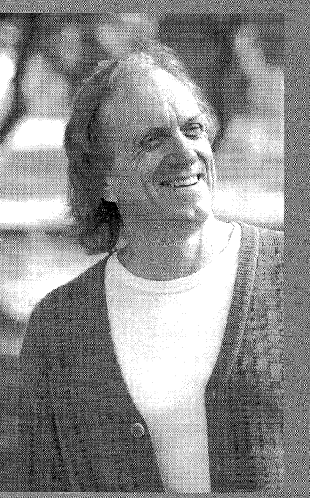
Murray Bowen
(1913–1990)
Courtesy of Bowen Family

Salvador Minuchin
Courtesy of Dr. Salvador Minuchin
The Minuchin Center

Virginia Satir
(1916–1988)
© Cengage Learning



Michael White
(1948–2008)
Courtesy of Dr. Michael White

12 FAMILY THERAPY

Irene Goldenberg, Herbert Goldenberg, and Erica Goldenberg Pelavin

Family therapy is both a theory and a treatment method. It offers a way to view clinical problems within the context of a family's transactional patterns. Family therapy also represents a form of intervention in which members of a family are assisted in identifying and changing problematic, maladaptive, repetitive relationship patterns, as well as self-defeating or self-limiting belief systems.

Unlike individually focused therapies, in family therapy the *identified patient* (the family member considered to be the problem in the family) is viewed as manifesting troubled or troubling behavior maintained by problematic transactions within the family or perhaps between the family and the outside community. Helping families to change leads to improved functioning of individuals as well as families. In recent years, therapeutic efforts have been directed at broadening the context for understanding family functioning, adopting an ecological focus that takes the individual, the family, and the surrounding cultural community into account (Robbins, Mayorga, & Szapocznik, 2003).

OVERVIEW

Basic Concepts

When a single attitude, philosophy, point of view, procedure, or methodology dominates scientific thinking (and thus assumes the character of a *paradigm*), solutions to problems are sought within the perspectives of that school of thought. If serious problems arise that do not appear to be explained by the prevailing paradigm, however, efforts are made to expand or replace the existing system. Once the old belief system changes,

perspectives shift and previous events may take on entirely new meanings. The resulting transition to a new paradigm, according to Kuhn (1970), is a scientific revolution.

In the field of psychotherapy, such a dramatic shift in perspective occurred in the mid-1950s as some clinicians, dissatisfied with slow progress when working with individual patients or frustrated when change in their patients was often undermined by other family members, began to look at the family as the locus of pathology. Breaking away from the traditional concern and investigation of individual personality characteristics and behavior patterns, they adopted a new perspective—a family frame of reference—that provided a new way of conceptualizing human problems, especially the development of symptoms and their alleviation. As is the case with all paradigm shifts, this new viewpoint called for a new set of premises about the nature of psychopathology and stimulated a series of family-focused methods for collecting data and understanding individual functioning.

When the unit of analysis is the individual, clinical theories inevitably look to internal events, psychic organization, and the patient's intrapsychic problems to explain that person's problems. Based on a heritage dating back to Freud, such efforts turn to the reconstruction of the past to seek out root causes of current difficulties, producing hypotheses or explanations for *why* something happened to this person. With the conceptual leap to a family framework, attention is directed to the family context in which individual behavior occurs, to behavioral sequences between individuals, and to *what* is now taking place and *how* each participant influences, and in turn is influenced by, other family members.

This view of *reciprocal causality* provides an opportunity to observe repetitive ways in which family members interact and to use such data to initiate therapeutic interventions. Family therapists therefore direct their attention to the dysfunctional or impaired family unit rather than to a symptomatic person, who is only one part of that family system and, by his or her behavior, is seen as expressing the family's dysfunction.

The Family as a System

By adopting a relationship frame of reference, family therapists pay attention both to the family's *structure* (how it arranges, organizes, and maintains itself at a particular cross section of time) and to its *processes* (the way it evolves, adapts, or changes over time). They view the family as an ongoing, living system, a complex, durable, causal network of related parts that together constitute an entity larger than the simple sum of its individual members. That system, in turn, is part of a larger social context, the outside community.

Several key concepts are central to understanding how systems operate. *Organization* and *wholeness* are especially important. Systems are composed of units that stand in some consistent relationship to one another, and thus we can infer that they are organized around those relationships. In a similar way, units or elements, once combined, produce an entity—a whole—that is greater than the sum of its parts. A change in one part causes a change in the other parts and thus in the entire system. If this is indeed the case, argue systems theorists, then adequate understanding of a system requires study of the whole rather than separate examination of each part. No element within the system can ever be understood in isolation since elements never function separately. The implications for understanding family functioning are clear: A family is a system in which members organize into a group, forming a whole that transcends the sum of its individual parts.

The original interest in viewing a family as a system stems in part from the work of Gregory Bateson, an anthropologist who led an early study in which he and his colleagues hypothesized that schizophrenia might be the result of pathological family

interaction (Bateson, Jackson, Haley, & Weakland, 1956). Although not a family therapist himself, Bateson (1972) deserves special credit for first seeing how a family might operate as a *cybernetic system.* Current views of the origins of schizophrenia emphasize genetic predispositions exacerbated by environmental stresses, but Bateson's team should be recognized for first focusing attention on the flow of information and the back-and-forth communication patterns that exist within families. Rather than studying the content of what transpires, family therapists were directed to attend to family processes, the interactive patterns among family members that define a family's functioning as a unit.

A Cybernetic Epistemology

A number of significant shifts in clinical outlook occur with the adoption of a cybernetic epistemology. For example, the locus of pathology changes from the identified patient to the social context, and the interaction between individuals, rather than the troubled person, is analyzed. Instead of assuming that one individual causes another's behavior ("You started it. I just reacted to what you did"), family therapists believe both participants are caught up in a circular interaction, a chain reaction that feeds back on itself, because each family member has defined the situation differently. Each argues that the other person is the cause; both are correct, but it is pointless to search for a starting point in any conflict between people, because a complex, repetitive interaction is occurring, not a simple, linear, cause-and-effect situation with a clear beginning and end.

The simple, nonreciprocal view that one event leads to another, in stimulus-response fashion, represents *linear causality.* Family therapists prefer to think in terms of *circular causality:* Reciprocal actions occur within a relationship network by means of a network of interacting loops. From this perspective, any cause is seen as an effect of a previous cause and becomes, in turn, the cause of a later event. Thus, the attitudes and behavior of system members, as in a family, are tied to one another in powerful, durable, reciprocal ways, and in a never-ending cycle.

The term *cybernetics,* based on a Greek word for "steersman," was coined by mathematician Norbert Wiener (1948) to describe regulatory systems that operate by means of *feedback loops.* The most familiar example of such a mechanism is the thermostat in a home heating system; set to a desired temperature, the furnace will turn on when the heat drops below that setting, and it will shut off when the desired temperature is reached. The system is balanced around a set point and relies on information fed back into it about the temperature of the room. Thus, it maintains a dynamic equilibrium and undertakes operations to restore that equilibrium whenever the balance is upset or threatened.

So, too, with a family. When a crisis or other disruption occurs, family members try to maintain or regain a stable environment—*family homeostasis*—by activating family-learned mechanisms to decrease the stress and restore internal balance.

Families rely on the exchange of information—a word, a look, a gesture, or a glance that acts as a feedback mechanism, signaling that disequilibrium has been created and that some corrective steps are needed to help the relationship return to its previous balanced state. In effect, information about a system's output is fed back into its input, to alter, correct, or govern the system's functioning. *Negative feedback* has an attenuating effect, restoring equilibrium, whereas *positive feedback* leads to further change by accelerating the deviation. In negative feedback, a couple may exchange information during a quarrel that says, in effect, "It is time to pull back or we will regret it later." In positive feedback, the escalation may reach dangerous, runaway proportions; the quarreling couple may escalate an argument to the point when neither one cares about the consequences. In some situations, however, positive feedback, though temporarily

destabilizing, may be beneficial if it does not get out of control and if it helps the couple reassess a dysfunctional transactional pattern, reexamine their methods of engagement, and change the system's rules. That is, a system need not revert to its previous level but may instead, as a result of positive feedback, change and function more smoothly at a higher homeostatic level (Goldenberg & Goldenberg, 2008).

Subsystems, Boundaries, and Larger Systems

Following largely from the work of Minuchin, Nichols, & Lee (2006), family therapists view families as comprising a number of coexisting subsystems in which members group together to carry out certain family functions or processes. Subsystems are organized components within the overall system, and they may be determined by generation, sex, or family function. Each family member is likely to belong to several subsystems at the same time. A wife may also be a mother, daughter, younger sister, and so on, thus entering into different complementary relationships with other members at various times and playing different roles in each. In certain dysfunctional situations, families may split into separate long-term coalitions: males opposed to females, parents against children, father and daughter in conflict with mother and son.

Although family members may engage in temporary alliances, three key subsystems will always endure: the spousal, parental, and sibling subsystems (Minuchin, Rosman, & Baker, 1978). The first is especially important to the family: Any dysfunction in the spousal subsystem is bound to reverberate throughout the family, resulting in the scapegoating of children or co-opting them into alliances with one parent against the other. Effective spousal subsystems provide security and teach children about commitment by presenting a positive model of marital interaction. The parental subsystem, when effective, provides child care, nurturance, guidance, limit setting, and discipline; problems here frequently take the form of intergenerational conflicts with adolescents, often reflecting underlying family disharmony and instability. Sibling subsystems help members learn to negotiate, cooperate, compete, and eventually attach to others.

Boundaries are invisible lines that separate a system, a subsystem, or an individual from outside surroundings. In effect, they protect the system's integrity, distinguishing between those considered insiders and those viewed as outsiders. Boundaries within a family vary from being rigid (overly restrictive, permitting little contact among the members of different groups) to being diffuse (overly blurred, so that roles are interchangeable and members are overinvolved in each other's lives). Thus, the clarity of the boundary between subsystems and its permeability are more important than the subsystem's membership. Excessively rigid boundaries characterize *disengaged families* in which members feel isolated from one another, and diffuse boundaries identify *enmeshed families* in which members are intertwined in one another's lives.

Boundaries between the family and the outside world need to be sufficiently clear to allow information to flow to and from the environment. In systems terms, the more flexible the boundaries, the better the information flow; the family is open to new experiences, is able to alter and discard unworkable or obsolete interactive patterns, and is operating as an *open system.* When boundaries are not easily crossed, the family is insular, is not open to what is happening around it, is suspicious of the outside world, and is said to be operating as a *closed system.* In reality, no family system is either completely open or completely closed; rather, all exist along a continuum.

Cybernetics Revisited and the Postmodern Challenge

The early, radical assumptions proposed by systems theory (circular causality, feedback loops, boundaries, subsystems) were groundbreaking in their relationship-focused and

holistic character but were limited because they were confined to outside observers attempting to describe what was occurring within a system (Becvar, 2003). A later refinement, sometimes called second-order cybernetics, acknowledged the effect of the observer (the family therapist) on his or her observations; by helping define the problem, the observer influences goals and outcomes. Each family member's perceptions of the presenting problem began to be acknowledged as important and valid, because how each member constructs reality influences and is influenced by a larger social context. Postmodern views, popular today, are especially rejecting of the systems metaphor as based on mechanistic models. Postmodernists argue that our notion of reality is inevitably subjective; there are no universal truths out there ready to be described by "objective observers" (Gergen, 1999).

All family systems thus are influenced by one or more of society's larger systems—the courts, the health care system, schools, welfare, probation, and most currently the psychological challenges inherent in the cybersystem. This frontier presents new challenges to therapists who must be aware and understand the complications of virtual relationships and boundaries. Untangling the web of relationships, both perceived and real, can be difficult for the practitioner and presents both legal and ethical issues. (Pelavin & Moskowitz-Sweet, 2009).

Although such contact with the larger system may be time limited and generally free of long-term conflict, numerous families become entangled with such systems, and this entanglement sometimes impedes the development of family members. Family therapists today pay close attention to such interactions, looking beyond the dysfunctional family itself and integrating the recommendations of the various agencies in order to provide a broad, coordinated set of interventions to achieve maximum effectiveness.

Gender Awareness and Culture Sensitivity

Challenged by postmodern inquiries into the diversity of perspectives for viewing life, as well as by the feminist movement, family therapists have begun to look beyond observable interactive patterns within a family, and today they examine how gender, culture, and ethnicity shape the perspectives and behavior patterns of family members. Indoctrinated early into gender-role behavior in a family, men and women have different socialization experiences and as a result develop distinct behavioral expectations, are granted disparate opportunities, and have differing life experiences. Work and family roles and responsibilities have changed dramatically in the last 30 years, requiring new male–female interactions and family adaptations (Barnett & Hyde, 2001).

Gender, cultural background, ethnicity membership, and social class are interactive; one cannot be considered without the others. As Kliman (1994) notes, the experience of being male or female shapes, and in turn is shaped by, being poor or middle-class or wealthy, or being African American, Chinese, or Armenian. Contemporary views of family therapy emphasize taking a *gender-sensitive outlook* in working with families, being careful not to reinforce (as therapists sometimes did in the past) stereotyped sexist, patriarchal attitudes, or class differences. Today, family therapists pay more attention to differences in power, status, and position within families and in society in general.

Similarly, family therapists today believe a comprehensive picture of family functioning at the minimum requires an understanding of the cultural context (race, ethnic group membership, social class, religion, sexual orientation) and the form of family organization (stepfamily, single parent-led family, gay couples, etc.) of the family seeking help. Adopting a broad, multicultural framework leads to a pluralistic outlook, one that recognizes that attitudes and behavior patterns are often deeply rooted in the family's cultural background. That pluralistic viewpoint also enables therapists to better understand the unique problems inherent in the multitude of families today that do not fit the historical model of the intact family (Sue & Sue, 2007).

Developing a *culturally sensitive therapy* (Prochaska & Norcross, 1999) necessitates moving beyond the white, middle-class outlook from which many therapists operate (prizing self-sufficiency, independence, and individual development) and recognizing that such values are not necessarily embraced by all ethnic groups. For example, many clients from traditional Asian backgrounds are socialized to subordinate their individual needs to those of their families or of society in general. In developing a multicultural framework, the family therapist must recognize that acculturation is an ongoing process that occurs over generations and that ethnic values continue to influence a client family's child-rearing practices, intergenerational relationships, family boundaries, and so forth.

A culturally competent family therapist remains alert to the fact that how he or she accesses or counsels a family is influenced not only by professional knowledge but also by his or her own "cultural filters"—values, attitudes, customs, religious beliefs and practices, and (especially) beliefs regarding what constitutes normal behavior (Madsen, 2007). To ignore such built-in standards is to run the risk of misdiagnosing or mislabeling as abnormal an unfamiliar family pattern that might be perfectly appropriate to that family's cultural heritage (McGoldrick & Hardy, 2008). Similarly, the culturally sensitive therapist must be careful not to overlook or minimize deviant behavior by simply attributing it to cultural differences. According to Falicov (2000), the family therapy encounter is really an engagement between a therapist's and a family's cultural and personal constructions about family life. This includes the role of spirituality on the part of both the clinician and the client, tapping spiritual resources for coping, healing, and resiliency (Walsh, 2009). If religious or previously established family rituals do not satisfy the system's needs, creating collaborative rituals can be healing to the family (Imber-Black, Roberts, & Alva Whiting, 2003).

Therapeutic intervention with a wide variety of families requires the therapist to help family members understand any restrictions imposed on them as a result of such factors as gender, race, religion, social class, or sexual orientation. Cultural narratives (White, 2007) specifying the customary or preferred ways of being in a society are sometimes toxic (racism, sexism, ageism, class bias) and thus inhibiting and subjugating to the individual, family, and group. Here the therapist must provide help in addressing the limitations imposed by the majority culture if the family is to overcome societal restrictions.

Other Systems

Differences between family therapy and other therapeutic approaches are less clear cut than in the past, as systems ideas have permeated other forms of psychotherapy. Although therapists may focus on the individual patient, many have begun to view that person's problems within a broader context, of which the family is inevitably a part, and have adapted family systems methods to individual psychotherapy (Wachtel & Wachtel, 1986). For example, *object relations theory* has emphasized the search for satisfactory "objects" (persons) in our lives, beginning in infancy. Practitioners of psychoanalytically based object relations family therapy, such as Scharff and Scharff (2006), help family members uncover how each has internalized objects from the past, usually as a result of an unresolved relationship with one's parents, and how these imprints from the past—called *introjects*—continue to impose themselves on current relationships, particularly with one's spouse or children. Object relations family therapists search for unconscious relationship-seeking from the past as the primary determinant of adult personality formation, whereas most family therapists deal with current interpersonal issues to improve overall family functioning.

Conceptually, Adlerian psychotherapy is compatible with family therapy formulations. Far less reliant on biological or instinctual constructs than is psychoanalysis,

Adlerian theory emphasizes the social context of behavior, the embeddedness of the individual in his or her interpersonal relationships, and the importance of present circumstances and future goals rather than unresolved issues from childhood. Both Adlerian psychotherapy and family therapy take a holistic view of the person and emphasize intent and conscious choices. Adler's efforts to establish a child guidance movement, as well as his concern with improving parenting practices, reflect his interest beyond the individual to family functioning. However, the individual focus of his therapeutic efforts fails to change the dysfunctional family relationships that underlie individual problems.

The person-centered approach developed by Carl Rogers is concerned with the client's here-and-now issues, is growth oriented, and is applicable to helping families move in the direction of self-actualization. Its humanistic outlook was particularly appealing to experiential family therapists such as Virginia Satir (1972) and Carl Whitaker (Whitaker & Bumberry, 1988), who believed families were stunted in their growth and would find solutions if provided with a growth-facilitating therapeutic experience. Experiential family therapists are usually more directive than Rogerians and, in some cases, act as teachers to help families open up their communication processes (for instance, using methods developed by Virginia Satir).

Existential psychotherapies are phenomenological in nature, emphasizing awareness and the here and now of the client's existence. Considered by most family therapists to be too concerned with the organized wholeness of the single person, this viewpoint nevertheless has found a home among some family therapists, such as Walter Kempler (1991), who argues that people define themselves and their relationships with one another through their current choices and decisions and what they choose to become in the future rather than through their reflections on the past.

Behavior therapists traditionally take a more linear view of causality regarding family interactions than do most systems theory advocates. A child's tantrums, for example, are viewed by behaviorists as maintained and reinforced by parental responses. Systems theorists view the tantrum as an interaction, including an exchange of feedback information, occurring within a family system.

Most behaviorists now acknowledge that cognitive factors (attitudes, thoughts, beliefs, expectations) influence behavior, and cognitive–behavior therapy has become a part of mainstream psychotherapy (Dattilio & Epstein, 2005). However, rational emotive behavior therapy's view that problems stem from maladaptive thought processes seems too individually focused for most family therapists (Ellis & Dryden, 2007).

HISTORY

Precursors

Freud, Adler, Sullivan

Family therapy can trace its ancestry to efforts begun early in the last century, led largely by Sigmund Freud, to discover intervention procedures for uncovering and mitigating symptomatic behavior in neurotic individuals. However, although Freud acknowledged in theory the often-powerful impact of individual fantasy and family conflict and alliances (e.g., the Oedipus conflict) on the development of such symptoms, he steered clear of involving the family in treatment, choosing instead to help the symptomatic person resolve personal or intrapsychic conflicts.

Adler went further than Freud in emphasizing the family context for neurotic behavior, stressing the importance of the family constellation (e.g., birth order, sibling rivalry) on individual personality formation. He drew attention to the central role of the

family in the formative years, contending that family interactive patterns are the key to understanding a person's current relationships both within and outside the family.

Harry Stack Sullivan, beginning in the 1920s, adopted an interpersonal relations view in working with hospitalized schizophrenics. Sullivan (1953) argued that people were the product of their "relatively enduring patterns of recurrent interpersonal situations" (p. 10). In spite of not working directly with families, Sullivan speculated on the role that family played in the transitional period of adolescence, thought to be the typical time for the onset of schizophrenia. Sullivan's influence on Don Jackson and Murray Bowen, two pioneers in family therapy who trained under Sullivan, as well as on his colleague Frieda Fromm-Reichmann, is apparent both in their adoption of Sullivan's early notion of redundant family interactive patterns and in their active therapeutic interventions with families.

General Systems Theory

Beginning in the 1940s, Ludwig von Bertalanffy (1968) and others began to develop a comprehensive theoretical model embracing all living systems. General systems theory challenged the traditional reductionistic view in science that complex phenomena could be understood by carefully breaking them down into a series of less complex cause-and-effect reactions and then analyzing in linear fashion how A causes B, B causes C, and so forth. Instead, this new theory argued for a systems focus in which the interrelations between parts assume far greater significance: A may cause B, but B affects A, which in turn affects B, and so on in a *circular causality.* General systems theory ideas can be seen in such family systems concepts as circular causality and the belief that symptoms in one family member signal family dysfunction rather than individual psychopathology.

Group Therapy

John Bell (1961) developed a therapeutic approach called *family group therapy,* applying some of the social psychological theories of small-group behavior to the natural group that is the family. Adopting group therapy's holistic outlook, family therapists involve entire families in the therapeutic process, believing that kinship groups are more real situations and provide a greater opportunity for powerful and longer-lasting systems changes as a result of family-level interventions.

Beginnings

Research on Schizophrenia

A number of researchers, working independently, began in the 1950s to zero in on schizophrenia as an area where family influences might be related to the development of psychotic symptoms. Taking a linear viewpoint at first and seeking causes of the schizophrenic condition in early family child-rearing practices, the researchers ultimately branched out into a broader systems point of view. Early efforts by the following are particularly noteworthy: Bateson's group in Palo Alto, Theodore Lidz's project at Yale, and the efforts at the National Institute of Mental Health (NIMH) of Murray Bowen and Lyman Wynne. The idea of seeing family members together for therapeutic purposes came later, as a result of research discoveries and subsequent theorizing.

A landmark paper by Bateson, Jackson, Haley, and Weakland (1956) speculated that *double-bind* communication patterns within a family may account for the onset of schizophrenia in one of its members. Double-bind situations exist when an individual, usually a child, habitually receives simultaneous contradictory messages from the same

important person, typically a parent (verbally, "I'm interested in what you are telling me" but nonverbally, by gesture or glance signaling, "Go away, you are bothering me, I don't care about you") who forbids comment on the contradiction. Compelled to respond, but doomed to failure whatever the response, the child becomes confused and ultimately withdraws after repeated exposure to such incongruent messages, unable to understand the true meaning of his or others' communications. Schizophrenia was thus reformulated as an interpersonal phenomenon and as a prototype of the consequences of failure in a family's communication system.

Lidz and his colleagues (Lidz, Cornelison, Fleck, & Terry, 1957) hypothesized that schizophrenics did not receive the necessary nurturance as children and thus failed to achieve autonomy as adults. According to this premise, one or both parents' own arrested development was responsible, especially because the parents were likely to have a conflict-ridden marriage, providing poor role models for children. These researchers distinguished two patterns of chronic marital discord that were common in schizophrenic families. In one, labeled *marital skew,* extreme domination by one emotionally disturbed partner is accepted by the other, who implies to the children that the situation is normal. In the *marital schism* scenario, parents undermine their spouses, threats of divorce are common, and each parent vies for the loyalty and affection of the children.

Bowen was especially interested in the symbiotic mother-child bonds that he hypothesized might lead to schizophrenia. Hospitalizing entire families on the research wards for months at a time in order to observe ongoing family interactions, Bowen (1960) broadened his outlook, observing emotional intensity throughout these families. As a result, he moved from his previous psychoanalytic viewpoint to one that emphasized reciprocal functioning, in what he labeled the *family emotional system.*

Lyman Wynne, who succeeded Bowen at NIMH, turned his attention to the blurred, ambiguous, confused communication patterns he and his associates found in families with schizophrenic members (Wynne, Ryckoff, Day, & Hirsch, 1958). Wynne coined the term *pseudomutuality* to describe a false sense of family closeness in which the family gives the appearance of taking part in a mutual, open, and understanding relationship without really doing so. The members of these families have poorly developed personal identities and doubt their ability to accurately derive meaning from personal experiences outside the family, preferring to remain within the safe and familiar family system with its enclosed boundaries.

Psychodynamics of Family Life

Trained in psychoanalytic work with children, Nathan Ackerman nevertheless saw the value of treating entire families as a unit in assessing and treating dysfunctional families. In his landmark book *The Psychodynamics of Family Life,* often considered the first text to define the new field, Ackerman (1958) argued for family sessions aimed at untangling interlocking pathologies, thus endorsing the systems view that problems of any one family member cannot be understood apart from those of all other members.

By working therapeutically with nonschizophrenic families, Ackerman demonstrated the applicability of family therapy to less disturbed patients. By 1962, he in New York and Don Jackson on the West Coast founded the first journal in the field, *Family Process,* with Jay Haley as editor. This periodical enabled researchers and practitioners to exchange ideas and identify with the growing field of family therapy.

Delinquent Families

One project combining theory and practice was led by Salvador Minuchin (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) at the Wiltwyck School for Boys in

upper New York State, a residential setting for delinquent youngsters from urban slums. Recognizing the limitations of traditional methods for reaching these boys, who were generally from poor, underorganized, fatherless homes, Minuchin developed a number of brief, action-oriented therapeutic procedures aimed at helping reorganize unstable family structures.

Current Status

The current trend in family therapy is toward eclecticism and integration of therapeutic approaches (Lebow, 1997) since no single technique fits all clients or situations. Multisystemic approaches, research-based whenever possible, are being used to treat a variety of behavioral and emotional problems in adolescents and entire families as therapists select and borrow from one another's theories to address a current therapeutic problem. However, according to Goldenberg and Goldenberg (2008), eight theoretical viewpoints and corresponding approaches to family therapy can be identified.

Object Relations Family Therapy

The psychodynamic view is currently best expressed by object relations family therapists (Hughes, 2007 Scharff & Scharff, 2006), who contend that the need for a satisfying relationship with some "object" (i.e., another person) is the fundamental motive of life. From the object relations perspective, we bring *introjects*—memories of loss or unfulfillment from childhood—into current dealings with others, seeking satisfaction but sometimes "contaminating" family relations in the process. Thus, they argue, people unconsciously relate to one another in the present largely on the basis of expectations formed during childhood. Individual intrapsychic issues and family interpersonal difficulties are examined in a therapeutic setting. Helping family members gain insight into how they internalized objects from the past and how these objects continue to intrude on current relationships is the central therapeutic effort, along with providing understanding and instigating change. Treatment is aimed at helping members become aware of those unresolved objects from their families of origin and at increasing their understanding of the interlocking pathologies that have blocked both individual development and fulfillment from family relationships.

Experiential Family Therapy

Experiential family therapists such as Satir and Whitaker believe that troubled families need a "growth experience" derived from an intimate interpersonal experience with an involved therapist. By being real or authentic themselves, and often self-disclosing, experiential therapists contend that they can help families learn to be more honest, more expressive of their feelings and needs, and better able to use their potential for self-awareness to achieve personal and interpersonal growth.

For Virginia Satir, building self-esteem and learning to communicate adequately and openly were essential therapeutic goals. Calling his approach *symbolic—experiential family therapy,* Carl Whitaker gave voice to his own impulses and fantasies and depathologized human experiences as he helped family members probe their own covert world of symbolic meanings, freeing them to activate their innate growth processes. Currently, experiential family therapy is best represented by *emotion-focused couple therapy* (Greenberg & Goldman, 2008), an attachment-theory-grounded experiential approach based on humanistic and systemic foundations that attempts to change a couple's negative interactions while helping them cement their emotional connection to each other.

Transgenerational Family Therapy

Murray Bowen argued that family members are tied in thinking, feeling, and behavior to the family system and thus that individual problems arise and are maintained by relationship connections with fellow members. Those persons with the strongest affective connections (or *fusion*) with the family are most vulnerable to personal emotional reactions to family stress. The degree to which an individualized, separate sense of self independent from the family (or *differentiation of self*) occurs is correlated with the ability to resist being overwhelmed by emotional reactivity in the family; the greater the differentiation, the less likely the individual is to experience personal dysfunction.

Bowen (1978) believed that the child most vulnerable to dysfunction is the one most easily drawn into family conflict. He maintained that the most attached child will have the lowest level of differentiation, will be the least mature and thus have the hardest time separating from the family, and is likely to select as a marital partner someone who is also poorly differentiated in his or her family. The least differentiated of their offspring will marry someone equally undifferentiated, and so forth. In this formulation, problems are passed along to succeeding generations by a multigenerational transmission process. Bowen maintained that schizophrenia could result after several generations of increased fusion and vulnerability.

Another transgenerational family therapist, Ivan Boszormenyi-Nagy (1987), emphasizes the ethical dimension (trust, loyalty, entitlements, and indebtedness) in family relationships, extending over generations. He focuses on the relational ethics within a family aimed at preserving fairness and ensuring fulfillment of each member's subjective sense of claims, rights, and obligations in relation to one another. To *contextual therapists* such as Boszormenyi-Nagy, the patterns of relating within a family that are passed down from generation to generation are the keys to understanding both individual and family functioning.

Structural Family Therapy

Minuchin's (1974) structural view focuses on how families are organized and on what rules govern their transactions. He pays particular attention to family rules, roles, alignments, and coalitions, as well as to the boundaries and subsystems that make up the overall family system. Symptoms are viewed as conflict defusers, diverting attention from more basic family conflicts. Therapeutically, structuralists challenge rigid, repetitive transactions within a family, helping to "unfreeze" them to allow family reorganization (Minuchin, Nichols, & Lee, 2006).

Strategic Family Therapy

This approach involves the designing of novel strategies by the therapist for eliminating undesired behavior. Strategists such as Jay Haley (1996) are not particularly interested in providing insight to family members; they are more likely to assign tasks to get families to change those aspects of the system that maintain the problematic behavior. Sometimes indirect tasks, in the form of *paradoxical interventions,* are employed to force clients to abandon symptoms. Therapists at the Mental Research Institute in Palo Alto believe families develop unworkable "solutions" to problems that become problems themselves. Consequently, these therapists have evolved a set of brief therapy procedures employing various forms of paradox aimed at changing undesired family interactive patterns (Watzlawick, Weakland, & Fisch, 1974).

In Milan, Italy, Mara Selvini-Palazzoli and her colleagues (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978) developed *systemic family therapy,* a variation of strategic family

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.)

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.

ANNOTATED BIBLIOGRAPHY

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.