and lesbian individuals in the United States continues to impact family functioning. A systemic perspective is helpful because GL family life occurs within the context of the broader society and a reciprocal interaction between culture and family is evident in experiences like family-of-origin life/coming out, couple relationships, and parenting (Goldberg, 2009).

Green (2012) notes that the family-of-origin experience of young people who ultimately come out as gay or lesbian is unique because, unlike ethnic minorities who share that status with their family members, they "rarely have parents or siblings who share their same sexual minority status" (p. 179). They often must navigate "the process of accepting and disclosing one's sexual orientation to oneself and others" (Goldberg, 2009, p. 576) alone or without parental guidance. A variety of sociopolitical factors influences the process, including ethnic, religious, political, socioeconomic, and employment attitudes of acceptance or rejection of GL identity in the individual's contextual surround. Peer relations are especially important, being a "family of choice" (Green & Mitchell, 2008).

Goldberg (2009) suggests that opportunities for interaction and dating are increasing and attitudes toward gay relationships have become more positive, although negative feelings and discrimination still exist. Research suggests that same-sex and heterosexual relationships are similar on a number of relationship quality factors (Kurdek, 2004). Most sexual minority couples manage life without therapy, but some may seek therapy for issues regarding commitment, gender-associated activities, boundaries, or psychological distress (like depression) related to the experience of bias; however, it is important to remember that some same-sex couple issues may not be due to sexual identity (Green & Mitchell, 2008). Sexual minority couples typically experience less family support than do heterosexual couples, as well as social and legal issues that may negatively impact relationship stability (Goldberg, 2009). Recent changes in legal recognition of same-sex couples may mitigate some of those effects.

A substantial percentage of gay and lesbian couples parent children, some from former heterosexual relationships, as well as an increased number by adoption and use of insemination techniques and technologies, although barriers remain. Key issues in same-sex parenting include "social support; division of labor; parenting abilities; and child outcomes" (Goldberg, 2009, p. 582). Parenthood seems to increase extended family support and friendships with heterosexual parents and some decrease in interaction with gay and lesbian friends who are not parents (Green, 2012). An extensive study of parenting and child outcomes found "positive mother–child relationships and well-adjusted children," and "no significant differences were identified between lesbian mothers and heterosexual mothers for most of the parenting variables" (Golombok et al., 2003). Research on sexual minority parenting is increasing rapidly in sophistication and specificity of variables; there are more lesbian parenting research studies than gay parenting; research is needed on LGBT families of color and of differing socioeconomic status (Biblarz & Savci, 2010). Recent research is just beginning to include bisexual (Ross & Dobinson, 2013) and transgender families (Downing, 2013); these emerging areas of

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BOX 15.6 THINKING LIKE A CLINICIAN

Working with a Person with HIV

Sergei is a 17-year-old illegal immigrant from Russia. A week ago, he was admitted to a hospital after overdosing on heroin. He also had been attacked and sustained multiple stab wounds, although none were life-threatening and the wounds are healing well. A nurse tells you that Sergei was accompanied to the hospital by a young man who told the staff that Sergei recently had been diagnosed with HIV. She did not know if the young man was Sergei's friend, boyfriend, or partner. A meeting has been planned that will include Sergei and his parents to discuss the young man's needs regarding-drug use and HIV status. In advance of the meeting, you learn from Sergei's mother that although she and her husband will attend the meeting, the father has more or less disowned his son.

You meet Sergei in the hospital a few days before the family meeting. He strikes you as angry, even nasty. Initially you are repelled by him, but you don't know why. He tells you nothing at all about himself and rather curtly dismisses you. He says he wants to get out of the hospital. When you mention the upcoming meeting with his parents, he flies into a rage and tells you he absolutely won't participate.

Use the following questions to help you consider how to help Sergei.

1. What special needs might Sergei or his family have as illegal immigrants that are relevant to his present circumstances? What might you need to do in advance of meeting with Sergei and his family regarding their immigration status?
2. What needs might Sergei have with respect to the possibility of his being gay? How might you address these when you meet the family? What if he isn't gay? What differences, if any, would the status of his sexual orientation make with respect to your work with Sergei and his family?
3. How might you help Sergei and his family work with his HIV status? What cultural, social, language, and medical issues do you anticipate?
4. What questions do you have for other members of the medical family therapy team? How might you all work together to help Sergei and his family?
5. What goals do you see for your work with Sergei and his family? Identify three.

research will be important for understanding the unique experiences of different members of the LGBT community (Green, 2012).

LO 5 Psychoeducation: Teaching Skills to Specific Populations

Psychoeducation is an evidence-based intervention that educates families so that they might develop skills for understanding and coping with disturbed family members or troubled family relationships. This approach to family therapy supports and empowers families with schizophrenic members, as noted, violent families (Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998), those including alcohol or substance abuse (Ozechowski, Turner, & Waldron, 2003), families struggling with chronic illness (Rolland, 2012), or even those simply wishing to improve relationship skills (Markman, Stanley, & Blumberg, 2010). Psychoeducation relies on traditional, experimental methods to develop verifiable intervention procedures. Some family therapists integrate postmodern with psychoeducational approaches (Béres & Page Nichols, 2010).

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Psychoeducation, like most new models, creates a collaborative therapist–family partnership to teach management and skill-building techniques to help families gain a sense of control. They also help families experience their strengths and resiliency to deal with problems that affect all family members, not simply the symptomatic person. With less severe problems, programs offer skills training in enhancing family relationships, improving couple communication, or helping couples become more effective parents or stepparents. Kiefer, Worthington, Myers, and Kliewer (2010), for example, have shown how training parents to forgive transgressions in parenting partners reduces negative emotions, increases positive emotions, and reduces parenting stress.

Psychoeducational practitioners utilize many of the techniques of more traditional family therapy in their interventions, including joining the family, establishing an alliance with all members, maintaining neutrality, and assessing how best to foster positive outcomes. Interventions are *manual based*, using reproducible how-to-do-it techniques that can be copied by all mental health workers without requiring high levels of training.

Psychoeducational practices are not derived from any specific theory of family functioning, nor do they adhere to any one set of family therapy techniques. They often combine family systems theory, cognitive behavior therapy, educational psychology, and aspects of structural therapy. In certain cases, such as schizophrenia, they also include psychopharmacological treatment. Overall, psychoeducation helps families maximize their effectiveness as they attempt to cope with mentally or physically disabled family members or deteriorating family relationships. Or they simply help families learn new problem-solving techniques for successful marital or parent–child relationships.

Relationship Education Programs

Psychoeducation has been extended to couples or families without a symptomatic member who wish to acquire better skills or learn strategies for coping more effectively with everyday relationship problems (couple conflicts, parent–adolescent conflicts). It can be used to prevent the occurrence of problems before they develop, say before marriage (see Box 15.7), or perhaps upon remarriage when stepchildren are involved. Here the therapist educates people in the skills they need to manage potential difficulties in life transitions. Brief, practical, positive in tone and outlook, and cost effective, this form of intervention, when successful, helps empower people to function more effectively within marriage, family, or work situations. The Coalition of Marriage, Couple, and Family Education was formed in 1996 as a subspecialty within the field of marriage counseling. Some practitioners are clergy, bringing with them a clearly articulated set of moral and spiritual beliefs.

Programs involving relationship enhancement, preparation for marriage or childbirth, couple enrichment, and parent effectiveness training are examples of these psychoeducational efforts along with the behavioral parent skills training procedures we described in Chapter 12. The therapist joins the family and identifies client strengths and growth potential along with potential problem areas, delivering educational training and not psychotherapy. Many are packaged as seminars, video or audio programs, or books written for the public. Among these are the behavioral research–based *Marriage Survival Kit* (Gottman & Gottman, 1999), or solution-oriented therapist Michelle Weiner-Davis's 1992 *Divorce-Busting*. Termination

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BOX 15.7 CLINICAL NOTE

Underlying Factors in Premarital Counseling

One or both clients may come to premarital counseling with a vague sense of unease about their future together. While such apprehension is common, in some cases it opens for discussion previously overlooked or denied potential sources of conflict (in-laws, money, career conflicts, children) that, if not explored and resolved, can lead to distress later in their marriage.

occurs when the content has been delivered or when a previously agreed-upon time frame has been completed (Fournier & Rae, 1999).

Relationship Enhancement

Probably the best-known family skills training approach is the highly developed and researched Relationship Enhancement (RE) program created by Bernard Guerney Jr. (1977) at Penn State (Cavedo & Guerney, 1999). Guerney, one of the authors of the breakthrough *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), had also worked with Carl Rogers, and his client-centered orientation is evident in his interventions with families. Empathy, genuineness, positive regard for clients, and other Rogerian principles are clear in Guerney's work, as is his interest drawn from his work with Minuchin in developing techniques for helping troubled family relationships. Barry Ginsberg, a student of both Bernard and Louise Guerney, husband and wife colleagues, described the contemporary practices of RE as combining psychodynamic, behavioral, communication, and experiential systems perspectives (Ginsberg, 1997, 2000).

RE empathy-building programs provide training in core skills, which together help couples or families become more emotionally engaged (Scuka, 2005):

- *Conflict management*: effectively manage emotions and conflict situations
- *Expressive (owning)*: gaining awareness of one's own feelings, taking responsibility for them without projecting them onto others, and asserting them
- *Empathic responding (receptive)*: learning to listen and gain an understanding of the other person's feelings and motives
- *Discussion-negotiation*: learning to listen and give back a sense of understanding the meaning of what was heard; partners may "switch" positions between "listener" and "speaker"
- *Facilitation*: avoid disrupting communication by staying on track
- *Problem/conflict resolution*: create realistic solutions endorsed by both partners
- *Self-change*: improve the rapidity of behavior change
- *Helping others change*: patient support of partner's change
- *Generalization*: consolidating skills and applying them throughout life
- *Maintenance*: ensure continued use of the developed skills

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RE is an intensive, time-limited program usually involving 10 sessions that may extend over several months. It teaches clients to recognize their problems more clearly and to understand how learning specific skills (such as improving their self-concept, how to recognize and express—or "own"—what they are feeling, how to accept each other's feelings, how to engage one another and negotiate and work through problems, how to achieve interpersonal satisfaction and become emotional partners) helps them deal with their ongoing lives and also with problems they may encounter in the future (Ginsberg, 2000). Understanding the inherently subjective nature of experience allows a new frame of reference for understanding others and improved expressive skills (Scuka, 2011). Both didactic presentations and skills practice occur in sessions, and homework assignments (practicing, generalizing, and maintaining learned skills) emphasize the client's responsibility for therapeutic success. With greater trust in their own ability to solve problems, they are in a better position to deal with potential future challenges. Table 15.1 demonstrates the differences between the educational and medical practice models.

RE also offers cognitive instruction—critically examining one's thoughts, attitudes, and values—along with behavioral instruction—building skills for handling emotions or engaging in interpersonal relationships. The practitioner's values are explicitly stated, and the client–therapist relationship is one of shared planning and decision making. The signature techniques involve not only empathy, nonjudgmental acceptance, and fostering genuine conversations between clients but also teaching clients to recognize and acknowledge feelings and to express them openly and honestly.

TABLE 15.1 Educational model versus medical model

Educational Model	Medical Model
Emphasizes developmental processes, psychological needs, and life stresses	Emphasizes sickness (maladaptation/pathology)
Deemphasizes insight and etiology	Emphasizes insight and etiology
Problem lies within individual's control	Problem lies outside the individual's control
Client agrees to learn from the practitioner (teacher)	Client depends on the expertise of the practitioner for change
Best healing and change come from the client's own efforts	Healing is dependent on the practitioner's skill
Clients are encouraged to seek the knowledge and resources they need	Generally, clients under the exclusive care of the provider
Methods include setting goal(s), understanding rationale and methods of skill, skill practice and learning, generalizing the problems of everyday life, and maintaining skills	Methods include diagnosis, treatment, and cure
No distinction between prevention and amelioration	Methods are skewed more toward treatment than prevention

Source: Ginsberg (1997), p. 3

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Research demonstrates the programs' effectiveness in skills building with premarital, marital, and special populations (enhanced communication reported by participants; greater ability to resolve conflict together; improvement in the relationship, a greater sense of trust and intimacy) as compared to other treatments (Accordino & Guerney, 2003), but long-term effects are unknown, so follow-up sessions are recommended.

PREPARE/ENRICH

In order to evaluate a couple's preparation for marriage, David Olson and colleagues (Olson, Fournier, & Druckman, 1997) developed the PREPARE (PREmarital Personal And Relationship Evaluation) Inventory. This well-researched and reliable 165-item instrument, filled out separately by each person, is designed to help premarital couples better understand and discuss their families of origin and identify differences in outlook. This initiates a process of reconciling differences to develop a harmonious relationship.

Computer scored and standardized on national norms, results are presented in graphic profile form on a Couple and Family Map, supplying information to the couple regarding their "relationship strengths" and "growth areas" where further work appears to be necessary. Eleven content areas are explored by the couple with the premarital counselor:

- Marriage expectations (what each expects regarding love, commitment, dealing with conflict)
- Communication (the degree of comfort each feels about sharing emotions, listening, and being listened to)
- Sexual relationship (feelings and concerns regarding affection, sexual behavior, family planning)
- Personality differences
- Financial management
- Attitudes regarding conflict resolution
- Preferences for how to spend leisure time
- Expectations about the amount of time spent with family and friends
- Attitudes regarding marital roles
- Spiritual beliefs
- Children and parenting



BOX 15.8 CLINICAL NOTE

Paying Attention to the Referral Source

Therapists need to pay special attention to the referral source in premarital cases. Does the couple's church require it? Did the rabbi suggest it? Were they referred by a friend who had gone through the experience prior to marriage? Or did one member of the couple suggest it out of doubts about aspects of their forthcoming marriage?

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BOX 15.9 THINKING LIKE A CLINICIAN

Preparation for Marriage

A couple you are working with has completed the PREPARE inventory in advance of being married. Although many strengths were identified in the results, two "growth areas" emerged: financial management and attitudes regarding marital roles.

1. Pose a question you might ask to help them explore these growth areas.
2. What information would you provide to the couple?
3. How would you identify strengths in the other areas in the inventory to help the couple in facing the two growth areas?
4. What strategies can you suggest to the couple as they begin to face their conflicting views on finances and marital roles?
5. What communication rules apply to this process?

PREPARE is especially useful for its early identification of potential conflict areas and for promoting couple dialogue (Stahmann & Hiebert, 1997). The current "customized version" tailors the results to the relationship category (cohabiting, engaged) and family structure (with/without children), reflecting the diversity of contemporary couples (Olson-Sigg & Olson, 2011). According to PREPARE/ENRICH (2015), more than 3 million couples have taken the PREPARE Inventory (or its companion ENRICH Inventory for married couples), and there are more than 100,000 PREPARE/ENRICH counselors worldwide. See Box 15.9: Thinking Like a Clinician to practice working with couples preparing to marry.

The Prevention and Relationship Enhancement Program (PREP)

The Prevention and Relationship Enhancement Program (PREP), recently revised by Markman, Stanley, and Blumberg (2010), is a carefully designed approach to help couples improve their relationship before problems set in and lead to conflict and the risk of divorce. Originally developed in the early 1980s, this *social learning approach* "focuses on teaching appropriate communication and conflict skills, and provides information to help couples evaluate expectations, understand relationship commitment, and enhance positive connections through friendship and fun" (Scott, Rhoades, Stanley, Allen, & Markman, 2013, p. 131). It is regularly researched and updated (Ragan et al., 2009).

Couples are taught constructive communication and conflict-resolution skills, along with realistic attitudes and expectations about marriage. In particular, they learn to develop behavioral interactive patterns that satisfy the emotional and psychological needs of each partner. Couples learn to resolve disputes effectively without injuring the relationship and in a timely manner so that avoidant patterns do not build up. PREP is applied to couples at various points in a relationship (premarital, cohabiting, married, and previously divorced preparing for second marriages). The usual program includes 12 hours of interaction over a weekend or several sessions using lecturers and skill coaches (Ragan et al., 2009). PREP supplies resources for further study. Markman, Stanley, and Blumberg (2010) have described positive steps to preserve a marriage, based on ongoing research.

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Howard Markman at the Center for Marital and Family Studies at the University of Denver is a well-known behavioral researcher who studies marital distress and its prevention (Markman, Rhoades, Stanley, Ragan, & Whitton, 2010). Outcome results of the PREP program suggest couples develop positive communication skills and reduce negative communication, improve relationship satisfaction, and lower the risk of divorce (Scott et al., 2013). Long-term follow-ups, up to 4 years after intervention, generally show that couples continued to rate the impact of the program on their communication behaviors positively. Compared to both a matched control group and a group that declined participation, these couples showed significant group differences in avoiding negative communication patterns (withdrawal, denial, dominance, negative affect), according to Silliman, Stanley, Coffin, Markman, and Jordan (2002). There is preliminary evidence for adding an emphasis on spirituality and prayer to enhance cultural sensitivity in the PREP model with African-American couples (Beach et al., 2011). Versions for special populations (military, incarcerated, religious, and low income) have been developed (Ragan et al., 2009).

Other Couple and Marriage Programs

Less carefully researched but popular and widespread is *Marriage Encounter*—a worldwide weekend retreat enrichment program for couples, frequently sponsored by church groups—directed at raising couple awareness of communication, problem solving, sexual intimacy, and spiritual issues in an effort to prevent marriage complacency or deterioration. Such programs appeal to couples who have a satisfactory relationship but wish to make improvements, or those who wish to examine and reaffirm their relationship.

Marriage Encounter programs first appeared in Spain in the early 1960s, developed by a Jesuit priest, Father Gabriel Calvo. He arranged weekend retreats to provide support and enrichment for Catholic married couples (Chartier, 1986). Similar religiously oriented programs have been adopted by Protestant and Jewish groups. In addition to couples in long-standing marriages, premarital and remarried couples have also found the experience enlightening and beneficial (Stahmann & Hiebert, 1997). Some denominations require engaged couples to participate in such a program before they can be married in church.

Some nonreligious programs, such as Couples Communication (CC), also have become popular. The well-researched, skills-focused CC program is educationally focused rather than remedial, enhancing satisfactory communication skills (self-awareness, self-disclosure, effective listening, and so on). CC usually involves 8 to 12 hours of structured skills training. A meta-analysis of CC studies found "clinically relevant positive outcomes" on a variety of measures of improved communication but diminution in the quality of communication over time (Butler & Wampler, 1999, p. 223).

Better Marriages, an international nonsectarian organization headquartered in North Carolina, offers marriage enrichment groups led by lay married couples who have successfully been through the couple leadership training program (Better Marriages, 2015). Didactic material is minimal; the major emphasis is on skill building through partner dialogue. Leaders share their personal experiences rather than lecture or advise. Outcome studies, especially long term, are needed to demonstrate evidence for these models.

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Family Violence

Intimate partner violence (IPV) and child maltreatment occur in families at disturbing prevalence rates (12–20% per year for IPV; 12.1 per 1,000 per year for documented child maltreatment), and the two co-occur frequently (Owen, Knickerbocker, Heyman, & Slep, 2009). Improved diagnostic criteria for IPV in the DSM-5 and the ICD-11 enhance the ability of family therapists to screen for IPV and improve the precision of research in the area; the criteria include particular acts with a significant or potential impact (Heyman, Slep, & Foran, 2015). There are a variety of risk factors for IPV, including lower socioeconomic status, proximity to high community violence, and younger-age couples; psychological problems, aggression issues, and substance abuse create risk for male-to-female IPV (Owen et al., 2009). The interventions that currently demonstrate the strongest effectiveness in reducing IPV are motivational enhancement approaches and cognitive-behavioral couples therapy. Couples therapy "may be appropriate for couples in which the physical IPV is mild or moderate and there is no fear of the partner" if both commit to a "no violence" agreement and a safety plan (Heyman et al., 2015, p. 77).

Child maltreatment increases the likelihood of a variety of problems through adolescence and into adulthood, including conduct disorder that can become antisocial personality disorder, ADHD, mood disorders, academic problems, and substance abuse, as well as health concerns (Slep, Heyman, & Foran, 2015). Although most individuals who experienced or witnessed abuse as a child do not become perpetrators or victims of abuse as adults, family-of-origin maltreatment does increase the risk as compared to the general population. Parental attributions of blame to a child for problematic behavior increase the risk of physical abuse (Owen et al., 2009). New criteria for child maltreatment in DSM-5 and ICD-11, noting acts and impacts, reflect advances in understanding the problem and may improve screening, but a number of contextual issues and pragmatic concerns must be carefully addressed by the therapist (Slep et al., 2015). Treatment focuses on improving parenting ability and the bond between parents and children (Slep et al., 2015). The Triple P Positive Parenting Program (Sander, 2012) is an example of one such evidence-based program disseminated internationally.

Divorce and Remarriage

Now a common part of the family life cycle (McGoldrick & Shibusawa, 2012), divorce is frequently followed by cohabitation or remarriage (often with stepfamily dynamics) and presents distinct challenges for families, as outlined in what follows.

Divorce

Although the divorce rate has declined in recent years, the likelihood of first marriages eventually ending in divorce is still almost 50%, but it may be less for recent marriages (Greene et al., 2012). Divorce is stressful, beginning with the actual process of divorce.

Collaborative divorce "is a family-centered, non-adversarial, interdisciplinary-based, interprofessional process for divorcing" (Nurse & Thompson, 2009, p. 475). It moves away from

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the typically adversarial dispute between divorcing partners to enhance cooperation and the potential for flourishing after the divorce. The model is based on five assumptions: (1) couples divorce due to feelings that must be managed to benefit all involved; (2) divorce is a process, not a legal event; (3) the process has effects that continue for several years; (4) although painful, there is room for optimism in the transition; and (5) navigating family relationships, legal processes, and financial arrangements is best accomplished with experts in each domain (Nurse & Thompson, 2009, p. 477). As part of the team, a family therapist prepares the individuals to collaborate and learn to communicate in a new way in order to resolve divorce issues.

Adjustment to divorce "involves a process perspective that addresses stress, risk, and resilience" due to "stressful changes and disruptions in the social and physical environments of adults and children" (Greene et al., 2012, p. 102). Adults may experience a variety of consequences, but research suggests that these depend on risk and resilience factors (e.g., low income relates to many stressors, but socioemotional support may mitigate some of the negative effects; Greene et al., 2012). Children of divorce, in contrast to children with married parents, experience greater risk for decreased academic performance, increased affective and behavioral problems, relationship difficulties, and decreased self-esteem, with differences by age group at time of the divorce and gender, and usually take 2 to 3 years for initial adjustment. See Box 15.10 for statements about children of divorce that are all true, but seem to contradict each other because they address risk, but not reality for all children. Critical factors are the nature of the relationship with the residential and nonresidential parent and the frequency and intensity of conflict between the parents (Pruett & Barker, 2009).

Stepfamily Programs

There are 15 to 20 million stepfamilies in the United States; a notable increase in cohabitation, childbirth outside marriage, frequent remarriage after divorce, and ethnic



BOX 15.10 EVIDENCE-BASED PRACTICE

Children of Divorce

Greene and colleagues (2012) summarize the research on child adjustment to divorce with a series of "seemingly incongruent statements" (p. 107):

1. Children of divorce are at serious risk for maladaptation.
2. Most children display no serious difficulties after their parents' divorce.
3. Substantial numbers of children of divorce are better adjusted than those from nondivorced households.
4. Some children's lives are enhanced by their parents' divorce.
5. Negative effects of divorce on children generally resolve soon afterward.
6. Children may be adversely affected even into adulthood by parental divorce.
7. Many of the negative effects associated with divorce exist well before the marriage ends.

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differences in divorce and remarriage create a wide variety of stepfamily experiences (Browning & Bray, 2009). Inevitably, living through a series of disruptive transitions—from intact family to single parenthood to cohabitation and/or remarried family—generates a series of structural and relationship shifts and role changes requiring in some cases major adaptations and reorganizations for parents and children alike (Goldenberg & Goldenberg, 2002).

Successful adaptation to stepfamily life calls for the ability to recognize and cope with a variety of problems: stepparents assuming a parental role, rule changes, jealousy and competition between stepsiblings as well as between birth parents and stepparents, loyalty conflicts in children between the absent parent and the stepparent, and financial obligations for child support. Children and adults alike come with expectations from previous families, and stepfamilies must come to terms with these differences. Stepfamilies must deal with losses and changes, negotiate different developmental needs of their members, create a parental coalition, and establish new traditions of their own (Visher & Visher, 1988, 1996). Parenting and stepparenting are particularly stressful aspects in most stepfamilies, both during the early years of remarriage and in stepfamilies of longer duration (Browning & Bray, 2008). Psychoeducational programs help family members understand common stepfamily relationship patterns, especially their differences from life in intact families, enhancing compatibility and unity. Knowing that other families are dealing with the same issues is often comforting.

Browning and Artelt (2012) describe a 10-step model for working with stepfamilies:

1. Identify the stepfamily structure and relate structure to research findings.
2. Recognize subsystems in the stepfamily and plan treatment around them.
3. Normalize aspects of the stepfamily experience through psychoeducation.
4. Enhance empathy between stepfamily members.
5. Modify unrealistic expectations and create rules for family life.
6. Correct problematic beliefs and labels about others.
7. Value and support the original family subsystems (parent–child).
8. Educate the stepfamily about aspects of their systemic interaction.
9. Facilitate cohesion across the entire residential stepfamily, working with parents.
10. Improve communication and cohesion across the entire stepfamily system.

One resource for stepfamilies is the National Stepfamily Resource Center at Auburn University, a clearinghouse for information, research, training, and educational materials. For practice in working with stepfamilies, see Box 15.11: Thinking Like a Clinician.

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BOX 15.11 THINKING LIKE A CLINICIAN

Negotiations within a New Stepfamily

The Davis family has come to you for help. Molly and Conrad Davis married 1 year ago. Each has two children from their first marriages. Molly's children Mary and Kyle are 8 and 10 years old, respectively. Conrad's children Steve and Jenny are 16 and 17.

Molly and Conrad tell you that while everyone seemed at first to get along well when they all moved in together, over the last 6 months trouble has arisen. Mary has become angry and Kyle depressed. Steve's grades are falling, and the principal at his school called to say that he regularly cuts class, and Jenny has withdrawn from all family activities. Molly says that the difficulty with the children has put a significant strain on the marriage. Read the following excerpt from a therapy session and respond to the questions that follow.

CONRAD: I understand that it takes some time to get used to new conditions, but this is getting out of hand. Molly and I provide a loving home environment. There is nothing wrong with what we are doing.

MOLLY: But Conrad, clearly something is wrong since everyone is so unhappy.

CONRAD: Well, it's time to get over it. I am the father. You are the mother. That's it.

(You notice that Mary has been paying careful attention to what her parents are saying.)

YOU: Mary, what do you think about the changes at home?

(At first she says nothing, but soon you see her face harden with anger.)

MARY: I want to go home to my daddy!

CONRAD: Mary, honey, I am your daddy now.

MARY: No you aren't! I want my real daddy.

(Molly moves to embrace Mary, but with one stern look from Conrad, she backs away.)

MOLLY: (to you in a subdued voice) The children's father wasn't always the kindest person. He could be a little harsh.

MARY: My daddy. I want my daddy. I want to live with him instead of with them!

YOU: (After a moment, you address the other children) How about you all? How are you feeling?

JENNY: Clearly, it was better for every one of us before Molly and Dad married. I have no interest in having little kids around. They are trying to force all four of us to get along. I don't see why I should have to. I am going to college next year, and then I plan to have nothing to do with Molly and her kids. I really don't see why because my mother died and my father remarried that I have to play along with anything. I had one mother and don't want another.

CONRAD: Be quiet, Jenny!

YOU (TO JENNY): So you don't like the new arrangement any more than Mary. I guess you have something in common. (To the boys) How about you two?

(Kyle remains quiet and looks to be on the verge of tears.)

STEVE: I don't mind the munchkins like Jenny does, but I don't like where we live. I don't know why we couldn't stay in our old house. I had my friends. We could have lived there instead of where we live now. They didn't even ask us what we thought of moving.

MOLLY: Steve, dear, you know we needed a fresh start.

STEVE: No, *you* needed a fresh start. I was very happy with the old arrangement. If you had to marry, the least you could have done is to let me have my friends.

CONRAD: You can make new friends. The house is nicer than our old one, and we live in a nicer neighborhood.

STEVE: Sorry, that's all about you, not me. I wanted to stay put. I liked my school. You didn't care that I was popular there. Now I have to start all over, and guess what: These kids are a bunch of snobs. All they care about is what they wear and what they drive to school. I couldn't care less.

CONRAD: Maybe you should. Those kids sound like they can teach you a thing or two about how to get ahead.

(*Continued*)

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STEVE (TO YOU): Do you see how he doesn't give a damn about what I say or feel?

MOLLY: Steve! Your language! (*Steve rolls his eyes.*)

1. What developmental issues can you identify for each child as they experience their new living arrangement?
2. What communication issues within the system do you detect?
3. Identify the losses felt by the children and indicate ways you might help the family appreciate and address these losses to improve the current family.
4. Indicate issues with boundaries experienced in this family. What might you say to the family to help address them?
5. What advice might you give to Conrad and Molly about who should discipline the children and how it might be done differently?
6. What does the fact that the stepparents moved to a new home without consulting the children tell you about how decisions are made? What advice might you give them about future decision making that involves important family matters?
7. What are your thoughts about how to handle Mary's wish to live with her biological father? What might you ask Molly and Conrad about this matter?
8. What might you tell the parents to help them better appreciate their children's needs and feelings?

SUMMARY

Family therapists work in a variety of settings to serve many client populations from a systemic perspective, including schools and education, individual mental disorders in the family context, primary medical care and the family, gay and lesbian families, relationship psychoeducation, family violence, and divorce and stepparenting.

There is a significant relationship between families and schools in child development. They interact in reciprocal fashion to socialize children, so family therapy is particularly helpful by improving communication, using assessment to target interventions, focusing on parental motivation to change, and having a long-term perspective for improvement.

Family therapy has demonstrated effectiveness in working with mental disorders, including depression and anxiety, substance abuse, eating disorders, and serious mental illness. There is a connection between family dynamics and childhood mood disorders, so interventions that include the family are warranted. Similarly, family relationship factors interact in a circular fashion with adult depression. Cognitive-behavioral couples therapy targets both elements and has research support for its effectiveness over 15 to 20 sessions. Substance abuse may be treated effectively with couple or family therapy. Motivational enhancement and relapse prevention, two common aspects of drug and alcohol treatment, have been adapted to couples therapy. There are several evidence-based family interventions for adolescent substance abuse, and behavioral couples therapy has strong support for treating both the relational and substance use problems. Family interventions are currently among the primary treatments for adolescent eating disorders. The Maudsley program for anorexia nervosa uses four phases to engage clients, challenge symptoms, address developmental issues, and plan for a future without the disorder. Psychoeducational efforts are prominent in working with families in which there is a member with a serious mental illness, such as schizophrenia or bipolar disorder. Therapists offer support and teach empowering coping skills, decreasing the likelihood of symptomatic relapse. Schizophrenia is viewed as a biological

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disease best treated with medication in combination with workshops in which families learn to reduce their level of expressed emotion.

Medical family therapy emphasizes the collaboration of an interdisciplinary team in serving patients with illnesses, traumas, or disabilities. The biopsychosocial approach is designed to help families better cope with problems associated with illness, lower conflict over managing medication, communicate better with medical providers, and in some cases make constructive lifestyle changes to prevent disease and prolong health. Family therapists may provide psychoeducation, consultation, referral resources, or co-therapy with other healthcare providers. The Collaborative Family Healthcare Coalition is a cooperative effort by providers from various disciplines to promote a coordinated, family-centered approach to offering comprehensive medical/psychological services.

Gay and lesbian families experience particular stressors due to a history of discrimination and sociopolitical factors. Particular challenges include coming out to one's family of origin, social interaction and dating, and parenting. Research suggests that same-sex and heterosexual relationships are similar on several quality dimensions, although sexual minority couples often experience less family support and social–legal issues that may lower relationship stability. Many gay and lesbian couples parent children, and research finds substantial similarity between lesbian mothers and heterosexual mothers on parenting factors. Most research has focused on lesbian parents; more is needed on gay parents.

Relationship education programs are psychoeducational endeavors designed to help families acquire coping skills for managing everyday relationships more effectively or preventing the occurrence of problems before they develop. Brief, practical, and cost effective, these programs address relationship enhancement, marriage preparation, couple enrichment, parent effectiveness training, and stepparenting preparation.

Family violence includes intimate partner violence and child maltreatment, and the two co-occur frequently. New criteria for both focus on specific acts with a significant or potential impact (act + impact). There are evidence-based family treatments for both problems. Divorce and subsequent relationships that create stepfamilies are common today. Nonadversarial processes like collaborative divorce have been created to help families navigate the initial challenges of divorce. Risk and resilience factors may be part of treatment for adults and children of divorce. Stepfamily therapy involves psychoeducation to help stepfamilies negotiate challenges related to family structure, unrealistic expectations, dyadic relations, communication, and cohesion, among other issues.

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16

Evidence-Based Family Therapy

LEARNING OBJECTIVES

- LO 1 Justify why research should be integrated into the clinical training of students
- LO 2 Compare and contrast qualitative and quantitative research
- LO 3 Discuss the various models to assess and classify families
- LO 4 Explain how families cope with various situational stresses and demands throughout the life cycle using the Circumplex Model and the McMaster Model
- LO 5 Describe the Dyadic Adjustment Scale (DAS). Why would you consider using it?
- LO 6 Explain three aspects of both process and outcome research in family therapy

When family therapy first emerged, it was primarily focused on research; any therapy for families in those early years was intended to maintain contact with research families (Wynne, 1983). Seeing family members together for therapeutic purposes came later and followed from research discoveries and subsequent theorizing. It "was taken for granted that a therapist and a researcher were of the same species (although the therapist had a more second-class status)" (Haley, 1978, p. 73). As the field evolved, however, practice took center stage, and many practitioners saw research as having little if any practical relevance to therapy. The pioneer family therapists generated many new and exciting clinical techniques, in most cases without benefit of research support. They focused on what appeared to work in meeting real-world needs. On the other hand, most researchers believed family therapists too readily adopted new techniques despite lack of research evidence for their effectiveness. The result was a divide between research and practice.

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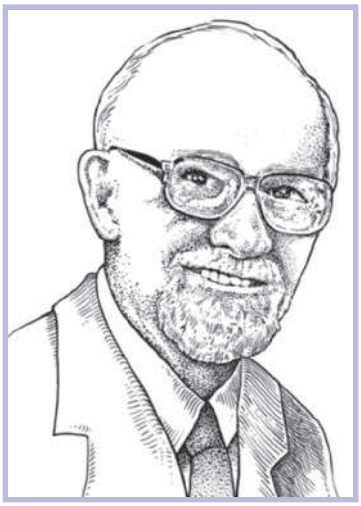
LO 1

Today, there is a strong focus on combining research and practice with full value and attention to both (Lebow, 2012). Throughout this book, we have presented numerous examples of recent research evidence for family and couples therapy. Investigators are discovering ways to elaborate theory and clinical practice that supports a range of approaches (Sexton & Datchi, 2014). Karam and Sprenkle (2010) acknowledge that the gap between clinical research and practice is a major challenge for family therapy training programs, so they propose 10 practical ideas for integrating research interests into clinical training programs so students are "research informed" in their developing clinical experience. The 10 instructional points are as follows:

1. Share with students how research has contributed to the evolution of the faculty member's own clinical work and professional development.
2. Expose students to demonstrations of how supplemental, nonclinical research findings that are relevant to the study of marriage and the family can be used to psychoeducate clients in therapy sessions.
3. Teach students how to locate, comprehend, and critically evaluate research findings.
4. Demonstrate the power of research to confirm or disconfirm commonly held beliefs.
5. Advocate for the inclusion of multiple types of research evidence.
6. Clarify the distinction between "efficacy" and "effectiveness" research, and explore controversies surrounding empirically supported treatments.
7. Outline historical and theoretical MFT roots in evidence-based practice.
8. Introduce "progress research" and, if feasible, incorporate instruments into the training that give therapists direct feedback.
9. Emphasize the role of common factors, as well as model-specific mechanisms of change.
10. Refine core research course content to promote research and practice integration.

Researchers continue to develop practice-relevant, innovative procedures and diverse methodologies for measuring family functioning and the effectiveness of clinical interventions (Sprenkle, 2012). Although there is no shortage of measurement tools for couples and families—they number well over 1,000—researchers and clinicians today are paying closer attention to reliability and validity as they use self-report and observational techniques tailored to family interaction (Snyder, Cozzi, & Mangrum, 2002). In addition, they are paying attention to larger systems of social influence: peers, schools, community, and neighborhood influences (Liddle, Bray, Levant, & Santisteban, 2002). Research evidence is informing the delivery of clinical services by many practitioners.

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Lyman Wynne M.D., Ph.D.

Increased funding by government agencies (such as the National Institute of Mental Health and the National Institute of Drug Abuse) and pressure from managed-care insurance companies to provide evidence-based treatments increased family-focused research, especially real-world (rather than university laboratory) studies of couples and families that provided evidence for intervention techniques for marital and family problems (Liddle, Bray, Levant, & Santisteban, 2002). Innovative clinical research strategies and conceptual frameworks were suggested (Kazdin, 2003) that introduced sophisticated methodologies and valid measures to study complex family interactions, a previous impediment to meaningful research with families. Such breakthroughs are especially important when dealing with complex multidimensional interactions (Sexton & Datchi, 2014).

LO 2 Qualitative and Quantitative Research Methodologies

Twenty-first-century family researchers employ both quantitative and qualitative research methodologies to explore a variety of content areas (marital problems, alcohol and drug abuse, physical and mental illness, to name a few) and diverse family structures (single-parent families, stepfamilies, racially blended families, and gay and lesbian families). While quantitative methodologies are more likely to be funded and be preferred by some professional journals, qualitative research is valuable for certain types of study. Quantitative measures describe and assess hypotheses and outcomes, whereas qualitative research tends to be an initial exploration or in-depth analysis of particular issues. The gap between family therapy practice and research can be closed to the extent that quantitative methodologies and qualitative research coalesce (Pinsof & Wynne, 2000).

Recently, qualitative research has acquired comparable prestige to quantitative methods in many areas of the social sciences (Denzin & Lincoln, 2011; Kopala & Suzuki, 1999). Silverstein and Auerbach (2005) suggest that qualitative research is *hypothesis generating*, while quantitative research is likely to be *hypothesis testing*. They are complementary forms of inquiry rather than competing paradigms or methodologies. A closer look at quantitative and qualitative research clarifies overall present-day research efforts.

Many scientific disciplines rely on quantification—observing phenomena, formulating a theory to account for what is being observed, generating hypotheses or predictions to test that theory experimentally, controlling variables, and recording and statistically analyzing resulting data. If the predicted observation is verified, the hypothesis is strengthened because the results were correctly deduced, and support is obtained for the theory from which the hypothesis was derived. Quantitative research, then, calls for the careful integration of experimental design, reliable and valid measurement, and relevant statistical analyses in order to isolate what is being studied (Black, 1999).

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Despite the well-established place of quantitative research, critics contend that it may be premature to rely exclusively on this method with family therapy because a multitude of interacting variables are involved in understanding family processes. Rather than polarize the field into quantitative versus qualitative methodologies, researchers today increasingly are adopting the viewpoint that the two can coexist and meet the current need for greater methodological diversification. For example, Gottman's intervention research with couples (Gottman, Ryan, Carrere, & Erley, 2002) combines quantitative and qualitative methods and intertwines research and practice. Qualitative research methods (Willig, 2013) can extend, enrich, and complement quantitative methods. Gilgun (2005) points out that qualitative approaches are useful for theory building, concept development, descriptions of lived experiences and the meaning people attribute to events, as well as the creation of items for surveys, assessment instruments, and other evaluation tools.

Quantitative research emphasizes experimentation, large samples whenever feasible, data collection and statistical analysis, objectivity, and verification. Consistent with a modernist and structural outlook, the researcher is an outside observer who manipulates variables and measures resulting changes. Qualitative research, on the other hand, is more consistent with postmodern, poststructural viewpoints. It tends to be exploratory and open ended, directed more at discovery than at evaluating a set of hypotheses. It expands and enhances quantitative research techniques, delving into greater depth, considering cultural variations, and exploring interpersonal interaction (Chenail, 2005). Qualitative research methodologies are especially well suited for describing complex phenomena, defining new constructs, discovering new relationships among variables, and trying to answer "why" questions (Sprenkle, 1994). Well-designed qualitative research is rigorous and trustworthy, advancing the field of family therapy (Gale & Dolbin-MacNab, 2014).

Although qualitative investigations of complex phenomena may begin modestly, with small samples, their results may lead to the discovery of new relationships among variables, leading to theory development. As illustration, Alexander and Barton (1995) cite the early field-defining paper by Minuchin and colleagues (1975) on their preliminary work with diabetic children, which ultimately led to the breakthrough treatment of psychosomatic families, including children with anorexia nervosa (Minuchin, Rosman, & Baker, 1978).

While both quantitative and qualitative methods generate knowledge, the latter is apt to have far greater appeal to clinicians, since it is consistent with their everyday clinical procedures and is thus more likely to capture the essence and the richness of the therapeutic family-therapist encounter. Moreover, the qualitative method is compatible with systems theory in emphasizing context, multiple perspectives, and client perspectives. Postmodernists such as the social constructionists note another limitation of quantitative research by arguing that scientific observation never really can be objective and unbiased—a fundamental axiom of quantitative research methodology. Scientific assumptions and the language used to express them are just as subject to the epistemological problems posed by deconstruction as any other form of language, and so the claim of objectivity from this perspective is just as impossible as it would be with any other form of language. These clinicians look for

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the personal, subjective meaning each of us gives to the same event. Thus, they favor the discovery aspect of qualitative research, shunning any quantitative undertaking that begins with the assumption that we can know, let alone measure, someone's world in any real or absolute sense. Some postmodernist thinkers (De Haene, 2010) question on a radical level the separation of research and experience and see instead a convergence of narratives that encompass both. Advances in narrative research and a wider definition of what counts as evidence allow some postmodernists to reconsider the role of research in relation to practice (Strong & Gale, 2013).

Many clinicians have been slow in embracing clinical research and using its findings to inform their practices (Williams, Patterson, & Miller, 2006). Clinicians in general are likely to be more interested in data revealing *clinical significance* (say, the extent to which a specific previously dysfunctional family, following treatment, develops sufficient skills to become functional) rather than *statistical significance* (group differences in improvement between families receiving treatment and those who receive no treatment). In some cases, differences between the groups may be statistically significant, but those who improved statistically may not have become functional as a result of treatment; clinical significance provides such information (Sprenkle & Bischoff, 1995).

Interestingly, early theory-generating research in the field, such as the work of Bowen or Wynne at the National Institute of Mental Health (NIMH), had a markedly qualitative or discovery-oriented flavor. It was only later, as researchers sought greater scientific control and ways of testing the effectiveness of their therapeutic procedures, that more rigorous research designs as well as more formal data collection and more precise statistical analysis occurred. The use of mixed methodologies seems to characterize the field today, as researchers recognize that combining methods can address issues of clinical relevance, like the therapeutic alliance and processes of change (Gambrel & Butler, 2013). As Liddle, Bray, Levant, and Santisteban (2002) observe, today's intervention researchers, partly because of funding-related issues



BOX 16.1 EVIDENCE-BASED PRACTICE

Quantitative–Qualitative Collaboration in Family Research

Innovative research methodologies are now available for studying the complex relationships found in couples and families that make such undertakings directly applicable to clinical practice (Bray, 2005). Both quantitative and qualitative methods are useful; they employ a multitude of measurement techniques and statistical analyses. Recent outcome research is directed at understanding the processes for bringing about therapeutic change.

Qualitative approaches are especially useful in shedding light on specific issues that large-scale quantitative surveys cannot. These methods (in-depth interviewing, case studies, observations by teams through one-way mirrors, audio- and videotapes, focus groups, analysis of personal journals or other documents, content analysis of narratives, oral histories, explorations of belief systems) usually search for universal principles by examining a small number of cases intensively; the researcher is often a participant (rather than the objective, outside observer) who deals with any resulting subjectivity by making the researcher role explicit (Moon, Dillon, & Sprenkle, 1990).

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involved in large projects, are becoming more integrative, combining different kinds of research designs, methodologies, and genres of research questions into a single proposal. See Box 16.1 for illustrations of the collaborative use of qualitative and quantitative methods. Family therapists increasingly are asked to justify the treatment they offer by providing valid and reliable scientific data about its costs and effectiveness. As Pinsof and Wynne (1995) observe,

> Now, for the first time, family clinicians, training directors, clinic administrators, and family organizations have anxiously begun to clamor for "hard evidence" about the effectiveness of marital and family therapy that they can present to students, third-party payers, legislative bodies, and fellow professionals. (p. 341)

LO 3 Couple and Family Assessment Research

An ongoing debate among family therapists regards the applicability of formal research-based procedures for assessing couple and family processes. Proponents argue that accurately measuring relevant phenomena lies at the heart of any scientific discipline (Snyder, Cozzi, & Mangrum, 2002). Measurement instruments for a wide range of relational variables (couple, parent–child, entire family) have advanced considerably, and advocates point to reliable and valid test instruments for appraising the cognitive, affective, communication, and interpersonal patterns within families, including multiple levels—individuals, dyads, nuclear family, extended family and related social systems, community, and cultural systems (carefully avoiding measurement error due to cultural bias).

All therapists make evaluations based on their previous experiences with families. All engage in clinical assessments, likely using a combination of interviews and behavioral observations, or perhaps relying on structured test inventories or presenting clients with interactive tasks they are encouraged to complete together. Few family therapists regularly engage in formal assessment procedures using standardized test instruments (Lebow & Stroud, 2012). Many, however, do so informally, forming impressions of individual family members as well as global impressions of whole families without the aid of formal test instruments. Such assessments are likely to continue across sessions, revised as new impressions are formed. Behaviorally oriented family therapists in particular value administering their own specific standardized tests to couples or families.

Theoretical orientation often determines what therapists look for—structuralists focus on boundaries and overall transactional patterns; strategists observe triads, hierarchies, and patterns that maintain symptoms; Bowenians evaluate levels of differentiation; and so forth. Social constructionists are interested in how clients view their world and tend to be less concerned with how scores show how well client responses fit a tester's preconceived categories; for them, emphasis is on the primacy of personal meaning, as clients create new realities for their lives (Neimeyer & Neimeyer, 1993). Clearly, despite attempts to integrate quantitative and qualitative research, for some clinicians the difference between the two is significant and incompatible with deeply held interests. Some therapists believe that formal testing prior to therapy, especially where the subsequent therapist is also the family evaluator, gets family therapy off on the wrong foot. By interacting in a more genuine way with families from the start, many believe they do not need to undo any artificial relationship created as a result of a formal test inquiry.

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Family assessment first provides guidance for what the clients need and how best to intervene, and later, an evaluation of clinical progress and therapeutic outcome. L'Abate (1994) challenges those who shun formal testing, contending that an overall impressionistic view of the family system may obscure differences in individual contributions to the problem, and thus both a systems (family) and psychological (individual) assessment are needed. As he puts it:

> A traditional systems perspective stresses the subjective nature of the therapist's understanding of the family, whereas a psychological perspective finds an additional need for the objective understanding of the family and therefore uses both subjective (interview) and objective observations (questionnaires, rating sheets, tests). (p. 4)

Families, of course, are complicated systems, difficult to assess and quantify. Acknowledging the complexity of measuring systemic concepts, some researchers have persisted in developing instruments for assessing family functioning. We present a sampling of the most prominent and carefully researched family assessment instruments.

Self-Report Measures

Typically designed in the form of questionnaires, self-report measures are the most widely used method for assessing family relations and processes (Bray, 2002). They elicit family members' attitudes, values, roles, self-perceptions, and satisfaction with family relationships. Easy to gather and inexpensive to use, self-report measures expose each family member's privately held thoughts and viewpoints, which are not directly open to therapist observation. Having each person in the family give his or her separate, subjective perspective on family relationships helps the therapist discover an "inside" picture that then can be related to better comprehending interactions within the family (Grotevant & Carlson, 1989). Self-report measures can also be administered at various stages of family treatment, measuring both change and the effectiveness of the previous interventions (Touliatos, Perlmutter, Strauss, & Holden, 2001).

Some critics contend, however, that such measures are nonobjective, running the risk of providing inaccurate information. Bias in presenting oneself or others in a favorable or unfavorable light and the possibility of faulty recollections can be additional problems. Note that results are individual perceptions and do not yield relational data (Bray, 2002).

LO 4 The Circumplex Model

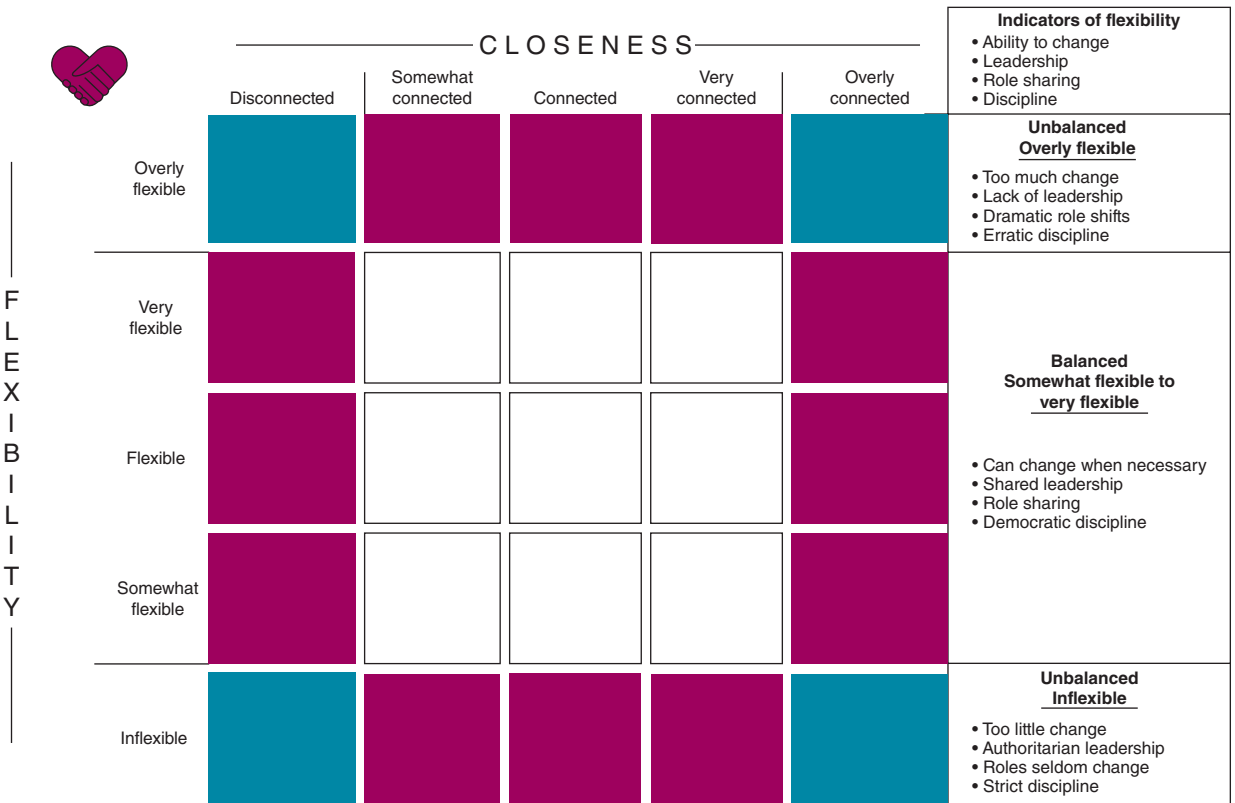
A carefully researched and validated example of an "insider" or family member's view of two central properties of family life—flexibility and cohesion—may be obtained from the assessment developed by David Olson and his colleagues, now in its fourth version (Olson, 2011). Their investigation, which has extended for more than 35 years and resulted in more than 1,200 publications, has been directed at understanding how families cope with various situational stresses and demands throughout the life cycle. While the instrument originally was developed primarily with intact Caucasian two-parent families, it now has been studied with multiform families (single-parent-led families, stepfamilies, same-sex couples) and socioeconomically and ethnically diverse groups (Lebow & Stroud, 2012).

Olson, at the University of Minnesota, and associates created a family map (Figure 16.1) that depicts 25 types of couple or family relationships. Grounded in systems theory, the

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model is based on a family's degree of *flexibility* (its ability to permit changes in its role relationships, family leadership, and relationship rules) and *cohesion* (the emotional bonding of family members to one another). A third dimension, *communication*, involves the family's skill level in listening to each other and facilitates or impedes family movement on the two primary dimensions. Flexible family functioning balances stability and change; cohesion requires a balance between enmeshment and disengagement.

As seen in Figure 16.1, there are five levels of family closeness (cohesion), ranging from disconnected (disengaged) to overly connected (enmeshed). Flexibility, designed to measure how families balance stability and change, also has five levels, from inflexible or rigid to overly flexible or chaotic. With too much cohesion, the family is enmeshed and its members overly entwined in each other's lives. With too little, the members remain distant, isolated, and disengaged. Excessive flexibility leads to too much change, unpredictability, and possible chaos; too little may cause rigidity and stagnation. The three balanced levels on each dimension represent various degrees of optimal family functioning; the extremes are indicative of relationship problems for the family over time.



Indicators of closeness	Unbalanced Disconnected	Balanced Somewhat connected to very connected	Unbalanced Overly connected
Separateness (I) vs. togetherness (we)	Too much (I) separateness	Good I-we balance	Too much (we) togetherness
Closeness	Little closeness	Moderate to high closeness	Too much closeness
Loyalty	Lack of loyalty	Moderate to high loyalty	Loyalty demanded
Independence	High independence	Interdependent	High dependency

FIGURE 16.1 Couple and family map

Source: Olson & Gorall (2003)

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A family's placement on this grid is determined by its members' responses to a 42-item self-report research instrument called the Family Adaptability and Cohesion Evaluation Scale (FACES IV; see Olson, 2011). Each family member completes the test twice. Responses indicate how he or she currently views the family as well as his or her description of ideal family functioning. The discrepancy between the two provides a measure of satisfaction: the greater the discrepancy, the less satisfaction.

Continuing research on the Circumplex Model has focused on exploring cohesion and flexibility fully and improving the reliability, validity, and clinical utility of FACES (Olson, 2011). As noted in Chapter 15, Olson and his colleagues (Olson-Sigg & Olson, 2011) continue to improve a related assessment device evaluating a couple's preparation for marriage (PREPARE).

Family Environment Scale

A second self-report questionnaire, the Family Environment Scale (FES), widely used in family research since its introduction by Rudolph Moos (1974), attempts to assess the impact of the family environment on individual and family functioning. Moos began his research with the assumption that all social climates have characteristics that can be portrayed (and thus

TABLE 16.1 Subscales of the family environment scale

Relationship Dimensions	
1. Cohesion	The extent to which family members are concerned and committed to the family and the degree to which family members are helpful and supportive of each other
2. Expressiveness	The extent to which family members are allowed and encouraged to act openly and to express their feelings directly
3. Conflict	The extent to which the open expression of anger and aggression and generally conflictual interactions are characteristic of the family
Personal Growth Dimensions	
4. Independence	The extent to which family members are encouraged to be assertive, self-sufficient, to make their own decisions, and to think things out for themselves
5. Achievement orientation	The extent to which different types of activities (e.g. school and work) are cast into an achievement-oriented or competitive framework
6. Intellectual–cultural orientation	The extent to which the family is concerned about political, social, intellectual, and cultural activities
7. Active recreational orientation	The extent to which the family participates actively in various kinds of recreational and sports activities
8. Moral–religious emphasis	The extent to which the family actively discusses and emphasizes ethical and religious issues and values
System Maintenance Dimensions	
9. Organization	How important order and organization are in the family in terms of structuring the family activities, financial planning, and explicitness and clarity in regard to family rules and responsibilities
10.Control	The extent to which the family is organized in a hierarchical manner, the rigidity of family rules and procedures, and the extent to which family members order each other around

Source: Moos (1974)

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measured) accurately. For example, some are more supportive than others, some more rigid, controlling, and autocratic. In others, order, clarity, and structure are given high priority. Moos argued that to a large extent, the family environment regulates and directs the behavior of the people within it.

The Family Environment Scale (Moos & Moos, 2009), now translated into at least 11 languages, has proven to be a reliable and valid test instrument (Boyd, Gullone, Needleman, & Burt, 1997; Sanford, Bingham, & Zucker, 1999). It is a valuable clinical research tool for evaluating key aspects of a family's functioning and has been used in more than 500 studies, although some questions about the relevance of the scale to more diverse, contemporary families have been raised (Lebow & Stroud, 2012). Easy to administer, the scale contains 90 statements to be labeled "true" or "false" by each family member ("Family members really help and support one another"; "Family members often keep their feelings to themselves"; "We fight a lot in our family"). Respondents are asked to rate their families as they see them and then as how they would ideally like their families to be. (Once again, the discrepancy provides a measure of satisfaction.)

Ten subscales make up the Family Environment Scale, see Table 16.1. A score is obtained for each, and average scores for the family are placed on a family profile. The family whose profile is shown in Figure 16.2, made up of parents and two children in their early twenties, is strongly upwardly mobile, emphasizing personal development (especially achievement and

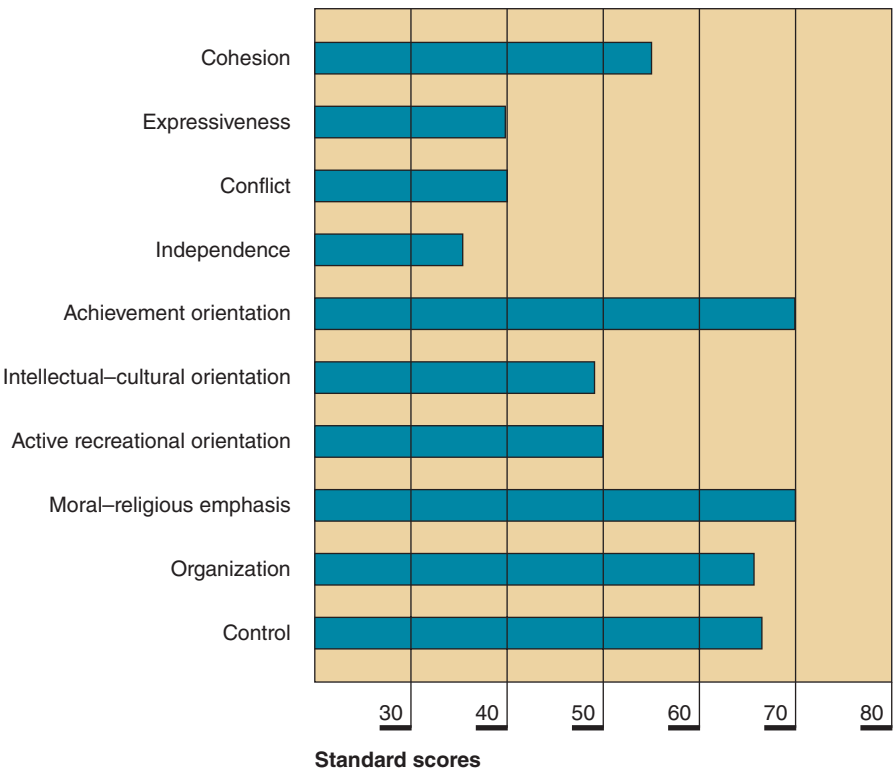


FIGURE 16.2 Family environmental scale scores for achievement-oriented family
Source: Adapted from Moos (1974)

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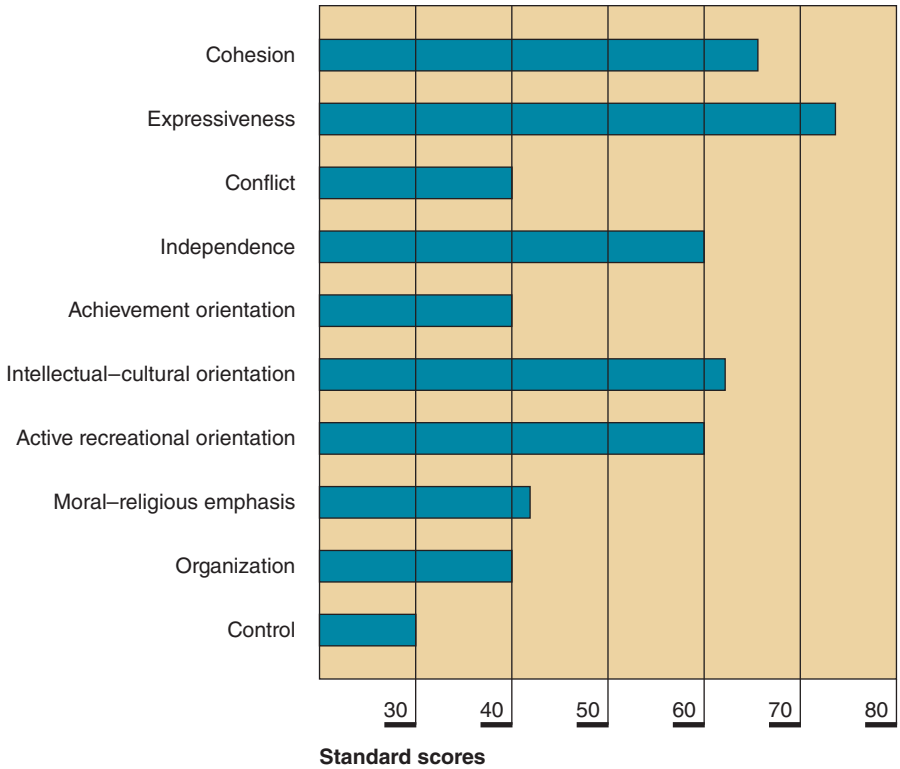


FIGURE 16.3 Family environmental scale scores for high-relationship, low-control family
Source: Adapted from Moos (1974)

moral–religious emphasis) above other aspects of family life. These same two factors are deemphasized by the young couple (no children) whose profile is depicted in Figure 16.3. They agree that for them, relationships are far more important than achievement, conflict is minimal, and control is low. This couple feels very positive about the social environment they have created.

Observational Methods

Observations in real time of interacting couples and families are especially appealing to those who prefer objective "outsider" measures of family functioning to what they consider the less reliable self-reports of family members. These observational measures are likely to take the form of *interactive coding schemes* (diagramming family interactive patterns along a series of cognitive, affective, and interpersonal dimensions) or *rating scales* (judging and scoring those overt, observable patterns along previously determined dimensions); see Grotevant and Carlson (1989). The former are designed to capture the moment-to-moment contingencies of the behavior of family members toward one another, while the latter seek a more global, objective summary judgment of family interdependent relationship patterns. Minuchin's use of mapping to chart a family's ongoing transactional patterns is an example of the use of an interactive coding system, while Bowen's judgment of a family member's degree of self-differentiation makes use of a rating scale. Carefully constructed test manuals often help ensure objectivity and enhance the reliability and validity of judgments made about family relationships. Observations can take

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BOX 16.2 THERAPEUTIC ENCOUNTER

Home-Based Services

Home-based services, long a part of social work and case management activity, have now begun to be practiced by others for family assessment and clinical intervention (Thomas, McCollum, & Snyder, 1999). The practice provides the observer with an opportunity to watch people in their natural surroundings, dealing with parent–children interaction regarding homework, television viewing, bedtime rules and their enforcement, and so forth. Discord, conflict, coalitions, and alliances may all surface. The display of religious artifacts, photographs, trophies, mementos, and such round out the picture of family life. A common observational technique calls for the therapist to give the family the task of identifying a problem and then to watch how they go about discussing it, negotiating differences in view, and arriving at a solution. One potential challenge is maintaining professional boundaries so as not to be caught up in the family triangles, alliances, or coalitions or induced into playing the role of a missing family member.

place in the therapist's office, a university laboratory or clinic, or in the client's home. See Box 16.2 for more information about home-based family observation and services.

LO 4 The McMaster Model of Family Functioning

One long-term, empirically based research project—begun in the 1950s at McGill University in Montreal and later shifted to McMaster University in Ontario, Canada—attends to family structure and organization as well as family transactional patterns. Continued during the 1980s at Brown University in Providence, Rhode Island, the McMaster Model (Epstein, Ryan, Bishop, Miller, & Keitner, 2003; Ryan, Epstein, Keitner, Miller, & Bishop, 2005) focuses on those dimensions of family functioning identified by research as having the most impact on the emotional and physical well-being of family members:

1. *Basic task area* (how the family deals with problems of providing food, money, transportation, shelter)
2. *Developmental task area* (how they deal with problems arising as a result of changes over time, such as first pregnancies or last child leaving home)
3. *Hazardous task area* (how they handle crises that arise as a result of illness, accident, loss of income, job change, and such)

A family's difficulty in coping with these three task areas is especially indicative of a propensity to develop clinically significant problems.

The McMaster Model includes a self-report instrument (the Family Assessment Device, or FAD; Epstein, Baldwin, & Bishop, 1983) and the observational Clinical Rating Scale (Epstein, Baldwin, & Bishop, 1983), with both probing family functioning in six crucial areas:

A. *Family problem solving* (the ability to resolve problems sufficiently well to maintain effective family functioning)

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B. *Family communication* (how, and how well, a family exchanges information and affect; also whether communication is clear or masked, direct or indirect)
C. *Family roles* (how clearly and appropriately roles are defined, how responsibilities are allocated and accountability is monitored in order to sustain the family and support the personal development of its members)
D. *Affective responsiveness* (the family's ability to respond to a given situation with the appropriate quality and quantity of feelings)
E. *Affective involvement* (the extent to which the family shows interest in and values the particular activities and interests of its members)
F. *Behavior control* (the pattern the family adopts for handling dangerous situations, situations involving social interactions within and outside the family, and for satisfying members' psychobiological needs such as eating, sleeping, sex, handling of aggression, and so on)

The FAD measures family functioning using 60 self-report items, resulting in scores on each dimension as well as a General Functioning scale. It is the most used outcome measure in family therapy outcomes studies between 1990 and 2005 (Sanderson et al., 2009), but there are concerns about its applicability across cultures (Lebow & Stroud, 2012). The Clinical Rating Scale assesses these dimensions as the therapist rates them on a seven-point scale (from 1, *severely disturbed*, to 7, *superior functioning*); a rating lower than 4 suggests the need for therapeutic intervention. See Box 16.3: Thinking Like a Clinician for experience in working with an observational method of assessing family functioning.

The Beavers Systems Model

This well-established measurement instrument provides a means for ordering families along a progressive continuum with respect to their competence—how well they perform the necessary and nurturing tasks of organizing and managing themselves (Beavers & Hampson, 2003). Robert Beavers and associates (Beavers & Hampson, 1993) developed and fine-tuned a 14-item rating scale to be used in assessing and classifying family functioning. At the low end are leaderless, chaotic, invasive families, with diffused boundaries between its members. At the high end, families are described as composed of autonomous individuals who share intimacy and closeness but at the same time respect separateness. The observational assessment, based on the Beavers Interactional Competence Scale, measures family functioning at a particular moment in the family's life. Thus repeated measures chart the family's progress, say after a specific period of therapy. By viewing functional/dysfunctional patterns as a continuum, the scale endorses the idea that growth and adaptation in families is possible.

Families are rated along two axes: their interactive style and their degree of competent family functioning (see Figure 16.4). Such items as the family's response to the needs of the children, overt adult conflict, degree of expression of angry or hostile feelings, and the ratio of positive to negative feelings expressed all go into making up the style rating. Families

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BOX 16.3 THINKING LIKE A CLINICIAN

Using Observational Methods for Assessing Family Functioning

Observational measures generally take the form of interactive coding systems that address (1) cognitive, affective, and interpersonal dimensions of moment-by-moment family functioning and (2) observable overall patterns.

Using a scale of 1 to 7, where 1 signifies severely disturbed and 7 signifies superior functioning, rate the functioning of each interaction of each family member in terms of cognitive, affective, and interpersonal functioning. Use the columns to the right to record your evaluation. Use the space below to qualitatively describe any overall patterns that you detect regarding overall functioning.

The Perelli family has come for their initial session with you. You know little about Giovanni (the father), Marta (the mother), Paolo (eldest son, age 17), or Angelo (youngest son, age 15 1/2). Your initial phone call was with Marta, who said that the family was struggling with constant bickering that often escalated into screaming matches, especially between Giovanni and Paolo. Everyone, however, can become volatile, except Angelo, who tends to be withdrawn.

Transcript of session, after initial greetings and introductions	**Cog.**	**Affect.**	**Interpersonal**
MARTA: All we seem to do is fight. It's really bad between my husband and Paulo. If they aren't screaming at each other, they don't talk to each other for days. The worst is at dinner. I haven't enjoyed a meal with my family in ages. I think Giovanni is upset because Paolo is doing more on his own and doesn't want his father poking around in his business. That's normal for a boy, isn't it?			
GIOVANNI: I am angry with Paolo because he is disrespectful. Plain and simple. If I talked to my father like he talks to me, I'd have caught one upside my head. My father didn't have to raise his voice. All he had to do was look at us and we knew . . .			
MARTA: So what, you want to be your father? He was a brute. You think this is a good thing?			
GIOVANNI: He wasn't a brute, he was strict. We knew what was what. There was a line, and we didn't cross it.			
MARTA: So you want a line for Paolo not to cross? I don't get it! Strictness is one thing, but why all the screaming?			
GIOVANNI (his voice tightly controlled, but rising in volume): Ask Paolo why all the screaming. If he didn't act like such a prince, I wouldn't yell. And he's luckier than I was; I've never raised a hand to him. Never! I sure have wanted to.			
PAOLO: Congratulations, you aren't a child abuser.			
GIOVANNI (to the therapist): See what I have to put up with? Smart guy with the smart attitude.			
THERAPIST: Giovanni, can you tell me more about respect and disrespect?			

(*Continued*)

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GIOVANNI: What's to tell? A good son respects his father.			
THERAPIST: In what way?			
GIOVANNI: A good son doesn't wise off to his father, and he turns to his father for guidance. The only thing Paolo turns to me for is money. That's it.			
THERAPIST: What do you say to this, Paolo?			
PAOLO: If my father could see one inch in front of his face, he would see that I am not like him. I never was and never will be. He has nothing to tell me about anything that I care about.			
THERAPIST: What do you care about?			
PAOLO: I care about precisely three things, none of which Julius Caesar here understands: getting into Princeton, my girlfriend (whom both my parents hate), and getting into Princeton.			
MARTA: We do too care about your getting into Princeton. It would be great for you.			
PAOLO: You think so, but he doesn't. He wants me to go into his business. I know it and you know it. I refuse. Period. End of sentence. No. Will not. Can't make me. Or to quote my eloquent father: "Fugget about it."			
GIOVANNI: He's impossible now. With a fancy ivy school education, he'd be completely out of reach. He already thinks he's better than me. He really is a snob. I can't stand his snobbishness.			
THERAPIST: You worried about losing Paolo?			
GIOVANNI: No, I am not worried that he is turning away from me but from his mother and brother.			
THERAPIST: Why not you?			
GIOVANNI: No matter how bad it gets, fathers and sons don't ever leave each other.			
PAOLO: Like a bad case of acne.			
THERAPIST (to Giovanni): So help me to understand why Paolo's going to Princeton would be such a problem.			
GIOVANNI: We live in Chicago. Princeton is in New Jersey. He couldn't come home except on holidays. This will kill his mother.			
MARTA: It's not going to kill anyone, least of all me. Sons grow up and do what they have to do. I can count on all my fingers and toes times a million the number of times you've told Paolo that a man's gotta do what a man's gotta do. I think it's going to kill you for him to go, and you're too proud to admit it. I also think that deep down you're jealous that he's going to a fancy school when you didn't but could have.			
GIOVANNI: So now you're going to tell the doc how I feel—like you're an expert.			
MARTA: Sweetheart, I am an expert on how you feel.			

(*Continued*)

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GIOVANNI: That's what you think.			
MARTA: How else do you think I managed to stay sane living with you all these years?			
GIOVANNI (to the therapist): Now you see where Paolo gets it?			
THERAPIST: Well, how do you feel about what Marta is saying? Could it be that you will miss Paolo?			
GIOVANNI: When I went into the army, my father once told me that he never missed me while I was away. He knew that I was doing what I had to do. But that when the time was nearing for me to come home on leave, he started getting so excited that he called everyone—my mother, my sisters and brothers, even the dog—by my name. That's when he missed me. I loved when he told me that.			
THERAPIST: That's a wonderful memory. Do you feel similarly toward Paolo?			
GIOVANNI: I just told you how I felt. Weren't you listening?			
The session continues. After a while the therapist says:			
THERAPIST: We haven't heard from you, Angelo. Is there anything you want to say?			
At first Angelo doesn't say anything. But after a few moments and a little more gentle encouragement, he speaks.			
ANGELO: I don't really have anything to say.			
THERAPIST: Well, do you have any thoughts about all the yelling that goes on?			
ANGELO: No. I mean it's not good. But, you know. I . . .			
THERAPIST: You know I think it's important that you have a chance to talk too when you want to.			
ANGELO: Thanks.			
MARTA: Angelo's the quiet one. He listens. Sometimes I think he's the only one in this family with any sense.			

Review the scores noted above and describe your overall impressions of each family member's cognitive, affective, and interpersonal capacities.

Respond to the following questions to help form an understanding of relevant patterns of interaction for each family member and for the family as a whole.

1. Identify each person's strengths and weaknesses in her or his ability to communicate honestly and directly.
2. Do you notice any potential triggers to the yelling behavior?
3. What role does each family member play in the session?
4. Do you notice any cognitive, affective, or interpersonal issues in any family member that would impede the family's ability to address the yelling behavior?
5. What would you point out to each family member to help him or her start addressing the yelling behavior?

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with **centripetal** styles tend to be inner oriented and to view relationship satisfactions as emanating from within the family. Those in extreme **centrifugal** families are viewed as outwardly directed and more openly expressive of anger. These family members tend to seek satisfaction from outside the family (Hampson & Beavers, 1996).

The competence dimension is judged by observing the expressions of power, the presence of parental coalitions, how clearly family members communicate, and so forth, as indicated on the horizontal axis. The arrow shape of the diagram is intended to convey that extremes in style—whether profoundly centripetal or centrifugal—are associated with poor family functioning. Taken together, family style and family competence judgments provide a useful snapshot of current family functioning and offer a guide to how and how best to begin to intervene in helping improve family functioning.

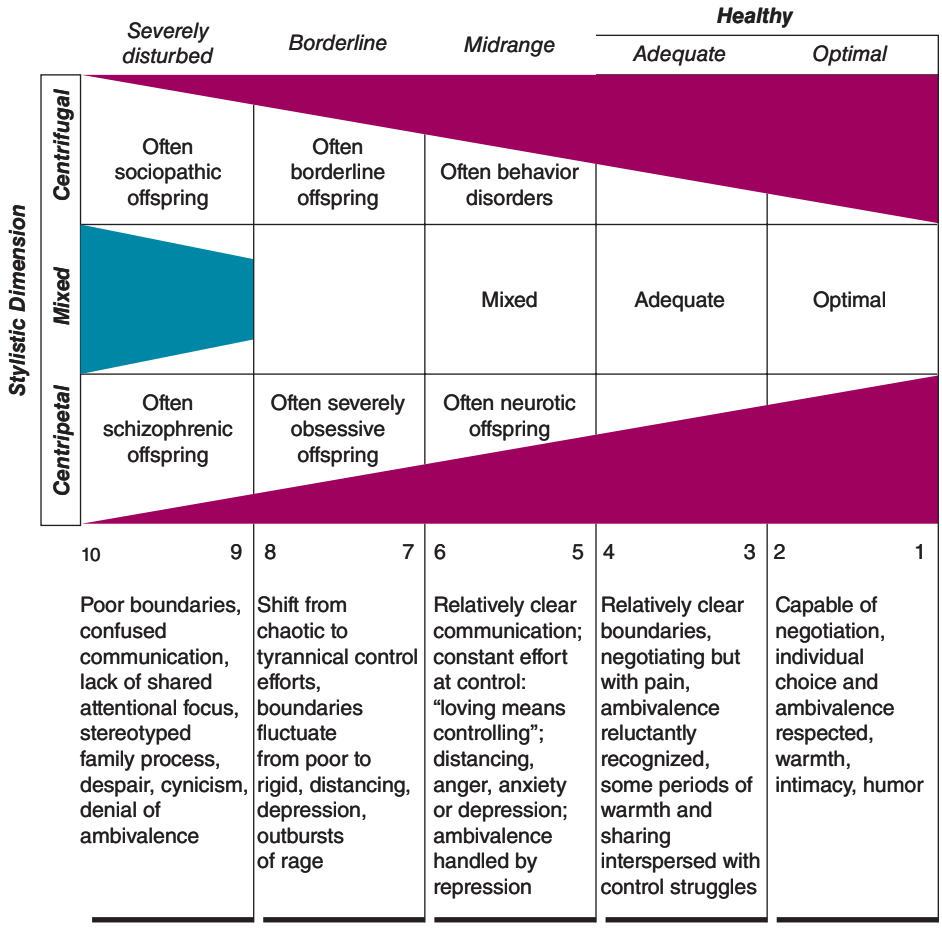


FIGURE 16.4 **The beavers systems model, in the form of a sideways A, with one leg representing centripetal families and the other leg representing centrifugal families**

Source: Beavers & Voeller (1983), p. 90

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LO 5 Dyadic Assessment

In order to understand family dynamics, it is often helpful to assess couple relationships that contribute to family patterns and processes. The Dyadic Adjustment Scale (DAS) is a 32-item self-report assessment of dyadic satisfaction, cohesion, consensus, and affectional expression (Spanier, 1976). A review of couple and family therapy outcomes studies found the DAS to be the most frequently used outcome measure, by far. Originally a measure of adjustment (quality), it has been interpreted as measuring couple satisfaction and correlates with other measures of satisfaction, like the Satisfaction with Married Life Scale (Ward, Lundberg, Zabriskie, & Berrett, 2009). It has been found to accurately assess female and male perspectives (South, Krueger, & Iacono, 2009) as well as demonstrate strong reliability across all cohabiting couples, regardless of sexual orientation, ethnicity, and marital status (Graham, Liu, & Jeziorski, 2006). In attempts to resolve some psychometric concerns, shorter versions of the DAS have been created to capture the global idea of distinguishing between distressed and nondistressed couples, notably the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), a 14-item scale. It can be used to note clinically significant change in therapy (Anderson et al., 2014). Other couple instruments, such as PREPARE/ENRICH (Olson-Sigg & Olson, 2011; see Chapter 15), are clinically useful or valuable for research on clinical outcomes, like the Marital Satisfaction Inventory-Revised (Snyder & Aikman, 1999).

Individual Assessment in Couple and Family Therapy

A systemic perspective includes an awareness of individual issues that interact with couple and family dynamics (Stanton & Welsh, 2012). Nurse and Sperry (2012) note the applicability of several individual, standardized assessments for couple and family evaluation (such as the MMPI-2, MCMI-III, Rorschach Inkblot Test, and the Kinetic Family Drawing Test), combining them with interviews, observation, clinical records, and collateral information to provide input to couples and families (p. 83). Stanton and Nurse (2009; Nurse & Stanton, 2008) describe a model of personality-guided couple therapy that uses the MCMI-III to assess personality factors that interact reciprocally in couple relationships. The MCMI (Millon & Bloom, 2008) is a 175-item inventory for people who present for therapy; it provides 14 personality categories and 10 clinical dimensions. For couples therapy, there are identified couple personality interaction patterns that may help both individuals understand, empathize, and manage the personality-driven behaviors in the relationship.

LO 6 Family Therapy Process and Outcome Research

What constitutes therapeutic change? What are the conditions within therapy that facilitate or impede such changes? How are those changes best measured? How effective is family therapy in general, and are some treatments or therapeutic models more efficacious than others for dealing with specific clinical problems or clients from a specific community or culture?

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Do certain therapist or family characteristics influence outcomes? Is family therapy the most cost-effective way to proceed in a specific case, especially in comparison with alternate interventions such as individual therapy or drug therapy? Or would a combined set of therapeutic undertakings be most effective in a specific case? How do race, ethnicity, gender, age, and sexual orientation factor into potential results? These are some of the questions that researchers in family therapy continue to grapple with in an effort to understand and improve the complex psychotherapeutic process.

Psychotherapy research investigates the *therapeutic process* (the mechanisms of client change) to develop more effective methods of psychotherapy. There is considerable research evidence that couple and family therapy is effective for virtually every type of disorder and for various relational problems in children, adolescents, and adults (Sexton, Datchi, Evans, LaFollette, & Wright, 2013; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013). Now, researchers have turned their attention to comparative outcome studies in which the relative advantages and disadvantages of alternate treatment strategies for clients with different sets of problems are being probed. The research lens has broadened to examine the application of couple and family therapy to specific clinical problems in specific settings, as well as research on process variables that examines specific change mechanisms (Sexton & Datchi, 2014), so that differential outcomes from various therapeutic techniques can be linked to the presence or absence of specific therapeutic processes. Such investigations may identify specific interventions that result in more effective treatment (Hogue, Liddle, Singer, & Leckrone, 2005).



Richard T. Nowitz /Science source

This researcher is reviewing a series of videotapes of therapy sessions with the same family, rating certain interactive patterns along previously determined empirical categories in an effort to measure changes as a result of family therapy.

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Process Research

How do couples or families change as a result of going through a successful therapeutic experience? What actually occurs, within and outside the family therapy sessions, that leads to a desired therapeutic outcome? Is there evidence for a set of constructs common to all effective therapies? Do specific therapies make use of these concepts in different ways that are effective? The emphasis today has shifted from broad outcome research to focus on treatment specificity, the particular change mechanisms in couple and family therapy. Clinicians appreciate this research because it aligns with their experience of therapy, making research relevant to practice (Sexton & Datchi, 2014).

Process research identifies and operationally describes what actually takes place during the course of therapy. These variables impact "how the intervention works differently in different contexts with different parameters" (Sexton et al., 2013, p. 590). What are the day-to-day features of the therapist–client relationship, the actual events or interactions that transpire during sessions that together make up the successful therapeutic experience? Can these be catalogued and measured? What specific clinical interventions lead to therapeutic breakthroughs? How can these best be broken down into smaller units that can be implemented by others in a manner consistent with the evidence-based method and thus taught to trainees learning to become family therapists? Are there specific ways of intervening with families with specific types of problems that are more effective than other ways? What role does therapist gender play in therapy? What about therapeutic style (proactive or reactive, interpretive or collaborative, and so on)? What factors determine who remains in treatment and who drops out early on? How do cultural variables influence the therapeutic process? In a review of family interventions, Sexton and colleagues (2013) identified the therapeutic alliance (the nature of the relationship between therapist and clients); model-specific fidelity and adherence (faithful implementation of the model as designed); and client factors (symptom severity, socioeconomic status, etc.) as major moderators and mediators in the interventions. From a practical economic viewpoint, family therapy research must demonstrate to insurance companies, managed-care organizations, government agencies, and mental health policy makers that its product is an effective treatment that should be included in any package of mental health services and benefits (Pinsof & Hambright, 2002).

Process research does not simply concern itself with what transpires within the session but also with out-of-session events occurring during the course of family therapy. Finally, the experiences, thoughts, and feelings of the participants are given as much credence as their observable actions. Thus, certain of the self-report methods we described earlier in this chapter may provide valuable input in the process analysis.

Process research attempts to reveal how therapy works and what factors (in therapist behaviors, patient behaviors, and their interactive behaviors) are associated with improvement or deterioration. For example, a researcher might investigate a specific process variable concerning family interaction—who speaks first, who talks to whom, who interrupts whom, and so forth. Or perhaps, attending to therapist–family interaction, the researcher might ask if joining an anorectic family in an active and directive way results in a stronger therapeutic alliance than joining the family in a different way, such as being more passive or more reflective. Or perhaps the process researcher wants to find out what special ways of treating families with alcoholic members

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BOX 16.4 THERAPEUTIC ENCOUNTER

What Within-Session Mechanisms Stimulate Change?

- Alliance between the family and a caring, competent therapist attuned to the family's presenting problem, especially if established early in therapy; this alliance builds confidence, hope, and a feeling of safety
- Cognitive changes in clients: greater awareness and understanding and a shared sense of purpose
- Behavioral changes in clients: sustaining engagement with one another
- An emotional experience leading to having one's feelings validated by other family members
- Maintenance of the therapeutic focus on strengthening family relations rather than blaming the identified patient
- Promotion of constructive dialogue and the therapist's effort to block the exchange of negative affect and interactional impasses
- Greater self-disclosure, which makes participants feel vulnerable but listened to and protected
- Sustained engagement, which leads to the feeling all members are working together for the overall family good

Sources: Christensen, Russell, Miller, & Peterson, 1998; Heatherington, Friedlander, & Greenberg, 2005; Helmeke & Sprenkle, 2000; Sexton, Robbins, Hollimon, Mease, & Mayorga, 2003

elicit willing family participation as opposed to those that lead to resistance or dropouts from treatment. Are there certain intervention techniques that work best at an early treatment stage and others that are more effective during either the middle stage or terminating stage of family therapy? See Box 16.4 for examples of therapeutic mechanisms that may initiate change.

Immediate client feedback on the therapeutic process is an important form of clinically relevant research. Many family therapists informally invite feedback from clients, but the process may be enhanced by the use of more formal means of monitoring progress, like the Systemic Inventory of Change (STIC: Pinsof & Chambers, 2009) and the System for Observing Family Therapy Alliances (Friedlander et al., 2006). Both provide focused questions regarding the therapeutic alliance and treatment progress. For example, the STIC asks clients to rate the statement, "Some of the other members of my family and I do not feel safe with each other in this therapy" (Pinsof & Chambers, 2009, p. 443). Family therapists may conduct research on their own interventions by using computerized feedback systems to inform the process and progress of treatment (Sexton & Datchi, 2014).

Some models evidence what Heatherington, Friedlander, and Greenberg (2005) refer to as well-articulated theories about systemic change processes. *Emotionally focused couple therapy* (see Chapter 9) is based on considerable research on the role of emotion in therapy, integrates such research with attachment theory, and offers a step-by-step manualized therapeutic plan to help clients access and process their emotional experiences. *Functional family therapy* (Chapter 12) applies behavioral and systems theories to treat at-risk adolescents. Techniques for building therapeutic alliances and reframing the meaning of problematic behavior have been integrated into successful process studies, especially related to retention in therapy (Sheehan & Friedlander, 2015).

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Empirically supported process studies thus far have been carried out primarily in the behavioral and cognitive-behavioral approaches. These brief, manualized treatment methods, with specific goals, are not necessarily the most effective but are easier to test using traditional research methodology than other treatment methods. Least well defined, for research purposes, are the social constructionist therapies. By and large, they have not yet developed testable propositions (e.g., how does the miracle question in solution-focused therapy affect client outcomes beyond a shift in "language games"?; Heatherington, Friedlander, & Greenberg, 2005). See Chapters 14 and 15 for recent attempts at addressing some of these concerns. Similarly, while narrative therapists purport to "re-author" people's lives, how precisely can that be measured, and how do we know when re-authoring has been successful? For most models discussed in this text, greater evidence for the specifications of change mechanisms is still needed to meet the research criteria for how best to tap into the therapeutic change process.

Outcome Research

Ultimately, all forms of psychotherapy must respond to this question: Is this procedure more efficient, more cost effective, less dangerous, with more long-lasting results than other therapeutic procedures (or no treatment at all)? To be meaningful, such research must do more than investigate general therapeutic efficacy; it must also determine the conditions under which family therapy is effective—the types of families, their ethnic or socioeconomic backgrounds, the category of problems or situations, the level of family functioning, the therapeutic techniques, the treatment objectives or goals, and so on. Effective research needs to provide evidence for what models work best for what specific problems, and under what conditions (Sexton et al., 2013). This is termed family intervention research (Liddle, Bray, Levant, & Santisteban, 2002) and may be defined as "a systematic approach to understanding the practices, their outcomes, and the varying moderating and mediating variables that may affect the success or failure of different clinical interventions" (Sexton, Kinser, & Hanes, 2008, p. 165).

By linking process issues with outcome results, the family therapist would be proceeding using an empirically validated map. The Society for Family Psychology of the American Psychological Association convened a task force to develop a classification of evidence-based treatments; they describe levels of evidence from evidence-informed (limited research support) to evidence-informed with promising preliminary evidence (one rigorous research analysis or several limited studies) to evidence-based treatment (well-formulated models with two or more rigorous studies) in order to categorize family interventions with a commitment to clinically relevant outcomes (Sexton, Gordon, Gurman, Lebow, Holtzworth-Munroe, & Johnson, 2011). This model is illustrated in Figure 16.5. It has been used by Darwiche and deRoten (2015) to identify multidimensional family therapy (Liddle, 2009), functional family therapy (Alexander et al., 2013; Sexton, 2011), brief strategic family therapy (Szapocznik et al., 2012), and family-focused grief therapy (Kissane & Lichtenthal, 2008) as Level III: Evidence-Based Treatments.

Major reviews of couple and family therapy interventions establish the efficacy and effectiveness of these treatments for a variety of treatment issues and client populations (Sexton et al., 2013; Sprenkle, 2012; von Sydow et al., 2013). Sexton and colleagues (2013, pp. 589–590), consistent with the strength-of-evidence model above, suggest that seven factors must be considered in rating couple and family therapies: (1) *intervention* type, from broad approaches to

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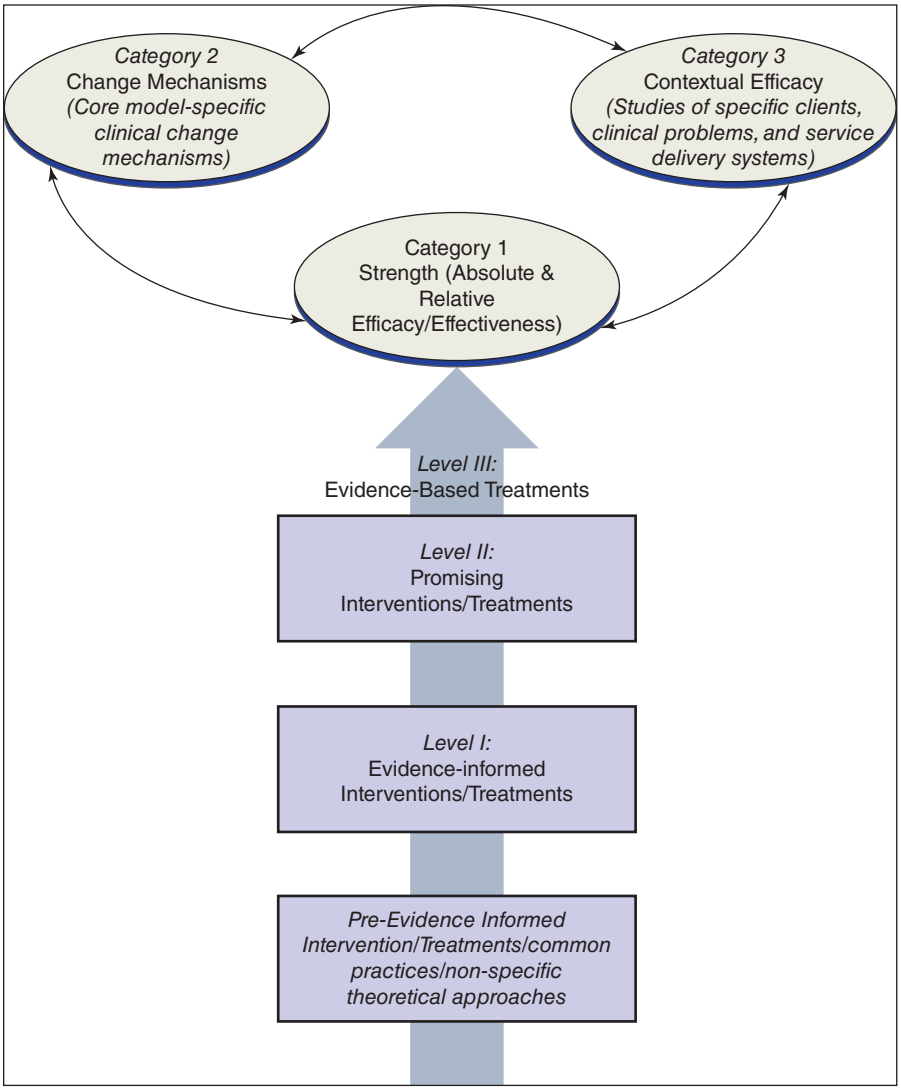


FIGURE 16.5 Levels of evidence model
Source: Sexton et al. (2011)

detailed and structured methods, perhaps in a manual; (2) *clinical outcomes*, "the effectiveness of a CFT intervention for general and specific client concerns" (p. 590); (3) *strength of research* reflects the rigor of the research and the strength of the outcome measures; (4) *client characteristics*, including demographic and diversity factors that impact generalizability of the findings; (5) *common therapeutic processes* employed that moderate outcomes; (6) the *context* reflects the setting in which the treatment was provided; and (7) *quality* is a measure of confidence in the findings.

Sprenkle (2012) notes the importance of randomized clinical trials (RCTs) in assessing couple and family therapy interventions but stresses that RCTs can include qualitative depth dimensions and common factors. He also notes the more challenging issue that most RCT research is conducted by the originators of the specific models under investigation, creating what he terms "allegiance" issues that warrant caution in the interpretation of the results. The flip side

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of this concern is his finding that the strongest current CFT research, based on methodology ratings, comes from research teams that have been together for more than 10 years, focused on specific models like multisystemic therapy, functional family therapy, or brief strategic therapy. Additional aspects impacting the strength of research included use of behavioral outcomes in addition to self-report, use of concrete outcomes not readily distorted, a focus on fidelity to treatment design, inclusion of minority participants, comorbid participants who reflect the prevalence or co-existing problems in real life treatment, use of multiple sites with longitudinal follow-up, inclusion of cost effectiveness, consideration of specific change mechanisms, independence of the research (conducted by others than model developers), and research in real-life practice settings and not just in a funded research context (Sprenkle, 2012).

Evidence supporting family-level interventions is strong for child and adolescent conduct or behavioral problems; many combine family therapy with parenting programs (Sexton et al., 2013). A review of systemic therapy for child and adolescent externalizing disorders examined 47 RCTs and found systemic therapy is equally or more efficacious; no adverse effects; superior engagement and retention rates, although minority participants had lower rates than majority participants; enduring positive effects; and positive outcomes across several aspects of functioning (von Sydow et al., 2013, p. 608). Family-based treatments for substance-abusing adolescents, adolescent bipolar disorder, and youth depression have received empirical support (Sexton et al., 2013). Sprenkle (2012) provides a summary list of couple and family therapies that have several RCTs that demonstrate evidence that they achieve valuable results; see Table 16.2.



BOX 16.5 EVIDENCE-BASED PRACTICE

Efficacy Studies versus Effectiveness Studies

Published outcome research studies appear in one of two forms: *efficacy studies*, conducted under controlled ("laboratory") conditions, and *effectiveness studies*, as in the everyday practice ("in the field") of providing family therapy services (Pinsof & Wynne, 1995). Efficacy studies seek to discover whether a particular treatment works under ideal "research therapy" situations, while effectiveness studies seek to determine whether the treatment works under normal real-life ("clinic therapy") circumstances. Historically, most outcome studies have focused on efficacy, in effect asking whether a specific treatment approach works under ideal, controlled research conditions. Unfortunately, as Pinsof and Wynne (2000) have pointed out, such laboratory studies, while more readily funded and publishable than are effectiveness studies, nevertheless often bear so slight a likeness to what practitioners do in their everyday practice that they are likely to have little, if any, impact on the practices of most marriage and family therapists.

Efficacy studies are able to approximate ideal experimental requirements: Patients are randomly assigned to treatment or no-treatment groups, treatment manuals define the main procedures to be followed, therapists receive training and supervision to ensure standardization of interventions, multiple outcome criteria are designed, and independent evaluators (rather than the therapist or clients) measure outcomes. Such a "dream" setup, with controlled conditions, lends itself to a clarification of what components of the therapy specifically affect certain outcomes. However, the conclusions from such studies, usually carried out in university clinics or hospital settings, are often difficult to translate into specific recommendations for therapy under more real-world, consultation-room conditions.

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TABLE 16.2 Evidence-based practice: problems/issues with strong couple and family therapy effects

- Adolescent conduct disorder/delinquency
- Getting adolescent and adult substance abusers into treatment
- Adolescent and adult substance abuse
- Childhood and adolescent anxiety disorders
- Childhood oppositional defiant disorder
- Adolescent anorexia nervosa
- Family management of adult schizophrenia
- Coping for family members of alcoholics unwilling to seek help
- Getting adult alcoholics into treatment
- Adult alcoholism
- Moderate and severe couple discord
- Adult depression when combined with couple discord
- Couple violence associated with alcoholism and drug abuse
- Situational (not characterological) couple violence
- Type I diabetes for adolescents and children

Source: Adapted from Sprenkle (2012), p. 25

Evidence-Based Family Therapy: Some Closing Comments

The demand for accountability can be seen in medicine and education as well as in psychology, where professionals are being pressured to base their practices on evidence whenever feasible. For psychotherapy, there is increasing momentum to establish an empirically validated basis for delivering healthcare services (Goodheart, Kazdin, & Sternberg, 2006; Kazdin & Weisz, 2010; Nathan & Gorman, 2007), based on the assumption that clinical interventions backed up by research will make the effort more efficient, thereby improving the quality of healthcare and reducing healthcare costs (Reed & Eisman, 2006).

Both researchers and practitioners are interested in making therapy more effective. Academically based clinical researchers have been especially supportive of this idea and have



BOX 16.6 EVIDENCE-BASED PRACTICE

Assumptions Underlying Evidence-Based Therapy Research

- A homogeneous client population is studied.
- Clients are randomly assigned to treatment or no treatment.
- Therapists are carefully selected, trained, and monitored.
- Specific interventions are prescribed.
- Treatment is designed for a specific disorder or diagnosis.
- Treatment is brief and of a fixed duration.
- Treatment manuals are employed to ensure all receive same interventions.
- Process change mechanisms are articulated.
- Clear goals are delineated.
- Multiple outcome measures are specified.
- Follow-up procedures over extended periods are employed.

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attempted to apply the methodology of scientific research to the therapeutic endeavor, often developing efficacy treatment programs under rigorous and controlled conditions that they believe generalize to real-world problems dealt with by practitioners. Practicing clinicians, who also would like to base their interventions on evidence, nevertheless complain that these narrow treatments based on randomized controlled clinical trials for specific diagnostic categories are of limited use with the varied populations and types of problems they see in their practice (Goodheart, 2006). Many contend that while the efforts to improve the quality and cost effectiveness of psychotherapy, as well as enhancing accountability, are clearly laudable, to date evidence that empirically validated techniques improve healthcare services or reduce costs in everyday practice is still limited.

The widely accepted definition of evidence-based practice (APA, 2005) is as follows: Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and patient values.

The definition affirms the contributions of

- research evidence (quantitative and qualitative methodologies, clinical observations, single-case studies, process and outcome research)
- clinical expertise (therapist skill, judgment and experience in assessment, case formulation, treatment planning, techniques of intervention)
- patient characteristics (personality, specific problem, cultural background, gender, sexual orientation, social and environmental context, race)

One difficulty in reconciling the views of practitioners and researchers is that they operate in different worlds—the former focused on service to clients, the latter on expanding understanding of a clinical phenomenon or testing the effects of new procedures (Weisz & Addis, 2006). Experienced clinicians are apt to be integrationists, taking what's most appropriate from a variety of theories or techniques to help their specific client or family, and are not likely to be content to follow fixed rules from manualized guidelines in treating clients who seek their help. This choice is based on a general conviction that no one approach adequately addresses every clinical situation that arises. Westen, Novotny, and Thompson-Brenner (2004) suggest that researchers might do better by focusing on what works in real-world practice than on developing new treatments or manuals from the laboratory. There also continues to be debate on what constitutes research evidence and on the extent to which psychotherapy is a human encounter in which *common factors* (attention from a caring therapist, the expectation of improvement, catharsis, hope, feedback, safety in a confidential relationship) help produce successful outcomes, regardless of therapeutic model (Sprenkle, Davis, & Lebow, 2009).

Nevertheless, there is a growing acceptance of the place of evidence-based studies in clinical practice, and practitioners may experience increased pressure from third-party payors and government agencies to base their interventions on established evidence-based treatments. Clinicians in the future will be held increasingly accountable for providing outcome assessments for their clinical interventions.

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SUMMARY

Research in family therapy preceded the development of therapeutic intervention techniques, but priorities changed, and the proliferation of techniques outdistanced research. That situation has now begun to even out, and a renewed family research–therapy connection is beginning to be reestablished. Some practitioners, likely in the past to dismiss research findings as not relevant to their everyday needs and experiences, have found qualitative research methodologies more appealing and germane than the more formal, traditional experimental methodologies based on quantitative methods.

Various models to classify and assess families exist, employing either a self-report or an observational format. Most noteworthy are the Circumplex Model of family functioning based on the family properties of flexibility and cohesion and the Family Environment Scale. Observational measures, with which family therapists observe behaviors, have been designed by Beavers to depict degrees of family competence and by the McMaster Model to classify family coping skills. Measures of couple adjustment and individual factors that influence family dynamics are also used in research and practice.

Both the process and outcome of family therapy interventions have been studied with increased interest in recent years. The former, identifying what mechanisms in the therapist–client(s) encounter produce client changes, helps ensure greater therapeutic effectiveness. Outcome research, including both efficacy and effectiveness studies, having established that marital and family therapy are beneficial, has turned its attention to evidence-based practices—what specific interventions work most effectively with what client populations. Of particular interest today is the search for the relative advantages and disadvantages of alternative therapeutic approaches for individuals and families with different sets of relational difficulties. Evidence-based family therapy is likely to become increasingly important due to efforts to make therapy more effective and cost efficient.

RECOMMENDED READINGS

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17

Comparative View of Family Theories and Therapies



LEARNING OBJECTIVES

- LO 1 Compare and contrast family therapy models based on their units of study and time frame
- LO 2 Explain how different models understand functional and dysfunctional families
- LO 3 Differentiate between the assessment procedures used in behavioral, Bowenian, and structural family therapy
- LO 4 Discuss the relative importance of insight versus action to change lives
- LO 5 Explain the difference between common factors in family therapy and model-specific treatments
- LO 6 Discuss some factors that may extend therapy
- LO 7 Explain your position on the integration of family therapy approaches
- LO 8 Describe the role of medication in the field of family therapy

In this final chapter, we present a wide view of the various models we have considered, reviewing some of the similarities and differences among them. It is important to note at the outset that originators of theories by necessity focus on a relatively narrow set of concepts, staking out positions that attempt to make their contributions unique. Little effort generally is directed toward seeking similarities with other theories; indeed, the opposite is usually the case. However, on closer examination, we find that overlaps in theory and technique, as well as notable differences, can be seen. Purists in theory are many; purists in practice less so. Ideally, it is important for students and clinicians to learn a variety of theories and to fit specific techniques, regardless of theoretical origin, to appropriate client populations and needs. Most family therapists start out following one theoretical framework and its set of clinical procedures but soon learn to supplement and adapt where the theory is inadequate for certain clients. In practice, then, most therapists become eclectic, ultimately adopting (and adapting) techniques that their experience tells them work best with specific sets of problems. The personality and interests of individual therapists also influence the theories they choose to practice.

With so many theories, some investigators have attempted integration. The question of integration raises numerous issues in theory, clinical practice, and training. Many view eclecticism as inevitable today in the landscape of varied theoretical approaches; others feel that integration is possible only under very specific contexts. For some, eclecticism reflects experience grounded in an appreciation of the

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therapeutic factors common to the diverse approaches, while others see it as an absence of theoretical rigor.

Many therapists believe it is harder to stick with a single theory or set of techniques in working with families than when treating individuals. Systems are complex, and each family member has specific needs that may conflict with those of fellow family members. By definition, members of a family are at different stages of life cycle development and may require different intervention procedures. The therapist needs to evaluate and respond to each member, to the entire family system, and, further, the larger system of which all are a part, including extended families, the community, culture, race, socioeconomic status, and ethnicity. In the end, skilled clinicians are more alike in what they do with families than their different theories would suggest. Intangibles—personal experience, involvement, focused interest, energy, sensitivity, empathy, warmth, humor, and so forth—as well as theoretical knowledge and therapeutic know-how may be the key variables that in some combination, along with an awareness of evidence-based research findings, make for clinical effectiveness.

LO 1 Family Theories: A Comparative Overview

For the remainder of this chapter, we separate family theories from clinical procedures and highlight the similarities and differences among models.

Units of Study: Monads, Dyads, and Triads

Many of the early family therapy pioneers (Bowen, Jackson, Wynne, Boszormenyi-Nagy), themselves largely schooled in classical psychoanalysis, did what most revolutionaries do—they rejected out of hand the then-mainstream theory of psychoanalysis. They especially rejected the psychoanalytic focus on intrapersonal dynamics—the *monadic* view that problems reside within the individual that prevailed among psychoanalysts of the time. Instead, they insisted on the then-radical position that people can be understood more accurately and can be more easily helped if viewed systemically, in the context of their relationships. How people interact with one another, how they define themselves within that relationship, the coalitions and alliances they form—these all require the broader *dyadic* (two-person) and *triadic* (three-person) viewpoints. Thus, boundaries, enmeshments, disengagements, subsystems (Minuchin) or triangles, symbiosis, fusion (Bowen), or relational ethics and family loyalty (Boszormenyi-Nagy) all look beyond the individual to his or her recursive patterns of behavior within a system.

Today there is less polarity—intrapsychic or interpersonal—among models than a difference in emphasis. All family therapists attend to individual, dyadic, or triadic factors in family functioning; the differences lie in the weight and focus they give to each. Many psychoanalytically oriented therapists are less insistent on paying exclusive attention to conflicting forces within each family member. In general, modern psychoanalysis has morphed into object relations theory, and the new look is more relationship based. Object relations family therapists, still interested in intrapsychic conflict, understand family relationships by studying the imprints from the past that each partner brings to the marriage. As we discussed in Chapter 7, object relations, self psychological, intersubjective, and relational psychoanalysis all value the

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real relationship between people even as they also account for the internalized and distorted unconscious "objects" or narcissistic personality elements that had their origins in early real relationships. For example, a husband–wife dyad may contain examples of projective identification as the partners project unwanted parts of themselves onto the other.

Behavior therapists are likely to see the symptomatic person as the problem. In the case of an adolescent runaway, the behaviorist is apt to accept the parents' view and will then teach them skills with which to cope with the family crisis. Experiential family therapy, along with psychoeducational therapy, also attends to the individual but within a family context. The former, viewing problems as arising from flawed interactions and communication lapses between family members, might focus on helping the individual express feelings (Satir) but always within the context of ongoing family transactions (emotionally focused family therapies). Psychoeducational therapists, when treating individuals with serious mental disorders, tend to accept the definition of individual pathology; but they recognize the malignant effect of that person's chronic problematic behavior on family functioning. Consequently, they direct their therapeutic efforts at helping the entire family reduce the level of emotionally intense exchanges between its members, reducing family tensions and helping avoid relapse in their symptomatic member.

By definition, family therapists conceptualize from a dyadic or triadic position, recognizing that people define one another (and themselves) through their interactions. Early communication/strategist therapists emphasized both the dyadic and triadic nature of symptom formation as interpersonal messages, and Haley in particular searched for the three persons involved in any human behavioral exchange. Bowen's theory is clearly triadic, particularly his concept of triangles as the basic building blocks of a family's emotional system. Similarly, structuralists are triadic—boundary diffusion between two people inevitably involves reciprocal relationships (enmeshments, disengagements) with a third participant. Triadic explanations, such as coalitions and alliances, broaden the lens, providing a larger context for understanding behavior.

What about the newer therapies, influenced by postmodern and poststructural thought? Solution-focused, collaborative, and narrative therapists frequently direct attention to solving the individual's problems, leading some critics to contend that the focus on the family is lost. On the other hand, Michael White's narrative colleagues never lose sight of the family; indeed, they try to change the direction of the family's energy in order to help the family detach from a restraining storyline. Similarly, solution-focused therapists help family members exchange their "problem" focus for a "solution" arrived at together, and Harlene Anderson attempts to help each member "dissolve" his or her version of the "problem." Although they may not directly address the pattern of family conflict, all three persist in getting the family as a whole to abandon seemingly intractable, self-restricting stories about themselves for new, more satisfying self-descriptions.

Time Frame: Past, Present, Future

Another dimension with which to compare models involves how theories consider time: the past, present, or future. Early family therapy pioneers broke with the psychoanalytic search of the past for explanations of current difficulties, preferring to focus on here-and-now family

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interactions. Without denying the influence of past experiences on present functioning, most theorists looked to ongoing transactions, turning to past experiences only if necessary to enhance understanding of current family dynamics. Today, among family therapists, there remains disagreement on which time frame to emphasize in dealing most effectively with the family's presenting problem.

Long-term, classical psychoanalysis with individuals does focus attention on conflicts developed in each client's early formative years. Today, lengthy treatment is out of favor despite some evidence demonstrating the lasting efficacy of psychoanalysis relative to other, often shorter-term, treatments whose benefits may not last over time (Knekt et al., 2011; Shedler, 2010; Westen, Gabbard, & Ortigo, 2008). Other approaches to psychoanalysis—object relations, self psychological, intersubjective, and relational—explore unconscious conflicts from perspectives other than those that are drive based (see Chapter 7). All, however, are concerned with remediating symptoms and promoting self-awareness.

The past remains an important element of all contemporary psychoanalytically informed family therapy. But with the greater attention today on relatedness, current real relationships among the family and the therapist also are important in therapy. It can be very powerful for a husband to realize that the coldness attributed to him by his wife has its origins in the way he experienced his father's emotional distance and unavailability. The therapist extends this awareness to show how this aspect of the past informs his marriage today. From a psychoanalytic perspective, the unconscious is ahistorical. The unconscious cannot know or experience the measurement of time. This is what allows for past experience to be relevant to today. Projections and identifications, for example, may have their origins in the past, but this is true only from a conscious perspective. From the perspective of the unconscious, projections and identifications are timeless. One learns in therapy how to relate to them in the here-and-now through conscious awareness.

The transgenerational models are most apt to attend to unfinished and recurring business from families of origin. Bowen, for example, was interested in the client's degree of family fusion, Boszormenyi-Nagy in his or her sense of family loyalty and obligation. Both Bowen and Boszormenyi-Nagy helped families understand the impact from past generations on their values, behavior patterns, attachments, ways of examining and resolving problems, power issues, and so forth. Bowen's efforts to develop genograms with his client families helped explicate for them a transgenerational basis for their current behavior. Boszormenyi-Nagy's insistence that family debts and obligations may be rooted in the past serves a similar function. Framo and Whitaker also adopted a multigenerational outlook, the former by inviting clients to bring in families for family-of-origin sessions, the latter by bringing in grandparents as consultants to ongoing family sessions.

Most family therapies today, on the other hand, tend to be ahistorical, encouraging families to deal with issues they face in the present without looking to the past. Experiential (Satir, Kempler), communication/strategic/Milan (the Palo Alto group, Haley, Madanes, Selvini-Palazzoli), and structural (Minuchin) family therapists all may be considered to emphasize the present. Behavioral/cognitive family therapists want to know what circumstances

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currently help maintain the present problem or symptom in order to direct interventions at extinguishing the undesirable thoughts and behavior.

Social constructionists (like de Shazer) deal with problems in the present, looking at future solutions. They do not look at the past for clues to the origin of the problem, nor do they dwell in the present. Beginning immediately, they look for signs of change and work toward future solutions. The past is questioned only to help the client recall earlier solutions that might be employed again in the current situation.

Narrative therapists also help clients search for unique outcomes—times when they overcame a problem-saturated story—in the service of "thickening" stories of success as an aid to overcoming future hurdles. For them, the past is a repository of successful resilient efforts at overcoming problems that can be applied to current difficulties.

Psychoeducationally oriented therapists, working with posthospitalized schizophrenics and their families, offer practical strategies for making day-to-day life together more harmonious and less stressful. They are not interested in how the symptoms emerged, who is to blame, or what in the past caused the present family difficulties. Rather, they teach families how to stop perpetuating the problem. Similarly, short-term educational programs teach ways of coping with marital or parent–child conflict and emphasize skills development without considering the possible origins of the presenting difficulties.

LO 2 Functional and Dysfunctional Families

All theories have at least an implicit—if in some cases unstated—viewpoint regarding normal family functioning. Bowen essentially bypasses the issue of normality with his concentration on optimal functioning and the related issues of differentiation and the separation of emotional and intellectual functioning. If we assume that most people lead lives they can manage (and proceed hesitantly if at all beyond those limits), then many may appear to have their lives in balance by remaining at relatively low levels of differentiation from the nuclear family emotional system. (The daughter who involves her mother as a partner in rearing her child is an example here.) How well that person functions, then, is dependent on the level of stress they encounter or are able to avoid. According to Bowen, a well-differentiated person can become dysfunctional but is likely to recover rapidly and with minimal impairment by calling upon a variety of coping mechanisms at his or her disposal. By contrast, a poorly differentiated person gets caught up in family turmoil and recovers less well or quickly. The ideal marriage, according to Bowen, is two highly differentiated partners who achieve emotional and intellectual intimacy without a loss of autonomy.

Modern psychoanalytic theories, including object relations viewpoints, say a lot about functional and/or dysfunctional families. They stress the importance of the infant's attachment to the mother or other caregiving figure as crucial to the development of a strong, cohesive self in an adult. Internalized images and introjects from the past shape future relationships, including marital choices. Splitting, projective identification, and object hunger all play a role in marriage, which is influenced by infantile experiences. However, it is important to keep in mind that as influential as these unconscious

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dynamics are in selecting love relations, so too are unconscious memories of nurturance, love, mirroring, and other pleasant experiences from the past that a person feels or hopes a partner will provide in the present. And beyond these, a partner can also help a person separate from so-called dysfunctional dynamics by virtue of her or his inherent difference from past object relations. In other words, the present can help mitigate the deleterious influences of the past in both unconscious and conscious terms. Object relations therapists help make conscious the impact of unconscious objects. Self psychologists mirror narcissistic needs in a healthy and helpful way that imparts a strengthened sense of self-esteem. Intersubjective and relational analysts may use themselves in working with clients as a means of creating new paradigms of relating even as unconscious dynamics express themselves in the therapeutic work. Experiential family therapists adopt a humanistic, egalitarian stance and view functional families as self-actualizing; they have free choice and self-determination and tend to operate as open systems. Individual development through the seeking of new experiences is encouraged and supported by the family. From the perspective of these models, dysfunction arises from societal pressures to deny and suppress natural impulses, consequently inhibiting spontaneity and growth.

Minuchin and the structuralists see normal family life as ever changing and continuously making accommodations to changing conditions. What distinguishes functional from dysfunctional families is the flexibility in functional families to modify their structure to adjust to changing life cycle stages or to adjust to role changes or situational crises. The clarity of boundaries between subsystems within the family and an effectively functioning spousal subsystem help ensure stability despite changing conditions.

Interactional family therapists at the Mental Research Institute believe dysfunction arises from persistent faulty solutions to common difficulties. Mishandled, self-defeating, more-of-the-same solutions imposed by the family are not a symptom of some underlying problem, but those flawed solutions represent the problem itself. Behavioral/cognitive family therapists, supported by research investigations into marital conflict, stress the importance of a positive communication exchange of rewarding behavior between partners in maintaining a happy relationship. Dysfunctional marriages, according to Gottman, are filled with negativity—criticism, contempt, stonewalling, and defensiveness.

Solution-focused therapists downplay ideas of functionality and/or dysfunctionality, since they contend that whatever label we use to explain another's behavior is in the eyes of the beholder and therefore an inadequate criterion of normality or abnormality. They add that ethnicity, race, type of family organization, sexual orientation, and so forth must be factored into any appraisal of a family. Collaborative therapists such as Harlene Anderson, also working from a social constructionist framework, are not interested in labels but rather in "dissolving" problems and co-creating new stories in their place. Narrative therapists, departing from the "therapist as expert" position, honor each family's unique heritage and avoid pathologizing labels, which they view as thin descriptions unfairly imposed on families by doctors or others with definitional powers in society.

Table 17.1 compares some of the differences in theoretical viewpoints among the various models of family therapy.

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TABLE 17.1 A comparison of theoretical viewpoints in family therapy

Model	Primary Theme	Unit of Study	Time Frame	Title or Derivation	Leading Figures	Major Concepts
PSYCHO-DYNAMIC	Unresolved conflicts from past continue to attach themselves to current objects, relationships, and situations	Classical: monadic; individual intrapsychic conflict brought to current family relations Contemporary: often more dyadic focusing on how previous relationships express themselves in present relationships	Past; early internalized family conflicts lead to interpersonal conflicts within present-day family	Classical: psychoanalytic; object relations theory; self psychology; intersubjective; relational	Ackerman, Scharff & Scharff, Framo, Kohut, Stolorow, Atwood, Lachman, Mitchell, Aron	Interlocking pathology; scapegoating; role complementarity introjects; attachments; projective identification; splitting; narcissism; self objects; the relationship and the unconscious dynamics that influence it
EXPERIENTIAL	Free choice; self-determination; growth of the self; maturity achieved by overcoming impasses in process of gaining personal fulfillment	Dyadic; problems arise from flawed interactions and communication lapses between family members (e.g., husband and wife)	Present; here-and-now data from immediate, ongoing interactions	Symbolic-experiential; gestalt; human validation; emotionally focused	Whitaker, Kempler, Satir, Greenberg, Johnson	Symbolic factors represent family's internal world and determine meaning given external reality; self-awareness of the moment; self-esteem; clarity of communication; explore inner experiences and relationships
TRANSGEN-ERATIONAL	Emotional attachments to one's family of origin need to be resolved.	Triadic; problems arise and are maintained by relational binds with others	Past and present; current marital relations assumed to result from partner's fusions to their families of origin or to unpaid "debts" and obligations	Family systems theory; contextual	Bowen; Kerr; Friedman; Papero, Boszormenyi-Nagy	Differentiation of self vs. fusion; Triangles; multigenerational transmission process; family ledger; ethics; family legacies; entitlements
STRUCTURAL	Symptoms in an individual are rooted in the context of family transaction patterns, and family restructuring must occur before symptoms are relieved.	Triadic; family enmeshment and disengagement involve family subsystems and family system as a whole	Present; ongoing interactions maintained by unadaptive family organization; typically unable to deal with transitions in the family life cycle	Structural family theory	Minuchin; Montalvo; Aponte; Fishman	Boundaries; subsystems; coalitions; enmeshment and disengagement

(*Continued*)

TABLE 17.1 Continued

Model	Primary Theme	Unit of Study	Time Frame	Title or Derivation	Leading Figures	Major Concepts
STRATEGIC	Redundant communication patterns offer clues to family rules and possible dysfunction; a symptom represents a strategy for controlling a relationship while claiming it to be involuntary.	Dyadic and triadic; symptoms are interpersonal communications between at least two and probably three participants in reciprocal relationships	Present; current problems or symptoms are maintained by ongoing, repetitive sequences between family members	Communication theory; strategic family theory	Haley; Madanes; Weakland; Watzlawick; Jackson; Keim	Symmetrical and complementary communication patterns; paradox; family hierarchy
MILAN	Dysfunctional families are caught up in destructive "games" and are guided by belief systems that do not fit the realities of their lives.	Triadic; problems express connecting relationship patterns between family members	Present; recognition of circular nature of current problems helps family abandon previous limited linear perspectives	Systemic family theory	Selvini-Palazzoli; Boscolo; Cecchin; Prata; Tomm	Paradox and counterparadox; invariant prescriptions; circular questioning; second-order cybernetics
BEHAVIORAL/ COGNITIVE	Personal functioning is determined by the reciprocal interaction of behavior and its controlling social conditions.	Monadic; symptomatic person is the problem; linear view of causality.	Present; maladaptive behavior in an individual is maintained by current reinforcements from others.	Learning theory; social learning theory	Patterson; Stuart; Liberman; Alexander; Falloon; Ellis; Beck; Meichenbaum; Gottman	Conditioning; reinforcement; shaping; modeling; schemas
SOCIAL CONSTRUC-TIONIST	People use language to subjectively construct their views of reality and provide the basis for how they create "stories" about themselves.	Triadic; family problems are stories its members have agreed to tell about themselves	Present and future; current problems based on past "stories" that influence current choices and behavior	Social construction theory	de Shazer; O'Hanlon; Goolishian; Hoffman; Andersen; Anderson	No fixed truths, only multiple perspectives of reality; constructions of meaning
NARRATIVE	Problem-saturated stories people tell themselves organize their experiences and shape their subsequent behavior.	Triadic; family unites to revise self-defeating stories	Past as repository of successful efforts to overcome problems; future for re-authoring stories and developing options	Narrative theory	White; Epston	Poststructural; thin and thick descriptions
PYSCHO-EDUCATIONAL	Educational information reduces stress on families and improves their coping skills.	Dyadic and triadic; range covers nonclinical premarital and marital couples to entire families with physical and mental disorders	Present and future; enhancing existing skills to improve future quality of life	Educational psychology; cognitive behavior therapy; family systems theory	Anderson; Falloon; Goldstein; McFarlane; McDaniel; Guerney; Markman; Vishner	Use of empirically based procedures to manage schizophrenia; expressed emotion; collaborative family healthcare; marriage preparation and relationship enhancement

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Family Therapies: A Comparative Overview

In a further comparison, we look at six dimensions of the therapeutic process: the therapist's role, the model's use of formal or informal assessment procedures, the issue of insight versus action intervention mode, key methods of intervention for each model, the duration of therapy (crisis, brief, long term), and the goals of treatment.

The Role of the Therapist

Psychoanalysts are interested in creating a safe, holding environment in which to examine and attempt to resolve the client's unconscious conflicts that interfere with current family relationships. They are empathetic, attentive, and interested in exploration; and they listen without rushing to advise or reassure. In providing clarification or insight into intrapsychic or interpersonal conflicts, they offer interpretations to each participant separately (rather than focusing on the family system) and then examine transference and countertransference reactions. Many psychoanalysts have introduced into their practices a more immediately involved relationship with clients. Through self-disclosure, they carefully include their own experience as a means of helping people experience relationships in a new way. Intersubjective and relational psychoanalysts in particular work to co-construct new psychic conditions for the client (and analyst). In much the same way that narrative therapists help clients write thicker narratives of their own lives, many contemporary psychoanalysts support the mutuality of the therapeutic interaction as a means of "writing" a new conscious story. Indeed, the contemporary analyst might even be less interested in helping the client write new stories about prevailing conditions in life than in helping her or him to become a skilled writer and reviser of personal stories that account for new experiences, awarenesses, personal capabilities and so forth.

Experiential family therapists strive for active, spontaneous, honest, and open encounters in therapy. Satir, with her warm and personal manner, provided a role model for straight talk and clear communication, all directed at increasing client self-esteem. She often relied on touch—unlike Kempler, whose confrontational style, insistent and often uncomfortably open and direct, provoked clients into engaging in honest emotional exchanges with him and with each other. Whitaker—spontaneous, without a plan of engagement prior to a session with clients, and eschewing a neutral stance—shared his feelings and fantasies in order to allow his clients to feel free and safe enough to do the same.

Bowenian coaches attempt to minimize their emotional impact on the family (and, in turn, avoid being caught up in any family emotional turmoil). They attempt to be calm and low-key, experienced external experts who use questioning to help define and clarify the family's emotional system. They try to remain in nonanxious emotional contact with family members, careful not to be triangled into the family's entangling conflicts and toning down family emotional expression but at the same time directing efforts to help members gain greater self-differentiation (take "I" positions). They help clients return to their families of origin after coaching them to continue their differentiating efforts.

Structuralists, strategists, and Milan therapists all move in and out of the therapeutic process at key points. Structuralists join the family system in a leadership role, accommodate to the family style, map out the structure the family has developed, and go about helping them

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change that structure to adapt to changing conditions. As active stage directors, they carefully plan how to adjust to each family, reframe messages, and help families create flexible boundaries and harmonious, integrated subsystems. Strategists are also active and manipulative, issuing directives, relabeling behavior, sometimes prescribing symptom maintenance, and employing other paradoxical techniques. Using a wide variety of techniques, they tailor interventions to specific symptoms and custom-design problem-resolving strategies to eliminate the presenting problem. The Milan group employs many strategic techniques but adds the unique contributions of positive connotations, rituals, and circular questioning (an especially provocative and effective intervention that may allow the system to heal itself). Milan therapists make frequent therapeutic use of an active and intervening observing team behind the one-way mirror.

Solution-focused therapists help clients define the changes they are looking for. They do not spend time speculating on the origins of presenting problems. Assuming clients know what it is they wish to change, these therapists collaboratively engage in therapeutic conversations ("miracle questions," "exception questions"), helping clients construct solutions. Therapists who adopt the linguistic approach of Goolishian and Anderson also use collaborative procedures, viewing clients as conversational partners. Therapist and clients engage in a joint search for altered or new meanings, attitudes, and narratives. Narrative therapists, as coauthors, also help clients develop new meanings, using questioning to aid clients as they revisit and rewrite old, self-defeating stories, replacing them with preferred empowering stories about actively directing their futures.

Feminist family therapists typically are active in helping both men and women overcome stereotypic thinking about gender roles. They, like the narrative therapists, help family members identify those damaging, culturally influenced, sexist practices that stifle individuality. Psychoeducational family therapists are active teachers or coaches, interested in inculcating skills to aid in reducing family conflict.

LO 3 Assessment Procedures

All family therapists engage in some form of evaluation with families, beginning with the initial session and continuing throughout treatment, as the therapist gathers data and formulates (and reformulates) hypotheses. As therapy proceeds, some initial speculations may be confirmed and built upon, others rejected because of new information, still others changed as the therapist modifies his or her assumptions and shifts therapeutic strategies. While some family therapists consider a formal assessment procedure to be central to their therapeutic planning, others consider it peripheral, believing that one should not sit in judgment of others (the client knows best what he or she needs). Whether formally or not, all therapists make some sort of appraisal of new client families, if only by comparing them to other families with whom they have worked.

Behavioral family therapists are particularly interested in defining and, if possible, measuring the maladaptive problem, using standardized interview procedures and formal test instruments. How frequently does the undesirable behavior occur? What events preceded the appearance of the behavior? What are its consequences? What reinforcements maintain the problem? The more commonly encountered cognitive-behavioral therapists are likely to

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employ questionnaires and inventories for each family member to get a sense of different perspectives about the family problem. In particular, they want to assess not just the frequency but also the reciprocal patterns between members that perpetuate the behavior, all in preparation for introducing a cognitive restructuring program.

Bowenians begin by gathering historical data in the form of genograms, allowing the therapist and family members together to ferret out family patterns extending over several generations. In the process, the therapist and the family obtain an inside picture of unresolved issues and family patterns from the past, and the family identifies issues that have hampered family functioning over generations. Other family therapists interested in longitudinal history also look for patterns from the past that impose themselves on current family functioning. Boszormenyi-Nagy might assess intergenerational indebtedness; psychoanalytic therapists focus on unconscious conflicts from the past within each partner in a relationship that hinder their attempt to develop intimacy. A feminist therapist working with a couple might review with them a history of exposure to sexist attitudes or current gender discrimination that negatively affects optimal marital functioning.

Another group of family therapists interested in assessment prefers a cross-sectional view of family functioning instead of adopting a longitudinal framework. What led the couple or family to seek help *now*? A Mental Research Institute (MRI) strategic therapist might wonder aloud if the family has gotten stuck, trying the same solutions and meeting the same frustrating barriers again and again, thus perpetuating the problems.

Structuralists rely on observation of the family in action, mapping transactional patterns, provoking enactments to detect boundary problems such as enmeshment and disengagement. They might perceive the family as stuck at a transition point, needing to restructure but unable to move beyond the impasse without therapeutic intervention. Affiliating with the family, they are in a position to understand its organizational structure and ongoing transactional patterns, its subsystems and hierarchical design. Experientialists, especially cross-sectional ("here-and-now"), help families search for suppressed feelings and impulses that need to be unblocked in order to gain greater growth and fulfillment.

A third viewpoint shows minimal to no interest in the family's history and current system of functioning. Social constructionists believe their view is just one of many perceptions of the situation, and the clients' knowledge about themselves takes priority. Believing that they are not objective observers with a truthful interpretation of reality, social constructionists adopt the egalitarian viewpoint that they need to engage families in conversation, not evaluation. Such a collaboration results in the therapist and family members examining the family's stories about themselves (and especially the meaning families give to those stories) that families can re-author for greater empowerment.

Solution-focused therapists focus from the start on simply finding the skeleton keys (general guides) to move clients toward solutions. In this brief approach, problems are not uncovered and assessed; rather, the thrust is toward solution development and client empowerment. The collaborative approach of Harlene Anderson also adopts a "not knowing" attitude by the therapist, meaning she does not determine or have set ideas about what is wrong with the family and what needs to change. That shared determination emerges from the conversation

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together. Narrative therapists, too, do not feel they have special privileges over their clients, nor are they interested in playing expert diagnostician of another person's motives or personality characteristics. What they are interested in doing is liberating people from a sense of helplessness and despair. Their persistent questioning is directed at exploring and expanding beliefs and visions about the future, not in gathering data for assessment or diagnostic purposes.

LO 4 Insight and Action Modes

All therapies are about change; but what is the best, quickest, and most lasting way to achieve such change? Is it by clients gaining insight or new understanding of their situation, perhaps the origins of their problems, in preparation for making changes in their lives? Or is it by taking actions—trying out new ways of thinking or behaving—that lead to new experiences and, subsequently, changes in their lives? Or is some combination of insight and action most effective? If so, does one need to precede the other?

The early family therapists, especially those with classical psychoanalytic training, believed insight produced understanding and clarification, focusing on the underlying conflicts from the past that continued to undermine current functioning. These therapists contended that by gaining greater self-awareness of such things as interlocking pathology or role complementarity or the function of the symptom in the family system, these families would then take actions on their own behalf.

Ackerman, for example, used psychodynamic techniques such as confrontation and interpretation to expose both intrapsychic and interpersonal conflict when working with troubled families. Bowen also helped clients gain insight into their role in family triangles and other interpersonal aspects of the nuclear family emotional system, encouraging them to use that understanding to attempt new relational patterns—new actions—based on these insights. Stressing the importance of action—they were often breaking away from individual ("talk") psychoanalysis—these therapists nevertheless saw insight as a necessary prerequisite for change through action.

Do action and change necessarily follow from gaining insight? Obviously not, since most of us know we should lose weight, exercise more, drink in moderation, have regular physical checkups, stop smoking, get sufficient sleep, and so on; but we fail to do so on a regular basis, even as we admit such behavior would be in our own best interest. Is insight into hidden and unresolved conflicts always necessary for behavioral change to occur? Strategists argue that a family need not gain insight into causes before experiencing change. Behavioral/cognitive family therapists are also emphatically unconcerned with insight or inferred underlying motives, pragmatically focusing on observable behavior and what needs repair. For them, the search for underlying causes calls for high levels of inference and often ends up producing useless explanations at the cost of needed action.

But a psychoanalyst would argue that free association allows for maximum client self-exploration with respect to the past, present, and future. Relational and intersubjective analysts are particularly interested in the unconscious processes that occur between clients and therapists in the analytic work. Psychoanalysts do concern themselves with behavioral change. No analyst would be content to have understanding without change.

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Structuralists also combine action and insight—new actions lead to new experiences that in turn lead to new insights and understanding. Enactments, for example, may demonstrate successful actions that make insight possible and later can be added to the family repertoire. Restructuring helps families view the world differently, and these new views inevitably lead to members flexibly trying out new roles and new experiences. Gestalt therapist Kempler also tries for dramatic emotional breakthroughs in the session, believing these will later be carried forward into greater spontaneity and self-expression.

The Milan group, especially Cecchin and Boscolo, looking beyond insight-versus-action interventions, invites families to examine their *meaning system* and break through old games by building family consensus about reality in an effort to discover new possibilities not previously considered. Their later formulations have led to the current cognitive emphasis prevalent in the social constructionist therapies. Cognitive change opens avenues for fresh ways of thinking, not necessarily for gaining new understanding.

Narrative therapy bypasses any insight-action dichotomy by focusing instead on cognitive change (finding new meanings) and the collaborative search for more optimistic, productive solutions that are within the client. Narrative therapists provide a climate in which client and therapist can co-construct alternative stories in place of those that have left family members or kinship groups feeling defeated and hopeless. In this technique, narrative therapists are joined by advocates of reflecting teams and the linguistic, conversational techniques in giving priority to new meanings over action.

LO 5 Key Methods of Intervention

COMMON FACTORS There is substantial support today for *common factors* that are effective across a variety of theoretical approaches to family therapy (such as highly important client characteristics, like readiness to change, motivation, willingness to work hard, personality, and family support; therapist characteristics, such as positivity, friendliness, adaptability to client needs, and cultural sensitivity; and the therapeutic alliance, including shared goals and careful connection with the various individuals and dyads in family therapy) (Blow, Sprenkle, & Davis, 2007; Karam, Blow, Sprenkle, & Davis, 2015; Lebow, 2014). Proponents of common factors in family therapy argue "psychotherapy works predominantly not because of the unique set of interventions (what we call the model-driven change paradigm) but rather because of a set of common factors of mechanisms of change that cuts across all effective therapies" (Sprenkle, Davis, & Lebow, 2009, p. 2).

Lebow (2014, pp. 123–128) notes several common factors that are unique to couple and family therapy, including a multisystemic focus and relational frame; strategic and ethical mixture of individual, couple, and family formats; careful management of multiperson sessions to create a safe environment; use of family homework to encourage change; careful shaping of therapeutic conversation to promote positive family process through curiosity, solution-oriented language, positive reframing, and a focus on family strengths; tendency toward short-term family therapy; enabling change and creating continuing family processes to maintain change; and a focus on change at the metalevel as changes in one aspect of the family system impacts other areas.

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Although it is sometimes positioned as a choice between common factors or model-specific factors, it is possible that both may interact in effective treatments (Eisler, 2006). "Just as many common factors work through models, models in turn work through therapists" (Blow, Sprenkle, & Davis, 2007). Sexton (2007) takes this one step further by proposing, "the therapeutic process is seen as a multi-layer change process including the client's change process, the relational interaction between therapist and client, the specific mechanism within a therapy, and common factors" (p. 104). This approach is consistent with the systemic properties of reciprocity and complexity in interaction.

MODEL-SPECIFIC INTERVENTIONS Despite the role of common factors across models, advocates of particular models rely on certain specific and defining techniques, as noted below.

Psychodynamic family therapists use *interpretation* to help clients understand the unconscious meaning of their thoughts, verbalizations, and behavior. They may clarify or challenge client statements or make comments that link one event with another ("You're afraid to commit to your relationship with Jada, here, because you suspect your mother was unfaithful to your father and covered it up"). To maximize client freedom, these therapists tend not to take the lead, sometimes deliberately becoming silent to provoke greater family exchange. Over the past several decades, interpretation has been extended ever more frequently toward helping clients understand transference (and countertransference) dynamics between the therapist and clients to more immediately demonstrate to all parties how previous relationships unconsciously affect ones in the present. Interpretations, whether individual or interpersonal in nature, are not isolated expressions of meaning making. Collectively, they provide data about a wide range of unconscious experience that, taken together, can be likened to a new narrative. Since the unconscious is viewed as dynamic, an important goal is to help people become more effective explorers of their own inner and interpersonal experience as time continues into the future and after therapy has concluded. For example, if a husband understands how his parents' relationship has informed his own marital relationship, he is better able to separate from any deleterious results to make freer and more personally satisfying decisions in his own marriage. Experiential family therapists are often *confrontational* in an effort to provoke self-discovery or self-examination. ("You always seem to change the subject or make a joke whenever we discuss your sex life together. What's making you so uncomfortable that you need to cover it up?") They may introduce verbal or physical *exercises* (sculpting, role playing, reconstruction) to encourage the expression of feelings and often use *self-disclosure* to stimulate similar open behavior in clients.

Bowenians question, coach, and encourage individual efforts at *self-differentiation* by teaching clients to take "I" positions expressing how they truly feel. Contextual therapists appeal to fairness, promoting the *balancing of the family ledger*. Structuralists work on clarifying *boundary diffusion* and use *enactments* to introduce changes in the family structure. They join and accommodate to the family's interactive style and use *reframing* to relabel a family's perception of an event and make it more conducive to change. Strategists also utilize the reframing technique and, in addition, use *directives* and *paradoxical interventions* to bring about

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change. Milan therapists use *positive connotations* and *circular questioning* to help family members learn about the perceptions of other members.

Behaviorists and cognitive behaviorists attend to the *contingencies of reinforcement*, first observing and analyzing how families reinforce undesirable or problematic behavior. After such a functional analysis, they rely on *skills training* and *cognitive restructuring* to help families modify thoughts about the meaning of an event. Psychoeducational family therapists make use of similar techniques to teach skills to specific populations.

Solution-focused therapists address efforts to arrive at successful solutions by utilizing a variety of techniques—*miracle questions*, *exception-finding questions*, *scaling*. The narrative therapist's trademark is *externalization*, by which the problem is recast as outside the symptom bearer, and the family is united to deal with the oppressive agent. By a series of persistent questions, clients are encouraged to adopt previously subjugated stories that replace negative and self-defeating dominant stories.

LO 6 Crisis, Brief, and Long-Term Family Therapy

All family therapists must be prepared to help families in crisis. Whether dealing with a new referral or a family currently in treatment to whom a crisis occurs, the family therapist must respond without delay, in some cases seeing the family daily (for varying lengths of time) during the crucial period, usually lasting several weeks or less. The discovery of a spouse having an affair, a sudden job loss by the major breadwinner, a suicide attempt by an adolescent, the accidental death of a child—these are crises requiring a quick therapeutic response. In severe situations, such as those involving danger to oneself or others, psychiatric hospitalization may be necessary. In all cases, therapists try to help the family discover its restitutive or resilient forces to reestablish stability, at the same time helping them, whenever possible, develop new and effective coping mechanisms.

Brief family therapy is usually defined as less urgent, and it has an agreed-upon termination point. The duration of most family therapy has become shorter than in the past, particularly in managed care and clinics. Brief or time-limited therapy, say with a marital couple in distress, is highly focused on the presenting problem. Its aims are limited to achieving a specific goal, like establishing more effective ways to resolve differences between spouses or decisions about divorce and child custody arrangements.

Strategic therapists, particularly those at the Brief Therapy Project at the Mental Research Institute, limit treatment to 10 sessions, informing clients at the start as a motivator. Some solution-focused therapists offer still fewer sessions but do not announce a time limit in advance. They immediately work with clients on solutions with the expectations of change using client resources, often requiring a handful of sessions to reach the agreed-upon goals. The Milan group also sets limits on the number of sessions.

Social constructionists and narrative therapists are also oriented to provide brief, problem-driven help, although the length of treatment is not their main concern. Their focus is on language shaping a person's experiences and sense of reality. Correspondingly, they aim their interventions at cognitive changes as clients reconstruct their experiences through developing new stories.

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While there are few long-term family therapies—psychoanalytic couples therapy may be the exception—some approaches contend that change takes time, and thus they require several weeks or even months before therapy termination. Experiential models with vague goals of "growth" or "self-fulfillment" tend to have arbitrary endpoints, letting the family members decide when they wish to stop. Structuralists wait to see how well the family has restructured its dysfunctional sets and how flexible it has become to accommodating change before terminating the sessions. Bowenian therapy, too—with goals of changing a large, extended family system—may be of considerable duration.

In some cases, families with severe and/or multiple problems require long-term help, or perhaps help from time to time extending over years as new and difficult situations arise for them. Long-lasting unresolved problems (persistent bickering, gambling episodes, disputes with in-laws, chronic alcoholism, violence, periodic infidelities, cycling in and out of serious depression) may prolong treatment. In some situations, family therapy may begin as brief but extend to long-term treatment as more underlying conflicts are uncovered. Clients may return to their family therapist, who has become familiar with their problems, for brief visits at different key decision-making phases of their lives if that person has been helpful in the past.

Goals of Treatment

All family therapy models provide an opportunity for change based upon client perceptions of new choices. Differences arise between models in how they go about achieving this goal. Some (psychodynamic) do so by providing insight, some (experiential) by encouraging open communication and emotional expression, some (behavioral/cognitive) by building skills and cognitive restructuring, some by expanding the family system through the use of reflecting teams or outside witness groups. Regardless of procedures, all attempt to create a therapeutic environment conducive to self-examination in order to reduce discomfort and conflict, to mobilize family resilience and empowerment, and to help the family members improve their overall functioning. Table 17.2 compares the different models along several key therapeutic dimensions.

Some models seek extensive changes. Object relations psychoanalysts, for example, identify and help clients gain awareness of introjects from the past that negatively intrude on current ways of dealing with others. More focused in their aspirations, some (solution-focused or strategic) therapists help families solve the immediate problem they came to therapy to resolve; they are content with symptom reduction. Therapists using psychoeducational approaches are satisfied if they can help a family cope with serious disorders and keep its diagnosed member from returning to the hospital (or at least reducing the necessary number of such returns). Narrative therapists cognitively focus on problem resolution but go beyond that, challenging the family to revise its relationship with the problem and encouraging members to re-author their lives in more hopeful ways.

Different theorists have different priorities regarding what requires change. Satir was insistent that family members learn to communicate with greater clarity, asking for what they want and expressing how they feel in a direct and undisguised manner. Whitaker wanted to make certain that what clients said was congruent with what they were experiencing internally

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in an effort to increase authenticity. Both believed clients enhance their ability to live more fulfilled lives as individuals and as a family through self-discovery.

Bowen, in contrast, argued that individuation or self-differentiation was the key to staving off anxiety and avoiding being swept up in the family's emotional system. Structuralists such as Minuchin set out to change those parts of the family system that call for reorganizing—its boundaries, its hierarchy, perhaps its parental subsystem.

Competing family models try to facilitate new ways of perceiving, feeling, and behaving in different ways. Some do so formally, in some cases following step-by-step procedures. Structuralists, for example, join the family, accommodate to its style, assess the family structure, and so forth before making therapeutic moves directed at restructuring flawed parts of the system. Cognitively oriented family therapists also follow prescribed therapeutic formats. Some approaches (solution focused), however, are less structured and pragmatic, aiming their interventions at finding new solutions to presenting complaints, and not particularly concerned about any underlying set of problems. If some models (experiential) have imposing goals (self-actualization), others (strategic) are content with more modest specific aspirations (resolving the presenting problem).

LO 7 A Final Word on Theoretical Integration

We have tried throughout this book to show the rich history of theory and practice in family therapy. By presenting a range of theoretical perspectives and allied clinical approaches, we intended to convey the diversity and rigor of our field.

CHALLENGES IN MIXING THEORIES

In this chapter, we offered several ways to compare different theories, but we did not broach the question of whether theories can fairly be integrated. That is, can we conceive of theories joining in some fashion that does not harm the integrity of each theoretical element or the emerging new theory? If so, will the philosophies that underscore the theories have to be rewritten or merely ignored for the sake of assumed practical convenience? For example, is an evidence-based approach to narrative therapy possible, or is it a contradiction in terms? Would the theorist who advocates such an approach be inspired or theoretically off base? Throughout this book, we offered examples of research and clinical explorations that attempted these kinds of integrations (Coop, Baucom, & Snyder, 2004; Dickerson, 2010; Jacobs, Kassil, Scott, & Davey, 2010; Ramisch, McVicker, & Sahin, 2009).

Let's look at an example that we mentioned in Chapter 13. Ramisch, McVicker, and Sahin (2009) postulated an integration of solution-focused therapy and structural family therapy in working with low-conflict divorced parents in their need to renegotiate appropriate co-parental boundaries and imagine and acquire new parenting goals for radically changed circumstances. Throughout the book, we have indicated that solution-focused therapy is postmodern (avoids any interest in final answers or inviolate meaning) and structural therapy is modern (supports the positivist discovery and articulation of "meaning") in orientation. Can these two apparently opposite positions be integrated?

First the authors utilize a structural approach in "encouraging" the parents to develop appropriate co-parental boundaries that "direct and influence" subsequent interactions among

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TABLE 17.2 A comparison of therapeutic techniques and goals in family therapy

Model	Role of Therapist	Assessment Procedures	Key Methods of Intervention	Insight vs. Action	Title or Derivation	Goals of Treatment
PSYCHO-DYNAMIC	Classical: neutral; blank screen upon whom each family member projects fantasies; contemporary: active and egalitarian participant in translating unconscious dynamics into conscious awareness	Unstructured; ongoing effort to uncover hidden conflict within and between family members	Interpretations regarding the unconscious meaning of individual verbalizations and behavior and their impact on family functioning; mirroring of client's inner experience; appropriate self-disclosure to help make conscious unconscious interpersonal experience	Insight leads to conflict reduction, symptom remediation, enhanced awareness, and improved interpersonal relations.	Psychoanalytic; object relations; self psychology; intersubjective; relational	Individual intrapsychic change; resolution of family pathogenic conflict; detriangulation; removal of projections; individuation; interpsychic change
EXPERIENTIAL	Egalitarian; active facilitator providing family with new experiences through the therapeutic encounter	Unstructured; search for suppressed feelings and impulses that block growth and fulfillment	Confrontation to provoke self-discovery; self-disclosure by therapist models desired behavior; exercises (e.g., sculpting, family reconstruction) to uncover previously unexpressed inner conflicts	Self-awareness of one's immediate existence leads to choice, responsibility, and change.	Symbolic-experiential; gestalt; human; validation; emotionally focused	Simultaneous sense of togetherness and healthy separation and autonomy; genuineness; learning to express one's sense of being; building self-esteem; relieving family pain; overcoming blockages to personal growth; overcoming negative interactive patterns
TRANSGEN-ERATIONAL	Coach; direct but nonconfrontational; detriangulated from family fusion; aids family in developing relational fairness	Family evaluation interviews with any combination of family members; genograms; attention to intergenerational indebtedness	Teaching differentiation; individuation; taking "I" stands; reopening cut-off relations with extended family; balancing family ledgers	Rational processes used to gain insight into current relationships and intergenerational experiences; leads to action with family of origin	Family systems theory; contextual	Anxiety reduction, symptom relief, and increased self-differentiation of individuals leads to family system change; restoration of trust, fairness, ethical responsibility

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STRUCTURAL	Active; stage director manipulates family structure to change dysfunctional sets	Observation of family transactional patterns for clues to family structure; family mapping; enactments; tracking	Joining; accommodating; reframing; helping families create flexible boundaries and integrated subsystems	Action precedes understanding; change in transactional patterns leads to new experiences and corresponding insights	Structural family theory	Restructured family organization; change in dysfunctional transactional patterns; symptom reduction in individual members
STRATEGIC	Active; manipulative; problem focused; prescriptive; paradoxical	Unstructured; search for family's repetitive, destructive behavior patterns and flawed solutions that perpetuate the presenting problem	Paradoxical interventions; prescribing the symptom; therapeutic double binds; directives; pretend techniques; relabeling	Action-oriented; symptom reduction and behavior change brought about through directives rather than insight and understanding	Communication theory; strategic family theory	Symptom relief; resolution of presenting problem
MILAN	Neutral; active therapeutic partner; offers hypotheses as new information for family belief system; use of reflecting team behind one-way mirror	Unstructured; nonmanipulative; collaborates with family in developing systemic hypotheses regarding their problems	Positive connotations; circular questioning; reframing; paradox; invariant prescription; rituals	Emphasis on family gaining new meaning rather than insight or action based on therapist choice of therapeutic outcome	Systemic family theory	System change chosen by family because of new meaning given to their life patterns; interruption of destructive family "games"
BEHAVIORAL/ COGNITIVE	Teacher; trainer; model of desired behavior; contract negotiator	Structured; reliance on formal standardized tests and questionnaires; behavioral analysis before commencing treatment	Reinforcement of desired behaviors; skills training; contingency contracting; positive reciprocity between marital partners as well as parents and children; self-regulated modification of thoughts and activities	Actions taught to reward desired outcomes and ignore or punish undesired behavior; unconcerned with insight	Learning theory; social learning theory; behavioral/ cognitive theory	Modification of behavioral consequences between persons in order to eliminate maladaptive behavior and/or alleviate presenting symptoms; cognitive restructuring

(*Continued*)

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TABLE 17.2 (*Continued*)

Model	Role of Therapist	Assessment Procedures	Key Methods of Intervention	Insight vs. Action	Title or Derivation	Goals of Treatment
SOCIAL CONSTRUCTIONIST	Collaborative; engages in therapeutic conversation; nonexpert co-constructing meaning and understanding	Unstructured; examination of explanations and interpretations families have used to account for their views of "truth"	Solution focus rather than problem focus; miracle questions; exception-finding questions; use of reflecting teams; conversational partners in "dissolving" problem	Emphasis on gaining new meaning through narrative reconstruction of stories families have told about themselves	Social construction theory	Learning and creating new viewpoints by giving new meanings or constructions to old sets of problems
NARRATIVE	Collaborative; help clients rewrite old self-defeating stories, replacing them with empowering stories with multiple options	Unstructured; no privileged position over client's views; do not believe in expert position or correct view of objective reality	Externalization of restraining problem, redefining it as outside the family and unwelcome; search for new options and unique outcomes; use of definitional ceremonies, letters, and supportive leagues	Attempt to achieve cognitive change and give new meaning to co-constructed alternative stories	Narrative theory	Separate person from problem; liberation; re-envision past and rewrite future
PSYCHO-EDUCATIONAL	Builds and maintains supportive, collaborative partnership with family; facilitates family learning management skills	Assessment of family stress level, expressed emotion in order to tailor problem-solving training to each family; identifies problem areas to aid in skills acquisition	Education; social support; skills training; relationship building	Action: developing techniques to reduce rehospitalization for mental disorders; partnership with physicians in healthcare; short-term educational programs	Psycho-educational family therapy; medical family therapy	Harness family strengths and resiliencies to improve their communication patterns and learn more effective coping skills

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family members. Here the therapist takes the lead by encouraging the couple in this direction. The therapist is separate from the couple—not, as postmodernists would insist, part of the group of meaning-making participants. But a question arises. Is the directive therapist role theoretically defensible to the postmodernist (solution-focused) one?

Returning to the example, once these new parental boundaries are firmed up, the authors employ a variation of the miracle question (see Chapter 13) to help parents gain confidence in making changes in their behaviors. The miracle question may help parents set new goals for themselves and increase their ability to communicate within changing family conditions. All of this is, of course, exploratory, and any outcome is quite specific to any given family. The therapist is not directing anything. Is this absence of structure acceptable to the structuralist (modernist)? The authors go on to say that once the miracle question is articulated and explored, the clients should be assessed on a scale of 1 to 10 regarding how close or distant the parents feel to meeting their goals. How do postmodernists view the use of a grading scale? It would seem that there are challenges to integrating models that maintain distinct theoretical orientations.

Sooner or later, all students and practitioners must face or return to the dilemma of whether to ally themselves with one theory or another or, as in the case outlined previously, make ostensibly creative combinations of them. One could argue that the authors of the case presented here offer a creative way of using two theories to address a serious problem. There is no attempt at synthesizing the two; instead they are, as it were, positioned next to each other. The contradictory philosophical underpinnings of each (structure versus open exploration; therapist as authority versus therapist as co-creator of meaning) would seem to be less important than the practical outcome of the combination. One could also argue that the two theories used together are theoretically inconsistent—a theoretically muddled attempt to synthesize modernist and a postmodernist assumptions.

MODELS OF INTEGRATION Dickerson (2010) notes the present-day trend toward integration but argues that integration is possible only between theories and practices that occur within specific epistemologies. She identifies three: (1) individualizing, (2) systems, and (3) poststructural. She asserts that one can integrate theories within each of these epistemologies, and one can "adopt practices and some theoretical concepts across theories and across epistemologies" (which is perhaps the case with the preceding example), but it is theoretically impossible to integrate theories across epistemologies. In short, one can "meaningfully" bring together divergent theories, but in doing so, one cannot consider these admixtures of different theories integrated unless they align under a metatheory that accounts for all the divergent elements now newly reconstituted into a theoretically consonant whole.

In another model, Jacobs, Kassil, Scott, and Davey (2010) argue for a "flexible" approach that "creates synergy" in practice by promoting complementarity between evidence-based practice and postmodern approaches. On the surface, one could scarcely imagine a more discrepant pairing of theories—postmodernism eschewing absolute meaning and evidence-based practice insisting on empirically validated best practices. The authors compare and contrast the two approaches and suggest that the contradictory philosophies inform a "promising"

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direction for flexible adaptations of evidence-based practice that would exchange perceived theoretical rigidities with a more flexible approach.

Lebow (2014) notes a trend toward integration and argues that couple and family therapy has developed "an integrated body of work and one overarching coherent field of endeavor in which clinical decision making is primarily about which concepts and intervention strategies have particular relevance to a particular case or problem, what strategies are most useful at what point in time, and how to create the most coherent and acceptable work with clients" (p. 26). He suggests that unlike pragmatic eclecticism without a conceptual foundation, integration "presumes a more extensive melding of approaches into a metalevel framework that explicates how the component ideas and strategies fit together" (p. 28); such integrated models reflect a comprehensive understanding of change, increased ability to align with particular clients, openness to new treatment ideas, and consistency with the research that indicates the importance of common factors and the lack of demonstrated superiority of any one treatment model (Lebow, 2014, p. 31).

Finally, Integrative Family and Systems Treatment (I-FAST) is gaining prominence as a meta-level approach to treatment for at-risk adolescents that purports to be more adaptable and flexible in real-world treatment environments (Fraser et al., 2014). I-FAST is constructed in three levels: Level 1—theoretical and philosophical constructs from systems theory, social constructivism, and a strengths orientation; Level 2—common factors with demonstrated evidence, like the therapeutic alliance, collaborative interaction with the family, and teamwork with community organizations; and Level 3—practice phases and procedures are defined, including collaboration, a specific goal orientation, monitoring family interaction, initiating change, and building resilience (Fraser et al., 2014, pp. 3–20). There is initial support for the model's effectiveness in lowering the severity of problems and enhancing child client functioning, but research identifies the need to provide support to therapists to develop internal agency expertise for sustainability (Lee et al., 2015).

LO 8 Psychopharmacology and Family Therapy

Before concluding this section, a word should be said about how couples and family therapists—from whatever theoretical orientation—interact with psychopharmacology. Do the various theories have a place for this popular treatment protocol? And if so, how does a respective theory incorporate the use of medication?

Depression is a common presenting problem in family therapy. The National Institute for Mental Health (NIMH) reports in 2011 that more than approximately 15.5 million American adults experience depressive disorders, including major depressive disorder, dysthymic disorder, and bipolar disorder (NIMH, 2011). An astounding 11.2% of children aged 13 to 18 have a diagnosis of depression. By 2020, depression is estimated to become in the United States the second-largest killer after heart disease. Obviously, the treatment of depression has for years included the prescription of antidepressant medication. This being the case, how well or how competently do family therapists work with drug treatments (understanding that unless the therapist is authorized to prescribe medication, he or she will be working with an appropriate medical authority)?

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There is not a great deal of research on this vital question. We don't know qualitatively or quantitatively very much on how narrative, transgenerational, psychoanalytic, social constructionist, and the like practitioners theorize about the role of medication vis-à-vis their theoretical orientation. One study points to a possible reason. Springer and Harris (2010) presented to a large group of AAMFT therapists a clinical scenario that described a client with a depressive episode and asked a series of questions about clinical practice. They determined that 35.7% of the respondents identified medication or a referral for medical treatment constituted a viable treatment option. Fully 80% of the respondents reported that they were inadequately trained about psychotropic medications. This suggests inadequate education and training among family therapists regarding psychotropic medication. Interestingly, many state licenses require medical referrals with certain diagnoses, so family therapists must know this important treatment possibility.

This growing dilemma represents a vital area of further exploration for both clinicians and theorists. What are your views on the use of psychotropic drugs? On the integration of theoretical perspectives? On your own personal theoretical orientation? To help you to think about these questions and to assist you in formulating your own unique theoretical orientation or orientations, see Box 17.1: Thinking Like a Clinician.



BOX 17.1 THINKING LIKE A CLINICIAN

Formulating Your Own Theoretical Orientation

Review Tables 17.1 and 17.2. In the appropriate boxes, indicate a positive and a negative aspect of each of the theoretical perspectives listed at the left, based on the extensive information in this text. This is a personal exercise, so each pro and con should reflect your own worldview (beliefs about the relationship between individual and group; human capacity for evil; degrees of freedom in decisions; mind–body relations; and being-versus-becoming values), philosophy of family therapy, professional goals, values, beliefs, and intellectual and clinical interests (Simon, 2006; Watts, 1993). Consider how you might integrate theoretical aspects or select techniques of other approaches if they mesh with your preferred theory. Rate on a scale of 1 (low) to 5 (high) how much the approach "fits" you. When you are finished, see if you have clarified your own theoretical stance.

THEORY AND PRACTICE	PROS	CONS	MY RATING (1–5)
Psychodynamic			
Experiential			
Transgenerational			
Structural			
Strategic			
Milan			
Behavioral/Cognitive			
Social Constructionist			
Narrative			
Psychoeducational			

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SUMMARY

Overlaps in theory and technique, as well as notable differences, characterize today's models of family therapy. Regardless of model, families need to be looked upon as systems; beyond that, the family must be viewed in the context of its extended family and the community, as well as its cultural, racial, social class, and ethnic attributes.

Family theories differ in their emphasis on units of study (monad, dyad, and triad), depending on their primary focus on the individual family member or the family context. All operate from a dyadic or triadic position, based on the view that people define themselves through their interactions with others. The time frame emphasized might be primarily past, present, or future. All theories draw distinctions between functional and dysfunctional families. Some operate with distinctive ideas of what constitutes normal behavior, based on the past, while others take a here-and-now position in conceptualizing the basis for current difficulties.

Family therapy techniques of intervention can be differentiated by the role of the therapist (ranging from neutral to collaborative) and by the assessment procedures the technique utilizes (ranging from formal to informal appraisals and from longitudinal to cross-sectional emphases). All models attempt to achieve change in the most efficient way; some favor action preceding insight, and some favor the reverse. Family therapy may be crisis oriented, brief, or long term, depending on such factors as urgency, clinic policy, managed-care restrictions, degree of chronicity, or type of intervention. The goals of treatment may be alike for many models but differ in the extensiveness of change they seek and the priorities they give to what requires change. While some approaches are formal and follow set procedures, others are informal, pragmatic, and limited to resolving the presenting complaint.

Although therapists regularly borrow from other theories, there are challenges in combining models, especially if one simply uses a pragmatic eclecticism without a cohesive theoretical frame. The integration of approaches is increasing, especially when evidence-based common factors for change are used as a unifying rationale.

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GLOSSARY

ACCOMMODATING A therapeutic tactic, used primarily by structural family therapists, whereby the therapist attempts to make personal adjustments in adapting to the family style in an effort to build a therapeutic alliance with the family.

ALIGNMENTS Clusters of alliances between family members within the overall family group; affiliations and splits from one another, temporary or permanent, occur in pursuit of homeostasis.

ANOREXIA NERVOSA Prolonged, severe diminution of appetite, particularly although not exclusively in adolescent girls, to the point of becoming life-threatening.

ATTACHMENT The quality of the relationship between infant and principal caregiver that affects a person's sense of self and relationships with others. Attuned attachment between mother and child will likely lead to relatively stable senses of self and others, whereas misattuned or traumatized attachments may lead to disturbed senses of self and relationships with others.

BASELINE A stable, reliable performance level, against which changes, particularly of a behavioral nature, can be compared.

BEHAVIORAL ANALYSIS An assessment procedure in which a therapist identifies the targeted behavior to be changed, determines the factors currently maintaining the behavior, and formulates a treatment plan that includes specific criteria for measuring the success of the change effort.

BEHAVIORAL COUPLES THERAPY Training couples in communication skills, the exchange of positive reinforcements, cognitive restructuring, and problem-solving skills in order to facilitate marital satisfaction.

BEHAVIORAL MODEL The viewpoint that objective and experimentally verified procedures should be the basis for modifying maladaptive, undesired, or problematic behaviors.

BEHAVIORAL PARENT TRAINING Training parents in behavioral principles and the use of contingency-management procedures in altering or modifying undesirable behavior in their children.

BINUCLEAR FAMILY A postdivorced family structure in which the former spouses reside in separate households and function as two separate units; their nuclear family is thus restructured but remains intact.

BIPOLAR DISORDER An affective disorder in which the patient experiences alternating periods of depression and mania.

BLANK SCREEN In psychoanalytic therapy, the passive, neutral, unrevealing behavior of the analyst, onto which the patient may project his or her fantasies.

BOUNDARY An abstract delineation between parts of a system or between systems, typically defined by implicit or explicit rules regarding who may participate and in what manner.

BOUNDARY MAKING A technique of structural family therapists aimed at realigning boundaries within a family by changing the psychological proximity (closer or farther apart) between family subsystems.

CENTRIFUGAL Tending to move outward or away from the center; within a family, forces that push the members apart, especially when the family organization lacks cohesiveness, so that they seek gratification outside, rather than within, the family.

CENTRIPETAL Tending to move toward the center; within a family, forces that bind or otherwise keep the members together so that they seek fulfillment from intrafamilial rather than outside relationships.

CERTIFICATION A statutory process established by a government agency, usually a state or province, allowing persons who have met predetermined qualifications to call themselves by a particular title and prohibiting the use of that title without a certificate.

CIRCULAR CAUSALITY The view that causality is nonlinear, occurring instead within a relationship context and through a network of interacting loops; any cause is thus seen as an effect of a prior cause, as in the interactions within families.

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CIRCULAR QUESTIONING An interviewing technique, first formulated by Milan systemic therapists, aimed at eliciting differences in perception about events or relationships from different family members, particularly regarding points in the family life cycle when significant coalition shifts and adaptations occurred.

CLASSICAL CONDITIONING A form of learning in which a previously neutral stimulus, through repeated pairing with a stimulus that ordinarily elicits a response, eventually elicits the response by itself.

CLOSED SYSTEM A self-contained system with impermeable boundaries, operating without interactions outside the system, resistant to change and thus prone to increasing disorder.

CO-THERAPY The simultaneous involvement of two therapists, often for training purposes, in working with an individual, couple, or family.

COALITIONS Covert alliances or affiliations, temporary or longterm, between certain family members against others in the family.

COGNITIVE BEHAVIORAL THERAPY A set of therapeutic procedures, derived from behavior therapy, that attempts to change behavior by modifying or altering faulty thought patterns or destructive self-verbalizations.

COGNITIVE MODEL Pertaining to mental processes, such as thinking, remembering, perceiving, expecting, and planning.

COGNITIVE RESTRUCTURING An intervention procedure whereby the therapist attempts to modify client thoughts, perceptions, and attributions about an event.

COMPLEMENTARITY The degree of harmony in the meshing of family roles, as between husband and wife; to the extent that the roles dovetail satisfactorily, the partners both are able, together, to provide and receive satisfaction from the relationship.

COMPLEMENTARY A type of dyadic transaction or communication pattern in which inequality and the maximization of differences exist (for example, dominant/submissive) and in which each participant's response provokes or enhances a counterresponse in the other in a continuing loop.

CONDUCTOR A type of family therapist who is active, aggressive, and charismatic, openly and directly confronting the family's dysfunctional interactive patterns.

CONFIDENTIALITY An ethical standard aimed at protecting client privacy by ensuring that information received in a therapeutic relationship will not be disclosed without prior client consent.

CONJOINT Involving two or more family members seen together in a therapy session.

CONJOINT SEX THERAPY Therapeutic intervention with a couple in an effort to treat their sexual dysfunction.

CONSTRUCTIVISM The belief that an individual's knowledge of reality results from his or her subjective perceiving and subsequent constructing or inventing of the world rather than resulting from how the world objectively exists.

CONTEXTUAL Pertaining to circumstances or situations in which an event took place; as a therapeutic approach, an emphasis on the relational determinants, entitlements, and indebtedness across generations that bind families together.

CONTINGENCY CONTRACT An agreement, usually in written form, made by two or more family members specifying the circumstances under which each is to do something for the other so that they may exchange rewarding behavior.

CONTINUING EDUCATION Voluntary or, increasingly, mandated postgraduate training, typically in the form of workshops and in-service training programs.

COUNTERPARADOX In systemic family therapy, placing the family in a therapeutic double bind in order to counter the members' paradoxical interactions.

COUNTERTRANSFERENCE According to psychoanalytic theory, the analyst's unconscious emotional responses to a patient that are reminiscent of feelings he or she experienced with a person in the past.

CULTURE Shared behaviors, meanings, symbols, and values transmitted from one generation to the next.

CYBERNETIC The study of methods of feedback control within a system, especially the flow of information through feedback loops.

DECONSTRUCTION A postmodern procedure for gaining meaning by reexamining assumptions previously taken for granted, in the service of constructing new and unencumbered meanings.

DEFENSE MECHANISM According to psychoanalytic theory, the process, usually unconscious, whereby the ego protects the individual from conscious awareness of threatening and therefore anxiety-producing thoughts, feelings, and impulses.

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DETRIANGULATE The process of withdrawing from a family role of buffer or go-between with one's parents so as to not be drawn into alliances with one against the other.

DEVELOPMENTAL TASKS Problems to be overcome and conflicts to be mastered at various stages of the life cycle, enabling movement to the next developmental stage.

DIFFERENTIATION OF SELF According to Bowen, the separation of one's intellectual and emotional functioning; the greater the distinction, the better one is able to resist being overwhelmed by the emotional reactivity of his or her family, thus making one less prone to dysfunction.

DISENGAGEMENT A family organization with overly rigid boundaries, in which members are isolated and feel unconnected to each other, with each functioning separately and autonomously and without involvement in the day-to-day transactions within the family.

DOUBLE-BIND The view that an individual who receives important contradictory injunctions at different levels of abstraction—about which he or she is unable to comment or escape—is in a no-win, conflict-producing situation.

DRIVE THEORY The psychoanalytic theory that instinctual forces such as sex or aggression create tension states that motivate the individual to take action to lessen the tension.

DYAD A liaison, temporary or permanent, between two persons.

E-THERAPY Therapy that involves the use of the Internet.

ECOMAP An appraisal tool designed to graphically depict a family's connections with outside agencies and institutions, enabling the therapist to examine pictorially those relationship bonds that connect the family to these systems.

EGO According to psychoanalytic theory, the mediator between the demands of the instinctual drives (id) and the social prohibitions (superego); thus, the rational, problem-solving aspect of personality.

EMOTIONAL CUTOFF The flight from unresolved emotional ties to one's family of origin, typically manifested by withdrawing or running away from the parental family or denying its current importance in one's life.

EMOTIONALLY FOCUSED THERAPY (EFT) An experiential approach, based on humanistic, systemic foundations and attachment theory, that attempts to change a couple's or family's negative interactions while helping them to cement their emotional bond.

ENACTMENT In structural family therapy, a facilitating intervention in which the family is induced by the therapist to enact or play out its relationship patterns spontaneously during a therapeutic session, allowing the therapist to observe and ultimately to develop a plan or new set of rules for restructuring future transactions.

ENCOUNTER GROUP A kind of therapeutic group in which intense interpersonal experiences are promoted in order to produce insight, personal growth, and sensitivity to the feelings and experiences of others.

ENMESHMENT A family organization in which boundaries between members are blurred and members are overconcerned and overinvolved in each other's lives, limiting individual autonomy.

ENTROPY The tendency of a system to go into disorder, and, if unimpeded, to reach a disorganized and undifferentiated state.

EPISTEMOLOGY The study of the origin, nature, and methods, as well as the limits, of knowledge; thus, a framework for describing and conceptualizing what is being observed and experienced.

ETHNICITY The defining characteristics of a social grouping sharing cultural traditions, transmitted over generations and reinforced by the expectations of the subgroup in which the individual or family maintains membership.

EXCEPTIONS In solution-focused therapy, attention to the times when the problem did not occur, intended to help build problem-solving skills.

EXPERIENTIAL MODEL An approach to family therapy that accounts for the unique conflicts and behavior patterns of each family from a psychodynamically informed or Gestalt perspective.

EXPRESSED EMOTION The degree of affect expressed within a family, especially noteworthy in families with schizophrenic members, where emotionally intense and negative interactions are considered a factor in the schizophrenic's relapse.

EXTERNALIZATION In the narrative approach, helping families view the problem or symptom as occurring outside themselves in an effort to mobilize them to fight to overcome it.

FAMILY CRISIS THERAPY A crisis-oriented therapeutic approach in which the family as a system is helped to restore its previous level of functioning; in some cases, as with schizophrenia, rehospitalization can be avoided.

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FAMILY GROUP THERAPY The intervention technique developed by Bell based on social-psychological principles of small-group behavior.

FAMILY LEDGER A concept and therapeutic technique from transgenerational models of therapy that denotes a multigenerational accounting system of what has been given and who, psychologically speaking, still owes what to whom.

FAMILY LIFE CYCLE The series of longitudinal stages or events that mark a family's life, offering an organizing schema for viewing the family as a system proceeding through time.

FAMILY LIFE FACT CHRONOLOGY An experiential technique of Satir's in which clients retrace their family history, particularly the family's relationship patterns, to better understand current family functioning.

FAMILY MAPPING An assessment technique used by structural family therapists to graphically describe a family's overall organizational structure and determine which subsystem is involved in dysfunctional transactions.

FAMILY PROJECTION PROCESS The mechanism by which parental conflicts and immaturities are transmitted, through the process of projection, to one or more of the children.

FAMILY RECONSTRUCTION An auxiliary therapeutic approach developed by Satir, whereby family members are guided back through stages of their lives in order to discover and unlock dysfunctional patterns from the past.

FAMILY SCULPTING A physical arrangement of the members of a family in space, with the placement of each person determined by an individual family member acting as "director"; the resulting tableau represents that person's symbolic view of family relationships.

FAMILY SYSTEMS THEORY The theory advanced by Bowen that emphasizes the family as an emotional unit or network of interlocking relationships best understood from a historical or transgenerational perspective.

FEEDBACK The reinsertion into a system of the results of its past performance as a method of controlling the system.

FEEDBACK LOOPS Those circular mechanisms by which information about a system's output is continuously reintroduced into the system, initiating a chain of subsequent events.

FEMINIST FAMILY THERAPY A form of collaborative, egalitarian, nonsexist intervention, applicable to both men and women, addressing family gender roles, patriarchal attitudes, and social and economic inequalities in male–female relationships.

FIRST-ORDER CHANGES Temporary or superficial changes within a system that do not alter the basic organization of the system itself.

FIRST-ORDER CYBERNETICS A view from outside the system of the feedback loops and homeostatic mechanisms that transpire within a system.

FUNCTIONAL ANALYSIS A behavioral assessment of a problem in order to determine what interpersonal or environmental contingencies elicit the problematic behavior and how to extinguish or reduce its occurrence.

FUNCTIONAL FAMILY THERAPY A therapeutic approach based on systems theory, cognitive theory, and behavioral principles in which clients are helped to understand the function or interpersonal payoff of certain of their behaviors as a prelude to substituting more effective ways to achieve the same results.

FUSION The merging of the intellectual and emotional aspects of a family member, paralleling the degree to which that person is caught up in and loses a separate sense of self in family relationships.

GENDER A learned set of culturally prescribed attitudes and behaviors presumed to be masculine or feminine, associated with but distinct from the biological status of being male or female.

GENDER-SENSITIVE FAMILY THERAPY A therapeutic perspective, regardless of theoretical persuasion, that examines the impact of gender socialization on the outlooks, attitudes, behaviors, and interpersonal relationships of men and women; its aim is to empower clients to make sexist-free role choices rather than be limited by roles determined by their biological status as male or female.

GENOGRAM A schematic diagram of a family's relationship system in the form of a genetic tree and usually including at least three generations; used in particular by Bowen and his followers to trace recurring behavior patterns within the family.

GESTALT FAMILY THERAPY A form of experiential family therapy, loosely based on the principles of Gestalt psychology, that focuses on here-and-now experiences in an effort to heighten self-awareness and increase self-direction.

HOLDING ENVIRONMENT A psychoanalytic concept referring to a therapeutic space analogous to the mother–infant environment that allows the patient to

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safely explore feelings and thoughts, often with a sense of play.

HOMEOSTASIS A dynamic state of balance or equilibrium in a system or a tendency toward achieving and maintaining such a state in an effort to ensure a stable environment.

HUMAN VALIDATION PROCESS MODEL A model of family therapy that emphasizes the collaborative efforts of therapist and family members to achieve family "wellness" by releasing the potential viewed as inherent in every family.

HUMANISTIC The life-affirming view that emphasizes each person's uniqueness and worth, as well as potential for continued personal growth and fulfillment.

HYPOTHESIZING As used by systemic therapists, the process by which a team of therapists forms suppositions, open to revision, regarding how and why a family's problems have developed and persisted; to facilitate asking relevant questions and organizing incoming information, it occurs before meeting the family.

IDENTIFIED PATIENT (IP) The family member with the presenting symptom; thus, the person who initially seeks treatment or for whom treatment is sought.

INFORMATION PROCESSING The gathering, distilling, organizing, storing, and retrieving of information through a system or between that system and larger systems.

INFORMED CONSENT The legal rights of patients or research subjects to be told of the purposes and risks involved before agreeing to participate.

INTEGRATIVE COUPLES THERAPY A behaviorally based technique emphasizing the emotional acceptance of behavior in a partner who is not open to change.

INTERPERSONAL Interactional, as between persons.

INTERPRETATION In psychoanalysis, a primary tool for solving psychical symptoms by which unconscious conflicts are made conscious via verbal expression. To be effective, the analyst must time the interpretation to the point when the client can receive and process it.

INTERSYSTEM APPROACH A cognitive-affective-behavioral systemic model proposed by Geral Weeks to provide a theoretical foundation for sex therapy. It incorporates many contextual factors in the understanding of sexual functioning instead of focusing on techniques alone.

INTERSUBJECTIVE FIELD The interactive space that involves both the therapist and client in which both parties are implicated in unconscious or psychodynamic intimacy, exploration, and change.

INTRAPSYCHIC Within the mind or psyche; used especially in regard to conflicting forces.

INTROJECTS Imprints or memories from the past, usually based on unresolved relationships with one's parents, that continue to impose themselves on current relationships, particularly with one's spouse or children.

INVISIBLE LOYALTY In contextual family therapy, a child's unconscious commitment to help the parents, as in becoming the family scapegoat.

JOINING The therapeutic tactic of entering a family system by engaging its separate members and subsystems, gaining access in order to explore and ultimately to help modify dysfunctional aspects of that system.

JOINT LEGAL CUSTODY A term used in the law to denote the rights of divorced parents to share in certain major decisions (e.g., religious upbringing or choice of schools) regarding their children.

LICENSING A statutory process established by a government agency, usually a state or province, granting permission to persons having met predetermined qualifications to practice a specific profession.

LINEAR CAUSALITY The view that a nonreciprocal relationship exists between events in a sequence, so that one event causes the next event, but not vice versa.

MALPRACTICE A legal concept addressing the failure to provide a level of professional skill or render a level of professional services ordinarily expected of professionals in a similar situation.

MANAGED CARE A system in which third-party payors regulate and control the cost, quality, and terms of treatment of medical (including mental health) services.

MARITAL QUID PRO QUO An initial rule arrangement or bargain between husband and wife regarding the ways in which they intend to define themselves vis-à-vis one another in the marital relationship.

MARITAL SCHISM A disturbed marital situation characterized by family disharmony, self-preoccupation, the undermining of the spouse, and frequent threats of divorce by one or both partners.

MARITAL SKEW A disturbed marital situation in which one partner dominates the family to an extreme degree and in which the marriage is maintained at the expense of the distortion of reality.

MEDICAL FAMILY THERAPY A form of psychoeducational family therapy involving collaboration with physicians and other healthcare professionals in the treatment of persons or families with health problems.

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METACOMMUNICATION A message about a message, typically nonverbal (a smile, a shrug, a nod, a wink), offered simultaneously with a verbal message, structuring, qualifying, or adding meaning to that message.

METARULES A family's unstated rules regarding how to interpret or, if necessary, to change its rules.

MILAN SYSTEMIC MODEL An approach to family therapy with origins in the strategic tradition that adapted postmodern/second-order cybernetics perspectives designed to help families examine their own thoughts, attitudes, beliefs, and the meanings they attach to their own behaviors.

MIMESIS A tactic used particularly by structural family therapists, who attempt to copy or mimic a family's communication and behavioral patterns in order to gain acceptance by the family members.

MIRRORING A psychoanalytic technique in which aspects of the client's inner life are reflected back in a nonjudgmental way to strengthen a sense of self and encourage self-esteem. Mirroring is not empathy, as the former is used to normalize behavior rather than simply understanding it.

MONAD Properties or characteristics of a single individual.

MULTIGENERATIONAL TRANSMISSION PROCESS The process, occurring over several generations, in which poorly differentiated persons marry similarly differentiated mates, ultimately resulting in off spring suffering from schizophrenia or other severe mental disorders.

MULTIPLE FAMILY THERAPY A form of therapy in which members of several families meet together as a group to work on individual as well as family problems.

MULTIPLE IMPACT THERAPY A crisis-focused form of intervention in which members of a single family are seen all together or in various combinations for intensive interaction with a team of professionals over a 2-day period.

NARCISSISTIC PERSONALITY DISORDER A pattern of outlandish self-investment and exhibitionistic recognition seeking in which the individual attempts to evoke attention and admiration from others but is himself or herself unable or unwilling to empathize with their needs or desires.

NARRATIVE THERAPY A postmodern therapeutic approach in which the therapist and family members co-construct new stories about their lives that encourage the possibility of new experiences.

NEGATIVE FEEDBACK The flow of corrective information from the output of a system back into the system in order to attenuate deviation and keep the system functioning within prescribed limits.

NEGENTROPY The tendency of a system to remain flexible and open to new input, necessary for change and survival of the system.

NETWORK THERAPY A form of therapy, typically carried out in the home of a patient (for example, a schizophrenic recently discharged from a hospital), in which family members, friends, neighbors, and other involved persons participate in treatment and rehabilitation.

NEUTRALITY As used by systemic family therapists, a nonjudgmental and impartial position, eliciting all viewpoints, intended to enable the therapist to avoid being caught up in family "games" through coalitions or alliances.

NUCLEAR FAMILY A family composed of a husband, wife, and their off spring, living together as a family unit.

NUCLEAR FAMILY EMOTIONAL SYSTEM An unstable, fused family's way of coping with stress, typically resulting in marital conflict, dysfunction in a spouse, or psychological impairment of a child; their pattern is likely to mimic the patterns of past generations and to be repeated in future generations.

OBJECT RELATIONS THEORY The theory that the basic human motive is the search for satisfying object (human) relationships and that parent–child patterns, especially if frustrating or unfulfilling, are internalized as introjects and unconsciously imposed on current family relationships.

ONE-PERSON PSYCHOLOGY A phrase referring to the classical psychoanalytic understanding of the analyst and patient being distinctly separate people, with the analyst in possession of objective knowledge about the patient that is imparted to her or him via interpretation and other interventions. (See *two-person psychology.*)

OPEN SYSTEM A system with more or less permeable boundaries that permits interaction between the system's component parts or subsystems and outside influences.

OPERANT CONDITIONING A form of learning in which correct or desired responses are rewarded or reinforced, thus increasing the probability that these responses will recur.

OPERANT INTERPERSONAL THERAPY A marital therapy approach based on operant conditioning theory, particularly the exchange between partners of positive rewards.

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ORGANIZATION The notion that the components of a system relate to each other in some consistent fashion and that the system is structured by those relationships.

ORGANIZING PRINCIPLES In intersubjective psychoanalysis, the mutually informing unconscious patterns established by client and analyst that structure their experiences together.

PARADIGM A set of assumptions delimiting an area to be investigated scientifically and specifying the methods to be used to collect and interpret the forthcoming data.

PARADOXICAL INJUNCTION A communication to obey a command that is internally inconsistent and contradictory, as in a double-bind message, forcing the receiver to disobey in order to obey.

PARADOXICAL INTERVENTION A therapeutic technique whereby a therapist gives a client or family a directive he or she wants resisted; as a result of defying the directive, a change takes place.

PEER REVIEW A process of assessing another therapist's professional procedures or intended procedures; under managed-care contracts, such evaluations in a case-by-case procedure are performed by a case management coordinator representing a third-party payor.

PERMEABILITY The ease or flexibility with which members can cross subsystem boundaries within the family.

PHENOMENOLOGICAL The view that to fully understand the causes of another person's behavior requires an understanding not of the physical or objective reality of the person's world but of how he or she subjectively experiences that world.

POSITIVE CONNOTATION A reframing technique used primarily by systemic family therapists whereby positive motives are ascribed to family behavior patterns because these patterns help maintain family balance and cohesion; as a result, the family is helped to view each other's motives more positively.

POSITIVE FEEDBACK The flow of information from the output of a system back into the system in order to amplify deviation from the state of equilibrium, thus leading to instability and change.

POSTMODERN(ISM) A philosophical outlook rejecting the notion that there exists an objectively knowable universe discoverable by impartial science and instead arguing that there are multiple views of reality ungoverned by universal laws.

POWER Influence, authority, and control over an outcome.

PRESCRIBING THE SYMPTOM A paradoxical technique in which the client is directed to voluntarily engage in the symptomatic behavior; as a result, the client is put in the position of rebelling and abandoning the symptom or obeying, thereby admitting it is under voluntary control.

PROBLEM ANALYSIS An investigation of a presenting problem, typically carried out by behaviorists, in order to determine as precisely as possible what behavioral deficiencies require targeting.

PROJECTIVE IDENTIFICATION An unconscious defense mechanism whereby certain unwanted aspects of oneself are attributed to another person (e.g., a spouse), who is then induced or incited to behave according to the first person's projected but split-off feelings.

PSEUDOHOSTILITY A process by which families employ bickering and turmoil to maintain their relationship, avoiding tenderness and covering up deeper feelings, often of greater underlying hostility.

PSEUDOMUTUALITY A homeostasis-seeking relationship between and among family members that gives the surface appearance of being open, mutually understanding, and satisfying, when in fact it is not.

PSYCHOANALYSIS A comprehensive theory of personality development and set of therapeutic techniques developed by Sigmund Freud in the early 1900s.

PSYCHODRAMA A form of group therapy in which participants roleplay themselves or significant others in their lives to achieve catharsis or to resolve conflicts and gain greater spontaneity.

PSYCHODYNAMICS The interplay of opposing forces within an individual as the basis for understanding that person's motivation.

PSYCHOPATHOLOGY A disease concept derived from medicine, referring to the origins of abnormal behavior.

PUNCTUATION The communication concept that each participant in a transaction believes whatever he or she says is caused by what the other says, in effect holding the other responsible for his or her reactions.

REACTOR Therapist whose style is subtle and indirect and who prefers to observe and clarify the family process rather than serve as an active, aggressive, or colorful group leader.

REDUNDANCY PRINCIPLE Repetitive behavioral sequences within a family.

REFLECTING TEAMS A process involving two-way mirrors in which team members observe a family and then

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discuss their thoughts and observations in front of the family and therapist. Later, the therapist and family discuss the team's conversations about them.

REFRAMING Relabeling behavior by putting it into a new, more positive perspective ("Mother is trying to help" rather than "She's intrusive"), thus altering the context in which it is perceived and inviting new responses to the same behavior.

REINFORCEMENT A response, in the form of a reward or punishment, intended to change the probability of the occurrence of a previous response.

RELABELING Verbal redefinition of an event in order to make dysfunctional behavior seem more reasonable and understandable, intended to provoke in others a more positive reaction to that behavior.

RELATIONAL ETHICS In contextual family therapy, the overall, long-term preservation of fairness within a family, ensuring that each member's basic interests are taken into account by other family members.

RESILIENCY The ability to maintain stability and rebound in response to loss or trauma.

RESISTANCE A psychoanalytic concept that accounts for the unconscious opposition to therapeutic change.

RITUALS Symbolic ceremonial prescriptions offered by a therapist, intended to address family conflict over its covert rules, to be enacted by the family in order to provide clarity or insight into their roles and relationships.

RUBBER FENCE As proposed by Wynne, a shifting boundary around a family, intended to protect them from outside contact, arbitrarily permitting certain acceptable bits of information to penetrate but not others.

SCHEMAS Relatively stable cognitive structures involving underlying core beliefs a person develops about the world.

SCHIZOID The inability to form social relationships or to concern oneself with the desires, needs, or feelings of others.

SCHIZOPHRENIA A group of severe mental disorders characterized by withdrawal from reality, blunted or inappropriate emotion, delusions, hallucinations, incoherent thought and speech, and an overall breakdown in personal and social functioning.

SCHIZOPHRENOGENIC MOTHER According to Fromm-Reichmann, a cold, domineering, possessive but rejecting mother (usually married to an inadequate, passive husband) whose behavior toward her son is thought to be a determining factor in his schizophrenic behavior.

SECOND-ORDER CHANGES Fundamental changes in a system's organization, function, and frame of reference, leading to permanent change in its interactive patterns.

SECOND-ORDER CYBERNETICS A view of an observing system in which the therapist, rather than attempting to describe the system by being an outside observer, is part of what is being observed and treated.

SELF PSYCHOLOGY An object relations–based theory, advanced by Kohut, that emphasizes the role of narcissism in forming an authentic and coherent sense of self.

SELF OBJECTS According to Kohut, unconscious images or representations of another person or object viewed by infants as extensions of themselves while they are in the process of gaining self-esteem.

SHAPING A form of behavioral therapy, based on operant conditioning principles, in which successive approximations of desired behavior are reinforced until the desired behavior is achieved.

SIBLING POSITION The birth order of children in a family, which influences their personalities as well as their interactions with future spouses.

SOCIAL LEARNING THEORY The theory that a person's behavior is best understood when the conditions under which the behavior is learned are taken into account.

SOCIETAL REGRESSION Bowen's notion that society responds emotionally in periods of stress and anxiety, offering short-term "Band-Aid" solutions, rather than seeking more rational solutions that lead to greater individuation.

SPLITTING According to object relations theory, a primitive process by which an infant makes contradictory aspects of a mother or other nurturing figure less threatening by dividing the external person into a good object and a bad object and internalizing the split perception.

STEPFAMILY A linked family system created by the marriage of two persons, one or both of whom has been previously married, in which one or more children from the earlier marriage(s) live with the remarried couple.

STRATEGIC THERAPIES A therapeutic approach in which the therapist develops a specific plan or strategy and designs interventions aimed at solving the presenting problem.

STRUCTURAL APPROACH A therapeutic modeldirected at changing or realigning the family organization or structure in order to alter dysfunctional transactions and clarify subsystem boundaries.

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SUBSYSTEM An organized, coexisting component within an overall system having its own autonomous functions as well as a specified role in the operation of the larger system; within families, a member can belong to a number of such units.

SUPRASYSTEM A higher-level system in which other systems represent component parts and play subsystem roles.

SYMBIOSIS An intense attachment between two or more individuals, such as a mother and child, to the extent that the boundaries between them become blurred, and they respond as one.

SYMBOLIC-EXPERIENTIAL FAMILY THERAPY (S-EFT) MODEL A multigenerational approach that uses therapy to address both individual and family relational patterns. The therapist assumes a pivotal role in helping family members dislodge rigid and repetitive ways of interacting by substituting more spontaneous and flexible ways of accepting and dealing with their impulses.

SYMMETRICAL A type of dyadic transaction or communication pattern characterized by equality and the minimization of differences; each participant's response provokes a similar response in the other, sometimes in a competitive fashion.

SYMMETRICAL ESCALATION A spiraling competitive effect in the communication between two people whose relationship is based on equality so that vindictiveness leads to greater vindictiveness in return, viciousness to greater viciousness, and so forth.

SYSTEM A set of interacting units or component parts that together make up a whole arrangement or organization.

SYSTEMIC FAMILY THERAPY A Milan-model therapeutic approach in which the family, as an evolving system, is viewed as continuing to use an old epistemology thatno longer fits its current behavior patterns; the therapist indirectly introduces new information into the family system and encourages alternative epistemologies to develop.

SYSTEMIC THINKING A cognitive reorientation that uses a systemic paradigm to organize thinking in therapeutic problem solving. Systemic therapists develop mental habits that enhance their ability to identify systemic elements and intervene effectively in systems.

SYSTEMS THEORY A generic term in common use, encompassing general systems theory and cybernetics, referring to the view of interacting units or elements making up the organized whole.

THERAPEUTIC CONTRACTS As used by behavioral family therapists, written negotiated agreements between family members to make specific behavior changes in the future.

THERAPEUTIC DOUBLE BIND A general term that describes a variety of paradoxical techniques used to change entrenched family patterns.

"THIRD WAVE" OF BEHAVIORAL THERAPY Contemporary behavioral therapies that shift from a sole emphasis on behavioral change to incorporate acceptance, emotion, and mindfulness.

TIME OUT A behavioral technique for extinguishing undesirable or inappropriate behavior by removing the reinforcing consequences of that behavior; the procedure is used primarily with children.

TOKENS A behavioral technique in which tokens (points, gold stars) are dispensed contingent upon the successful completion of previously designated desired behaviors; the accumulated tokens can be redeemed later for money or special privileges.

TRACKING A therapeutic tactic associated with structural family therapy in which the therapist deliberately attends to the symbols, style, language, and values of the family, using them to influence the family's transactional patterns.

TRANSFERENCE In psychoanalytic treatment, the unconscious shifting onto the analyst of a patient's feelings, drives, attitudes, and fantasies, displaced from unresolved reactions to significant persons in the patient's past.

TRANSGENERATIONAL APPROACHES In family therapy, these models accent how current family patterns, alliances, and boundaries are embedded in unresolved issues from the families of origin.

TRIAD A three-person set of relationships.

TRIANGLE A three-person system, the smallest stable emotional system; according to Bowen, a two-person emotional system, under stress, will recruit a third person into the system to lower the intensity and anxiety and gain stability.

TRIANGULATION A process in which each parent demands that a child ally with him or her against the other parent during parental conflict.

TWO-PERSON PSYCHOLOGY A term from more contemporary forms of psychoanalysis and psychodynamic psychotherapy that recognizes the

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mutuality—unconscious and conscious—in the therapeutic dyad that leads to co-constructed therapeutic gains. (See *one-person psychology*.)

UNBALANCING In structural family therapy, a technique for altering the hierarchical relationship between members of a system or subsystem by supporting one member and thus upsetting family homeostasis.

UNDIFFERENTIATED FAMILY EGO MASS Bowen's term for an intense, symbiotic nuclear family relationship; an individual sense of self fails to develop in members because of the existing fusion or emotional "stuck-togetherness."

UNIQUE OUTCOMES In narrative therapy, those instances when the client did not experience the problem; such outcomes are intended to help contradict a client's problem-saturated outlook.

WHOLENESS The systems view that combining units, components, or elements produces an entity greater than the sum of its parts.

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