Reframing changes the meaning attributed to a behavior without changing the "facts" of the behavior itself. Strategic family therapists are most likely to use this technique because it enables them to help clients change the basis for their perceptions or interpretation of events. This altered perspective leads to a change in the family system as the problematic behavior becomes understood from a new perspective. Reframing, then, is a method for bringing about second-order changes in the family system.

2. *Therapeutic Double-Binds.* Another technique favored by strategic and systemic family therapists is putting the family in a *therapeutic double-bind* by directing families to continue to manifest their presenting symptoms: Obsessive people are asked to think about their problem for a specific period of time each day; quarreling husbands and wives are instructed to indulge in and even exaggerate their fighting. By instructing family members to enact symptomatic behavior, the therapist is demanding that the presentation of the symptom, which they have claimed is "involuntary" and thus out of their control be done voluntarily. Such paradoxical interventions are designed to evoke one of two reactions, either of which is sought by the therapist. If the patient complies, continuing to be symptomatic, there is the admission that the symptomatology is under voluntary control, not involuntary as claimed, and thus can be stopped. On the other hand, if the directive to continue the symptom is resisted, the symptom will be given up.

3. *Enactment.* Most likely to be used by structural family therapists, *enactments* are role-playing efforts to bring the outside family conflict into the session so that family members can demonstrate how they deal with it and the therapist can start to devise an intervention procedure for modifying their interaction and creating structural changes in the family. Encouraged by the therapist, the family members act out their dysfunctional transactions rather than talking about them. This gives the therapist an opportunity to observe the process directly instead of relying on family members' reports of what occurs at home. Also, because of the immediacy of this approach, the therapist can intervene on the spot and witness the results of such interventions as they occur.

Helping "unfreeze" family members from repetitive family interactions that end in conflict, the therapist has a chance to guide them in modifying the interactions. By introducing alternative solutions calling for structural changes in the family, the therapist can help the family create options for new behavior sequences. Treating the family of an anorectic adolescent, Minuchin (Minuchin et al., 1978) might arrange to meet the family for the first session and bring in lunch, thus deliberately provoking an enactment around eating. Observing their struggles over their daughter's refusal to eat, Minuchin can demonstrate that the parental subsystem is not working effectively. If parents begin to cooperate with one another in encouraging their daughter to eat, they form a stronger union. At the same time, the daughter is relieved of the too-powerful and destructive position she has been maintaining. The enactment impels the family to look at the system they have created together and to change the dysfunctional behavior displayed in the session.

4. *Family Sculpting.* Rather than putting their feelings or attitudes toward one another into words, which may be difficult or threatening, family members each take a turn at being a "director"—that is, at placing each of the other members in a physical arrangement in space. The result is often revealing of how the "director" perceives his or her place in the family, as well as that person's perception of what is being done to whom, by whom, and in what manner. Individual perceptions of family boundaries, alliances, roles, and subsystems are typically revealed, even if the "director" cannot, or will not, verbalize such perceptions. The resulting graphic picture of individual views of family life provides active, nonverbal depictions for other members to grasp. Because of its nonintellectualized way of putting feelings into action, family sculpting is especially suited to the experiential approach of Satir.

5. *Circular Questioning.* This technique is often used by systemic family therapists (Boscolo et al., 1987) to focus attention on family connections rather than individual symptomatology. Each question posed to the family by the therapist addresses differences in different members' perceptions about the same events or relationships. By asking several members the same question regarding their attitudes toward those situations, the therapist is able to probe more deeply without being confrontational or interrogating the participants in the relationship. In this nonconfrontational therapeutic situation, the family can examine the origin of the underlying conflict. Advocates of this technique believe questioning is a therapeutic process that allows the family to untangle family problems by changing the ways they view their shared difficulties.

6. *Cognitive Restructuring.* This technique of cognitive–behavior therapists, based on the idea that problematic behavior stems from maladaptive thought processes, tries to modify a client's perceptions of events in order to bring about behavioral change. Thus, a partner may have unrealistic expectations about a relationship and catastrophize a commonplace disagreement ("I am worthless"). As Ellis (2005) suggests, it is the interpretation that causes havoc, not the quarrel itself. Cognitive restructuring can significantly modify perceptions ("It's upsetting that we're arguing, but that doesn't mean I'm a failure or our marriage is doomed").

7. *Miracle Question.* In this solution-focused technique (de Shazer, 1991), clients are asked to consider what would occur if a miracle took place and, upon awakening in the morning, they found the problem they brought to therapy solved. Each family member is encouraged to speculate on how things would be different, how each would change his or her behavior, and what each would notice in the others. In this way, goals are identified and potential solutions revealed.

8. *Externalization.* In an effort to liberate a family from its dominating, problem-saturated story, narrative therapists employ the technique of externalization to help families separate the symptomatic member's identity from the problem for which they sought help. The problem is recast as residing outside the family (rather than implying an internal family deficiency or individual pathological condition) and as having a restraining influence over the life of each member of the family. Instead of focusing on what's wrong with the family or with one of its members, all are called upon to unite to deal with this external and unwelcome story with a will of its own that dominates their lives. Thus, rather than the family concluding that "Mother is depressed" and therefore creating problems for the family, the symptom is personified as a separate, external, burdensome entity ("Depression is trying to control Mother's life"). By viewing the problem as outside themselves, the family is better able to collaborate in altering their way of thinking and developing new options for dealing with the problem rather than merely being mired in it.

Mechanisms of Psychotherapy

Family therapists generally take an active, problem-solving approach with families. Typically, they are more interested in dealing with current dysfunctional interactive issues within the family than in uncovering or helping resolve individual intrapsychic problems from the past. Past family transactional patterns may be explored, but this is done to home in on ongoing behavioral sequences or limiting belief systems that need changing rather than to reconstruct the past.

Depending on their specific emphases, family therapists may try to help clients achieve one or more of the following changes.

1. *Structural Change.* Having assessed the effectiveness of a family's organizational structure and its ongoing transactional patterns, family therapists may actively challenge rigid,

repetitive patterns that handicap optimum functioning of family members. Minuchin, for example, assumes the family is experiencing sufficient stress to overload the system's adaptive mechanisms, a situation that may be temporary due to failure to modify family rules to cope successfully with the demands of transitions. Helping families modify unworkable patterns creates an opportunity to adopt new rules and achieve realignments, clearer boundaries, and more flexible family interactions. Through restructuring, the family is helped to get back on track so that it will function more harmoniously and the growth potential of each member will be maximized.

2. *Behavioral Change.* All family therapists try to help clients achieve desired behavioral changes, although they may go about it in differing ways. Strategic therapists focus treatment on the family's presenting problems: what they came in to have changed. Careful not to allow families to manipulate or subdue the therapist and therefore control the treatment, strategic therapy is highly directive, and practitioners devise strategies for alleviating the presenting problem rather than exploring its roots or hidden meanings. Through directives such as paradoxical interventions, they try to force the symptom bearer to abandon old dysfunctional behavior. Similarly, *systemic therapists* (the Milan approach of Selvini-Palazzoli and her colleagues) may assign tasks or rituals for the family to carry out between sessions. These typically are offered in paradoxical form and call for the performance of a task that challenges an outdated or rigid family rule. Behavioral change follows from the emotional experience gained by the family through enactment of the directive.

3. *Experiential Change.* Therapists such as Satir, Whitaker, and Kempler believe that families need to feel and experience what previously was locked up. Their efforts are directed at growth-producing transactions in which therapists act as models of open communication, willing to explore and disclose their own feelings. Satir was especially intent on helping families learn more effective ways of communicating with one another and on teaching them to express what they are experiencing. Kempler also tries to help family members learn to ask for what they want from one another, thus facilitating self-exploration, risk taking, and spontaneity. Whitaker champions family members giving voice to underlying impulses and symbols. Because he sees all behavior as human experience and not as pathological, clients are challenged to establish new and more honest relationships, simultaneously maintaining healthy separation and personal autonomy. Emotionally focused couples therapists, too, help clients recognize how they have hidden their primary emotions or real feelings (say, fear of rejection) and instead have displayed defensive or coercive secondary emotions (anger or blaming when afraid). Their therapeutic efforts are directed at accessing and reprocessing the emotions underlying the clients' negative interactional sequences.

4. *Cognitive Change.* Psychodynamically oriented family therapists are interested in providing client families with insight and understanding. Boszormenyi-Nagy stresses intergenerational issues, particularly how relationship patterns are passed on from generation to generation, influencing current individual and family functioning. By gaining awareness of one's "family ledger," a multigenerational accounting system of who, psychologically speaking, owes what to whom, clients can examine and correct old unsettled or unredressed accounts. Framo (1992) also helped clients gain insight into introjects reprojected onto current family members to compensate for unsatisfactory early object relations. He had clients meet with members of their families of origin for several sessions to discover what issues from the past they may have projected onto current members and also to have a corrective experience with parents and siblings. Narrative therapists, such as White, open up conversations about clients' values, beliefs, and purposes so that they have an opportunity to consider a wide range of choices and attach new meanings to their experiences.

APPLICATIONS

Who Can We Help?

Individual Problems

Therapists who adopt a family frame of reference attend primarily to client relationships. Even if they work with single individuals, they look for the *context* of problematic behavior in planning and executing their clinical interventions. Thus, for example, they might see a college student, far away from family, for individual sessions but continue to view his or her problems within a larger context in which faulty relations with others have helped create the presenting troublesome behavior and are still maintaining it. Should the parents arrive for a visit, they might join their child for a counseling session or two to provide clues regarding relationship difficulties within the family system and assist in their amelioration.

Intergenerational Problems

Family therapists frequently deal with parent–child issues, such as adolescents in conflict with their parents or with society in general. Minuchin's structural approach might be adopted to help families, particularly at transition points in the family life cycle, adapt to changes and modify outdated rules. Here they are likely to try to strengthen the parental subsystem, more clearly define generational boundaries, and help the family craft new and more flexible rules to account for changing conditions as adolescence is reached. To cite an increasingly common example, families in which the children are raised in this country by foreign-born parents often present intergenerational conflicts that reflect differing values and attitudes. Intervention at the family level is often required if changes in the family system are to be achieved.

Two promising family approaches, aimed at treating delinquency or other behavior problems in adolescents, as well as at reducing recidivism, are functional family therapy (Sexton & Alexander, 1999) and multisystemic therapy (Henggeler, Schoenwald, Borduin, & Rowland, 2009). Both have garnered considerable research support, and both offer systems-based, cost-effective programs that community providers can adopt in working with at-risk adolescents and their families.

Marital Problems

Troubled marriages are common today, and many of the problems involving symptomatic behavior in a family member can be traced to efforts by the family to deal with parents in conflict. In addition to personal problems of one or both spouses that contribute to their unhappiness, certain key interpersonal difficulties are frequently present: ineffective communication patterns; sexual incompatibilities; anxiety over making or maintaining a long-term commitment; conflicts over money, in-laws, or children; physical abuse; and/or conflicts over power and control. These issues, repeated without resolution over a period of time, escalate the marital dissatisfaction of one or both partners, placing the marriage in jeopardy. Couples who enter therapy conjointly, before one or both conclude that the costs of staying together outweigh the benefits, are better able to salvage their relationship than if either or both seek individual psychotherapy.

Treatment

The Family Therapy Perspective

Family therapy represents an outlook regarding the origin and maintenance of symptomatic or problematic behavior, as well as a form of clinical intervention directed

at changing dysfunctional aspects of the family system. Adopting such an outlook, the therapist may see the entire family together or may see various dyads, triads, or subsystems, depending on what aspects of the overall problem are being confronted by the therapist. Methods of treatment may vary, depending largely on the nature of the presenting problem, the therapist's theoretical outlook, and her or his personal style.

However, family therapy involves more than seeing distressed families as a unit or group. Simply gathering members together and continuing to treat the individuals separately, but in a group setting, fails to make the paradigm shift called for in treating relationships. Nor is it enough to perceive individual psychopathology as the therapist's central concern while acknowledging the importance of the family context in which such psychopathology developed. Rather, family therapy calls for viewing the amelioration of individual intrapsychic conflicts as secondary to improving overall family functioning.

To work in a family systems mode, the therapist must give up the passive, neutral, nonjudgmental stance developed with so much care in conventional individual psychotherapy. To help change family functioning, the therapist must become involved in the family's interpersonal processes (without losing balance or independence); must be supportive and nurturing at some points and challenging and demanding at others; must attend to (but not overidentify with) family members of different ages; and must move swiftly in and out of emotional involvements without losing track of family interactions and transactional patterns (Goldenberg & Goldenberg, 2008).

The *social constructionist family therapies,* which are currently gaining in popularity, place particular emphasis on the egalitarian, collaborative nature of therapist–family relationships. Family members are encouraged to examine the "stories" about themselves that they have lived by as together the therapist–family system searches for new and empowering ways to view and resolve client problems.

Indications and Contraindications

Family therapy is a valuable option in a therapist's repertoire of interventions, not a panacea for all psychological disturbances. However, it is clearly the treatment of choice for certain problems within the family. Wynne (1965) suggests that family therapy is particularly applicable to resolving relationship difficulties (e.g., parent–children; husband–wife), especially those to which all family members contribute, collusively or openly, consciously or unconsciously. Many family therapists go beyond Wynne's position, arguing that all psychological problems of individuals and of groups such as families ultimately are tied to systems issues and thus amenable to intervention at the family level.

Under what circumstances is family therapy contraindicated? In some cases, it may be too late to reverse the forces of fragmentation or too difficult to establish or maintain a therapeutic working relationship with the family because key members are unavailable or refuse to attend. Sometimes one seriously emotionally disturbed member may so dominate the family with malignant and destructive motives and behavior or be so violent or abusive or filled with paranoid ideation that working with the entire family becomes impossible, although some members of the family may continue to benefit from the family therapy perspective.

Length of Treatment

Family therapy may be brief or extended, depending on the nature and complexities of the problem, family resistance to its amelioration, and the goals of treatment. Changes that most benefit the entire family may not in every case be in the best interest of each family member, and some may cling to old and familiar ways of dealing with one another. In general, however, family therapy tends to be relatively short term compared to

most individual therapy. In some cases, as few as 10 sessions may eliminate problematic behavior; others may require 20 sessions or more for symptoms to subside. Strategic therapy quickly focuses on what problems require attention, and then the therapist devises a plan of action to change the family's dysfunctional patterns in order to eliminate the presenting problem. Structural approaches tend to be brief as the therapist joins the family, learns of its transactional patterns, and initiates changes in its structure leading to changes in behavior and symptom reduction in the identified patient. The object relations approach, on the other hand, as is consistent with its psychoanalytic foundations, tends to take longer and to deal with material from earlier in clients' lives.

Settings and Practitioners

Outpatient offices, school counselor settings, and inpatient hospital wards all provide places where family therapy may be carried out. No longer out of the mainstream of psychotherapy, where it dwelt in its earlier years, family therapy has been accepted by nearly all psychotherapists. Marital or couples therapy, now considered a part of the family therapy movement, has grown at an astonishing rate since the 1970s, as recently reflected in the American Board of Professional Psychology change of name to American Board of Couples and Family Psychology.

Psychiatrists, psychologists, social workers, marriage and family counselors, and pastoral counselors practice family therapy, although their training and emphases may be different. Three basic kinds of training settings exist today: degree-granting programs in family therapy, freestanding family therapy institutes, and university-affiliated programs.

Stages of Treatment

Most family therapists want to see the entire family for the initial session since overall family transactional patterns are most apparent when all participants are together. (Very young children, although they are encouraged to attend the first session, are not always expected to attend subsequent meetings unless they are an integral part of the problem.) After establishing contact with each member present and assessing the suitability of family sessions for them, therapists who are interested in family history, such as Bowen, may begin to construct a family genogram. Others, such as Haley, may proceed to negotiate with the family about precisely what problem they wish to eliminate. Minuchin's opening move is to "join the family" by adopting an egalitarian role within it, making suggestions rather than issuing orders. He accommodates to the family's style of communicating, analyzes problems, and prepares a treatment plan. Solution-focused therapists, such as de Shazer, discourage clients from the start from speculating on the origin of a particular problem, preferring instead to engage in collaborative "solution talk"—that is, discussing solutions they want to construct together.

The middle phase of family therapy is usually directed at helping the family members redefine the presenting problem or symptomatic behavior in the identified patient as a relationship problem to be viewed within the family context. Here the family becomes the "patient," and together they begin to recognize that all have contributed to the problem and that all must participate in changing ingrained family patterns. If therapy is successful, families, guided by the therapist, typically begin to make relationship changes.

In the final stage of family therapy, families learn more effective coping skills and better ways to ask for what they want from one another. Although they are unlikely to leave problem free, they have learned problem-solving techniques for resolving relationship issues together. Termination is easier in family therapy than in individual therapy

because the family has developed an internal support system and has not become overdependent on an outsider. The presenting complaint or symptom has usually disappeared, and it is time for disengagement.

Evidence

The early family therapy pioneers, eager to create new and exciting techniques for treating families, did so largely without benefit of research support. In the ensuing years, a kind of cultural war developed between researchers and practitioners. The former contended that clinicians too readily adopted trendy techniques without pausing to evaluate their effectiveness beyond anecdotal data, and the latter maintained that the research being published often seemed trivial and unrelated to their daily work with people with real problems. That schism is now being addressed by a set of research investigations that are better integrated with the delivery of clinical services by family therapists (Sprenkle & Piercy, 2005).

In part as a response to the pressure from managed-care companies to provide validated treatment and in part as a result of increased funding for such research from government agencies such as the National Institute of Mental Health, meaningful studies are being undertaken to determine which family therapy procedures offer empirically based intervention techniques for a variety of family-related problems. Some practitioners, accustomed to relying on their individual experiences rather than on research data, are starting to find themselves forced by third-party payers such as HMOs to justify their interventions by supplying evidence-based data, when available, in order to receive reimbursement for their services.

Evidence-based practice refers to an attempt by researchers to assess the strengths and limitations of the current research data on psychotherapy. It has been shown that the treatment method, the therapist, and the treatment relationship are major contributors to the success or failure of therapy. It is less clear from research what the contributions of the system are to the process. There remain many disorders, problems, constellations, and family dysfunctions where data are sparse (Levant, 2005). Therapeutic research efforts typically are directed at *process research* (what actually occurs during a therapy session that leads to a desired outcome) and *outcome research* (what specific therapeutic approaches work best with which specific problems). The former—and more elusive—approach attempts to operationally describe what actually transpires during a successful session. Is it the therapeutic alliance between a caring, competent therapist and a trusting family that builds confidence and offers hope? Is it insight or greater understanding, or perhaps a shared therapeutic experience with a therapist and other family members, that leads to change? Is it the promotion of constructive dialogue encouraged by the therapist or the blocking of negative affect? Are there certain intervention techniques that work best at an early stage of family treatment and others that are more effective during later stages (Christensen, Russell, Miller, & Peterson, 1998; Heatherington, Friedlander, & Greenberg, 2005)?

Linking certain within-session processes with outcome results would lead to developing an empirically validated map to follow, but unfortunately this is not yet available for most models, with some exceptions. *Emotion-focused couple therapy* integrates research with attachment theory and spells out manualized procedures to be followed. *Functional family therapy* successfully combines systems and behavioral theories with carefully designed research backing. In general, evidence-supported studies thus far have been carried out primarily on behavioral and cognitive–behavioral approaches. These brief methods, with specific goals, are not necessarily the most effective, but they are easier to test using traditional research methodology than are other treatment methods.

Outcome research in family therapy must deal with the same problems that hinder such research in individual therapy, with the additional burden of gauging and measuring the various interactions taking place within a large and complex unit (the family) that is in a continuous state of change. Some family members may change more than others, different members may change in different ways, and the researcher must take into account intrapsychic, relationship, communication, and ordinary group variables in measuring therapeutic effectiveness. In addition, attention must be paid to types of families, ethnic and social backgrounds, level of family functioning, and the like. In recent years, qualitative research methods, discovery-oriented and open to multiple perspectives, have become more popular. Unlike more traditional quantitative research methodology, qualitative analyses are apt to rely on narrative reports in which the researcher makes subjective judgments about the meaning of outcome data. Qualitative research (based on case studies, in-depth interviewing, and document analysis) is especially useful for exploratory purposes, whereas quantitative techniques are more likely to be used in evaluating or justifying a set of experimental hypotheses.

Published outcome research today is likely to take one of two forms: *efficacy studies* or *effectiveness studies* (Pinsof & Wynne, 1995). The former, which are more common, attempt to determine whether a particular treatment works under ideal conditions such as those in a university or medical center. Interview methodology is standardized, treatment manuals are followed, clients are randomly assigned to treatment or no-treatment groups, independent evaluators measure outcomes, and so on. Effectiveness studies seek to determine whether the therapy works under normal, real-life conditions, such as in a clinic, social agency, or private practice setting. Most research to date is of the efficacy kind and is encouraging, but it is not always translatable into specific recommendations for therapy under more real-world, consultation room conditions. Overall results from surveys (Shadash, Ragsdale, Glaser, & Montgomery, 1995), based mainly on efficacy studies, indicate that clients receiving family therapy did significantly better than untreated control-group clients.

The current thrust of outcome research continues to explore the relative advantages (in terms of costs, length of treatment, and extent of change) of alternative treatment interventions for clients with different specific psychological or behavioral difficulties. Evidence supporting family-level interventions has been especially strong for adolescent high risk, acting out problems, and parent management training, all of which are based on social learning principles. Psychoeducational programs for marital discord have also proved effective, as have programs for reducing relapse and rehospitalization in schizophrenic patients.

The recent rush to develop evidence-based family therapy represents a need for the accountability increasingly expected of professionals in medicine, education, and elsewhere. Within psychotherapy, there is increasing commitment to establishing an empirically validated basis for delivering services that work (Goodheart, Kazdin, & Sternberg, 2006; Nathan & Gorman, 2007). Clinical interventions backed up by research are intended to make the therapeutic effort more efficient, thereby improving the quality of health care and reducing health care costs (Reed & Eisman, 2006), a goal practitioners and researchers share. However laudable, the effort is costly and time consuming, requiring a homogeneous client population, clients randomly assigned to treatment or no-treatment groups, carefully trained and monitored therapists who follow manuals indicating how to proceed, with multiple goals that need to be measured, follow-up studies over extended periods to see whether gains made during therapy are maintained, and so on.

Westen, Novotny, & Thompson-Brenner (2004) argue that researchers might do better by focusing on what works in real-world practice than by devoting their efforts to designing new treatments and manuals from the laboratory. Although everyone would agree that integration of the best available research and clinical expertise represents an

CASE EXAMPLE

Background

Although the appearance of troublesome symptoms in a family member is typically what brings the concerned family to seek help, it is becoming increasingly common for couples or entire families to recognize they are having relationship problems that need to be addressed at the family level. Sometimes, too, therapy is seen as a preventive measure. For example, adults with children from previous marriages who are planning to marry may become concerned enough about the potential problems involved in forming a stepfamily that they consult a family therapist before marriage.

Frank, 38, and Michelle, 36, who are to marry within a week, referred themselves because they worried about whether they were prepared or had prepared their children sufficiently for stepfamily life. The therapist saw them for two sessions, which were largely devoted to discussing common problems they had anticipated along with suggestions for their amelioration. Neither Frank's two children, Ann, 13, and Lance, 12, nor Michelle's daughter, Jessica, 16, attended these sessions.

Michelle and Frank had known each other since childhood, although she later moved to a large city and he settled in a small rural community. Their families had been friends in the past, and Frank and Michelle had visited and corresponded with each other over the years. When they were in their early 20s, before Frank went away to graduate school, a romance blossomed between Frank and Michelle and they agreed to meet again as soon as feasible. When her father died unexpectedly, Michelle wrote to Frank, and when he did not respond, she was hurt and angry. On the rebound, she married Alex, who turned out to be a drug user, verbally abusive to Michelle, and chronically unemployed. They divorced after 2 years, and Michelle, now a single mother, began working to support herself and her daughter, Jessica. Mother and daughter became unusually close in the 12 years before Michelle and Frank met again.

Frank also had been married. Several years after his two children were born, his wife developed cancer and lingered for 5 years before dying. The children, although looked after by neighbors, were alone much of the time, with Ann, Frank's older child, assuming the parenting role for her younger brother, Lance. When Frank met Michelle again, their interrupted romance was rekindled, and in a high state of emotional intensity they decided to marry.

Problem

Approximately 3 months after their marriage, Frank and Michelle contacted the therapist again, describing increasing tension between their children. Needing a safe place to be heard (apparently no one was talking to anyone else), the children—Ann and Lance (Frank's) and Jessica (Michelle's)—eagerly agreed to attend family sessions. What emerged was a set of individual problems compounded by the stresses inherent in becoming an "instant family."

Frank, never able to earn much money and burdened by debts accumulated during his wife's long illness, was frustrated and guilty over his feeling that he was not an adequate provider for his family. Michelle was jealous over Frank's frequent business trips, in large part because she felt unattractive (the reason for her not marrying for 12 years). She feared Frank would find someone else and abandon her again, as she felt he had done earlier, at the time of her father's death. Highly stressed, she withdrew from her daughter, Jessica, for the first time. Losing her closeness to her mother, Jessica remained detached from her stepsiblings and became resentful of any attention Michelle paid to Frank. In an attempt to regain a sense of closeness, she turned to a surrogate family—a gang—and became a "tagger" at school (a graffiti writer involved in pregang activities). Ann and Lance, who had not had the time or a place to grieve over the loss of

their mother, found Michelle unwilling to take over mothering them. Ann became bossy, quarrelsome, and demanding; Lance, at age 12, began to wet his bed.

In addition to these individual problems, they were having the usual stepfamily problems: stepsibling rivalries, difficulties of stepparents assuming parental roles, and boundary ambiguities.

Treatment

From a systems viewpoint, the family therapist is able to work with the entire family or see different combinations of people as needed. Everyone need not attend every session. However, retaining a consistent conceptual framework of the system is essential.

The therapist had "joined" the couple in the two initial sessions, and they felt comfortable returning after they married and were in trouble. While constructing a genogram, the therapist was careful to establish contact with each of the children, focusing attention whenever she could on their evolving relationships. Recognizing that parent–child attachments preceded the marriage relationship, she tried to help them, as a group, develop loyalties to the new family. Boundary issues were especially important because they lived in a small house with little privacy, and the children often intruded on the parental dyad.

When seeing the couple together without the children present, the therapist tried to strengthen their parental subsystem by helping them to learn how to support one another and share child-rearing tasks. (Each had continued to take primary responsibility for his or her own offspring in the early months of the marriage.) Jealousy issues were discussed, and the therapist suggested they needed a "honeymoon" period that they had never had. With the therapist's encouragement, the children stayed with relatives while their parents spent time alone with each other.

After they returned for counseling, Frank's concerns over not being a better provider were discussed. He and Michelle considered alternative strategies for increasing his income and for his helping more around the house. Michelle, still working, felt less exhausted and thus better able to give more of herself to the children. Frank and Lance agreed to participate in a self-help behavioral program aimed at eliminating bedwetting, thus strengthening their closeness to one another. As Lance's problem subsided, the entire family felt relieved of the mess and smell associated with the bedwetting.

The therapist decided to see Ann by herself for one session, giving her the feeling she was special. Allowed to be a young girl in therapy and temporarily relieved of her job as a parent to Lance, she became more agreeable and reached outside the family to make friends. She and Lance had one additional session (with their father), grieving over the loss of their mother. Michelle and Jessica needed two sessions together to work out their mother–daughter adolescent issues as well as Jessica's school problems.

Follow-Up

Approximately 12 sessions were held. At first the sessions took place weekly, later they were held biweekly, and then they took place at 3-month intervals. By the end of a year, the family had become better integrated and more functional. Frank had been promoted at work and the family had rented a larger house, easing the problems brought about by space limitations. Lance's bedwetting had stopped, and he and Ann felt closer to Michelle and Jessica. Ann, relieved of the burden of acting older than her years, enjoyed being an adolescent and became involved in school plays. Jessica still had some academic problems but had broken away from the gang and was preparing to go to a neighboring city to attend a junior college.

The family contacted the therapist five times over the next 3 years. Each time, they were able to identify the dyad or triad stuck in a dysfunctional sequence for which they needed help. And each time, a single session seemed to get them back on track.

SUMMARY

Family therapy, which originated in the 1950s, turned its attention away from individual intrapsychic problems and placed the locus of pathology on dysfunctional transactional patterns within a family. From this new perspective, families are viewed as systems with members operating within a relationship network and by means of feedback loops aimed at maintaining homeostasis. Growing out of research aimed at understanding communication patterns in the families of schizophrenics, family therapy later broadened its focus to include therapeutic interventions with a variety of family problems. These therapeutic endeavors are directed at changing repetitive maladaptive or problematic sequences within the system. Early cybernetic views of the family as a psychosocial system have been augmented by the postmodern view that rejects the notion of an objectively knowable world, arguing in favor of multiple views of reality.

Symptomatic or problematic behavior in a family member is viewed as signaling family disequilibrium. Symptoms arise from, and are maintained by, current, ongoing family transactions. Viewing causality in circular rather than linear terms, the family therapist focuses on repetitive behavioral sequences between members that are self-perpetuating and self-defeating. Family belief systems also are scrutinized as self-limiting.

Therapeutic intervention may take a number of forms, including approaches assessing the impact of the past on current family functioning (object relations, contextual), those largely concerned with individual family members' growth (experiential), those that focus on family structure and processes (structural) or transgenerational issues, those heavily influenced by cognitive–behavioral perspectives (strategic, behavioral), and those that emphasize dialogue in which clients examine the meaning and organization they bring to their life experiences (social constructionist and narrative therapies). All attend particularly to the context of people's lives in which dysfunction originates and can be ameliorated.

Interest in family systems theory and concomitant interventions will probably continue to grow in the coming years. The stress on families precipitated by the lack of models or strategies for dealing with divorce, remarriage, alternative lifestyles, or acculturation in immigrant families is likely to increase the demand for professional help at a family level.

Consumers and cost-containment managers will utilize family therapy even more often in the future because it is a relatively short-term procedure, solution oriented, dealing with real and immediate problems. Moreover, it feels accessible to families with relationship problems who don't wish to be perceived as pathological. Its preventive quality, helping people learn more effective communication and problem-solving skills to head off future crises, is attractive not only to families but also to practitioners of family medicine, pediatricians, and other primary care physicians to whom troubled people turn. As the field develops in both its research and clinical endeavors, it will better identify specific techniques for treating different types of families at significant points in their life cycles.

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Goldenberg, H., & Goldenberg, I. (2008). *Family therapy: An overview* (7th ed.). Pacific Grove, CA: Brooks/Cole–Thomson Learning.

This text describes the major theories and the assessment and intervention techniques of family therapy. Systems theory and family life cycle issues are outlined, a historical discussion of the field's development is included, and research, training, and ethical and professional issues are considered.

Goodheart, C. D., Kazdin, A. E., & Sternberg, R. J. (2006). *Evidence-based psychotherapy: Where practice and research meet.* Washington, DC: American Psychological Association.

This timely text outlines the current controversies surrounding the issue of developing an evidence-based body of knowledge to support psychotherapy approaches.

Haley, J., & Richeport-Haley, M. (2007). *Directive family therapy.* New York: Haworth.

This text provides practitioners with directive family techniques to identify client problems, formulate treatment plans, and then carry them out to achieve lasting therapeutic change. Using case examples, this text shows problem-solving directives in action.

McGoldrick, M., & Hardy, K. V. (Eds.). (2008). *Re-visioning family therapy: Race, culture, and gender in clinical practice* (2nd ed.). New York: Guilford Press.

These authors have brought together several dozen experts to provide detailed information about a wide variety of racial and ethnic groupings. Common family patterns are delineated for each group, and suggestions are offered for effective family interventions tied to the unique aspects of each set.

Sexton, T. L., Weeks, G. R., & Robbins, M. S. (Eds.). (2003). *The science and practice of working with families and couples.* New York: Guilford Press.

This useful, up-to-date handbook is filled with discussions of the foundation and theories of family therapy and its application to special populations for whom family therapy is recommended. A large section is devoted to issues surrounding evidence-based couple and family intervention programs.

Sue, D. W., & Sue, D. (2007). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: John Wiley.

Authors Derald Wing Sue & David Sue define and analyze the meaning of diversity and multiculturalism, covering racial/ethnic minority groups as well as multiracial individuals, women, gays and lesbians, the elderly, and those with disabilities. This book is up to date and includes new research and a discussion of future direction in the field.

CASE READINGS

Family therapy trainers commonly make use of videotapes and DVDs of master therapists demonstrating their techniques with real families since these provide a richer sense of the emotional intensity of family sessions than what is available from case readings alone. Tapes are available to rent or purchase from the Ackerman Institute in New York, the Philadelphia Child Guidance Center, the Georgetown University Family Center, the Family Institute of Washington, DC, and many other training establishments.

Three texts deal largely with descriptions and analyses of family therapy from the vantage point of leading practitioners:

Grove, D. R., & Haley, J. (1993). *Conversations on therapy: Popular problems and uncommon solutions.* New York; Norton.

Grove and Haley, apprentice and master therapist, respectively, offer a question-and-answer conversation regarding specific cases seen at the Family Therapy Institute of Washington, DC, and together they devise strategies for intervening effectively in problematic situations.

Napier, A. Y., & Whitaker, C. A. (1978). *The family crucible.* New York: Harper & Row.

This text gives a full account of cotherapy with one family, including both parents; a suicidal, runaway, teenage daughter; an adolescent son; and a 6-year-old daughter.

Satir, V. M., & Baldwin, M. (1983). *Satir step by step: A guide to creative change in families.* Palo Alto, CA: Science and Behavior Books.

Using double columns, Satir presents a transcript of a session accompanied by an explanation for each intervention.

Two recent casebooks contain descriptions offered by family therapists with a variety of viewpoints. Both effectively convey what transpires as family therapists attempt to put theory into practice.

Dattilio, F. (Ed.). (1998). *Case studies in couple and family therapy: Systemic and cognitive perspectives.* New York: Guilford Press.

Leading figures from each school of family therapy briefly summarize their theoretical positions, followed by detailed case studies of actual sessions. The editor offers comments throughout in an attempt to integrate cognitive–behavior therapy with a variety of current family therapy systems.

Golden, L. B. (2003). *Case studies in marriage and family therapy* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.

This text contains 19 case studies that highlight the major approaches taken to family therapy. Seasoned marriage and family therapists share real-life session data and explore their own decision making and personal experiences.

Other valuable works include the following:

Oxford, L. K., & Wiener, D. J. (2003). Rescripting family dramas using psychodramatic methods. In D. J. Wiener & L. K. Oxford (Eds.), *Action therapy with families and groups: Using creative arts improvisation in clinical practice* (pp. 45–74). Washington, DC: American Psychological Association. [Reprinted in D. Wedding & R. J. Corsini (Eds.). (2008). *Case Studies in Psychotherapy* (5th ed.). Belmont, CA: Brooks/Cole.]

This recent case illustrates how the techniques of psychodrama can be applied in a family therapy context.

Papp, P. (1982). The daughter who said no. In P. Papp, *The process of change* (pp. 67–120). New York: Guilford. [Reprinted in D. Wedding & R. J. Corsini (Eds.). (2011). *Case studies in psychotherapy* (6th ed.). Belmont, CA: Brooks/Cole.]

This classic case illustrates the way a master family therapist treats a young woman with anorexia nervosa.