therapy that has had its greatest success with psychotic and anorectic patients. Selvini-Palazzoli (1986) believed behavioral symptoms in families represent "dirty games" in which parents and symptomatic children engage in power struggles, the children using their symptoms to try to defeat one parent for the sake of the other. Boscolo and Cecchin (Boscolo, Cecchin, Hoffman, & Penn, 1987) in particular have refined a number of interviewing techniques, such as *circular questioning,* to help family members examine their family belief system in the process of helping empower them to exercise their prerogative of making new choices for their lives. Boscolo and Cecchin offer a systemic epistemology based on second-order cybernetics in which the therapist, rather than attempting to describe the family system as an outside observer, is viewed as part of what is being observed and treated. Like other participants, the therapist is seen as someone with a particular perspective but not a truly objective view of the family or what is best for it. Their approach enhanced the development of the postmodern-influenced social construction therapies.

Cognitive–Behavior Family Therapy

The behavioral perspective—the idea that maladaptive or problematic behavior can be extinguished as the contingencies of reinforcement for that behavior are altered—has been expanded in recent years by including a cognitive viewpoint (Beck & Weishaar, 2005; Berg, Dolan, & Trepper, 2008; Ellis & Dryden, 2007). Working with couples or offering training in parenting skills, cognitive restructuring is designed to help clients overcome dysfunctional beliefs, attitudes, or expectations and to replace their self-defeating thoughts and perceptions with more positive self-statements about themselves and their future. Beyond changing current distorted beliefs, clients are taught how better to evaluate all beliefs. Cognitively based couples therapy is directed at restructuring distorted beliefs (called *schemas*) learned early in life (from the family of origin, the mass media, and/or the family's ethnic and socioeconomic subculture). These negative schemas affect automatic thoughts and emotional responses to others and call for cognitive restructuring to modify or alter faulty perceptions. (Wills, 2009).

Social Constructionist Family Therapy

Influenced primarily by postmodern thinking, social constructionists are at the forefront of challenging systems thinking, especially the simple cybernetic model presented by the early family therapists. They contend that each of our perceptions is not an exact duplication of the world but, rather, a point of view seen through the limiting lens of our assumptions about people. The view of reality each of us constructs is mediated through language and is socially determined through our relationships with others and with the culture's shared set of assumptions. Valuing diversity, these therapists maintain that ethnicity, cultural considerations, gender issues, sexual orientation, and so forth must be addressed in determining a family's functioning level.

Family therapy from a social constructionist outlook requires collaboration between therapist and family members without preconceived notions of what constitutes a functional family or how a particular family should change. Instead, therapist and family members together examine the belief systems that form the basis for the meaning they give to events, and then they jointly construct new options that change past accounts of their lives and allow them to consider new alternatives that offer greater promise. Leading proponents of this view included Steve de Shazer (1991), Berg (Berg, Dolan, & Trepper, 2007) (*solution-focused therapy*) and Harlene Anderson (1997) (*collaborative language systems approach*).

Narrative Therapy

Narrative therapists such as Michael White (1995) argue that our sense of reality is organized and maintained through the stories by which we circulate knowledge about ourselves and the outside world. Families who present negative, dead-end stories about themselves typically feel overwhelmed, inadequate, defeated, and without future choices. Their self-narratives concede being beaten and fail to provide options that would allow change. The dominant cultural narratives also make them feel they cannot live up to what is expected of them. Therapeutic help comes in the form of learning to reduce the power of problem-saturated stories and reclaiming their lives by substituting previously subjugated stories in which they were successful. The therapist's role is not to help clients replace one story with another but to help them view life as multistoried, with numerous options and possibilities.

Narrative therapists are concerned not with how family patterns produced the problem but with how the problem affected the family. The therapist's task, according to narrative therapists, is to help liberate families from such feelings of hopelessness by collaborating with them in exploring alternative stories, making new assumptions about themselves, and opening them up to new possibilities by re-authoring their stories. *Externalization* (viewing the problem as outside themselves rather than as an internal part of their identity) helps them notice alternative choices and paves the way for alternative stories.

White is especially interested in helping clients reexamine the oppressive stories that formed the basis for how they have lived their lives and in working with them to construct new alternatives, whereas de Shazer helps clients view their problems differently, engaging them in dialogue directed at finding new and empowering solutions.

PERSONALITY

Family therapists as a group do not subscribe to a single, unified theory of personality, though all view individual development as embedded in the context of family life. Expanding on Sullivan's (1953) emphasis on the role of interpersonal relationships in personality development, family therapists believe that behavior is the product of one's relationships with others. Symptomatic conduct in any individual family member is a response to that person's current situation, although it may have its roots in past experiences within the family.

Theory of Personality

Clinicians who adopt a family systems outlook have varying theoretical bases. Individual personality is not overlooked but is instead recast as a unit of a larger system, the family, which in turn is seen as part of a larger societal system. Nevertheless, family therapists remain aware that no matter how much individual behavior is related to and dependent on the behavior of others in the family system, individual family members remain flesh-and-blood persons with unique experiences, private hopes, ambitions, outlooks, expectations, and potentials (Nichols, 1987). Most family therapists try to remain focused on family interaction without losing sight of the singularity of the individual. The ultimate goal is to benefit all those who make up the family.

How a therapist views personality development depends largely on her or his initial theoretical framework. In keeping with their psychoanalytic roots, object relations theorists (Hughes, 2007) believe that people's fundamental need is for attachments—seeking closeness and emotional bonding to others, based on how needy or insecure they are as adults as a result of early infant experiences. These therapists investigate individual "object-loss" growing up, believing that if one's relational needs are unmet by parents

or other caregivers, the child will internalize both the characteristics of the lost object and the accompanying anger and resentment over the loss. The resulting unresolved unconscious conflict develops into frustration and self-defeating habits in the adult, who continues, unconsciously and unsuccessfully, to choose intimate partners to repair early deprivation.

Behaviorally oriented family therapists believe that all behavior, normal and abnormal, is learned as a result of a process involving the acquisition of knowledge, information, experiences, and habits. Classical conditioning, operant conditioning, and modeling concepts are used to explain how personality is learned. Following the early lead of B. F. Skinner, some strict behaviorists question whether an inner personality exists, maintaining that what we refer to as "personality" is nothing more than the sum of the environmental experiences in one's life. Rejecting explanations that imply the development of internal traits, they search instead for relationships between observable behavior and observable variations in the person's environment. In their view, situations determine behavior.

Those behavior therapists who adopt a more cognitive orientation believe that people do develop personality traits and that their behavior is based at least in part on those traits and does not arise simply in response to situations. These family therapists contend that certain types of cognitions are learned, become ingrained as traits, and mediate a person's behavior. Perceptions of events, attitudes, beliefs, expectations of outcomes, and attributions are examples of such cognitions. Especially when negative or rigid, these cognitions can contribute to negative behavior exchanges within a family. Intervention is an attempt to change maladaptive cognitions.

Many family therapists view personality from a *family life cycle* perspective (Carter & McGoldrick, 2005). This developmental outlook notes that certain predictable marker events or phases (marriage, birth of first child, children leaving home, and so on) occur in all families, regardless of structure or composition or cultural background, compelling each family to deal in some manner with these events. Because there is an ever-changing family context in which individual members grow up, there are many chances for maladaptive responses. Situational family crises (such as the death of a parent during childhood or the birth of a handicapped child) and certain key transition points are periods of special vulnerability.

Both continuity and change characterize family systems as they progress through the life cycle. Ordinarily, such changes are gradual and the family is able to reorganize as a system and adapt successfully. Certain discontinuous changes, however, may be disruptive, transforming a family system so that it will never return to its previous way of functioning. Divorce, becoming part of a stepfamily, serious financial reverses, and chronic illness in a family member are examples of sudden, disruptive changes that cause upheaval and disequilibrium in the family system. Symptoms in family members are especially likely to appear during these critical periods of change as the family struggles to reorganize while negotiating the transition. Family therapists may seize the crisis period as an opportunity to help families develop higher levels of functioning by helping them galvanize their inherent potential for resiliency to better cope with upheaval or loss (Walsh, 2003).

Variety of Concepts

Family Rules

A family is a rule-governed system in which the interactions of its members follow organized, established patterns. Growing up in a family, members all learn what is expected or permitted in family transactions. Parents, children, relatives, males, females,

and older and younger siblings all have prescribed rules for the boundaries of permissible behavior—rules that may not be verbalized but are understood by all. Such rules regulate and help stabilize the family system.

Family therapists are especially interested in persistent, repetitive behavioral sequences that characterize much of everyday family life because of what these patterns reveal about the family's typical interactive patterns. The term *redundancy principle* is used to describe a family's usually restricted range of options for dealing with one another. Attending to a family's rules represents an interactive way of understanding behavior rather than attributing that individual behavior to some inferred inner set of motives. Don Jackson (1965), an early observer of family behavioral patterns, believed that family dysfunction was due to a family's lack of rules for accommodating to changing conditions.

Family Narratives and Assumptions

All families develop paradigms about the world (enduring assumptions that are shared by family members). Some families view the world as friendly, trustworthy, orderly, predictable, and masterable and thus are likely to view themselves as competent and to encourage members to share their views, even when disagreement is likely to ensue. Others perceive the world as mostly menacing, unstable, and thus unpredictable and potentially dangerous. This latter group is likely to insist on agreement from all family members on most if not all issues in an effort to present a united front against any intrusion or threat. The narrative the family develops about itself, derived largely from its history and passed from one generation to the next, has a powerful impact on its daily functioning.

Families inevitably create narratives or stories about themselves, linking certain family experiences together in a certain sequence to justify how and why they live as they do. Certain dominant stories (how they were orphaned at an early age, how they lived with alcoholic parents, how their parents' divorce frightened them about commitment to a relationship, how their grandmother's love and devotion made them feel loved and cared for, and so on) explain their current actions and attitudes. Narrative therapists such as White (2007) contend that our sense of reality is organized and maintained through the stories by which we circulate knowledge about ourselves and our view of the world we live in. Beyond personal experiences, the meanings and understandings that families attribute to events and situations they encounter are embedded in their social, cultural, and historical experiences (Anderson & Gehart, 2006).

Pseudomutuality and Pseudohostility

One result of Wynne's NIMH studies of families with schizophrenic members (Wynne, et al., 1958) was his observation of their recurrent fragmented and irrational style of communication. He discovered an unreal quality about how they expressed both positive and negative emotion to one another, a process he labeled *pseudomutuality*. Wynne reported that members in these families were absorbed with fitting together at the expense of developing their separate identities. Rather than encourage a balance between separateness and togetherness, as occurs in well-functioning families, members in Wynne's group seemed concerned with the latter only, apparently dreading expressions of individuality as a threat to the family as a whole. By presenting a facade of togetherness, they learned to maintain a homeostatic balance, but at the expense of not allowing either disagreements or expressions of affection. The tactic kept them from dealing with any underlying conflict, and at the same time, the surface togetherness prevented them from experiencing deeper intimacy with one another.

Wynne's research also identified *pseudohostility,* a similar collusion in which apparent quarreling or bickering between family members is in reality merely a superficial tactic for avoiding deeper and more genuine feelings. Members may appear alienated from one another, and their antagonism may even appear intense, but the turmoil is merely a way of maintaining a connection without becoming either deeply affectionate or deeply hostile to one another. Like pseudomutuality, it represents a distorted way of communicating and fosters irrational thinking about relationships.

Mystification

Another masking effort to obscure the real nature of family conflict and thus maintain the status quo is called *mystification.* First described by R. D. Laing (1965) in analyzing the family's role in a child's development of psychopathology, the concept refers to parental efforts to distort a child's experience by denying what the child believes is occurring. Instead of telling the child, "It's your bedtime," or explaining that they are tired and want to be left alone, parents say, "You must be tired. Go to bed." In effect, they have distorted what the child is experiencing ("I'm not tired"), especially if they add that they know better than the child what he or she is feeling.

Mystification, then, occurs when families deal with conflict by befuddling, obscuring, or masking whatever is going on between members. This device does not deter conflict but rather clouds the meaning of conflict and is called into play when a family member threatens the status quo, perhaps by expressing feelings. A husband who says, in response to his wife's query about why he appears angry, "I'm not angry. Where do you dream up these things?" when he actually is angry is attempting to mystify her. His apparent intent to avoid conflict and return matters to their previous balance only leads to greater conflict within her. If she believes him, then she feels she must be "crazy" to imagine his anger, and if she trusts her own senses, then she must deal with a deteriorating marital relationship. Mystification contradicts one person's perceptions and, in extreme or repeated cases, leads that person to question his or her grip on reality.

Scapegoating

Within some families, a particular individual is held responsible for whatever goes wrong with the family. *Scapegoating* directed at a particular child often has the effect of redirecting parental conflict, making it unnecessary for the family to look at the impaired father–mother relationship, something that would be far more threatening to the family. By conveniently picking out a scapegoat who becomes the identified patient, other family members can avoid dealing with one another or probing more deeply into what is really taking place.

Scapegoated family members are themselves often active participants in the family scapegoating process. Not only do they assume the role assigned them, but they may become so entrenched in that role that they are unable to act otherwise. Particularly in dysfunctional families, individuals may be repeatedly labeled as the "bad child"—incorrigible, destructive, unmanageable, troublesome—and they proceed to act accordingly. Scapegoated children are inducted into specific family roles that over time become fixed and serve as the basis for chronic behavioral disturbance. Because the family retains a vested interest in maintaining the scapegoated person in that role, blaming all their problems on one member, changes in family interactive patterns must occur before scapegoating will cease. Otherwise, the scapegoated person, usually symptomatic, will continue to carry the pathology for the family.

PSYCHOTHERAPY

Theory of Psychotherapy

There is no single theory of psychotherapy for family therapists, although all would probably agree with the following basic premises:

1. People are products of their social connections, and attempts to help them must take family relationships into account.
2. Symptomatic or problematic behavior in an individual arises from a context of relationships, and interventions to help that person are most effective when those faulty interactive patterns are altered.
3. Individual symptoms are maintained externally in current family system transactions.
4. Conjoint sessions, in which the family is the therapeutic unit and the focus is on family interaction, are more effective in producing change than attempts to uncover intrapsychic problems in individuals via individual sessions.
5. Assessing family subsystems and the permeability of boundaries within the family and between the family and the outside world offers important clues regarding family organization and susceptibility to change.
6. Traditional psychiatric diagnostic labels based on individual psychopathology fail to provide an understanding of family dysfunctions and tend to pathologize individuals.
7. The goals of family therapy are to change maladaptive or dysfunctional family interactive patterns and/or to help clients construct alternative views about themselves that offer new options and possibilities for the future.

Systems thinking most often provides the underpinnings for therapeutic interventions with the family. By viewing causality in circular rather than linear terms, it keeps the focus on family transactional patterns, especially redundant maladaptive patterns that help maintain symptomatic behavior. When family interrelationships are emphasized over individual needs and drives, explanations shift from a *monadic* model (based on the characteristics of a single person) to a *dyadic* model (based on a two-person interaction) or *triadic* model (based on interactions among three or more persons).

In a monadic outlook, a husband fails to pay attention to his wife because he is a cold and uncaring person. Adopting a dyadic mode, people are viewed in terms of their interlocking relationships and their impact on one another. Here the therapist looks beyond the separate individuals who make up the couple, focusing instead on how these two individuals organize their lives together and, more specifically, on how each helps define the other. From a dyadic viewpoint, a husband's indifference arouses his wife's emotional pursuit, and she demands attention. Her insistence arouses the fear of intimacy that led to his withdrawal to begin with, and he retreats further. She becomes more insistent and he less available as their conflict escalates. A family therapist helping such a couple will direct attention to their interactive effect, thus making the dyad (and not each participant) the unit of treatment. Seeing the couple conjointly rather than separately underscores the therapist's view that the problem arises from both partners and that both are responsible for finding solutions.

In a triadic model, the family therapist assumes that the presenting problems result from the dyad's inability to resolve the conflict, which causes other family members to be drawn into it. A preteenage son who frustrates his father by refusing to do his homework and thus is performing badly at school may be doing so in alliance with his mother against his father, indirectly expressing her resentment at her husband's

authoritarian behavior. The couple's original dyadic conflict has become a triadic one in which multiple interactions occur. Merely to develop a behavioral plan or contract for the boy to receive money or special television or videogame privileges in return for completing school assignments would miss the complex family interaction involved. Family therapists would look at the overall impact of the symptomatic behavior in context; the youngster may or may not be included in the entire treatment, which certainly would deal with the unspoken and unresolved husband–wife conflicts and the recruitment of their child to express or act out their tensions.

In the example just presented, the child's symptom (the school problem) maintains the family homeostasis but obscures the underlying and unexpressed set of family conflicts. Symptoms often function in maintaining family homeostasis; in this case, attention to the school problem keeps the parents from quarreling with each other and upsetting the family balance. If the school problem did not at some level sustain the family organization, it would not be maintained. Thus, the systems-oriented therapist might wonder: (1) Is the family member expressing, through symptoms, feelings that the other members are denying or not permitting themselves to experience? and (2) What would happen to other family members if the identified patient were to become symptom free? (Wachtel, 2007). Symptoms thus serve a protective purpose or are stabilizing devices used in families. As a consequence, although they may not do so consciously, families may be invested in the maintenance of the symptom for homeostatic purposes.

Even though the idea that symptoms may serve a purpose in helping maintain family stability has been a mainstay of family therapy theory, critics argue that it suggests that families need a "sick" member and are willing to sacrifice that person for the sake of family well-being. *Narrative therapists* such as White (2007) reject the notion that a child's problems necessarily reflect more serious underlying family conflict. In White's view, families may be oppressed rather than protected by the symptomatic behavior. White's efforts are directed at getting all family members to unite in wresting control of their lives from the oppressive set of symptoms.

Family therapists usually are active participants with families and concentrate on current family functioning. They attempt to help members achieve lasting changes in the functioning of the family system, not merely superficial changes that will allow the system to return to its former tenuous balance. Watzlawick, Weakland, and Fisch (1974) distinguish between *first-order changes* (changes within the system that do not alter the organization of the system itself) and *second-order changes* (fundamental changes in a system's organization and function). The former term refers to specific differences that take place within the system, and the latter involves rule changes in the system—in effect, changing the system itself.

For example, the following is a first-order change: The Ryan parents were concerned with the repeated school absences of their son Billy, and in an attempt to correct his behavior, they told him that any time they learned he was truant from school, he would be grounded the following Saturday.

The following is a second-order change: The Ryan parents were concerned with the repeated school absences of their son Billy. After consulting with a family therapist for several sessions, they realized that by struggling with Billy, they only encouraged his rebelliousness and thus were involved in sustaining the truant behavior. They also came to recognize that Billy's relationship with the school was truly his own and that they should back off from intruding. Attempting to change the rules and pull themselves out of the struggle, they told Billy that from now on, whether or not he went to school was between him and the school and that henceforth he would be responsible for his education.

As in these examples, a problematic family on their own may try first-order changes by attempting to impose what appear to be logical solutions to their problems. Assuming the problem to be monadic—the result of Billy's rebelliousness—they are employing

negative feedback, attempting to do the opposite of what has been occurring. The family actually may make some changes in behavior for a brief period, but they are still governed by the same rules, the cease-fire is not likely to hold, and Billy will probably return to his school absences sooner or later.

Second-order changes, based on positive feedback, call for a change in the way the family organizes itself. Here the rules of the game must change, viewpoints must be altered, and old situations must be seen in a new light, providing a revised context in which new behavior patterns may emerge. Most people try to solve everyday problems by attempting first-order changes and repeating the same solutions in a self-perpetuating cycle, which only makes things worse. Especially with seriously troubled families, fundamental second-order changes in the system are necessary so that the family members can give different meanings to old feelings and old experiences.

Process of Psychotherapy

The Initial Contact

Family therapy begins when the client asks for help. One family member or a coalition of members begins the process by seeking help outside the family, thus acknowledging that a problem exists and that the family has been unsuccessful in its attempts to resolve the problem by themselves. While the caller is assessing whether the right person has been contacted, the therapist is forming tentative hypotheses about the family. How self-aware is the caller? What sort of impression is he or she trying to make? What other members are involved? Are they all willing to attend the initial session?

Initial contact, whether in person or by telephone, provides an opportunity for a mini-evaluation and also represents the therapist's first opportunity to enter into the family system. If the therapist is careful not to get maneuvered into taking sides, be engulfed by family anxiety, or become excessively sympathetic or angry with any member on the basis of what the caller is reporting, then he or she can establish the rules of the game for further family sessions.

The Initial Session

The family therapist usually encourages as many family members as possible to attend the first session. Entering the room, members are encouraged to sit where they wish; their chosen seating arrangement (such as mother and child close together, father sitting apart) offers the therapist an early clue about possible family alliances and coalitions. Welcoming all members separately as equally important participants, the therapist becomes aware that some members may need extra support and encouragement to participate.

Each person's view of the problem must be heard, as well as the first-order solutions the family has attempted. Observing family interactive patterns, particularly repetitive behavioral sequences that occur around a problem, the therapist tentatively begins to redefine the identified patient's symptoms as a family problem in which each member has a stake. Together, therapist and family explore whether they wish to continue working together and who will attend; if they choose to discontinue, outside referrals to other therapists are in order. If they agree to stay, treatment goals are defined.

Engaging the Family

Beginning with the initial session, the therapist tries to build a working alliance with the family, accommodating to their transactional style as well as assimilating their language

patterns and manner of affective expression. The therapist tries to create an atmosphere in which each member feels supported and able to voice previously unexpressed or unexplored problems. By "joining" them, the therapist is letting them know they are understood and cared about and that in such a safe climate, they can begin to confront divisive family issues.

Assessing Family Functioning

Like all forms of psychotherapy, family therapy involves some form of assessment, formal or informal, as the clinician attempts, early in the course of therapy, to learn more about the family in order to make more informed treatment decisions. (1) Is treatment for the entire family needed? (2) Who are the appropriate family members with whom to work? (3) What underlying interactive patterns fuel the family disturbance and lead to symptoms in one or more of its members? (4) What specific interventions will most effectively help this family? In later sessions, the therapist continues to revise hypotheses, basing subsequent interventions on assessments of the success of previous attempts to alter dysfunctional repetitive family patterns.

Cognitive–behavior family therapists are apt to make a careful, systematic behavioral analysis of the family's maladaptive behavioral patterns, often using questionnaires, pinpointing precisely which behaviors need to be altered and which events typically precede and follow that behavioral sequence. What exactly does the family mean by their child's "temper tantrums"? How often do these occur, under what circumstances, how long do they last, what specific reactions does each family member have, and what antecedent and subsequent events are associated with the outburst? The therapist tries to gauge the extent of the problem, the environmental cues that trigger the behavior, and the behaviors of various family members that maintain the problem. The assessment, continuously updated, helps the therapist plan interventions to reduce undesired or problematic behaviors.

Experiential family therapists spend less time on a formal family history. They work more in the here and now, helping families examine current interactive patterns with little regard for historical antecedents. Assessment is an informal, ongoing process indistinguishable from the therapeutic process itself. Such therapists attempt to provide families with an experience, using themselves as models to explore their own feelings and give voice to their own impulses. Carl Whitaker, an experiential therapist, insists on controlling the structure of the therapy at the start of treatment, making certain that the family is not successful in imposing its own definition of the upcoming therapeutic relationship and how it should proceed. Later, he believes, the family members must be encouraged to take responsibility for changing the nature of their relationships.

Many family therapists agree with Salvador Minuchin (1974) that they get a better sense of how families function by interacting with them over a period of time than from any formal assessment process. Therapists observe how subsystems carry out family tasks, how alliances and coalitions operate within the family, how flexible are family rules in the face of changing conditions, and how permeable are the boundaries within the family and between the family and the outside world. These observations help family therapists modify and discard hypotheses and adjust intervention strategies on the basis of refined appraisals of family functioning.

History-Taking

As is consistent with their theoretical leanings, object relations family therapists such as Scharff and Scharff (2006) contend that an examination of family history is essential to understanding current family functioning. Because they believe people carry

ideal solution, the fact remains that practitioners and clinical researchers operate from different perspectives. (The former are client focused and dedicated to improving services; the latter are science focused and dedicated to understanding and testing clinical phenomena.) Experienced practitioners are likely to be integrationists, taking the best from different approaches on the basis of their experience with what works with whom. Now that students are trained in academia on manualized techniques, they are more likely to be able to follow manualized guidelines in treating their clients.

Psychotherapy in a Multicultural World

The 21st century sees an increasing number of challenges for therapists in dealing with the issues stimulated by a multicultural population. As our consulting rooms fill with immigrant populations and the number of mixed-heritage families increases exponentially, we must attend to basic principles in working with "the Other"—people different from ourselves in certain meaningful ways.

It is critical for therapists to understand the movements taking place in the general society and in specific cultural environments. The therapist must be aware of his/her personal strengths and, most importantly, his/her weaknesses, biases, and prejudices (Axelson, 1999).

Understanding when consultation is appropriate or when referral is necessary also is important. Tuning in to the client's internal/external frame of reference allows the therapist to see the world through the client's eyes. Because the family therapist has other members of the family in the room for corroboration, it is easier to differentiate idiosyncratic behavior from culturally determined thinking or action. It is a logical step for the therapist to move from the family to the family of origin to the multicultural family genogram to a global perspective in family therapy (Ng, 2003). That perspective should include information on ethnic, economic, religious and political factors influencing family dynamics.

An important part of the development of the family therapy movement was the corrective action that occurred as a result of the women's movement in the 1980s (McGoldrick, Giordano, & Garcia-Preto, 2005) when the issue of "white male privilege" became a hot topic in family therapy circles. The awareness that gender bias determined the way people were seen and treated in the consulting room was a radical new idea and set the stage for future attention to issues beyond gender, such as race, social class, immigration status, and religion and their influence on the therapy process. Multicultural expertise was recognized as necessary to understand a variety of areas such as boundary lines, communication rules, displays of emotions, gender expectations, rituals, immigrant and refugee status, and the way these variables affect therapy.

The theory of social construction in family therapy has provided an additional philosophical foundation for multicultural counseling. The narrative model of Michael White takes a stand against the imposition of dominant culture imperatives. White recognizes the misuse of power as a central construct in the presentation of dominant culture, giving voice to local alternative knowledges (Epston & White, 1990). Clients are the experts on their own experiences. Working with diverse ethnic and racial groups, including Australian Aborigines, White used a reflecting team approach, which included the participation of traditional and indigenous healers from the community. White believed that therapy does not exist in a vacuum; emerging stories of change must be shared with the client's larger cultural community to be meaningful. This obviates, somewhat, the problem of the personal feelings of the therapist, supplanting them with the reflections of the community. This process can be translated on an international level and can incorporate the voices of other groups within the client's community. It is central to White's philosophy that the therapist collaborates with the client to determine which audience can best witness their stories of change.

attachments of their parental introjects (memories from childhood) into their current relationships, these therapists are especially interested in such matters as how and why marital partners chose each other. That choice is seen as seeking to rediscover, through the other person, the lost aspects of primary object attachments that had split off earlier in life. Similarly, contextual family therapists (Boszormenyi-Nagy, 1987) examine with their patients those interconnections from the past that bind families together in an effort to help them discover new ways of making fresh inputs into stagnant relationships.

Bowen (1978) began with a set of evaluation interviews aimed at clarifying the history of the presenting problem, especially trying to understand how the symptoms affect family functioning. He tried to assess the family's pattern of emotional functioning as well as the intensity of the emotional process of the symptomatic person. What is this family's relationship system like? How well differentiated are the various members? What are the current sources of stress, and how adaptive is the family?

Because Bowen believed dysfunction may result from family fusion extending back over generations, he probed for signs of poor differentiation from families of origin. To aid in the process, Bowen constructed a family *genogram,* a schematic diagram in the form of a family tree, usually including at least three generations, to trace recurring family behavior patterns. Hypotheses developed from the genogram, such as fusion/differentiation issues or emotional cutoffs from family, are used to better understand the underlying emotional processes connecting generations. Careful not to become drawn into the family's emotional system, Bowen used this information to coach family members to modify their relationships and especially to differentiate themselves from their families of origin.

Satir (1972) attempted to get families to think about the relevant concepts that formed the basis of their developing relationships by compiling a family life chronology for each family member. More than simply gathering historical facts, this represented an effort to help people understand how family ideology, values, and commitments had emerged in the family and influenced current family functioning. Later, she used the therapeutic technique of family reconstruction, guiding family members back through stages of their lives in an attempt to discover and unlock dysfunctional patterns from the past.

Structural and strategic family therapists pay less attention to family or individual histories, preferring to focus on the current family organization, coalitions, hierarchies, and so on. They are concerned with developing ways to change ongoing dysfunctional family patterns, and they typically show less concern for how these patterns historically emerged.

Social constructionists pay particular attention to how the various family members view their world rather than attempting to act as outside observers evaluating client responses. From their perspective, any preconceived views by the therapist of what constitutes a functional family fail to attend to the diversity inherent in today's pluralistic society. The personal outlook of each family member is privileged, and all such outlooks are valued equally.

Facilitating Change

Family therapists use a number of therapeutic techniques to alter family functioning.

1. *Reframing.* This technique involves relabeling problematic behavior by viewing it in a new, more positive light that emphasizes its good intention. (To an adolescent angry because he believes his mother is invading his privacy: "Your mother is concerned about your welfare and hasn't yet found the best way to help." Labeling her as wishing to do well for her son, rather than agreeing with her son's perception that she does not trust him, alters the context in which he perceives her behavior, thus inviting new responses from him to her behavior.)