

Basic Family Therapy

Basic Family Therapy

Sixth Edition

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Foreword

It was a pleasure and a privilege to read the sixth edition of this book. It is more difficult, however, to write an adequate introduction, as there are few enthusiastic phrases that have not already been invoked to describe the various editions of Philip Barker's book that have appeared since the first in 1981. The previous editions have been described as '*A Classic Book for Clinicians*' (*British Journal of Psychiatry*) and as '*Comprehensive and Stimulating*' (*Journal of Clinical Psychiatry*). In *Contemporary Psychiatry*, an enthusiastic reader gushed, '*There is an exhilaration at being exposed to a thorough and articulate scholar,*' while suggesting the book '*should be required reading for all students in mental health disciplines*'.

I would like to be clear that this is an eminently readable book for those who are new to the discipline. Anyone who is not new to the discipline, however, and has seen a previous version will know this; readers and reviewers before me have commented on the skill of the author, who could write a book on the complex and theoretically diverse domain of family therapy that is at once scholarly yet thoroughly accessible.

Readers of previous editions will find the update worthwhile and may be reassured to note a familiar ordering to many of the chapters. For new readers, a quick tour of the book is warranted to provide a road map. Chapter 1 reviews the evolution of family therapy beginning in the 1950s and, consistent with previous editions, uses a decade-by-decade approach to chronicle theoretical advances in the field. The chapter succinctly summarizes the influence of the postmodern approach on family therapy. Chapter 2 moves to a discussion of healthy families and their development, including a distinction between 'normal' and 'healthy' families. The authors use the framework provided by Barnhill and Longo to discuss the developmental stages of families. Chapter 3 reviews important theoretical concepts underlying family therapy, such as theoretical influences derived from individual and group therapy. The authors reflect on the importance of systems thinking and system theory, control theory, cybernetics, learning theory and communication theory, returning to the influence of postmodern approaches and the collaborative model.

Chapter 4 begins the transition to the clinical environment with a cogently articulated argument for why it is important that the therapists have a well-developed model to guide therapeutic encounters. Both Philip Barker and Jeff Chang provide their own perspectives on how they acquired coherent models of therapy, finishing the chapter with some suggestions on selecting and adapting a model of therapy.

The book then transitions into the most clinically oriented sections, beginning with a review of various methods for assessing families (Chapter 5) and progressing through setting of treatment goals (Chapter 7), indications and contraindications for family therapy (Chapter 8) and practical tips for dealing with issues such as reluctant or missing family members (Chapter 9). Chapter 11 outlines approaches for complex problems, including providing a detailed approach to, and a clinical vignette of, a paradoxical intervention. Chapter 13 returns us to a more theoretically oriented discussion that knits the various clinical chapters into a coherent method of conducting therapy.

Throughout the chapters there are concise and effective clinical vignettes that highlight important concepts and keep the reader focused on the real world. More recent editions of this book had incorporated the (then) emerging perspective of family therapy as a collaborative process in which the family members and the therapist are partners. This perspective is woven into the fabric of this text and, I believe, contributes to the warmth that emanates from the pages. It seems clear that these are therapists who are fully and respectfully engaged with the families they encounter, not only treating them, but learning from them, always understanding something new. If it is possible for a book to not only educate but to *model* an approach to therapy, this one does so.

The remaining chapters deal with 'specialty issues'. Chapter 14 is devoted specifically to couples therapy, while Chapter 15 deals with termination of treatment and interruptions. As in earlier editions, the book includes not only an outline of how to approach family therapy from a clinical perspective, but also from the educational and research domains. Chapter 16 provides an overview of teaching family therapy, including objectives, approaches and learning to supervise. Rounding out the tour, Chapter 17 reviews topical issues in research, including a section on how family therapists may be more involved in research.

Philip and Jeff note in their introduction that the field of family functioning is becoming more complex, which increases the challenge of producing a true beginner's textbook. They have risen fully to the challenge and the result is a superbly enjoyable and informative discussion of practical approaches to family therapy. This has been the authors' first experience of turning the extremely successful single-authored edition (Philip Barker wrote the first five editions as a sole author) into a joint effort and that too appears to have been accomplished with no appreciable difficulty. How many drafts passed between them, I do not know, but this version is seamless in voice, level of detail and focus on the clinical setting.

I would challenge any reader to identify the sections written by one or the other with any reliability. The authors also write of their fascination with family therapy and, as suggested above, this shines through each section. Their obvious pleasure and enthusiasm for helping families, and the creative, flexible but theoretically grounded approaches they describe for approaching families can only come from therapists who have become highly fluent in their therapeutic languages.

The only thing disappointing about this book is that it left me wanting something that I am doubtful I will receive—*Beyond the Basics of Family Therapy* written with the same relaxed, engaging and clinically relevant style.

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Introduction

It has been 6 years since the fifth edition of this book was published, and there have been many developments in family therapy over the course of these years. Increasingly, family therapy is being seen as an important therapeutic resource, as well as a legitimate area for study and research. Various new approaches to the treatment of families in distress continue to emerge, and the approaches already in use are continually being refined and their application better understood.

What is clear, and has been for quite some time, is that there are many ways of helping families in difficulty. As I pointed out in my introduction to the fifth edition, one size most definitely does not fit all. The inescapable truth is that the whole field of family functioning, and the ways this can go awry, are becoming ever more complex. This, in turn, makes the task of producing a clear, easily understood beginners' text all the more challenging. And so, much as I love writing, I realized that having an experienced family therapist as my co-author would be a good idea. I was, therefore, singularly fortunate when Dr. Jeff Chang presented himself and offered to work with me on this edition.

Jeff, a counselling psychologist specializing in work with families, has 30 years of experience in this field. Over the years he has honed his skills in using a family systems approach to a whole range of clinical problems. In other words, he was just the person I needed to work with me on this new edition. So welcoming him as my co-author was a breeze.

The purpose of this book remains the same as that of earlier editions. Its aim is to present the basics of its subject for those coming to family therapy afresh. It does not aim to go deeply into any of the material it presents. Instead, it offers references that the reader who wants to learn more can consult. In other words, as its title implies, it presents the basics of the subject.

Jeff and I hope that this new edition of *Basic Family Therapy* will be a helpful introduction to its subject, and that its readers will find this field of study as fascinating as we do.

Philip Barker
March, 2013

Chapter 1

The Development of Family Therapy

Family therapy emerged, in the years following the Second World War, as a novel means of helping people with psychiatric, emotional and relationship problems. Previously, such people's problems had generally been understood as being theirs, rather than existing in their families or wider social environments. While their family environments often appeared problematic – whether they were considered cause or effect of the subjects' difficulties – the 'solution' favoured was often to remove the patient/client from their family and local environment to a different setting. This was sometimes a psychiatric hospital or institution far removed from the subject's home and family.

The treatment of the individual sufferer, whether living at home or not, continued to be focused on the individual rather than the family group. Before the Second World War, and up to the 1950s, even the 1960s, psychoanalysis reigned supreme. The work of Sigmund Freud and of such contemporaries of his as Carl Jung and Alfred Adler was highly regarded and influenced strongly the therapeutic approach of many practitioners.

The pioneers of family therapy, on the other hand, rejected this approach. Instead, they advocated tackling the family and other environmental problems in the setting where they operated. In its day, this was a somewhat revolutionary idea.

Family therapy's early years

Family therapy was but one of the several new therapeutic approaches that emerged during the 1950s. These included a variety of new drugs, especially a range of antipsychotics and antidepressants. Chlorpromazine was the first antipsychotic to become available. It was soon followed by many others, mostly related chemically and pharmacologically to it. It is no exaggeration to say that chlorpromazine and similar compounds revolutionized the treatment of schizophrenia, a condition which the early family therapists had struggled to understand and treat effectively.

At about the same time antidepressant drugs made their appearance. The first of these was a 'tricyclic' compound named imipramine. It was soon followed by other similar drugs. Then behaviour therapy, and its close relative, cognitive behavioural therapy, joined the throng of new treatments. As new treatments came on the scene, the shackles of psychoanalysis and other psychodynamic approaches were gradually loosened.

Despite the developing competition, the family therapy pioneers continued their studies of the *families* of individuals with schizophrenia and other mental disorders. One of the first of these was Christian Midelfort whose book *The family in psychotherapy* was published in 1957. This was followed, in 1958, by *The psychodynamics of family life*, by Nathan Ackerman, one of the foremost of the family therapy pioneers. Ackerman pointed out that while psychiatrists had 'acquired adeptness in the retroactive study of mental illness, in the minute examination of family histories . . . they (had) not yet cultivated an equivalent skill in the study of family process in the here and now' (Ackerman, 1958, p. 89). He went on to say that, by acquiring skills in working with whole family groups, we would come to add 'a new dimension to our insights into mental illness as an ongoing process that changes with time and the conditions of group adaptation'. Prophetic words indeed!

Family therapy sprung up in a variety of centres that were not initially closely connected. Each tended to be inspired and led by an, often charismatic, creative therapist. Ackerman was one of the first of these. His second book, *Treating the troubled family*, was published in 1966 and was one of the first books focusing on the treatment of 'the family as an organic whole'.

Another pioneer was John Elderkin Bell, but he did not publish descriptions of his work until the early 1960s (Bell, 1961, 1962), and his book *Family therapy* did not appear until 1975 (Bell, 1975).

During the 1950s, several groups embarked on the study of subjects suffering from schizophrenia, and their families. In 1952, Gregory Bateson obtained a grant to study communication and its different levels. He was joined in 1953 by Jay Haley and John Weakland, and by a psychiatrist, William Fry. In 1954 the group initiated a 'Project for the Study of Schizophrenia'. Don Jackson joined this group as a consultant and as the supervisor of psychotherapy with patients with schizophrenia. This group's work had a profound influence on the thinking of many family therapists. Bateson and his colleagues introduced the concept of 'double bind', discussed in a later section.

The Mental Research Institute (MRI) was founded by Don Jackson, in Palo Alto, California, in 1959. Although Jackson acted as consultant to the Bateson group, the MRI was a separate entity. It had an important role in the development of family therapy, and continued after Bateson's group disbanded in 1962.

Theodore Lidz (Lidz & Lidz, 1949) began studying the families of patients with schizophrenia at Johns Hopkins Hospital, Baltimore, in 1941, later moving to Yale University. He introduced the concepts of *schism*, the division

of the family into two antagonistic and competing groups; and *skew*, where there is one partner in the marriage who dominates the family to a striking degree, as a result of serious personality disorder in at least one of the partners.

Lyman Wynne started studying the families of schizophrenic patients while on the staff of the National Institute of Mental Health, which he joined in 1952. In 1972, he became a professor in the Department of Psychiatry at the University of Rochester, New York, and continued his studies there until his retirement. He introduced the concepts of *pseudo-mutuality* and *pseudo-hostility*.

A person in a pseudo-mutual relationship (Wynne, Ryckoff, Day, & Hirsch, 1958) tries to maintain the idea or feeling that he or she is meeting the needs of the other person, in other words, that there is a mutually complimentary relationship. Those involved in pseudo-mutual relationships are concerned with fitting together at the expense of their respective identities. Genuine mutuality, by contrast, thrives upon divergence, the partners in the relationship taking pleasure in each other's growth. In pseudo-mutuality, there is dedication only to the facade of reciprocal fulfilment, not to its actuality.

Pseudo-hostility exists when a hostile relationship is a substitute for a true, intimate relationship, which is absent. Wynne and his colleagues concluded that the families of 'potential schizophrenics' are characterized by pseudo-mutuality and consequently have rigid, unchanging role structures to which they cling, as they feel they are essential.

Wynne et al. (1958) also introduced the concept of the 'rubber fence', a psychological boundary by which family members are confined within the family system. If necessary the 'fence' can move to ensure that the members remain part of a self-sufficient social system.

Other early family therapy pioneers included Carl Whitaker and Ivan Boszormenyi-Nagy, both of whom were psychoanalytically trained but became family therapists. Boszormenyi-Nagy and his colleague, James Framo, edited the book *Intensive family therapy* (1965). Boszormenyi-Nagy founded the Eastern Pennsylvania Psychiatric Institute in Philadelphia in 1957.

Boszormenyi-Nagy, with colleagues James Framo, David Rubinstein, Geraldine Spark and Gerald Zuk, developed an approach to family therapy that paid particular attention to its multigenerational aspects. They introduced the term 'invisible loyalties', the title of a book of which Boszormenyi-Nagy was co-author (Boszormenyi-Nagy & Spark, 1973). This group believed that therapy should not be limited to the nuclear family, or to current transactions, but should also consider multigenerational linkages.

Two other pioneers were Murray Bowen and the British psychiatrist Ronald Laing. Bowen (1960) saw schizophrenia as a process requiring three generations to develop. Laing also studied the families of patients with schizophrenia. His findings concerning the first 11 patients and families were reported by Laing and Esterson (1964). He was interested in the process of

mystification (see Laing, 1965), which he linked with the ‘six ways to drive the other person crazy’ proposed by Searles (1959).

It will be clear from the above brief summary that much of the work of the early pioneers of family therapy was devoted to the study of the processes occurring in their patients, particularly those suffering from schizophrenia. But in the matter of *therapy*, that is of relieving their patients of their symptoms or remedying the underlying causes of the symptoms, little progress was made. It was perhaps unfortunate, viewed with the benefit of hindsight, that so much attention was given to schizophrenia at the expense of other psychiatric disorders.

The 1960s

Bateson’s group disbanded in 1962, but most of the pioneers mentioned above continued their work with families during the 1960s. Despite having had psychoanalytic training, Jackson increasingly concentrated on the study and treatment of interpersonal processes. His work was reported in a series of papers, some written with John Weakland (Jackson & Weakland, 1959, 1961; Jackson, 1961, 1965). Jackson was also co-author of *Pragmatics of human communication* (Watzlawick, Beavin, & Jackson, 1967), which set out much of what had been discovered at the MRI concerning human communication, especially in families. Jackson died in 1968.

Jay Haley, originally a member of Bateson’s group, was also much influenced by the work of Milton Erickson, which he later described in *Uncommon therapy: The psychiatric techniques of Milton H. Erickson* (Haley, 1973). *Strategies of psychotherapy* (Haley, 1963) set out Haley’s early position, and a series of publications have since traced his development as one of the most creative of the fathers of family therapy (Haley, 1967, 1976, 1980, 1984).

Haley took a directive approach in treating families. He also saw many family problems as due to confused or dysfunctional hierarchies within the family. So he worked actively to get families to do something different that would help them change their dysfunctional ways of interacting.

During the 1960s, Murray Bowen expanded his work by tackling families with children who had problems other than schizophrenia. He also described what he called the *undifferentiated ego mass*, observing that in many troubled families members often lacked separate identities (Bowen, 1961).

In the mid-1960s, Bowen experienced an emotional crisis, which he came to understand as related to the process of *triangulation* in his family of origin. Triangulation occurs when a third member is drawn into the transactions between two people. Instead of communicating directly with each other the couple communicate through the triangulated third person, who may be a child. Bowen came to believe that this situation existed in his family of origin. He, therefore, returned to his family in Pennsylvania and managed to ‘detriangulate’, as he described in a paper he published anonymously (Anonymous, 1972). This is included in *Family therapy in clinical practice*.

Ackerman continued his work throughout the 1960s, and in 1961, he and Jackson co-founded *Family Process*, the first journal devoted to family therapy. He made many other contributions to the family therapy literature (Ackerman, 1961, 1966, 1970a, 1970b, 1970c). He died in 1971.

Virginia Satir joined Jackson shortly after he founded the MRI. Her book *Conjoint family therapy* (Satir, 1967) influenced many therapists. She was particularly interested in the communication of feelings in families and in the personalities and development of the individuals in the family.

Salvador Minuchin, a native of Argentina and a psychoanalytically trained psychiatrist, came to New York to work with young delinquents at the Wiltwyck School for Boys in New York City. Realizing the limitations of the current methods used to treat these boys and their families, he and his colleagues developed their own treatment methods, reported in *Families of the slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). This embodied the 'structural' approach, more fully described in *Families and family therapy* (Minuchin, 1974). It is discussed further in Chapter 5.

Minuchin also advocated the use of the one-way observation screen. Prior to its introduction, family therapists rarely watched each other working. Therapists in training were able only to report to their supervisors what they believed had happened during their therapy sessions. Family therapists opened up the process, both by being able to observe what was happening through one-way observation screens and, later, by the use of closed-circuit television and audiovisual recordings.

Although most of the early family therapists worked in the United States there were developments elsewhere. A 'family psychiatric unit' was established at the Tavistock Clinic, London, in the late 1940s. Under the direction of Dicks (1963, 1967), the staff of this unit worked mainly with marital couples who were having problems in their relationships. Another British therapist was Robin Skynner, who made two noteworthy contributions to the family therapy literature before the 1970s (Skynner, 1969a, 1969b). In Germany, family therapy had made enough progress that Horst Richter could, by 1970, publish his book *Patient familie*. This was later translated into English and published as *The family as patient* (Richter, 1974). In Montreal, Canada, Nathan Epstein led the 'family research group' at the Department of Psychiatry of the Jewish General Hospital. His team developed one of the earlier systems for describing family functioning, the 'Family Categories Schema' (Epstein, Rakoff, & Sigal, 1968).

The 1970s

Many feel that family therapy came of age in the 1970s. It was increasingly accepted in major psychiatric centres, and family therapists began to address themselves to a wider range of disorders. Many new centres for the study and development of family therapy were established and many new books appeared.

In 1971, the American Association for Marriage and Family Therapy (AAMFT) developed the first set of standards for the approval of family

therapy training programmes. This resulted, in 1975, in formalized accreditation standards. In 1978, these were recognized by the United States Department of Health, Education, and Welfare. This was an important step in the professionalization of family therapy in the United States and Canada.

Papp (1977) edited *Family therapy: Full length case studies*, which presented the work of 12 prominent family therapists, including herself. Each contributed an account of the treatment of a family. The book provides a snapshot of family therapy in the 1970s and illustrates the diversity of approaches used by therapists at that time. Hoffman's (1981) *Foundations of family therapy: A conceptual framework for systems change* surveyed the state of family therapy as the 1970s came to an end.

The Philadelphia Child Guidance Clinic, under Salvador Minuchin's leadership, became one of the world's leading family therapy centres. The child guidance clinic was closely associated with the Children's Hospital of Philadelphia, facilitating the joint study of children with psychosomatic disorders and their families. This led to the book *Psychosomatic families: Anorexia nervosa in context* (Minuchin, Rosman, & Baker, 1978).

Jay Haley spent several years at the Philadelphia Child Guidance Clinic before going to Washington, DC, where, with his wife, Cloe Madanes, he founded the Family Institute of Washington, DC. Also established in Washington, DC, by Murray Bowen, was the Georgetown Family Center.

During the 1970s Murray Bowen continued to refine his theory, renaming the 'undifferentiated family ego mass' the 'nuclear family emotional system'. He ceased treating the families of schizophrenics, applying his methods instead to a wider range of problems. Wynne, on the other hand, continued his studies of schizophrenia and their families and built up a team of researchers at the University of Rochester (Wynne, Cromwell, & Matthyse, 1978). They also addressed the issue of the relative 'invulnerability' of some children by studying the presence of healthy communication patterns and other aspects of healthy family functioning that may coexist with disturbed family relationships.

In Canada, Nathan Epstein and his colleagues made the Department of Psychiatry at McMaster University, Hamilton, Ontario, an important centre for the practice and teaching of family therapy. With colleagues he developed, from the Family Categories Schema, the McMaster Model of Family Functioning (Epstein, Bishop, & Levin, 1978) and, later, the McMaster Model of Family Therapy (Epstein & Bishop, 1981).

The 1970s also saw important developments in Europe, especially Italy and Great Britain. In Milan, Italy, Mara Selvini Palazzoli played a major role in setting up the Institute for Family Study. This was founded in 1967 but had its main impact in the 1970s. She was one of the four psychoanalytically trained psychiatrists who became the 'Milan Group'. The others were Gianfranco Cecchin, Giuliana Prata and Luigi Boscolo. They were much influenced by the work of the Palo Alto therapists, especially Bateson, and by Watzlawick and his colleagues. They found that families often came for help, yet seemed determined to defeat the attempts of their therapists to

help them change. They proposed the term ‘families in schizophrenic transaction’ for such families and described them, and their treatment, in the book *Paradox and Counterparadox* (Palazzoli, Boscolo, Cecchin, & Prata, 1978; the book was originally published in Italian in 1975).

Among the contributions to family therapy made by the Milan group were their techniques of ‘circular interviewing’ and ‘triadic questioning’, whereby the therapist asks a third family member about what goes on between two others; their concept of developing hypotheses about the functioning of a family in advance of the interview and then devising questions to test the hypotheses; developing a better understanding of how the ‘symptom’ is connected to the ‘system’; and their way of structuring each therapy session. The latter comprised a five-part ‘ritual’ consisting of a pre-session discussion, the interview, the inter-session discussion, the intervention and the post-session discussion.

In Rome, Maurizio Andolfi started working with families early in the 1970s and in 1974 founded the Italian Society for Family Therapy. By 1979, he was able to publish an excellent systems-based book, *Family therapy: An interactional approach* (Andolfi, 1979).

In Britain, Skynner, in 1976, published *One flesh: Separate persons* (published in the United States as *Systems of family and marital psychotherapy*). This provided a view of family therapy as seen by a British psychiatrist trained in the Kleinian School of Therapy. Important work was also being done at the Family Institute in Cardiff, Wales. The first director of this institute, Walrond-Skinner (1976), published *Family therapy: The treatment of natural systems*, a book addressed primarily to social workers. Brian Cade and Emilia Dowling were among other members of the staff of this institute who were responsible for placing it in the forefront of family work in Britain. Walrond-Skinner (1979) also edited the book *Family and marital psychotherapy*, with contributions from 11 British family therapists, giving a wide-ranging view of the British family therapy scene at that time.

Milton Erickson must be mentioned here. Erickson was not a family therapist. He was an unconventional but creative psychiatrist who made much use of hypnosis in his practice of psychotherapy. He studied hypnotic phenomena throughout his long career and published extensively on hypnotherapy. He greatly influenced Haley who wrote *Uncommon therapy: The psychiatric techniques of Milton H. Erickson* (Haley, 1973), a fascinating description of how Erickson worked.

Erickson’s importance in the development of family therapy is due to his interest in the interpersonal processes in which his patients were engaged and his use of strategic and solution-focused methods of treatment. Traditional psychodynamic psychotherapy explores and aims to resolve the repressed conflicts of individuals. The objective of the family therapist is rather to get the family members to *do* something different, to interact with each other in a different way; this was how Erickson approached many of the clinical problems with which he was confronted. Moreover, he found, as family therapists have too, that telling people what to do does not always

work. Instead indirect, or ‘strategic’, methods, including paradoxical ones, may be needed.

Conversations with Milton H. Erickson, MD, Volumes II and III (Haley, 1985a, 1985b), consist of transcriptions of conversations between Erickson and, in most cases, Jay Haley and John Weakland. These took place in the 1950s and early 1960s and make it clear that Erickson had by that time developed many innovative, strategic ways of helping families change. Erickson’s influence on the mainstream of family therapy has mainly been indirect, however. He himself wrote little on the subject and his innovative ideas were spread mainly by those who studied with him, notably Haley and Jackson.

The 1970s also saw an explosive development of the family therapy literature. Books not so far mentioned include *Family therapy: Theory & practice* (Guerin, 1976), *The family life cycle* (Carter & McGoldrick, 1980) and the first two editions of this book (Barker, 1981, 1986). Many new journals joined *Family Process*.

The 1980s

The 1980s saw something of a *rapprochement* between the various schools of family therapy. Many of the pioneers were charismatic characters with strongly held views. So in family therapy’s early days, it was hard to discern a body of knowledge which all, or even most, family therapists would accept. Increasingly, however, a middle ground was defined, if not precisely, as therapists of previously distinct schools began to accept and use the concepts and techniques of others.

New concepts and techniques also continued to emerge. These included the ‘narrative’ approach and the technique of ‘externalizing’ problems of the creative Australian therapist, Michael White (White & Epston, 1990); various cognitive approaches to treating family problems (Epstein, Schlesinger, & Dryden, 1988); and the ‘systematic family therapy’ of Luciano L’Abate (1986). In *Milan systemic family therapy* (Boscolo, Cecchin, Hoffman, & Penn, 1987), two of the original members of the Milan group, with Lynn Hoffman and Peggy Penn, set out a method of therapy developed from that presented in *Paradox and counterparadox* (Palazzoli et al., 1978). Minuchin’s contribution in the 1980s was *Family Kaleidoscope* (Minuchin, 1984). Beautifully written, it presented this great family therapist’s views of the contemporary family and how families may be helped. Another development was brief, ‘solution-focused’ therapy. *Patterns of brief family therapy* (de Shazer, 1982) was influential in this. It describes the work of the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin, and is presented as a ‘practical integration of Milton Erickson’s clinical procedures and Gregory Bateson’s theory of change’:

The work at BFTC owed a lot to the MRI approach as well. This book describes a quite stylized approach to therapy, employing a therapy team,

one member being the ‘conductor’, the person who goes into the room with the family, the others being the observers behind the one-way screen. The team, observers and conductor devise interventions, which are often tasks for the family to perform that may enable the family see their problems in a different light. In other words, the problems are ‘reframed’.

In de Shazer’s next book, *Keys to solution in brief therapy* (de Shazer, 1985) the distinctive solution-focused approach began to emerge. de Shazer and his colleagues devised an approach in which the characteristics of the problem were noted and ‘skeleton keys’ were devised as solutions for each type of problem. Soon after, the BFTC staff published an article entitled *Brief therapy: Focused solution development* (de Shazer et al., 1986). This article was not only a homage to the MRI approach (Weakland, Fisch, Watzlawick, & Bodin, 1974), but also represented a clear break from it.

The BFTC group advanced the idea, quite radical at the time, that a therapist does not need to know much about a problem in order to build solutions. One only needs to know *what the client wants*, that is, what hypothetical solutions would look like – elicited by the ‘miracle question’, or other similar questions. This was more fully described in de Shazer’s (1988) next book, *Clues: Investigating solutions in brief therapy*.

During the 1980s, books appeared focusing on various particular aspects of family therapy such as ‘transgenerational patterns’ (Kramer, 1985); ‘doing therapy briefly’ (Fisch, Weakland, & Segal, 1982); the use of rituals (Imber-Black, Roberts, & Whiting, 1988); ‘families in perpetual crisis’ (Kagan & Schlosberg, 1989); and the use of family systems principles in family medicine (Glenn, 1984; Henao & Grose, 1985) and in nursing (Wright & Leahey, 1984, 2005); the families of adolescents (Mirkin & Koman, 1985); and the alcoholic family (Steinglass, Bennett, Wolin, & Reiss, 1987).

In *Expanding the limits of family therapy* (Nichols, 1987) Nichols says, on page x, ‘If people were billiard balls, their interaction could be understood solely on the basis of systemic forces. The difference is that human beings interact on the basis of conscious and unconscious expectations of each other’. In advocating for the inclusion of consideration of family members’ personal experience in the family therapist’s thinking, Nichols takes further the ideas of Kirschner and Kirschner (1986).

1990s and the new millennium

Family therapy now has an established place among the psychotherapies. The initial enthusiasm of some has given way to a more balanced view of its place in the therapeutic scheme of things.

Steinglass (1996), writing as the journal *Family Process* entered its 35th year of publication, mentioned family therapy’s ‘ups and downs’. He used its approach to major mental disorders as an example. He pointed out that during the 1960s and 1970s family therapists were ‘hot on the trail’

of family factors that might cause or contribute to schizophrenia, but they largely abandoned this as evidence of genetic factors emerged. Yet during the 1990s, they were back working with patients with schizophrenia and their families, psychoeducational family therapy now being viewed as important.

Some of the assumptions made, implicitly if not overtly, during the 1960s have been questioned. For example, free and open communication within families was assumed to characterize healthy functioning. But an in-depth examination of the question of secrets in families (Imber-Black, 1993) showed that this is not a simple issue. Some secrets are 'functional' and the borderline between pathological secrecy and appropriate privacy is not always clear.

In the book *Therapy as social construction* (McNamee & Gergen, 1992), a series of writers questioned many of the traditional views of the process of therapy. The editors wrote of how they saw that there had been 'a generalized falling-out within the academic world with the traditional conception of scientific knowledge' (p. 4). The concept of the scientist, or the therapist, being the 'expert' who will solve people's problems has come to be questioned. Many now believe that solutions of many of our problems must come from within.

But family therapy theories come and go. Thus, the concept of the 'functionality' of symptoms and the behaviour of family members was popular in the early days of family therapy, but later fell into disrepute. But now it is being suggested that it may have a place and needs to be revisited (Roffman, 2005). New approaches to therapy have continued to be developed. The use of the 'reflecting team' (see Hoffman, 2002, pp. 149–168) is but one example.

During the 1990s, interest increased in the application of cognitive behavioural methods in family therapy. In *Understanding and helping families: A cognitive-behavioral approach*, Schwebel and Fine (1994) described and discussed the 'cognitive-behavioural family model' (CBF). The basis of this approach is the assumption that the 'experiences, thoughts, emotions and behaviours (of individuals) are heavily shaped by the manner in which they cognitively structure their world' (p. 30). Therapy aims 'to help participants become aware of and correct' their unhealthy cognitions.

In Chapter 3 (pp. 36–55) of their book, Schwebel and Fine describe the *family schema*. In CBF, this term describes 'all the cognitions that individuals hold about their own family life and about family life in general' (p. 50). These cognitions are 'the guidance system that directs the individual's family related behaviour' (p. 55) and may need to be a focus of attention. Since that was written, the application of cognitive behavioural techniques in family therapy has received increasing attention (Dattilio, 2005; Dattilio & Epstein, 2005).

Another development has been increased attention to spiritual issues. These have come to be seen by many as an important consideration when working with families (Hodge, 2005).

Family therapy is also being applied to an ever-widening range of family types and ethnic groups. For example, the September 2005 issue of *Contemporary Family Therapy* was devoted to *Treating Indian Families: In India and Around the World*.

Nurturing queer youth: Family therapy transformed (Fish & Harvey, 2005) addressed the issue of working with 'sexual minority youth'. The authors prefer this term or, more simply, *queer youth*, to terms such as *gay*, *lesbian*, *bisexual* and *transgendered*, because they consider the former term to be more inclusive. They point out that young people are 'coming out', to themselves, to their families and to their wider environment at ever younger ages. Fish and Harvey discuss the challenge of working with such young people and their families.

The second edition of *Family therapy in changing times*, by Gorell Barnes (2004) took a broad look at the diversity of family forms created by such things as:

- New cohabitation and marriage patterns
- The choice by some of lone parenthood
- Divorce and re-partnering
- Gay and lesbian parenting
- Migration
- Cultural diversity

The book discusses methods of working with families affected by such circumstances.

The family forms that Barnes considers are but a few of the many that exist around the world. Religious practices and cultural traditions vary enormously. For example, in the Muslim faith the sexes worship separately, whereas Christian couples can, and usually do, worship together (Hünler & Gençö, 2005). In some countries, polygamy is accepted and indeed, as this is written, King Mswati II of Swaziland has, probably, 14 wives and 23 children, though 3 is the usual maximum number of wives.

The 1990s saw the emergence of the 'post-modern' approach to therapy. This was well described in Harlene Anderson's (1997) book *Conversation, language, and possibilities*. The 'post-modernists' reject the concept of the therapist as the expert with the skills and knowledge to promote change in the family so that it becomes more 'functional'. Instead, therapy becomes a collaborative endeavour involving family and therapists as equals. Anderson (1997, p. 32) writes:

In the modern perspective therapy constitutes a dominant cultural-truth-informed, *therapist-led endeavour* and yields *therapist-determined possibilities*. These truths determine and actualize a priori, across-the-board diagnoses, goals and treatment strategies. (Anderson's italics)

Anderson (1997, Chapters 5 and 6) goes on to provide one of the clearer descriptions of the post-modern approach to therapy. No longer is the therapist 'an objective, neutral, and technical expert who is knowledgeable about

pathology and normalcy and who can read the inner mind of a person like a text' (p. 93). By contrast, in the collaborative approach the focus 'is on a relational system and process in which client and therapist become conversational partners in the telling, inquiring, interpreting, and shaping of the narratives' (p. 95). Anderson continues:

A client brings expertise in the area of content: a client is the expert on his or her life experiences and what has brought that client into the therapy relationship. When clients are narrators of their stories, they are able to experience and recognize their own voices, power and authority. A therapist brings expertise in the area of process: a therapist is the expert in engaging and participating with a client in a dialogical process of first-person storytelling. It is as if the roles of therapist and client were reversed: *The client becomes the teacher*. A therapist takes more of an 'I am here to learn more about you from you' stance. (p. 95)

Out of such collaboration, solutions to the client's problems are expected, by the post-modern therapist, to emerge.

Lynn Hoffman is a talented writer who has been intimately involved in the family therapy scene since 1963, when she was engaged to edit Virginia Satir's *Conjoint family therapy*. In *Family therapy: An intimate history* (Hoffman, 2002) Hoffman recounts, as puts it on page xi, her 'journey from an instrumental, causal approach to family therapy to a collaborative, communal one'. The book, however, offers more than this, providing an insightful, if somewhat selective, account of the development of family from 1963 to about the year 2000.

Innovative approaches to helping those involved in troubled relationships continue to be proposed. Sue Johnson has described *emotionally focused therapy* (EFT) (Johnson, 2008). She understands many 'conflictual' relationships in terms of attachment theory. Jones (2009) provides a helpful outline of EFT.

Johnson emphasizes the role of emotional bonding in human relationships, which she considers as important in adult relationships as in those that develop between children and their parents. Jones (2009) quotes Marion Bogo: 'In EFT, you take behaviour that on the outside looks provocative, negative, and outrageous, and you reframe it in terms of a person's best efforts to get their needs for attachment met'. Johnson calls this 'the howl for connection'.

Johnson provides a fuller discussion of EFT in the book *Hold me tight* (2008), with many illustrations of this therapeutic approach.

Family therapy continues to come up with charismatic and creative therapists who offer us new ways of helping people in troubled relationships. One of these is John Gottman (Sue Johnson may be another). Gottman claims to have developed a 'revolutionary' method of helping couples. Its essence is the reinforcement of the positive aspects of a relationship. Gottman has also identified four emotional reactions which, he says, are destructive and,

therefore, may lead to divorce. These are criticism, defensiveness, stonewalling and contempt, the latter being the most important.

On the other hand, Gottman has set out seven principles in his book, *The seven principles for making marriage work* (Gottman & Silver, 2000). Gottman and his wife Dr. Julie Gottman founded the non-profit *The Relationship Research Institute* and the for-profit *Gottman Institute*, which is concerned with training therapists.

Gottman's seven principles are probably not as revolutionary as he claims. They seem, to some extent at least, to be logical extensions of previous work by other therapists and researchers. This does not invalidate them of course.

Common factors theory (Duncan, Miller, Wampold, & Hubble, 2009) has been applied to psychotherapy generally as well as to family therapy. It postulates that as there are many forms of psychotherapy that have been shown to be of benefit these are likely to have factors in common. There is vigorous debate about whether an emphasis on the *common* factors in effective therapy (*client characteristics and extra-therapeutic factors*, the *therapeutic relationship*, the *therapist's model or technique* or *hope and expectancy*) should be emphasized over the *specific* factors found in particular therapeutic approaches (Sexton & Ridley, 2004; Sprenkle & Blow, 2004). Discovering how to operationalize these factors, it is suggested, could lead to more effective treatment for the disorders concerned. However, the fact that two or more modes of treatment are equally effective does not necessarily mean that they have factors in common. Although there has been significant model development in this area (Davis & Piercy, 2007a; 2007b), and there is some promising research evidence (Anker, Duncan, & Sparks, 2009), more is required.

The field of family therapy is a lively one, with help being provided to many who suffer from a variety of emotional, relationship and other difficulties. At the same time, its practitioners continue to develop new treatment methods and to evaluate those in current use.

Summary

Family therapy has developed since the Second World War as a new way of dealing with the human problems that were previously addressed by individual or group psychotherapy methods. It was based on a new conceptualization of how these problems come to exist. Formerly, they were thought to be mainly the result of intrapsychic processes, or the 'psychopathology' of individuals, which was believed often to have its roots in early childhood experiences.

The family approach, by contrast, is based on the belief that these problems are related to the current interactions taking place between the individuals in the family and, sometimes, between these individuals and other social

systems. It also takes into account multigenerational and extended family factors.

Initially, family therapists worked mainly with patients suffering from schizophrenia and their families, but they have come to apply their methods to the full gamut of psychiatric disorders. In its early days, family therapy was divided quite sharply into schools of thought and practice. Over time, however, a common body of knowledge has emerged and this continues to expand. Family therapy methods are nowadays being applied to an ever-increasing number of cultural and ethnic groups and family forms.

Recent years have seen the development of 'post-modern' approaches, in which therapy is seen more as a collaborative endeavour between clients and therapist. This is in contrast with the 'modern' approach, in which the therapist plays the role of 'expert' who has the training, skills and insights to intervene so as to resolve clients' problems. Many other innovative approaches are also being proposed and tested in clinical practice and research programmes.

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Chapter 2

Healthy Families and Their Development

What is a healthy family?

Is the family that is here with me today a healthy one?

What are their strengths and weaknesses that may help determine how healthy they are?

These are the kind of questions therapists ask themselves when a family comes seeking help.

As we have seen, families vary. There is no one type of ‘normal’ family.

But can we define a ‘healthy’ family? Perhaps, but well-functioning families also come in many forms. The most important consideration is the extent to which the family provides for the needs – material, emotional and spiritual – of its members. So how can we tell whether, and to what extent, the needs of the members of a family are being adequately met?

The first and second editions of this book, published in 1981 and 1986, respectively, had an outline on the front covers of a four-member family – a father, mother and two children, a boy and a girl – the archetypical nuclear family. But nowadays such families are in the minority in many cultures and societies. Twenty-three percent of UK families with dependent children are lone female-headed households (Gorell Barnes, 2004, p. 47).

In recent years I (PB) have rarely seen families in which the child or children are living with their two natural parents, neither of whom has been married previously. While this might be partly because such families have fewer problems and thus seek help less often, the statistical fact is that such families are becoming ever rarer and make up a smaller and smaller proportion of the population.

There have been substantial increases in the rates of divorce, of single, never-married women raising children on their own, of blended families and of other ‘atypical’, but not necessarily unusual, family constellations. In addition, increasing numbers of women work outside the home, so that many young children spend much of their time in day care.

Determining whether a family is ‘healthy’ is a challenge, probably greater than that of determining whether an individual is physically healthy. We can assess the health of individuals by measuring a variety of indicators: blood pressure, cholesterol levels, haemoglobin levels, fasting blood sugar, height

and weight and body/mass index – to name just a few. But similar data are not available for use as indicators of emotional health.

There have been many suggestions as to what the criteria for normal families should be. These were addressed from various theoretical viewpoints in the original edition of the book *Normal family processes* (Walsh, 1982). A decade later, in the second edition of her book Walsh (1993, pp. 3–4) writes:

Over the past decade, attempts to define family normality have become more complicated and more important—clinicians and family scholars have been further humbled in addressing normality by our increasing awareness that all views of normality are socially constructed, influenced by our own world view and by the larger culture.

So the time may have come for us to abandon the search for the ‘normal’ family and seek instead the ‘healthy’ family. Perhaps that is what Froma Walsh, the author of the above book, was really looking for when she discussed criteria for ‘normality’. She distinguished families that function asymptotically; those that function optimally; and those that function in a way that is statistically average. Normality may also be defined in terms of the processes occurring in the family of which Walsh wrote:

Basic processes involve the integration, maintenance, and growth of the family unit, in relation to both individual and social systems. What is normal—either typical or optimal—is defined in temporal and social contexts, and it varies with the different internal and external demands that require adaptation over the course of the family life cycle. (Walsh, 1982, p. 6)

Thus the question of what is a normal – or a ‘healthy’ – family is not an easy one. Nevertheless Froma Walsh has soldiered on to provide answers, undeterred by the complexity of the subject, and the fourth edition of *Normal family processes* (Walsh, 2012) appeared while this chapter was being revised. It has proved to be a goldmine of information and will surely be a major resource for all who wish to get to terms with, and understand, the changes that have occurred, and continue to occur, in the lives of families. The emphasis is on the American scene, but much of the information surely applies to the white, English-speaking, middle class populations of many other countries.

At nearly 600 pages, this book may not be for everyone concerned with families, but all who aspire to work with families in any therapeutic setting would certainly gain much from reading at least the initial ‘overview’ (Chapter 1). This chapter is entitled ‘The New Normal: Diversity and Complexity in 21st Century Families’. It has two sections. One is headed ‘The Changing Landscape of Family Life: The Broad Spectrum of Normal Families’ and the other ‘Families in Transformation: A Pluralistic View of Normal Families’.

We cannot here go into this subject matter in any depth, but it is all there in this new edition of Walsh’s book. It must suffice us to list the contents of the rest of the book:

- Part 2: Varying Family Forms and Challenges
- Part 3: Cultural Dimensions in Family Functioning
- Part 4: Developmental Perspectives on Family Functioning
- Part 5: Advancing Family Systems Research and Practice

Ethnic variations

The importance of ethnicity has long been recognized. What is acceptable and functional in one ethnic group may not be so in another. As therapists, most of us probably, at least at an unconscious level, tend to lean towards norms and values similar to those of the culture in which we have grown up. This may make it hard to engage families from other cultures and ethnic groups, and so lead to therapeutic failure. A good knowledge of the ethnic variations to be found in the population with which one is working is therefore important.

McGoldrick, in the first edition of *Ethnicity and family therapy* (McGoldrick & Carter, 1982), reviewed the relationship between ethnicity and family therapy. She pointed out that ethnicity is ‘deeply tied to the family’ and is transmitted by means of the family. She emphasized that family therapists should pay careful attention to the cultural influences on families. This is surely even truer now than it was when McGoldrick wrote these words.

The third edition of *Ethnicity and family therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005) reviewed some 47 ethnic groups and is by no means exhaustive. Its emphasis is on immigrants to America from other parts of the world. Thus the chapter dealing with ‘Families of African Origin’ does not consider in any depth African families that have remained on that continent. That may be because in much of Africa families are too poor and preoccupied with the tasks necessary for physical survival to seek help with family relationship problems. But in some parts of Africa, notably South Africa, family therapy is practised.

Yet another challenge is provided by the ethnically mixed marriage. Nowadays we may be confronted with families in which the partners come from families of origin with different cultural standards and values. The challenge can be even greater when they also come from different ethnic groups. It is usually helpful to approach such families with an attitude of respectful curiosity, valuing and validating the uniqueness each partner brings to the union.

The functions of families

Most of us who work with families would probably agree that the functions a family should serve include:

- Provision of the basic necessities of life for its members.
- The rearing and socialization of children.

- Provision for the legitimate expression of the marital couple's sexuality.
- Provision of mutual comfort and support.
- Reproduction and the continuation of the species.

The above do not all apply to every family. Some couples do not have children; in others the children have grown up and left home.

Societies, mostly in the 'developed' world, help with the rearing and socialization of children by providing schools, which socialize as well as educate, and sometimes other institutions – youth groups, boy and girl scouts, church groups, summer camps and so on – that supplement what the family does. They also wait in the wings for families to run into trouble, providing social service agencies to assist families or to take over the care of children, when families fail to do this properly. In varying degrees they may provide financial and material help to needy families.

In the past, and even today in some parts of the world, many of the functions now carried out by society's agencies were performed by the extended family. This consisted of a kinship network of grandparents, uncles, aunts, adult siblings, cousins and other relatives. Sometimes people unrelated by blood, but living in the same social network, also participated. But in industrial, especially large urban societies, a smaller role is generally played by the extended family and the neighbourhood community. Thus the parent or parents are faced with bigger tasks to perform than used to be the case. This is not to say that extended family networks no longer exist. They do, but they are fewer than they were, especially in large urban communities and where there is a high level of migration.

Family therapists are concerned with all forms of family life, whether traditional or not. All these forms aim, explicitly or implicitly, to meet the needs of their members, but what these are considered to be may vary. For example, pre-marital sex may or may not be considered acceptable; and the increasingly common practice of unmarried couples living together is no longer frowned upon in many societies. The family therapist must be sensitive to, and take into account, the standards and the moral and cultural values of the families coming to them for treatment.

AIDS has had devastating effects on family life. In sub-Saharan Africa, for example, there are millions of 'AIDS orphans'. Consequently many families are headed not by lone mothers but by children, some as young as 11 or 12 years.

Family development

Families are not static entities. They are continually changing, and there is a cycle of formation, growth, decline and dissolution that they all follow, with various diversions possible along the way.

Our therapeutic approaches must take into account the current developmental stage of the family. Nichols (1996) emphasized this, in *Treating*

people in families: An integrative framework, in successive chapters dealing with:

- Families in formation
- Expanding families
- Contracting families
- Postparental couples
- Families in transition due to divorce
- Families in transition due to remarriage

Previous descriptions of family development include those of McGoldrick and Carter (1982) and Duvall and Miller (1985). However, these seem increasingly outdated in that they assume, implicitly if not explicitly, that the normal process is that of a young couple meeting, courting, getting married, having and rearing children, then retiring and becoming grandparents. While this sequence of events still sometimes occurs, it is far from the current norm. It does not take account of the teenage girl who gets pregnant as a result of a casual sexual encounter; nor of ‘arranged’ marriages and other marriages that result from parental pressure; nor of gay couples who, in some jurisdictions, may be legally married and adopt children. And as we have seen, in some countries polygamy is still legal and practised.

The current reality is that families rarely develop in entirely smooth and predictable ways. Apart from situations such as those mentioned previously, development may be affected by the death of family members; the separation or divorce of the spouses; the late birth of a child or children after the others have grown up; the arrival of new children in a reconstituted family; chronic illness; financial setbacks; migration from one culture to another; natural disasters; military service; war; and many other circumstances.

The clinical importance of family developmental stages

Two main areas need to be considered when a family presents for treatment. One is the family’s developmental stage. The other is the family’s structure and way of functioning.

Many of the clinical problems with which families present are related to difficulties in making the transition from one developmental stage to the next. When this is the case the therapist needs to consider how the developmental process can be freed or assisted. Are there any road blocks, either in the family’s social context or within the family itself, that can be removed with the help of the therapist?

Barnhill and Longo (1978) defined nine *transition points* which need to be negotiated as the family passes from stage to stage. Despite the changes

in families and the wide variety of family forms we encounter nowadays, the concept of transition points remains useful. Those suggested by Barnhill and Longo were:

- 0–1: Commitment of the couple to each other.
- 1–2: Developing new parental roles, as husband and wife become father and mother.
- 2–3: Accepting the new personality, as the child grows up.
- 3–4: Introducing the child to institutions outside the family, such as school, church, scouts, guides and sports groups.
- 4–5: Accepting adolescence, with the changed roles associated with this, and the parents' need to come to terms with the rapid social and sexual changes occurring in their son or daughter.
- 5–6: Allowing the child to experiment with independence in late adolescence and early adulthood.
- 6–7: Preparations to launch, the term used by Barnhill and Longo for the process whereby the parents come to accept their child's independent adult role, which includes starting his or her own family.
- 7–8: Letting go – facing each other again, when child-rearing is finished and the couple face each other as husband and wife alone again.
- 8–9: Accepting retirement and/or old age, with the changed lifestyle involved.

While accepting that many families are headed by single parents rather than couples and that family forms are more variable now than when Barnhill and Longo (1978) put forward the concept of transition points, the fact remains that any family is faced with the need to negotiate transitions.

Just as an individual's development may be fixated at a particular stage – when it has failed to proceed beyond that stage at a time when it normally would have done so – so may a family fail to make one or more of the needed transitions. A family may also regress, that is, go back to an earlier transition point, usually when faced with some stress. Barnhill and Longo also put forward the concept of 'partial fixation', when a family life cycle transition has not been successfully achieved, although a partial and even superficially satisfactory, though often precarious, adjustment has been made.

Optimal family functioning

Kirschner and Kirschner (1986, Chapter 2) introduced the concept of 'optimal functioning'. They considered the marital transactions; the rearing transactions; and the independent transactions. The latter refers to the functioning of the individual family members in their own activities, be they vocational, educational, social or recreational.

In two-parent families, the *marital transactions* are the foundation on which everything else rests. The marital couple first needs to meet each other's needs. As 'reparental' figures for each other, each spouse can provide inputs that were lacking in the partner's family of origin. A spouse may programme the other for self-confidence and success through suggestions and directives regarding productive behaviours. Education, modelling, confrontation, validation, encouragement and inspiration may also be provided (Kirschner & Kirschner, 1986, p. 30).

If the marital relationship is a poor one, the foundations for a successful, well-functioning family unit are lacking, or at least shaky. It is hard for a couple who do not get along well together to function effectively as a parental team. An important part of the assessment of a family, therefore, is the assessment of the quality of the marital relationship.

The essential question is whether the marital partners get satisfaction out of their relationship. Ideally, they nurture, affirm and support each other, and the relationship should be one of mutual trust and respect. Elements of romance and intimacy are involved in this, and the couple needs also to have effective ways of recognizing and resolving conflict.

Nowadays many families are headed by single parents. Such parents need to perform the same tasks as couples, but must find the support they need elsewhere than in the marital relationship. An important part of the process of working with one-parent families is identifying the sources of support, and the social networks, available to such families, and involving those supports, directly or indirectly, in the treatment process. The estranged parent of the children may be important in this regard.

The *rearing system* comprises the way the parental couple work together to rear and care for their children. The parents should be agreed on the principles to be used in doing this, and the care provided according to these principles should meet the needs of their children and foster their healthy development. It is the transactions, or the network of relationships, between the parents and the children, and also those between the children, that largely determine how the children develop.

Finally, the therapist should consider the relationships that exist between the members of the family and the wider community of which the family is a part. In the terminology of the 'comprehensive family therapy' of Kirschner and Kirschner (1986), these are the *independent transactions*. In an optimally functioning family these enable family members to function autonomously outside the family. A successful outcome of child-rearing is one which produces children who can do this.

In view of the enormous variety of family forms and ethnic variations with which therapists may be called upon to work, and the fragmentation of families that occurs in many of the troubled areas of our planet, the above considerations may be somewhat simplistic. Moreover, the ethnic variations are legion and only a few are discussed in McGoldrick et al. (2005).

Summary

Families vary greatly in their composition. Healthy family functioning can take many forms and the variety of forms has been increasing. The cultural values of families, and their ethnic backgrounds, are also relevant factors.

Families pass through a series of developmental stages as they are formed, bear and rear children, then launch the children into the world, leaving the marital couple alone again, although usually with the new role of grandparents. The family therapist must always consider the stage that has been reached by a family presenting for treatment and whether the family is having, or has had, difficulty surmounting a particular developmental hurdle.

The concept of 'optimal family functioning' is helpful. It is concerned not just with the absence of problems, but also with whether the needs of the marital couple and the children are being met as well as they might be.

A family should both meet the current emotional and psychological needs of all its members and prepare the children for an autonomous existence in the wider world into which it will, at the appropriate time, launch them.

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Chapter 3

Some Basic Theoretical Concepts

Every therapist needs a theory of change. This determines how one behaves in the therapy room with clients. As family therapy developed, it quickly became clear that it needed new conceptual underpinnings. Theories of how *families* function, how problems develop and how change in their functioning is promoted were needed. This is not to say that the psychological and biological make-up of individuals – their intelligence, personality, emotional states and defence mechanisms – are irrelevant. Far from it! These should be considered when we work with families, but considering them alone is not sufficient. The family is more than a collection of individuals.

To conceptualize the functioning families, family therapists have appropriated concepts from such theoretical schemes as general systems theory, cybernetics, learning theory, communications theory and neuroscience. Let us first, however, examine some of the attempts to adapt pre-existing psychological theories to family therapy, before turning to other theoretical ideas.

Theories derived from individual and group psychotherapy

Psychodynamic theory

Many of the early family therapists relied heavily on psychodynamic theory. Ackerman (1956) introduced the idea of ‘interlocking pathology’, arguing that the psychopathology of the different members of a family fitted together to produce the family system the therapist encountered. Bowen’s concept of the ‘undifferentiated ego mass’ is another example of the application to families of ideas derived from the study of individual psychopathology. Bowen originally used this term, which he later discarded, to describe the ‘central family oneness’ he observed in many families, especially those of patients suffering from schizophrenia. He believed family members had not become emotionally autonomous to a healthy and appropriate degree (Bowen, 1961).

Satir (1967) wrote of the relationship between individual psychopathology and family dynamics. She believed that people whose views of themselves

are poor depend on what others think of them. They present a ‘false self’ to the world rather as Winnicott (1960) defined the term. This false self is designed to present to others the impression that the person wants them to have. It is based on the identification by the subject with others. Such people, Satir said, are liable to marry each other. Each partner is deceived by the psychological defences of the other, that is, by the false self the other presents to the world. At the same time, each has fears of disappointment and difficulty in trusting others, including their respective mates. This may lead to marital difficulties.

While many other early family therapists came into the field with psychoanalytic training – for example, Lidz, Wynne, Minuchin, Dicks, Boszormenyi-Nagy, Skynner and Epstein – according to Nichols (2009, p. 238), they ‘traded in their ideas about depth psychology for those of systems theory’. It is difficult to know how far these early family therapists used their understanding of individual psychodynamics to facilitate their work with families. Consideration of the psychopathology of individuals is, however, evident in the work of many of them, for example, in that of Dicks (1967) and Skynner (1976). Psychodynamic theory does not, however, seek to explain the workings of family systems.

The Milan team were psychoanalysts turned family therapists. Starting with *Paradox and Counterparadox* (Palazzoli, Boscolo, Cecchin, & Prata, 1978), they probably had more influence on family therapy in the 1980s than any other group.

Group therapy

The aim of much group therapy is to help the members of the group gain insight via group interaction. The therapist’s role is principally that of a facilitator, a catalyst and, sometimes, an interpreter of what is happening between the group members.

While family members can certainly learn things of value to one another in group therapy, families are quite different from a group of unrelated strangers in a therapy group. Their long-shared history, their established psychological defences and their set attitudes towards each other may make it hard for them to engage in the confrontation that often occurs in group therapy. Instead, they may simply re-enact the same characteristic interpersonal patterns as they do at home, unless the therapist does something active to change this.

Other theories that have been used in family therapy

Cybernetics

Cybernetics is a term that was introduced by Weiner (1948) to describe self-sustaining regulatory systems. This process requires a receptor of some

sort, a central mechanism and an effector, connected to form a feedback loop. An example is a thermostatically controlled central heating system. The thermostat is the receptor; it constantly measures the temperature in the space to be heated. It is connected to a central mechanism, the furnace. When the temperature drops to a certain level, the furnace is switched on and the heat is distributed, via the effector channels, to the area to be heated. When the temperature rises to another predetermined level, the reverse occurs and the furnace is shut off. This illustrates *homeostasis*, the tendency of systems, or at least some of them, to maintain themselves in a fixed, steady state.

Early in the history of family therapy, some of the ideas of cybernetics were adopted by therapists trying to understand the fixed, but dysfunctional, processes occurring in families. The difficulties many families had changing their behaviour were 'explained' by saying that homeostatic mechanisms tended to maintain the *status quo*, rather than permit needed changes to occur. As de Shazer (1985) asks, does introducing a concept such as homeostasis really *explain* anything or simply describe a process? Moreover, how does one explain change in the face of homeostasis?

Feedback is either positive or negative. This should not to be confused with the colloquial meaning often given to 'positive feedback' (praise) or to 'negative feedback' (criticism). Positive feedback is *deviation amplifying*, that is, it perpetuates and may amplify an interpersonal pattern. Negative feedback is *deviation minimizing*, meaning that it inhibits or de-escalates an interpersonal pattern.

Positive feedback usually operates within a range of acceptable behaviour, while negative feedback limits the range. For example, a couple becomes progressively angrier at each other (*deviation amplification*) until a certain maximum intensity is reached, and they stop short of physical violence (*deviation minimization*). Thus, in families there are often periods of positive feedback regulation, which are limited by negative feedback. A change in the relationship between those involved implies that there is also a change in the regulatory limits of the control system.

A further development of cybernetics was the control theory¹ (McFarland, 1971). This considers not only feedback mechanisms, but also *feed-forward* controls. Feedforward processes are governed by factors that are independent of the immediate results of the activity. They include deliberate, goal-oriented behaviour. For example, Tomm (1980) cited the planning of families who send their children to private schools in order to have them attain particular educational or social goals. The accomplishment of these goals will not lead to any modification of the original plan.

Tomm (1980) described a 'cybernetic systems' model of therapy. While this was a systems-based model and took into account such factors as

¹This should be distinguished from the *control theory*, as described by psychiatrist and reality therapy developer Glasser (1994), which later evolved into *choice theory*.

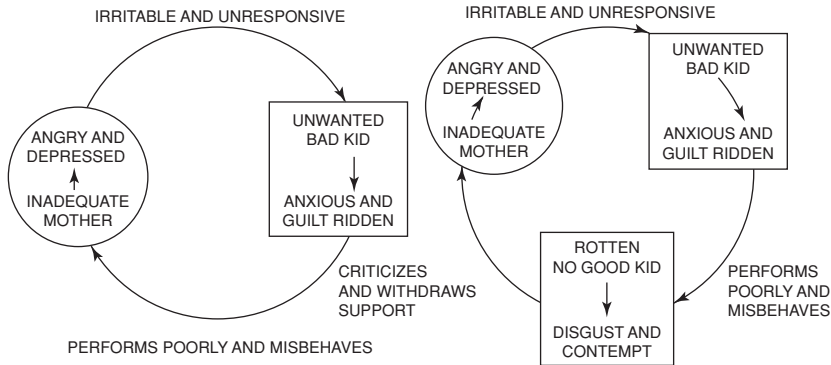


Figure 3.1 Dyadic and triadic parent-child patterns (Reproduced with permission from 'Towards a cybernetic-systems approach to family therapy at the University of Calgary' in Freeman D.S., ed., 1980, *Perspectives on Family Therapy*, Toronto: Butterworth).

interpersonal and subsystem boundaries, attachments and coalitions, control mechanisms, family rules, collective beliefs and goals, it emphasized cybernetic regulatory mechanisms, which were represented by circular pattern diagrams (CPDs). These illustrate the repetitive, stable and self-regulating interaction patterns within families. An example is given in Figure 3.1.

Tomm points out that the control mechanisms operate through multiple channels, largely non-verbal. This was a precursor to his later work on *pathologizing interpersonal patterns* (PIPs) and *healing interpersonal patterns* (HIPs), which incorporated the influence of culture, ethnicity, gender and power (Strong, Sutherland, Couture, Goddard, & Hope, 2008).

CPDs are of value in that they facilitate circular, rather than linear, thinking in the therapist, direct one's attention to parts of a circular pattern which may not be immediately obvious and help the therapist choose the point at which to intervene (see the discussion below of *punctuation*). Linear thinking (see the next section) may present problems because it tends to mobilize feedforward mechanisms and may fail to make use of the constructive potential of negative feedback.

Although cybernetics is a superficially attractive model to understand some of the phenomena we observe in families, its mechanistic outlook makes it far from adequate as a theory. Control theory (McFarland, 1971) was a precursor, however, to the idea that persons within families exercise personal agency, making deliberate, conscious plans that can lead to 'feed-forward' processes. Further, by the mid-1980s, many (Lipchik & de Shazer, 1986; Penn, 1982, 1985; Tomm, 1986) thought of the therapist as part of the *therapeutic system* (i.e. therapist + family) that ought to be considered – a *second-order cybernetic* approach.

In fact, an early paper by Penn (1985), reflecting a second-order cybernetic view, conceptualized hypothetical questions about the family's future

questions as 'feedforward'. We suggest that control theory is a bridge between simple cybernetics, in which the family is the unit being examined, assessed and intervened upon from the outside, and second-order cybernetics, in which the therapist + family is the unit under consideration. The second-order cybernetic approach is discussed below.

Systems theory

General systems theory was proposed by von Bertalanffy as a general theory of the organization of parts into wholes. A system was defined by von Bertalanffy (1968, p. 55) as 'a complex of interacting elements'. Hall and Fagan (1956) worded the same concept slightly differently. They defined a system as 'a set of objects together with the relationships between the objects and between their attributes'. These definitions do not specify what the 'parts' or 'objects' may be. They may be living or non-living. The theory is designed to cover physical phenomena and machines as well as biological systems.

von Bertalanffy (1968) distinguished *open* from *closed* systems. Closed systems are those in which there is no interaction with the surrounding environment, as in a chemical reaction in a closed container. Such systems obey rules different from those obeyed by open systems. Closed systems, for instance, show *entropy*, the tendency to reach the simplest, least ordered possible state from whatever may be the starting situation. Thus, if two gases that do not react chemically with each other are introduced into a closed container, the result will be a diffuse, complete mixing of the two. Once this process is complete, the system is said to be in a state of *equilibrium*.

Open systems, such as families, do not show entropy. Instead, there is a steady inflow and outflow of relevant information across the boundary of the system. If the characteristics of the boundary remain the same and the outside environment is also unchanged, a *steady state* is reached. The environment of most open systems is, however, liable to change. There may also be alterations in the characteristics of the boundary. These properties of open systems make change and evolution possible. To make things even more complicated, the individual family members may change.

For family therapy purposes, the term *systems thinking* (Beckett, 1973) is probably more appropriate than *systems theory*. The importance of systems theory to family therapy lies in the ideas and concepts it has brought to the field. These include the following:

- (1) Families (and other social groups) are systems having properties that are more than the sum of the properties of their parts.
- (2) The operation of such systems is governed by certain general rules.
- (3) Every system has a boundary, the properties of which are important in understanding how the system works.
- (4) The boundaries are semipermeable, that is to say, some things can pass through them while others cannot. Sometimes certain materials can pass one way but not the other.

- (5) Family systems tend to reach relatively, but not totally, steady states. Growth and evolution are possible, indeed usual. Change can occur, or be stimulated, in various ways.
- (6) Communication and feedback mechanisms between the parts of a system are important in the functioning of the system.
- (7) Events such as the behaviour of individuals in a family are better understood as examples of *circular causality*, rather than as being based on *linear causality*.
- (8) Family systems, like other open systems, appear to be purposeful.
- (9) Systems are made up of *subsystems* and themselves are parts of larger *suprasystems*.

Some characteristics of systems

Systems thinking (the use of von Bertalanffy's, (1968) ideas without employing the mathematical models he proposed) has more to offer family therapy than simple cybernetics, which is mainly concerned with feedback mechanisms. The idea of *circular causality*, as opposed to *linear causality*, as a basis for understanding the processes occurring in families, is, however, common to both. Linear causality describes the process whereby one event causes another. Thus, when it starts to rain a man may put up his umbrella. However, putting up an umbrella does not cause the rain. This is a case of linear causality because event A (the onset of rain) is the cause of event B (the umbrella being put up), while event B does not affect event A.

Circular causality is the term used for the situation that exists when event B does affect event A. Thus if person A tells another person B to do something, and that person does it, this in turn will affect the behaviour of person A, who, for example, may then be more likely to ask B to perform the task again when the need arises.

A slightly more complex example of circular causation is that of a family with a boy who is anxious about going to school. His mother, too, is worried and she turns to her husband, who fails to reassure or support her. Instead, he speaks angrily to his son, which seems to make the boy still more anxious. The boy's increased anxiety then leads to a further increase in the mother's anxiety. The son's school refusal worsens and the mother turns with greater force to her husband, who gets even angrier with the boy, and so the circular process continues.

In this case, who is 'causing' the problem? Indeed, what is the problem? Is it the mother's anxiety, which is communicated to both the father and the son? Is it the boy's school refusal? Is it the father's unsympathetic and angry behaviour towards the boy and his failure to support his wife? To the systemic therapist, the problem is none of these things; the problem lies in the family's interactional patterns as a whole. A circular process is occurring and it is the system that must be addressed in therapy, not any one person, not even any one dyadic interaction.

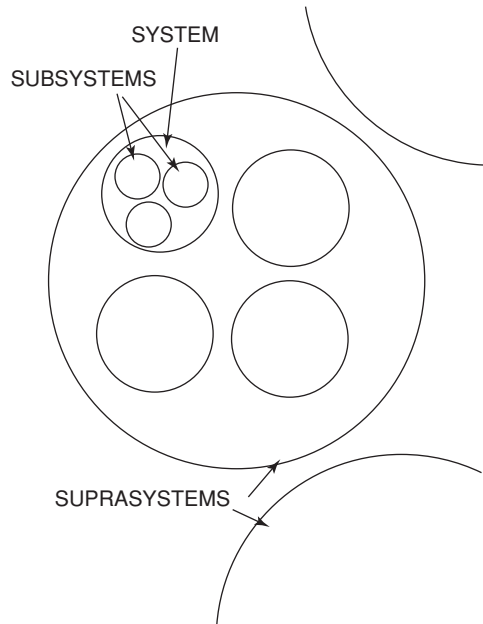


Figure 3.2 The relationship between systems, subsystems and suprasystems.

An important concept derived from systems theory is that of the relationship between systems, subsystems and suprasystems. All living systems are composed of subsystems (Figure 3.2). So if a family is the system under study, it will be found to consist of various individuals or groups of individuals that function as subsystems. Examples are parental, marital and child subsystems; there may also be boy and girl subsystems, or subsystems consisting of older and younger children. Such subsystems have their subsystems too; an individual human being is also made up of various systems, whether physical (renal, cardiovascular, nervous and so on) or psychological (ego, id, superego).

Suprasystems to which families may belong include the extended family, the village, the neighbourhood, the tribe, a faith community and so on. These in turn are part of larger suprasystems, until we get to nations, groups of nations and planet earth itself. The earth, of course, is but a part of a still larger celestial system.

The system upon which family therapists usually concentrate is the family. However, family therapists are also interested in the subsystems and, usually, the suprasystems of the families they are treating (Robbins, Mayorga, & Szapocznik, 2003). There may be problems in a family's subsystem pattern. Figure 3.3 illustrates a pattern that may be associated with problems. The diagram represents over-close involvement (or 'enmeshment') of the mother and the son and under-involvement of the parents with each other. The two subsystems are circled. A more satisfactory situation might be that shown in

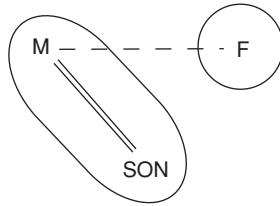


Figure 3.3 A problematic subsystem pattern.

Figure 3.4. Many other, more complicated, subsystem patterns are possible and indeed common.

Every system has a *boundary*, which marks it off from its surroundings. Living systems have readily identifiable physical boundaries, consisting of skin, mucous membranes, the bark of trees and so forth. The boundaries of emotional and psychological systems are not visible in the same way, but they are equally important. They control emotional interchanges, closeness and joint actions. The boundary between one subsystem and another is characterized by restricted emotional interchange, compared with that between those individuals within the one subsystem. Similar considerations apply to the boundaries between systems and their suprasystems.

Some families have relatively impervious boundaries, so that they are quite isolated from the social environment in which they exist. Others have highly permeable boundaries and so may be unduly susceptible to events and changes in their wider social environment. The boundaries of all open systems are, to some degree, semipermeable, that is, they allow some things to pass through and prevent others from doing so (Figure 3.5). By this means the integrity of the system and its distinctness from the surrounding environment are maintained.

Subsystems have boundaries too, and work on subsystem boundaries is often an important part of family therapy, particularly when a structural approach is used. The structural therapist's approach to the situation in Figure 3.3 might be to establish a clearer boundary between the mother and the son and a closer relationship between the mother and the father, leading to a situation such as that depicted in Figure 3.4. Now there are clear

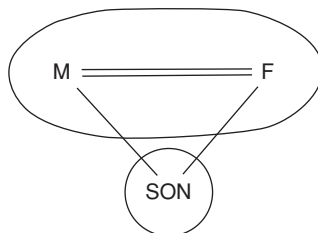


Figure 3.4 A satisfactory subsystem pattern.

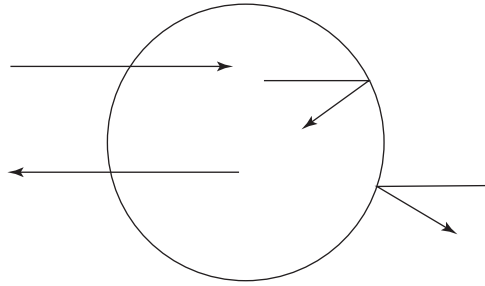


Figure 3.5 Semipermeable boundaries in an open system.

boundaries around each of the two subsystems: that made up of the parents and that comprising the son.

Boundaries distinguish systems from other related systems and determine how they relate to each other. The nature and amount of communication, verbal and non-verbal, that occurs across them, is important in establishing boundaries. Much of this communication is concerned with emotional issues, rather than cognitive ones. Structural therapy, which above all else deals with boundary issues, and communication theory (discussed below) thus have much in common.

Feedback

Systems thinking takes in the ideas about feedback, which form the basis of cybernetics, but goes further. The systemic therapist considers not just the feedback processes that are occurring, but also the processes whereby change occurs in the family system. Referring to the ‘recursive loops’ that are characteristic of living systems, Hoffman (1981, p. 339) pointed out that these loops ‘are never totally closed, since there is always space for new information. Each cycle comes round to a new position, sometimes so minutely different from the previous one as to be imperceptible, but sometimes representing a major shift’. Family therapy is a matter of promoting this process, by highlighting small changes, drawing new distinctions that make a difference to the family, altering the feedback and amplifying change.

Learning theory

Several processes by which learning may occur have been identified. These may be summarized as follows:

- (1) *Respondent conditioning*, which changes behaviour by altering the circumstances leading up to it. Pavlov’s classical experiments with dogs are examples of this. By pairing the ringing of a bell with the presentation of food, the dogs were conditioned to salivate simply when the

bell was rung. For example, post-traumatic stress disorder – when an individual experiences symptoms in the absence of the original threatening situation, but in the presence of similar stimuli – can be viewed this way.

- (2) *Operant conditioning* changes behaviour by altering the circumstances following it – usually by *reinforcement* – a stimulus that increases the frequency, intensity or duration of the target behaviour. Families reinforce the behaviour of other family members in all kinds of ways, deliberately and unwittingly. A common example is a parent praising a child who puts away his toys, resulting in an increase in this behaviour.

However, *reinforcement* is only defined as such when it actually increases the behaviour in question. On the other hand, in operant conditioning terms, *punishment* is defined as the administration of an aversive stimulus, resulting in a decrease in the behaviour. Often, parents' well-meaning attempts to punish behaviour, for example, yelling at a child who has lied, may inadvertently increase (reinforce) the very behaviour it is intended to decrease. Family members often *mutually reinforce* each other's behaviour. For example, if a wife yells at her husband for coming home late, she may actually inadvertently be *negatively reinforcing* late arrivals, increasing their frequency as he avoids the aversive consequence of being yelled at. However, the increase in late arrivals may reinforce (increase the frequency of) yelling. Or, a parent may yell at a child with the intention of decreasing a problematic behaviour, but with the opposite effect. It is important to note that operant conditioning does not consider the intent of one's actions or the meaning that one attaches to the behaviour of another. Operant conditioning simply describes behaviour functionally, in terms of its increase or decrease.

- (3) *Modelling* is the process of learning by imitating the behaviours of others. A young child may pick up a key, insert it into a lock and try to turn it, despite never having been taught to do this; the child is just modelling what he or she has seen others doing. Similarly, children will pick up a telephone and 'talk' into it just as their parents do, even though they may not yet have acquired speech. Children are likely to imitate their parents' inappropriate behaviours as well.

The family therapist can similarly be a powerful model for family members. For example, the way the therapist relates and talks to the children in a family can be a model for parents. Often, family problems are conceptualized in terms of skill deficits in parenting or couple behaviour, which are amenable to interventions that entail modelling appropriate skills and providing performance feedback (Gottman, 1999; Jacobson & Margolin, 1986; Stuart, 1980).

- (4) *Cognition* is sometimes termed 'figuring things out'. By thinking a problem through, or just noticing something and considering its implications, we come up with new ideas and behaviours (D'Zurilla,

Maydeu-Olivares, & Gallardo-Pujol, 2011). Moreover, the practice of interrupting and replacing maladaptive cognitions that drive problematic emotions and behaviour, usually described as *cognitive* or *cognitive-behavioural therapies*, has been frequently used in family therapy (e.g. Dattilio, 2011).

Historically, *behaviour therapy*, which focuses on observable behaviour, has been distinguished from *cognitive* or *cognitive-behavioural* approaches. As cognitive approaches were emerging in the 1970s and early 1980s, behaviour therapists questioned their legitimacy, given that cognitions – thoughts – cannot be directly observed, promoting vigorous debate (e.g. Beck & Mahoney, 1979; Ledwidge, 1978, 1979; Mahoney & Kazdin, 1979).

In current practice, behavioural and cognitive approaches are often blended (Gehart, 2010), with little theoretical distinction (Chang, 2011). Therapeutic approaches that focus primarily on behaviour consider cognition (Gottman, 1999), and approaches that focus primarily on cognition value observable behavioural change (Dattilio, 2011). Nonetheless, for the sake of conceptual clarity, approaches to family therapy that emphasize respondent conditioning, operant conditioning and modelling are generally considered *behavioural*, while those that target thinking are labelled *cognitive* or *cognitive-behavioural*.

All therapists probably make use of ‘learning theory’, even though they may not conceptualize what they do in such terms. They are likely, for example, to try to demonstrate clear and direct communication (modelling), and to respond positively, whether verbally or non-verbally, attempting to reinforce healthy changes in families they treat (operant conditioning).

When learning theory is applied to families purposefully, patterns of reinforcement, skills and maladaptive cognitions are carefully studied to develop a functional analysis. This enables the development of an intervention plan using one or more of the above approaches to promote change.

As noted above, typically in families, maladaptive behaviours are reciprocally reinforced. Our description of reciprocal reinforcement is much the same as deviation amplifying feedback. From a behaviour therapy perspective, therapists look for reinforcing and discriminating stimuli from other family members, which may maintain the ‘disturbed’ behaviour of a particular member. This does not necessarily mean that the other members are *causing* the behaviour of the identified patient; that person’s behaviour is also part of, probably, a number of feedback loops, or patterns of reciprocal reinforcement, and so may equally be seen as causing the behaviour of the others – *circular causality*.

As Nichols (2009, p. 268) pointed out:

The behaviorists’ focus on modifying the consequences of problem behavior accounts for the strengths and weaknesses of this approach. By concentrating on presenting problems, behaviorists have been able to develop an impressive array of effective techniques. . . . However, treatment may succeed with the symptom but fail the family. Attitudes and feelings may

change along with changes in behavior but not necessarily. Teaching communication skills may not be sufficient to resolve real conflict. Behavior change alone may not be enough for family members whose ultimate goal is to feel better.

Communications theory

The identification of communication problems in families and their remediation have been central to family therapy since its early days.

In *Pragmatics of human communication*, Watzlawick, Beavin, and Jackson (1967) defined the three aspects of human communication: syntax, semantics and pragmatics.

Syntax refers to the conventions used when words are put together in sentences and paragraphs to express meaning; it comprises the grammatical rules of the language.

Semantics is concerned with the meanings of words; it deals with the principles that govern the relationship between words or sentences and their meanings, the clarity of language and its use in particular situations. While the meanings of words may be defined in dictionaries, in practice people do not always stick to such definitions (Wittgenstein, 1953). In many families (and other settings) there are private languages and shared systems of communication that it is helpful for the therapist to understand.

Pragmatics is the study of the behavioural effects of communication. These are related as much, perhaps even more, to the non-verbal behaviour of those involved and to the context of the communication as they are to the semantic content of what is said. It is well known that non-verbal cues, as well as the context of a communication, can convey, for example, that something is being said as a joke, or a threat, or an apology and so on, even though the words used are the same.

Watzlawick et al. (1967) proposed some 'tentative axioms of communication'. They considered that these properties of communication had 'fundamental interpersonal implications', which have provided the basis for much work done by family therapists. These are:

It is impossible not to communicate. All behaviour, occurring when one person is in the presence of another, carries some sort of message. There is no opposite of behaviour, no 'non-behaviour', so there can be no 'non-communicating'. A man sitting silently ignoring everyone around him is communicating, at the very least, that he does not want to speak with those around him. Depending on the context and how far it would normally be socially appropriate to speak under the circumstances, he may be communicating a great deal more also. Moreover, communication is more than just what is said; it takes in posture, gesture and tone of voice, as well as context.

The relationship aspects of communication. Communication has *relationship aspects* as well as content. Communications do not just give information; they also define the relationships between those communicating. Thus, the utterances, 'I wonder if you would mind shutting the door?' and 'How many

more times do I have to tell you to shut that damned door?’ are both requests to the person addressed to close the door, but the relationship defined is clearly different. Often the same sentence, spoken in a different way, can imply a different relationship. Compare ‘I *think* you’re wrong’ with ‘I think you’re *wrong*’.

Punctuation. *Punctuation* is an important feature of communication. In a series of interactions, it is not always clear what is stimulus and what is response. Thus, a wife may nag because her husband comes home late, while the husband comes home late because his wife nags. Each may thus consider the other to be the ‘cause’ of the conflict. How the series of events is perceived depends on how the sequence of behaviours is punctuated. Each partner may punctuate it differently, and thus come to consider the other to be the ‘cause’ of the problems.

In family therapy, this is more the exception than the rule, and it is up to a family therapist to punctuate the interaction in a way that permits the therapist, as much as possible, to avoid taking up the perspective of one member of the family. In such situations, a major problem may be the inability of the marital pair to discuss the question of the punctuation of such processes, that is, to *metacommunicate* (or communicate about the communication) on the issue, and it is up to the therapist to facilitate this.

Digital and analogic communication. Communication can be *digital* or *analogic*. In digital communication, messages are coded into spoken or written words. The meaning of the messages is clear from the nature and ordering of the words, as in sentences such as, ‘John is entering the theatre’ or ‘The show starts at 8.00 p.m.’ In such sentences, facts are being communicated by the use of the verbal code.

Analogic communication is non-verbal. It is mediated by gesture, body and limb postures, facial expression, tone of voice and the sequence, rhythm and cadence of the words themselves. It also takes in poetry, music, painting and other forms of artistic expression. Other modes of analogic communication are caresses, blows, kisses, hugs and other forms of contact. Also, the ways people dress, use make-up and generally present themselves carry their own analogic messages. Analogic communications are very relevant in family therapy, for the therapist must be fully alert to and understand, to the greatest possible extent, the messages the family members are sending each other. ‘Fats’ Waller, the jazz musician and singer, summed up the difference between digital and analogic communication in one of his recordings many years ago, with the phrase, ‘Tain’t what you say, it’s the way that you say it’.

The distinction between these two types of communication is discussed further by Watzlawick (1978) in *The Language of Change*. Watzlawick reviewed the evidence that digital and analogic communications are associated with, respectively, the left and the right cerebral hemispheres. When one’s digital and analogic messages conflict, it is usually the analogic message that is the more accurate reflection of how the person is feeling. It also tends to be the one that is received by the person being addressed.

Symmetrical and complementary interaction. Any relationship between two people, or between two groups of people, may be, in varying degrees, symmetrical or complementary. When an interaction is described as symmetrical, this implies that the participants are on an equal footing. Complementary interaction occurs based on inequality. Examples are many: doctor–patient, penitent–confessor and servant–master interactions. In these cases, the complementary relationship conforms to the customs of the culture. Marital couples and other pairs of people may relate and communicate in a complementary or symmetrical fashion, though of course there are differing degrees of each. Either style of relating is compatible with healthy functioning. Flexibility is, however, generally to be desired, and if patterns of relating become rigid and inflexible, problems may develop.

When one person addresses a communication to another, the latter may respond in one of three ways. The first is *acceptance* of the communication: the person responds to the question or remark in an appropriate way. The second is *rejection*: the person addressed does not reply but may continue reading, listening to something else or looking out of the window. This is still communication, of course, but it is less direct and clear. The third, and generally the most pathologizing, is *disconfirmation*. This is the giving of offhand, uninterested, illogical, irrelevant or contradictory replies. Such replies may be delivered in a bored, laconic or sarcastic way. The person replying is, by means of the reply, labelling the original speaker as a person of no account.

Symptoms may themselves be communications. In other words, having the symptom conveys a message. Sleepiness, feeling tired or frail health may be an individual's way of saying he or she does not want to listen to another person or participate in a particular activity.

Paradoxical communication. Finally, communication may be paradoxical. Watzlawick et al. (1967) defined a paradoxical communication as a 'contradiction that follows correct deduction from consistent premises'. Examples of paradoxical remarks are 'I am lying' or 'I will visit you unexpectedly this evening'. The logical fallacy of such statements was pointed out by Whitehead and Russell (1910) in their *theory of logical types*. This states that anything that involves all of a collection cannot be one of the collection. In the same way, we cannot deal with language and *metalanguage* as if they were of one class. Thus, the statement 'I am lying' is both a statement and a statement about the statement (i.e. a *metastatement*). It is therefore meaningless. The same applies to the remark 'I will visit you unexpectedly this evening'. To say that I will visit you is fine, but to say that the visit will be unexpected is a communication at a different level in the language hierarchy. It could only be logically stated by someone observing the events from outside the interaction.

Hierarchies. Haley (1963, p. 4) saw relationships as involving struggles for power, and he asserted that 'When one person communicates a message to another he is maneuvering to define a relationship'. According to Haley (1976, p. 103), 'When a child has temper tantrums and refuses to do what

his mother says, this situation can be described as an unclear hierarchy'. Creatures of any sort who are organized together make up a status, or power, ladder. Confused hierarchical arrangements, as exemplified by the above mother–child communication sequence, tend to be associated with symptoms. A hierarchy may be confusing or ambiguous, or there may be a coalition between members at different levels.

The *sequence* of communications defines the hierarchy. Thus, if A repeatedly tells B to do something, and B does it, then B is probably lower in the hierarchy than A. If this hierarchy is inappropriate and associated with symptoms, a goal of therapy might be to change the sequence of events or, in other words, the hierarchy or power structure. This, incidentally, cannot usually be done simply by providing the family members with insight into their situation. More creative and, often, less direct methods may be needed.

Other concepts and terms

From homeostasis to coherence

Coherence refers to one of the concepts that have emerged as part of the quest for new epistemologies by those who work with families. Dell (1982) used *coherence* as a sort of shorthand term for 'organized coherent system'. He defined it as follows: 'Coherence simply implies a congruent interdependence in functioning whereby all aspects of the system fit together. It would seem to be adequate for describing the behaviour of a system being itself without inadvertently implying anything more than that' (Dell, 1982, p. 31).

Dell advocated the abandonment of the concept of homeostasis, because it suggests a process that prevents change occurring in the system. But, he asserted that there is no such specific thing as homeostasis. It is just an 'imperfectly defined explanatory notion'. He recommended that we should simply accept systems as they are. He sided with the noted Chilean zoologist, Maturana (1978), who asserted that everything is 'structure determined'.

That means that individuals behave out of their coherence; they can behave in no other way. Control is impossible. Their coherence determines how they will behave, and no amount of determined attempts to control them will ever change that fact. Moreover, an individual's coherence specifies his reaction to the other's attempts to control him. The coherence will, in most cases, 'respond' in a different way than was intended by the attempt to control.

You can lead a horse to water, but you cannot make it drink. Each successive attempt to make the horse drink results in the coherence (which is the horse) doing whatever it does under that particular perturbation. The coherence always determines. The best that can be achieved is for the owner of the horse to discover the perturbation to which the coherence (the horse) 'responds' with drinking behaviour (Dell, 1982, p. 37).

Dell suggested that therapy is a matter of discovering what particular inputs (or *perturbations*) produce the changes required in those coming for therapy. This seems to be a helpful idea, more helpful than the concept of homeostasis. The concept of the ‘resistant’ family may also be unhelpful. It may be better to regard the failure of a family or an individual to respond to a therapeutic intervention (i.e. a ‘perturbation’) as due to the selection by the therapist of the wrong perturbation for those particular circumstances, rather than labelling the family or the individual ‘resistant’.

The above ideas do not tell us anything much about how to determine which perturbation is likely to result in the desired response. This is the very essence of therapy, of course, and will be the subject of most of the rest of this book. However, Dell’s concept of coherence is a precursor to the more contemporary idea of *constraints* (Breunlin, 1999), which we will discuss below.

Our two brains and first- and second-order change

A concept that some therapists have found useful concerns the different functions the two cerebral hemispheres are believed to have. Many who present with problems do not accept reasonable suggestions about how they might rid themselves of their problems. This seems to be because much of what we do is determined not by our conscious, rational minds, but by our emotions, deep-rooted attitudes and habitual ways of reacting and behaving.

Watzlawick (1978), in *The Language of Change*, addressed the question of how change occurs in psychotherapy. He distinguished *first-order change* from *second-order change*. First-order change is simply the result of a conscious decision to do something differently, for example, to try harder to accomplish a task or to tackle it in another way. Second-order change involves a change in attitude or the reframing of a situation, so that things are perceived differently. It goes beyond the application of logical, rational measures to something much less logical, like laughing at one’s earlier attempts to try harder or responding to a paradoxical approach (Barker, 1981, 1996).

According to Watzlawick (1978), the two cerebral hemispheres have different functions. Each also has its own language, corresponding to the digital and analogic languages mentioned above:

[Digital language] is objective, definitional, cerebral, logical, analytic; it is the language of reason, of science, explanation, and interpretation, and therefore the language of most schools of psychotherapy. [Analogic language] . . . is much more difficult to define—precisely because it is not the language of definition. We might call it the language of imagery, of metaphor, of *pars pro toto*, perhaps of symbols, but certainly of synthesis and totality, and not of analytical discussion. (Watzlawick, 1978, pp. 14–15)

Watzlawick goes on to suggest that the second of the two ‘languages’ is more effective in producing the kinds of changes sought in psychotherapy. This language is believed to be the business primarily of the right cerebral hemisphere, which ‘tends to draw illogical conclusions based on clang associations and confusions of literal and metaphorical meanings, to use condensations, composite words and ambiguities, puns and other word games’ (Watzlawick, 1978, p. 24). The left hemisphere, on the other hand, deals with the direct, logical and rational communication of ideas.

Second-order change, Watzlawick (1978) suggests, involves making contact with, and presumably producing changes in, the processes occurring in the right hemisphere. The left hemisphere functions as a sort of logical watchdog, guarding the right hemisphere against undue outside influence. It must therefore be bypassed. Watzlawick describes methods of ‘blocking the left hemisphere’. This may involve reframing the problem or the use of paradox, metaphor or hypnosis, any of which may be effective when direct methods are not. Metaphors can be powerful aids to communication when direct methods prove ineffectual (Barker, 1985, 1996).

The ‘new epistemology’ and a second-order cybernetic approach

Epistemology is a term much loved by family therapists. It refers to the theory on which a body of knowledge is based – *How does one know what one knows?* As family therapy revolutionized how practitioners conceptualized human problems, and as new theoretical models for treating families evolved, the field turned to new epistemologies.

Because families are complex, and the causes of problems are difficult to locate with certainty, the field has moved epistemologically, from a linear view of causality, to a simple cybernetic view, to a second-order cybernetic view. A linear approach conceptualizes problems individually. A simple cybernetic perspective is concerned with patterned homeostatic mechanisms (Hoffman, 1981), while a second-order cybernetic considers the therapist as a part of the system, and the *constraints* on change: *What constrains the family from acting differently?*

This shift led to the use of the term *the new epistemology* by some therapists, which is misleading because it suggests the existence of a specific, new, generally accepted way of thinking about and understanding families. But, there is no one new epistemology. The evolutionary process in our understanding of families, and of how change occurs, is an ongoing process.

Postmodern discursive therapies

This epistemological shift (Hoffman, 2002), beginning in the mid-1980s and continuing to the present, drove a change in practice. Family therapists had conceptualized family functioning as something that could be assessed from

the outside, as if the therapist, neutrally standing apart from the family, could diagnose its structure or interactions and intervene. A cybernetic approach to understanding families might suggest this approach.

Emerging from various therapeutic traditions, in the mid-1980s, several authors (Fleuridas, Nelson, & Rosenthal, 1986; Lipchik & de Shazer, 1986; Penn, 1982, 1985; Tomm, 1987a, 1987b, 1988) wrote about the *interview as intervention* and the therapist as an integral part of the system. The family cannot be ‘assessed’ without consideration of the therapist as a part of that system. Also, assessment, in and of itself, is an intervention (O’Hanlon & Weiner-Davis, 1989). Thus, a second-order cybernetic approach developed.

Conceptualizing the interview as the intervention, the idea of *therapy as conversation* (Gilligan & Price, 1993; Hoyt, 1994, 1996, 1998) emerged. No longer is the therapist the ‘expert’ who assesses the family, forms an opinion as to the nature of its ‘problems’ and intervenes to help the family change its way of functioning. The aim, which may be implicit or explicit, is to help the family function in a way that conforms more closely to society’s norms.

Therapy becomes less *intervention* and more *conversation*. Solution-focused therapy (de Shazer, 1985, 1988, 1991, 1994; de Shazer et al., 2007), narrative therapy (Freedman & Combs, 1996, White, 2007; White & Epston, 1990), interventive interviewing (Tomm, 1987a, 1987b, 1988), reflecting teams (Andersen, 1987, 1991; Brownlee, Vis, & McKenna, 2009; Chang, 2010; Friedman, 1995) and collaborative language systems (Anderson, 1997; Anderson & Gehart, 2006) are among the approaches that are described as *postmodern* approaches to therapy.

In these approaches, language is not seen as simply a representative of reality and as a medium for content, but constitutive of social reality (Mills & Sprenkle, 1995; Shotter, 1993). Through collaborative questioning that focuses on client preferences, knowledge and solutions, these approaches place the therapist and the clients on an equal footing, flattening the hierarchy. They work together, first to clarify the changes the family wishes to make, and then to find ways for the family to make those changes.

From coherence to constraints

Going beyond Dell’s (1982) description of coherence, postmodern approaches, in one way or another, seek to erode the *constraints* that prevent families from acting in accord with their preferences. Rather than thinking in terms of *positive explanation* (‘What propels the family to act as they do?’), it is often more useful to think in terms of *negative explanation* (‘What constrains the family from acting as they prefer?’) (Bateson, 1972; Breunlin, 1999; White, 1986).

Postmodern approaches generally employ questions that highlight clients’ solutions and knowledge (De Jong & Berg, 2013; White, 2007); elucidate interactional patterns in which the problem is embedded and/or lead to

healing (Strong et al., 2008); and deconstruct the discourses that support the problem (Monk & Gehart, 2003).

Style versus method: common or model-specific factors?

The family therapy literature is replete with discussions of the relative importance of the ‘aesthetics’ of therapy, as opposed to the techniques used. L’Abate (1986, p. 7) put this well:

These two major variables can be reinterpreted in terms of the two faces of family therapy: *style*, that is the aesthetic quality of the therapist’s personality and techniques, which, as a whole, are nonrepeatable events, and *method*, the pragmatic quality of the therapist’s professional preparation and competence, which include repeatable types of interventions.

The *common factors* perspective (Duncan, Miller, Wampold, & Hubble, 2010) refers to the idea that all effective therapies rest on four common factors, here listed in the order of the size of their contribution:

- client characteristics and extra-therapeutic factors;
- the working alliance or therapeutic relationship;
- the model or technique; and
- the effect of hope, placebo and expectancy.

In the psychotherapy literature in general, and in the family therapy literature in particular, there has been a vigorous debate about this. The common factors perspective stands in contrast with the ‘model-driven change paradigm’ (Davis, Lebow, & Sprenkle, 2012, p. 36), which asserts that therapeutic change can best be explained by the unique aspects of specific treatment approaches, and the therapist is little more than a delivery system, as a hypodermic needle or a tablet is a delivery system for medication.

Accordingly, the model-driven approach de-emphasizes the role of the family therapist in facilitating change, giving credit to specific factors inherent in the treatment model (Sexton & Ridley, 2004). On the other hand, the common factors approach posits that it is not useful to refer to treatment models as abstractions separate from the therapist who ‘delivers’ the treatment. This might suggest that qualities of the therapist contribute more to the outcome than the treatment itself (Davis et al., 2012).

A middle ground, perhaps, is to think in terms of *allegiance effects* – the therapist’s belief in the model, which leads him/her to deliver treatment confidently, coherently, with a rationale that is plausible to clients and which strengthens the therapeutic alliance (Duncan, 2010). What cannot be questioned is that, to be effective as therapists, we need *relationship skills* – affect, warmth, sense of humour; and *structuring skills* – directness, self-confidence and technical expertise (Alexander & Barton, 1976).

Summary

The history of family therapy has been characterized by the continuing search for new theoretical schemes, sometimes referred to as new epistemologies, to aid in the study of the family processes and change processes. Theories derived from the study of individuals are of limited value when applied to families. Cybernetics, systems theory, control theory, learning theory and communications theory are among the models that have been used by therapists of various schools. All have proved useful, but none has been found to be entirely satisfactory.

The concepts of *coherence* – the idea that families constitute *organized coherent systems* determined by their structure and constraints – may be a more fruitful way of exploring what constrains the family from acting as they desire. This may be more useful than seeking to elucidate what ‘causes’ problematic behaviour. It implies that therapy should be a process of discovering what will perturb the organized system in a more useful way of interacting. Ideas about the respective functions of the left and right cerebral hemispheres may also be helpful in devising effective ways of promoting change.

Postmodern approaches have become increasingly popular in the last two decades, as their collaborative style and their focus on clients’ solutions are appealing. Finally, whether change occurs as the result of factors common to all therapy approaches, or model-specific factors, is a matter of much recent debate, but it is clear that the therapeutic relationship is at the centre of therapeutic outcome.

It seems likely that family therapists will continue to use ideas from a variety of theoretical schemes, much as carpenters, electricians and other technicians carry around a variety of tools and pieces of equipment.

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Chapter 4

Adopting and Refining a Model of Family Therapy

In Chapter 3, we discussed several theoretical foundations for family therapy. These provide background for some of the philosophical ideas behind specific family therapy models, but do not provide a coherent framework for practice. We argue for the need for family therapists to have a coherent model of family therapy, describe how therapists develop their models of therapy and suggest some steps you might take as you develop your own approach to therapy.

The nature of theories and models

The three classic theories of psychotherapy – psychodynamic, behavioural and person-centred – in which many of the current family therapy models are grounded, were grand in their scope (Anderson, Lunnen, & Ogles, 2010). Freud advanced the notion that all problems are libidinally caused. He applied his theory widely to history, culture, religion and art (Makari, 2008). Skinner wrote a fictional account of a utopian society based on operant conditioning (Skinner, 1948) and a major treatise on the benefits of radical behaviourism after methods of behaviour therapy had been developed (Skinner, 1971). Rogers' (1961) person-centred approach extended beyond therapy, offering a vision of society founded on autonomy and self-determination. Contemporary models of psychotherapy and family therapy are not so grand, but they do give us some pragmatic guidance about how to conduct ourselves in the therapy room.

Models clarify the therapist's role

Many of the early family therapists were powerful, charismatic figures who assumed a strong leadership role during therapy sessions. It sometimes seemed that the sheer power of the therapist's personality played a major role in promoting change in families. Even therapists with less powerful personalities took a leading role in the therapy process. Not unreasonably perhaps, they saw it as their job to promote change any way they could.

Often there was not a lot of discussion of therapeutic goals with the family. There tended to be an implicit assumption on the therapist's part that the objective of treatment was to restore, or guide, the family towards some sort of perceived 'normal' functioning.

Given our contemporary models of family therapy, the above approach has come to have less appeal. For one thing, our concept of the 'normal family' has taken a beating. The many family forms now extant preclude our considering any one family form as 'normal'. As we saw in Chapter 2, it may be more appropriate to consider whether a family is 'healthy' or 'functional'. Particularly in postmodern approaches to therapy, the therapist is no longer the master of the therapy room, but an equal, or even a humble member of the group of people gathered there. The model of family therapy you use will guide you in the stance you take as a therapist – how directive or collaborative you are, whether you position yourself as an expert or as a consultant.

Models help us build on the pioneering ideas of others

As Drapela (1990, p. 24) states, 'Rather than having to "reinvent the wheel" in professional terms, we can spend our energy on developing our own operational framework'. Adopting a model of family therapy enables us to develop conceptual skills (a specific conceptualization of families and of therapy), perceptual skills (know what to look for and how to organize our observations coherently) and executive skills (how to actually conduct the session) (Tomm & Wright, 1979).

Contrary to conventional wisdom, family therapists do not usually select models of therapy because they are 'the most effective'. While there is increasing interest, in medicine generally and also in the mental health field, in *evidence-based practice* (Patterson, Miller, Carnes, & Wilson, 2004), assessing the available evidence is not easy. First, most research that is conducted via randomized clinical trials (RCTs) can tell us that a particular treatment is *empirically supported*, that is, it is effective for a given population or problem, but that falls short of showing us the best treatment. Second, because the treatment in an RCT is standardized and because the participants in such research must meet specific inclusion criteria (e.g. one diagnosis with no comorbidities, no other potentially confounding treatments), what is being evaluated is but an analogue of real-world family therapy (Messer, 2001). In clinical practice, clients often present with messy, complicated situations, rather than with a single problem. RCTs may tell us a good deal about potential elements of effective treatment for a particular problem or population, but the situations therapists face in community practice are more complicated. Third, many empirically supported family-based treatments are delivered in large-scale institutional programmes (Sprenkle, 2012). Again, while these can be useful in guiding practice, it is unlikely that we can follow these models or programmes to the letter. Finally, the common factors approach is quite clear in saying that no particular theory,

model or approach to therapy is superior to any other; no differences in effectiveness exist between treatment approaches intended to be therapeutic; and there is no connection between the techniques of a specific model and its outcome (Ahn & Wampold, 2001).

Models help us conduct treatment coherently and confidently

If empirically supported treatments only vaguely represent real life and are hard to reproduce, and no model of therapy is superior to others, why bother to adhere to a model of family therapy at all? Significantly, advocates of the common factors approach and those who believe in the specific factors of therapy models agree that *how* the treatment is delivered is important, although they disagree about why. We know that *allegiance effects* ‘the degree to which a practitioner . . . believes a particular therapy to be efficacious . . .’ (Anderson et al., 2010, p. 150), are particularly potent. ‘Considerable evidence now exists that belief in or commitment to a particular method of treatment has a significant influence on treatment outcome’ (Anderson et al., 2010, p. 151).

Both novice and experienced therapists use particular models because they have personal appeal in terms of values and operational style (Chang, 2011; Ronnestad & Skovholt, 2003). Accordingly, believing in a treatment model or technique without being rigid permits a family therapist to work with families confidently. ‘[T]herapists need not spend any time searching for the right treatment for a particular disorder. Instead, the “best” methods are those (a) intended or believed to be therapeutic; (b) delivered with a cogent rationale; and, above all, (c) acceptable to the client’ (Anderson et al., 2010, p. 151). Acceptability to the client is critical – this both supports and is supported by the therapeutic alliance with a family.

This is not to say that the specific effects of psychotherapy or family therapy models are nil. The couple sitting in front of you may benefit more from an approach focused on attachment and emotion than a model that features instruction and skill development, or vice versa. The family with the unruly adolescent in your office may benefit more from an approach that encourages parents to be in charge than a model that encourages emotional expression, or vice versa.

Developing your model of family therapy

My (JC) research with beginning therapists (Chang, 2011) described, among other things, how they developed their models of therapy. As they learned about models of therapy in their graduate courses, they questioned the relevance of what they were learning. One trainee stated, ‘The link was severed between theory and practice . . .’ (p. 415). Beginning therapists are exposed to a variety of theoretical models, teachers or supervisors and

often experience theoretical confusion. One trainee ‘followed the way the wind blew’ (p. 415) before finding a personally congruent theoretical model. However, when novice therapists begin to actually use particular models of therapy, theory comes alive to them, and they experience the model in action. Many therapists focus on one particular model of therapy, not because it is “true” or the most effective, but because it provides clear procedural and theoretical guidance and a solid base from which to operate.

Once therapists have left the novice stage, practicing relatively independently, they have the freedom to experiment with new approaches or techniques. Seasoned therapists often assume a stance of *pragmatism*, in which they exercise flexibility, based on a sound grounding in one or more approaches, and avoid overdependence on one theory (Kottler & Shepard, 2011). Late career therapists incorporate ideas from outside of psychology and psychotherapy – art, literature, theatre, film, philosophy, etc. (Ronnestad & Skovholt, 2003).

Our experiences in developing our respective approaches might be instructive and are given below.

Philip’s perspective

My first family therapy teacher and supervisor was Duane Bishop of McMaster University. He was one of the developers, with Nathan Epstein, of the McMaster model of family therapy. I believe that was a good starting point for me. I went on to study the work of Salvador Minuchin, Ivan Boszormenyi-Nagy, Jay Haley, Milton Erickson, the Milan Group and many others. More recently, I have collaborated with colleagues using the ‘reflecting team’ and other postmodern approaches. Over the years, I have attended conferences, conventions, lectures and demonstrations. I have also done much reading and have viewed videotapes by a wide range of therapists. These experiences are what have made me the therapist I am today.

Jeff’s perspective

In the mid-1980s, I was working in a children’s mental health agency, where my colleagues were interested in brief strategic and Ericksonian methods. I was intrigued by some of the dramatic interventions performed by Erickson and others that apparently brought about rapid cures, but I could not quite figure out how to pull off these miraculous changes. My supervisor alerted me to *Keys to Solution in Brief Therapy* (de Shazer, 1985), which laid out a systematic approach to brief therapy. I immersed myself in the solution-focused approach (de Shazer, 1988, 1991, 1994; de Shazer et al., 2007), which focuses on *what’s going right*, as opposed to the aetiology of problems. Shortly thereafter, I met and trained with White (1986, 2007; White & Epston, 1990), one of the originators of narrative therapy. Since then, I have integrated these approaches under the umbrella of social constructionism

(West, Bubenzer, & Bitter, 1998). More recently, I have become interested in how to promote resilience in families by building up systemic resources, mainly thinking in terms of ecosystemic theory (Bronfenbrenner, Morris, Lerner, & Damon, 2006), and have used these ideas to develop school-based mental health programming.

Selecting and adapting a model of family therapy

As you consider the models of family therapy in this book and develop your own emerging model of family therapy, here are some suggestions as to how you might proceed.

Find a model of family therapy that you think is consistent with your values and temperament. Learn enough about it to make sure that this model will be congenial to your way of being in the world and that its philosophical tenets make sense to you. Finding a model that fits for you will make it more effective.

Many family therapists start by learning one approach to family therapy. Although this may seem limiting at first, it can be a good way to gain an initial sense of mastery and provide you with a context to integrate conceptual skills (knowing the ‘ins and outs’ of the model), perceptual skills (knowing what to look for and how to make sense of it, in light of your theoretical model, when you see it) and executive skills (intervening with families while being guided by a coherent model). Seek out readings, trainings and supervision that will support your continued development. If possible, use video recordings to support your skill practice.

Soon you will have mastered your model to the point where it guides your behaviour as a therapist fairly well most of the time; you can generally explain, in light of your model, why you are doing what you are doing; and your clients are making progress and you can explain why. It may then be time to begin to experiment with integrating approaches from other models. If you choose to do this, make sure you are clear about how the approaches you are integrating fit together. As you do so, maintain a spirit of openness, experimentation and intellectual rigour.

Summary

In this chapter, we have suggested why it is important to have a coherent theoretical model of family – it can clarify your role as a therapist, help us build on the work of innovators who have gone before us and help us organize your observations and case conceptualizations. Your journey to develop your theoretical framework will probably be somewhat winding, intellectually stimulating and a great deal of hard work.

Enjoy!

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Chapter 5

Models for the Assessment of Families

Preparing to write this chapter, I (JC) asked my Facebook friends the following question:

What tells you that a family is a ‘strong family’? Or an ‘effective’ family or a ‘solid’ family? On the other hand, what tells you that a particular family is ‘in trouble’, ‘on shaky ground’ or, to use an already overused word, ‘dysfunctional’. You could answer in terms of adjectives, phrases or accounts of what they do or don’t do.

Before reading the responses below, please take a moment to answer this question for yourself.

Here’s how respondents described strong or functional families:

- ‘In a strong family, the family members are supportive of each other. Being able to trust one another and openly communicate are other qualities of a strong family’.
- A Danish colleague received these responses from a client family:
 - ‘If it is a good family, they are happy when being together’ (13-year-old girl).
 - ‘You would have to be in the family, to . . . see if they consider each other’s needs’ (16-year-old girl).
 - ‘They would have to listen to each other in order to be a good family’ (father).
 - ‘If the parents talk politely with their children instead of scolding them when do something they shouldn’t – I would say it is a pretty decent family’ (grandmother).
- ‘Strong families stick together and can tolerate shit’.
- ‘. . . display of affection/love, voicing gratitude/appreciation for each other, offering support (emotional and otherwise), being honest even when it’s not popular’.
- ‘. . . resilient, allow reasonable expression of emotion, kids need to know adults are in charge of the family, allow family members to define themselves . . . ’

On the other hand, ‘dysfunctional’ families are described as follows:

- ‘... not anger so much as indifference. Lack of interest or concern about other family members and their needs, interests, and hopes’.
- ‘... angry, fearful, self-doubting, low energy...’
- ‘Dysfunctional families have too much drama and can’t get organized’.

As we shall see, these comments from laypersons cover many of the factors sampled by formal systems of family assessment.

As we have seen, our models of family therapy inform what we look for and how we organize what we see, and guide our intervention planning. How we conceptualize family functioning is important for several reasons. We require reliable and valid research measures to describe family functioning and the family factors that maintain or inhibit problems. Most readers, however, are family clinicians for whom a comprehensive framework for assessment is necessary for planning intervention.

Critical distinctions in assessment

First, we will make four important distinctions about how the word ‘assessment’ is used. One distinction is between *formal* and *informal* assessment (Erford, 2013). Formal assessment requires a written report for use by a decision-maker. For example, a court may require a report to decide on the care of children in child protection or post-divorce; or a school system may require a cognitive assessment to determine special education measures. On the other hand, therapists do informal assessment, sometimes called *general assessment* (College of Alberta Psychologists, 2012), to formulate treatment or intervention. We assume that most readers are interested in informal assessment.

Another important distinction is between *standardized* and *nonstandardized* assessment techniques. Standardized assessment techniques, that is, psychological tests, are normed against relevant populations, enabling comparisons between the test-taker (whether it is a family, couple or individual) and the general population. As such, validity (whether the test actually measures what it purports to) and reliability (whether the test yields pretty much the same result with repeated administrations) are important. Nonstandardized assessment techniques (e.g. drawings, play-based techniques, self-report numerical scaling) may elicit useful information about the client’s experience, but do not enable the practitioner to infer anything outside of that.

A third distinction is whether the practitioner takes a *collaborative* or an *expert* approach. A standardized assessment technique can tell us how an individual, couple or family compares to the norm on a certain characteristic. More important is how a family therapist uses this information. A collaborative approach would find a family therapist asking clients for their experience in the light of test results, while an expert approach would

invite the therapist to claim knowledge about the family irrespective of the family's experience.

A final distinction is between *model-specific* and *integrative* approaches to family assessment. In Chapter 4, we asserted that our working models of family therapy guide how we observe a family's presentation, make sense of our observations, and intervene. However, this approach does not permit a family therapist to consider whether other approaches to therapy might be useful. On the other hand, the approaches to assessment we describe in this chapter are integrative. They conceptualize family functioning across numerous dimensions, permitting family therapists to integrate techniques from various theoretical homes.

Conceptual approaches to family assessment

Several integrative approaches to family assessment have been developed. We describe each one in terms of their underlying conceptual base. We then describe the assessment techniques (e.g. client self-report instruments, therapist checklists, observational tasks, clinical interview guides) developed by the originators of the approach.

Approaches derived from the Family Categories Schema

The *McMaster model of family functioning* (Miller, Ryan, Keitner, Bishop, & Epstein, 2000) and the *Process model of family functioning* (Skinner, Steinhauer, & Sitarenios, 2000) are both derived from the Family Categories Schema (Epstein, Rakoff, & Sigal, 1968). They largely consider the same dimensions of family functioning, but differ in five main ways. First, the McMaster approach addresses the *current functioning* of the family, rather than its past development or present developmental stage. Second, the Process model considers intrapsychic, interpersonal and overall family systems characteristics, while the McMaster model deemphasizes how one family member's intrapsychic make-up might affect the family system. Third, the Process model considers the interrelationship between factors. Fourth, the Process model considers the social context of the family. Fifth, the McMaster model provides a pragmatic, integrative approach to treatment, while the Process model provides general recommendations to guide treatment. The McMaster model can be seen as more parsimonious, while the Process model is more comprehensive.

The commonalities of these approaches are illustrated in Table 5.1.

Task accomplishment and problem solving

These functions are viewed similarly in each of these approaches. They entail:

- Identifying the tasks to be accomplished.
- Exploring alternative approaches and selecting one.

Table 5.1 Family assessment frameworks based on the Family Categories Schema

McMaster Model	Process Model
Problem solving	Task accomplishment
Communication	Communication (including affective expression)
Roles	Role performance
Affective responsiveness	
Affective involvement	Affective involvement
Behavioural control	Control
	Values and norms

- Taking action.
- Evaluating (or monitoring) results and making any necessary adjustments.

The McMaster model has an additional stage in the process of *problem solving*, namely communicating the existence of the problem to whomever needs to know about it.

Both models distinguish family tasks as *basic*, *developmental* and *crisis*. *Basic* tasks include the provision of survival needs. *Developmental tasks* support the healthy development of members by adjusting as the family life cycle unfolds. Difficulties in making transitions from one developmental stage to the next often presage family problems.

Crisis tasks tax the family’s skills and resources to the limit and sometimes beyond. They include dealing with unexpected or unusual events, such as the death of a family member, serious illness, job loss, natural disaster, loss of the family home or migration. Some families might handle adverse events (e.g. receiving a bad school report about a child or discovering that a teenager has been shoplifting or is smoking marijuana) with equanimity, while others may react dramatically: ‘A family’s capacity to accommodate to stress and avert potential crises is an excellent indicator of family resilience or health’ (Steinhauer, Santa-Barbara, & Skinner, 1984, p. 79).

Roles

Roles are ‘prescribed and repetitive behaviours involving a set of reciprocal activities with other family members’ (Steinhauer et al., 1984). Task accomplishment requires a suitable allocation and coordination of roles and family members to do what their roles require. Most of the time, families do not allocate roles formally; roles evolve from habitual patterns of behaviour. Sometimes, however, it is necessary for family members to get together and agree upon who will do the shopping, clean the house, mow the lawn, feed the cat or whatever needs to be done.

Communication

The McMaster model considers mainly verbal communication, not because non-verbal communication is unimportant, but because it is difficult to

quantify. The Process model does, however, consider non-verbal, called *latent* content, which includes *metacommunications* expressed by voice tone, facial expression, eye contact or its lack, body language and choice of words.

Both models consider the clarity, directness and sufficiency of communication. Communications may be *affective* (the expression of feeling), *instrumental* (related to the ongoing activities of everyday life) or neither affective nor instrumental (e.g. the expression of opinions on works of art). In considering the process of communication, *clear*, as opposed to *masked* (vague, disguised or ambiguous), communication is generally desirable, as is *direct* communication (sent directly from sender to receiver, rather than through a third person). Indirect communication is more easily distorted and more likely to place the third party in a difficult position. With respect to content, is sufficient information being communicated between family members?

Affective involvement

Affective involvement is a matter of ‘the degree and quality of family members’ interest and concern for one another’ (Steinhauer et al., 1984, p. 83). Ideally, a family will meet the emotional needs of all its members, until members can meet their needs from outside the family, beginning during adolescence. Both models focus on the depth of communication and distinguish various communication *types*:

- (1) *Uninvolved*, describing disconnection rather ‘like strangers in a boarding house’.
- (2) *Interest (or involvement) devoid of feelings*, in which involvement arises from a sense of duty or need for control.
- (3) *Narcissistic involvement*, in which involvement is meant to bolster one’s feelings of self-worth, rather than real concern for the other.
- (4) *Empathic involvement*, based on a real understanding of the needs of others.
- (5) *Enmeshment* as described in the Process model, or *over-involvement* and *symbiotic involvement*, as described in the McMaster model.

The McMaster scheme has a separate dimension called *affective expression*, which, in the Process model, is subsumed into *affective involvement*.

Control

Control in the Process model, or *behaviour control* in the McMaster model, refers to how family members influence one another. There are four basic styles of behaviour control: *rigid*, *flexible*, *laissez-faire* and *chaotic*. *Rigid* control is high on predictability, but low on constructiveness and adaptability. It may work quite well for day-to-day tasks and roles, but is less successful for navigating transitions in family life. Steinhauer et al. (1984) pointed out that rigid control invites subversion, passive-aggressive behaviour, power struggles and the displacement of anger outside the family.

Flexible control is predictable, constructive and adaptive when family circumstances change. Flexible control ‘assists task accomplishment because its supportive and educational tone encourages family members to participate and to identify with the ideals and rules of the family’ (Steinhauer et al., 1984, p. 83).

Laissez-faire control is also predictable, but low on constructiveness. In effect, ‘anything goes’. These families display inertia and indecision, rather than organization and action. Task accomplishment, communication and role allocation are ineffective. Children raised in these disorganized families are often insecure and display attention-seeking behaviour and poor impulse control and self-regulation. Entry to school, where conformity to certain standards of behaviour is expected, can be hard for them.

Chaotic control is unpredictable, switching from rigid to flexible to laissez-faire, so that no one knows what to expect. Changes occur more according to the whim or mood of the family members than on the actual needs of the family. This instability and inconsistency results in poor functioning in a number of domains of family life.

Values and norms

As described by the Process model, this dimension considers the family’s moral and religious values, and its norms, ‘the sum total of what is/is not acceptable within that family’ (Steinhauer et al., 1984, p. 84). With increased interest in cultural diversity (e.g., McGoldrick et al., 2005), it is now widely recognized that family therapists must understand the values of the families they treat if they are to be effective.

Assessment instruments

Epstein, Bishop and colleagues developed the Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983), a standardized self-report instrument; the McMaster Clinical Rating Scale (MCRS; Miller, Kabacoff, Bishop, Epstein, & Keitner, 1994), which is completed by the assessor after a family interview; and the McMaster Structured Interview of Family Functioning (McSIFF; Bishop, Epstein, Keitner, Miller, & Zlotnick, 1980). This combination of assessment modalities provides a comprehensive system of family evaluation. The McMaster model gave rise to *Problem centered systems therapy of the family* (Epstein & Bishop, 1981), an integrative approach to family therapy that contains the major stages of *assessment, contracting, treatment and closure*, each containing a series of sub-steps.

Skinner, Steinhauer, and Santa-Barbara (1995) developed the Family assessment measure, third edition (FAM-III). Family members aged 12 and older complete the Dyadic Assessment Scale, reporting on the relationship between oneself and each other family member; a Self-Rating Scale, describing one’s perceived connection with the family; and the General Scale, assessing family functioning in general.

The Circumplex model

The Circumplex model (Olson, 1986, 1990, 1991, 1993; Olson, Russell, & Sprenkle, 1989) conceptualizes family functioning in terms of three key dimensions: *cohesion*, *flexibility* and *communication*.

Cohesion

Cohesion is ‘the emotional bonding that family members have towards one another’ (Olson, 2000, p. 145). At the middle ranges, or as Olson designates them, *balanced*, family functioning is healthy. For example, a *separated* relationship is characterized by some, but not an extreme amount of, emotional separateness. Family members value time apart, typically engage in separate activities, but are adequately supportive of one another. A *connected* relationship is characterized by emotional closeness and loyalty, and time together is more highly valued than individual time, but separateness is tolerated.

At one extreme, families are *disengaged*, showing extremely low cohesion. Family members tend to operate very separately, in terms of their interests and activities. Significantly, they do not experience being able to turn to others in the family for support. At the other extreme, families are *enmeshed*. Emotional closeness is paramount in the family and loyalty is required; independence, private space and dissent are not permitted; and family members mainly focus inwardly within the family. At the extremes, disengagement or enmeshment maintains clinical problems.

Flexibility

Flexibility is ‘the amount of change in [a family’s] leadership, role relationships and relationship rules’ (Olson, 2000, p. 147). This dimension refers to how leadership is expressed, how changes in roles and rules are negotiated and how families balance stability and change. The amount of flexibility in a family is distinguished as *rigid* (very low), *structured* (low to moderate), *flexible* (moderate to high), or *chaotic* (extremely high). Like cohesion, Olson hypothesizes that mid-range families are more likely to have healthy relationships and less likely to display pathology, while the extremes are usually associated with problematic functioning.

Communication

Communication, the third dimension of the Circumplex model, is a facilitating dimension, helping families modify their levels of cohesion and flexibility. This dimension comprises family members’ listening skills (empathy and attentive listening), speaking skills (speaking for oneself and not speaking for others), self-disclosure (sharing feelings about self and relationships), clarity, staying on track and respect.

Assessment instruments

Previous editions of the Family Adaptability and Cohesion Evaluation Scales (FACES; Olson, 2008) have been criticized on the basis that they did not properly measure cohesion and adaptability at their extremes (Franklin, Streeter, & Springer, 2001). The fourth edition of the FACES (FACES-IV), a standardized self-report instrument, contains 24 items. Franklin et al. (2001) found that the Cohesion dimension of FACES-IV strongly supports Olson's theoretical model of family functioning, given that the enmeshment and disengagement subscales are reliable and valid.

Olson (1990) also developed the Clinical Rating Scale (CRS), used by therapists or researchers to assess cohesion, flexibility and communication based on observations of the family. Olson (2000) suggests that the CRS is useful to train therapists and researchers in the Circumplex model and its use in treatment planning. The Circumplex model assumes that, in families at the extremes of cohesion (enmeshed and disengaged) and flexibility (rigid and chaotic), problems can be reduced by assisting families to move towards a balance and improving communication skills, thus increasing the capacity of the family to adapt to change over time.

The Beavers Systems Model of Family Functioning

The Beavers Systems Model of Family Functioning (Beavers & Hampson, 2000) conceptualizes family functioning along two axes: *family competence* and *family style*. Family competence comprises 'structure, available information, and adaptive flexibility . . .' (Beavers & Hampson, p. 128). *Family competence* requires both the structure and capacity to adapt to changes that occur through the family life cycle. Beavers and Hampson maintain that the most competent families 'intuitively have a systems approach to relationships' (p. 129). That is, family members can appreciate multiple perspectives and understand that the behaviour of family members is interrelated and embedded in interpersonal patterns, and therefore, less likely to blame one another.

Family style is concerned with the 'stylistic quality of family interaction' (Beavers & Hampson, 2000, p. 130), and is classified as either *centripetal* or *centrifugal*. Centripetal families find their most satisfying relationships within the family, as opposed to the outside world. On the other hand, centrifugal families' members seek satisfaction outside the family. As the competence of families increases, extreme centripetal or centrifugal styles moderate, and competent families adapt to meet their changing needs.

At the extremes, severely disturbed centripetal families display nearly impermeable boundaries. They maintain a strict division between the family and the outside world. The emotional development of children is often impaired. Within the family there is a great deal of conflict between the normal developmental need for separateness and individuation and the family's insistence on togetherness and family loyalty. Severely disturbed

centrifugal families have a porous boundary with the outside world. Members are frequently disconnected for long periods of time and may be openly hostile. These families may be unable to exhibit vulnerability or tenderness and may even be disdainful or contemptuous of such emotions.

Assessment instruments

Beavers and Hampson (1990) have developed two therapist observation scales that sample family competence and family style: the *Beavers Interactional Competence Scale* (BICS) and the *Beavers Interactional Style Scale* (BISS), in which trained observers rate the family as they discuss the question ‘What would you like to see changed in your family?’ The BICS assesses the family’s overall health and competence in the following dimensions:

- (1) Structure of the family:
 - Overt power (from chaotic to egalitarian).
 - Parental coalitions (from parent–child coalition to strong parental coalition).
 - Closeness (from indistinct boundaries to distinct boundaries).
- (2) Mythology (from congruent to incongruent).
- (3) Goal-directed negotiation (from extremely efficient to extremely inefficient).
- (4) Autonomy:
 - Clarity of expression (from clear to unclear).
 - Responsibility (from regular to rare acceptance of responsibility for actions).
 - Permeability (from open to unreceptive).
- (5) Family affect:
 - Range of feelings (from direct expression of a wide range to little expression).
 - Mood and tone (from warm and optimistic to cynical and pessimistic).
 - Unresolvable conflict (from severe unresolved conflict to none).
 - Empathy (from consistent empathy to none).
- (6) Global health pathology (from pathological to healthy) (Beavers & Hampson, 2000).

Beavers and Hampson (2000) report that the BISS reliably distinguishes between families of hospitalized adolescents and non-clinical families.

The BISS evaluates families on the continuum of centripetal to centrifugal, via the following eight subscales:

- (1) Meeting dependence needs (from need ignored to met alertly).
- (2) Managing conflict (from open to covert).
- (3) Use of physical space.
- (4) Appearance to outsiders (from trying to make a good impression to being unconcerned).
- (5) Professed closeness (emphasizing vs. denying closeness).
- (6) Managing assertion (discouraging vs. encouraging assertion).

- (7) Expression of positive and negative feelings.
- (8) Global style (from centripetal to centrifugal).

Preliminary validation research indicates that the BISS distinguishes between families of adolescents exhibiting internalizing problems (which are correlated with centripetal family style) and those exhibiting externalizing problems (which are correlated with centrifugal style).

Beavers and Hampson (1990) also developed the 36-item Self-Report Family Inventory (SRFI), which can be completed by family members aged 11 and older. Respondents endorse 5-point Likert items, from which clinical scales are derived that reflect Beavers' theory. The SRFI discriminates between families of members with specific psychiatric diagnoses.

The Darlington Family Assessment System

Wilkinson (1998, 2000) developed the Darlington Family Assessment System (DFAS), in the context of children's mental health services in Darlington, United Kingdom. Table 5.2 describes the dimensions of family functioning considered by the DFAS.

These dimensions of family functioning overlap with many domains of family functioning in family assessment models described above. However, the DFAS stands out in several ways. First, Wilkinson (1998) sees family assessment as a historical and cultural product that is socially constructed. Family functioning is determined by multiple and intertwined factors and incorporates multiple levels of analysis. Second, Wilkinson anchors family

Table 5.2 Conceptual framework for the DFAS

Child-centred problems
■ Child health (physical)
■ Child development (including self-care, communication, independence)
■ Emotional disturbance (mood disturbances and their effects)
■ Relationships (within and outside the family)
■ Conduct (behaviour towards others)
■ Negative life events (bereavement, separations or other traumas)
Parent-centred problems
■ Parental health (physical)
■ Parental health (psychological)
■ Marital partnership
■ Parenting history (parents' experience of being parented)
■ Parents' social support
Parent-child interaction
■ Care (including over-involvement)
■ Control (including over-control)
Whole family functioning
■ Closeness and distance (attachment patterns in the family)
■ Power hierarchies
■ Emotional atmosphere + rules (family affective patterns)
■ Contextual stresses (living conditions, poverty, stigma)
■ Summary of family development (in relation to problems and life cycle)

assessment in family life cycle transitions, viewing family development as an ‘integrating “metadimension”’ (Wilkinson, 1998, p. 143). Third, Wilkinson relies on established principles of psychotherapy integration in guiding family therapists to develop pragmatic treatment plans for families. Wilkinson is eminently practical in linking assessment to specific intervention plans.

Most importantly, Wilkinson (1998) gives specific guidance to family therapists on how to engage families and larger systems in treatment. He applies the concept of *customer position* (Berg, 1994), suggesting that family therapists first consider whether a particular person is defined as part of *the problem*. Next, he suggests considering who in the family is a *customer*, that is, whether he or she desires any changes, the strength of the desire and the changes desired. If not, to what extent are family members in sympathy with which the person who is labelled as the problem is viewed (e.g., as ‘sick’ [sympathetic] or ‘bad’ [unsympathetic]). Next, he recommends that therapists consider the respective optimism or pessimism about change, and their willingness to take action to facilitate change. Finally, he suggests that therapists consider key self-concepts with which family members see themselves.

Wilkinson (1998) also suggests a collaborative, rather than investigative, interview style. He suggests giving a preamble that normalizes family problems (e.g. ‘I don’t believe there is a right or wrong way to bring up children. Lots of ways can work, but people often have different ideas about it. Do both of you ever disagree about how to handle the children?’). This can help clients to be less defensive and resistant. Wilkinson also suggests that family members may be more likely to collaborate if therapists ask permission to inquire about specific areas. Wilkinson stresses the importance of gaining the perspective of children and notes that, at times, it may be useful to enlist the motivation available in the larger system outside the family.

Respective utility of family assessment models

The approaches to family assessment described above conceptualize family functioning in different, but overlapping ways. Several studies have evaluated the concurrent validity of these instruments (Green, Kolevzon, & Vosler, 1985; Hampson, Beavers, & Hulgus, 1988; Hampson, Hulgus, & Beavers, 1991; Rodick, Henggeler, & Hanson, 1986). However, the utility of a family assessment framework rests on its ability to guide therapists to plan intervention and accurately distinguish between clinical and non-clinical populations.

In an Irish sample, Drumm, Carr, and Fitzgerald (2000) compared the utility of the McMaster model, the Circumplex model and the Beavers model at distinguishing between clinical and non-clinical families, and distinguishing between families with members with different diagnoses. Three groups of 20 families each (clinical families with a child diagnosed with an emotional disorder, clinical families with a child diagnosed with a mixed disorder of conduct and mood and normal controls) were assessed using the Beavers Clinical Rating Scale (Beavers & Hampson, 1990), the MCRS

(Miller et al., 1994) and the Circumplex Clinical Rating Scale (Olson, 1990). All the instruments correctly classified over 85% of the non-clinical cases.

The Beavers scale was most sensitive at distinguishing families with children with emotional disorders, while the McMaster scale was best at detecting families with children diagnosed with mixed disorders of emotion and conduct. The Circumplex model correctly distinguished non-clinical families from clinical, but was slightly poorer at classifying mixed disorder or emotional disorder cases. The McMaster checklist was more likely to identify family strengths.

Summary

There are many existing schemes for assessing families. These schemes help us clarify our conceptualizations of our client families. There is considerable consistency between these approaches, but there are also important distinctions. In addition to offering useful concepts for understanding families, the Darlington approach provides guidance on how family therapists should position themselves in relation to families.

Research data on the relative merits of the different assessment frameworks are beginning to emerge. Whatever theoretical scheme is used, it is important to develop a clinical understanding of how the family functions. We also need to be clear about the family's developmental stage and whether its current problems are related to difficulties surmounting a developmental challenge.

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Chapter 6

The Family Diagnostic Interview

When a therapist starts to work with a family the first one or two interviews are usually 'getting to know you' sessions. Also, rather than using terms such as 'assessment' or 'evaluation', which may have judgemental overtones, I prefer to talk about 'coming to understand' the family.

The assessment (or whatever it is to be called) may be considered in stages, which may overlap:

- (1) The initial contact.
- (2) Joining the family and establishing rapport.
- (3) Defining the desired outcome.
- (4) Reviewing the family's history, determining its present developmental stage and constructing a genogram.
- (5) Assessing the current functioning of the family.
- (6) Developing a diagnostic formulation.
- (7) Offering the family feedback and recommendations.
- (8) Arranging whatever further interviews, diagnostic procedures or referrals are recommended.
- (9) When a professional colleague has referred the family, informing that person of the results of the assessment, and of any recommendations arising from it, including any proposed treatment plans.

The initial contact

The initial contact may come from a family member seeking help or from a professional colleague. When colleagues refer, I like to receive a written request with all available relevant information. If the referring professional is to have an ongoing professional relationship with the family, there should be open communication between that person and the therapist, subject to the agreement of the family members.

The importance of the initial contact with the family can scarcely be overstated. The family should be told how the therapist works, who should come to the first interview, how long the interview will take and what will happen when they arrive at the clinic or office. If fees are payable, they should be explained and it should be established whether they are to be

paid by a third-party insurer or by the family. Some therapists like to make the initial contact themselves, while others leave it to a receptionist or secretary. The latter can work well if that person knows how the therapist works, can discuss the above issues knowledgeably and has good skills in communicating over the telephone.

Some family members do not realize why the therapist will want to see the whole family. Often only one family member is perceived as having problems, yet the essence of the family therapy approach is to view, and treat, such problems within the context of the entire family. Several points may be made to explain why all family members should attend:

- (1) The problems of an individual family member can often be best understood in the context of that person's family.
- (2) The behaviour of any one family member inevitably affects other members.
- (3) Other family members can often be part of the solution to the problem. It is usually unhelpful to suggest that they are a *part* of the problem, even though that may be the case.

When a child is the identified patient, it may be easy to persuade parents that *they* are important, but they may be reluctant to bring children whom they consider to be well adjusted and problem free. In that case the point can be made that the well-functioning children may have much to offer the 'problem' child, in that they have the skills to function well in the family – skills the identified patient may need to learn. They may also be able to help the therapist develop a fuller understanding of how family members interact and influence each other.

Reluctance to attend on the part of certain family members may arise from a fear that they will be blamed for the family's problems. They may also harbour feelings of shame or fear that they will be embarrassed. In dealing with reluctance to attend, these possibilities should be borne in mind, and if necessary dealt with.

Joining the family and establishing rapport

Establishing rapport starts with the initial contact. It should be a main objective of the first interview, perhaps the first several interviews, and rapport must be maintained throughout treatment. Psychotherapy probably fails more often because of the failure to establish or maintain rapport than for any other reason.

Establishing rapport has been given other names. Minuchin (1974) wrote of 'joining' the family. Karpel and Strauss (1983) referred to 'building working alliances'. Nichols (1996) used the term 'therapeutic alliance', implying that 'the family system comes into the therapist's world and the two systems interdependently construct the basis of trust and co-operation necessary for working together to achieve desired change' (p. 98). Rapport may be

defined as ‘a state of understanding, harmony and accord. People in rapport feel warmly about each other’.

As rapport develops, the participants become increasingly involved with each other. Hypnotherapists have long recognized the importance of rapport, and know that failure to induce a hypnotic trance is usually due mainly, if not entirely, to the lack of sufficient rapport. Erickson, Hershman, and Sector (1961, p. 66) described rapport as:

... that peculiar relationship, existing between subject and operator, wherein, since it [hypnosis] is a co-operative endeavour, the subject’s attention is directed to the operator and the operator’s attention is directed to the subject. Hence, the subject tends to pay no attention to externals or the environmental situation.

When rapport is well developed, therapists can say almost anything, even quite outrageous things, to clients without their becoming upset. Even remarks that could be construed as insulting will be taken to have been meant caringly or in jest, or not seriously.

Rapport may be achieved by both verbal and non-verbal means. The non-verbal are probably the more important. The *non-verbal communications* the therapist offers a family start at the first contact, even if it is a telephone conversation, since one’s tone of voice and manner of speaking convey powerful messages. A warm, friendly tone of voice and a respectful, interested and accepting approach are important. Many therapists like to greet new families personally in the waiting room, making the acquaintance briefly of each family member. I like to address them by name, if I know their names, and shake hands with each (except for very small children). If I do not know their names, I ask for them as I greet them, at the same time telling the family who I am and expressing pleasure at their arrival. It is important, of course, to *appear* pleased to see the family, not just to say so.

Comfortable physical surroundings can assist in promoting rapport. The therapist’s mode of dress also carries its own message. People seeking therapy, generally like their therapist to be respectably dressed and well groomed, though dress that is too formal can be off-putting to some.

The therapist’s manner and behaviour are by far the most important factors, and excellent rapport can be established in prison cells, in classrooms, in public parks or on the beach. Rapport is promoted by matching or ‘pacing’ the behaviour of those with whom you wish to establish rapport. You can do this by matching your clients’ body posture and movements, respiratory rhythm, speed of talking and voice tone and volume. You can also either ‘mirror’ or ‘cross-match’ their movements. Mirroring is the moving of, say, your left arm or leg in response to similar movements of the client’s right arm or leg. ‘Cross-matching’ occurs, for example, when the therapist’s hand or finger is moved in rhythm with movements of the client’s foot. Movements which may be matched include such things as crossing and uncrossing

the legs, the tilting of the head to one side or the other and leaning forward or settling back.

You do not need to match all the behaviours of those with whom you seek to establish rapport. Matching should be done sensitively and unobtrusively. If done so, clients do not become consciously aware of it. While it is not possible to match simultaneously the behaviours of all members of a family, you may observe common things about their behaviour which you can use. Otherwise, you may match the behaviour of the different family members in turn, perhaps as you speak to each one; and many of the other behaviours I have mentioned are shared with the whole family. These include your courteous, respectful manner and mode of dress.

The developers of 'neuro-linguistic programming' (NLP) paid much attention to rapport-building processes. NLP was developed from the study of such highly effective communicators as Milton Erickson and Virginia Satir. The above matching and mirroring devices are part of what the authors of the literature on NLP call 'pacing'. They write:

When you pace someone—by communicating from the context of their model of the world—you become synchronised with their own internal processes. It is, in one sense, an explicit means to 'second guess' people or to 'read their minds', because you know how they will respond to your communications. This kind of synchrony can serve to reduce resistance between you and the people with whom you are communicating. The strongest form of synchrony is the continuous presentation of your communication in sequences which perfectly parallel the unconscious processes of the person you are communicating with—such communication approaches the much desired goal of irresistibility. (Dilts, Grinder, Bandler, Bandler, & DeLozier, 1980, pp. 116–117)

Your *verbal communications* can also assist or impede the development of rapport. It is important to listen carefully to the family's language. How they understand their world and their problems will be reflected in their language. By using this you can powerfully promote rapport.

Rapport is also helped by matching the predicates used by those with whom you wish to establish rapport (Bandler & Grinder, 1975; Bandler, Grinder, & Satir, 1976). A predicate is a word that says something descriptive about the subject of a sentence. Predicates include verbs, adjectives and adverbs. Some people tend to use visual rather than auditory or feeling predicates, as, for example, in the phrases, 'I see what you mean', 'things are looking brighter' or 'that is a pretty hazy idea'. Examples of the use of auditory predicates are 'I hear what you're saying', 'that sounds terrible' or 'it was like music to my ears'. Sentences such as 'I'm facing a lot of heavy problems', 'that feels like a good idea' or 'that's a big weight off my shoulders' illustrate the use of 'kinesthaetic' or feeling-type predicates.

Rapport can be enhanced by matching your predicates with those of the person with whom you are in conversation. Of course most people use

predicates of all three types, as well as some olfactory ('this business smells fishy to me') and gustatory ('it leaves a bad taste in my mouth') ones. But most have a preferred way of processing information and it can be helpful to note this and use it to enhance rapport.

In addition to matching predicates, it can be helpful to listen carefully to the vocabularies of the family members you are interviewing, noting the kinds of words and expressions they use. This enables you to match their vocabularies. Few things impede the establishment of rapport as much as the use of words and expressions that clients do not understand. This is especially important when you are dealing with children, whose vocabulary depends partly on their age, but it also applies to adults. Thus the vocabulary of a university professor is likely to be different from that of an unskilled labourer who left school at the age of 15.

Other useful rapport-building devices include accepting family members' views of things without challenging them in the early stages of your contacts with them, adopting a 'one-down' position, and talking of experiences and interests you have in common with members of the family.

The 'one-down' position is especially helpful when family members see the therapist as powerful, even threatening. Some people have a long history of problems with authority figures. Here the one-down approach may help. It might consist simply of saying that you know little about the job a family member has and asking that person to explain something about it to you, or asking children to spell their names for you. Or it could be a matter of expressing doubts about how fully you understand the family or its situation. In such situations it may be appropriate to offer interventions in a tentative, doubtful way. Nowadays therapists often find themselves working with clients from ethnic minorities and various 'non-conventional' families. Asking them, from a 'one-down' position, about their family values and traditions is a way of both obtaining useful information and working with them. It can also be a means to establish a cooperative, equal role, rather than an authoritarian one.

Therapists of the 'post-modern' school, for example, Anderson (1997), prefer to take a 'conversational' approach. This involves speaking *with* their clients rather than interviewing them in any sort of formal way.

It may be unclear what the true nature of a family's problems is. The therapist and family may have differing views, but it is the family members' views that are more important. It is generally best to avoid trying to impose our opinions on the nature of the family's problems on to the family. It is unhelpful to get into arguments or disputes with our clients. Initially, at least, we should accept the family's view of their situation.

Identifying common experiences can be useful in building rapport. These might consist of having lived in the city, county, province or state the family comes from. I was once seeing a family at a time when I had a stiff and painful back. I mentioned this as I eased myself slowly into my chair, and it transpired that the mother in the family also had back

problems. This at once gave us something in common on which to exchange a few words. Common hobbies, sports and pastimes may be used in similar ways.

Defining the desired outcome

Psychotherapy generally goes better if it has well-defined goals. Indeed, there is no way to define success if no desired outcome has been agreed. Nevertheless, therapy goals may be modified as treatment proceeds, and the family's potential for change becomes increasingly apparent. The defining of therapy goals is discussed in the next chapter.

It is important, at this stage, to give family members the opportunity to express their concerns. Turning too rapidly to the family history, or even raising issues you may be curious about, can put some families off. This is an aspect of the 'pacing' mentioned above.

Reviewing the family's history, determining its developmental stage and constructing a genogram

In many cases, these tasks can conveniently be tackled together. The emphasis placed on them varies from one therapist to another. I find it helpful to have an understanding of how the family has come to be where it is. Much of this information can be gathered in the course of the construction of the genogram.

I like to start by establishing the make-up of the family. Who are its current members? A good beginning is to ask first who lives in the family's current home. Are all the members of the household present? If not, who is absent from the interview? How are the family members related? The following questions need to be modified, for example, if you are dealing with a one-parent family, or a blended family.

A good way to approach the family's history is to start with the parents' birth and childhood. It may be helpful to preface these questions with an explanation. You may say that you are interested in how the present family came to be and want to understand something of its background. You may then ask the parents where they were born and brought up, enquire about their childhood experiences, how they got along at school and what they did after they left school. As they answer these questions they will probably speak of their parents and siblings. If not, you may prompt them to do so. They can next be asked how they met and courted and then to outline the course of the marriage or common-law relationship so far.

It may be convenient to ask next about the birth of the children and the children's development to date. It will probably be clear by now what stage in its life cycle the family has reached. Family members may also have mentioned any difficulties the family has had, or is having, in surmounting any of the family transition points mentioned in Chapter 2.

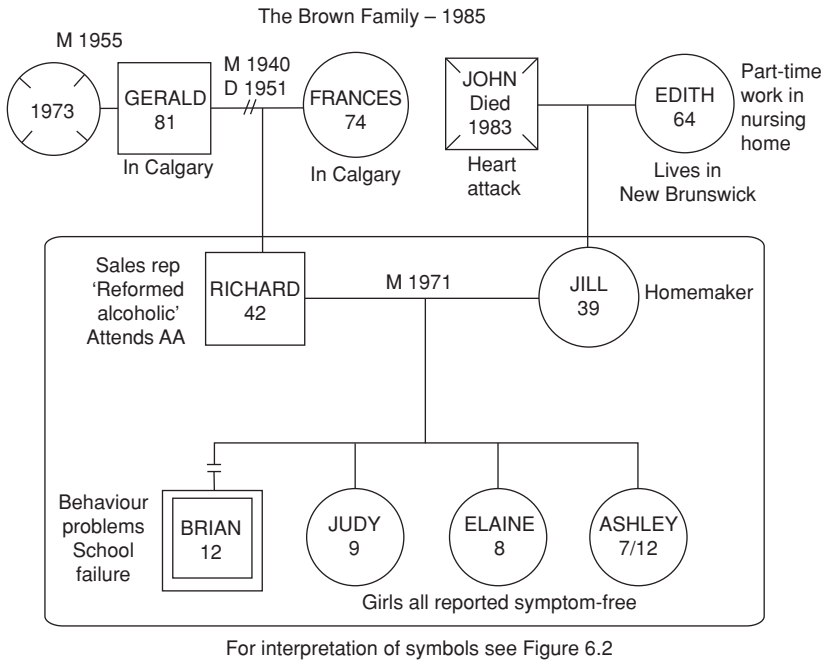


Figure 6.1 An uncomplicated genogram.

The genogram

A *genogram* (sometimes called a *geneogram*), or family map, is useful in both assessment and treatment. Guerin and Pendagast (1976) drew attention to its value, and it has become widely used since then. It gives a concise, graphic summary of a family’s current composition. It should also show the extended family network, the ages of the family members and the dates of the parents’ marriage and of any divorces or separations. It indicates how all the family members are related and it can also show who the identified patient is, although I usually omit this information when I am engaging family members in constructing a genogram. The geographical locations of the family members can be indicated, together with brief summaries of the salient points concerning each family member, for example, occupation, school grade, health and important points from individuals’ past histories (illnesses, accidents, losses, incarcerations and so forth).

While some therapists prepare the genogram later using the information they have obtained from the family during sessions with them, I prefer to prepare it with the assistance of the family members. Specimen genograms are shown in Figures 6.1 and 6.2. Figure 6.1 shows a relatively uncomplicated family situation. The oldest child is adopted, the maternal grandfather is dead, the paternal grandparents were divorced when the father was aged 8,

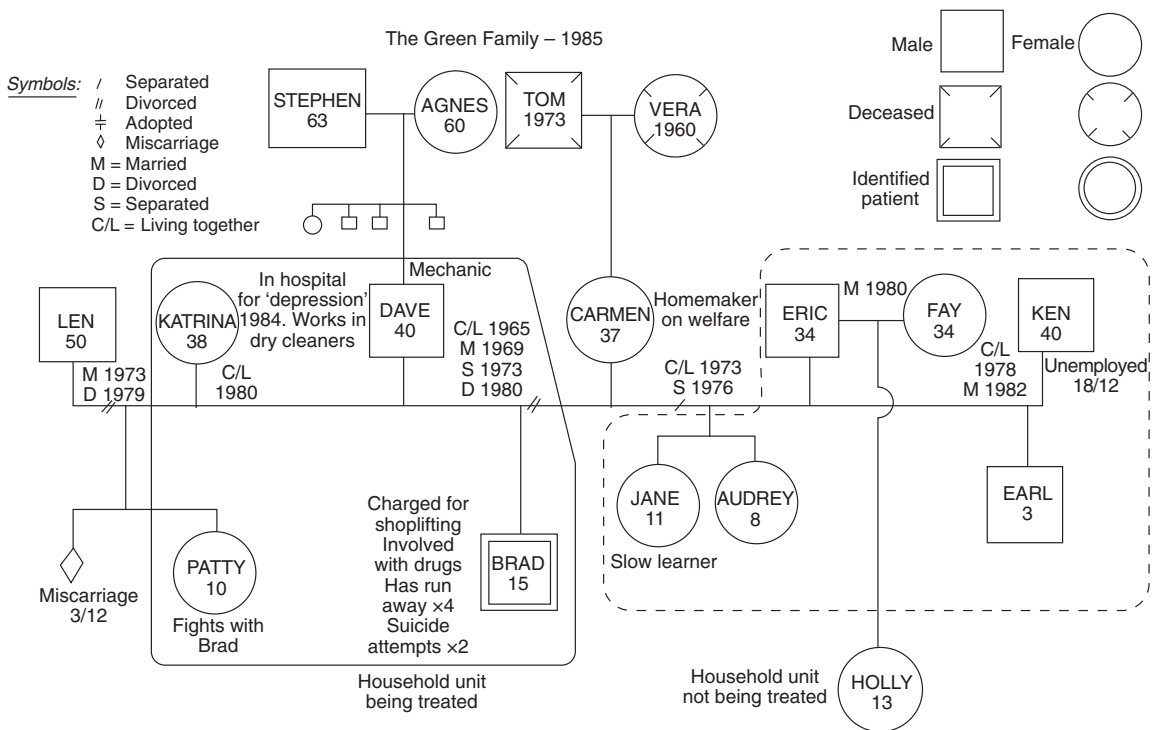


Figure 6.2 A complex genogram.

the paternal grandfather remarried 4 years later and his second wife died in 1973.

Figure 6.2 shows a more complex family constellation. In this family the parents of the identified patient, Brad (distinguished by a double boundary), cohabited in a 'common-law' relationship from 1965 to 1969, after which they got married. They separated in 1973 and were legally divorced in 1980. Carmen, Brad's mother, then had had a common-law relationship (with Eric) and is now married to Ken, with whom she lives with her two children by Eric and a 3-year-old by Ken. Brad and his father, Dave, live with Katrina and her 10-year-old daughter by her former husband, Len. She also had a previous pregnancy which ended in a miscarriage in 1974. Carmen is an only child and both her parents are dead. Dave is the fourth in a family of one girl and four boys.

A genogram can contain information about the health, behaviour, strengths or problems of the people shown in it. These points can be written beside the symbols representing the family members. While such information is not an integral part of a genogram, it can be helpful to include it.

I like to involve all family members, except those too young to understand, in the preparation of the genogram. The establishment of rapport can often be advanced during this process, and much information about how the family functions is often obtained. Even reticent family members are generally willing to share relevant information and are often surprised to recognize that while they know much about some areas of the family history, they know little about others. As information is discussed, it may become clear that spouses are unfamiliar with information about each other's families that it was assumed they knew (Holman, 1983, p. 69).

Genograms in family assessment (McGoldrick & Gerson, 1985) is the definitive source of information on the construction, interpretation and clinical uses of genograms, with many illustrations.

A subsequent volume *Genograms: Assessment and intervention* (McGoldrick, Gerson, & Petry, 2008) goes even more deeply into the construction and clinical value of the genogram. It contains 90 genograms and shows how genograms can bring to light a family's history of divorce, suicide, estrangement, triangulation and other happenings. The intergenerational patterns of such events will often be revealed. If the earlier book was a mine of information, this one should be compared to a complex of mines and mining operations. All who are seriously interested in family therapy or family studies generally will find this book an invaluable source of information.

Friedman, Rohrbaugh, and Krakauer (1988) described the 'time-line genogram'. This has a vertical axis that is a time scale which may go back 100 years or so. Life events and relationship data are recorded along the time line. There is a 'progeny line' which extends diagonally below the horizontal 'marriage line' and records the dates of birth of the children. The data are thus spread out according to the temporal relationships of the events charted on the genogram.

The time-line genogram is an interesting idea but does not seem to have been widely adopted. It is more complex than a regular genogram and takes longer to construct and to interpret. So it may be less suitable for routine clinical practice.

Assessing the current functioning of the family

The assessment process aims to achieve an understanding of the current functioning of the family. There are only two reliable ways of obtaining information about family relationships. One is to observe the interactions between family members; the other is to ask questions which bear on the relationships between the members and study carefully the family's responses, both verbal and non-verbal. It is advisable to do both, but the therapist usually learns more about how a family functions from the experience of interacting with it than from asking questions.

A family's description of its functioning is only one aspect of a complete assessment. The formal organizational structure may be described, but this says little about how the different parts habitually interact and about the functioning of the system as a whole. The questions asked of family members are not, therefore, usually about *how* the family functions as a group or organization; instead they are designed to reveal this indirectly.

There are many ways of interviewing families, some direct, others, in varying degrees, indirect. Palazzoli, Boscolo, Cecchin, and Prata (1980) suggested 'three guidelines for the conductor of the session'. They recommended that the interviewer first develop some *hypotheses* about the family system. One always knows something of a family, even before the first interview; for instance, its composition and the fact that it contains, for example, a rebellious child, an anorexic adolescent or a depressed adult. Whatever information is available is the basis of the hypotheses with which the therapist starts.

Palazzoli et al. (1980, p. 5) define a hypothesis as 'an unproved supposition tentatively accepted to provide a basis for further investigation, from which a verification or refutation can be obtained'. Having developed such suppositions, the therapist then proceeds to test them. This is an active process, the therapist asking a series of questions designed to explore the patterns of the family's relationships, beliefs and attitudes. Palazzoli et al. (1980, p. 5) believed that if the therapist were to behave in a passive fashion, that is, as an observer rather than a mover, the family, 'conforming to its own linear hypothesis, would impose its own script, dedicated exclusively to the designation of who is "crazy" and who is "guilty", resulting in zero information for the therapist' (Palazzoli et al., 1980, p. 5).

Hypotheses, the Milan group believed, must be systemic, that is, they must concern the family system as a whole. It is not enough to say that somebody may be depressed or anxious about something. This may be the case, of course, but to treat a family system successfully it is necessary to consider

the *relationships* between the family members and how these fit together to make up the family system as a whole. This does not mean that the mental states and psychopathology of individual family members are irrelevant. Far from it! They may be of great significance, though information about them is obtained in different ways. It is also information of a different order.

This brings us to the concept of *circularity*. The Milan associates derived many of their ideas from the work of Gregory Bateson (see Ruesch & Bateson, 1968). A 'Milan-style' interview is a circular process. The therapist responds to information the family provides about relationships by formulating more questions, to which the family then responds again, and so on. The questions are framed in a circular way too. Their method is to ask one member of the family to describe the interactions or relationships between two others.

Many of the questions concern differences between such things. The therapist seeks information about differences in how family members react to particular events, view certain behaviours, worry about things, handle children, understand the family's problems and so on. This style of interviewing has considerable therapeutic potential. For example it

- opens up the system to new information.
- allows members to learn about themselves from others: it gives them a 'third-person' perspective.
- allows members to take a reflective rather than a reactive stance to other members. This may lead to increased understanding and empathy between family members.

Triadic theory, which is the idea that two people (or groups or even agencies) in conflict tend to involve a third person or group in the conflict, has been described as 'one of the cornerstones of many models of family therapy' (Coppersmith, 1985). Bowen's views on 'triangles', outlined in Chapter 1, and the concepts labelled alliances, coalitions and detouring, described in Chapter 3 as part of structural therapy's theoretical basis, are also examples of triadic thinking. The process of bringing in a third person is sometimes referred to as 'triangulation'.

Coppersmith (1985) points out that the ability to think in terms of triads (or triangles, which are essentially the same thing) is an important skill for the family therapist. It is the basis of the style of interviewing practised and advocated by Palazzoli et al. (1980). The therapist is always thinking of the various triads in the family and how they function. The questions asked of a family member, or group of members, are often about differences between the behaviours or responses of two other members or groups of members; and the emphasis is on relationships between people rather than on the behaviour of individuals.

There are some other important practical points about interviewing families, using the ideas of Palazzoli et al. (1980):

- (1) It is better to ask questions about specific behaviours which occur between family members, rather than about how people feel about the

situation or about how they interpret or understand it. For example, the therapist might ask one of the children in a family questions about behaviours. For example, the members of a family in which one child is physically aggressive to a younger one might be asked the following questions:

When Chad hits Dorothy, who is most likely to step in and try and stop him? And who is the next most likely to do this? And then? . . . (And so on, until it is determined who is least likely to intervene.)

- (2) It can be helpful to ask questions about changes in the patterns of relationships. These may concern differences before and after certain specific events. Thus, members of a family that has recently moved from one place of abode to another might be asked about differences in the behaviours of members relative to one another before and after the move. Similarly, the situation before and after a marital separation, a remarriage, an illness or accident affecting a family member or a child's entry into school or departure to university might be explored.
- (3) Questions can be asked about how the behaviour of family members varies in different circumstances, whether these are real or hypothetical. For example:

Who would be most upset if Eric was seriously ill?

Do Frances and Gillian fight more when Dad is at home than when he is not?

What does Mummy do when Harry misbehaves? Does she react in any way differently when Dad is at home?

Neutrality is the last of the three attributes that the Milan group recommend. When asking questions in the way described above, the therapist may seem to be allied with the person being questioned, while that questioning is occurring, but the alliance shifts when the questioning moves to another family member. During the session, the therapist will be allied in turn with all the family members and 'the end result of the successive alliances is that the therapist is allied with everyone and no one at the same time'. The Milan authors also advise that the therapist declare no judgements, whether implicit or explicit, while interviewing the family. To do so would have the effect of allying the therapist with one or more of the individuals or groups within the family.

There are other approaches to interviewing families, and not everyone uses the methods advocated by the Milan associates. Karpel and Strauss (1983), for example, in their book, *Family Evaluation*, described a more direct style of questioning. They recommend questions and remarks like:

Can you tell us a little bit about how you were feeling after your father died?

Or,

So when he died you felt responsible? (both from p. 124)

These authors sometimes address intrapsychic processes quite directly. They are clearly concerned with intrapsychic processes (which the above questions address), as well as interpersonal ones. The Milan group therapists might have preferred to ask other members how they thought the person concerned felt when the father died. They might also have asked each member to rate the family in terms of who was most upset, down to who was least upset. Similarly, each member could have been asked who they thought felt most responsible for the father's death, who came next and so on.

Karpel and Strauss (1983) also describe a series of 'probe questions', designed 'to probe the broad area of family structure in a routine, organized fashion that is both direct and non-threatening' (p. 136). The probe questions cover such subjects as the layout of the home; a typical day in the life of the family; rules, regulations and limit setting within the family; and the alliance and coalitions within the family. Thus, Karpel and Strauss might say:

I'd like to get a better idea of who spends a good deal of time with whom in the family, whom each of you is most likely to talk to when something is on your mind? (p. 142)

It seems these authors use many more direct questions than the Milan group. For example, they describe asking a daughter how she reacted when her mother behaved in a particular way, whereas the Milan associates would probably have asked this question to another family member.

Other areas that Karpel and Strauss suggest as subjects for probe questions are family disagreements, previous family crises and the changes the family members desire to make (which we will consider in Chapter 7).

Assessing how a family functions is by no means simply a matter of asking questions and getting replies. Families tend to reveal more by what they do than by what they say. So the therapist should observe who sits where in the room; who plays or talks to whom; who tells who to do what; whether the children do what their parents tell them; who laughs; who cries; what the other family members do when one of them is upset; whether the parents agree or disagree, for example, about a misbehaving child; how outgoing or inhibited are the various family members; and so on. The extent to which the family is either well ordered or 'chaotic' is often evident before any questions are asked.

We may summarize by saying that there are many ways of obtaining information about families, and there are few scientific data to tell us which is the best. Some interview styles seem to suit certain families better than others. Therapists also develop their own personal styles and use techniques with which they are comfortable and which fit their theoretical models of how families can be helped to change. However we achieve it, we need to come to an understanding of the family system as well as of the individuals in it. The relationship patterns and habitual ways of interacting should be a major focus.

The last decade or two have seen the adoption by ‘post-modern’ therapists of a ‘conversational’ approach, a gentler collaborative way of finding out about the family (Anderson, 1997; Anderson & Goolishian, 1988; Goolishian, 1990).

Developing a diagnostic formulation

At this stage, it is necessary for the therapist, or team, to review the information that has been obtained. Many find it helpful then to develop a *diagnostic formulation*. This involves considering how the family functions, whether the presenting problems are related to its way of functioning and, if so, how they are related.

While the human systems to which a person belongs are always relevant, therapists should always bear in mind that sometimes other factors are more important. Physical conditions, such as hyperthyroidism, hypothyroidism, porphyria, cerebral tumours and many other diseases of the nervous system, have particular psychiatric manifestations. Whatever the state of the family system, such conditions require their own specific medical treatment. Referral for assessment and any needed treatment of co-existing medical disorders may be appropriate.

Some psychiatric disorders also appear to have causes which are physical, rather than being related primarily to family factors. In many cases of bipolar affective disorder, the swings between moods of depression, normality and mania occur in a regular cyclical pattern with little or no apparent relationship to external circumstances. In such cases, family therapy may not be the principal treatment needed. However, family therapy may be required even when the presenting problem in one or more members has a predominantly biological cause, since the presence of such a condition does not provide immunity from family dysfunction. Indeed, the reverse is true. Such disorders make family dysfunction more likely, since they are stressful. Emotional factors are often closely tied in with the family situation. These can also be important in the genesis, and the exacerbation, of physical conditions (see Minuchin, Rosman, & Baker, 1978).

An important issue that the formulation should address is the extent to which the presenting problems are a feature of family dysfunction and how far they are due to other, perhaps physical or intrapsychic, causes. In many instances, it is not an ‘either/or’ question that must be answered. Even if there are no relevant physical *disorders* affecting any of the family member – and often none is evident – the temperaments, cognitive styles and physical characteristics of the family members are relevant and important factors.

The formulation should summarize the therapist’s understanding of the family. It is not just a listing of factors but a description of their interplay and relative importance. It should include a description of the family system, using whatever theoretical model the therapist favours. The family’s

developmental stage, and whether it is having difficulty dealing with one of the ‘transition points’ discussed in Chapter 2, should be considered.

There is much to be said for making a written formulation. It should be concise and clear and should provide a logical explanation of the case but with mention of areas of uncertainty. It should lead to a treatment plan or, perhaps, a plan for further assessment or investigation. In most cases it will contain the following information:

- (1) A brief description of the problems which have led the family to seek help, and of the changes they hope will result from therapy.
- (2) Mention of the family’s make-up, with the members’ ages, relationships and occupations, and the family’s developmental stage. Much of this information may be provided by attaching the genogram to the formulation.
- (3) The therapist’s understanding of the family, the nature of its current problems and how these are being maintained, using whatever theoretical model the therapist finds helpful. The relative importance and interrelation of the various factors maintaining the current situation should be described.
- (4) The family’s strengths, assets and motivation for change.
- (5) Information about the family’s ecological context or suprasystem, and how this is affecting the family.

When treatment appears to be needed, the formulation should lead logically to a treatment plan and, usually, a prognosis: a statement of the expected outcome, with and without treatment.

Offering the family feedback and recommendations

I like to give the family a short break while I develop the formulation. When one or more observers have been watching the session, or colleagues have been participating, the formulation will be developed by the group. Co-therapists will of course want to discuss their findings and develop a joint formulation.

The form the feedback takes will depend on the theoretical orientation of the therapist(s), as well as on the nature of the family’s case. It is not simply, or even mainly, a matter of explaining the formulation to the family. Generally, insight in itself is not particularly helpful. Knowing how the therapist understands their problems does not necessarily lead to change. Indeed, when a strategic approach to treatment is planned it may impede it.

The feedback should always include any recommendations the therapist has regarding further investigation or assessment of the family, and it should state whether treatment is recommended and, if so, what type. The feedback is often the start of therapy. Depending upon the therapist’s theoretical orientation, it may take the form of agreeing to a contract for the family to do certain things, as is the practice of those who use the McMaster Model of

Family Therapy or it may be less direct and intended to reframe the situation in a therapeutically helpful way. A narrative approach may be suggested or one based on social construction theory.

I often find it useful at this stage to ‘positively connote’ what the family members are doing. What is positively connoted is the *intent* behind the actions of family members, not necessarily the actions themselves. For example, parents may be using inappropriate methods in their attempts to discipline a child, and may even be physically abusing the child, but their intent, namely to rear their child to behave in a socially acceptable way, is nevertheless commendable.

The concept, derived from the work of Milton Erickson and described by Lankton and Lankton (1983), of ‘best choice’ may be helpful at this stage of the assessment. Erickson believed that people always make the best choice of behaviour available to them in their particular circumstances. It may prove unfortunate, even destructive, but it is the best available to those concerned, taking into account their state of mind and their situation. Therapy, therefore, is a matter of giving the family members more choice, and alternative, more effective options. Sometimes the therapy plan can helpfully be presented in this way.

Discussing and arranging the next step

It is important that the family leave the first interview knowing what is to happen next. This may be just a matter of setting the date and time of the next appointment. Sometimes other recommendations may be made, such as referral to a colleague for further investigation or specialized treatment. When the family contains a child or children who are having social or academic problems at school, contact with the school, and perhaps a visit to the school, may be suggested. Indeed, Aponte (1976) recommended that when the main problems are at school, the first interview should be a family–school interview. The therapist may sometimes wish to obtain information from professionals who have previously treated the family, or members of it. In that case the necessary forms of consent, authorizing release of this information, should be signed by the appropriate family members.

The question of who should attend future sessions sometimes arises at this stage. If one or more important people were absent from the first interview, the therapist should either ask the family to bring the missing person(s) to the next session – which is quite appropriate if the person concerned is a child – or discuss with the family how to approach the missing individual(s). If these are adults, it may be better for the therapist to make the approach, with the permission of the family. I have outlined a metaphorical approach to this issue elsewhere (Barker, 1985, pp. 25–27).

At times it may be helpful to have extended family members who do not live in the household present at certain sessions. On the other hand, the therapist may wish to see fewer people, perhaps just the marital couple,

next time or even for a series of sessions. In that case also, the plan should be explained and agreement sought.

Feedback to referring professionals

When a family is referred by another professional person it is both courteous and good clinical practice to send that person a written report of the results of the assessment. This should make it clear how the therapist thinks the referrer can assist in the ongoing treatment of the family. This may involve no more than the referrer not getting involved in the issues the therapy is addressing, but referring questions the family may ask about those issues back to the therapist. Or it might suggest a more active involvement by the referrer or by the family physician, paediatrician, child welfare social workers, school staff and others. In that case joint planning by all concerned will be important. Sometimes it is helpful to supplement the written report with a telephone call.

I believe it is also a good practice to let the family have a copy of my report to the referring professional. This provides a model of open communication, as well as making the statement that all concerned – family, therapist, referring professional and sometimes others – are part of a team working together to resolve the problems.

When other professionals are to be involved, the informed consent of the family members must be obtained.

Summary

The assessment of families needs to be both systematic and flexible. The initial contact should lead to the establishment of rapport and the gaining of the family's trust. Whatever model of family functioning is employed, the main focus is on the family system: the pattern of the relationships between the members. The construction of a genogram is usually a valuable part of the assessment process. At the same time, the therapist should not overlook the characteristics of the individual family members.

A 'triadic' approach to interviewing families, which involves thinking about groups of three individuals, or collections of individuals, and how they interact, is helpful. The family's developmental stage, and whether it is having difficulty making the transition from one stage to the next one, should be considered.

The assessment leads to a diagnostic formulation. Feedback is then provided to the family. Any treatment recommended is explained. Referring sources should be kept informed, especially if they are still involved. Other outside professionals may need to be contacted and, in some cases, their involvement in the treatment endeavour may be helpful.

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Chapter 7

Establishing Treatment Goals

Family therapy aims to produce changes in families. The desired changes may be in the behaviours of family members, in their emotional states or relationships or in the family's overall functioning. For this endeavour to succeed there must be clearly defined and agreed goals, because without defined objectives, family and therapist have no way of judging whether and when therapy has been successful.

Negotiating the objectives of treatment and reaching agreement on them is not always easy, especially when there is pre-existing disagreement between family members. It may take a whole session, sometimes several, but the time is well spent. Indeed, the process itself can be therapeutic.

Steve and Terri had been married 8 years. They had two daughters, one aged 7 years and the other 6 months. Steve was a busy professional man and Terri a homemaker who worked occasionally as a receptionist. They presented with concerns about the behaviour of their 7-year-old daughter, Vivienne.

Vivienne was an attractive, highly intelligent but rather sulky and sullen girl. She was having relationship difficulties with other children at school, where she also exhibited mild behaviour problems and was thought not to be performing up to her academic potential. A much bigger problem, it soon emerged, existed in the marital relationship.

Steve and Terri had met hitch-hiking at a time when Steve was still a student and Terri had just left a home where she had not been happy. They married soon afterwards, both still in their teens. At first things went well for the couple. Until Vivienne's birth Terri worked as a waitress, then as a receptionist, helping support Steve as he continued his studies at university. Terri realized that Steve had to study hard and for long hours and at first accepted without protest that she got little of his attention. Vivienne arrived sooner than the couple had planned to start a family, and with her birth Terri started to feel increasingly unhappy and lonely. Her parents disapproved of her marriage and also looked down on her, she felt, because she was the only child in their family who had not gone on to higher education.

Eventually Steve completed his university studies and graduated. He obtained a job working for a large company which demanded much of its trainee executives. He also started attending evening classes, playing

squash with colleagues after work and staying out drinking with his friends after these activities. Terri was left, literally, holding the baby at home. She felt trapped in the relationship, estranged from her family of origin and powerless.

My (PB) first session with this family was spent exploring the situation and what the couple wanted from therapy. As the seriousness of the marital situation became clear, I asked each spouse to paint a word-picture of his or her desired outcome. They both found this an interesting experience and each was surprised by the picture of the ‘ideal marriage’ which the other presented. This exercise took up the remainder of the first session, so that no time was left for any other therapeutic work. I therefore made an appointment to see them the following week.

When they came, Steve and Terri reported a change for the better in their relationship. While not all their problems were resolved and Vivienne continued to cause them some concern, they had clearly been helped by learning what each other wanted of the marital relationship.

Even if agreement is never reached and treatment is not started, time spent discussing treatment objectives may not be wasted. Therapy embarked upon on the basis of misunderstood goals seldom produces results that are satisfactory to any of those concerned. The one possible exception to this is the long-running therapy in which some clients get involved to achieve ‘emotional growth’ or ‘make gains’ – the ‘gains’ never being defined in any precise way. Such therapy resembles a hiking trip embarked upon with no idea of where the hikers want to go nor of what they will do when they finally arrive somewhere. Such therapy, like this sort of hiking, can be enjoyable, of course, but it may not be the best way to achieve particular results quickly.

The setting of objectives and the description of an outcome frame do not always have as positive an effect as they did in the above case. As it happened, the marital partners were able to make significant changes simply in response to a discussion of the desired objectives. The lesson is that some relationships suffer because the partners are unaware of what each other wants.

Defining the desired state

It is helpful to obtain a clear picture of the ‘desired state’ that families coming for therapy wish to reach. How this differs from the present situation should also be defined as precisely as possible.

Many family members, and individuals too, come to therapy with negative goals. Parents want their children to stop having tantrums or fighting with each other; or a spouse wants his or her partner to stop arguing; or a couple want their teenage daughter to stop refusing to eat the food they

offer her. These are all valid reasons for seeking professional help, assuming that common-sense measures have proved ineffective, but they are not adequate as outcome descriptions. To put it another way, a description of your 'desired state' requires more than a statement of what you *don't* want to be happening.

A comprehensive picture of how you *would* like things to be is as useful to both client and therapist as an architect's mental image is to the architect, of the building for which plans must be developed.

So, rather than accept 'negative' objectives, it is better to ask family members to reframe their objectives in positive terms. If the children are not to have tantrums, how should they react in situations in which they have been having tantrums? If they are not to fight, how should they deal with their disagreements? What should replace the arguments the couple have been engaging in?

Presumably the arguments have served some purpose. So too, we may assume, has the teenage girl's refusal to eat. While the objective of having the girl eat more is perfectly reasonable, it might be helpful to consider also the purpose of her refusing food her parents have prepared, and how that purpose might be served in other ways.

We often find that questions such as the above have scarcely been considered by many families seeking therapy. Even when families' goals are stated in positive terms, these are often vague and ill-defined. Perhaps they want 'to be a happy family' or 'to get along well together'. These may be useful starting points for the discussion of treatment goals, but they are not in themselves adequate outcome descriptions. What do they mean by a 'happy family'? Again, what does 'getting along well' mean for this family? Exactly how would they be relating to each other if they were getting along 'well'?

Families sometimes describe their objectives in comparative terms. They want to be 'happier' or 'to do more things together'. We must ask them to elaborate on such statements. If they are to be happier, the next question may be 'happier than what?' And in what circumstances? What would the family look like, and what would it be doing, if it were happier? What things would they choose to be doing together, where would they be done and how often? And how does all this differ from the way things are now? There may prove to be disagreement on such points, so that what looks like an agreed objective is not really one at all. Indeed fundamental differences may be concealed in such statements. If so, resolving these differences might become a goal of therapy.

I (PB) have found it helpful to get families to describe, in as much detail as possible, how things will be when (and not if!) therapy is successfully concluded. This is the process described above in the case of Steve and Terri. The descriptions you ask for should be sensory based. Ask your clients how they will *sound* when therapy is complete and even have them act it out. The more the family members act out their aimed-for state, the easier it is likely to be for them to achieve it, for they have already, if only briefly, done so.

By talking about how things will be *when* therapy is complete, you embed in your statements the message that it will end successfully. On the other hand, if you discuss how things will be *if* therapy reaches a successful conclusion, you are implying doubts about this, which is not the way to inspire confidence in those who come to you for help.

Once the desired state has been described there are still some questions to be considered:

- (1) Will there be any drawbacks to the desired state? Will anything that at present offers gratification to someone in the family, or serves some useful purpose, be lost, without being replaced by a satisfactory alternative? For example, if the daughter who at present won't eat starts to eat the food her mother prepares, will this result in less closeness between mother and daughter, since there will be no further need for battles or discussions about the daughter's diet? Or will it mean less closeness between the parents because they will no longer need to spend long hours discussing their daughter's eating problem?
- (2) What other consequences will follow once the changes the family seek have occurred? Careful consideration of how things will be for all members of the family when the specified changes have been made may lead to second thoughts. This in turn might lead to further modification of the objectives.
- (3) What has so far stopped the family from making the changes they say they would like to make? This question is closely related to the foregoing ones but asking it in this way may place the issue of what is causing the symptoms to continue, in a different perspective.
- (4) Under what circumstances are the changes desired? Context is important in the setting of objectives. Thus while it is generally a good thing to be happy, there are circumstances in which this may not be appropriate, for example, following a bereavement or other loss. Disagreements and even arguments, especially if they are constructive, can be useful in the right context. So can most other behaviours. Aggression may be needed to defend your loved ones, or even yourself, and there probably are occasions for the telling of 'white lies', for example, when the secret police want to take your loved ones away for execution. Most 'symptoms' may therefore have value in some circumstances. There are times when it is appropriate to refuse food or to get angry or to feel tired or to be undecided about something – even to lie.
- (5) How quickly does the family want to change? This is not only a useful thing to know, but also a good question to ask because of the statement embedded in it, namely that change *will* occur if therapy is undertaken. By asking such a question you dismiss, by implication, the issue of whether change is possible and replace it with that of how quickly the changes should, and will, occur.

Intermediate and final goals

Sometimes it is helpful to distinguish short-term from long-term goals. Psychotherapy may be likened to travelling through a jungle, where it may not be possible to see your final objective and where you cannot survey, from your starting point, the route that will get you there most quickly and easily. So it is often best to plan your journey in stages. A good way to proceed is to climb a tree, survey your route to the next landmark – it may be another large tree – and then repeat the exercise as often as necessary until you reach your objective.

Family therapy, too, is often best approached in stages. Intermediate goals, equivalent to the trees the jungle traveller climbs to survey the next stage of the journey, may be set and reached along the way. Each is an opportunity to review progress and even to set a new course. The intermediate goals may not always need to be made explicit to the family, but the point that every journey starts with the first step can sometimes usefully be made. Setting goals should also be done in such a way as to suggest that they are attainable.

The metaphor of an avalanche, which starts with the movement down the mountain of a small quantity of snow or a few rocks, leading to a massive shift of material down the slope, may be useful. Similarly what look like small therapeutic interventions may have disproportionately large results.

Motivating families to consider and set objectives

Many families readily understand the desirability of defining their objectives, but some question it and seem satisfied with vague ideas and ill-thought-out notions about what they want from treatment. In such cases the importance of well-defined objectives can be explained metaphorically. The following story, reproduced from *Using metaphors in psychotherapy* (Barker, 1985), illustrates the value of careful preparation.

Norman, a man who was well skilled with his hands, wanted to build a garden shed. So he went to a store that sold materials and supplies for the 'do-it-yourself' market and asked for advice. The salesman he spoke to asked him a lot of questions, many of which he was not immediately able to answer. The salesman wanted to know what kinds of things Norman planned to keep in the shed, how big it should be, on what sort of ground it was to be built and with what materials, what kind of floor Norman wanted it to have, what tools and equipment Norman already had at home and how much he could afford to spend on the shed.

Norman realized that he needed to give a lot more thought to his project than he had done so far. So he first gathered together all the items he intended to keep in the shed, including his lawn-mower, electric hedge-clipper and wheelbarrow, his garden tools, the fertilizer spreader and a couple of bags of fertilizer, his children's bicycles, some flower pots and

seed boxes and sundry smaller items. He was now able to estimate the size of shed he would need.

Next Norman assembled all his wood-working and other tools. These had been scattered in various parts of his house, and some had not been used for years. Indeed he was surprised by some of his finds, tools he had long forgotten acquiring. The total was impressive and it seemed as if Norman might have just about all the equipment he needed.

Norman now examined carefully the site where he planned to erect the shed. It was damp and it seemed safer to plan to have a wooden floor raised up, perhaps on concrete blocks, above ground level.

Finally Norman reviewed his financial situation. The salesman had given him a rough idea of what sheds made of different materials would cost and it seemed that he would be able to afford a cedar wood shed, which was what he had originally hoped to build.

Norman now had a pretty clear idea of what the shed he was going to build would look like, the work that would be involved in constructing it, and what it would cost in time and money. He decided to go ahead with it, and was ready to return, properly prepared, to the store to buy the materials he needed, to receive instructions and a plan of how to build the shed; also to purchase those few additional tools he needed.

Maintaining and developing a family's motivation is important at all stages of therapy. The period when goals are being discussed presents an opportunity for the therapist to promote this process. Some family members may not believe that the changes they desire can be achieved. Sometimes the whole family thinks this. Some families even seem to come to therapists with the expectation that there will be no change! Their aim seems to be simply to prove that nothing can be done. (I believe they are the sort of people Watzlawick (1983) wrote about in *The situation is hopeless but not serious.*) The process of goal-setting and the discussion of the outcome frame can, if approached optimistically and in a business-like fashion, greatly reassure families that they, along with the rest of the human race, have the potential for change.

Summary

Family therapy, like most human activities, is more likely to be successful if it has clear goals. Time and effort spent in defining goals are usually well repaid. Well-defined goals assist the therapist in developing a treatment plan, and they offer encouragement to the family, especially if the result is an agreed set of objectives that appear realistic.

The 'desired state' is that which, when achieved, will constitute a completely satisfactory therapy result. It should be stated in positive, rather than negative, terms. That is to say it should describe how things *will* be at the successful conclusion of treatment, rather than how they will *not* be.

Other important points about goal-setting are as follows:

- (1) Aim for specific, definable objectives.
- (2) Determine the context in which the new behaviours are desired. The old ones may still have their uses under certain circumstances.
- (3) Have the family consider whether there will be any drawbacks to the desired state. If there will be, are the changes worth making?
- (4) What other consequences will follow once the changes desired have been made?
- (5) What has stopped the family making the desired changes so far?
- (6) How quickly does the family want to change?

It is sometimes helpful to have intermediate goals, to be achieved during the course of therapy.

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Chapter 8

When Is Family Therapy Indicated?

Family therapy aims to change the functioning of families. That might seem a simple enough concept, but families do not usually come complaining of the way they function. Usually someone comes, or is brought, with particular symptoms or behavioural problems. The therapist must then decide which therapeutic option, of the wide range which nowadays exists, is likely to be most helpful.

Family therapists tend to understand human problems in relationship terms. In the early days of family therapy this approach was seen by some of the pioneers as almost a panacea for all human problems. Indeed, Haley (1980), in his book *Leaving home*, claimed that his methods were equally appropriate whether the identified patient is schizophrenic, anorectic, delinquent, addicted to heroin, antisocial, violent or mentally retarded.

While the families of such patients may have problems requiring attention, claiming family therapy as the primary treatment modality for them all seems to be going beyond what the evidence supports. By contrast, Steinberg (1983), in his text on adolescent psychiatry, paid much attention to the question of when family therapy should be used. He considered family therapy a distinct form of treatment, with its own particular place within the wider range of therapies. This is probably the current thinking among mental health professionals generally.

In a sense, all therapy with any one or more persons who belong to a family group is family therapy, since change in any one family member inevitably has its impact on the whole family. But that begs the issue of knowing whether we should be working with the whole family, with a part of it or just with one member? In practice, the various forms of family therapy *are* different from therapies which take the individual as their focus, even though the latter, when effective, has effects in the family as a whole. Moreover, therapists skilled in working with families may be less skilled in working with individuals whereas those who concentrate on individual psychotherapy may be less skilled in family therapy.

A second issue is that of physical illness. As we have seen in Chapter 6, psychiatric symptoms can be due to endocrine disorders (e.g. hypothyroidism and hyperthyroidism), metabolic disorders (e.g. porphyria), infections (e.g.

syphilis) and many other diseases of the brain. Medical and surgical therapies are available for such conditions, and family therapy should not be the primary treatment for them; the families of those with such conditions may, however, need therapy.

A third point is that other psychiatric treatments, pharmacological as well as psychotherapeutic, are available. It is therefore necessary to consider when one of these may be the treatment of first choice. Schizophrenia is nowadays usually treated pharmacologically, and most psychiatrists caring for such patients do not see family factors as being the principal ones to be addressed in treatment. Yet the family environment has its effects and its characteristics may help determine whether the patient with schizophrenia relapses.

Similarly, antidepressant drugs are sometimes the best treatment for depressed individuals, and the use of anxiolytic drugs for anxious patients may have to be considered, if only as a short-term crisis measure.

Finally, it seems that systems theory, as Searight and Merkel (1991) put it, 'may have significant limitations in accounting for family dysfunction and for guiding intervention'. Nichols (1987) pointed out that in the last analysis it is individuals that change, not systems. Change in the system is a result of the changed behaviour of the individuals in it. Intervention in the system, which is the basis of so much family therapy, may not always be the only or even the best way of promoting change.

It is remarkable how many textbooks on family therapy gloss over the issue of the indications for family therapy. For example, *Integrating Family Therapy* (Mikesell, Lusterman, & McDaniel, 1995), *Treating People in Families* (Nichols, 1996) and *Family Therapy Techniques* (Carlson, Sperry, & Lewis, 2005) are all silent on the issue of when family therapy, rather than some other treatment method, is indicated. One might expect that this would have been the subject of research, but no such research is included in *Research Methods in Family Therapy* (Sprenkle & Piercy, 2005).

Basic criteria for employing family therapy

Two conditions should exist before family therapy is recommended. These are as follows:

- (1) Evidence of a malfunctioning family group.
- (2) Evidence that the family dysfunction is related to the problems for which help is being sought.

For these criteria to mean anything, the terms 'malfunctioning' and 'dysfunction' have to be defined. Unfortunately, as we saw in Chapter 2, there are no agreed norms for the functioning of families. Some families which seem to be functioning in quite unusual ways appear to be free of clinical problems, while others appear relatively 'normal', at least at first acquaintance, and yet contain members with severe clinical problems. In addressing

issues of this sort the models of family functioning reviewed in Chapter 5 are useful. They direct our attention to specific aspects of family interaction which can be the focus of therapy. This is more important than deciding whether a family is 'normal' or not, although the attempt by Beavers (1982) to define 'healthy, midrange, and severely dysfunctional' families was a bold attempt to do this. Another helpful concept is that of 'optimal family process', described by Kirschner and Kirschner (1986). These authors also addressed in a helpful way the issue of when whole family groups should be treated and when therapy should focus on individual members.

Whether or not you choose to compare the families you see with some theoretical norm, it is important to make the best judgement possible of whether the presenting problems can be understood on the basis of the way the family functions. In doing this, it can be helpful to use as a guide one of the models suggested in Chapter 5 or one of the several other models that are available.

Occasionally, families present themselves as family units and define their problems in family terms, and with increasing public awareness of family therapy this may be happening more often. In such cases family therapy is usually the best approach. Often, however, involvement of the whole family, when it occurs, happens at the therapist's initiative.

Differing views on the place of family therapy

Some therapists pay more attention than others to the assessment of whether or not family therapy is indicated. Beal (1976) investigated the differences between therapists, using a modified version of a scale developed by the Group for the Advancement of Psychiatry (1970) when it rated the theoretical orientation of therapists. He found that therapists at the 'A' end of the scale, that is, those who are primarily concerned with the appropriate expression of emotion in the family, are more concerned about the indications and contraindications for therapy than are therapists at the 'Z' end, those concerned chiefly with family structure and communication pathways. To this latter group problems are interactional (they do not reside in individuals but in the processes of interaction going on in a family or other social system) and behavioural (consisting of behaviour 'which is stimulated and shaped by the behaviour of others') (Weakland, 1977, p. 23). Weakland (1979, p. 57) also wrote of how the family approach to treatment has come to be applied to 'the whole spectrum of recognized psychiatric problems, except the manifestly organic'.

Unfortunately the question of what is 'manifestly organic' is often hard to answer. The system of an identified patient with an obviously organic problem, for example, cerebral palsy, may or may not be badly functioning. Moreover, many medical problems are nowadays seen as having multiple and complex causes. Bronchial asthma is a good example. In severe cases there are often structural changes in the lungs and in all cases the

physiological control of respiratory function is abnormal. In addition, allergy and infection are important factors in precipitating attacks. A comprehensive treatment plan cannot overlook these factors. In a sense, asthma is 'manifestly organic', certainly once there are structural changes in the lungs, but there is reason to believe that attacks of asthma can be precipitated by processes occurring in the family system (Minuchin et al., 1975).

Haley (1976, pp. 170–178) explains the difference between orientation A and orientation Z in his usual lucid way. The A therapist, he says, is attempting to achieve understanding of the problems and emotional growth in individuals, whereas the Z therapist is working to produce specific changes in particular behaviours without being concerned about understanding or insight. The indications which each type of therapist considers appropriate are therefore bound to be different. In addition, the A therapist is typically willing to use traditional group therapy techniques, whereas the Z therapist sticks to the family or other naturally occurring groups.

Then there is the question of schizophrenia. Is *it* organic? Many, probably most, psychiatrists would say 'yes'. There are certainly genetic factors involved. There is also evidence pointing to various biochemical abnormalities in the brain. Yet there is also reason to believe that the likelihood of relapse in schizophrenic patients discharged from hospital is influenced by family factors (Leff & Vaughn, 1985). The *Clinical Practice Guidelines – Treatment of Schizophrenia* (Canadian Psychiatric Association Working Group, 2005) has a chapter on 'psychosocial interventions' that includes a section on family interventions. So in developing a comprehensive treatment plan for the subject with schizophrenia, and indeed for those suffering from a variety of other disorders, family therapy is often one element.

Some views on indications

The indications for family therapy, like the objectives of treatment, should be positive ones. Walrond-Skinner (1978), defining family therapy as 'the psychotherapeutic treatment of the family system, using as its most basic medium conjoint interpersonal interviews', identified four approaches to the subject. The first is the *exclusive approach* position. This is very much the Z therapist's position. Disturbance in an individual is to be dealt with by treating the system of which the individual is a part. Family therapy, perhaps better called systems therapy since systems other than family groups may be the focus of treatment, thus becomes a new orientation to both understanding and treating psychiatric disorders and one suitable for almost universal application.

At the other extreme, Walrond-Skinner defined the *treatment of last resort* position, family therapy only being employed when all else has failed. If this view of the place of family therapy is taken, it may be applied only to particularly severe and serious disorders, so that its chances of success are likely to be limited.

The *diagnostic aid* position is taken, according to Walrond-Skinner, by those who see family therapy as an adjunct which may be used to assist in treatment selection and to promote the more effective use of individual, group or in-patient treatment. It may also be used intermittently, perhaps during 'a crisis phase of therapy', and can be useful in overcoming intrapsychic or interpersonal resistance to therapy.

Finally there is the *differential treatment* position taken by clinicians who consider family therapy along with other treatments which might be used. Whether it is selected depends in part on whether the therapist's theoretical model suggests that it will be effective. Such clinicians also take into account their clinical experience and their understanding of the literature on the subject in deciding what treatment to recommend.

Neither of the first two of the above positions seems tenable. While the 'systems approach' to families and their treatment is indeed a new way of tackling mental health problems, it does not mean that all other approaches must be abandoned or are of no value. Indeed, many family therapists use other approaches when these are needed by the individuals or families they are treating. It is also clear that family therapy can be more than a treatment of last resort. Indeed there are probably few therapists who nowadays take that point of view.

The 'diagnostic aid' position may be tenable if family therapy is not conceived as limited to it. It does seem, however, that family therapy can be a powerful treatment when properly used in the right cases. But it should only be embarked upon after a careful consideration of the relative merits of the full range of available treatments.

Walrond-Skinner (1978) went on to suggest the following indications:

- (1) Symptoms considered by the therapist to be embedded in a dysfunctional system of family relationships. If the symptoms appear to be expressing the 'pain or dysfunction' of the family system, family therapy will probably be the best treatment. There remains the difficulty of assessing whether this criterion is met. How to set about this was alluded to in Chapter 6.

Temperamental and/or physical factors in child and parents may interact with relationship difficulties in the nuclear family, extended family systems problems and perhaps extrafamilial factors. The causes are, however, less important than the cure, and if there is a family systems problem related to the presenting symptoms, family therapy may be helpful.

- (2) Problems presented by those seeking help to produce some change in a relationship rather than to deal with problems in an individual family member. Examples are marital difficulties, including those involving sexual problems, child-parent relationship problems and problems between siblings.
- (3) Separation difficulties. These are considered by many therapists to be best treated by family therapy. Indeed they are really no more than

examples of the kind of relationship difficulties mentioned above. Thus a family containing an adolescent girl trying to separate from her family or an overprotected younger child who is having difficulty growing up may be helped by family therapy. Family therapy may be equally useful when members need to become closer to each other, that is, when the process of separating has gone too fast or when marital partners have never become sufficiently close. During the latter parts of the family life cycle, however, many of the tasks with which families have difficulty concern the separating out process as children leave the home and go their various ways.

- (4) Family therapists with a psychoanalytical viewpoint believe family therapy to be of value with families 'functioning at a basically paranoid-schizoid level, with part object relationships, lack of ego boundaries and extensive use of denial, splitting and projection' (Skynner, 1969). Such families bear similarities to those in which Bowen (1966) described an 'undifferentiated ego mass'. The idea is that basic psychological functions are scattered among the family members, who are not properly functioning individuals in their own right. It may be that such a description is only another way of referring to many of the families covered under items (1), (2) and (3) above.
- (5) Family therapy has been used for severely disorganized families, functioning badly and in poor socio-economic circumstances. A project to help such families was described by Minuchin, Montalvo, Guerney, Rosman, and Schumer (1967) in the important book *Families of the Slums*.

The 'decision tree'

Clarkin, Frances, and Moodie (1979) reviewed the limited research literature on the indications for family therapy and employed this to construct a 'decision tree' for use in determining whether family therapy or some other form of treatment should be used. These authors proposed four steps, as follows.

Step 1. Is family or marital evaluation indicated?

The authors defined family evaluation as one or more family interviews designed to assess the structure and process of family interaction, in order to discover how this is related to the behaviour and symptoms of individual members. They concluded that situations in which family or marital evaluation is almost always essential include the following:

- (1) When a child or adolescent is the presenting patient.
- (2) When the presenting problem is sexual difficulty or dissatisfaction.
- (3) When the presenting problem is a serious family or marital problem, especially when the future of the marital relationship, the adequate care

of the children in the family or family members' vocational stability or health is at stake.

- (4) When there has been a recent stress or emotional disruption in the family, caused by such family crises as serious illness, injury, loss of job, death or the departure from the home of one of the family members.
- (5) When the family or the marital pair, or an individual within the group, defines the problem as a family issue and family evaluation is sought.

Clarkin et al. (1979) also suggested that family evaluation is usually indicated when admission of a family member to hospital for psychiatric treatment is being considered. In such circumstances family evaluation is of value for history-gathering, to clarify the relationship between family interaction patterns and the course of the identified patient's illness and to negotiate a treatment plan with the whole family. Other 'less powerful' indications for family evaluation include the following:

- (6) Situations in which more than one family member is simultaneously in psychiatric treatment.
- (7) When improvement in a patient coincides with the development of symptoms in another family member or a deterioration in their relationship.
- (8) When individual or group therapy is failing or has failed, and the patient is very involved with family problems, has difficulty dealing with family issues or shows evidence of too intense transference to the therapist; or when family cooperation appears necessary in order that the individual can change.
- (9) When, during individual evaluation, it appears that the advantages to the family of the patient's symptoms can be understood in the light of the psychological functioning of the family.

Step 2. Deciding whether either family or marital treatment is required

This step involves deciding whether treatment using a family or marital therapy approach, as opposed to individual treatment, sex therapy or in-patient treatment in hospital, is required. Clarkin and his co-authors suggested that family or marital therapy may be indicated:

- (1) When marital problems are a presenting problem.
- (2) When a family presents with current problems in the relationships between family members.
- (3) When there are chronic and severe problems in perception and communication. These include projective identification, in which members blame each other for the problems and disclaim their own parts in them; paranoid-schizoid functioning, as mentioned above; and various severely disturbed forms of communication such as are seen in schizophrenia.

- (4) In the presence of adolescent antisocial behaviour, such as promiscuity, drug abuse, delinquency or violent behaviour.
- (5) When there are adolescent separation problems.
- (6) When there is found to be control or manipulation of the parent by the child.
- (7) Following the failure of other treatment, for example, when individual therapy sessions have been used mainly to discuss family problems.
- (8) When the family group is motivated to accept treatment but an individual is not.
- (9) When improvement in one family member leads to symptoms or deterioration in another.
- (10) When more than one person needs treatment and resources are available for only one treatment.

The next choice is between family and marital therapy. In making this choice the therapist must consider whether the main problems are in the spouse subsystem or in the family as a whole and also the motivation of the different family members to become involved in one or other type of therapy.

If marital therapy is selected, the decision then has to be made whether or not to include sex therapy as a part or even the major part of this. The decision will depend upon whether sexual problems are present, how severe they are and whether the marital problem is clearly centred around the sexual difficulties. In addition the couple must be motivated to have sex therapy and be willing and able to carry out the appropriate tasks.

Finally, the therapist must decide whether 'family crisis therapy' should be considered as an alternative to admission to hospital. Family crisis therapy is an approach described by Langsley et al. (Langsley, Pittman, Machotka, & Flomenhaft, 1968; Langsley, Flomenhaft, & Machotka, 1969). It consists of an intense but brief family intervention performed at the time of crisis. It is discussed further in Chapter 17.

Timing is another issue, though it is not directly addressed by Clarkin et al. (1979). The selection of a particular approach to therapy does not preclude the use of another one at a different time. Decisions regarding the timing of therapeutic interventions can significantly affect outcome.

Step 3. Deciding on the duration and intensity of therapy

The choice here is between family crisis therapy, brief family therapy and long-term family therapy. The former is most likely to be indicated when the problems with which the family presents are associated with a developmental or other crisis, and particularly when the problems are acute and urgent.

Brief family therapy, which the authors defined as lasting less than 6 months and consisting of sessions no more often than once a week, is indicated for less urgent problems. These include the following situations:

- (1) When there is a focal symptom or conflict involving a child, adolescent or marital pair and the family is highly motivated to change.
- (2) When family involvement is necessary to support another method of treatment, such as regular attendance at a day hospital.
- (3) When a couple presents seeking help in deciding whether to separate.
- (4) In family situations too complex to be understood in a brief evaluation. In this situation, brief family therapy may enable the therapist to learn more about the situation and test the response to treatment.

Long-term therapy may be indicated for more complex and chronic problems, especially where a family's motivation to change is strong and in instances where the family has failed to respond to family crisis therapy or brief treatment.

Step 4

This step is not explored by Clarkin et al. (1979), but consists of determining which family therapy approach is likely to be most useful in a particular case. Currently there are few sound data on this.

The practical value of the 'decision tree' is unclear. While it was derived from an extensive review of the literature, this had many limitations. It consisted largely of personal views arising out of therapists' own clinical experiences, rather than being based on scientifically sound studies. We have summarized it here because the principle of using a decision tree along the lines suggested seems a sensible approach. One first considers the circumstances in which family or marital evaluation is indicated and then considers a number of steps leading up to the selection of a particular form of treatment, if any is required.

In addition to the above indications, certain authors have advocated the use of specific approaches to family therapy in particular disorders, for example, psychosomatic conditions (Minuchin, Rosman, & Baker, 1978) and 'families in schizophrenic transaction' (Palazzoli, Boscolo, Cecchin, & Prata, 1978).

Contraindications for family therapy

There are even fewer hard data on the contraindications for family therapy than there are on the indications. Walrond-Skinner (1976) commented that lists of contraindications may say more about therapists' own areas of defensiveness than about the likely effectiveness of the therapy. She also commented that what to one therapist is a contraindication may to another be a challenge. Nevertheless she did suggest the following contraindications:

- (1) There may be practical limitations to family therapy. If key family members are unavailable for geographical or other reasons or are completely unmotivated to become involved in treatment, family therapy

may have to be ruled out. Another factor is the availability of a suitably trained and experienced therapist. Family therapy is a complex and often difficult undertaking, and it is important that the skills of the therapist be matched to the needs of the family. If this is not so it may be better not to start until a suitably skilled therapist is available, either to carry out the treatment or to provide 'live' supervision behind a one-way screen.

- (2) Family therapy may be contraindicated because the family presents too late in the course of the disorder. The outlook may be too poor to justify the necessary expenditure of time and money, though this is very much a value judgement and the question of whether a family wishes to spend its money on family therapy is perhaps its decision, rather than the therapist's.

Ackermann (1966) mentioned as a contraindication 'the presence of a malignant, irreversible trend towards break-up of the family which may mean that it is too late to reverse the process of fragmentation'. Yet the fact that a family is likely to break up, or is in the process of breaking up, does not necessarily mean that family therapy is inappropriate. Sometimes people seek help in separating or divorcing amicably and with as little damage as possible to all concerned, and the therapist may be able help them achieve this.

- (3) It may be dangerous to attempt family therapy when 'the emotional equilibrium is so precariously maintained that attempts to change the relationship system may precipitate a severe decompensation on the part of one or more family members'. It is certainly the case that many families maintain themselves in a precarious and stressful adjustment. In some cases an alteration in the family situation could increase the stress faced by one or more individuals. This in turn could lead to a worsening of their condition with perhaps depression or even suicide.

These are issues requiring mature clinical judgement, including careful assessment of suicidal and other risks. Such risks should always be borne in mind when deciding whether or not to embark on family therapy or any other treatment. Walrond-Skinner (1976) also mentions that it may be felt unwise to embark on family therapy when one or more members are organically ill, lest this raises hopes of a 'magical' cure of the organic illness. This risk can usually be avoided by the clear setting of objectives, as discussed in Chapter 7.

- (4) Some therapists consider that family therapy may be contraindicated in the presence of depression or severe emotional deprivation in one or more members. Walrond-Skinner suggested that the combination of individual treatment for the members with these symptoms may in such cases be combined with sessions for the whole family.

Kirschner and Kirschner (1986) described an approach taking into account, and providing treatment for, both family systems problems and individual psychopathology in family members. Comprehensive family therapy (CFT) seems to offer the prospect of helping families in

which there is severe psychopathology in one or more members. These are challenging families, hard to engage and to help, and CFT may offer a rational approach to them.

The need to consider the individuals in the family, as well as the functioning of the family system, is also the main theme of Nichols' (1987) book.

- (5) Finally, Walrond-Skinner (1976) advocated caution when the family is referred by an agency such as a court or school. In such cases there may be a hidden agenda, for example, the family's desire to avoid a more severe sentence or to prevent a child from being expelled from a school, rather than a real wish to change.

If the family is deeply involved with other agencies, the therapist's relationship with these agencies and their role in the treatment and the disclosure of any information arising from it should be clearly defined before therapy is begun. Sometimes it is found that it is the family/agency system that should be the focus of treatment.

Clarkin et al. (1979), in describing their 'decision tree' for the selection of patients for family therapy, also listed contraindications which had been mentioned in the research literature. Many are similar to a lack of motivation for, or strong prejudice against, family therapy. The inclusion of members who are in the process of 'individuation', for example, a young adult who has just left the family, may not be desirable, lest it compromise the individuation process (Glick & Kessler, 1974).

Summary

In the early days of family therapy, some therapists regarded family therapy as an effective treatment for virtually all non-organic psychological disorders. Nowadays it is generally looked upon as one of a variety of therapy approaches, each of which has its place in the treatment of emotional and behavioural disorders. While there is a school of thought that considers anything that produces change in a family system as family therapy, even the treatment of an individual family member, in practice it is necessary to decide whether or not to make the family system the main focus of therapy.

Family therapy should be considered when (a) there is a malfunctioning family group and (b) the problems which therapy is to address are related to the functioning of the family. It is likely to be of value when the presenting problems concern children or adolescents; when families present complaining that members have problems in relating to each other; and when a family appears to be having difficulty making the changes required to pass from one developmental stage to the next, for example, when adolescents start to become more autonomous.

Family therapy is neither a ‘cure-all’ nor a treatment of last resort, but an effective way of dealing with problems embedded in a dysfunctional family system. It may sometimes be usefully combined with the treatment of individual family members.

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Chapter 9

Practical Points in the Treatment of Families

Involving reluctant family members

In Chapter 6, we considered some points that can be made to family members who do not understand why the whole family should come to the initial assessment interview. Making these points does not always result in everyone attending, however. Sometimes reluctance disappears once the key family members realize how interdependent the family members are. The family members may also need to come to understand, perhaps by being given examples, that emotionally healthy and well-functioning family members usually contribute helpfully to the therapeutic process.

Karpel and Strauss (1983) discussed how a therapist may negotiate full attendance at a family assessment interview. They also made suggestions about when to compromise, and when not to do so, on the matter of full attendance. They recommended that, at least in the initial phone contact, the reluctant family members should be told simply that the goal of the interview is to gather as much information as possible about the presenting problem. They warn that

Going beyond a variant of the ‘information-gathering’ rationale for the family evaluation . . . may lead the caller (usually a parent) to feel that he or she is being blamed for the family’s troubles. Or it may cause the caller to become angry and defensive over someone implying that there is something wrong with his or her family. (Karpel & Strauss, 1983, p. 100)

Reluctance or refusal to attend may be met with at any point in the assessment or treatment process. The therapist then has various choices. One is to decline to start, or continue, with therapy. While this may occasionally be the best course of action, we must bear in mind that the refusal of the reluctant family member(s) to attend is probably but one manifestation of the family’s problems. It is hardly logical to decline to offer help to a family because of the very problems for which they require help. So what alternatives do we have?

There are four categories of family members who may decline to attend: parents or marital partners; dependent children; 'adult' children; and extended family members (grandparents, uncles, aunts, cousins and so forth).

A missing parent or marital partner

If the presenting problem concerns a child, or the marital relationship, and one parent (or marital partner) declines to attend while the other wishes to do so, this suggests that there may be marital problems, or major difficulties in the functioning of the pair as a parental couple.

When one parent is reluctant to be involved from the start, direct communication with this person by the therapist may be effective. In making contact, taking a 'one-down' position may be helpful. That is you say, in effect, that you need the help of the reluctant person. Your message is, 'I need your help in order to be effective in helping your son (or your daughter, your family, your wife, or whoever is being presented as the problem)'. This approach is much to be preferred to saying that the person must come because the therapist, as an 'expert', insists. Even less helpful is to suggest that the person concerned is a part of the problem.

If marital difficulties are the main presenting problem it is important to involve both partners. If one asks for help and the other is unwilling to come, even in response to a direct request from the therapist, it can be useful to see the partner who is asking for help, at least once. The purposes of such a meeting may be

- to explore possible means whereby the other partner may be induced to attend; or
- to assess the mental state of the partner who is seeking help, since that person may have a disorder which can be treated other than by marital therapy; or
- to explore whether it may be possible to start treatment of the marital difficulties by seeing the one partner; or
- some combination of the above.

If the identified patient is a child, and it is a two-parent family, success often depends on having both parents involved from the start. If only one agrees to come, or actually shows up for the first interview, I usually see the children with the one parent, but during the first interview I focus on the issue of the missing parent and how that person might become involved in the treatment. Sometimes the reluctant parent becomes willing to attend when the family returns home and talks about the session, mentioning perhaps that the things the absent parent feared (e.g. that they would be told the family was a 'bad' one or that the problem was the parents' fault) did not happen.

If after two or three sessions one parent is still failing to attend, a further direct approach by the therapist, perhaps by telephone, may be successful.

Again it is often helpful to use the ‘one-down’ approach. The therapist may say ‘After two (or three) sessions with your family, I find I need your help more than ever. I’m sure the information you can give me will make things a lot clearer’. Another approach is to plead confusion. You may say you feel defeated by the problem the family presents and may only be able to make progress with the help of the person concerned.

If this approach fails, and the presence of the missing parent seems vital if progress is to be made, this may be the time to suggest that there should be no further sessions until the missing parent is available. This is risky and may present ethical problems, but it may precipitate a crisis leading to the involvement of the missing parent. Or it may result in the family situation deteriorating further or the child’s symptoms worsening. Such developments seem sometimes to be necessary before change for the better can start.

When parents are divorced or separated, and the identified patient is a child, therapy usually starts with the family in which the identified patient lives. But parenthood does not end with divorce, and involvement of the other parent is often desirable at some stage, even if the children do not have regular contact with that parent. When there *is* regular contact, problems in the relationship between the two parents, or families, often continue despite the separation. Such problems usually need to be the focus of therapeutic attention. Having both parents present at some sessions may be helpful. This emphasizes that they each still have a parental role despite the separation or divorce.

Unresolved issues between separated parents may persist for many years. Sometimes the children are used as pawns in a game in which the parents continue to play out their feelings towards each other.

Achieving a joint meeting of two separated parents can be difficult, but is often worth working hard to achieve. I (PB) usually meet first with each parent, and any new marital partner either one may have. These meetings can be used to discuss how important both parents are to their children and to explain the benefits that accrue when separated parents work together on parenting issues. The purpose of the sessions should be defined as that of dealing with children’s issues, rather than aiming to repair the marital relationship.

Once this has been made clear, parents may become more willing to come.

Missing dependent children

Children, and particularly adolescents, who are living at home in the care of their parents sometimes object to coming to family therapy sessions or their parents may be willing to bring only the identified patient, on the grounds that that child has the problem and therefore no one else need be involved.

We thus have two possible problems. That of children or adolescents who object to coming is the simpler. If the parents have decided that the family

should have therapy, and that the children should attend, the children should be expected to come, just as they are expected to go to school, or to bed at night, or to do any of the other things which parents reasonably expect of their children. If a child refuses to come, this is a therapeutic issue. It may be necessary to see the parents, and any children who will come, and work out a means of enabling the parents, or parent, to gain control of their child(ren).

The situation is different when it is the parents who are reluctant to have a child or children attend. They may not want the other children involved because they see the problems as residing in the identified patient. Involving anyone else in the treatment might threaten that assumption. Another question is that of who is to control the therapy process: Is it to be the therapist or the family? It is a paradox that a family may seek the help of a therapist, but sometimes then dictate how the treatment should proceed. If the therapist yields to the family's wishes, this may simply result in the family continuing in its usual dysfunctional way. Change, though desired, can also be threatening or it may be a matter of 'better the devil you know than the one you don't'.

So how may we address this dilemma? It can often be resolved by presenting therapy as a collaborative endeavour, rather than one in which the therapist takes on the role of expert and prescribes how the treatment process should go. Instead it is usually better to say, 'Let's work together on this'. This is not a manipulative manoeuvre. Far from it! It is reality, for unless therapist and family work together, and pay due regard to each other's views, progress may be impeded or may not occur at all.

Many reasons are offered for parents' refusal to bring certain children. They do not want them to miss school, because they are already behind in their studies and may fail if they miss any more. Or the other children are unaware of the identified patient's problems (something which in reality is rarely the case) and should not be bothered about it, or might even be harmed in some way by knowing about it. Or the other children would miss out on some sporting or other activity which is important to them.

The simplest way of dealing with parents' objections to bringing the other children is to explain why it is helpful to see everyone, at least at the first session. Who should attend future sessions can be discussed at that meeting, and this can be an ongoing process as treatment proceeds. It is a fact that therapists are generally more effective the more information they have about the family and the members of it. That should be made clear to the family. At the same time, the point should be made that no one will be pressured to reveal information or discuss topics they do not wish to mention. But as they become more confident in the therapist, and rapport develops, they may in due course become more forthcoming.

Sometimes it is possible to achieve a meeting of the whole family by initially agreeing to family members' requests or conditions simply as a

means of engaging them. It may then later be possible to get everyone to attend without the conditions. The following case illustrates this.

Jason, aged 11, his father, Ken, and his stepmother, Lynn, presented themselves for the first interview. One full sister, two stepsiblings and a baby recently born to Ken and Lynn were left at home, although Ken and Lynn had been asked to bring the whole family. The parents complained that Jason was presenting a host of behavioural problems and that these were getting steadily worse. As a result, he had recently been placed in a foster home. Ken and Lynn seemed unshakable in their belief that the problem was solely Jason's, though I (PB) thought there was evidence of a number of family systems' problems. Ken, supported by Lynn, insisted that Jason required hypnosis, which would solve all his behavioural problems.

I decided to go along with this idea and saw Jason three times, each time doing some hypnotherapy. Jason proved to be an excellent hypnotic subject and the sessions were used to help him gain access to some good feelings about himself, related to various successful past experiences, and to improve his self-image. At the conclusion of these three sessions I suggested a meeting of the whole family to discover what changes the family members had observed in Jason, who had been spending his weekends at home.

Presented in this way, the parents found the idea of a family meeting acceptable. They even asked if they could bring the baby, before I had had a chance to tell them that I did want everyone to come, including the baby. When at last the family meeting occurred, it proved possible to do a great deal more than ascertain the changes the other family members had observed in Jason, although the session started with an enquiry regarding Jason's recent behaviour. Moreover the family seemed to find the family interview that was carried out neither alarming nor threatening. Nor did they feel they were being criticized, as they had apparently thought they might be.

The use of treatment strategies such as those discussed in Chapter 1 may also help.

Missing adult children

'Adult' children may be divided into those who have physically left home and those still living in the parents' home. It may not be reasonable to expect the former group to come to sessions against their will, though many are glad to help resolve a problem in their family of origin. All the therapist should do in these cases is to invite the independent children to come for sessions whenever it appears that this would be helpful. If the reasons for inviting them have been explained to them, and they refuse, this should be accepted.

The situation is different with adult children still living at home, even if they are wage-earning and contributing their share of the household budget. Sometimes such individuals decline to come to therapy sessions. Whether the parents should expect them to do so, even unwillingly, depends in part

on the 'contract', written or more probably unwritten, on the basis of which these children are still living at home.

This contract may be unclear, and an aim of therapy might be to make it clear and achieve acceptance of it by all concerned. Such families may not have resolved the issue of whether these adult children should obey certain family rules, rather than doing exactly as they like in their parents' home. In practice there have always to be some rules family members must adhere to. Whether mandatory attendance at family therapy sessions should be one of them may be a matter for negotiation.

While the above issues may need to be dealt with in therapy, the decision as to whether children, young or adult, should attend rests ultimately with the parent(s). We must tell family members what we believe will lead to the best and quickest therapeutic outcome, and why. When our clients decline to accept our advice we always have to consider whether we can still hope to treat them effectively. If we believe we cannot, we must tell them so. What look like blocks to therapy, because our clients decline our advice, may however sometimes be overcome by careful development of rapport.

Extended family members

Extended family members are usually best contacted through the family member to whom they are most closely related. Most often this is one of the marital pair. Extended family members often attend willingly, but if they are reluctant to do so direct contact by the therapist, to explain why seeing them would be helpful, may yield results.

Maintaining a therapeutic alliance

A collaborative, rather than a controlling, approach to families tends to yield the best results. It is true that some families have firm views on the form treatment should take, based on their understanding of the family's problems. But their presentation for therapy usually means that their understanding of the problems has not led to their resolution. Nevertheless the family's views are not irrelevant and we should always treat them with respect.

Unfortunately, the idea that the therapist can work some sort of 'magic' on the family has been encouraged by some therapists and authors. It is encompassed in the titles of such books as *The structure of magic, Volume 1* (Bandler & Grinder, 1975) and *Volume 2* (Grinder & Bandler, 1976), and *Magic in action* (Bandler, 1984). M.P. Nichols (1987, p. 53) observed that, 'Client families induce therapists to play magician because they long for a magically protective relationship'. He goes on to suggest that:

Many therapists attempt to capitalize on their clients' idealization, realizing that it lends power to their directives, but ignoring that the complement

of the powerful therapist is a humble and insignificant family. Authoritarianism bothers us least when we are the ones deferred to.

M.P. Nichols (1987, p. 55) also suggests that whereas the pioneers of family therapy sought to rescue their patients from ‘the Freudian vision of the person ruled by unconscious forces in the form of inexorable repetitions of the past’, they have tended to replace this with a vision of rule by ‘the system’.

The truth, of course, is that no one limited set of variables can explain anything as complex as human behaviour. The attempts by our families to control the treatment process must be recognized for what they are: manifestations of the family’s way of functioning or its ‘psychopathology’. In most instances our response may need to be something between passively accepting the family’s stance and directly confronting it on the basis of our supposed expertise.

In the early stages of therapy it is often best to go along with a family’s viewpoint, at least in some measure, but without losing sight of what is happening. As rapport and trust develop, the family members may become more willing to follow suggestions. Taking a ‘one-down’ position, as described above, may be helpful. Strategic approaches, such as the use of paradox or of metaphorical ways of communicating a point of view, may also help. Telling stories such as the following can sometimes enable the family to view its situation differently, and get involved constructively in therapy.

I remember a very caring family I worked with before I came to the city where I now live. The parents were deeply concerned about their 13-year-old daughter, Patricia, who had started running away and getting into trouble with the law. Her mother brought her to see me and told me they suspected also that she was on drugs, though she denied it and the parents had no proof. There were two other children in the family, both girls and both older than the daughter who was in trouble. Neither of them had been in trouble and the parents had no particular concerns about them.

As none of the other members of the family appeared to have any problems the reasons for the daughter’s behaviour were a real puzzle to the family. Their family doctor suggested that they bring Patricia to see me, and she came to my office with her mother. I had long talks with both of them and at the end of it all I was as puzzled as the family. The mother and daughter were pleasant people and they appeared quite open in the interview situation. From what the mother told me it seemed that the parents had handled their daughter’s problem behaviour sensibly; they hadn’t overreacted, they’d spent long hours discussing the problems with her, trying to figure out what had gone wrong and what they could do about it, and they had imposed reasonable sanctions in response to Patricia’s misdeeds, though these had not been effective.

In those days I didn’t always ask the whole family to come when I first saw a child, as I do nowadays. But I now felt I needed more information. Naturally I first thought of the father. So I called him up and said I needed his help. I asked him to bring the whole family, including the other two

daughters, to see me. I said I thought probably he, and perhaps the other girls too, could help me understand the youngest daughter's problems.

The father wasn't too keen on the idea nor, he told me, would the other girls be. He was very busy at his work and therefore reluctant to take time off. He feared losing his job, a fear which I felt probably wasn't fully justified as he had a long and excellent work record with his firm. The other girls were good students at school, they had exams coming up and didn't like missing school. I commented that this was interesting since Patricia had a negative attitude towards school and was not doing well there. Eventually, after a good deal of discussion, the father agreed to come and to bring the whole family.

I was quite new to family therapy in those days and was surprised by how much I learned from that first interview with the whole family. The father was a perceptive person. He told me a lot about the relationship between Pat and her mother that I hadn't even guessed when I just saw the two of them. The other daughters, too, gave me much new information. Seeing them together made me realize how close they were emotionally. The mother had said they were close, but it wasn't till I met them, and saw how they interacted, that I realized the true nature of their relationship.

It was also only when I saw the whole family that I appreciated how different the two older girls were in looks compared to Patricia. They were both strikingly attractive blondes with slim figures, whereas Pat was a little overweight, had mousy-coloured hair and an altogether less striking appearance. Seeing the whole family helped me a lot. The problem for me was to understand how, in what seemed a basically healthy, normal family, there could be one member with problems such as Patricia's.

This story, reproduced from *Using metaphors in psychotherapy* (Barker, 1985), makes a number of points which might help motivate reluctant family members to attend for an assessment interview. It also offers those to whom it is told a different way of looking at family situations, especially those in which there may appear to be only one person who has a problem. The various points it makes are discussed further in the book from which it is quoted.

Involving children in family sessions

It is important that all family members are involved in the treatment process, even very young ones. Dare and Lindsay (1979), Guttman (1975) and Ackerman (1970) are among the authors who have addressed the issue of how to involve children in family therapy. Nichols (1996, p. 99) is another author who has written of the importance of involving all family members, including the children. Even children who are preverbal should be acknowledged in some fashion.

Dare and Lindsay (1979) expressed two concerns. One was that family therapists may not learn the skills needed to communicate effectively with children and to provide them with settings in which they can express what is

going on in their inner worlds, an issue also raised by McDermott and Char (1974). The other is that the changes in personality structure that individual therapy seeks to bring about in children will not occur in the course of family therapy. But they believe that neither of these concerns is justified if suitable steps are taken to involve the children.

But why is it so important to involve children in the family therapy process? Dare and Lindsay (1979), like Satir (1967), Skynner (1976), Kirschner and Kirschner (1986), M.P. Nichols (1987) and W.C. Nichols (1996) are concerned both with the family system and with the psychological development of its members. A system cannot exist without transactional content and they believe that systems theory and psychodynamic views are complementary rather than antagonistic. Along with Boszormenyi-Nagi and Spark (1973) and Bowen (1976) they are interested in the relationship between the current interactional pattern in the family and the interpersonal patterns of the past.

The way family members have interacted in the past often seems to be reflected in the present intrapsychic structures of the family members. In other words developing children take into themselves, and incorporate into their internal models of the world, patterns of behaviour, attitudes and beliefs, and also family myths, learned from their parents, and to a lesser extent from other family members. These in turn have been learned from *their* parents, and so on.

Byng-Hall (1973) discussed the role that family myths may play in the functioning of some families. He regarded their use as a form of defence against examination of the real issues facing the family. Children are often repositories of such myths, and through them a family's defences can sometimes be penetrated.

Children are, and should be seen as, active participants in the current interactional system and also as repositories of the history of the family. The content of their play and other communications is important, and many therapists believe that steps must always be taken to help child members of the family express themselves.

Dare and Lindsay (1979) recommended the provision of a few good-quality materials, chosen specially for each family. They keep the toys or play materials for each family in a separate locker. A small dolls' house has been found to be a useful adjunct for young children. A 'family' of people for the house provides a group upon which young children can project their family knowledge and fantasies. For older children, and those who are well defended against direct expression using family figures, domestic or zoo animals may be useful. A toy telephone, bricks, a dolls' tea set, plasticine, modelling clay, pencils, crayons and paper are also useful items. Dare and Lindsay (1979) make it clear that the children's drawings will be kept as records of their work, not taken home by the family.

From the start of the first session any children present should be actively involved. They should be asked their names and greeted individually. Little ones can sometimes be held for a time by the therapist. Interest should be

shown by the therapist in both the verbal and the non-verbal contributions of the children. By all these means the therapist shows that he or she is approachable at a childhood level and that childlike feelings are acceptable.

Making free and accepting contact with the children need not undermine parental authority, though the latter must always be acknowledged and respected. Dare and Lindsay (1979) take care to refer to the parents either as 'mother' and 'father', or as 'Mr' and 'Mrs'. Interruption of their speech by the children is not permitted.

Throughout therapy Dare and Lindsay (1979) make every effort to attend to and understand the children's communications. Their play materials and drawings are given careful attention, and it is made clear that the therapist wants everything to be understood by the children, who should ask about things they do not understand. Giving children and childhood things high status sometimes produces scepticism or disbelief in the parents, but this is usually soon shaken by the accuracy, perceptiveness and unexpectedness of the children's knowledge. Dare and Lindsay (1979) state that the material produced by children can be 'extraordinarily forceful'. That is also my (PB) experience. It can help overcome parental resistance, and historical and other data the parents thought were secret may be revealed.

Involving children in this way not only facilitates the production of content, but it also helps reveal the transactional patterns of the family and current interpersonal processes. Children, like adults, reveal a great deal non-verbally. Thus those who sit stiffly on their chairs during a therapy session raise questions about the family's control structure. Fear, dependency, depression, the seeking of attention and the response of parents to their children's play or the overtures they make to them – all these are indications of aspects of the functioning of the family.

The construction of the genogram during the first or second session provides an opportunity for the children to participate. They usually enjoy it and sometimes come up with valuable comments about the family and its members. Jackie, aged 10, was adopted at the age of 4, after living until then with various members of her natural family. During my first meeting with the family we constructed a detailed genogram of the family she was living in. When it seemed to be complete, I asked if there was anyone else who should be added. Jackie responded immediately with, 'Now, what about *my* family?'

All these devices are designed to prevent 'family' therapy becoming marital therapy in the presence of the children. There are of course times when marital therapy is needed, but Dare and Lindsay (1979) believed that many therapists move towards it because they are more comfortable communicating verbally with adults than they are making contact with children.

Regardless of how frequently it is desirable to move from whole family to marital therapy, however, family therapists should certainly have the skills and be familiar with the techniques that are necessary to contact and involve

children in therapy as members of the family group. This applies whatever the orientation of the therapist and whether or not intrapsychic processes are given prominent consideration by the therapist.

The therapist's use of self

Family therapists have generally taken a more active role in their work than is usual in other forms of psychotherapy, although this may be less true of the narrative, constructionist and 'postmodern' methods currently in vogue.

The more active the therapist's role, the more important the therapist's personality. Many of the pioneers of family therapy were powerful, charismatic figures. How far this is helpful or necessary is not clear, but every therapist must learn to use her or his personality to best advantage. Particular approaches may suit therapists with particular personalities and temperamental styles. Some therapists have difficulty using certain approaches effectively, but quickly become skilled with others.

Properly supervised practice can enable the novice to gain confidence and use effectively any of the ways of approaching families and using therapy techniques mentioned in this book.

Versatility and flexibility of style and the ability to use humour, playfulness, drama and passion are useful assets in the family therapist. It is also important for the therapist to be comfortable with the expression of emotion.

Transference issues

The term 'transference' is used here to mean the feelings projected on to a therapist by family members. These feelings are associated with previous relationships, often with parental or authority figures of whom the therapist may be an unconscious reminder. This process is not stressed in the family therapy literature but merits consideration.

Skygger (1976, pp. 206–208) discussed the development of transference phenomena during family therapy. He did not recommend encouraging transference. He also pointed out that it is less likely to develop the less the therapist is a 'blank screen'. Family therapists are generally more active and spontaneous and reveal more of themselves than individual therapists, so the projection of patients' own feelings on to them is less likely.

Transference can nevertheless develop. Family sessions can, for example, cause hostility previously kept under control by mental defence mechanisms to be projected into the transference. This may need to be interpreted and discussed.

The transference process is two way. Families can arouse feelings in their therapists in much the same way as therapists arouse feelings in their clients. This is called counter-transference. Such processes may be associated with

the therapist's emotional needs. Skynner (1976) suggested that members of helping professions tend to have defensive systems that deal with inner conflict by taking 'parent' roles towards clients or patients. The latter then take the 'baby' role in response.

We should always bear in mind the possibility that transference or counter-transference issues may be interfering with our treatment. Such issues are more likely to surface the more the therapist takes a passive role. The less intense and frequent the sessions the greater are the chances of avoiding such problems. It is better if previously repressed feelings are expressed between family members rather than towards the therapist. They can then be dealt with in the course of therapy.

Contracts

Many family therapists establish specific contracts with the families they treat. These often concern the number of sessions proposed and their frequency, who should attend, the goals of therapy, any fee that is payable and other issues. Some, like Epstein and Bishop (1981), have family and therapist sign a written contract at the end of the assessment process and before treatment begins.

Establishing a contract, which specifies the number of sessions and their frequency, has several advantages. First, it can define the length of time the therapist considers will be needed to produce the changes sought. It thus sets a programme for change. Second, it can define the part to be played in the process by the family members and the therapist. Third, it can provide for 'homework' to be done between sessions, with the implication that the families will work on their problems between sessions, as well as during them.

A time-limited contract also provides an exit point for the family, so that it is less likely to feel trapped into extended therapy. Knowing that there is a projected end-point may make it easier for them to enter treatment.

Perhaps the most important part of a contract is the specification of the changes for which the family and therapist are meeting together to achieve.

The spacing of sessions

Therapists' views on the spacing of family sessions vary. In the early days of family therapy many therapists saw families weekly, even more often, perhaps because in individual therapy this had been the usual practice. Nowadays there is a tendency for therapists to see families less often, as infrequently as once a month, or sometimes even less often than that.

Palazzoli (1980) set out a rationale for seeing families less frequently and demonstrated that, in her experience, families seen less often did as well, or

better than, those seen more frequently. It seems that when strategic and systemic methods are used, more widely spaced sessions may be best, whereas when more direct, and especially behavioural, methods are employed it may be preferable to see families more frequently.

Spacing sessions at greater intervals has several advantages. One is that a therapist can handle a bigger caseload. Another is that, as we have seen, there is less likelihood of the family becoming over-involved with the therapist, so that transference problems are diminished or avoided. Modern family therapy may involve family members in carrying out tasks or performing rituals between sessions. These can often, with benefit, extend over the course of several weeks. Finally, systems change takes time, and a week, or even two, may not be long enough for a well-designed intervention to have much impact on the family system.

Confidentiality

An important feature of family therapy is the openness it promotes. When all members of the family are meeting together and talking about the issues with which treatment is dealing, the question of keeping certain information confidential, as between family members, does not arise. We can model free and frank communication and can encourage it. For example, a therapist might comment, when one person says something uncomplimentary to another, 'I'm impressed that you decided to clear the air and get those feelings out in the open'. This connotes positively the intent behind the statement, rather than the statement itself.

In family therapy, information emerging in therapy naturally becomes available to all members of the family. So if a member is absent from a session, the others will feel free subsequently to share with that person what happened and what was said during the session. I find it helpful to make this clear at the start of treatment, especially when treating families that have had difficulty sharing information and communicating effectively with one another, that is 'disengaged' families.

Family members sometimes try to obtain individual attention or communicate information to the therapist outside the therapy sessions. This may involve phone calls to the therapist or taking the therapist aside at the end of a session and requesting a private talk. Another, healthier approach is to ask openly for a private talk, while the other family members are present.

The meaning of such behaviours should be carefully considered. Whether private interviews should be granted, and how to respond to telephone calls, must be decided in the light of what is known about the family system. Such issues may be best brought to the family sessions for discussion.

Sometimes therapists see subgroups of families for certain sessions and ask those present not to share what is said with the other family members. This can be a way of strengthening boundaries that are too permeable or diffuse. If this is to be done it should of course be made clear to the other family

members that this is a private talk the therapist and the family members concerned are having and that its content may not be shared with the rest of the family. Their agreement should be obtained for this. Some strategic therapy plans involve such confidential talks with certain family members.

Jane, a 13 year old with a severe sleeping problem and school refusal, had an enmeshed relationship with her mother, while her father was largely uninvolved with the family. He declined to come to therapy, but the mother and Jane were seen on one occasion, and during the latter part of the session I interviewed them separately. I told Jane, while I was seeing her on her own, to see how long she could stay awake each night and telephone me, without her mother's knowledge, at certain set times to tell me. She was not to discuss her sleeping habits with her mother at all. I told her mother, when I saw her alone, that she could talk to Jane about any subject except sleeping, which must not be discussed. She could however discuss it, when the children were not present, with her husband.

My plan was to separate mother and daughter, having Jane become involved with me by reporting to me how long she was staying awake, while at the same time promoting sleep by a paradoxical injunction. Because Jane's sleep problems were her mother's main preoccupation and something she could scarcely help talking anxiously about, she was given permission to discuss it with her uninvolved husband as a means of bringing him more into the family.

The strategy was successful and the sleep problem had resolved within 2 weeks. School attendance also became normal shortly afterwards, and the mother found that when she told her husband of her concerns regarding Jane he showed more interest than she had expected. In this case some secrets between family members were essential to the treatment strategy employed.

The content of family therapy sessions is of course strictly confidential so far as people outside the family group are concerned. Information should not be released by the therapist without the family's permission.

Observers

Family therapists make extensive use of one-way observation screens and closed-circuit television. By such means the treatment is observed by one or more other therapists. These can assist the therapist in understanding the family and devising intervention strategies. Dealing with families is a complex process. Many things, both verbal and non-verbal, are going on at once and it can be helpful to have several people watching and listening. de Shazer (1982) regarded the total team as being 'the therapist' and refers to the member who goes into the therapy room with the family as 'the conductor'.

Observation through one-way screens is commonly used by supervisors in teaching family therapy. It enables them to watch their students in action

and, using a telephone, to intervene in the treatment if necessary. Communication by telephone between therapist and/or family, and those observing, can also have other therapeutic uses (Coppersmith, 1980).

Closed-circuit television can serve a similar purpose to observation through a one-way screen, especially when a large audience, or one situated at a distance from the treatment room, wishes to watch a therapy session. Videotape recordings are often used, both for supervision and review of sessions, and to enable therapists to watch themselves in action. They enable therapists to learn more about their own functioning, as well as that of the families they are treating. Videotape recordings are not, however, a substitute for live observation, since intervention during sessions by supervisors or the other observers is not possible when a videotape is reviewed. Ideally sessions should be observed and also taped for subsequent review. Videotape replay has itself been used as a therapeutic device (see Chapter 12).

Whatever form of observation or recording is proposed should be explained to the family in advance and consent obtained. It is usual to get a signed consent to record sessions. Written consent is not usually considered necessary in order to have observers watch, but the family should always be told who is watching, and if they wish they should be allowed to meet the observers. Only rarely do families object to being observed, once it is explained that they have not just one therapist, but a team devoted to helping them. Families raising objections to being videotaped may be told that records are always kept of therapy sessions, usually in written form, and that the tape recording is only a better, more comprehensive form of clinical record. They should also be assured that the tape will not be released to anyone outside the clinical team without their permission.

What should the therapist do if family members do object to being observed and/or tape recorded? This depends in part on the philosophy of the institution in which the therapy is being conducted. If team therapy, as described, for example, by de Shazer (1982), is the basic approach of a centre, it might be better, unless the centre can offer other treatment approaches, to suggest that the family seek help elsewhere. On other occasions it may be quite appropriate for an experienced therapist to proceed without the help of observers or recordings, perhaps after warning the family that treatment might take longer, or be more difficult, without the additional help.

The situation is different when the family is to be treated by a student. In this case proper supervision, which might need to be 'live' depending on the nature of the case and the experience of the student, is essential. To proceed without it, when it is needed, would be unethical. In such cases it is necessary to consider whether any other way of treating the family is available.

Serious objections to being observed or tape recorded come mostly from individuals with paranoid personalities or paranoid psychoses. When this is the case the management of the paranoid person, or family system, becomes a clinical issue, often a difficult one, with which the therapist or team must deal.

Co-therapy

From the early days of the family therapy movement there have been those who have believed that a co-therapy team, that is two therapists working in the room with the family, is preferable to having a single therapist work with the family, at least in many instances. As with many other issues that arise in family therapy this is one on which there is a lack of good data. The advantages claimed for co-therapy include the following:

- (1) Better observation of what is going in the family group. It is certainly true that a single therapist cannot observe all the events, verbal and non-verbal, that take place in a family interview. If two therapists are present, less may be missed.
- (2) The therapists can supply each other with mutual support. Each can also watch for signs that the other is getting over-involved with the family or is losing objectivity in dealing with the family system.
- (3) The therapists can model healthier ways of relating and communicating than the family use. When the co-therapists are a man and a woman, they may help to model a better relationship for marital and parental couples.
- (4) In the type of strategic therapy in which two incompatible alternative courses of action may be presented to the family, the therapists can say they disagree about which would be the better. One of them can present one alternative while the other presents the second. This can get the family thinking about their options, as well as making the point that there is often no certainty about what is the best course of action.
- (5) It can be a valuable learning experience for the therapists. Each may learn from the other, and a less experienced therapist may learn from a more experienced one.
- (6) Two, or even more, therapists may be required for very large families and, especially for multi-family therapy (see Chapter 12), simply to monitor events, keep the therapy process under control and maintain contact with all members of the family.

Most of these advantages have been questioned:

- (1) It has been said that experienced therapists are able to observe enough of the family process to make appropriate interventions. There is no hard evidence that observing everything, or more than one therapist can observe, improves results.
- (2) Experienced therapists in their day-to-day work do not require the support of co-therapists. When they require assistance with families they can seek consultation with colleagues. Students and other inexperienced therapists should receive support from their supervisors, either by means of live supervision or through review of videotapes of their work.

- (3) Modelling can usually be done by therapists working on their own, using members of the family group as partners in the process. When family members do not have the appropriate skills these can be taught by the therapist. This can itself be a useful therapeutic strategy.
- (4) It is not necessary to have two therapists in the room to present two different viewpoints to a family. One view can be put forward as the therapist's while the other can be that of the observing team, or the two views can be presented as those of two groups within the team. Even if you are working without a team, it is still possible to say that you can see two possible courses of action but are unsure which would be better.
- (5) Other learning experiences are available without the use of co-therapy. One-way observation and review of videotapes enable students to watch skilled and experienced therapists at work without the necessity of being in the therapy room.
- (6) While it seems generally to be agreed that more than one therapist is needed for multiple family therapy, it is less clear that this applies with big families. My own experience in trying to see on my own a family of two parents, 14 children and the marital partners of two of these suggested, however, that it would have been helpful to have someone else present. It was hard even to remember everyone's names, let alone form a clear view of how the family system operated!

Two other problems with co-therapy are the additional cost of paying two therapists and the greater complexity of the process. Careful planning is necessary, as well as subsequent review of each session by the co-therapists, who should also have similar theoretical orientations, comparable skills and a satisfactory working relationship.

It seems that co-therapy is used in some centres more than in others, perhaps more as a matter of policy than because of firm evidence that it yields better results than treatment by a single therapist. Most therapists work on their own. Of the 11 case studies in the book *Family therapy: Full length case studies* (Papp, 1977), only two were treated by co-therapy teams. In one of these Carl Whitaker started out as the sole therapist, but was joined by David Keith in the fourth interview. The decision to bring in a co-therapist was made because of the 'close lock-in' or 'profound intimacy' which Whitaker felt had developed between himself and the mother, herself a professional therapist.

The other co-therapy case was a marital one treated by James Framo and his wife who had worked together as co-therapists for 5 years. There are other instances of marital couples working together as co-therapists, for example, Robin Skynner and his wife (1976) and Lankton and Lankton (1983).

While there are no clearly established benefits of co-therapy, it seems that it has its place in certain circumstances. For example, co-therapy of a creative and fascinating kind was reported in the book *The family crucible*

(Napier & Whitaker, 1978), which described the co-therapy treatment of a family (actually a composite of a number of families) in a singularly clear and well-written way.

Summary

This chapter has considered some practical points that may require attention during family therapy. Attendance of the whole family for assessment, which is usually desirable except when the problem is purely a marital one, may be resisted. It can usually be achieved by persistence, careful explanation and avoidance of confrontation in the therapist's early contacts with the family.

Family therapists need to learn to use their personality assets to best advantage. We all have characteristics which we can turn to good use in family therapy, and we need to identify and capitalize on these.

Involving children in family sessions is important. Children are often repositories of their families' myths and histories and much can be learned from their contribution to family sessions.

Family members may project their feelings and attitudes on to their therapist, though this happens to a lesser extent than in individual therapy. At times such transference issues require to be dealt with. Also discussed have been the spacing of sessions, the issues of confidentiality, and the use of observers and of team members who are not in the room with the therapist. Co-therapy teams are sometimes used but their place in family therapy is unclear though it seems they can be used creatively in some circumstances.

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Chapter 10

Common Family Problems and Their Treatment

Introduction

In this chapter, we describe some common family problems. We first describe task accomplishment problems, which we further distinguish as basic, developmental, and crisis. Next, we describe communication problems, and summarize some approaches to their treatment. We then examine poorly defined or dysfunctional role patterns, specifying two situations in which problematic role patterns tend to emerge. Finally, we describe problems of behavioral control. Because the approaches, we have included some principles to follow when giving families direct injunctions.

Task accomplishment problems

Task accomplishment problems (Steinhauer, Santa-Barbara, & Skinner, 1984) are the failure to provide for the basic needs of family members. The most dramatic and serious examples of these usually come to the attention of family therapists by way of child protection authorities. Oliver and Buchanan (1979) reported an extreme example. They presented a horrifying story of an extended family network, starting with a developmentally disabled young woman, the six men with whom she successively lived, and their children and their descendants. Altogether 40 members of the family, and their spouses or partners, were studied. Throughout this extended family, there was a gross failure of basic task accomplishment, with physical neglect, assaults on the children, incest, prostitution, sometimes taught to the children by the parents – and a total failure to provide the basic elements of care.

Unfortunately, cases as severe as these are not uncommon. Oliver and Buchanan's (1979) account is distinctive because it was systematically described and published. However, family therapists who collaborate with child-protective agencies are only too familiar with similar situations, usually characterized by at least some of the following: intergenerational poverty; individual psychopathology or substance abuse on the part of parents; intimate partner violence; poor attachment on the part of the children who

have received little consistent care; cultural marginalization; and intergenerational trauma. However, for every extreme example of the failure of a family to provide the most basic care for their children, there are many other serious, though milder, cases.

There are three different types of task accomplishment problems: *basic*, *developmental* and *crisis*. These categories are not discrete and often overlap. However, they are useful distinctions to the extent that they can help us develop a treatment plan.

Basic tasks consist of the provision of food, clothing, shelter, health care and a minimal amount of supervision and nurturance. Families in which there is serious failure of basic task accomplishment tend not to present themselves voluntarily for family therapy, but are referred, often with coercion, by the child protection system and are sometimes court ordered.

Developmental tasks are associated with the growth of individuals or changes in a family's composition or situation. Examples are the changes necessitated by the birth of children, their entry into school, the onset of adolescence, the departure from home as grown-up children or the physical or cognitive decline of elderly parents. There may be problems navigating any of the 'transition points' described in Chapter 2. Certain families cope well at some stages in their development, but have difficulty at others. For example, development may proceed smoothly until the children reach adolescence, when major adjustments in family functioning may be needed.

Crisis tasks do not regularly or predictably occur in the course of family development and often present special challenges. Some families function well until faced with crises such as serious illness or death of a family member, job loss, migration from one culture to another or loss of the family home by disaster or foreclosure. Others seem able to deal well with a whole series of crises.

Basic, developmental and crisis tasks comprise a sort of hierarchy, in that if basic tasks are not performed well, it is unlikely that developmental or crisis ones will be. Similarly, families will probably not handle crisis tasks well if they do not handle developmental tasks adequately. However, the reverse does not necessarily apply. It does not follow that if crisis tasks cause a family difficulty, developmental ones will also do so, or that the failure to cope with developmental tasks is likely always to be associated with failure in basic task performance.

Developmental task accomplishment problems: a hierarchy of intervention

As there is a hierarchy of task accomplishment problems, there is also a hierarchy of intervention strategies. Severe task accomplishment problems that invite the attention of childprotective services usually require intervention across a number of contexts. For less severe problems, there is a range of direct interventions that can be used.

Assessing families' information and beliefs. Families tackling developmental tasks often lack information both about the transition that they are

encountering and about the support to apply it. While most middle-class families have ample access to information through the internet, books and community resources, at times they still find it difficult to apply what they know. For example, if a family has trouble adapting to an adolescent's striving for independence, this may result in an escalating pattern of increasing defiance by the young person. Then there may develop increasingly harsh discipline by the parents. In such a situation, a family therapist might ask the following questions to assess the parents' information and beliefs:

- What are your ideas about what Kyle is going through as he goes through these changes as a young teenager?
- How did your parents support you in making the transition from childhood into your teens?
- What have you done so far to shift your parenting to balance your need for reassurance and Kayla's need to spread her wings?

Such questions can be applied to other developmental transitions. As therapists build on the family members' responses, they can ascertain if they simply lack information about these somewhat predictable family transitions or have constraining beliefs (Wright, Watson, & Bell, 1996) that can inhibit them from adapting well. If the issue is simply an information deficit, it is often quite straightforward to refer the family to online information sites with reliable information about family functioning (e.g. the American Association for Marriage and Family Therapy's *Consumer Updates* at www.aamft.org), perhaps with the commitment to follow up in a therapy session.

Social support. When family members have appropriate information, but cannot seem to implement it, it is time to consider 'What has so far stopped the family making the changes they say they would like to make?' as suggested in Chapter 7. At times, clients may simply need social support. Clients may describe 'feeling alone' or 'not having anyone to talk to' about a problem or family transition. While offering social support is certainly part of what a family therapist has to offer, some clients may find it more beneficial to meet regularly with a self-help or support group. This can be thought of as an ecosystemic intervention as described in Chapter 12.

Some groups may offer parents the chance to share experiences with others going through the same difficulties, whether it is parenting an unruly adolescent, dealing with an 'empty nest' or adapting to the increased care needed by an elderly parent. With these families, a brief course of treatment or even a single consultation may be all that is required. Brainstorming with the family about how to implement necessary changes, and following up on and evaluating the results, may suffice. Some families simply require a direct approach to developing treatment goals and implementing concrete behavioural changes. Family therapists can conceptualize this as a way to support the family's capacities at problem solving or task accomplishment (Steinhauer et al., 1984).

Structural interventions. In situations where families are poorly organized to deal with development tasks, a *structural* approach may be useful

(Minuchin, 1974). Some structural family therapy techniques are designed to *create* new interactional sequences. For example, in *enactment*, the therapist guides family members to perform new patterns of behaviour, allowing the therapist to observe how family members interact and see how the problem behaviour is embedded in the interactional sequence of transactions. The therapist directly instructs family members to act in particular ways that are more useful. This disrupts existing patterns, testing the system's ability to adopt alternative, more functional rules.

In *boundary-making*, the therapist defines some interactions as open to certain members, and closed to others. For example, parents may disagree about the best way to permit a child to take responsibility for herself – one parent may be involved in 'micromanaging' the child's behaviour, while the other maintains a *laissez-faire* attitude. A family therapist might block the micromanaging parent from intervening, direct the less involved parent to take a more active role and coordinate this within the session. Boundary-making restructures the family, not only by directly changing family interactions, but also by changing the interaction rules of the system.

Crisis tasks

Crisis tasks do not regularly or predictably occur in the course of family development, and often present special challenges. The demands of the situation may exceed the family's coping resources and social support. Golan (1998) distinguished between a *shock crisis* (the result of a sudden event) and an *exhaustion crisis* (brought on by prolonged excessive demands), both of which lead to acute onset. Coping with crisis determines post-crisis functioning; families may decline in functioning, or they may evolve renewed, more effective family dynamics.

A crisis task often begins with a health emergency on the part of one family member, which in turn affects the rest of the family system. Carr (1995) described the dynamics of families in which a member has had acute myocardial infarction (AMI), which generally apply to a wide variety of health crises. Family members are physically isolated from the patient, but wish to be near the patient. Remaining at the hospital, families may also feel emotionally isolated. The practicalities of travelling to and from the hospital, securing child care and continuing to manage household tasks may be demanding. Moreover, family members may fear the patient's death or permanent disability. Many family members feel guilty that they could have prevented the crisis or wrack their brains to ascertain the cause.

Families may also need to adapt to new roles resulting from the reduced capacity of the patient after the immediate crisis and potential financial changes if the patient is not able to resume work the same way. Family members may have clashing beliefs about how to handle the issue and may disagree about decisions if the patient is unable to make them independently. A health crisis affects the entire family, so routine physical and emotional

needs may go unmet. This disruption in routine family functioning is likely to increase family and patient stress.

Adams (1991) articulated an 11-component model of brief family crisis intervention. This largely resembles the components of the family diagnostic interview described in Chapter 6, but is highly compressed due to the crisis nature of the interaction. These components do not necessarily have to be executed in sequence, but are intended to be covered in one long session, with subsequent follow-up:

- (1) *Determine who is in crisis.*
In the initial telephone contact, learn who is requesting the appointment and who suggested it. Whether the call was the idea of someone in the family, or outside the family, it is important to understand who experiences the situation as a crisis and to what extent.
- (2) *Determine the symptoms of each person in crisis.*
Ascertain the problems identified in the patient identified, including risk to self or others and any acute symptoms.
- (3) *Identify the hazard leading to the crisis, for each person in crisis.*
What is the specific event that led a loss or threat to the sense of self? Why now? What's new?
- (4) *Determine the meaning of the hazard (loss), for each person.*
How will the threat or loss, if actualized, affect each family member? This will provide the focus for the rest of the intervention. This may be different for each family member.
- (5) *Determine affective connections to the family's past experiences.*
Because crises are unfamiliar, usual coping strategies may be ineffective, which can promote a sense of helplessness. Asking about previous emotional connections (e.g. 'When in your life have you felt most like you have been feeling during this crisis?') can clarify the precipitants for a decline in family coping.
- (6) *Determine the relevant past coping resources, for each person.*
Ask family members to recall previous coping attempts. Even 'unsuccessful' attempts, if refined, can provide possible solutions.
- (7) *Determine components of the crisis that render past coping resources ineffective, for each person.*
The similarities and differences with previous crises can be used to develop solutions or avoid previously unsuccessful or unacceptable ones.
- (8) *Formulate the dynamic relationships among the present and past interpersonal and emotional aspects of the crisis for the family.*
What is the interrelationship between the factors described by the family?
- (9) *Provide family members with a cognitive grasp of what has happened.*
State your formulation to the family, so all members can understand it. Families in crisis are usually open and can benefit from

a clear account of how all the relevant factors in their situation fit together.

(10) *Support affective integration of what has happened.*

While it is useful for clients to come to an intellectual understanding of the crisis, it is also important to support them to express their emotional reactions to the crisis.

(11) *Mobilize family members' coping resources.*

The family therapist supports the family's efforts to resolve the situation, guided by their intellectual and emotional understanding of the crisis. Provide information and guidance to seek additional social supports, make concrete changes and plan for the future.

Serious basic task accomplishment problems

Families with serious task accomplishment problems typically come to the attention of family therapists through child protection authorities. These families, who are often labelled 'multi-problem', present some of the greatest challenges for family therapists. Madsen (2007), referring to them instead as 'multi-stressed families', reports that family therapists often experience difficulties in their therapeutic relationships because of the family's difficult behaviour; the erosion of therapists' feelings of competence and sense of therapeutic direction; a loss of hope; and reduced work-life balance. Indeed, treating families with multiple stressors can feel overwhelming.

Madsen (2007, p. 22) recommends that family therapists who work with multi-stressed families adopt a position as an *appreciative ally* – characterized by 'a spirit of respect, connection, curiosity, and hope'. Professionals often describe 'multi-problem' families as 'resistant'. As an appreciative ally, it is useful to view the situation from the clients' perspective. Some clients do not acknowledge that there is a problem. In this situation, it is useful to join with the client by listening with curiosity and be a good host.

Clients referred by statutory bodies may feel they are treated disdainfully by 'the system' (and at times they may be right!). It is useful to commiserate with clients, affirming that you 'understand how you could feel that way'. It is also helpful to listen carefully for clients' intention to do better; descriptions of desire about preferred outcomes (keeping in mind that it is necessary to transform desires, hopes or wishes into goals; see Chapter 7); or acknowledgement that they need to change. It is useful to compliment clients on appropriate aspects of their behaviour or intentions. It is usually not useful to attempt to convince clients of the need for change.

Clients who perceive a problem, but see it as outside of their control, should be approached empathically. Family therapists should be watchful for evidence of change and listen carefully for what the client is motivated to change and perhaps even passionate about.

It may be useful to ask clients how they cope with the present situation, which can invite conversation about how they actually do have some

influence over the problem. Asking them to describe what is different when things are better without implying that they *should* change may also do the same. Look for the positive intention behind complaints. For example, Madsen (2007) describes his work with a father who complained about his son's foul mouth, which Madsen reframed into the father's desire for his son to grow up to be a respectful man. Keep in mind, however, that these conversation starters are not strategies to get clients 'to see the light', but an intentional way to position oneself to respect the client.

Madsen makes an important distinction: The 'reluctant' or 'resistant' family is not the problem; it is the family's position with respect to the problem. Additionally, it is immensely helpful to start small, focus on family strengths, get to know the family apart from the problem(s), and attend to what family members are willing and able to do. Members of families with basic task accomplishment problems often evaluate themselves poorly, readily feel criticized and are easily threatened by authority figures, so the approaches described here may help diffuse their defensiveness. They may not have achieved the *basic trust* in the world as Erikson (1965) described, so trust is often a major issue.

Whether family members do not acknowledge problems or feel powerless over them, *positive connotation* of their motives, however unfortunate the consequences, can be helpful. Few parents, for example, deliberately harm their children. Their attempts to care for them, though, may fail for many reasons, some of these residing in their own life experiences and personality limitations. The actions of parents who yell at their children in a demeaning way or physically punish them to the point of serious injury can be connoted as an attempt to train their children to behave well. These are unsuccessful, even harmful, attempts to be sure, but they may be the best choices parents can make at a given time.

In Chapter 3, we suggested that thinking about constraints – *What prevents family members from behaving otherwise?* – is more useful than focusing on causes – *Why do they behave as they do?* Parents' histories, personalities, emotional states and current circumstances all place limitations on the choices they are able to make. Many parents who fail to provide for the basic needs of their children expect to be blamed or criticized. They may have a strong sense of guilt about what has happened. They do not expect to meet someone who positively connotes their intentions by saying that they obviously care a lot about their children, enough perhaps to go to extreme measures to bring their children's behaviour under control. They need to experience the therapist as someone who is on their side and wants to understand what has happened and how they can get out of the dilemma they are in.

Therefore, by attributing good intentions to whatever the family members have done, we can establish ourselves as being there to help, not criticize. Once this has been achieved, it may be possible to use a direct approach to meeting the family's goals. A direct approach may not succeed, but it may be the first time the family members have given serious thought to how

they might overcome their task accomplishment problems. Many prove to have resources they have not used, resources of which they may have been unaware. While no one approach is uniformly successful in family therapy, if direct methods have not been tried previously, it is usually best to start by using them. If they are not successful, any of the strategic or other special approaches described in later chapters may be required.

Communication problems

Clients often conceptualize family problems in terms of communication problems: 'We have trouble talking'; 'We simply don't seem to be on the same wave length'; or 'We just can't seem to get through to each other'. Communication theory as a theoretical foundation for family therapy was discussed in Chapter 3. As part of the assessment process, we note both the family's verbal and the non-verbal communications, and discrepancies between the messages sent via each of these two channels. We must also consider the clarity, directness and sufficiency of communications, both verbal and non-verbal, and the availability and openness of those to whom communications are addressed.

In the following case example, the failure of communication, especially between the father and the other members, became obvious when it emerged that the father knew little of what went on in the family. The information passing between Harry and the rest of the family was certainly not sufficient, although when the family members did speak to each other they did so with a good degree of clarity. There was, however, a tendency for communication to be indirect, with Frances acting as a sort of telephone exchange. She seemed to have freer communication with the remainder of the family than anyone else did, and she did not appear afraid to tell her father things which might upset him or at least which the other two members of the family thought might.

Frances (10) and George (8) attended with their parents, Harry and Irene. Irene was a homemaker, while Harry had a job that took him away from home 4–5 months of the year, with individual trips lasting up to 6 weeks.

The presenting problems were George's severe temper tantrums and Irene's reported inability to control him, to the extent that she was fearful that he would do her serious physical harm. George had been referred to the emergency department because of a severe outbreak of violent behaviour at home a few days previously, while his father was away.

When the history of George's temper attacks was explored, Harry, who had returned home early because of George's admission to hospital, said they were a new phenomenon, of which he had just become aware. Frances, however, chipped in, saying that George had been losing his temper for at least 2 years. 'But my Mum doesn't tell my Dad because she's afraid he'll hit

George, and he doesn't lose his temper when Dad's at home'. I turned to Irene, who confirmed that Frances' statement was true. I then asked Harry if he had been aware of what had been going on when he was away. He said he had not been. Irene then admitted that she had been afraid to tell Harry about George's behaviour at home and about behaviour problems the school had reported.

During the remainder of the interview several other pieces of information emerged of which Harry, and in one case Irene, had been unaware. For example, the children agreed that when George was worried about something; the only person he would confide in about his worries was Frances. Neither parent had been aware of this, nor did they seem to realize how close the relationship between George and Frances was. Frances, it also emerged, confided freely in her mother, but neither child ever confided in Harry.

This family was treated using direct methods. They had never given much thought to how information was communicated within the family, and when this was discussed, they became interested. Initially, we worked on the communication problem in session. At the very first session, when Irene's failure to keep her husband informed about their son's behavioural problems emerged, there was progress towards resolving the difficulties. Harry did not react in the way Irene had feared he would. Instead of becoming angry and threatening, he expressed concern about the situation, and regret that he had not been more involved in the family. The family 'myth', that father would become angry, perhaps even violent, if he was told what was going on, was exploded.

With the therapist's encouragement, the other family members proved willing to share with the father the important facts about what had been going on. A *same-sex parenting programme* was also prescribed. Irene was put in charge of Frances, so that Frances was to come to her with any issues or requests; similarly important information the parents wished to communicate to Frances was to be told to her by her mother. Harry's role was that of a consultant to Irene, who was to consult him when she needed a second opinion on matters concerning Frances. Harry could also offer unsolicited advice, but Irene was to make final decisions on matters concerning Frances.

When this had been explained to the parents and to Frances, and they had agreed to follow the prescribed plan, I turned to George. However, before I could say anything George pointed to his father and said, with a smile, 'So that leaves me with him'. 'Yes, it does', I replied, and went on to explain that Harry's role in relation to George was to be exactly analogous to Irene's in relation to Frances. Harry accepted this readily, and George seemed quite delighted, though he could not bring himself actually to say so.

This quite direct intervention was designed to serve several purposes. It was aimed at altering family members' roles (an issue discussed later in this chapter), and it was intended to promote increased communication between Harry and his son, as well as between the parents, who would need to consult with each other on issues concerning their children. It was also a structural

intervention, aiming to get Harry more involved in the family and to break down the boundary between him and the rest of the family.

Finally, during this session, I asked the parents to set aside 10 minutes before they went to bed each night to discuss how the same-sex parenting programme was going and to ensure that they were keeping to the plan as agreed. This would also provide time for them to exchange any information about the children that they had not been able to share earlier in the day.

This was a lot of work to do in a single therapy session, but I felt I had been able to establish good rapport with the family. All members seemed well motivated, even desperate, for help. In other cases, it might have been necessary to spread the work done in this one session over several sessions. In the event the interventions were successful and only four therapy sessions were needed.

In the above family, communication, though insufficient, was usually clear when it occurred. In many families with problems, however, this is not so, and communication is either ambiguous or vague, or conflicting messages are given simultaneously.

Building communication skills

Whichever assessment scheme you use, you will notice if communication is direct or indirect, clear or masked (by irony, sarcasm or withholding), and the domains in which communication is more or less effective (instrumental or affective). You will likely also be able to see the tangles into which family members get themselves because of their communication missteps. Sometimes you will observe interpersonal patterns of interaction. For example, you may observe double bind communication, as described in Chapter 3. In double bind communication, messages sent in the digital channel contradict those sent in the analogic channel. For example, the verbal statement 'I love you' is contradicted by body language or emotional tenor that says the opposite. Another kind of contradiction occurs when one family member, requesting change from another, says, 'I want you to do it (i.e. the requested behaviour change), but I want you to really want to do it'. Here, even if the requested change is made, it is disqualified because the one making the change does not 'really want to' do it because it is a response to the other's request.

While, in some families, these patterns of interaction are entrenched, and require indirect interventions described in the next chapter, direct training in communication skills is often the simplest approach. There are myriad published approaches, emerging from behavioural approaches to couple therapy (Jacobson & Margolin, 1979; Stuart, 1980). In these approaches, *communication* is seen as one core component, along with *problem solving* and *behaviour exchange* (increasing the frequency of desired (by the recipient) caring behaviours). Based on modelling approaches based on learning theory described in Chapter 3, the therapist provides direct instruction of communication skills, for example: listening attentively; reflecting or summarizing

accurately; delivering clear non-blaming 'I' messages; being congruent in affect, body language, and verbal content (McKay, Fanning, & Paleg, 2006).

Generally, this is done by delivering a brief overview of the skill and its importance, modelling the skills, having the couple practice the skill, providing feedback and giving homework to practice. We will review these in Chapter 14.

We can also help promote better communication by appropriate modelling. It is important that our own communications are sufficient, clear and direct. A model of frank, open communication, in a context of emotionally warm relationships, characterized by courtesy and respect, can be of real value to many families. It sometimes happens that after a few sessions family members begin to adopt some aspects of their therapist's style of communicating.

Poorly defined and dysfunctional role patterns

As discussed in Chapter 5, families are apt to develop problems if the functions they must perform are not properly allocated or carried out. In most families, parents should take responsibility for the children by providing the necessities of life and giving the child love, emotional security and the feeling of being a worthwhile person. Parents must also provide sound role models for living in the society of which parent and child are members.

Children's roles depend on their ages. Normally developing children become progressively less dependent on their parents as they get older. Depending on cultural norms, they should take increasing responsibility for instrumental tasks within the household and, by adolescence, should play a substantial part in running it. Emotionally, too, children normally become more independent with increasing age. When adolescence ends, with emancipation from the family of origin, they should be relating to their parents more nearly as equals. Parents' roles change in a reciprocal way as their children mature.

Role performance problems exist when appropriate roles are either not allocated or, if they are allocated, not properly performed. During expected developmental transitions when family members adapt well, they usually reallocate roles without a great deal of trouble. However, difficult developmental transitions or unexpected events can trigger problematic patterns of interaction that give rise to the misallocation of roles. We will now focus on two particular family situations in which role allocation may be disrupted: conflictual separation, divorce and co-parenting; and families experiencing differential acculturation.

Conflictual separation, divorce and co-parenting

In 2004, there were 69 600 divorces in Canada. At then-current rates, almost 38% of those who married in 2005 will divorce before their 30th anniversary.

Although between 95% and 98% of divorces with children are not disputed in court, this does not necessarily mean that all is well with children's adjustment or parents' interactions, post-divorce.

The body of work by Wallerstein (Wallerstein & Kelly, 1996; Wallerstein & Lewis, 2007) indicates that most children survive divorce adequately and do not require any form of treatment. On the other hand, both children and adults in families experiencing divorce are more than twice as likely to seek mental health treatment as are the members of families with no parental separation. Moreover, one-quarter of children of divorce exhibit significant problems, as opposed to 10% of those from the so-called intact families (Ahrons, 1994; Hetherington, Bridges, & Insabella, 1998; Lebow & Rekart, 2007).

To a large degree, the field has focused on the effects of high-conflict divorce on children. Pre-separation conflict presages post-separation conflict, which is the strongest predictor of children's post-separation adjustment. It is clear that children are harmed by conflict between their parents in a difficult divorce (Boyan & Termini, 1999; Ehrenberg, 1996), which undermines the relationship between children and between one or both parents (Elrod, 2001). Apart from interparental conflict, other contributors to poor post-divorce child adjustment are economic decline, confusing or changing parenting schedules, adjustment to parents' new partners, relocation, less time or separation from the non-custodial parent, and a loss of steady parental support and contact (Kelly, 2002).

In less severe high-conflict cases, the parents may settle into a regime of *parallel parenting*. Parents parent differently from one another and have little or no communication. What communication exists is strained, if not frankly conflictual. The parental subsystem is simply not working. Even when the parenting of each parent, individually, is adequate, having siloed lives is problematic for children. They are often a conduit for parents' communication. An older child may feel responsible for the practical details of transfers of care, pick-up times or special events, or for tending emotionally to younger siblings.

In more serious cases, interparental conflict is more active. It may take the form of open conflict, which is naturally upsetting to children. In these cases, each parent may try to justify their behaviour or denigrate the other parent. Children, especially pre-teens who are unable to manage the cognitive dissonance of hearing their parents espouse entirely different positions, are prone to feel divided loyalties or pressure to choose one parent over the other.

Rather than nurturing children and supporting their development, consciously or unconsciously, parents are serving their own needs. In extreme cases, one parent intentionally villainizes the other. In the so-called resulting *parental alienation syndrome* (Gardner, 1998; Kelly, 2002), children exhibit intense dislike of one parent, openly denigrate him or her, heap unrealistic praise on the other parent and refuse contact or communication with the target parent, with unrealistic justification for either (Boyan & Termini, 1999).

The suprasystem in high-conflict divorces often exacerbates, rather than helps families. The legal system in countries based on English common law defines parents as adversaries. Legal processes such as placing evidence before the court by way of affidavit or testimony, cross-examination and disclosure can exacerbate conflict and ‘tit for tat’ interactions. Well-meaning (and not so well-meaning) lawyers may stimulate conflict and vicious cycles of interaction between the parents by asking their clients to collect evidence about the inappropriate conduct of the other parent, which in turn precludes them seeing any evidence of change in the other parent.

Recently, Wallerstein and Lewis (2007) analysed 25 years’ worth of post-separation longitudinal data from 60 families with 131 children. These families did not experience particularly high-conflict divorces, and the children did not exhibit pre-existing academic, emotional or behavioural problems. In one-half of the families, however, children experienced widely disparate parenting from at least one parent. There was no consistent birth order or gender pattern; in fact, the children retrospectively cited idiosyncratic factors like reminding a parent of the former spouse or not sharing interests with a parent.

Wallerstein and Lewis note that this disparate parenting led to ‘widely discrepant psychological adjustment’ (p. 226) in the now-grown children. They also note that the earlier assumption that siblings in post-divorce families receive much the same quality of parenting is not valid.

Discrepant acculturation

Industrialized countries draw many immigrants from the world over. In the United States, one out of six people is foreign born and one out of four is the child of foreign-born parents (Falicov, 2003). Many immigrants experience ambiguous loss – sadness and dislocation – in leaving familiar surroundings and supports, juxtaposed with hope for better opportunities. *Acculturation theory* suggests that immigrants leave behind their original culture and language for the culture and language of the host country.

However, several studies found that immigrants who leave too much of their country of origin behind have more psychological symptoms and drug use than those who stay somewhat connected to their language and cultural practices (Escobar, 1998). Moreover, problems like substance abuse, unplanned pregnancy, intimate partner violence and gang involvement are more common in the second and third generations than in the immigrant generation (Padilla-Rafalsky, 1994). The first generation’s connection to their original cultural identity likely provides a protective factor less available to subsequent generations.

In some immigrant families, adolescents desire to affiliate more strongly with the host country’s dominant culture than their parents prefer. The parents, on the other hand, wish to preserve their children’s connection to the culture and traditions of their country of origin. While dilemmas like this are common, if not moderated, they can give rise to interpersonal patterns that

identify the young person as ‘disobedient’ or ‘disloyal’. Another common dilemma occurs when women stay isolated at home and do not learn the language of the host country or conversely experience freedom unavailable to them in the country of origin, both of which may invite marital strife. When children translate for parents or become their principal guide in the host culture, this can disrupt the family hierarchy. At times, this can become problematic (Ferguson, Bornstein, Pottinger, 2012).

Idiosyncratic family roles

Symptoms often develop in family members who are cast, because of the nature of the family system, into idiosyncratic roles. The two particular family configurations described above provide particularly fertile ground for the development of such idiosyncratic roles.

The family scapegoat. This is probably the idiosyncratic role about which most has been written, though the term seems to be used less nowadays than it was in the earlier days of family therapy. It was first described, in relation to family functioning, by Vogel and Bell (1960). The term has biblical origins. The use of a scapegoat was one of the procedures laid down by Moses for use by the people of Israel. The priest was to lay his hands on the head of the goat and ‘confess over it all the iniquities of the Israelites and all their acts of rebellion, that is all their sins’. Having laid the sins on the goat’s head, the goat was to be sent into the wilderness, ‘to carry all their iniquities upon itself into some barren waste’ (New English Bible, 1970).

In the family therapy literature, *scapegoat* is used a little differently. The scapegoated family member, often a child with symptoms, appears to act as the person onto whom all the family’s problems are projected, but is usually maintained in the family system rather than being sent out into a ‘barren waste’ (Sometimes, though, the scapegoat is placed in an institution, which presumably plays that role.). Some families seem to depend on having a ‘bad’ child or parent for their often precarious stability; in this regard, ‘stable’ is not to be confused with ‘adaptive’ or ‘healthy’. Labelling an adolescent or young adult as disloyal to a family’s culture, actively denigrating the one’s former spouse in front of the children or treating a child harshly because he is ‘just like his father’ are some examples.

The parental child. *Parental child* is another idiosyncratic role. It is sometimes appropriate to give older children some responsibility for the care of younger ones, but if too much responsibility is given, especially if the delegation of authority is not explicit, the child may be unable to function as required and may develop symptoms. In high-conflict divorces, a child may tend to the emotional and practical needs of siblings or, more subtly, acts as an emotional caregiver for a parent perceived to be victimized by the other parent (Skynner, 1976, p. 417). A child from an immigrant family may end up the *de facto* head of the household if the parents are not fluent in the language of the host culture or savvy about day-to-day life skills.

Other special roles. These include the roles of *martyr*, *family angel*, *sick member*, *handicapped member* and *disturbed or crazy member*. The martyr perpetually sacrifices his or her interests for the good of the family. The *family angel* (Gross, 1979) sometimes plays a role that complements the scapegoat, as someone others can agree upon.

Sometimes the adoption of special roles by one or more members enables the family to function without obvious problems, but this may be at considerable cost to those in the special roles. Not all special roles are undesirable, however, and we must take care to understand the function that each one has in any family we are treating. It is necessary also to discover whether the pattern of role performance is related to the problems for which the family is seeking help.

Treatment of role performance problems. Often, direct interventions that permit the individual to cease performing his or her role are effective. Once the problems have been identified, the therapist and the family may be able to agree upon how family members' roles should change. In so doing, it can be helpful to start with the historical development of the dysfunctional roles. These may have had useful purposes at one time, but have outlived their usefulness or have even become inimical to healthy family functioning. The therapist then negotiates with the family members for them, or some of them, to play different roles. An example is the 'same-sex parenting' procedure mentioned above. It is a way of enhancing, and making more appropriate, the roles of parents. It may be a useful intervention when there are one or more parental children; when there is enmeshment between parent(s) and child(ren); or when there are deficient behaviour control mechanisms. Kirschner and Kirschner (1986, p. 35), in their description of 'optimal family process', stated:

The same-sex parent (SSP) tends to function as the primary programmer and disciplinarian. The SSP promotes maximum ego development by setting limits as well as progressively higher level goals and standards intrinsically suited to the child's unfolding skills and talents. The SSP uses rewards and discipline, education, inspiration, and modeling to help the child to attain these goals. The opposite-sex parent (OSP) functions primarily as the facilitator or mediator within the triangle If the SSP disciplines a misbehaving child in an inappropriate fashion, the other-sex parent (OSP) takes responsibility for correcting the interaction In a manner that creates a satisfactory rapprochement, the OSP is stable and loving and points out that the SSP still loves the child.

Behaviour control problems

The behaviour of one or more family members is the presenting problem in many families seeking therapy. Children and adolescents often draw the attention of referral sources for *externalizing disorders* – various forms of non-compliant, antisocial and aggressive behaviour. Usually, these fit

the diagnostic criteria for *conduct disorder*, *oppositional defiant disorder* or *attention deficit-hyperactivity disorder*, which are among the commonest child psychiatric disorders, although these terms do little more than describe certain patterns of behaviour. Children to whom these labels are applied have failed to learn the types of socially acceptable behaviour expected in their families and/or the wider social environment. Conduct disorders usually start as behaviour control problems in the children's families (Barker, 2004).

Styles of behaviour control. Various behaviour control styles – rigid, flexible, *laissez-faire* and chaotic – were described in Chapter 5. Although in reality there is an infinite number of ways in which family systems may be organized, this is a useful framework for conceptualizing behavioural control in families. It is also useful to remember that children may have particular needs, based on individual capacities and temperament, for which a particular style is more effective. The *fit* between style and individual need is important to consider.

Structural approach to behaviour control. Whether the parents work together is also an important determinant of effective behavioural control of their children. If we take a structural view of family functioning, families require clear subsystem boundaries with a well-defined parental system, adequately in touch with, but also distinct from, the child system.

Generally speaking, families require well-functioning spouse, parent and child subsystems. There should be clear, but not unduly rigid, boundaries between the subsystems. In large families, there may be more than one child subsystem, and there may also be a grandparental subsystem. The existence of a suitable hierarchy between generations is something that Haley (1976) emphasizes.

Yet there is no 'normal' or universally ideal family structure. The important questions are, *Does this family structure work without anyone suffering or developing symptoms?* and *Does it provide for the healthy growth of the family and its members?* Giving a child parental power can, as we have seen, cause problems, but it can also be appropriate, at least in some measure, in large families, or families where a parent (perhaps by virtue of disability or language or culture barriers) is poorly equipped to deal with family demands. In many AIDS-devastated countries, including those in sub-Saharan Africa, there are families in which both parents have succumbed to AIDS, so that children, some as young as 10 or 11, are left heading families. It is remarkable how well some of these children cope.

In structural therapy, the therapist works on the boundaries between systems and subsystems, promoting communication and emotional interchange where it is inadequate (as in disengaged relationships); and help erect barriers and create a necessary sense of separation, where there is undue enmeshment.

Behavioural parent training. Child behaviour problems can also be seen as the result of parents' deficits in behaviour management skills. Behavioural parent training has been around for over 40 years (Becker, 1971; Patterson,

1971). As the name implies, it consists of teaching parents principles of learning theory (e.g. reinforcement, punishment, extinction, time-out from reinforcement) and how to apply them with their children. When working with parents, a skill training approach is used, in which the therapist models the skills, asks the parents to emulate the modelled skill, gives behaviourally specific performance feedback and assigns homework. Dishion and Stormshak (2007) embed parent training in a comprehensive ecological approach to child and adolescent mental health services.

Although behavioural parent training as a stand-alone procedure targets the parents, it can bring about systemic change. For example, when parents can provide verbal reinforcement to their child in a matter-of-fact way, the pattern of interaction changes and the parents' capacity for behavioural control increases. If parents work together to implement their new skills, the parental subsystem is strengthened. When a parent can prompt a child about inappropriate behaviour calmly, the child is more likely to respond in a complementary pattern of compliance, as opposed to a symmetrically escalating pattern of defiance and yelling. Systemic change follows individual or subsystem change.

Delivering direct injunctions

Direct injunctions, or instructions given to clients to change their behaviour directly, are an important part of the treatment approaches discussed in this chapter. How families respond to them depends largely on their delivery. Good rapport with the family is an essential prerequisite, but attention to the following points increases further the likelihood that direct injunctions will be well received:

- (1) Make the instructions as precise as possible. Thus, rather than saying, 'Be kind to X' or 'Don't be rude to Y', say more precisely what the person concerned should do to be kind or to avoid being rude.
- (2) Use positive, rather than negative injunctions. It is better to give instructions for 'being polite' rather than for 'not being rude'.
- (3) Enlist other family members, when available and when it is appropriate, to remind the subject(s), in a calm, non-critical and non-judgemental way, of the injunction. Also, ask other family members to notice behaviour changes.
- (4) Use the force of your personality. Convey your enthusiasm for the plan of action you are putting forward and your conviction that it will work. Another application of therapists' own personalities is the use of hypnosis, which seems sometimes to increase people's suggestibility, as well as helping convince themselves that they *can* do what they are being asked to do.
- (5) Consider setting up a system of rewards or punishments, preferably rewards. This can be appropriate for children, but even parents and other adults, can be told to reward themselves, perhaps by going out to

- dinner together, or perhaps just by exchanging a few words of approval or praise, for successful implementation of the treatment programme.
- (6) Whenever possible tell clients to do something different rather than to stop doing something. The ‘different’ thing must be incompatible with the behaviour that you wish to discourage. Thus, it is better to tell people who are talking rudely to others what they *should* be saying, rather than what they should *not* say.
 - (7) Tell clients to do things in a different sequence. This can be effective in disrupting established, dysfunctional patterns of behaviour, for example, between spouses or between parents and children.

Summary

Some common family problems can be treated by direct methods of intervention. A direct approach can be successfully used with task accomplishment problems, communication problems, problems of role assignment and performance, behaviour control problems and structural problems – that is, those involving poorly functioning subsystem patterns. Problems in several of these categories, or even in all of them, may co-exist.

The first step in using direct methods of treatment is establishing rapport and a trusting relationship with the family. The problem or problems are then made explicit, and a plan of action designed to overcome the problems is then suggested or worked out with the family.

There are several ways to increase the likelihood of direct injunctions being taken up. Instructions should be precise, positive rather than negative, and delivered with conviction. Rewards for compliance may help. Family members may offer reminders to each other and altering the sequences of behaviours may be useful too.

Direct interventions involve ‘first-order’ change and this is not always sufficient, especially in the more seriously troubled families. In these cases, other approaches are needed. These are often indirect and part of a strategic plan, which we describe in the next chapter.

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Chapter 11

Complex Problems and Second-Order Change

The direct interventions discussed in the previous chapter may be effective with some families. They promote *first-order change* or simple behavioural improvement. However, more severe problems require a change of perspective and a more fundamental change in the family system. The family's situation, or some aspects of it, must come to be looked at differently and understood in a new way.

The approaches described in this chapter are designed to facilitate second-order change. They operate either by *changing interpersonal patterns of interaction* or by *changing meaning*. These approaches mainly come from *strategic therapy*, *Ericksonian therapy*, the *Milan systemic* approach, *solution-focused therapy*, *narrative therapy* and *collaborative language systems*. Some have common roots, apparently similar techniques, and are related or are precursors to others. Moreover, few family therapists practice purely one particular approach to therapy, instead of integrating concepts and techniques from several models. Several publications compare and contrast these approaches or describe integrations of them (Chang, 1998; Chang & Nylund, 2013; Chang & Phillips, 1993; Eron & Lund, 1996; MacKinnon, 1983; Monk & Gehart, 2003; Real, 1990; Selekman, 2008).

Interrupting problem patterns

Family problems can be conceptualized as embedded in cybernetic patterns, which are maintained by the coherence of the family system. The intervention techniques described in this section are designed to interrupt problem patterns.

Paradoxical injunctions

Paradoxical injunctions are directions or suggestions that family members continue their symptomatic behaviour in some way. Paradoxical interventions hand responsibility for the symptom over to the family. They can be used when families take a confrontational position with the therapist. There is seldom much to be gained from engaging in a symmetrical dispute with

clients. When such a situation exists or threatens to develop, a paradoxical approach may prove fruitful.

Frankl (1960) developed the technique of replacing efforts to extinguish symptoms by intentional, even exaggerated, efforts to carry out the symptomatic behaviour. He called this 'paradoxical intention'. Paradoxical techniques have also been described, with examples, by Watzlawick, Weakland, and Fisch (1974), Fisch, Weakland, and Segal (1982), Barker (1981) and Weeks and L'Abate (1982), among others.

In *Paradox and Counterparadox* (Palazzoli, Boscolo, Cecchin, & Prata, 1978), the Milan associates described a variety of paradoxical interventions they used with the families. 'Symptom prescription', a particular type of paradoxical injunction, is the term O'Hanlon and Hexum (1990) use to describe much of Erickson's work.

Weeks and L'Abate (1982) recommend using paradoxical techniques 'when a family and/or any of its subsystems is in a developmental crisis' (p. 58). They also describe some 'dysfunctional transactions where paradoxical intervention appears especially appropriate' (p. 60):

- (1) Expressive fighting and bickering. Members of a system relate to one another overtly by fighting. Weeks and L'Abate suggest that therapists who attempt to deal with such families in a straightforward way will find themselves at odds with them.
- (2) Unwillingness to cooperate with each other and complete assignments. This is a more passive and subtle way of expressing hostility. Such families may express verbal compliance with one another, but defeat each other non-verbally. There is often one marital partner who is more verbal and articulate than the other and who defeats the other by continuous complaints and diatribes. On the other hand, the second partner is more skilled non-verbally and achieves defeat of the first by non-verbal means.
- (3) Continuation of the same patterns in spite of all types of intervention, as seen in 'rigidly resistant' families.
- (4) 'Divide and conquer', the term used by Weeks and L'Abate for the situation, often seen in families in which there are teenagers skilled at separating the parents and exploiting any polarization there may be in the marriage.
- (5) Using disqualifying communications, such as self-contradictions, inconsistencies, subject switching, metaphors (which can be used by clients to avoid defining or facing issues directly) and making cryptic statements.

As with other strategic techniques, the use of paradox presupposes that the therapist and the family have agreed upon a desired outcome. The family should also be actively engaged in the therapy process before using these techniques. Weeks and L'Abate (1982) put forward 'basic principles' for using paradoxical methods, which are applicable to individuals as well as to couples and families:

Principle one. New symptoms are positively relabelled, reframed or connoted. The value of reframing and positive connotation to use symptoms to a positive effect will be discussed below.

Principle two. The symptom is linked to the other members of the family. Family therapy is based on understanding the relationship context of the clients' symptoms. Positively connoting the intent behind symptoms is often an effective way of putting symptoms in such a context.

Principle three. Reverse the symptom's vector, putting those concerned in charge of the symptom. With individuals, this involves the intentional enactment, or even deliberate amplification, of the symptom. With families, reversing the vector can be achieved either by having other members help the symptom-bearer have the symptom or by having the other members play a paradoxical role. As an example of the latter, Weeks and L'Abate (1982) discuss the case of a single-parent family in which a daughter is acting out and taking charge. To reverse the vector, the mother might be told to assume the role of the child, giving up her position of authority and pretending to be a helpless child. Such measures place the people concerned in charge of the symptom or symptoms, which is the first step towards bringing about change.

Principle four. Prescribe and sequence paradoxical interventions over time in order to bind off the reappearance of the symptom. Weeks and L'Abate (1982) suggest this sequence:

- (1) Positive relabelling, reframing or connotation
- (2) Symptom prescription
- (3) Predicting a relapse
- (4) Prescribing a relapse

Prescribing a relapse, in families who respond 'negatively' to injunctions, is of course a way of preventing relapse.

Principle five. The paradoxical prescription must force the client(s) to act on the task in some way. Good rapport is a basic requirement for ensuring that therapeutic prescriptions are carried out; in addition, they may be ritualized, for example, by prescribing them in a fixed sequence or by laying down that whenever event X occurs, the client is to have the symptom. Paradoxical prescriptions can also be put in writing.

Haley (1976, pp. 72–75) suggested eight steps in giving paradoxical directives:

- (1) A relationship must be established with the client(s), which should be defined as one directed to producing change.
- (2) The problem must be clearly defined.
- (3) Clear goals must be set. The therapist must understand precisely the changes the directive is designed to bring about.
- (4) A plan must be offered. It is helpful to offer some rationale for the paradoxical directive. This may be that it is necessary to continue with the symptom, or even increase its intensity, because to abandon it

would be 'too risky' or 'too difficult for the rest of the family'. For example, a 13-year-old boy and his stepmother were told that it was essential that they express their hostile feelings towards each other, since 'bottling them up' would create too much tension in them both. At the same time, a specific 15-min time each day was agreed for the expression of these feelings.

- (5) Anyone who is an authority on the problems must be disqualified. One way is to suggest that the person would be upset if the symptom disappeared. Another is to praise that person's self-sacrifice, but suggest another area of the subject's life where self-sacrifice would be more important. In the case above, the stepmother initially raised objections to the plan, saying that she did not believe in children and their parents insulting each other. It was, she said, against the principles she lived by. Her views were commended as praiseworthy, and the therapist said that he too did not believe in this sort of thing. He realized that it seemed crazy to encourage undesired behaviour, but it was important for him to know how the experiment would work out, in order to plan further treatment. He complimented the stepmother on her willingness to consider compromising her principles for this purpose, whereupon she agreed to take part in the suggested plan.
- (6) The paradoxical directive is given. In the case of the boy and the stepmother, they were to meet at a set time every day when each would say what he or she disliked in the other, and how the other person had irritated or annoyed him or her during the previous 24 hr. They could be as frank and insulting as they chose. However, such matters were only to be discussed at that time. If the son and stepmother were tempted to discuss them at other times, they were to postpone doing so until the set time.
- (7) The response is observed and the therapist continues to encourage the undesired behaviour, especially if the behaviour shows signs of improving. The therapist's pleasure at this turn of events should be hidden, and doubt expressed whether the improvement will continue. In the case mentioned above, there was a rapid improvement, but the therapist warned that it might not continue.
- (8) The therapist should not accept credit for the change as it occurs. Puzzlement is often better, combined with scepticism that the changes that have occurred are real and will continue.

There is often an element of challenge in paradoxical directives.

A simple, and often effective, example of the use of paradox is *symptom prescription*. The case of the mother and son who were told to meet together for 15 min daily, mentioned above, is an example. Another was described by Hare-Mustin (1975). This was the case of a 4-year-old with frequent and unpredictable temper tantrums. The therapist negotiated with the child and his family where the tantrums should occur, picking a safe place at home.

If the boy started to have a tantrum, he was to be taken to that place, the 'tantrum place'. By the next session a week later, Tommy had had only one tantrum, so the therapist then said it was necessary to decide what time the tantrums should take place. The period 5.00–7.00 p.m. was agreed upon. As expected, it proved hard for the child to have tantrums to order and they soon ceased.

It is also possible to prescribe that a symptom occurs during a therapy session. In most cases, the symptoms are not produced under these circumstances. This was so, for example, in the case of William, aged 8, and described at greater length elsewhere (Barker, 1985, pp. 30–32).

How and why do paradoxical directives work? It seems that an important factor is the taking over of the symptom by the therapist who, instead of attempting to stop it, is perceived by the client(s) as encouraging it, at least in certain circumstances. This is a new situation for the individual or the family, and it evokes a new response. This disturbs the family's homeostatic processes, so that some change in their way of functioning becomes necessary. O'Hanlon and Hexum's (1990) account of Erickson's work contains many elegant examples of the use of symptom prescription.

It is worth noting that in the case below, I (PB) implicitly reframed the family situation. I was presented, after the son had been used as an 'admission ticket', with a rebellious teenage girl as the problem and was, it seemed, expected to 'do something about it', even though the parents had already tried 'everything'.

To enter into treating the family on this basis is a recipe for failure. So, I reframed things so that the issue became the parents' problem. This was realistic. The daughter was quite happy living in her free hotel, and from her point of view, there was no need to make any changes. She did not even deign to come with the family to see me. If there was to be a change, the rest of the family had to make a move and it was through a paradoxical intervention that they were enabled to do so. Note, too, that the problem was that of overcoming a developmental hurdle – that of letting the daughter leave the nest and become an independent person in society – a situation in which paradoxical methods seem to have particular application.

A family came to me with complaints about the antisocial behaviour of their 13-year-old son, but actually talked about little except their 19-year-old unmarried daughter, Tina, and her son, aged $1\frac{1}{2}$. The father, mother, son and 17-year-old daughter all complained about Tina, who, characteristically, had refused to come to the family interview. They said that she took no part in caring for her son; consistently failed to contribute what she had agreed to pay for her keep and that of her son; was dirty, lazy, self-centred and a liar and was prone to taking others' belongings without asking. She often 'borrowed', and damaged, her sister's clothes and other property. She seemed to be in control of the household.

As an infant, Tina had had a kidney removed for cancer. Her parents had expected that she would die and had apparently indulged her greatly when she was younger. However, the cancer did not recur and she was now in good physical health.

I discussed the situation with the family. The parents were aware of the need to achieve control of their wayward daughter, but had tried 'everything' without any success. It seemed that the daughter used the family's apartment as a sort of free hotel. I pointed out that she would undoubtedly continue to do this if allowed, and that the only alternative would be to make staying in the household conditional upon certain specific behaviours, such as paying her 'rent', doing her share of caring for her son and of the household chores and acting as a constructive adult member of the family. If these conditions were not met, she would have to be asked to leave and live elsewhere. Changing the locks or seeking the help of the police to remove her might even be necessary.

Having spelt this out, I then said I believed this course of action would be impossible for the parents. Their concern and love for their daughter was too great. It would be better, and less distressing, for them to accept continuation of the present situation. So I advised against this plan, though not until after I had spelled it out in detail. The parents, led by the father, immediately said no, they *would* take control of their daughter. She was quite capable of taking care of herself and had done so when she first left home 2½ years previously. She was earning enough to rent her own apartment. The present situation had gone on long enough, they said. I expressed doubts about whether the parents could bring themselves to offer this choice to their daughter, at least if they were sincere in their intention to tell her to leave the home if she didn't shape up.

The parents left, expressing their intention to carry through with the plan, and they did so. The daughter decided to leave and found her own accommodation. She continued in her job, became financially self-supporting and signed over the guardianship of her son to her parents, a situation with which all concerned seemed well satisfied.

Changing an element of the problem. The therapist can suggest that family members continue their symptomatic behaviour, but alter it in some way. Because symptoms are embedded in circular patterns of interaction between family members, altering these patterns can 'put the brakes' on a problem and create openings for new patterns to emerge. Sometimes, new patterns of interaction emerge spontaneously, but more often this is only the beginning of sustained change, and the therapist must do further work. Often, after using an indirect or paradoxical method to interrupt a pervasive problem pattern, a family is more amenable to a direct approach.

There are several options for changing the elements of the problem (O'Hanlon & Beadle, 1994):

- (1) Increase or decrease the frequency of a behaviour.

Typically, a pattern intervention of this type begins with requesting the client(s) to increase the enactment of the problem. Once it is established that the problem is under the voluntary control of the client(s),

the therapist can ask them to change the frequency, including reducing the frequency of the problem.

- (2) Change the time of day a behaviour occurs.

This was illustrated in the above case example, when the stepmother and son were asked to meet for 15 min nightly to express their dissatisfaction with one another.

- (3) Lengthen or shorten the duration of a behaviour.

This operates much the same as increasing or decreasing the frequency of a behaviour. For example, asking two family members to lengthen the duration of an argument on purpose, with the rationale that it is necessary to 'get it all out', may interrupt or override the typical pattern that maintains the arguments.

- (4) Alter the location of a behaviour (e.g. room of the house, outdoors vs. indoors).

I (JC) asked a couple to move their marital arguments to the bathroom and stand in the bathtub while arguing. Aside from the inherent silliness of this suggestion, altering the location of the complaint interrupted the usual behavioural sequence that maintained the problem.

- (5) Add a new behaviour or element to the complaint.

In one couple I (JC) treated, the husband habitually and reflexively withdrew from tense situations with his wife, leaving the house to 'hang out with the boys at the bar'. Most of the time, he would drink to excess and return drunk, resulting in more tension with his wife. I did not ask him to change his behaviour, but simply to insert the elements of showering and dressing in clean clothes into the problem sequence. Most of the time, this interrupted his almost-automatic departure from the house, giving both of them time to think of a more productive way to defuse tension.

- (6) Change the sequence of behaviours or events.

In a case that I (JC) supervised, the mother and stepfather were dealing with their son's slowness to do chores, but became particularly annoyed by his leaving towels on the floor. They would lecture him about how the damp towels would mildew and damage the hardwood flooring, to which he would talk back and storm out of the house. The therapist suggested that the parents lecture their son pre-emptively, before noticing the towels on the floor, or that the young man storm out before, not after, the lecture. This restrained the pattern so that the family was receptive to some direct suggestions for change.

In addition to these six, solution-focused therapists (De Jong & Berg, 2013) have suggested similar ways of interrupting the problem pattern. Following a clear response to the Miracle Question, in which the family is asked to describe a problem-free future after a hypothetical miracle, the family can be asked to simply 'pretend the miracle happened'. In this case, they have already described specific behaviours and interactions. In effect, the pattern interruption comes from the family. When families have difficulty

generating a clear miracle picture, they can be asked to simply ‘do something different’ when they notice the problem emerging, and watch for what others are doing.

In the latter case, even if the family members do not do anything different, simply asking the family members to observe what others are doing differently can be quite potent. In fact, any time the family members are asked to observe others’ efforts to change, the problem pattern is interrupted. Families presenting for therapy are likely very attuned to the negative aspects of others’ behaviour, so asking them to observe others’ helpful behaviours can be a good start, especially with clients who might not quite be ready to take specific actions to solve family problems.

Declaring therapeutic impotence. Chapter 16 of *Paradox and Counterparadox* (Palazzoli et al., 1978) is entitled ‘The therapists declare their impotence without blaming anyone’. This strategic manoeuvre, which is a specific kind of paradox, can be effective when the family and the therapist have become locked in a symmetrical relationship. In such a situation, every intervention the therapist attempts is in some way blocked or disqualified, so that the strength of the symmetrical conflict steadily increases. The Milan associates described the delivery of this intervention as follows:

We say that in spite of the willing collaboration of the family, which has done everything possible to facilitate our understanding, we find ourselves confused and incapable of forming clear ideas, of helping them, and that the team has in no way clarified our ideas. The attitude of the therapists should be neither indifferent nor overdramatic but simply that of those who dislike acknowledging their incapacity in doing what has been asked of them. In saying this, we attentively observe the feedbacks of the various members of the family. We leave a pause of ‘suspense’ fix the date for the family’s next session and collect our fee. (Palazzoli et al., 1978, p. 148)

The timing of this intervention is important. Palazzoli et al. emphasized that it should not be done too soon. They suggest that the right time is when the ‘angry obstinacy of the therapists’ (the Milan group usually worked as a team), together with the family’s repeated disqualification of the therapists, indicates escalation of the symmetrical battle. The intervention is designed to put an end to the battle and is another example of the use of the *one-down* position in therapy. It also avoids the team appearing to be the initiators of change. If the team appears to be playing that role, a family as described here would tend to regard them as hostile and would continue to defend its position.

This device has the effect of creating a complementary relationship between the therapists and the family. It might seem that the team is giving over control to the family, but in reality, they are taking control. There is also a paradox in the contrast between the declaration of impotence on one hand and the collection of a fee and the making of a further appointment on the other. At a certain level, the intervention involves an invitation to

the family to come up with something new and challenges them to prove that the implication in the intervention, namely that their case is hopeless, is wrong.

Prescribing interminable therapy. Yet another strategic device is the prescription of interminable therapy. Its purpose is similar to that of declaring therapeutic impotence. The family problem is labelled as chronic and unlikely to change quickly. Such a prescription might be indicated when efforts to get the family to change quickly, or perhaps to change at all, have failed. In effect, the family is told that it will have to attend indefinitely at prescribed intervals. This intervention, too, incorporates a paradoxical element.

The invariant prescription. *The invariant prescription* is a ritualized task given to parents of children displaying severe problems like psychosis or anorexia. Palazzoli et al. (1978) hypothesize that the power struggle between generations sustains, and is sustained by, symptomatic behaviours. The invariant prescription is used when one or more children have inappropriately aligned with the other parent (e.g. becoming the mother's protector or the father's confidante). This technique requires parents to unite and relinquish their coalition with the children. Practically speaking, the therapist has the parents tell their children that they have a secret, but to never reveal it. The parents are instructed to go out together for varying periods of time, without telling the children where they are going or when they will return. This mysterious behaviour is designed to reconnect the parents and interrupt the pattern that maintains the child's serious problem.

Odd days/even days. Palazzoli et al. (1978) devised the *odd days/even days* tasks. One parent is instructed to make all the decisions about the 'problem child' on even days, that is, Tuesdays, Thursdays and Saturdays, while the other does the same thing on odd days, that is, Mondays, Wednesdays and Fridays. On Sundays, everyone is to behave spontaneously. Each parent, when it is his or her turn to be in charge, has absolute discretion to make decisions about the identified patient. The other parent does not participate in such decisions, unless consulted, and the parent who is in charge must note in writing any infringement of this rule by the other one.

Like many pattern interruption interventions, there is more to it than simply carrying out the task. Indeed, they can be useful even if the task is not carried out at all. The 'odd days/even days' prescription carries a number of implicit messages. One is that someone must be in charge of the children, which is not stated directly and might be disputed by some families if it were (e.g. 'They're old enough to look after themselves'). Another is that both parents must share the responsibility of caring for and making decisions relating to the children. Assigning the task conveys these points, even if the task is never carried out. The task also suggests that the parents need to have different roles or that one may be a more effective, or more appropriate, disciplinarian in certain circumstances. Finally, there is

an implied contrast between ‘spontaneous’ and controlled behaviour, and the opportunity is provided to observe, on Sundays, how far the family members have progressed in internalizing the lessons they have learned in therapy and thus behave ‘spontaneously’ in an acceptable fashion.

Techniques focusing on changing meaning

Reframing

Reframing, in its simplest form, is providing a new rationale or explanation for the problem. For instance, a child’s non-compliant behaviour may be reframed as the parents’ problem in controlling the child. This can be done during the course of conversation: when the parents have described the child’s difficult behaviour, the therapist might comment, ‘So you’re having a hard time finding effective ways of handling Billy and getting his behaviour under control’. This kind of statement is hard to deny, though some parents may respond by saying they, and perhaps others, have tried ‘everything’ and ‘nothing works’, the implication being that the child is ‘impossible’ and that the laws of learning theory have been suspended. Families may try to disqualify attempts to reframe situations in this way, but whatever the response, the therapist’s statement offers a new perspective on the situation. It is useful to carefully offer a new evaluation of the problem, so that the clients can be free to adopt or disavow your framing of the problem.

Other situations may be reframed during conversation as more serious, or less serious, than they have been considered, or as funny (when they have been considered serious), or surprising or indeed anything novel to the clients.

Developmental reframing. Developmental reframing (Coppersmith, 1981) is a form of reframing that labels behaviour, which has been regarded as in some way disturbed as ‘young’ or ‘immature’. Coppersmith’s (1981) three clinical examples were entitled, respectively, ‘He’s not bad, he’s just young’; ‘She’s not mad, she’s just young’; and ‘They do not need to divorce, they’re just young’. Labelling behaviour as immature can give it a meaning different than before. The teenage terror, who seems out of control and perhaps has temper tantrums like a toddler’s, is spoken of as being just a young child who has yet to grow up. It can be difficult for teenagers to continue to behave in the same way once their behaviours have been reframed in this way. At the same time, the parents may be encouraged to treat the young person as a child several years younger. This will probably mean less responsibility and fewer privileges than before. The latter becomes dependent on age-appropriate behaviour, and temper tantrums are not age-appropriate in the teenage years.

Positive connotation. *Positive connotation*, a particular kind of reframing, ascribes positive or noble motives to the symptomatic behaviour of family members, in contrast to the typical way of seeing symptoms as undesirable.

Palazzoli et al. (1978) found positive connotation important, even essential, in the treatment of many difficult families:

It . . . became clear that access to the systemic model was possible only if we were to make a positive connotation of *both* the symptom of the identified patient and the symptomatic behaviours of the others, saying, for example that all the observable behaviours of the group . . . appeared to be inspired by the common goal of preserving the cohesion of the family In this way, the therapists were able to put *all* the members of the group on the same level, thus avoiding involvement in any alliances or divisions into subgroups, which are the daily bread of such systems' malfunction. Dysfunctional families are in fact regularly . . . prone to such divisions and factional battles, which are characterized by the distribution of such stereotyped labels as 'bad', 'sick', 'weak', 'inefficient', 'carrier of hereditary or social taints', etc. (Palazzoli et al., 1978, p. 56)

It is not the symptomatic behaviour itself that is positively connoted, but the intent behind it. Palazzoli et al. (1978) assumed that the intent is to maintain the homeostatic balance within the family, so that it does not 'fall apart'. Positive connotation is also an important preliminary to the prescription of a paradoxical injunction. It makes a lot more sense to prescribe a behaviour which has been connoted positively rather than one that has been called 'bad'.

Normalizing. In the course of a family interview, it is also useful to *normalize* family problems. This is a form of reframing that can be used when family members believe that their experience is extremely unusual or that one or more members of the family are 'crazy'. Normalizing is to refer to a concern as if it is within the realm of normal human experience. For example, if the members of a newly blended family believe that the troubles they are experiencing are uniquely problematic, the therapist could respond, 'Maybe you expected that there would be an instant connection, or that things would come together more quickly. Actually, many families who are in the process of blending experience just what you are going through'.

Metaphor

Metaphor offers many possibilities for the indirect communication of ideas and for strategic intervention in families. Several sources (Barker, 1985, 1986; Battino, 2002; Gordon, 1978; Mills & Crowley, 1986) give comprehensive treatments of the use of metaphor. The most prominent is the work of Milton Erickson, who used metaphor extensively, both in therapy and in teaching. *My Voice Will Go With You* (Erickson, 1982) is a collection of Erickson's 'teaching tales' and makes fascinating and entertaining reading. In *A Teaching Seminar with Milton H. Erickson* (1980), Erickson again makes extensive use of metaphor, seldom answering a question from a student other than by telling a story with a meaning that in some way addressed the issue raised.

Metaphorical devices can be classified as follows:

- (1) Major stories designed to deal comprehensively with complex clinical situations (see Gordon, 1978).
- (2) Anecdotes and short stories aimed at achieving specific, limited goals.
- (3) Analogies, similes and brief metaphorical statements or phrases illustrating or emphasizing specific points.
- (4) Relationship metaphors. A relationship metaphor uses one relationship, for example, that between the therapist and one or more members of the family, as a metaphor for another relationship. Thus the therapist might explore why a family member is absent from a session by asking the family members who *are* present questions like ‘Did I last time say something tactless to your father?’ Or, ‘Did he feel left out of the discussion?’ Or, ‘Have I shown him insufficient concern?’ Or, ‘Did he feel in some way blamed for the family problems?’ Or, ‘How could I have made him feel more a part of the therapy process?’ Such questions may cause family members to think about their own relationships with the missing family member. Discussing the relationship between the therapist and the father thus serves as a metaphor for the relationship between other family members and the father.
- (5) Tasks and rituals with metaphorical meanings. These may be carried out during therapy sessions or assigned between sessions. An example of the former category is the ‘couples choreography’ described by Papp (1982). In this procedure, couples are asked first to close their eyes and have a ‘dream’ or ‘fantasy’ about their spouse. They are then asked to visualize themselves in the same fantasy. The fantasy is then enacted, under the therapist’s guidance. The marital relationship is thus defined in metaphorical terms, and ‘. . . penetrates the confusing morass of verbiage that often sidetracks both couple and therapist . . . and reveals the ulterior level of the relationship’ (Papp, 1982, p. 455). An extensive discussion of the types and uses of therapeutic rituals has been provided by Imber-Black, Roberts, and Whiting (1988).
- (6) Metaphorical objects. These are objects used during therapy to represent something other than what they actually are. Angelo (1981) described the use of an envelope containing a blank sheet of paper to represent a ‘family secret’ that is an issue the family members were having difficulty dealing with, namely the fact that the son was adopted. This way, the family was able to discuss what was ‘in the envelope’ without specifying its nature. This enabled that particular block in the therapy process to be overcome.

Here is another example:

William had severe tantrums that failed to improve despite several previous attempts at therapy. In the course of a family interview, I (PB) asked him to have a tantrum, so that I could see exactly what his tantrums were like. He declined to do so, despite some pressure from me. I therefore

asked the parents to keep an audio-recorder ready in the home at all times, so that the tantrums could be recorded and played back to me at the next session. This proved an effective way of eliminating the problem. The cassette recorder functioned as a metaphorical object and represented me, the therapist. William was now supposed to have tantrums, so that I could be given recordings of them. His tendency to respond negatively to what he was told to do, however, led him to abandon having them.

- (7) Artistic metaphors. These are artistic productions, such as drawings, paintings, clay models or structures built with 'Lego', which are used to represent a feeling state, experience or something else, which may be significant in the treatment process.

The therapeutic use of artistic metaphors was pioneered by Richard Crowley and Joyce Mills, and the creative way they have employed them is described in *Therapeutic metaphors for children and the child within* (Mills & Crowley, 1986). The essence of this technique is that clients who say, for example, that they are angry, or sad, or in pain, are asked to draw their pain, or to draw what 'angry' looks like. They can then draw the same thing getting better. The drawing thus becomes a metaphor for feelings, which people often have difficulty expressing in words. Artistic metaphors may be used to reframe a subject's experience in another sensory modality. The technique can be used during family therapy or in individual work with children or adults.

The above classification of metaphors is taken from *Using metaphors in psychotherapy* (Barker, 1985), which provides a fuller discussion of metaphorical methods of therapy and many examples. Further discussion of the use of metaphor is to be found in *Psychotherapeutic metaphors: A guide to theory & practice* (Barker, 1996).

Rituals

The performance of rituals is used by many family therapists as devices to promote change. Wolin and Bennett (1984) have pointed out that rituals are 'a powerful component of family life' and are 'central to the identity of the family'. Providing new rituals, or altering pre-existing ones, can promote change powerfully. The ritualizing of tasks assigned in strategic therapy plan can promote their performance.

Wolin and Bennett (1984) divided family rituals into family celebrations (weddings, baptisms, bar mitzvahs, religious celebrations and so forth); family traditions (ritualized activities specific to the family, such as summer vacations, visits to extended family members, family reunions, birthday and other parties and so on); and patterned family interactions, often not consciously planned (such as regular dinnertimes, bedtime routines for children, customary treatment of guests and weekend leisure activities). The modification, or prescribing, of rituals in any of these categories may be used to

promote change in families. Otto van der Hart, in his book *Rituals in Psychotherapy* (1983), describes how rituals may be used, both in psychotherapy and in other situations.

In *Rituals in Families and Family Therapy*, Imber-Black et al. (1988) define ‘five themes’ to ‘orient the therapist’s decision-making’ when therapeutic rituals are to be designed and used:

- (1) Membership
- (2) Healing
- (3) Identity
- (4) Belief expression and negotiation
- (5) Celebration

Rituals have long been used to assist people to move from one developmental stage to another. van der Hart (1983) discusses *rituals of transition*, which are features of the lives of many primitive tribal communities. Similarly, according to Wallace (1966, p. 203), ‘...rites of passage are a type of ritual which educates participants for, announces publicly, and initiates a new relationship’. In therapy, rituals can educate people for, announce and initiate new relationships.

Rituals can be used at any stage in therapy, including termination. When finishing treatment it can be helpful to give clients something to take away with them, as a continuing resource. Imber-Black et al. (1988, p. 82) describes how she did this with a family in which there was a 12-year-old girl with an eating problem. Two metaphorical objects were offered to the family at a ‘celebration’ dinner, to be used in a ritualized way. Among the very few foods the girl would eat were French fried potatoes. She had also been seeing a dietician who urged her to eat kiwi fruit, something she hated.

At the final session, the therapist handed the family a potato and a kiwi fruit. She asked them to freeze them ‘with the understanding that, in the future, when any member of the family felt that a family discussion was needed, the thawing out of the potato and the kiwi fruit would signal the call for such a meeting’. The two objects symbolized the process the family had been going through, and the ritual was designed to help them recall and again make use of the problem-solving skills they had learned during therapy. The ritual may also have been helpful because it gave the family time to reflect on the situation while the contents of the bowl thawed, rather than reacting precipitously.

Fay had lived in a common-law relationship with George for 18 months. The relationship was a stormy one and Fay was ambivalent about it. When she eventually decided to leave George she and her two sons nevertheless mourned his loss a great deal. Fay complained that she couldn’t sleep at night, thought constantly about George, was unable to concentrate and felt lonely. At the interview, she also appeared depressed. It seemed important that she discard the unhappy associations and memories, as she came to terms with the separation. Had she not resolved her feelings she might

have been tempted to seek reconciliation with George, as she had done with men with whom she had previously lived.

Fay still had a number of items in the house which reminded her of George. Some had belonged to him but he had left them behind, while others were things he had given her.

After exploring Fay's feelings and situation carefully with her, the therapist gave her the following task. She was to go through everything in the house that had belonged to George and decide whether it was worth keeping or whether it was something that would be better got rid of. The two classes of things were to be placed in different boxes. Fay was then to take the box of things that were not worth keeping, make a fire in the backyard and burn the box and its contents. As she did so she was to feel free to weep as much as she felt like doing.

The other box now contained all those things of George that Fay valued. These were to be packed up carefully and Fay was to dig a hole in her backyard and bury them. This was a symbolic act of preserving the good things about George and the happy times they had spent together.

Fay carried out the task as directed. When she returned to the therapist, however, she reported that she had been unable to weep at the burial because 'so much trash was not worth wasting tears over'. She also reported that she was now feeling a lot better and was once again getting a good night's sleep. She no longer appeared depressed and seemed to be making good progress in the business of mourning and coming to terms with the loss of George.

Fay was faced with the problem of making a transition in her life, and quite an abrupt one too. The ritual actions prescribed were designed to have appropriate metaphorical meanings and to assist her in making the transition. They did indeed appear to be helpful to her.

In this case, as with other rituals that mark a change in status, family members interact with one another differently based on the new status of one or more family members. Family therapists can be creative in collaborating with families to devise rituals marking progress in treatment or the 'victory' over problems. Particularly with children, such rituals can take on a celebratory air, including certificates and awards (Leslie, 2011; Madigan, 2011).

The use of humour

It can often help to see the funny side of things. This applies to family therapy as much as to many other of life's activities. Sutcliffe, Lovell, and Walters (1985), in an article entitled *New directions for family therapy: Rubbish removal as a task of choice*, pointed out that '...family therapists, if they take families seriously, need to be able to laugh and joke with them'. The article reframes the disposal of rubbish (in North America, we would call it garbage) as a worthwhile, indeed valuable activity, and one which we should not feel guilty about asking our children to perform. Nor need we be

reluctant to perform it ourselves, for it may be just what we, as therapists, need to do.

Frankl (1960) encouraged his patients to laugh at their symptoms, and Erickson also advocated the use of humour:

In teaching, in therapy, you are very careful to use humour, because your patients bring in enough grief, and they don't need all that grief and sorrow. You better get them into a more pleasant frame of mind right away. (Erickson, 1980, p. 71)

The use of humour is a very personal thing and depends, perhaps more than any other therapy device, on the therapist's personality and on non-verbal communications as well as verbal ones. The aim is to laugh *with*, not *at*, the family. Doing this can both help establish and maintain rapport and assist in reframing things. For example, children's behaviour, which may have been arousing their parents' severe disapproval, can sometimes have a funny side: another example of reframing.

However, humour is a double-edged sword. Wilkens (2001) found that family therapists participating in an online survey had little training in how to use humour. This may be connected to Meyer's (2007) finding that therapists believe that humour helps the therapeutic alliance, but clients found no difference. Moreover, clients who terminated prematurely received twice as many therapist attempts at humour as those who terminated therapy after meeting their goals.

Strategic teams

The Greek chorus. *The Greek chorus* (Papp, 1980) is a consultation group that watches the session through a one-way observation screen and sends a series of messages into the therapy room. Papp (1980) lists some of the types of messages sent by the chorus:

- Support messages. These simply praise or support certain aspects of the family.
- Public opinion polls. These take, and report to the family, the odds on the family changing. They can thus present families with challenges.
- Messages designed to surprise and confuse. Surprise and confusion can be important elements in promoting change, and these messages are intended to arouse the family's curiosity, stir up their imagination or provoke them into revealing hidden information.
- Messages disagreeing with the therapist's expressed opinion. Therapeutic 'splits' can help promote change; usually the therapist in the room advocates change, while the 'Greek chorus' advises against it at the present time or against the proposed speed of change.

- Messages offering advice from outside the circle of the therapist and the family. These can reframe situations and bring psychological pressures to bear on families in various ways.

While a consultation group is often helpful, it is especially so when complex paradoxical and other strategic interventions are used. It is costly in staff time, but may be worthwhile for difficult families. Moreover, the Greek chorus may consist mainly, even entirely, of students and thus be a valuable learning experience for them.

The debate. The debate as a strategic therapy device was described by Sheinberg (1985). It is a further application of the Greek chorus. The consultation group comes out from behind the one-way screen and stages a debate in the presence of the family. The debate concerns ‘... a dilemma that is a strategically constructed isomorph of the family situation. From this position, therapists have the option of changing levels between themselves and the family, asking the family to help solve the therapists’ dilemma so that they can be free to help the family’ (Sheinberg, 1985, p. 259). The family members are able to observe the therapists’ struggles to resolve their difficulties from a ‘meta’, or outside, position. From this different perspective, they may be able to find new solutions to their own dilemma.

A second-order cybernetic approach: therapy as conversation

In Chapter 3, we discussed a second-order cybernetic approach, in which the therapist considers himself or herself part of the therapeutic system. It is useful to again mention here, as the therapeutic practices we will now discuss are based on a second-order cybernetic approach to therapy. These practices roughly correspond with *postmodern* or *social constructionist* approaches to therapy (Anderson & Gehart, 2007; De Jong & Berg, 2013; Lock & Strong, 2012; Mills & Sprenkle, 1995; Monk & Gehart, 2003; Shotter, 1993; Strong, Sutherland, Couture, Godard, & Hope, 2008; White, 2007).

Atwood (1997), Chang (2013) and Hoffman (2002) locate the beginning of a second-order cybernetic approach in the mid-1980s, extending through the 1990s. This period saw a move away from approaches in which therapists assessed families from an expert position and then devised methods to change them. Atwood (1997), in her book *Challenging family therapy situations: Perspectives in social construction*, describes this evolution:

... the therapist [was] generally [considered] a diagnostician and assessor who acts upon the family to ‘fix’ their fusion, disengagement, rigidity, overprotection, conflict avoidance, symmetry, complementarity, hurts, wounds, dysfunctional patterns, communication problems, or whatever else is considered to need attention. (Atwood, 1997, p. 6)

Traditional family therapists adhere to a ‘first-order cybernetics stance’ and ‘tend to fit families into or compare them to a normative template’ (p. 6). This assumes that there is such a thing as a ‘normal’ family and the therapy’s task is to restore the family to normality. However, as we saw in Chapter 2, the concept of the ‘normal family’ is elusive, although each therapist may have his or her own ideas about this. Conversely, the *postmodern* approach (Atwood, 1997, p. 36) involves a ‘second-order therapeutic stance’: ‘[T]he therapist becomes part of the system and, as such, acts in collaboration with the client to co-create new stories, new possibilities, new ways of seeing and being’.

Interventive interviewing. *Interventive interviewing* is the logical outgrowth of a second-order cybernetic approach. Tomm (1987a, 1987b, 1988) coined this term to capture this approach to therapy. Therapy evolved to be less concerned about the end-of-session homework assignment or intervention task and more concerned about the interview or *therapeutic conversation* (Gilligan & Price, 1993). Interventive interviewing typically proceeds via questions that not only seek information but also imply or embed a particular message. The approaches we describe in this section include questions other than those described by Tomm, and borrow from several different models, which have in common that

Each holds as its central tenet that the way clients talk or ‘language’ about their problems will change their lives. Where these approaches differ is in their beliefs about the most helpful way to steer (or not to steer) the conversation. (Mills & Sprenkle, 1995, p. 369)

It is essential to reiterate that we are not recommending simply running through a list of questions, or that we are suggesting that questions, in and of themselves, trigger change. The form of these questions is meant to suggest a line of interviewing based on careful listening to clients’ responses and genuine curiosity.

Circular questions can be used to make connections, to *clarify problem-maintaining patterns of interaction* (Brown, 1997). They are formulated to elicit patterns that recurrently connect persons, objects, actions, perceptions, ideas, feelings, events, beliefs, contexts and so on. This can make the clients’ assumptions about relationships explicit and can create new meaning within the family. To *clarify the problem description*, one could ask a parent, ‘When you asked your daughter to go to her room, what did she do? Then what?’ This elicits a behavioural description and erodes assumptions that may accompany a label or diagnosis.

One could also ask about the *affective component of the problem*, which can help the therapist understand the meaning of, and motivation for, behaviour. A therapist could ask, ‘What feelings emerge when your husband criticizes you?’ or ‘When you can tell that she is angry at you, how do you respond emotionally?’, rather than asking, ‘How does that make you feel?’ which implies that one has no control over feelings. Asking about feelings in the context of a relationship clarifies mutual influence.

It is also useful to ask about the *relationship between beliefs and the problem*: ‘When your husband does not help with housework, what do you think he believes about the role of women?’ Or, ‘When your son acts impulsively, do you think this is “hard-wired” or do you think he can learn to slow himself down?’ Moreover, clients’ beliefs may be emblematic of larger cultural discourses: ‘How do the women you see in advertisements invite you to feel about yourself?’ Clients’ responses can invite them to reflect on aspects of their experience they may not have examined before.

Meaning questions can assist the therapist and the client to reflect upon their *interpretations of the problem*. For example, one could ask, ‘How do you understand it when he affirms that he does love you, but still forgets to do what he has promised?’ This can assist clients to draw connections between their interpretations and their reactions.

A therapist can also ask family members to comment on *the nature of their relationship* with each other. Making these assumptions explicit can provide an impetus for change: ‘When your son says he is coming home right after school and he doesn’t, how does that affect things between the two of you?’ Or, ‘When your wife expresses her anger, how does this affect your optimism about the future of your marriage?’

The interventive interviewing strategies cited above, in addition to eliciting and elaborating clients’ problem descriptions, can also challenge clients’ view of the problem by implicitly conveying a systemic perspective. Asking about differences between people can clarify the patterns maintaining the problem (e.g. ‘Of the two of you, who believes more strongly that Kenny can control his impulsivity?’).

Interventive interviewing strategies can also be used to *establish goals*. The Miracle Question (‘Suppose tonight when you are asleep, a miracle happens, and the problems we have been discussing simply vanish, but you don’t know the miracle happened because you were asleep, what will be happening the very next day that will tell you that a miracle has occurred?’) can be used to obtain a description of clients’ problem-free future that can be used to negotiate goals. Clients’ interpersonal descriptions of the miracle can be tremendously instructive to other family members.

Asking clients about *irregularities in the problem* – when it is better or worse – erodes the idea that the problem is monolithic and unchanging and enables clients to make distinctions about when things are better. Clients may or may not be able to *describe how they contribute to the improvement*. If so, they can be asked to elaborate their description (‘What do you think you did to get that to happen?’), expand their description to others in the family (‘What do you think your father noticed?’ and ‘Dad, when your son did this, what difference did this make to you? How did you respond?’) and repeat their helpful behaviour between sessions (‘Keep doing what you are doing’). If family members cannot describe how their behaviour makes a difference, simply asking them to *describe the differences* can attune them to further improvements. Either way, it is useful to ask for family-based descriptions of times when things are better.

Once a positive change has occurred, one can interview family members about *how they can keep the positive change moving forward* ('What will it take to stay on track?') or what these changes might mean to the family's future (e.g. 'How do you think you will handle this in the future, now that you know what you know?').

Externalizing the problem. Externalizing the problem is a practice from narrative therapy (Carey & Russell, 2004; Madigan, 2011; Madsen, 2007; White & Epston, 1990), in which the problem is objectified or even personified. This runs counter to the dominant cultural tendency to locate problems within persons or define a person as the problem. Persons or families are referred to as 'under the influence of' *anger, aggression, hopelessness* or, as in the case of a child with encopresis, *Sneaky Poo* (White, 1984). From being seen as inherent to a particular family member or relationships, a problem can become 'a separate entity and thus external to the person or relationship that was ascribed as the problem'. In other words, 'the problem becomes the problem' (White & Epston, 1990, p. 38). Therapy is then a matter of assisting the family in overcoming the effects of the externalized problem on the family.

According to White and Epston (1990, p. 39), externalizing conversations:

- (1) Decrease unproductive conflict between persons, including those disputes over who is responsible for the problem.
- (2) Undermine the sense of failure that has developed for many persons in response to the continuing existence of the problem despite their attempts to resolve it.
- (3) Pave the way for persons to cooperate with each other, to unite in a struggle against the problem and to escape its influence in their lives and relationships.
- (4) Open new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence.
- (5) Free people to take a lighter, more effective and less stressed approach to 'deadly serious' problems.
- (6) Present options for dialogue, rather than monologue, about the problem.

Narrative therapists usually ask families about how the externalized problem influences them ('What does Depression invite you to do, or not do?'), how it influences relationships ('How does Trouble get in between you and your mom? Your mom and dad?'), how much of the client or the family's life the problem occupies ('What percentage of your life does Timidity have a hold of?') or what a future under the influence of the problem might bring ('If you don't get a handle on Trouble, what do you think life will be like in a year? Two years? Five years?'). A therapist can then ask the family for their descriptions of what they do to reclaim their lives from the externalized problem ('What do you do to keep Depression at bay?' or 'What's different about the times Trouble is not so strong in your life?')

The reflecting team. Andersen (1987, 1995), a psychiatrist in Tromsø, Norway, stumbled upon the practice that has come to be known as the

reflecting team (RT). He and his teammates were observing from behind a one-way mirror. The therapist was ‘drawn into the pessimism of the family’ (Andersen, 1987, p. 415). After three unsuccessful call-ins, Andersen suggested the therapist and the family exchange places with the team, who reflected aloud about the family, while the family and the therapist observed. The groups again exchanged positions and the therapist solicited the family’s reaction to the team’s reflections. As Andersen continued this practice, he came to believe that RTs are more collaborative and egalitarian than simply sitting behind the mirror and giving his observations to the therapist without the family’s involvement. Andersen considered RT practices more consistent with his postmodern collaborative values.

Although Andersen (1987) offers a procedural description for RTs, he emphasizes that their purpose is to generate and offer multiple descriptions of the client situation. In contrast to a staged debate, the team members express their views tentatively without attempting to convince. The team members simply express multiple views and discuss their curiosity about the family, in a ‘both/and’ way. This mirrors Andersen’s social constructionist philosophical stance. A second-order cybernetic approach, in which the *therapist + client* is seen as a system, is represented. Family members are free to take up whatever part of the team’s reflections they find significant.

Therapeutic letters. Therapeutic letters are a device used most commonly by narrative therapists to reauthor and circulate the new story that has been developed in therapy. The letters can be used intermittently in therapy or at the end of a course of treatment. Typically, therapeutic letters describe how the externalized problem has influenced the family’s life. Then, the therapist writes of how the family has fought back against the problem or changed its relationship with the problem. The letter then describes in detail what narrative therapists call *unique outcomes*, instances when family members exercise mastery over the problem or reduce the problem’s influence in their lives. In a letter, the therapist may pose questions similar to those posed in an interview: ‘What do these new developments say about you as a person?’ or ‘As your mother stands strong in the face of Depression, how will this create space for you to live your life more in the way you would like?’ The therapist may wonder on paper about what new developments will come next.

With the permission of clients, therapeutic letters can be circulated to others in the clients’ social system, such as teachers, child protection workers and probation officers. Clients report tremendous value in letters, estimating that having one in hand to review is equivalent to the value of between three and ten sessions (Nylund & Thomas, 1994).

Summary

Systemic therapy addresses the family system as a whole. Direct methods of promoting change, discussed in the previous chapter, are sometimes effective and should generally be tried first. If they fail to bring about the desired

changes, indirect approaches, as we have outlined in this chapter, may be tried. They can be used either to interrupt the patterns that maintain problems or to change the meaning that family members ascribe to the problem or some aspect of the problem-maintaining context.

Interrupting the problem pattern usually takes the form of *paradoxically prescribing the problem* or some variant of it. This has the effect of changing the vector of the problem, disarming resistance, putting the clients in charge of the symptom and possibly challenging the family to prove the therapist wrong. We have described specific interventions designed to disrupt problem patterns (*the invariant prescription, declaring therapeutic impotence and prescribing interminable therapy*).

We described several therapeutic methods aimed at changing meaning. *Reframing* depends on the therapist generating an alternative explanation, evaluation or view of the problem. *Positive connotation* (ascribing 'positive' intent to symptomatic behaviours) and *normalizing* (placing troubles in an everyday context) are specific types of reframing. Metaphorical communication, rituals, using humour to give situations different meanings or values and the strategic use of teams (the Greek chorus and the debate) are other approaches to changing the meaning of the problem.

Finally, we described a *second-order cybernetic approach* to therapy, in which the family is not considered a separate entity to be assessed and the therapist + family is the system to be considered. This view lends itself to seeing *therapy as conversation*, an important part of which is *interventive interviewing*. These interviewing techniques permit a systemic framing of the problem, and defining the problem in a way that is solvable, as opposed to fixed. We also described how to use questions to invite clients to describe and amplify change. Finally, we introduced externalizing the problem, reflecting teams and therapeutic letters. These methods assume a collaborative relationship between the therapist and the clients, in which hierarchy is minimized to the extent possible.

The therapeutic procedures described in this chapter and the preceding ones are not mutually exclusive nor is the list exhaustive. The range of possible strategies is restricted only by the limits of the imagination and creativity of the therapist.

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Chapter 12

Other Therapeutic Approaches

There is probably no limit to how therapists might intervene with families. This chapter will outline some methods that we have not yet mentioned. The trend, during the last couple of decades, has been to enable families to find the resources within themselves to overcome their problems and achieve their goals. In addition, we will describe some innovative approaches to service delivery.

Experiential approaches

Experiential approaches to family therapy come from a variety of theoretical roots that share key assumptions about human functioning (Watson, Goldman, & Greenberg, 2011, p. 142). First, they emphasize subjective experience, focusing on bringing 'prereflective' experience into conscious awareness. Second, they assume that all persons have a drive towards growth and self-actualization. Therapeutic techniques focus on removing barriers to growth. Third, persons are capable of 'self-awareness, self-determination and choice'. Finally, therapists respect each person's subjective experience.

Family sculpting

One well-known experiential technique is *family sculpting*. Developed by Duhl, Kantor, and Duhl (1973), family sculpting consists of placing family members in positions and postures that represent their relationships and interactions. Any aspect of family functioning can be sculpted (e.g. closeness, power or anger).

Family sculpting requires a *sculptor*, whose view of the family is revealed in the sculpture; a *monitor*, namely the therapist, who guides the sculptor and the others; and the *actors*, who portray the sculptor's family system. There may also be an *audience*, who may be the same family members and the therapist or others who are not portrayed in the sculpture.

Walrond-Skinner (1976) suggested sculpting for families with young children in therapy, who may find it easier to express themselves non-verbally.

Sculpting can be used diagnostically, a substitute for asking a family for a verbal description of their problems or desired changes, and to help family members get in touch with their feelings. Sculpting can be used to overcome families' resistance to therapy or a creative strategy when you feel 'stuck'.

The therapist observes what happens as one member sculpts, and comments, emphasizing that this is just one view of the family and that the other members can express their points of view in the same way later. Once the tableau is completed, the therapist asks the sculptor also to enter it, as he or she deems appropriate. Both the process of sculpting and the finished tableau can be used to facilitate change in the family – for example, clarifying or changing communication, feelings or roles. The tableau can be easily captured in a digital image for later discussion.

Sculpting can be expanded to include other metaphorical expressions. For example, Zimmerman (1998) describes sculpting with stepfamilies, while Meyerstein (1998) uses props – for example, a pillow to block a family interaction, rope to bind a mother's hands in response to her description of feeling this way, a spoon to 'spoon-feed' a dependent adult child.

Enacting Satir's communication stances. Sculpting can be used to portray Satir's (1988) 'communication stances', which are characteristic positions that family members take. These are similar to problematic roles described in Chapter 10. For example, *the blamer* acts superior and critical. *The placator* tries to please, is compliant and is over-responsible. *The computer* is overly rational and does not show emotion. *The distracter* displays disorganized behaviour. Each stance is portrayed by a physical posture (placator: kneels/begs; blamer: points with index finger; computer: sits motionless; distracter: moves around willy-nilly). Enacting these communication stances during a common task (e.g. discussing what to cook for supper) permits family members to reflect on their experience. The therapist can encourage family members to assume different physical postures and help them explore the complementarities of the communication/physical postures experientially.

Role playing

Role playing is another *action technique* that can be useful when verbal approaches prove ineffective. It can be especially valuable in families who intellectualize their problems. Having them act out scenes or events from their lives can facilitate change. For example, a family might be asked to act out what happens when father returns home from work or at bedtime, if they report difficulties during these times. If family members are hesitant, the therapist may start with a simple, non-threatening scene, but if rapport has been well established, obtaining agreement is usually not difficult.

Like sculpting, role playing brings something of the reality of family life into the therapy session and gives the therapist material with which to work. This can be particularly helpful when the family is inhibited in the therapy room and so does not behave 'naturally', as they usually do.

Family psychodrama

Oxford and Wiener (2003) describe the use of dramatic techniques with a family hit hard by multiple losses. After setting the stage for this intervention and framing the problem in an externalized way (see Chapter 11), the therapist asked each family member to enact their experience of sadness, and then to speak to sadness about how sadness has influenced their lives. In the next session, they were asked to place themselves along a continuum representing the amount of control they thought sadness had over the family and how much they would like to have. This enabled them to reflect on what was different about the time they had more. Further exercises, with the family members portraying some aspect of their relationship with sadness, and others observing and commenting, helped them develop further steps in reclaiming their life from sadness.

Dynamic family play. Dynamic family play (Harvey, 2003) is useful when family members do not wish to enact family situations literally, because the material is emotionally charged, or where children may be more comfortable with play than speaking. Harvey uses tasks such as ‘follow the leader’, a joint drawing or improvising a story with stuffed animals to assess families’ attunement, management of leadership changes, connectedness, and so on. Harvey cited the example of a boy who avoided talking about his parents’ divorce. Metaphorically representing the family dynamics, the therapist instructed the family to play a game in which the boy was to avoid being hit by a scarf thrown by the parents. If he was hit, he would answer one question from a parent.

Similarly, Osborn (1998) describes a case where the couple’s relationship was affected by one partner’s childhood sexual abuse. They visualized ‘sexual abuse’ in an empty chair, directing their feelings about sexual abuse towards the chair. This helped them learn new ways of managing the problem.

Sample experiential techniques

Following are examples of interventions that a family therapist can use to introduce a different experiential frame to a family. A therapist can create an experience for the family that is markedly different from the norm. This can give the family the opportunity to reflect on the experience, discuss the changes they hope to make and plan concrete actions to implement changes.

Mirroring. Wiener (1998) describes mirroring, an exercise in which two family members face each other. The leader may do whatever physical motions he/she wishes, while the follower must follow, as they two maintain eye contact. At the therapist’s direction, the partners exchange roles. Or, the therapist can direct them to act mutually, still matching while maintaining eye contact, with no designated leader.

Wiener (1998) maintains that this exercise promotes attentiveness and cooperation and creates opportunity to deal with their needs to control, give

in or cooperate. The therapist then interviews family members about their preference for being the leader or the follower and the extent of mutuality.

Balloon bouquet. Hanson (1998) describes an intervention for families with difficulty expressing anger. Sitting in a circle, each family member blows up a balloon to represent a recent episode of anger. Family members then comment on each other's balloons, which leads to a conversation about how the family deals with anger. Family members can then dispose of their balloons as they please – letting go, popping it, letting all or some of the air out, and so on. Hanson has found that this permits the family to express anger in a non-threatening and even humorous way.

Video playback

Alger (1969, 1973) was a pioneer of video playback. A recording of a whole session or of selected segments can be used. Video replay enables family members to see what is going on in the family 'from the outside'. They can observe their verbal and non-verbal behaviour.

For families with a strong conscious desire to change, video can be a direct way to define necessary changes. In other families, it can motivate them to change. Wingfield (2002) defines Alger's (1973) approach as insight-oriented and confrontative. On the other hand, Ray and Saxon (1992) used video recordings in a non-confrontational way. After recording a session and selecting a segment exemplifying a problem-maintaining pattern, the therapist/team takes a 'one-down' position – acting confused and curious, as they show the family the video and asking them to explain the selected segment. They suggest that viewing the video can interrupt the problem-maintaining pattern.

While there are many studies on using video recordings in training, there are no published peer-reviewed accounts of video playback as therapy since Ray and Saxon (1992). Most are from the 1970s and two were published in the 1980s. Recently, Murphy (2012) provided a case description of his work with a family, school system and developmentally disabled young man. Given the state of current digital technology – inexpensive 'flip' cameras, smart phones, webcams and inexpensive or free video recording and editing software – the absence from the literature is surprising. For families willing to permit recording, this can be a convenient and powerful technique.

Family music therapy

Oldfield (2006, 2008), in the context of a child and family psychiatric unit in Cambridge, UK, developed *interactive music therapy*. Entering family work from a music therapy background, Oldfield has developed a short-term and pragmatic approach, using improvisational live music (playing and inviting family members to play instruments). She has found that playing music

together provides families with a positive experience, in contrast to their often negative interactions; family dynamics such as behavioural control, leadership and non-verbal communication are on live display, giving families new insights into their relationships; and participants have a non-verbal way to express feelings.

Family art therapy

‘The process of Art Therapy is based on the recognition, that man’s most fundamental thoughts and feelings, derived from the unconscious, reach expression in images rather than words’ (Naumberg, 1958, p. 511). While art therapy originated from psychoanalytic theory, more recently, art therapists have been incorporating many theoretical approaches, including family systems, into their work (Kerr, 2008a). Conversely, family therapists often use art media, largely to engage children in therapy (Chang, 1998; Gehart, 2007; Sori, 2006). There is a pragmatic convergence between art therapists and family therapists. For example, Manicom and Broonska (2003) integrated art therapy and family therapy in child protective work.

Kerr (2008a) states that art interventions reduce defensiveness by accessing ‘deeper’ material that cannot be intellectualized. The art product is a permanent expression of clients’ thoughts and feelings and provides valuable assessment data on the family’s structure, communications and boundaries. The creative energy going into art production is often liberating for families who feel mired in negative emotions. Finally, the non-verbal nature of art production clears the way for family members to communicate differently.

Contemporary family art therapy has developed from several theoretical branches of the family therapy tree: object relations (Parashak, 2008), Bowen family systems (Kerr, 2008b), structural family therapy (Hoshino, 2008), experiential (Kerr, 2008c), Adlerian (Sutherland, 2011) and narrative (Hoshino & Cameron, 2008).

Sample art techniques

Family albums. Hesse and Karakurt (2012) described the use of a family album to help children better understand their parents’ divorce, deal with their feelings and accept its finality. The therapist introduces the idea of a family photo album and invites the family to draw their own family album to tell about their family. The therapist can provide a worksheet or template with blank ‘frames’ as would be seen in a photo album, along with drawing materials. Under each frame is a description of the picture that the child will be drawing in the box. The therapist reads the description to the child, who draws his or her picture in the box. Possible descriptions include ‘Happy Times with my Family’, ‘Sad Times with my Family’, ‘Why I Think my Parents Got Married’, ‘Why I Think my Parents Got Divorced/Separated’ and ‘How I Want my Family to Be in the Future’. Once they have drawn pictures,

the therapist can interview the family with open-ended questions. The therapist should be especially mindful of the child's age, cognitive development and expressive language skills.

Creative genograms. Westelmajer (2012) devised the Creative Genogram to include exploration of historical trauma, maltreatment and behavioural symptoms, using symbols and colour coding created in a language understood by the family. She uses it to explore multigenerational trauma with children, adolescents and families in intensive residential treatment and with whom standard talk therapy had not been effective. The Creative Genogram provides families with a visual depiction, permitting them to see family patterns and interrupt them, allowing the family to tell their story from a different point of view. The Creative Genogram illustrates multigenerational family trauma through colours and symbols, exploring the connection between trauma and the maladaptive behaviour of children and adolescents.

After introducing genogram symbols, Westelmajer invites the family to draw the genogram on a large Bristol board (22.5" × 28.5") and a variety of coloured markers (at least ten colours, preferably with different colour intensities). She asks them to devise symbols and colour codes and a legend that includes all repeated symbols and colour coding. The family should depict *symptoms* and *traumatic events*, as they have presented across generations. Similarly, Roberson (2012) has developed a 'big feelings genogram' to graphically depict children's emotions during parents' divorce.

Outsider witness practices. Magnuson and Macdonald (2012) describe their adaptation of using *outsider witnesses*, sometimes known as reflecting teams (White, 2007), which we described in Chapter 11. Instead of the usual outsider witness or reflecting team process, in which a group of observers discuss the conversation between the therapist and the family while the family and therapist look on, the art product is viewed and the family members themselves reflect upon the art products.

Family play therapy

Play therapy is '... [t]he systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development' (Association for Play Therapy, 2012). Bettelheim (1987, p. 167) characterized play as 'the royal road to the child's conscious and unconscious inner world'. While play therapists focus mainly on the play of child clients, most use the child's difficulties as an entry point to working with the parents or the family as a whole.

For example, Davenport and Bourgeois (2008) reviewed the research on the influence of parenting on children's aggressive behaviour and parent-child play. They hypothesize that parent-child play dynamics can be generalized to family functioning in general. Their review of the literature summarized that harsh rejecting parenting practices, negative parental attributions

of children's behaviour, coercive parenting practices and the absence of positive parenting practices (support, warmth and security) all impair children's mental health. They suggest that play therapists work with parents to help them balance discipline and limit setting (the focus of many child behaviour management programmes) with nurturance and provide accurate information about child development.

Play therapists conceptualize their work in relational terms. For example, Benedict and Schofield (2010) conceptualize children's difficulties as attachment problems. Accordingly, for them, the central task of play therapy is the development or renewal of secure attachment, to the therapist and then to caregivers/parents.

Several recent sources (Callahan, Stevens, & Eyberg, 2010; Diaz & Liberman, 2010; Goodyear-Brown, 2010; Shelby, Avuina, & Warnick, 2010) describe approaches to parent-child therapy in which parent-child interactive play is used as the medium for therapy and the parent-child relationship is the focus of treatment. The therapist provides coaching to the parents, often in session, to improve their emotional attunement to the child and their parenting skills. Others (Knell & Dasari, 2010) recruit parents to help children generalize skills outside of the therapy room. Specific play procedures are described in these chapters.

Davenport and Bourgeois (2008) note that, although outcome research of play therapy demonstrates that it is effective, this is based on outcome measures like behavioural checklists, as opposed to assessment of underlying family dynamics. They suggest that more research is required to confirm the extent to which parent-child play dynamics generalize to the family's day-to-day life (Davenport & Bourgeois, 2008).

Family resilience and ecological interventions

The construct of *family resilience* (Becvar, 2013) emerged some two decades ago. Family therapists have long been aware of how *larger systems* influence family functioning (Imber-Black, 1988). More recently, practitioners and researchers working with families who had experienced adversity like physical and sexual abuse, parental substance abuse, chronic or life-threatening illness or natural disaster noticed that some families managed adequately or better, while others continued to live troubled lives or spiral downwards. Researchers began to ask what distinguishes individuals and families who rise above their adverse circumstances. It may be tempting to see these families as 'super families', but in fact, they struggle, working hard to communicate to express their care to one another.

Two recent reviews (Bhana & Bachoo, 2011; Sheridan, Eagle, & Dowd, 2005) indicate that resilient families exhibit:

- Cohesion (Beavers & Hampson, 2000), as expressed by family time and routines.

- Adequate problem-solving skills.
- Active and affective involvement with one another (Epstein, Baldwin, & Bishop, 1983) that conveys empathy. In families with children, parental involvement in school is positively correlated with behavioural, emotional and academic outcomes (Christenson & Sheridan, 2001).
- Social support, from within and outside the family.
- Shared beliefs and values, including spiritual beliefs (Walsh, 1996).
- The opportunity of a child to contribute to the well-being of the family. Ungar, Theron, and Didkowsky (2011), interviewing youth in five countries, found that they contributed to the well-being of families by taking on a specific role to help their families. Rather than seeing these children as ‘parentified’, they argue that these children contribute significantly and necessarily to the family’s well-being.

Dunst, Trivette, and Deal (1994) suggest these principles for family-centred service delivery: basing intervention efforts on needs identified by the family; utilizing existing strengths and competencies; maximizing the use of the family’s social network; and tailoring interventions with the family’s motivation and readiness. Accordingly, a family therapists often help families to gather social support outside of the immediate or the extended family (Dutta & Finlay-Musonda, 2007). In this section, we will describe several examples of ecological intervention.

Multisystemic therapy

Multisystemic therapy (MST) targets families of youth with serious problems (e.g. criminal offenders [including violent and sexual offenders], adolescent substance abusers, youth experiencing serious emotional problems). MST is based on several theoretical bases: Bronfenbrenner’s (1979) theory of social ecology, which considers the various social systems in which the young person is located; structural family therapy (Minuchin, 1974), which attends to boundaries and recurring interactional patterns; strategic therapy (Haley, 1976), which focuses on family hierarchy; social learning theory (Patterson, 1971), which focuses on modelling and reinforcement of behaviour; and cognitive-behavioural therapy (Dattilio & Nichols, 2011), which supports the development of problem-solving skills. These interventions are nested in a social ecological framework.

MST is delivered intensively by a team of two to four master’s level therapists, each of whom carries only four to six families, for 3–5 months. Treatment is delivered outside of office hours, in the family’s home or community. Family members, the caseworker and other professionals are interviewed about the case, including potential goals. The therapist assesses the strengths and needs of the system from a social ecological perspective (Bronfenbrenner, 1979). Evidence-based interventions are custom designed, with the specific goal of helping families develop a sustainable local support system.

MST has received wide acceptance. There are over 20 published outcome studies, including 18 randomized trials. It is delivered to more than 17 000 youth and families annually, at multiple sites. Significant effort has gone into studying MST's portability across locations.

Network therapy (Speck)

Network therapy (Speck & Rueveni, 1969; Speck & Attneave, 1971) gathers the kinship system, the family's friends and other significant people, sometimes as many as 30 or 40 people, to work on the problem. Rueveni (1975) described the use of four network sessions to treat a conflictual couple, with major disagreements about their 16-year-old son. Network therapy began when conventional therapy had not been effective. In addition to the family members, six of the son's friends came to the first session. Rueveni described considerable improvements in the family situation. Network meetings, without the therapist, continued for 3 months after the last of the four sessions. The author believed that network sessions facilitated 'intensity of the involvement and caring on the part of those network activists who maintained a continuous support'. The three family members improved in their ability to rely on each other for support. As with other ecological interventions described here, the process mobilizes extended family supports.

Network therapy (Galanter)

Independently, and without reference to the previous work by Speck, Galanter and Dermatis (2011) developed a systemic approach by the same name, for the treatment of substance abuse. It combines cognitive-behavioural relapse prevention, involvement of the client's support system and 'community reinforcement techniques'. The client's support network is composed up of people mutually agreed upon by the therapist and the client. Galanter found that the client's social network supports the client's abstinence, undercuts denial and supports the client's treatment plan. Outcome research found that the number of network sessions in which the client participated was positively correlated with treatment outcome.

Multiple impact therapy

Multiple impact therapy was developed by MacGregor (1962) at the University of Texas Medical Branch Hospitals at Galveston. The Youth Development Project, a research project treating adolescents referred from correctional services, dealt with some families in crisis who lived a long distance from the clinic. The team therefore developed a plan that treated entire families for 2 or 2½ days. A team of therapists of various disciplines

would meet with the family on their arrival, beginning with a team–family conference.

Next steps varied from family to family, but typically each family member was seen individually by a team member, and then in various configuration with other family members. At midday, the team would confer and further interviews would be held in the afternoon, the day ending with another team–family conference. The process would continue as required the next day, extending to a third day if necessary. A follow-up visit was required; in one-quarter of the cases, a further day’s treatment was arranged after about 2 months (MacGregor, 1962). Community resources such as local treatment agencies, teachers and ministers were extensively involved in the follow-up period.

Multiple impact therapy has not been widely practiced, likely because of the practical difficulties associated with gathering whole families for two or more days. It may be particularly valuable when families live at great distances from clinics, but as family therapists become more numerous, and as technologies such as Skype are available, this applies to fewer families.

The open dialogue approach

Developed in rural Lapland, Finland to meet the needs of patients experiencing psychosis, the *open dialogue approach* is based on the principles that ‘the social network of the patient, including the family and the professionals . . . should always be invited to participate, from the outset and for as long as required’ (Seikkula, Alakare, & Aaltonen, 2011). The team aims to respond within 24 hr of the contact with the patient. Treatment is flexible and collaborative. As the name implies, the generation of dialogue permits the unspoken to be spoken.

Coming from a social constructionist approach, treatment meetings are a key element of the open dialogue approach. *Dialogical equality*, in which the expertise of family members and all staff is valued equally, is the goal. Haarakangas, Seikkula, Alakare, and Aaltonen (2007) prefer multi-voiced conversations that include the nursing staff and family. Treatment meetings are viewed as *reflective dialogues*, in which decisions are not taken without consensus. Haarakangas et al. (2007) reflect that they have evolved from ‘experts’ to ‘dialogicians’ as their collaborative approach has developed.

Family group conferencing

Not a therapy approach as such, but an ecological approach to family intervention, *family group conferencing* (FGC) originated in New Zealand to address the over-representation of Maori children in the child protection and juvenile justice systems and the frequent exclusion of their families from decision making. FGC was developed as a culturally responsive way to involve the family, based on their kinship and spiritual beliefs (Connolly,

2006). The coordinator, who is usually at arms' length from the statutory authority, interviews all stakeholders – parents, extended family members, close friends and elders (if appropriate) – before the conference, often spending 20–40 hr in preparation.

The conference itself, held in a neutral location, typically lasts 4 hr. If appropriate for the family, the conference opens with culturally relevant prayers or spiritual practices, followed by introductions of participants and their relationship with the child in question. The meeting is focused on identifying family strengths and potential supports, as well as possible obstacles or worries. After all participants have expressed their perspective, and the statutory body has presented non-negotiable elements, the family is left in private as long as required to generate a plan for the child(ren). The entire group reconvenes when the family states that they are finished meeting. According to Pennell and Burford (2000), many of the plans generated by families are as good as or better than would be generated without their involvement.

FGC has been applied in Australia, France, South Africa, the United Kingdom, Sweden and the United States. In North America, FGC has been integrated with First Nations practices. Recently, the method has been applied in Guatemala to address adoption issues (Rotabi, Pennell, Roby, Bunkers, & McCreery, 2012).

Summary

The ecological approaches described in this section come from a variety of theoretical roots – social ecology theory, cognitive behavioural relapse prevention, social constructionism, culturally appropriate indigenous thought and so on – but share an emphasis on intervening in the social network of the person exhibiting problems. The developers formulated these approaches to respond to serious problems (e.g. youth conduct problems, psychosis, substance abuse, child protection issues) in their own backyard, often in isolated locales where traditional office-based family therapy delivered in 'the 50-min hour' is either not available or not effective.

Family therapy and serious mental illness

As we saw in Chapter 1, many of the pioneers of family therapy devoted much of their attention to the investigation and treatment of the families of people suffering from schizophrenia. However, 30 years ago, McFarlane (1983, p. 1) stated the following:

During the 25 years that family therapy has been developing, there has been, until very recently, a nearly linear decline in interest in the family treatment of schizophrenia. Reports of treatment techniques and even

research studies have dwindled in the family literature Drug therapy is still the mainstay . . . while research . . . has become almost completely oriented toward its biological aspects.

While very few currently believe that family dynamics alone cause serious mental disorders, as was postulated in the double bind theory of schizophrenia, it is generally recognized that the interpersonal context can greatly help or hinder the client. Accordingly, psychiatric services have implemented family-based interventions and introduced family systems approaches (Schweitzer et al., 2007; Stanbridge & Burbach, 2007; Webster, 2007).

Nichols (2009) traces the history of family therapy approaches as applied to serious mental disorders, from the mid-1950s, when both the ‘thorazine revolution’ and the ‘family therapy revolution’ emerged (p. 346), to the current day. While advances in psychopharmacology have dominated and changed the face of psychiatry, many psychiatrists were working with families (see Chapter 1). Some did so without a great deal of fanfare, and even covertly, given the dominance of the psychodynamic approach. The 1960s and 1970s saw the deinstitutionalization of psychiatric patients, with the US psychiatric hospital population declining from over half a million in 1955 to below 1 00 000 by 1990. According to Nichols, deinstitutionalization was a mixed blessing – fewer patients warehoused, but more ‘falling through the cracks’ or subject to the ‘revolving door syndrome’.

Schizophrenia

In the area of schizophrenia, *expressed emotion* (EE) was the subject of a series of methodologically sound and replicable studies at Britain’s Medical Research Council’s Social Psychiatry Unit (Leff & Vaughn, 1985). The researchers developed a structured interview protocol designed to sample five particular aspects of EE: *critical* and *positive* comments, *emotional overinvolvement*, *hostility* and *warmth*. Leff and Vaughn found that EE was positively correlated with relapse. The best results occurred with regular use of anti-psychotic drugs and low EE on the part of the relatives. The researchers also investigated a group of ‘depressed neurotic’ patients, to see if their findings generalized to other populations. The depressed neurotic patients were even more vulnerable to critical comments by relatives, but face-to-face contact between patients and relatives was not correlated with relapse, as it was among schizophrenic patients. Low face-to-face contact appeared to protect schizo-phrenic patients in ‘high-EE’ homes, but had no such function for depressives. The researchers concluded:

We interpret this as an indication of a poor relationship between a patient and a relative that predates the illness. We consider it likely that low contact and high criticism are both indicators of a poor marriage (virtually all these relatives were spouses) and that the poor quality of the marriage predicts relapse of depression. (Leff & Vaughn, 1985, p. 93)

It seems that high EE may predispose patients to relapse, but there is no clear evidence that it is a significant aetiological factor.

Communication deviance (CD), on the other hand, may play at least a small role in the aetiology of schizophrenia. CD consists of various forms of vague, ambiguous, wandering, illogical and idiosyncratic language, similar in some respects to schizophrenic thought disorder, but less severe. Singer, Wynne, and Toohey (1978) and Wynne (1981) developed instruments for measuring CD, finding it in the parents' communication with each other, as well as in the communication involving the patient. These abnormal communication speech patterns may be displayed by the parents' years before the onset of schizophrenia in their offspring and are similar to those that develop in the offspring. They may therefore play a part in the aetiology of the disorder, along with genetic and biological factors.

Intervention. If 'conventional' family therapy alone is not effective, what can a family systems approach offer? Leff, Kuipers, and Berkovitz (1983) described a trial of an intervention programme designed to reduce EE in the families of patients at high risk of relapse. All the patients received medication, while the experimental group also received a systemic treatment with two components: an educational programme, designed to help relatives understand the nature of schizophrenia and its symptoms; and a relatives' group, in which 'low-EE' relatives would help teach the necessary coping skills to the 'high-EE' relatives. Additional interventions (e.g. marital therapy or housing support) were implemented as required.

The results of this small-scale treatment trial (12 families in the experimental group and 12 in the control group) were encouraging. Critical comments and reduction in social contact, and reduced frequency of relapse occurred in the experimental group. Subsequent research echoes these early findings. The following factors appear to be helpful: developing a supportive relationship with caregivers; lowering emotional reactivity by reducing stress; helping the relatives develop problem-solving skills; reducing expressions of anger and guilt; being realistic about the capacities of the ill family member; and supporting relatives to set appropriate limits with the symptomatic member, while maintaining appropriate separateness. These elements are part of many intervention approaches in the literature: multiple family therapy (Laqueur, 1973; McFarlane, 1983), educational and supportive approaches (Zippel & Spaniol, 1987), behavioural family therapy (Falloon, 1991), assertive outreach (Wane, Larkin, Earl-Gray, & Smith, 2009); and the open dialogue approach described earlier in this chapter (Seikkula et al., 2011).

Mood disorders

Couples therapy. Beach and Whisman (2012) reviewed the available literature on couple and family intervention for depression. The relationship between marital distress and depression is well documented

(Lemmens, Buysse, Heene, Eisler, & Demyttenaere, 2007; Lemmens, Eisler, Migerode, Heireman, & Demyttenaere, 2007), but the relationship between parenting problems and depression has not been as well researched. Depressed parents exhibit more withdrawal and negative parenting behaviour. Using the *stress generation model* (Hammen, 2006), depression is a systemic phenomenon, fuelling, and being fuelled by, stressful life events. Accordingly, intervening to reduce stressors (i.e. marital distress or parenting troubles) can bring about improvement in depression.

Three randomized clinical trials (Beach & O'Leary, 1992; Emanuels-Zuurveen & Emmelkamp, 1996; Jacobson, Dobson, Fruzzetti, Schmalings, & Salusky, 1991) have demonstrated that marital therapy reduces the depression of one spouse. In fact, behavioural marital therapy and individual cognitive therapy are equally effective for depression in both distressed and non-distressed marriages. Behavioural parent training that actually results in the acquisition of more effective parenting skills reduces depression as well (Barlow & Coren, 2004).

The available research leaves one important question unanswered. Should every depressed client receive family intervention to relieve family stress? Some (Barbato & D'Avanzo, 2008; Beach, 2003) conclude that family treatment should be offered only when clients express distress about their marriage or parenting. On the other hand, Bodenmann et al. (2008) and Cohen, O'Leary, and Foran (2010) found that couple intervention can help depressed clients who do not report marital discord, and Beach et al. (2008) found that parenting interventions are helpful for depressed mothers who do not report distress about parenting. Accordingly, an important question for further research is how to distinguish who should receive specifically targeted couple or family intervention.

Family group intervention. The Anxiety and Depression Unit of the University Hospitals Leuven has developed a multi-family discussion group, which we provide here as one example of a *multiple family group*. The group is strength focused and uses techniques such as interventive interviewing, reframing, family life cycle exploration, externalizing the illness and metaphor. Instruction about depression and sharing of different experiences provides support for family members. The group is structured in the following way:

- Impact of the depression/treatment on the family unit
 - Couple (session 1)
 - Children (session 2)
- Couple issues (session 3)
- Restoring family functioning:
 - Couple (session 4)
 - Children (session 5)
- Relapse prevention (session 6)
- Follow-up session (session 7)

Mental health recovery movement

The *recovery movement* is a consumer-driven movement serving those with psychiatric diagnoses (Gehart, 2010). Aimed at empowering consumers, it has some commonalities with systemic therapies. Given that the World Health Organization has found that 28% of hospitalized psychiatric patients experience full recovery and 52% achieve social recovery (functioning in day-to-day life and relationships), the recovery movement aims to reduce pathologizing practices and create supportive environments for consumers. It has gained prominence in the United Kingdom, Ireland and Australia, before entering the United States in the last decade.

The Recovery Movement assumes that the social support networks and intimate relationships of psychiatric patients are integral to their well-being. Mental health problems are seen as an expression of interaction between the person and environment, and interventions should target relational functioning. The Recovery Movement also considers social discourses. Recovery entails the development of narratives that invite hope, agency and possibility and identify strengths (Gehart, 2010).

Summary

While family therapists are no longer looking to family interactions alone for the aetiology of severe mental illness, the literature clearly states that social support is useful to mobilize family members to support the patient. Conceiving of intervention systemically, whether it is delivered in multiple family groups, parenting workshops, community outreach, skills training or large meetings of a client's support network, can give a family therapist many avenues for intervention.

Mindfulness practices

Mindfulness is 'the direction of attention towards one's ongoing experience, in a manner that is characterized by openness and acceptance' (Bishop et al., 2004, p. 231). Mindfulness interventions are derived from Eastern meditation practice. Mindfulness practices invite one to attend to one's cognitions, emotions and sensations without judgement. There is no attempt to restructure cognitions or reject particular emotions. Mindfulness practices can be used as a self-regulation practice. Attention to physiological sensations and breath encourages physiological relaxation.

In individual psychotherapy, mindfulness practices have been incorporated into dialectical behaviour therapy (DBT; Linehan, 1993), acceptance and commitment therapy (ACT; Hayes, Masuda, & De Mey, 2003), mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and mindfulness-based cognitive therapy (MBCT; Segal, Teasdale, Williams, &

Gemar, 2002). Mindfulness as a clinical practice has warranted a voluminous handbook (Didonna, 2009).

Pruett and McCollum (2010) found that experienced meditators report these beneficial individual effects: increased awareness of sensations and affect; the ability to separate from their emotions and thoughts; acceptance of situations that may not change; and compassion and loving kindness for oneself and others. Consequently, in relationships, they experienced less reactivity and greater freedom and security and a new understanding of the interrelationship between separation and connection. It is arguable that these effects could benefit any relationship (Marlatt & Witkiewitz, 2002). Wachs and Cordova (2007) found a high correlation mindfulness and relationship satisfaction.

While mindfulness practices have become extremely popular, specific applications to family therapy have been slower to emerge. The handbook cited above (Didonna, 2009) does not contain a chapter applying mindfulness practices to family therapy. Carson, Carson, Gil, and Baucom (2004) evaluated *mindfulness-based relationship enhancement* (MBRE), an eight-session educational programme. They found that mindfulness improved couples' relationship satisfaction, autonomy, relatedness, closeness, acceptance of their partner; reduced relationship and individual emotional distress; increased members' optimism, spirituality, relaxation; and reduced psychological distress (Wachs & Cordova, 2007). Christensen, Sevier, Simpson, and Gattis (2004) suggest integrating mindfulness practices with cognitive behavioural marital therapy or integrative couple therapy. Beckerman and Sarracco (2011) describe integrating mindfulness practices with emotionally focused therapy.

Gehart and McCollum (2007) suggest that mindfulness practices invite shifts of perspective similar to some aspects of family systems thinking. For example, in most therapies, change is the focus, while mindfulness practices support acceptance of life 'as it is', or as Gehart and McCollum call it, 'engaged equanimity'. This is consistent with family therapy approaches that see problem-maintaining patterns as neither 'good' nor 'bad', or that reframe (Watzlawick, Weakland, & Fisch, 1974) or positively connote (Palazzoli, Boscolo, Cecchin, Prata, 1978) problems, and maintain a nonpathologizing attitude. They recommend that therapists assume a mindful presence of 'compassionate witnessing' (p. 220) and befriending the problem as a teacher, not an enemy.

Innovative formats for service delivery

Medical family therapy

Medical family therapy complements medical practice to help patients who have 'serious mental health or relational problems, whose medical and psychosocial issues are intertwined, or who are struggling to cope with their

own resources or a family member's illness' (Ruddy & McDaniel, 2003, p. 418). Medical family therapy is transtheoretical, drawing on a biopsychosocial perspective.

Primary health care is one practice setting for medical family therapists. Seventy-eight percent of clients with mental health issues first seek help from primary care physicians instead of mental health providers; primary care physicians prescribe up to seventy percent of psychotropic medications (Miranda, Hohnhmann, & Attkisson, 1994). Medical family therapists can educate physicians about the psychosocial correlates of somatic complaints and collaborate with physicians to treat psychosocial disorders.

Chronic illness is another practice area for medical family therapists. Chronically ill patients have higher rates of anxiety and depression than the general population. Moreover, there are many adaptations that families must make as they deal with a member's chronic illness: changes in family roles, the burden placed on caregivers, reduced earning power of the chronically ill member, accommodating treatment regimens, maintaining communication between family members about the illness and grieving losses (Ruddy & McDaniel, 2003). The onset, course, outcome, level of disability, predictability of course and aetiology (genetic or not) are important determinants of adaptation (Rolland, 2012). Medical family therapists provide psychoeducation to clients suffering from specific disorders and support clients to adapt to chronic illness.

Single-session therapy. Single-session therapy is not new. Single courses of therapy started with Freud and continue to the present day (Talmon, 1990). Talmon found that the most frequent duration of a course of treatment, irrespective of theoretical approach or setting, is one session. Recently, settings like health maintenance organizations and non-profit mental health services (Chang, 1992; Harper-Jaques, McElheran, Slive, & Leahey, 2008; Young, Weir, & Rycroft, 2012), that must provide efficient service, have intentionally implemented single-session therapy. This is particularly important to minorities, who more frequently drop out of therapy than clients of the dominant culture (Bobebe, Lopez, Scamardo, Solorzano, 2008).

Single-session therapy reflects the reality that change tends to be 'front-loaded' – the greatest amount of change occurs early in therapy. Moreover, Pekarik and Finney-Owen (1987) found that therapists estimate that clients need three times as many sessions as clients themselves do. A critical variable here is the belief system of the therapist. It is necessary that the therapist or the organization believes that one session can be useful.

There appears to be ample evidence for the effectiveness of a single session. Talmon (1990) found that 78% of clients were satisfied with a planned single session sandwiched between phone contacts. Miller and Slive (2004) found that 45% of clients felt that one session was sufficient to solve the presenting problem, 68% maintained improvement after 3–6 months and only 3% reported a decline in functioning. Miller (2008) later found that clients had an 82% satisfaction rate across presenting problems.

Single-session therapy is a pragmatic integration, borrowing from brief, solution-focused and strength-based approaches (Slive & Bobele, 2011).

The intervention is viewed as self-contained within one hour, and the focus is on the immediate context of the problem, not history or aetiology. Single-session therapy removes barriers to therapy, increases access and can be an effective in and of itself or as an adjunct to other treatment approaches (Stalker, Horton, & Cait, 2012).

School-based family therapy. Although health, including mental health is not the 'core business' of schools, schools are the only point of nearly universal access to young people. Children and adolescents spend close to half their waking hours in school. The quality of their experiences with teachers and peers affects emotional well-being, and transitions in education are significant events in their lives. Schools provide an entry point to the family.

Whitmore (2004) found that a significant proportion of US school counsellors, school psychologists and school social workers do family therapy. Powell's (2011) content analysis of school-based family therapy literature found that it was very effective with behaviour problems, improving relations between schools and parents and bringing about system change. Both Whitmore and Powell called for greater availability of family therapy services, suggesting that these could be integrated with whole school mental health programming. Courses and programmes in school-based family therapy (Carter, 2003; Terry, 2002) have been initiated.

Exemplary whole school programmes (e.g. MindMatters [Broomhall, Devlin, Anderson, & Doyle, 2004; Franze & Paulus, 2009]; Gatehouse Project [Patton et al., 2000]) intervene to build the systems and connections in school communities. Family therapists, whose training enables them to think systemically, can be an asset in such programmes. Chang and Laundry (2012) discussed the need for school-based family therapy to be delivered as part of universal mental health programming.

Home-based family therapy. Home-based family therapy has been used for the past three decades. It has been based on a variety of theoretical models, including solution-focused therapy (Berg, 1994), narrative therapy (Madsen, 2007), multisystem family therapy (Henggeler & Lee, 2003), social learning theory (Sayger, Horne, Walker, Passmore, & Laurence, 1988), functional family therapy (Alexander, Robbins, & Sexton, 2000) and structural-strategic family therapy (Jones & Lindblad-Goldberg, 2002), to name but a few. Contextual aspects of home-based family therapy seem to be more important than the specific theoretical framework. Mache and O'Connor (2010) identify several aspects of home-based therapy that differ from traditional office practice: the *environment and context*, the *family's roles and expectations*, the *therapist's roles and expectations*, the *therapeutic relationship* and the *focus of clinical work*. These elements mutually influence one another.

The *environment and context*, namely the home, provides the therapist access to the family's natural setting. This demonstrates the therapist's willingness to enter the family's environment and permits the therapist to observe the family in their home. The disadvantages are unexpected interruptions (e.g. telephone calls, television and visitors), but these interruptions provide valuable information about the rhythm of the family's life.

The family's *understanding of roles and expectations* changes, as they are seen on their 'home turf', not in a potentially disempowering professional office. Since most families referred for home-based therapy are considered 'multi-problem' (or, as Madsen [2007] terms it, 'multi-stressed'), with children at risk of placement, traditional therapy has not worked. The home-based therapist must use the family's 'host' role to gain their participation in treatment.

The *therapist's understanding of roles and expectations* changes, too, as it is important to embrace the 'guest' role and make clinical sense of how the family presents in the home. In-home observation can provide information that might not otherwise be apparent. Therapists must become accustomed to being somewhere that may feel foreign, especially if the family is culturally different.

The therapist must manage the *therapeutic relationship* differently than in office practice. It may be tempting to fall into a social visit, as opposed to developing a clear contract for therapy. The therapeutic goals are often statutorily determined, if a child is at risk for placement out of the home. Therefore, the therapist must navigate this carefully.

Home-based family therapy provides an ecologically based intervention that is accessible for families who have significant difficulties. While working in the home provides many advantages to therapists, they must also make adjustments to be effective in-home practitioners.

Conclusion

In this chapter, we have described a wide variety of interventions that can be used to augment your approach to therapy. Approaches such as family sculpting, role playing, family psychodrama and video playback can be used to introduce novel experiences to families. Expressive approaches like family music therapy, family play therapy and family art therapy can bypass conscious experience and intellectual defences and change family interactions. We then reviewed several ecological, larger system approaches that enhance family resilience and described family therapy's contributions to the treatment of serious mental illness. Mindfulness practices offer a promising avenue for developing further intervention or integrating into existing ones. Finally we reviewed four innovative formats for the delivery of family therapy: medical family therapy, single-session therapy, school-based family therapy and home-based family therapy.

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Chapter 13

A Method of Therapy

Every family therapist needs a coherent way of approaching therapy. Most use concepts derived from several schools of family therapy. It is not necessary to completely adopt any of the therapy models we have discussed so far, nor any other specific model. It is important, though, to have a coherent approach and to subscribe to a theory of how change occurs. This chapter describes a way to organize your therapeutic efforts, regardless of your theoretical orientation.

How therapists work and the methods they use depend partly upon their personalities ('what fits for you'; Simon, 2006), partly upon who has taught them and largely upon what they find works for them (allegiance effects; Duncan, 2010). The personalities of some therapists are better suited to certain types of therapy. For example, some feel comfortable with the use of humour, while others find this difficult. Some feel more comfortable being directive or confrontative. Based on theoretical assumptions, some focus more on emotional expression, while others focus on observable behaviour. The therapist's type of practice is another relevant variable. As we saw in Chapter 12, many interventions, especially ecosystemic ones, are not delivered in a '50-min hour' in an office-based practice. What is effective for many middle- and upper-income families, who function well instrumentally, may not be helpful to some families in different socio-economic circumstances and vice versa.

Most therapists, at least those who have not reached a state of professional stagnation, are constantly refining their conceptual, perceptual and executive skills (Tomm & Wright, 1979). Remarkably, the field of family therapy has been developing a wide variety of approaches at a rapid pace. Hoffman's (2002) book is a beautifully written account of how her approach to therapy developed over the course of some three decades.

So how should you, the therapist starting out in this field, proceed? Much will inevitably depend on the training you have received. You should by this time have acquired a philosophical approach, adopted a theory of change and developed a way of working with families. You will then want to continue incorporating new ideas and approaches as you learn of them. You may add some of the techniques we describe in this book. Others you will learn elsewhere or acquire during your clinical experience with families, and

in working with colleagues. Here, we offer a beginning framework on which you may build.

Treatment by stages

It may be useful to think of therapy as proceeding through a number of stages. Keep in mind that you do not need to undertake these lock step. We offer these stages to orient yourself, as you remain open to respond to clients' changing needs.

Establishing rapport and a working alliance

The importance of *establishing of rapport* can hardly be exaggerated. It enables the process of *joining* the family (Minuchin, 1974) or *bonding* as Kirschner and Kirschner (1986) called it. Sundet (2011) found that clients appreciate therapists' humanness, as expressed by self-disclosure, and 'blurring of boundaries' between therapists and clients. Clients also appreciate it when therapists honour their perspective. Finally, clients also need a sense of direction in therapy, feedback from therapists and 'reformulation' – a different way of thinking about the problem – as long as their own perspective is respected.

It is useful to ask about the day-to-day or week-to-week rhythm of the family's life and get to know them apart from the problem. Where does each member work or go to school? What part of it do they enjoy the most or, in the case of some young people, dislike the least? What do members of the family do when not at work or school?

Assessing the family

The relationship between assessment and intervention

In most situations, you will perform an informal assessment, as described in Chapter 5. We suggest you explore the problems the family experiences, as much as necessary for them to feel understood and taken seriously and for you to understand how the problem is enacted. However, it is more important to focus on the changes desired, and do your best to discover the family's strengths and successes.

As O'Hanlon and Weiner-Davis (1989) note, *assessment is intervention*. How you frame your questions and lead the conversation embeds messages to the family. Using *action descriptions instead of labels* (e.g. 'doing' or 'experiencing anxiety' vs. 'being anxious'), assuming *times without the problem* or *when the problem is less prominent* (e.g. 'When things aren't as bad . . . ' or 'When it does not last as long . . . ') and assuming the *client is an active agent* (e.g. 'When you seem to have more control . . . ' or 'What do you do sometimes to make things a little better?') can set the stage for change.

In a complementary way, *intervention is assessment*. Clients' response to your therapeutic interventions will give you new information about the family. This can tell you whether the particular intervention brings about the desired changes and may lead you to modify your understanding of the family and your treatment plan.

Explore problems

Sometimes a family's problems, or some of them, quickly emerge – even in the first few minutes of their first session. The family members may also quickly clarify the changes they seek. For example, there may be a concern that communication, or the control of members' behaviour, is not the way they would like them to be.

At other times, the family's account of problems is jumbled; family members disagree with one another if there actually is a problem or emphasize different aspects of the problem. It is important to maintain an equidistant position in relation to each family member, so as not to appear to side with anyone's view of the problem. When reflecting client statements or summarizing content, use language that acknowledges one family member's perspective without agreeing (e.g. 'When James walks away, you *perceive it as* ignoring you and being disrespectful, but, James *you say* you are walking away to protect everyone from your anger').

Most of the time, clients come to family therapy ready and eager to discuss problems. Often clients make *complaints* (e.g. 'My son is staying out all night and stealing cars' or 'I can't seem to find a job that suits me'). At other times, problems are expressed as statements of blame (e.g. 'If you weren't so distant, I wouldn't have to nag you to talk'). Clients also make *statements of process or means* – what they think they need to get better (e.g. 'We need family therapy' or 'I would like to talk about my feelings about having been sexually abused'). Still others express *dreams* (e.g. 'I'd like to go back to school and become a doctor'), *wishes* (e.g. 'It would be great if I didn't get nervous when I have to present in class'), *desires* (e.g. 'I would really like to have a better relationship with my daughter') or *hopes* (e.g. 'One day I'd like to overcome my tendency to get involved with women who aren't right for me'). Finally, some clients describe *deficits in internal states* (e.g. 'I need more self-confidence', 'I'm codependent' or 'I'm passive aggressive').

Some of these are statements of what is wrong (with oneself or with others). Some are statements of what is not wanted. Others are statements of what is wanted... eventually or vaguely. They differ temporally (the time frame for the desired outcome to occur), interpersonally (who else is involved in the problem and/or in the solution), attributionally (who is responsible/to blame) and realistically (whether it is practical and doable). It is the therapist's job to lead the conversation with families to move towards well-formed goals that are behavioural, temporally specific, clear in terms of who is to do what and practical: 'What will be different when this problem has been solved?'

Or, the family may simply appear to be overwhelmed with many problems. The family may have been experiencing several difficulties (e.g. poverty, illness, poor living conditions), but may have been ‘pushed over the edge’ by a crisis like the arrest of a teenaged child, the sudden onset of an illness or job loss). With overlapping problems, you can ask questions like this to prioritize:

- Which of these things are bothering you the most?
- Is there one particular issue that, if it got better, would improve some of the other problems?
- What would be easiest for us to tackle right now?

Family members are often surprisingly clear about what should change first and how problems are interrelated.

Sometimes, family members are clear about what should change. For example, if communication is something the family would like to improve, the therapist might choose, even in the first session, to try to promote more effective communication between the family members. This would be both a diagnostic and a therapeutic procedure. It would test the hypothesis that verbal communication between the family members concerned is poor and would reveal whether your intervention was effective.

Keep in mind that the family comprises different individuals with different views of the problem and different agendas for change. Lambert, Skinner, and Friedlander (2012) studied five families receiving services in a child and adolescent psychiatric unit, who had poor therapy outcomes and low scores on a working alliance scale. Families fell into three categories: disagreement about whether there was a problem and whether therapy was valuable; disagreement about the problem and goals, while seeing therapy as valuable; and agreement on the problem, but disagreement about the goals and value of therapy. In these situations, it is helpful for therapists to:

- *Encourage compromise between family members:* ‘Kelly, your dad sees the problem as your lack of cooperation, but you see his expectations as unrealistic. Do you think you could both come to the middle a bit? Dad, would it be OK for you to let up on some of your requirements? Kelly, could you work a little harder to pick up after yourself?’
- *Activate mutual support and caring:* ‘Josh, your mom has been talking about how all these pressures have been stacking up on her. As you listen to this, how would you like to encourage her?’
- *Encourage clients to ask about, and take, the perspective of others:* ‘As Ken goes through all these pressures at work, what would be your guess about what is going for him?’
- *Emphasize commonalities in family member’s views on the problem:* ‘OK, you agree that stress is affecting you both badly: George, you withdraw and go to your “man cave”, while Elaine, you panic and think he doesn’t love you. How about if we work on both your responses to stress?’

Eliciting the family's description of the circular patterns in which the problem behaviour is embedded can reduce mutual blame. Discussing the problem in externalized terms can enable family members to agree about the nature of the problem and join against a common enemy.

In any event, particularly for novices, it is important both to carry out an assessment as described earlier and to establish clear therapeutic goals. By the time you have completed these processes, the family may have made changes. These can occur as the members 'think out loud' about their situation with the therapist and change their points of view. Sometimes, as you ask about the family's problems and desired outcomes, they will tell you about the changes that occurred even before the appointment (Weiner-Davis, de Shazer, & Gingerich, 1987). Or, as you discuss issues with them using action descriptions instead of labels, assuming problem-free times and referring to clients as active agents, they may spontaneously tell you about improvements, which you can then amplify through the interview process.

Develop a coherent case conceptualization

Any of the *family assessment schemes* described in Chapter 5 can be used to conceptualize the family's functioning. It is helpful for novices to go through each dimension of a particular assessment framework, make a judgement about how the family functions on each of these dimensions and specify the behaviour of family members that supports your judgement. This will assist you to learn to think systemically, by connecting specific behaviours to the concepts of family functioning. If you can take the time to learn one particular model of family therapy, you will be able to develop a *theory-based case conceptualization*. For example, if you have learned the basics of emotionally focused therapy (EFT; Johnson & Zuccarini, 2011), you might conceptualize a partner's withdrawal as a disruption to the couple's attachment, which would lead to the theory-driven goal of supporting the couple to re-engage and remain connected to one another. Or if you have been trained in structural family therapy (Minuchin, 1974) and you notice that a father favours a child and blocks the mother from disciplining the child, you might interpret that as a coalition between the father and the child. Your theory-driven goal would be to block the coalition and strengthen the parental subsystem to discipline together. Developing theory-driven goals can help you make sense of what is happening in the family, but take care that your theoretical formulation does not overwhelm the clients' point of view, lest the client feel disrespected.

A family therapist can also focus on obtaining a detailed description of the problem pattern. Such a *pattern analysis* can direct the therapist where to target the intervention. As O'Hanlon and Weiner-Davis (1989) suggest, we suggest asking in terms of *videotalk* ('If I could see a video or movie of what happens...') to erode the fixed ideas embedded in diagnoses. I (JC) usually ask clients to add their *voice-over narration* to learn about the thoughts, emotions and bodily sensations associated with the problem, and

if relevant, what invites the client to think or feel that way. Eliciting a video description also opens the door for clients to describe the interpersonal context of the problem. This is particularly important when family members do not agree about the problem, or blame one another (or one particular family member).

After the therapist and the client have drawn out an interpersonal problem description, ask if the scenario described is representative of the problem (e.g. ‘Is this the usual way your arguments come up – disagreement about chores?’). Understanding the interpersonal context of the problem shows the therapist where to target the intervention.

It is also useful to know *how something is problematic*. This can help the therapist to understand the meanings that the clients attach to the problem. Take the situation of a heterosexual couple coming for therapy over the husband’s pornography use. The therapy would likely be framed differently if the wife objected to the pornography use because she thinks it is simply immoral, believes it interferes with their sex life, thinks it demeans and objectifies women, interprets it as a form of infidelity or ‘doesn’t mind it as long as we watch it together’. Or, the husband may think pornography use is a ‘sin’ but feels helpless to stop, thinks ‘it’s no big deal – why can’t she just get over it?’ or believes that feminist arguments against pornography are just ‘sour grapes by a bunch of man-haters’. It is important to distinguish if an undesired behaviour is problematic because it tangibly interferes with the family’s (or one member’s) functioning (e.g. a child ‘talking back’ and not complying with parents, resulting in important homework not being done; or depression preventing someone from working) versus simply being an undesirable state of affairs (e.g. a child’s short-lived defiance annoying a parent, or melancholic feelings occasionally causing one to feel ‘blue’). This may inform whether the goal of the therapy should be to alter one’s perspective to accept a situation that is not ideal or to change behaviour.

Revisiting Lambert, Skinner, and Friedlander (2012), disagreement about goals, tasks and methods interferes with therapy outcome. As discussed in Chapter 7, family members may have different levels of motivation and may be more or less amenable to taking action in therapy depending on the framing of the problem.

The question of *why now?* is important as well. When the problem is triggered by a specific event (e.g. a relationship break-up, arrest or suspension at school), this is usually obvious. But this is a more complex question when the problem is long-standing. The reason for seeking help may be as simple as now being able to afford it, but it is important to ask.

Whether you develop a case conceptualization based on an established framework for family assessment, a specific theory of family therapy or a descriptive pattern analysis, your conceptualization should provide you with sufficient guidance for intervention planning. More importantly, it is necessary to negotiate a problem definition that is reasonably acceptable to each member of the family.

Formulating goals

You have explored problems by asking for descriptions (not labels), assuming that problems are sometimes not present or less severe, embedding the message that clients are active agents, prioritizing problems according to client preference and encouraging a shared sense of purpose. The next step is to formulate therapeutic goals. Well-formed therapeutic goals (Berg, 1994) are:

- *Salient to the client(s)*. As we have described above, it is important to frame goals in a way that all family members can accept. Clients must believe that realizing the goal will be beneficial.
- *Small, rather than large*. Goals should be expressed in manageable, proximate terms – the next small step.
- *Described as the presence, rather than the absence of something*. As noted in Chapter 7, it is important to seek a description of the family's desired state and express goals positively.
- *Described as the beginning, rather than the end of something*. Rather than expressing goals as the end of an undesirable behaviour, it is more useful to express them as the start of something new. Clients may be more motivated if they experience themselves as 'on track'.
- *Described in specific, concrete and behavioural ways*. This permits clients and therapists to evaluate goal attainment.
- *Framed as 'hard work'*. Clients often come to therapy overwhelmed by problems. If goals are framed by the therapist as hard work, it is not the client's shortcoming, but the enormity of the task, that is the challenge. If clients have difficulty meeting goals, they can be addressed in a face-saving way. If goals are met, clients can take credit.
- *Practical and doable in the context of the client's life*. Clients must have the realistic means to accomplish their goals.

Chapter 7 describes our approach to goal-setting in more detail.

Introducing change strategies

Direct approaches

Most approaches to family therapy rely upon direct approaches to intervention. In some models of family therapy, the therapist intervenes directly in session. For example, if you are doing emotionally focused couples therapy, you might coach a husband to listen intently to his wife as she explains how his behaviour let her down and convinced her that she was alone, and to relate how he understood the impact of his behaviour on her. If you are practising from a structural perspective, you might unbalance a family in which a child is enmeshed with her mother by asking the father to manage the child's disruptive behaviour in session. Or, you may invite the family to participate in a family sculpting or other experiential exercise.

Much of the time, family therapists give direct interventions to be carried out between sessions. For example, if you are practising the Bowen family systems approach, you might suggest that a client visit members of his family of origin, with a view towards gaining more perspective and increasing his individuation. A behavioural marital therapist might assign clients to perform behaviours that their spouse requested, or self-monitor moods.

Creating and maintaining a receptive context. Several years ago, I (JC) was teaching a workshop on treating clients with long-term problems. A participant asked, ‘What I’m really wondering is, how do you get clients to do things?’ When I asked for elaboration, she continued, ‘Well, if people are really resisting, how do you get them to do things?’ I responded, ‘I listen carefully for what they are willing to, and ask them to do what they are willing to do already’. Her face registered disappointment, as I think she expected some recipe for bypassing clients’ reluctance and magically getting clients to follow directions. Clients’ willingness to do certain things (and not others) is but one part of the *working alliance*. Bordin (1979) conceptualized the working alliance in three components: tasks, goals and bond. *Tasks* are what the therapist and the client agree should be done to reach the client’s goals. *Goals* are what the client hopes to gain from therapy, based on his or her presenting concerns. The *bond* forms from trust and confidence that the tasks will facilitate goal attainment. The working alliance is the strongest predictor of psychotherapy outcome that a therapist can control.

Practically speaking, as described in Chapter 10, Madsen (2007) suggested that we come alongside families as *appreciative allies*. As we have already stated, it is important to maintain an *equidistant position*, not favouring any family member or his/her position; explore problems as actions instead of labels; conceptualize and describe problems as circular patterns (perhaps externalized); and frame problems and develop goals that clients accept.

It is important to listen and observe carefully to what clients are willing to do. Listening to clients’ accounts of what they have tried before and observing their reactions to suggestions will help you ascertain this. If the clients speak continually about how everything is ‘all someone else’s fault’, or present as powerless, it may be best to start small, perhaps by asking the clients to do a task of observation or prediction (de Jong & Berg, 2013). If the clients speak with passion or enthusiasm about something, incorporate this into your approach if you can. It is important to listen carefully to how the clients frame the problem or describe potential actions that they can take.

As Duncan, Miller, Wampold, and Hubble (2010) suggest, tapping into the *client’s theory of change*, which is sometimes implicit, can help as well. At the very least, with direct approaches, your rationale for the intervention should be clear to the clients. Families who have had previous unsuccessful therapy or those who adopt an oppositional stance from the start may be difficult to engage. It is all the more important to listen to them carefully, respect their need for autonomy and pace interventions with the family’s readiness before attempting to lead them.

Most families newly presenting for therapy are, however, keen to receive any input that they think may help. If a family fails to respond satisfactorily to a direct approach, this usually indicates that the therapist has misunderstood the clients' motivation, the therapist has misread the working alliance or some inadvertent rupture to the alliance has occurred. As Friedlander et al. (2006, p. 223) state:

[W]hen a family member indicates that the therapy is not useful, implies that the process is blocked, or shows indifference to what is being discussed or proposed, the therapist must recognize the threat to the alliance and redirect his or her efforts. To enhance engagement, therapists can change focus or change strategies, moderate the pace of the therapy, or work through the motivational impasse. Direct confrontation of clients who show indifference, lack motivation, or clearly express their alienation is generally contraindicated . . . ; it is only to be used when all other attempts to elicit collaboration have failed.

Giving directives. Assuming that you have carefully tended the working alliance, how directives are delivered can also make a difference. Haley (1976) provided a good account of how to do this, acknowledging his debt to Erickson. Haley indicated three purposes of directives. The first is the straightforward one of directing clients to change their behaviour by telling them to do things differently. The second purpose is to increase the involvement between the therapist and clients. When directives are to be carried out between sessions, they help maintain the relationship with the therapist between sessions. This applies whether or not the tasks are performed, since the family is either complying with the therapist's wishes or not.

Clients' response to directives provides useful information, particularly about a family's willingness and ability to change. Thus, a task may be done as instructed, not done at all, half done, attempted and failed or altered. Even talking about a proposed task often reveals useful information, for example, about the family's mealtime behaviour, if the task is one that is to be done at mealtimes.

How should directives be given? We have three alternatives:

- (1) Telling people to stop doing something.
- (2) Telling people to do something different.
- (3) Telling people to do things in a different sequence.

Telling people to stop doing something is usually not useful. In most cases, our clients already want to stop doing whatever it is, and simply telling them to stop does not help. There are, however, ways of increasing the effectiveness of direct injunctions:

- *Making the instructions as precise as possible.* This may involve repetition and having the family members repeat back, in detail, what they are to do.

- *Enlisting other family members* to remind and support those concerned of what is to be done.
- *Using the force of the therapist's personality.* How effective this is will depend on the quality of rapport that has been established.
- *Setting up a system of rewards or punishments.* Rewards are generally to be preferred to punishments.

Telling people to do something different is usually more effective than telling them to stop doing something. Thus, rather than telling parents to stop arguing about how to handle their child's behaviour, the therapist might ask them to list the possible ways of dealing with certain troublesome behaviours. These could then be discussed and a joint plan of action agreed upon. If it seems unlikely that the parents agree on a joint plan, they could be asked to return with their list of possible courses of action for discussion and, if possible, agreement at the next therapy session. With some families, it may be necessary for the whole process to be carried out in session with the therapist's active help, at least for the first few issues tackled.

Procedures like these can have more value than that of simply resolving particular problems. They can help couples learn to communicate and discuss issues and then to resolve them by the use of compromise and the rational consideration of alternatives.

Telling people to do things in different sequence can lead to changes in set, problematic patterns of behaviour. Specific guidance for how to do this is provided in Chapter 11.

Indirect approaches

Indirect methods that promote second-order change were discussed in Chapter 11. The techniques described there should be considered when direct methods fail and can be used simultaneously or in succession. Nowadays, more and more therapists practise from a post-modern or collaborative perspective, leading to more transparency and reduced hierarchy between the therapist and clients.

Following up and evaluating interventions

Following up on intervention is not simply a matter of administering a protocol. Like anything else you do, it requires listening carefully and responding to clients' responses. So far, you have clarified the problem, discussing it in a concrete, action-oriented way. You have developed a case conceptualization based on the client's reality and your coherent theoretical approach. You have paid careful attention to the working alliance, developed goals that are acceptable to the family and introduced change strategies based on the clients' stated goals and needs. What follows is a framework for following up and evaluating on your interventions.

How will the family and the therapist know that the therapy is successful or even just ‘on-track’? You may wish to use a combination of standardized family assessment instruments, as described in Chapter 5 and non-standardized evaluation techniques.

Standardized family assessment instruments

The family self-report instruments reviewed earlier can all be used to evaluate progress. In general, standardized instruments are useful when a therapist is interested in measuring improvements in underlying family functioning. The Family Assessment Measure, third edition (FAM-III; Skinner, Steinhauer, & Santa-Barbara, 1995), is one possibility. Each of its three scales (self-report, general and dyadic) takes about 20 min to administer.

The Family Adaptability and Cohesion Evaluation Scales, fourth edition (FACES-IV; Olson & Gorall, 2006), has 24 items. Although its brief format is quick and convenient to administer, it is more likely to provide data on underlying family characteristics than direct information on goal attainment.

Family members aged 11 and older can complete Hampson and Beavers’ (1996) 36-item Self-Report Family Inventory (SRFI). Respondents endorse 5-point Likert items, from which clinical scales are derived from Beavers’ theory. It too is more likely to yield data about underlying family dynamics than progress on specific goals.

Non-standardized evaluation processes

Numerical scaling. A simple way to invite clients to track their progress is to ask them to rate it numerically. There are a number of examples of this in the literature. Although most of these were developed in the context of individual therapy, they can easily be adapted to use with families. Wolpe (1969), the developer of systematic desensitization, devised the Subjective Units of Disturbance Scale (SUDS) to invite clients to rate their distress when exposed to progressively more anxiety-provoking stimuli, from 0 (absolute calm) to 100 (worst anxiety ever experienced).

Solution-focused therapists use *scaling questions* (de Jong & Berg, 2013) to evaluate progress and to negotiate the next small goal. After gaining a clear picture of the hypothetical solution (usually by asking the Miracle Question), a scaling question about progress would be phrased like this: ‘On a scale of 1 to 10, if 1 is the worst it’s ever been, and 10 is the morning after the miracle, where are you now?’ When a family has experienced many ups and downs with respect to the problem, their estimate of optimism is more relevant (‘On a scale of 1 to 10, if 1 represents no hope of things improving, and 10 that you are 100% confident that things will get better, where are you now?’). Solution-focused therapists also scale for motivation (1 = not willing to do anything about the problem, 10 = willing to do anything humanly possible); this is a simple way to assess clients’ readiness for change.

In a similar approach, known as Goal Attainment Scaling (Cytrynbaum, Ginath, Birdwell, & Brandt, 1979), clients and therapist develop co-develop a baseline rating, a desired outcome, and identify sequential steps leading to that outcome. This can be used with any problem, as long as the therapist and client co-develop the criteria for the points along the scale.

Numerical scaling can be converted to a graphic form by asking clients to do a 'temperature check' with an image of a thermometer or something else that represents gradations in the problem. Children and youth especially may gravitate to this.

Some might ask what we are measuring with these scales if they are subjective measures. Does one family member's '7/10' rating of progress represent the same thing as another member of the same family, or a member of another family altogether? Probably not. However, numerical scaling can help family members make distinctions about progress and optimism that progress will continue. When family members disagree about ratings, it is not useful to focus on who is 'right', but on how they would know that things had moved up 'one notch', thereby assisting them to negotiate the next goal and, hopefully, cooperate in bringing about more changes.

Expressive or graphic representations. If you have used expressive or experiential techniques in your work with a family, you can revisit these procedures to evaluate progress. Family drawings, sculpting or other activities can be used.

If the family has participated in constructing a genogram, you can revisit it, asking them to describe their changed perspectives on the family. An ecomap (Erford, 2012) can be used to track improvements to the family's social support network. Visual displays like this can provide concrete reminder of progress. Current digital technology allows us to easily photograph and share images.

Follow-up interviewing. In subsequent interviews, start by asking about progress since the last appointment. The nature of the task you asked the family to do will determine your opening question to the family. If you have asked the family to do a task that entails reflecting, observing or predicting, you might begin by asking, 'What have you noticed since our last session?' or 'What insights have you gained as a result of your homework?' If you asked the family to do a task that entailed some kind of action, you could ask, 'What's been better?' or 'What's been on the right track?' since the last session, if this can be done with sensitivity to the client.

If there has been relevant progress that the family attributes to their efforts, it is important to maintain the focus on positive change. Ask for a detailed description of the changes and the actions the clients took to bring them about. Interview the family in much the same way as you interviewed the family about the problem, using description instead of labels and drawing out an interpersonal description of the changes. If there has been progress or improvement towards the goal, but the family cannot attribute them to his or her efforts or if there are changes in other parts of the family's life that are not related to the goal, inquire about those changes. Again, listen

carefully for evidence of personal agency and clues as to what the client has done to bring them about. If these are not forthcoming, simply elicit a detailed description of differences. Simply describing the differences may cause the family to distinguish their contributions or give them insights into the conditions that contribute to change. This can yield conversation about useful client strengths and resources and permit clients to identify changes outside of therapy that could be relevant to the therapy.

If, after several sessions, the client reports no improvement or decline, there are a number of directions you can take to get the therapy on track. Inquire about what the family is doing to keep things from declining further, ‘hold off’ further decline or ‘hold their own’. This often yields usable descriptions of what family members are doing, or outside factors that are helpful.

It may also be careful to reflect, on your own or with a team. Consider whether you have misjudged the family’s motivation. Perhaps you have mistaken some family members’ statements of distress for readiness to take action. Reflect on whether the pace of change efforts is appropriate for the family or, better yet, ask them. Reflect on whether the problem definition is consistent with the clients’, and ask them about whether the ‘project’ you have undertaken together fits for them. Think about whether the specific intervention strategy you are implementing is consistent with the clients’ theory of change.

If these efforts to re-evaluate the goals you have formulated or your approach to therapy have not yielded positive results, then it may be useful to turn to indirect approaches, as described in Chapter 11.

Planning for further intervention. In keeping with a change focus, build on changes, if any, since the last session. If there has been some relevant progress that the client can attribute to his or her efforts, inquire about what is necessary to maintain these changes. This could include what the client can do to keep the changes going, or what next steps might be, or what adjustments may be necessary.

Termination in family therapy

‘Termination’, as applied to counselling and psychotherapy, was first considered by Freud (1937). He identified two conditions of appropriate termination:

... first, that the patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly, that the analyst shall judge that so much repressed material has been made conscious, so much that was unintelligible has been explained, and so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned. (p. 219)

Although the family therapy models covered so far have not focused much on ‘repressed material’, ‘internal resistance’ or ‘pathological processes’, we

likely can agree with Freud that termination should occur when goals are met and we are confident that relapse will not occur. Joyce, Piper, Ogrodniczuk, and Klein (2007), writing from an individual psychodynamic perspective, suggest that termination is a time to ‘[review] the work and gains of therapy, examin[e] the patient–therapist relationship, and reinforc[e] the internalization of therapeutic functions’. Narrative therapists might inquire about how the client’s and family’s identity has been re-authored in therapy (White, 2000).

Traditionally, termination has been conceptualized using a ‘termination as loss model’ (Quintana, 1993). The therapist–client relationship is the container for feelings of transference and countertransference (representing unresolved aspects of the parent–child relationship) to be worked through; the loss of the therapeutic relationship is a life crisis. On the other hand, Cummings (1990), the father of managed behavioural health care in the United States, asserts that many clients think of therapy as a periodic service to help with crises throughout the lifespan, like how patients periodically visit primary care physicians when they are ill. This is similar to how most counsellors in community or agency practice work.

Cummings (1990, p. 173) states:

In brief, intermittent psychotherapy throughout the life cycle, you can free yourself from the concept of the ideal therapist, where each of us (i.e., therapists) has to be all things to all people. You can free yourself from the concept of cure, and you can free yourself from the bother of termination (parentheses added).

Cummings is using ‘bother’ to refer to how termination is conceptualized by psychodynamic therapists.

Our recommendations about termination are described more fully in Chapter 15.

Summary

In this chapter, we have provided a systematic framework for organizing your family therapy interventions. After developing rapport and carefully tending to the working alliance with all family members, it is important to develop a thorough assessment. Assessment is not neutral – the way we conduct assessment affects how therapists and clients relate to the problem. Exploring the problem thoroughly and defining it in such a way that it can be solved can assist the therapist to develop a case conceptualization and goals, based on a coherent theory of change.

Regardless of your theoretical orientation, it is important to create a context that is receptive to your change strategies. We recommend beginning with direct interventions, based on carefully listening to the clients to learn what they are motivated for and how their beliefs about how change occurs.

If a direct approach does not seem to be effective, we first recommend that you re-evaluate the state of the working alliance and whether you have developed goals that are amenable to the family. If this does not bring about the desired outcome, it may be useful to use indirect or specialized approaches we describe in Chapters 11 and 12.

Clear goals lead to clear evaluation practices. Reduced government funding and, in some jurisdictions, the privatization of therapy services require that we can document that our work is effective. Follow-up, evaluation and, finally, termination are all used to anchor and amplify change.

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Chapter 14

Couple Therapy

Couple distress is one of the most common problems for which clients seek therapy. In the United States and Canada, the divorce rate is around 50%, half of which occur in the first 7 years of marriage. At any given time, approximately 20% of couples are distressed, with marital satisfaction decreasing in the first decade of marriage (Bradbury, Fincham, & Beach, 2000). Couple distress is strongly associated with emotional, substance abuse and health problems (Whisman & Uebelacker, 2006).

Orlinsky and Ronnestad (2005) found that of an international sample of psychotherapists 70% treat couples. However, most have little or no training in couple therapy. Despite the effectiveness of couple therapy (Shadish & Baldwin, 2003, 2005; Snyder, Castellani, & Whisman, 2006), couple therapy is poorly rated in the Consumer Reports consumer survey (Seligman, 1995), which did not control for therapist training. Moreover, couples tend to wait an average of 7 years to seek therapy (Gottman, 1994) – often too long to make a difference. Moreover, a healthy marital relationship is crucial to family functioning. The marital relationship is also the basis of the parental relationship. Marital distress interferes with co-parenting.

Sexual functioning is important to a couple's relationship. Sometimes sexual difficulties are just one aspect of a wider set of problems and disappear as the marital relationship improves. At other times, the sexual difficulties may be the primary problem and may require therapy directed specifically to them. In this chapter, we will discuss work with sexual problems short of specialized sex therapy.

The history of couple therapy

Marriage counselling

Early 'marriage counselling' was provided by clergy or other non-mental health professionals (Gurman & Snyder, 2011). In the United States, the Marriage Council of Philadelphia (now called The Council on Relationships), the Marriage Consultation Center in New York City and the American Institute of Family Relations (AIFR) in Los Angeles were operating by the 1930s. The origin of the AIFR reflected the non-professionalized status

of marriage counselling at the time. Paul Popenoe, whose study of human breeding led to his later professional interests – eugenics and marriage counselling – started AIFR. He was a proponent of mandatory sterilization of the mentally ill and the developmentally delayed, turning his full attention to marriage counselling when eugenics lost its popularity after World War II (Lepore, 2010; Popenoe, 2005). These early marriage counsellors took a largely pragmatic, directive and educational approach (Gurman & Snyder, 2011).

Psychoanalysis and couples

This pragmatic approach gave way to psychodynamic ideas, which held a near-exclusive sway. For example, Leslie (1964) proposed that marital problems result from partners' intrapsychic difficulties. Oberndorf (1938) suggested consecutive individual psychoanalysis. Later, Mittelman (1948) suggested concurrent psychoanalysis with both partners.

An important development was the publication of *Marital tensions* by Dicks (1967). Although Dicks viewed marital problems primarily psychodynamically, he also examined the interactional processes between partners. He recommended couples be seen conjointly, but emphasized individual intrapsychic processes and the use of the transference relationship to help the partners understand themselves and their problems relating to one another.

The psychoanalytic approach to couple therapy declined in influence in the 1960s and 1970s. According to Gurman and Snyder (2011), the approach was not effective because 'the emphasis on patient-therapist transference' was not balanced by the corresponding attention 'to the partner-partner transference' (p. 488). They also comment that psychoanalytic couple therapy was overtaken by competing, and separately developing, theories of family therapy.

The family therapy movement

While many models of family therapy proliferated in the 1960s and 1970s (see Chapter 1), Gurman and Snyder (2011) identify four particular family therapy theorists who influenced couple therapy: Jackson (Jackson, 1965; Lederer & Jackson, 1968), Satir (1964), Bowen (1978) and Haley (1963). Jackson emphasized the implicit *quid pro quo* in marital relationships, asserting that the main job of the therapist is to bring these implicit patterns to awareness and support more adaptive, conscious rules for the relationship. Many of the communication techniques that Jackson developed were adopted in behavioural approaches.

Satir (1964) assumed that in couple relationships people assume dysfunctional roles (e.g. *placator*, *rescuer*) based on poor self-esteem, and that therapy should foster self-expression and increase self-awareness and

authenticity. Her contributions set the stage for later experientially and attachment-based approaches.

Bowen (1978) saw couple work as a way to increase differentiation between partners. Lack of differentiation fuels anxiety, which invites the person to triangulate a third person (usually a child) to diffuse the anxiety. Marital distress indicates problems not only in the couple but also in one or both partners' family of origin. The couple therapist's job is to resist triangulation by either partner and support the partners to differentiate.

Haley (1963) suggested that couple interactions are based on dynamics of power and control. Problems are fuelled by overly rigid symmetrical or complementary patterns, or confused hierarchy. Because symptoms serve a function, in Haley's view, resistance to change is almost inevitable. Accordingly, Haley adapted Erickson's directive and paradoxical interventions. All four of these models have contributed a task-oriented and present-focused ethos to couple therapy.

General considerations in couple therapy

Working on marital problems: conjointly or individually?

It is generally thought that individual treatment for marital problems is inferior to conjoint therapy. Gurman and Kniskern's (1978, 1981) research reviews to this effect were challenged by Wells and Giannetti (1986). The exchange of views concluded with the discussants agreeing, conservatively, that:

- (1) There is very little acceptable evidence of the *inefficacy* of individual marital therapy.
- (2) There is *no* evidence . . . of the *efficacy* of individual marital therapy.
- (3) There is a *large* body of acceptable evidence of the *efficacy* of conjoint marital therapy (Gurman & Kniskern, 1986, p. 60).

While there is no head-to-head empirical answer to this question, there was more and better evidence that conjoint therapy helps couple distress than there is that individual therapy does. Since then, we have much more evidence that couple therapy is effective for couple distress (Lebow, Chambers, Christensen, & Johnson, 2012) and that couple therapy can be helpful for individual problems (Baucom, Whisman, & Paprocki, 2012)

More recently, Doherty (1999, 2006) has taken a different tack on this issue. He notes that both therapists and clients are embedded in our current consumer-oriented and self-focused culture. This, he asserts, invites therapists to overtly undermine marriages by urging clients to 'take care of themselves' to the exclusion of others. He also suggests that when a partner in individual therapy complains about his or her spouse, therapists are prone to pathologize the spouse or pathologize the client for staying in the relationship. He echoes concerns about the competence of couple therapists

and rebukes therapists who take a neutral position towards divorce. Instead, he suggests that we clearly support marriage in the absence of specific indications otherwise.

The alliance in couple therapy

Managing the working alliance with couples is a good deal more complex than with an individual. In individual therapy, the working alliance is the biggest contributor to therapeutic outcome, over which therapists have any control (Duncan, Miller, & Sparks, 2004). However, in couple or family therapy, family members have different agendas and may blame one another. We have already discussed how goals are affected by the working alliance (Chapter 7), and factoring the working alliance into one's overall approach to therapy (Chapter 13).

Using a multivariate analysis, Bartle-Haring, Glebova, and Meyer (2007) found that couples with emotionally reactive men were more likely to terminate therapy prematurely. Independently, Knobloch-Fedders, Pinsof, and Mann (2004) found a similar result. This is consistent with Symonds and Horvath (2004), who found that, in heterosexual couples, men's scores on a working alliance measure are more predictive of outcome than women's. Symonds and Horvath also found that when clients disagree about the alliance early in treatment, alliance and outcome are not highly correlated. This is consistent with earlier research (Pinsof & Catherall, 1986), which did not find a strong correlation between client-rated alliance and outcome.

Symonds and Horvath (2004) also found a strong correlation between alliance and outcome when partners agreed about the strength of the alliance and when both partners' alliance scores increased between sessions 1 and 3. This suggests that the connection between partners, which Symonds and Horvath have dubbed 'the allegiance' (p. 452), is just as important as either partner's alliance with the therapist. 'Allegiance' is essentially the same construct as 'Shared Sense of Purpose' as described in the System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, Heatherington, & Diamond, 2011).

For couple therapists, the practice implications are clear. Pay close attention to the alliance early in therapy. In particular, in heterosexual couples, men are likely more reluctant to engage in therapy than women; so it is important to cultivate engagement with men (see Shepard & Harway, 2012). Therapists should consciously nurture a shared sense of purpose with the couple. This is often easier said than done, especially when one partner may already have all but decided to leave the relationship, while the other is desperately trying to save it. Doherty (2012) has dubbed these *mixed agenda couples*.

Mixed agenda couples

Doherty (2012) eloquently describes the dilemma of the therapist seeing the mixed agenda couple. The typical 'helpful' stance taken by a therapist often

backfires; as the *leaning out* partner disengages more, the more the therapist discusses possible goals or contracts for therapy, while the *leaning in* partner becomes increasingly desperate. The leaning out partner can feel satisfaction/justification at having ‘tried’ couple therapy before giving up on the marriage, while the leaning in spouse ‘alternates between abject apologies, righteous scolding, and lectures about God’s will for marriage, the decline of the family, and the end of Western civilization as we know it’ (p. 46).

Doherty (2012) has identified three common errors that therapists make with mixed agenda couples: *pursuing the distancer*, *siding with the distancer* and *doing couple sessions only*.

Pursuing the distancer. Doherty asserts that the distancer may not be entirely settled on divorce and suggests that prematurely trying to engage the distancer in therapy to save the relationship invites him/her to distance even more. It likely replicates the marital dynamic and may push the distancer to conclude that therapy is ineffectual.

Siding with the distancer. In being ‘realistic’ about the marital problems, seeing that the distancer is not motivated for couple therapy, the therapist may effectively and inadvertently side with the leaning out spouse’s point of view. Doherty cautions that pushing for a decision about the goal of therapy – marital therapy or divorce therapy – can precipitously force a negative decision.

Doing couple sessions only. Doherty asserts, ‘Whether to stay and work on the marriage is a personal decision best pursued in individual conversations with the two parties, along with carefully facilitated couple-level conversations’ (p. 47). He suggests that, given the couple has not yet agreed to work on the relationship, it is more appropriate to permit them to vent, complain or disclose hurtful material individually with the therapist.

Discernment counselling. To give mixed agenda couples the necessary time to make a well-considered decision without the threat of divorce, Doherty has developed an intervention called *discernment counselling*. This is a short-term process to clarify whether to proceed to divorce or to work on restoring the marriage. He asks clients to take divorce ‘off the table’ for 6 months. Although the couple come in together for each appointment, most of the time is spent with the therapist individually. The therapist helps each partner prepare a summary of the individual time to provide to the other partner, and the therapist provides feedback, with a focus on what is possible to change.

Doherty believes it is important to refrain from calling this ‘couple therapy’ until there is a clear agreement to work on restoring the relationship. That way, if one partner suggests that couple therapy is not working, the therapist can clarify that they have not tried couple therapy yet; the purpose of discernment counselling is to help them decide if couple therapy is worth trying. Discernment counselling helps partners clarify their own contribution to the marital problems. To de-emphasize working on the marriage, Doherty describes to the clients the benefits of working on self, whether or not the relationship survives. Couples can benefit from this approach by

clearly deciding to work on the marriage, developing clearer decisions even if divorce is the result, increasing differentiation and avoiding half-hearted attempts at couple therapy.

Current approaches to couple therapy

Common principles in couple therapy

Benson, McGinn, and Christensen (2012) described a unified protocol for couple therapy. They suggest that all evidence-based models of couple therapy (and probably those that are not evidence-based) share five common principles:

- (a) *Altering the couple's view of the presenting problem to be more objective, contextualized and dyadic.* Across models, the authors suggest that therapists can use didactic methods; direct explanations of the circular nature of the couple's interactions, questioning techniques and having the couple observe relationship dynamics help the couple see the problem in a systemic way. They also suggest that as each member of the couple develops a working alliance with the therapist, they are less likely to be defensive and more likely to be open to taking some responsibility for the problem.
- (b) *Decreasing emotion-driven, dysfunctional behaviour.* In order to create a climate of emotional safety, the therapist must help the couple de-escalate harmful interactions.
- (c) *Eliciting avoided emotions.* The therapist should support couples to be open with one another. Withdrawal or avoidance permits the couple to escape anxiety, hurt or guilt inherent in conflict. The authors suggest that the therapist carefully assess the situation to elicit 'soft emotions' such as fear or hurt that underlie more difficult-to-process emotions like anger and criticism.
- (d) *Improving communication.* This may require direct instruction and performance feedback for communication skills.
- (e) *Promoting strengths.* The therapist should highlight past and present solutions and provide the partners feedback on the helpful actions they are taking. The authors urge therapists to focus on what the couple would find positive.

Using these common principles as a template for couple therapy, most of the treatment methods for families discussed earlier, can be used for marital problems. As with larger family groups, it is usually best to use direct methods first, unless they have already had a fair trial. Then, if the desired results have not been achieved, indirect strategies may be employed.

Benson et al. (2012) provide a framework to orient yourself to your work with couples regardless of the theoretical model you select. There are several edited volumes of couple therapy approaches (e.g. Carson & Casado-Kehoe,

2011; Gurman, 2008, 2010; Hahlweg, Grawe-Gerber, & Baucom, 2010; Harway, 2005; Leavitt, 2010; Wetchler, 2011) that describe a wide variety of approaches to couple therapy. We suggest that you explore specific models, through reading or workshops, and seek consultation as you begin to use a specific approach. In the rest of this section, we provide a sampling of some approaches that are most commonly used at present.

Behavioural couple therapy

Behavioural couple therapy (BCT) developed in the 1970s (Jacobson & Margolin, 1979; Stuart, 1980). Initially focusing on behavioural exchanges, BCT eventually incorporated communication skills training, problem solving and behavioural contracting (Johnson & Lebow, 2000).

Doss, Thum, Sevier, Atkins, and Christensen (2005) studied 134 couples and found that BCT was effective in improving relationship satisfaction as manifested in communication, behavioural frequency and emotional acceptance. Using the same sample of 134 couples, Gattis, Simpson, and Christensen (2008) examined the effectiveness of BCT when the couple were experiencing a conflict over child rearing, finding that the couples' conflict over child rearing decreased over the course of therapy and stayed low at a 2-year follow-up.

Functional analysis. A key step in BCT is functional analysis, which describes the antecedents and consequences of behaviour, to determine what maintains it. For instance, if avoiding communication results in less arguing, avoiding communication is reinforced. Reinforcers are not static and reinforcement erosion can occur (Atkins, Dimidjian, & Christensen, 2003).

Although BCT was well validated empirically (Atkins et al., 2003), some studies found that gains sometimes eroded once the couple finished therapy (Gehart, 2010). Therefore, Jacobson and Christensen (1996; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) developed a more affect-based, humanistic model called integrative behavioural couples therapy (IBCT), which emphasizes mutual acceptance between spouses. The original model was called traditional behavioural couples therapy (TBCT) to distinguish it from IBCT. A recent randomized clinical trial comparing TBCT and IBCT found that IBCT is superior at 2-year follow-up, with the differences in outcome declining at longer follow-up intervals (Christensen, Atkins, Baucom, & Yi, 2010).

TBCT interventions

Behaviour exchange. Therapists use *behaviour exchange* early in TBCT to help couples increase positive actions towards each other. This invites clients, who might try to change their partner, to change their own behaviour (Atkins et al., 2003). Behaviour exchange requires partners to describe

clearly the behaviours they would find supportive, providing specific guidance as to what one can do to support the other. Behaviour exchanges are useful to teach clients to monitor their own behaviour and assess its impact on their partners (Atkins et al., 2003). Positive actions generally boost relationship satisfaction quickly, but as couples turn their focus to enduring problems, their increased satisfaction may level off (Christensen et al., 2010). Jacobson et al. (2000) suggested that the *acceptance* intervention of IBCT (see below) complements direct strategies like behaviour exchange to produce robust behaviour change.

Communication training. A key aspect of TBCT is communication training, which provides structure by designating one partner as the speaker and the other partner as the listener (Atkins et al., 2003). This allows them to express their point of view and be assured that the other is listening. Communication training also includes instructions on collaborative problem solving. The first step is to agree on a clear definition of the problem. The couple then brainstorm possible solutions with the therapist, discussing the implications of each. The therapist leads the couple to consider all possibilities and coaches them to use their communication skills to prioritize each option. The therapist offers behaviourally specific feedback as the couple work through the decision-making process. When the couple have developed a solution, the therapist assists them to develop a contract specifying the terms of the agreement.

IBCT interventions

Case conceptualization. Jacobson and Christensen (1996) conceptualize cases in terms of a *theme*, the couple's primary conflict; the *polarization process*, the circular pattern that escalates the conflict; and the couple's *mutual trap*, the outcome of the polarization process. The case conceptualization organizes the therapist's interventions.

Acceptance. Whereas TBCT focuses on teaching couples prosocial behaviour or communication, IBCT includes strategies to help spouses accept their partner. According to Christensen et al. (2010, p. 226), 'IBCT therapists process partners' reactions to each other's communication, letting those natural contingencies shape each other's behaviour'. Jones, Christensen, and Jacobsen (2000) suggested that acceptance is the critical variable that distinguishes IBCT from TBCT. Shapiro, Gottman, and Carrere (2000) found that admiration and awareness might buffer the relationship through stressful transitions. If both partners are aware of the stress the other is experiencing and of the efforts each is making to be supportive and loving, the more satisfied each spouse will be with the relationship.

Emotionally focused therapy

Emotionally focused therapy (EFT) owes much to attachment theory. According to attachment theory (Bowlby, 1973), individuals have a basic

need for safe emotional connection with others. Individuals with secure attachments are emotionally responsive, especially in difficult times (Johnson, 2003), and believe that their emotional responsiveness will be reciprocated. This mutuality creates a pattern of reliable attachment, permitting secure individuals to cope effectively and be responsive caregivers.

Conversely, insecurely attached individuals are prone to fear that their intimates are not responsive and reliable, heightening their anxiety. They tend to be hyper-vigilant, ‘clingy’ and over-responsive caregivers. Avoidantly attached individuals are unlikely to express their anxiety, tend to avoid their own and their partners’ emotions, and are generally unresponsive caregivers (Carnelley, Pietromonaco, & Jaffe, 1996).

EFT works by creating and strengthening secure attachment between partners (Johnson, 2003), through three phases: *cycle de-escalation*, *restructuring interactional positions* and *consolidating/integration*. In *cycle de-escalation*, the therapist helps the couple identify patterns of interactions, emotions and unmet attachment needs. The therapist helps the couple de-escalate volatile sequences, monitors and fosters a positive alliance and expands and restructures key emotional experiences. The therapist directs enactments in sessions to clarify unhelpful patterns of interaction and shape more positive ones. The therapist focuses on the clients’ emotional experiences, both validating and evoking emotions.

In the second phase, the therapist helps the couple *restructure their interactions and relational positions* (e.g. *pursuer* or *distancer*). The therapist is most active in this phase, focusing on the emotional intensity to the extent a client can tolerate at any given time. For example, if a client cannot state an emotional response, the therapist will ask the client to express and explore how difficult this is. The EFT therapist focuses on the core emotions of fear, anger, sadness and shame, as they relate to attachment. The therapist also restructures the couple’s typical ways of regulating and expressing affect. When one partner expresses a great deal of blame for the other, the therapist works to soften the blame by addressing the attachment function of the blameful words or actions.

In the *consolidating/integration phase*, the couple find new solutions to their relationship problems, share their changed emotional experiences and continue to reorganize their cycle of interaction. The therapist reviews the accomplishments of the partners in therapy and helps with concrete problem solving. This is much easier than before because the couple are no longer driven by their problematic attachments patterns.

The Gottman method

Gottman and colleagues have conducted over 30 years of research on marital interactions. In three separate longitudinal studies, they have predicted divorce and marital stability with over 90% accuracy (Buehlman, Gottman, & Katz, 1992; Gottman, 1994, 1996; Gottman & Levenson, 1992) and predicted marital satisfaction among stable couples (Gottman, Coan,

Carrere, & Swanson, 1998). They have developed the *sound relationship house* model of marital interaction and an empirically derived programme of intervention. The sound relationship house is built on a foundation of friendship between the couple. There are several building blocks of such friendship: *love maps*, *fondness and admiration*, *turning towards versus turning away*, *positive sentiment override (PSO)*, the ability to deal with *perpetual problems* and *creating shared symbolic meaning and honouring life dreams*.

Love maps. Over half of all divorces occur in the first 7 years of marriage and 75% of marriages undergo a drop in marital satisfaction after the birth of the first child. This drop in marital satisfaction is often part of the cascade towards divorce. Using their oral history interview coding system, Gottman and associates found that the amount of ‘cognitive room’ an individual (particularly a husband) has about marriage predicts marital satisfaction. The ability of the husbands to maintain a ‘map’ of their wives’ inner world distinguished the 25% whose marriages did not decline after the arrival of the first child from the 75% whose did. Gottman and colleagues name this concept of cognitive room the *love map*.

Fondness and admiration. When partners express fondness and admiration for one another, they are more likely to have a satisfying, stable marriage (Buehlman et al., 1992). Fondness and admiration are a protective factor during stressful or transitional times (Shapiro & Walker, 1997).

Turning towards versus turning away. The concept of *turning towards versus turning away* was discovered in the Gottman research group’s apartment laboratory. If partners typically turn towards one another, rather than away, in mundane day-to-day interactions, it is ‘emotional money in the bank’. Too many withdrawals (turning away) deplete the emotional bank account. Over time, turning away distances the couple from one another, which may lead to emotional toxicity and divorce. Intervention entails teaching the couple to turn towards one another throughout the day.

Positive sentiment override. Couples’ ability to ‘turn around’ and exit an interaction that starts negatively consistently discriminates between distressed and non-distressed marriages. PSO (Lorber, 1997) occurs when one partner communicates with negative affect but the other interprets the communication as neutral. For example, if the husband expresses anger while the wife notices and responds without evaluating it negatively, this is characteristic of relationship satisfaction. In troubled marriages, wives rate their husbands’ anger negatively. The affective quality of typical day-to-day interactions underlies the response to anger.

Perpetual problems. Among distressed heterosexual couples, women are generally more likely to demand change during conflicts, while men are more likely to withdraw (e.g. Christensen, 1987, 1988; Christensen & Heavey, 1990; Cohen & Christensen, 1980). Women begin conversations about problems more often than men (Ball, Cowan, & Cowan, 1995; Oggins, Veroff, & Leber, 1993) and are more likely to criticize, while men are more likely to stonewall. Both criticism and stonewalling predict divorce (Gottman, 1994).

Gottman found that only 31% of problem-solving conversations were about issues that could be solved. On the other hand, 69% were *perpetual problems* that involve longstanding disagreements, often related to personality differences. For the 31% of marital problems that are resolvable, four skills were present in happy marriages: *softened start-up* (of problem-solving conversations) on the part of the women, the man *accepting influence* of the woman, *repair and de-escalation* (using positive affect) and *compromise* (Gottman et al., 1998). Positive affect during conflict resolution is difficult to produce on demand; rather, it is a result of the couple's underlying friendship.

In the case of perpetual problems, the affective state that is present when they discuss the problem determines marital satisfaction. Couples who maintain affect that permits them to express amusement and affection are less prone to negative responses like criticism, defensiveness, contempt, stonewalling and emotional disengagement.

Creating shared symbolic meaning and honouring life dreams. A final contributor to marital satisfaction is the construction of shared meanings. This involves honouring each other's individual life dreams, narratives, myths and metaphors. The belief that marriage is a vehicle to make dreams and aspirations come true is the basis for positive affect.

The Gottman method uses an extensive assessment battery based on the marital interaction research. Intervention largely takes an instructional and coaching approach.

Solution-focused therapy

Several recent sources (Connie, 2012; Nelson, 2010; Ziegler & Hiller, 2007) have described the solution-focused approach to couple therapy. Solution-focused therapy is a collaborative approach that focuses on what clients are already doing – accentuating the positive – that is in line with their stated goals and desires.

The first step is to elicit a problem description. The therapist should ask for clients to give behaviourally specific descriptions, to rate (on a scale of 1–10) their hopefulness about change and to normalize their situation to the extent possible. If the couple indicate they have any hope at all, the therapist asks about *hypothetical solutions* – ‘*What do the clients want?*’ – often using *The Miracle Question*. Skilfully asking for an interpersonal description of the solution pattern helps develop a shared sense of purpose, defuses mutual blame and points towards behaviourally specific and practical goals. In the solution-focused approach, solution building is a different enterprise than problem solving, so the hypothetical solution may not be directly related to the problem.

The therapist then asks if any part of the miracle is already happening. If so, the therapist asks how this came about and seeks a description of these times, including the differences between *partial miracles* or irregularities in the problem and the present situation. If clients are highly distressed, it

may be useful to ask about the difference between ‘when things are bad’ and ‘when things are even worse’. The therapist can use scaling questions to construct incremental changes (‘What will be different when it has gone from a 2 to a 3?’).

Subsequent sessions focus on amplifying change. Scaling questions are used to track progress, motivation and confidence. Termination typically occurs when clients give medium–high ratings (7 or 8) on progress and optimism. Trepper and Dolan (2008) have described an ‘emergency kit’ for relapse prevention, consisting of an audio recording or letter describing the detailed miracle description, responses to a series of questions focusing on resources in the relationship, a list of practical steps towards the miracle, a list of nurturing and centering activities, reminders of helpful spiritual or philosophical beliefs, and special advice or reminders.

Narrative couple therapy

Narrative therapy (Rosen & Lang, 2005) focuses on how the clients’ presenting problems are influenced by, and embedded in, cultural discourses and the institutions that promote them. With couples, cultural ideas about gender – how emotion should be expressed, the nature of ‘pink’ and ‘blue’ work, parenting and so on – are very influential. Therapists listen for openings to question the often taken-for-granted nature of these ideas and, through the interview, think out loud with the couple about the constraints operating on them.

Hearing the problem story. Couples generally enter therapy immersed in problems. Narrative therapists elicit a problem description in an externalized way. It is important to note that *externalizing the problem* is not simply a clever linguistic technique, but reflects the assumption that people are not their problems. Once externalized, the therapist will explore details of how the problem affects the lives of the partners over time. This is not simply an interview about ‘history’, but an exploration of how each person has constructed a meaning about the problem, as well as how they might have resisted the problem. The therapist also asks the couple how the externalized problem interferes with their relationship (e.g. ‘How does Defensiveness invite you to think about one another?’ or ‘Lisa, how does Stonewalling put you off from your efforts to care for Ken?’). It may be useful to externalize the circular pattern (Zimmerman & Dickerson, 1993).

Identifying and extending unique outcomes. Narrative therapists listen for what clients treasure outside of the problem – the *absent but implicit* (White, 2000). While clients may see the situation as uniformly negative, the therapist can locate contradictions in the problem-saturated story by listening carefully. The therapist can also ask directly about times when the problem has been less influential (e.g. ‘I understand that Defensiveness is currently very strong in your relationship. Tell me about a time when it did not seem to be as intrusive.’). The therapist asks about the clients’ preferences about whether and how they would like to change their relationship with the problem.

Once the couple identifies unique outcomes and their contribution to them, the therapist can extend unique outcomes by asking what the changes signify in their relationship ('What does this say about your connection to each other that you have been able to put Depression off to the side together?'), their history ('Who from your past would not have been surprised that you have been able to make these changes?'), their strengths ('What attributes in your background prepared you to have these changes?') and their individual and joint identity ('What is it that you admire about Jake that allowed him to get away from patriarchal ideas? How does that set the stage for the future of your marriage?').

Circulating the new story. Narrative therapists use reflecting teams and therapeutic letters to create an audience for change.

Divorce therapy and mediation

Family therapists are increasingly being consulted by couples who are separating or divorcing. While some therapists specialize in this work, all therapists who work with troubled families should have some familiarity with this area. Given that about 50% of marriages end in divorce, it is nearly inevitable to treat such clients. However, relationships between spouses rarely end with divorce, particularly when there are children. Family therapists have much to offer couples during and after a divorce.

Children of divorce face increased risk factors. Even when parents cooperate on co-parenting, the children may feel responsible for the divorce and may be burdened with guilt or they cling to the idea of their parents reconciling. Reduced financial resources; moving house, neighbourhood or school; or reduced contact with one parent and one side of the family all increase the children's risk of poor adjustment.

Ahrons (1994, 2011) conducted a longitudinal research beginning in 1979 with 98 divorced families containing 173 children, interviewing them as long as 20 years post divorce. She has advanced the often-misunderstood idea of *the good divorce* (Amato, Kane, & James, 2001). Based on her research, she suggests that the effect of risk factors on children can be buffered by measures like mediation and parent education, which help parents co-parent more cooperatively. These interventions resulted in reduced litigation, quicker settlements, better compliance with court orders, higher satisfaction with the process, more communication between parents and greater involvement of the children with the access parent (Emery, Laumann-Billings, Waldron, Sbarra, & Dillon, 2001). However, 12-year follow-up found no differences in the psychological well-being of children (Emery, Sbarra, & Grover, 2005).

In some cases, parents can cooperate adequately despite the disruption of divorce. They require only minimal assistance to create a supportive environment for their children. Therapeutic goals in these cases usually include renegotiation of roles; adjusting to changes in practical arrangements such as parenting time, transportation to school and activities; assisting

parents to communicate appropriately with each other and with the children (not through the children); expressing feelings about the separation and divorce; and reassuring children and supporting parents to reassure them about the status of future relationships. With most families, these tasks can be accomplished using a direct to treatment.

Mediation

Mediation is increasingly being sought by divorcing couples as an alternative to adversarial legal processes. In many jurisdictions, mediation is mandatory when parenting arrangements are disputed. Mediators, who are usually mental health professional or lawyers, focus on formal dispute resolutions. Although a mediator is not acting as a therapist, one's skills at interacting with families in distress and a family system's view are very helpful to mediators.

To practice competently, it is necessary to obtain training and supervision. UK Mediate, the Association for Conflict Resolution (formerly the Academy of Family Mediators, USA) and Family Mediation Canada are some organizations that offer training and may connect trainees with supervisors. In most places, mediation is not a restricted practice like psychotherapy. In some jurisdictions, government-funded mediation services are available. If you are interested in practicing family mediation, you should check on the qualifications required in your jurisdiction.

Parenting coordination

This is another alternate dispute resolution process sometimes practiced by family therapists. *Parenting coordination*, which requires specific training, combines educating parents about the needs of children post divorce and collaborative decision-making, and sometimes includes arbitration, in which the parenting coordinator may make binding decisions, if permitted by law.

Custody evaluation

About 5–10% of divorces with children require a *bilateral custody evaluation*. In these cases, the practitioner produces a formal assessment report that can be potentially be placed in evidence in court. Competent practice requires practitioners to be trained in assessment processes, child development, post-divorce dynamics for children and adults, relevant family law and court procedures. Parents may be litigious; so in addition to subject knowledge and clinical competence, it is necessary to be emotionally prepared as well.

Sex therapy

Sexual difficulties may be part of a wider marital problem. They are sometimes a central feature of marital problems, but may also be secondary to

marital conflicts arising from other causes, or part of a larger set of systems problems. In some cases, the marital partners' sexual difficulties cease with the resolution of the larger family systems problems, but in other cases, direct treatment of the sexual dysfunction is necessary.

Sex therapy, like other psychotherapy, used to be based principally on psychodynamic theories, conceptualizing sexual problems in terms of individual psychopathology, rather than interpersonal processes. But, much as family therapists have concerned themselves with interpersonal, rather than intrapersonal, processes, sex therapy nowadays considers interactional phenomena. It has also become clear that many sexual problems can be successfully treated using direct approaches.

An important event in the development of sex therapy was the publication of *Human sexual response* (Masters & Johnson, 1966), which led to the development of therapy methods based on their understanding of sexual behaviour, and *Human sexual inadequacy* (Masters & Johnson, 1970). Masters' and Johnson's approach was primarily behavioural, rather than intrapsychic. These became standard reference works, forming the basis for much modern sex therapy.

In 1974, Kaplan's *The new sex therapy* (Kaplan, 1974) appeared. Building on the work of Masters and Johnson, it examined the anatomy and physiology of the sexual response and the various factors that can affect sexual performance: physical illness, age, drugs, intrapsychic causes, relationship difficulties and faulty learning experiences. Kaplan described an assessment framework considering these factors, leading to a plan targeting the specific cause or causes of the problem. Kaplan (1979) took her understanding of sexual disorders further in *Disorders of sexual desire*. In this book, she was careful to distinguish the many different types of sexual problems and advocated broadening case conceptualization of sexual disorders beyond psychodynamic thinking.

Our review of the recent literature indicates that sex therapy is being integrated with numerous theoretical orientations: the biopsychosocial approach to medical family therapy (Hughes, Hertlein, & Hagey, 2011), the crucible approach (Schnarch, 2009), EFT (Johnson & Zuccarini, 2011), existential therapy (Barker, 2011), experiential therapy (Kleinplatz, 2007), feminist therapy (Young, 2007), mindfulness (Brotto & Heiman, 2007), narrative therapy (Hall, 2012), short-term dynamic therapy (Bianchi-Demicheli & Zutter, 2005) and transactional analysis (Parkin, 2009). The trend is that specific sexual techniques and exercises are integrated with therapy of different forms that deals with interpersonal relationship patterns.

McCarthy and Thestrup (2008) describe their integration of couple therapy and sex therapy. They recommend that couple therapists routinely ask about sexual functioning in a normalizing and open-ended way, with each couple they treat. For example, a therapist could ask, 'About 50% of couples have concerns or problems with sexual desire, arousal, orgasm or satisfaction. Do you view your sexual relationship as strength or a source of stress and problems?' They point out that when couples experience their sex life as

satisfying, sexuality makes a small positive contribution to the relationship. On the other hand, sexual problems make a large contribution to relationship distress.

They go on to describe the PLISSIT model, first articulated by Annon (1974). PLISSIT provides a hierarchy for planning sexual interventions:

P: Permission Giving. Permission-giving interventions could include a referral to a spiritual leader of the clients' faith to reinforce the role of sex in marriage. Another example is the therapist clearly communicating a sex-positive attitude, and that sexuality is an integral part of a relationship. Permission giving could also include processing negative sexual experiences, rather than permitting them to interfere with the clients' sexual relationship.

LI: Limited Information. This entails guiding clients to appropriate sources of accurate information and eroding misconceptions.

SS: Specific Suggestions. The therapist can make direct suggestions to enhance the sexual relationship, for example, normalizing the variability of sexual experiences, encouraging each person to take responsibility for sexual communication, understanding the relationship between physical health and sexual health and discussing potential sexual side effects of medication. This could also include common sexual skill training exercises.

IT: Intensive Sex Therapy. Most therapists will refer complex or chronic cases to a competent sex therapist. McCarthy and Thestrup identify sex therapy as a subspecialty requiring specific training and supervised clinical practice.

The PLISSIT framework can assist therapists in their clinical decision-making. It can help therapists conceptualize interventions for sexual problems and assist them to practice within the bounds of their competence.

Summary

Couple therapy is often an important aspect of family therapy. Sometimes a marital problem is at the heart of a problem that presents as a dysfunction in the wider family system. Couple therapy has increasingly concentrated on the interactional processes occurring between the marital pair, rather than on the partners' intrapsychic processes.

Couple therapy has evolved a great deal since its inception – from a non-professional endeavour, to a variant of psychoanalysis, to a subset of family therapy. We reviewed the efficacy of individual versus conjoint configuration for couple therapy, the alliance in couple therapy and the thorny problem of 'mixed agenda' couples.

After articulating five general principles of couple therapy, we described some representative approaches: TBCT, IBCT, EFT, the Gottman method,

solution-focused therapy and narrative therapy. We then described how family therapists can be helpful to families experiencing separation and divorce and provided an overview of sex therapy.

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Chapter 15

Terminating Treatment and Dealing with Treatment Interruptions

Teacher (1989) refers to termination as ‘a neglected topic’ and it is true that the literature tells us more about how to start and continue family therapy than about how to end it. But, as Lankton and Lankton (1983, p. 345) pointed out,

The termination of a therapy session, as well as the termination of the entire therapy relationship, has special meaning to clients . . . the therapist orients clients away from dependence on therapy to the interdependence of their social network. But individual coping styles and mechanisms for frustration tolerance will determine just how clients consciously anticipate their adjustment.

Treatment contracts

Some reasons for making formal contracts with families were discussed in Chapter 9. When a specific time-limited or session-limited contract exists, the family can prepare for termination from the start. Having a time limit can also provide a sense of urgency. ‘If we don’t get these issues sorted out by the fifth (or tenth, or whatever) session’, they may say to themselves, ‘we shan’t be able to achieve a solution to our problems’. A time-limited contract also helps families see therapy as a discrete process extending over a certain period of time, following which they will be able to continue their lives without needing the help of a therapist.

Contracts can be flexible. The frequency of sessions may be decreased as changes in the family occur and the intensity of the problems lessens. Some therapists foreshadow, at the outset, the possibility of negotiating a further contract at the end of the initial one. While there are advantages in a flexible approach, and in keeping options open, early talk about renewing time-limited contracts tends to remove much of the point of setting them

up. But if families raise the issue, I may tell them I am sometimes willing to do this.

When is a time-limited contract indicated? Firm data on this are lacking. Some therapists use such contracts and others do not, but no scientific study of the respective results seems to have been carried out.

The number of sessions recommended does not seem necessarily to be related to the severity of the family problem. For example, the Milan group (Palazzoli, Boscolo, Cecchin, & Prata, 1978) reported that they used ten-session contracts even for the very severely disturbed families they treated. Occasionally, they renewed the contracts for a further ten sessions, but in most cases they did not. The Brief Therapy Centre of the Mental Research Institute in Palo Alto also worked on the basis of limited-session contracts. The 97 cases reported by Watzlawick, Weakland, and Fisch (1974, p. 115), comprising identified patients with a wider range of problems than those treated by the Milan group, were seen for an average of 7 hrs each.

When a contract specifying when the therapy is to end exists, it is well to have a contingency plan ready in case the family asks for an extension. This plan need not be mentioned when the first contract is agreed. The choice lies between negotiating another contract, perhaps for a small number of further sessions; assuring the family they do not need any more treatment; or suggesting some other treatment. The latter could be something quite different, for example, individual therapy for a family member, involvement in a therapeutic group or self-help organization, non-time-limited family therapy (such as the 'interminable' treatment mentioned in Chapter 11) or referral to another therapist or agency.

Sometimes a family's request for further treatment once the initial contract has come to an end can be the occasion to get therapy on to a new footing. If treatment has failed to achieve the hoped-for results, a new approach, perhaps with new conditions and a new plan, may be employed.

Open contracts

The alternative to a time-limited contract is an open one: one which does not specify the length of the treatment nor the number of times the family will be seen. In *Family therapy: Full length case studies* (Papp, 1977), there are accounts of the treatment of 11 families by eminent family therapists. In none of them was there mention of the setting up by the therapist of a contract for a fixed number of sessions. This is despite the presence among the authors of two therapists (Weakland and Fisch) associated with the Brief Therapy Centre in Palo Alto and also of Papp herself, describing a family seen in the brief therapy project of the Ackerman Institute. This book, and the family therapy literature generally, suggests that open contracts are more commonly used than closed ones.

When the therapy contract is an open one, the management of the termination process is even more important. With closed contracts, families

know from the start when treatment will end and can prepare themselves for this. With open contracts this is not so, and at some point the subject of termination must be raised and related issues discussed.

Indications for ending treatment

The termination of family therapy may be initiated either by the therapist or by the family.

Termination on the initiative of the therapist

Termination on the initiative of the therapist may be indicated under any of the following circumstances:

(1) When the objectives set at the start of treatment have been met. Assessing whether or not this has happened is greatly helped if clear goals and objectives were agreed at the outset.

When the desired state has been achieved, or is being approached, I review with the family the changes that have taken place during the treatment. If the family members believe things have changed, I ask them to examine the changes that have occurred. What *exactly* has changed? What specific things are different, compared with the situation at the start of therapy? Do these changes amount to the achievement of the goals set when therapy began or at later stages?

Termination is often better accomplished when the family members are able to see the extent of the changes that have occurred and when they realize that their problem-solving skills have improved. Tomm and Wright (1979) suggested that a paradoxical question such as 'What would each of you have to do to bring the problem back?' helps the family understand better what has happened during the treatment.

(2) When there has been a change in the family's functioning such that further treatment is not necessary, even though the objectives originally specified have not been fully met. In other words, the family now has the resources it needs to deal with any remaining problems. Outside help is no longer needed.

There may have been structural changes in the family or improvement in the family's problem-solving skills. These may now enable the members to cope with the problems which previously defeated them. For example, there might have been an improvement in the effectiveness of the parental couple's ability to work together in caring for their children. So, although their children's behaviour might still present problems, the parents are now able to handle them effectively. If treatment is to be terminated in these circumstances, it is important that the changes that have occurred are labelled, explained and agreed by the family members, even though the means whereby they have been achieved may not need to be made explicit.

(3) If therapy has proved ineffective, despite having had a fair trial. This may be an indication for stopping the therapy, at least of the type that has been used so far. A possible source of failure, as Watzlawick et al. (1974, pp. 111–112) pointed out, is the setting of unrealistic or inappropriate goals. It is unrealistic to suppose that every family can achieve all the changes its members might desire, and sometimes there is a lack of agreement among the members about what they really want, though this may initially be camouflaged. Coleman and Gurman (1985) list as some of the causes of failure

- Inadequate understanding and analysis of the circumstances surrounding the referral, particularly with regard to the assessment of the problem.
- Insufficient goal setting, particularly with regard to who sets the goals.
- Conflictual goals that affect therapy outcome.
- Overlooking the role of the presenting problem.

Coleman and Gurman's (1985) analysis of therapeutic failures confirmed the importance of the initial assessment of family problems and of defining and agreeing therapeutic objectives, as set out in earlier chapters of this book.

(4) Loss or lack of family motivation. This is really an aspect of therapeutic failure, but issues of motivation must be considered separately. If therapy appears to be failing to achieve its objectives, it may be that the family does not really want to change or perhaps some members do while others do not. This is a delicate issue, for it can be tempting for the therapist to blame a family's lack of motivation for the failure of therapy. Yet we must also consider the therapist's limitations or lack of necessary skills or the choice of the wrong therapeutic approach for the family concerned.

Sometimes a family's apparently weak motivation, or a fear of change, may be part and parcel of the problem that brought it to therapy in the first place. We should, therefore, be cautious about blaming failure on the family's motivation. Part of our job is to motivate the families we see to do what they need to do to achieve their objectives. When a therapist starts wondering about his or her part in the failure of the therapy, or the family's lack of motivation, the time may have come to ask for consultation from a colleague.

There are various ways of motivating families. An optimistic attitude on the therapist's part, combined with the mention of how things will be when (not if!) therapy is successfully concluded and the embedding in conversation of statements that look forward to that situation, is useful.

Sometimes a strategic approach may be needed. Metaphorical methods may succeed where direct ones do not. A number of examples are to be found in *Using metaphors in psychotherapy* (Barker, 1985, particularly pp. 94–101). Stories about people who have come to a crossroads, or a fork in the highway, may be useful. The excitement, challenge or happy outcome of taking a new direction may be stressed and may serve as a metaphor for the adventure of entering therapy. Imber-Black, Roberts, and Whiting (1988,

p. 81) refer to ‘celebration rituals to end therapy’, and, as we saw earlier, she also describes (p. 82) a ritual prescribed at a closing dinner session, the identified patient being one with an eating disorder.

For those who believe that discontinuous change is not possible, Erickson’s story of Joe, the chronic and apparently incorrigible criminal whose life became suddenly and dramatically transformed, can be used. (It is to be found in Zeig, 1980, pp. 211–216, and is summarized in Barker, 1985, pp. 55–56).

(5) Tomm and Wright (1979) suggested that when continuing treatment does not appear to be cost-effective, it may be wise to consider termination. Sometimes progress is very slow, despite all the therapist’s efforts. In that case the therapist may clarify his or her limitations and initiate termination.

Termination on the initiative of the family

Termination on the initiative of the family may occur in various ways. The desire of the family to stop therapy may be manifest in failure to attend sessions, but there are often warning signs that this may be about to happen. These include failed appointments, last-minute cancellations, late arrival for sessions and the absence from sessions of family members who are supposed to be present. The content of the sessions may also provide hints about what is happening, such as when family members express dissatisfaction with the course of therapy or begin complaining about the practical difficulties of attending, the loss of time at work or the children’s lost schooling.

Treacher (1989) suggested that when the therapy has been ‘strategic’, clients should just drift away, perhaps in the above manner. She points out that in strategic therapy the objective of the therapist is to have clients change their behaviour without attributing the changes to any of the therapist’s interventions. She says: ‘It is therefore not surprising that this type of model has little to say about termination and is also very cautious about undertaking follow-ups’ (Treacher, 1989, p. 138). Too much emphasis on follow-up may be taken to suggest that the therapist is expecting, or at least fears, relapse.

Tomm and Wright (1979) recommended that whenever initiatives such as those above become apparent, the therapist should take certain steps. These include considering what problems remain and what goals have not been achieved; assessing why the family is inclining towards termination; and looking especially for any evidence that there is serious danger of deterioration if treatment stops at the current stage. The therapist may take any of the following steps:

- (1) Exploring with the family their motives for wishing to end treatment.
- (2) Reviewing with the family the present state of their problems and, if appropriate, renegotiating the therapy contract. It may be helpful for the therapist to point out the benefits which the therapy may still offer.

- (3) Actively encouraging the family to remain in treatment, should there be reason to believe that deterioration is likely if treatment ceases at its current stage. It can be helpful to seek out the support of any people, inside or outside the family, who are likely to benefit if therapy continues. It may be necessary for the therapist to bring to the notice of such people the benefits that are likely to accrue.
- (4) Accepting the family's wish to end treatment, and indicating respect for their right to make that decision. This is appropriate when there is evidence that termination is inevitable, and the therapist's wish to continue is stronger than the family's. In such circumstances, the chances of further change occurring as a result of therapy are slight.

How to terminate treatment

Treacher (1989) proposed that, at the point of termination, the following questions should be asked by the structural therapist.

- (1) What has happened to the presenting problem? Has it disappeared, or been reduced to a level which is now considered acceptable; or has it been reframed so that it is no longer seen as a problem?
- (2) What structural changes have taken place; that is, have family relationships changed in demonstrable ways?
- (3) What changes have taken place in individual and family beliefs, particularly those concerned with the problems discussed in therapy?

Treacher (1989) also described a way of operationalizing these questions. A problem area is explored in detail to establish what changes have occurred. The family is then asked what it will do if, for example, Johnny starts stealing (instead of Ben who has now stopped).

Lebow (1995) listed ten tasks that should be addressed in terminating family therapy:

- (1) Tracking progress in therapy to determine the appropriateness of ending it.
- (2) Reviewing the course of treatment as it proceeds.
- (3) Emphasizing the gains made and the clients' role in these gains.
- (4) Abstracting what has been learned from treatment and how it may be applied later.
- (5) 'Internalizing' the therapist, who may become an internalized family member.
- (6) Relating the ending of therapy to other endings in life.
- (7) Saying goodbye with an opportunity to express gratitude and exchange feelings.
- (8) Discussing the conditions for returning to therapy, for example, for 'booster' sessions.

- (9) Referring when continuation, for example, in a self-help group, is indicated.
- (10) Defining post-treatment availability.

My own practice is based on a modification of the model of Epstein and Bishop (1981). They identified four steps in the closure process:

- (1) Orientation.
- (2) Summarizing what has happened during treatment.
- (3) Discussing long-term goals.
- (4) Follow-up (which is optional).

During the *orientation* stage, I (PB) explain why I am raising the question of termination. This may be because the objectives appear to have been met, because the contracted number of sessions has been, or is about to be, completed or, less often, because there has been little or no progress.

The summary of what has happened during the therapy provides an opportunity for all concerned to review the progress that has been made and the present situation in the family. I go back to my notes on the initial sessions and review the problems that were identified then, enquiring about the status of each.

I next ask the family to discuss their *long-term goals*. I like to present treatment as part of a continuing process of family growth and development. This goes hand in hand with the growth and development of the individual family members.

I aim to help the family identify challenges it may face in the future and discuss how it may use its new-found strengths and psychological resources to meet such challenges. It can be helpful also to identify the outside resources that are available: extended family, friends, social and other agencies, the family doctor, professional workers in the mental health field, school counsellors and so on. *Follow-up*, the final stage, is considered below.

During the closure process, I take as optimistic a view as possible of the situation and the family's prospects. I do this even if the closure is due to the family's unwillingness to continue to attend, rather than because the goals of the therapy have been attained. I emphasize the family's strengths, those changes they have made and the effort they have put into achieving these changes. Even if the changes have been small, they should be pointed out. It may also be helpful to mention that family therapy is not the only means by which families make changes. Indeed most families, most of the time, are making changes, meeting challenges and surmounting developmental hurdles, without the help of therapists.

It is important to affirm families as treatment is terminated. I like to express confidence in their ability to continue to make necessary changes. I (PB) aim to give a message such as 'You've done well during treatment, and I believe you now know what you have to do in the future, and how to set about making any further changes you want'. It is not usually a good idea for us as therapists to take credit for the changes families make, however

clever we may think we are. Emphasis on the work the family has done is to be preferred.

Termination tasks and ritual

It can be helpful, when therapy sessions end, to leave the family with resources they can continue to use. These can consist of straightforward tasks, like arranging family meetings at regular intervals or when major decisions have to be made. Another possibility is to prescribe symbolic or metaphorical tasks, perhaps of a ritualistic nature. These tasks or rituals will often build on processes started during the therapy. They can be a means whereby the therapist can remain psychologically with the family, even though the sessions have ended. They are similar to post-hypnotic suggestions.

Ritterman (1983, p. 316), in *Using hypnosis in family therapy*, describes the deliberate use of post-hypnotic suggestions in work with a client who was having difficulty dealing with the death of her husband. Erickson, too, made frequent use of post-hypnotic suggestion, as implied in the title of the book *My voice will go with you* (edited by Erickson, 1982). The title is taken from one of the 'teaching tales' in the book.

Termination metaphors (Barker, 1985, pp. 184–185) can keep alive, at the unconscious level, something of what has happened during treatment. A termination ritual was described briefly when the use of rituals was discussed in Chapter 11.

Emotional and psychological aspects of termination

The ending of therapy may be a time of great emotional significance to family members. It may, consciously or unconsciously, remind them of previous separations or losses. Inexpertly managed, it can appear to clients as a rejection, but just as the death of a loved one can be the occasion to celebrate that person's life and achievements, so can the ending of treatment be an occasion to celebrate what has been achieved. Nevertheless, the therapist should always be on the lookout for signs that termination is proving difficult for the family or for some of its members. The Lanktons put it well:

The business of other unfinished 'goodbyes' may be revived. These may have nothing to do with the expressed purpose of the therapy but nevertheless be stimulated by the parallel situation. For example the death of a friend from college may have had nothing to do with the marital therapy sought by the client. Yet, at termination, the client or therapist may find the need for adequate adjustment to this past situation stimulated by the end of the session or the therapy. This is often typified by negative emotions, tensions, 'dead' spots, internal dialogues with deceased loved

ones, unexplainable preoccupations, or unexpected delayed stress reactions from involvement in, for instance, the Vietnam War. (Lankton & Lankton, 1983, pp. 345–346)

Fenell and Weinhold (1989, pp. 82–83) also point out that ‘when a termination date is set, frequently many conflicts and defenses begin to emerge’. They emphasize the need to identify the gains made during therapy and also the need to help each family member reduce his or her anxiety about separation. They point out that some couples or families try to prolong therapy rather than deal with their feelings of loss. Tapering off sessions or periodic follow-up sessions can help resolve such issues.

Similar reactions, I (PB) have found, may occur in response to my being late for or cancelling an appointment with a family. Punctuality and reliability on the part of the therapist are important (and not only in family therapy). When lateness or cancellations are unavoidable, the family should be told the reasons at the earliest opportunity, and the therapist should be prepared to deal with any emotional reactions that may occur.

Follow-up

When should the therapist offer follow-up contacts, designed to obtain information about a family’s progress? It can be tempting, when a family’s case is being closed, to offer an appointment or a telephone contact a few weeks or months ahead in order to check on whether progress is being maintained. While it may help families to feel that the therapist is still available to them, there is a danger of giving a message that further problems are likely. The family should not leave feeling that the therapist expects it to fall apart again. After you have expressed a positive view of the family’s competence, the message should not be weakened by any implication of doubt about the longer-term outcome.

A case can be made for saying that therapy is finished. You do not expect that further treatment will be needed. The family now has the resources to cope with any challenges it may meet. It may be permissible to add, ‘I (or we) will always be here if you need me (or us), of course, but I (or the team) really don’t believe you will’.

The problem with the above approach is that it deprives the therapist of follow-up information. Yet it is important for us to know whether changes in families that occur during treatment are maintained.

Fortunately there is a way of resolving this dilemma, at least in part. This is for the therapist to make it a policy to follow up every family at certain predetermined intervals, perhaps at 4 or 6 months or at both 6 and 12 months. If we do this, we can truthfully say to families, at closure, ‘You don’t need any more treatment, but it is my policy (or perhaps the policy of the agency or clinic), with all the families we see, to contact them after 6 months (or whatever interval or intervals are chosen), because we are

interested in knowing how they are getting along and what further progress they have made’.

An alternative is to say that the information is needed ‘for research purposes’, if the data are indeed to be used for research purposes. Such follow-up contacts can be foreshadowed when the initial treatment contract is discussed.

Follow-up contacts may be made by telephone, letter or an appointment at the clinic or office. A face-to-face meeting with the family generally gives the most information. It may need to be no longer than half an hour. Some families are willing to respond to a telephone call, but not to pay a visit to the therapist. Some respond to letters or questionnaires requesting information, but this seems to be the method that yields the least return.

Davis’ book *Terminating therapy: A guide to ending on a positive note* (Davis, 2008) provides exhaustive discussions of the many aspects of the termination process and is an excellent reference source.

A less formal and more personal discussion of this topic is *Terminating therapy, Part II: The ideal termination* by Howes (2008), published in *Psychology Today* in October.

Dealing with treatment interruptions

Sometimes the course of treatment is interrupted by such things as physical illness in the family, illness affecting the therapist, vacations or a move out of the area by the family or the therapist. Occasionally, these circumstances may lead to the termination of therapy, but more often there are better ways of dealing with them.

As far as possible, these issues should be discussed well in advance. If you are expecting to be away from your work for a time during the family’s projected course of treatment, the family should be warned of this, and the dates mentioned, before treatment starts. In the same way we should ask the families we see whether, and when, they expect to be away. In either case there should be agreement in advance about how absences will be managed.

Sometimes sessions can be scheduled to avoid vacations and other known forthcoming events. Longer breaks than usual can sometimes be used by the family to practise skills they have learned. If you are going to be absent for a long period, however, it may be best to arrange for a colleague to work with the family in your absence. In any case, someone should be available to deal with issues that cannot wait until you return.

We have already considered, in Chapter 9, what we can do when some family members fail to attend. If the entire family fails to attend regularly, this is an issue which usually needs to be addressed when the family does come. When this or other breaches of the contract by the family become serious problems, a session may be devoted to discussing them, and it may be necessary to renegotiate the contract. If the renegotiated contract is then broken this may be an indication for ending treatment.

Dealing with illnesses in families can present problems. While physical illness can afflict both the therapist and the family members, it can also be used by family members as an excuse for non-attendance. If you have doubts about whether illnesses reported in family members are genuine, or at least serious enough to prevent attendance, it is usually best to discuss these openly with the family. If therapy seems unlikely to be effective without the 'sick' member, whether the sickness is a 'genuine' physical illness or not, this may be a good reason to suggest suspending therapy until the person concerned has recovered. A new course of treatment, based on a new contract, may be offered when all necessary people can attend.

It is important always to remember that absence or sickness of family members may be manifestations of the problems which have brought the family to therapy. It makes little sense to suspend or terminate therapy because of these problems. Moreover, discontinuing treatment, or threatening to, is not always the best way of dealing with these difficulties. Through working with those family members who do attend it is sometimes possible to get the absentee members to come, and even to make beneficial changes in the family system without their being present.

Finally, we must always remember that we have an ethical responsibility to see families through, once we have accepted them for treatment, as long as they wish us to continue treating them. If we become incapacitated, or move away, we must ensure that they are properly handed over to the care of colleagues. Similarly, if families have to move away from us, we should do everything we can to put them in touch with help in their new locality, if that is their wish.

Summary

Bringing the treatment of a family to an end requires careful preparation. If a time- or session-limited contract has been made, the family should be better prepared for termination than when there is an 'open' contract.

Therapy may end on the initiative of either the therapist or the family. Termination may be indicated because the agreed goals have been achieved, because the family has acquired the skills to resolve the remaining problems on its own, because treatment has proved ineffective or because the family does not wish to continue.

When therapy ends, the changes that have occurred should be identified and long-range goals discussed. The family's progress, strengths and resources should be the focus of closing interviews. An affirming, optimistic attitude on the therapist's part is desirable. Tasks and rituals, which may have metaphorical significance, can keep memories of the therapy, and reframed attitudes, in the minds of the family.

Closure may bring out feelings related to past losses, and the therapist should be alert for these and ready to deal with them. Caution should be

exercised in arranging follow-up, lest families interpret the plans to mean that relapse is expected.

Plans to deal with necessary disruptions of a regular schedule of sessions should, whenever possible, be made well in advance. When other disruptions occur, both the stated reasons and any underlying factors should be explored. When interruptions are therapist-related, it is the therapist's duty to make suitable arrangements to meet the clients' needs, including referral to colleagues if need be.

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Chapter 16

Teaching and Learning Family Therapy

Family therapy training, like family therapy itself, emerged and developed in a somewhat haphazard way. In the 1950s and 1960s there were few formal training courses. Therefore, in order to learn to work therapeutically with families it was necessary to sit, metaphorically, at the feet of one of the, usually charismatic, masters who were developing their methods and refining their skills in working with families. The names of most of these masters are mentioned in Chapter 1.

As the field of family therapy developed, training courses started to appear. These were set up in various universities, colleges and other institutions. Some were part of free-standing family therapy centres. At first, many of them concentrated on teaching the methods of a specific therapy school, often one developed by one of the pioneers. In due course training programmes were established that used a more eclectic approach – rather as this book does.

Supervised clinical practice has always been the cornerstone of family therapy training. It was probably fortunate that, as training programmes were developing, one-way observation screens and, a little later, closed-circuit television equipment became available. These made it possible for trainees to observe their teachers at work without being physically present in the therapy rooms; similarly the teachers could observe their students at work. Trainees also needed to acquire an understanding of the theoretical basis of the practical work they are doing. Books, such as this one, and articles published in professional journals were important sources of such information.

In due course, organizations came to be established to set standards for training programmes and monitor the quality of the training provided.

The American Association for Marriage and Family Therapy (AAMFT) sets rigorous membership standards covering specialized academic training and supervised professional experience. It also examines and accredits centres which provide training in marital and family therapy. It requires its members to have a graduate degree in marital and family therapy,

or its equivalent. Courses in the following subjects are required for such a degree:

- Human development
- Marital and family studies
- Marital and family therapy
- Professional studies
- Research methodology

Members must also have had:

- 200 hr of supervision in the practice of marital and family therapy, of which no more than 100 hr may be in group supervision.
- 1500 hr of clinical experience of marital and family therapy.
- 2 years of work experience, after the graduate degree, and while receiving supervision from an AAMFT-approved supervisor.

The association publishes *The Journal of Marital and Family Therapy*. It also has a Code of Ethics, the latest (2012) revision of which is outlined in Chapter 18. Further information about the association is available on its website.

In the United Kingdom, the leading family therapy organization is the Association for Family Therapy and Systemic Practice. Its activities and the requirements for its various categories of membership are described in its website. It also has a Code of Ethics and Practice, which the members are expected to follow. It publishes the *Journal of Family Therapy and Context*, 'the magazine for family therapy and systemic practice [that] covers news and views on issues of concern to all professional groups working with children and families in a therapeutic environment'.

The association distinguishes three levels of training for aspiring family therapists:

The foundation level

The intermediate level

The qualifying level

Outlines of what each of these levels involves are to be found in the association's website.

Whether family therapy should be a separate discipline, like dentistry or veterinary medicine, or whether it should remain primarily a field of practice in which professionals from other disciplines can choose to specialize, like hypnotherapy, is not agreed. The pioneers of family therapy came from various disciplines, but many were physicians, usually psychiatrists, for example, Midelfort, Ackerman, Bowen, Wynne, Lidz, Whitaker, John E. Bell, Laing, Boszormenyi-Nagy and Minuchin. But there were notable exceptions, such as Haley, Weakland, Satir, Watzlawick and Bateson. Today, the proportion of physicians among those practising family therapy is probably lower.

There is a case for family therapy remaining as one of the treatment skills possessed by therapists who are also adept in other approaches. Such

therapists can choose which approach to use, according to the needs of their clients. On the other hand, there is also a need for expert, specialist family therapists, who will make this their main, or even their only, field of practice. Such experts can act as consultants to other therapists, treat some of the more complex cases themselves and play major roles in teaching family therapy and advancing the subject through research.

Currently, family therapy is practiced by, and therefore taught to, people from various mental health disciplines notably social work, clinical psychology and psychiatry. Professionals from other groups, for example, nursing and occupational therapy, are also learning family therapy. But there has also emerged a new professional group, those who have not previously trained in another field.

Much family therapy training is structured to meet the needs of students already trained in other professions. Family therapy concepts and skills are also taught as a part of social work, psychiatry, clinical psychology, child care work, nursing and other courses. This does not make graduates of these courses fully trained family therapists, but exactly how much you need to know to set yourself up in practice as a family therapist is not generally agreed. In many jurisdictions anyone can legally do this, so it is wise for those seeking family therapy to check the training and credentials of their prospective therapists. A university degree or diploma in family therapy (and such degrees and diplomas are becoming increasingly available) is an indication that the practitioner has received training and has reached an acceptable level of proficiency in the field.

Who learns family therapy?

To become a fully competent family therapist, able to practice independently, a period of full-time instruction is desirable, though part-time training can be effective also. Those with some professional experience in the mental health field often prove better equipped to undertake this training than those who lack such experience, and a range of varied life experiences as well as emotional maturity and a secure family life are helpful too.

Figley and Nelson (1989) surveyed members of the American Family Therapy Association and approved supervisors of the AAMFT. Those who participated, a total of 372, 60% male, 40% female and 94% Caucasian, completed a questionnaire which asked for their opinions on the most important skills and personal traits needed by family therapists. It is interesting that about one-half of the top 'generic skills' identified were considered by the authors as more appropriately described as 'personal traits'. It seems, therefore, that the presence of certain traits may be an important factor to be taken into account in the selection of family therapy trainees.

Part-time training courses are offered in many centres. These will naturally spread the training over a longer period which may be an advantage in that it gives the student a longer time to consolidate his or her skills before

leaving formal training. Part-time courses can provide sound training, and many family therapists have trained part time.

Quite apart from formal training courses in family therapy, there is much to be said for providing an introduction of the field for all who are training in any of the mental health disciplines. This should provide an understanding of what family therapy is, and when it may be useful, without aiming to make each student a family therapist.

The different possible learning experiences

It is helpful to distinguish training, teaching, supervision and consultation. Wendorf (1984) pointed out that supervision and training are often confused with therapy and consultation. He uses 'training' as a 'general term meaning the transfer of knowledge and skills', while 'supervision' is the 'hierarchical arrangement of training in which a superior "oversees", evaluates, suggests, gives feedback to, pushes or advises a trainee'. 'Consultation' means 'the giving of feedback and suggestions but with no hierarchical training relationship necessarily involved'. 'Teaching' is not differentiated from training by Wendorf (1984), but the term is perhaps best used in this context to describe the more formal conveying of knowledge, as in lectures and seminars, though it can also be used in a broader sense.

Methods of learning family therapy

The means whereby students learn family therapy probably vary as much as the various schools of therapy vary in their approach to treating families. For example, an issue on which there appear to be diametrically opposed views is that of whether or not training should include an examination and review of the trainees' own family background and experiences. In some centres, these issues are explored in depth, with role-playing exercises and an examination of the trainee's current feelings towards, and relationships with, his or her own family. In others, nothing of this sort is done.

At the 1980 meeting of the American Orthopsychiatric Association there were several presentations on family therapy training. Views expressed on this issue varied from those of Epstein and Bishop (whose work we have referred to previously), who said that going into trainees' own family experiences was quite unnecessary and an unwarranted intrusion into their private lives, to those of Philip Guerin, of the Centre for Family Learning, New Rochelle, NY, who maintained that it was important to do this and stressed it strongly in his description of the training programme at New Rochelle.

The wide divergence of views on this matter was clear also from the review of the literature on family therapy and supervision by Liddle and Halpin (1978). Liddle himself, however, believes that work with the trainee's family is not relevant to the learning of a therapeutic model orientated towards

solving presenting problems within a family contract (Liddle, 1980). In this latter paper, Liddle contrasts his approach with that of Murray Bowen, who required each of his trainees to complete a 'family voyage' with his or her family of origin.

More recently, this issue has been discussed in a paper by Young et al. (2003). This describes 'a process that aims to integrate family of origin work with skills development'. This builds on an approach in use at the Bouverie Centre in Melbourne, Australia.

Keller and Protinsky (1984) described what they called a 'self-management model for supervision' in marriage and family therapy and adopted a point of view similar to Bowen's. They used 'a model of supervision that places emphasis on increasing self-awareness and the therapeutic management-of-self in the clinical setting'. They find Bowen's 'three-generational emphasis' useful in understanding how family interactional patterns are transmitted and particularly, the patterns of triangulation in which people, including therapists, get involved.

Keller and Protinsky (1984) required each 'supervisee' to present a personal three-generational genogram. The supervisee's family of origin is then carefully examined and probed. That person's videotape therapy material is then presented, and the supervisor and the other 'supervisees' scrutinize it for 'evidences of his or her management-of-self processes'.

Like Bowen, Keller and Protinsky (1984) pay much attention to the process of *triangulation* – the tendency of two people to draw a third person into their relationship, especially when the relationship is in difficulty. Triangles, as Bowen (1978) has repeatedly emphasized in his writings, are commonly found in troubled families. When spouses are in conflict they may involve a child and either, or both, of them may try to use that child as an ally, or in some other way, in their dispute. A parent/child pair or two children in a family may similarly triangulate a third family member, or someone in the extended family or outside it altogether may be triangulated in by family members. Patterns of triangulation in therapists' families of origin may, Keller and Protinsky (1984) believe, be repeated in their interactions with their clients, supervisors and peers. Their paper describes how they assist therapists to be aware of such tendencies and thus avoid reacting in ways which may not be therapeutically useful.

Coppersmith (1985) reviewed the concept of 'triads', as it is used in family therapy. She pointed out that the ability to 'think in threes', and to analyse complex triads, is a skill required by family therapists. Indeed she stated that teaching triadic theory is 'a crucial aspect of family therapy training'. As an aid to teaching this she developed an exercise, involving a series of role-played simulations, to be enacted and discussed by trainees. These range from 'a simple non-problematic triadic organization to a complex, potentially problematic triadic system' (Coppersmith, 1985, p. 62). She found this to be a useful way of teaching both beginners and experienced therapists seeking further training.

It is not difficult to see how self-knowledge, and an understanding of one's family of origin and one's current family, might be of help in dealing with

an emotionally challenging family situation. Yet whether such understanding *does* make for better therapy has not been established. Many effective therapists have not undergone an examination of their families of origin. Much may also depend on the style of therapy the therapist will be using. Examining one's own family background may be more important for those who use a 'Bowenian' or extended family systems approach, and perhaps also for those who use experiential methods than for therapists of other schools.

Family therapy training usually consists of a combination of theoretical instruction and supervised practical experience, whether or not trainees are required or encouraged to examine their own family backgrounds. Theoretical knowledge may be obtained from formal teaching experiences, such as lectures, seminars and tutorial classes. It should be supplemented by reading the relevant literature. There has been an explosion of literature in our field over the course of the last 40 years, so that students, especially when they are first embarking on the study of family therapy, require guidance on what to read. One of the purposes of this book is to provide such guidance.

Audiovisual aids

The practical aspects of family therapy are learned by assessing and treating families under supervision. Audiovisual aids are used extensively in this process. I have referred in Chapter 1 to Minuchin's emphasis, in the early days of family therapy, on the importance of the 'live' observation of therapy, as opposed to the acceptance of trainees' reports of what they believed happened during their therapy sessions. It is probably better to supervise all therapy 'live', but it is especially important in family therapy, when there are several people to observe, and a great deal is going on, both between family members and between therapist and family.

The simplest audiovisual aid is the one-way observation screen. This enables observers to watch therapy without themselves being in the therapy room. It is sometimes called a 'one-way mirror', but the 'therapy room' side does not necessarily, nor invariably, have a mirror surface. A sound amplification system enables those viewing the therapy to hear what is happening in the therapy room. This arrangement is the easiest way of conducting live supervision of therapy.

Persaud (1987) raised the interesting question of what effect the one-way mirror has on the process of family therapy. He reviewed several papers that reported comparisons of subjects' behaviour in the presence of a mirror with their behaviour in the absence of one. For example, college students, all of whom had said that cheating was morally wrong, were given a timed IQ test and a chance to work illicitly beyond the time limit. Initially, 70% cheated in this way, whereas when a mirror was introduced the rate was reduced to 7% (Diener & Wallbom, 1976). It seems, from this and other articles Persaud (1987) quotes, that the presence of the mirror may affect behaviour. How

much, and for how long, and whether the effect fades as subjects get used to the mirror is not clear.

As family therapy has developed, relatively inexpensive closed-circuit television and videotape equipment has become available. Closed-circuit television can serve the same purpose as observation through a one-way screen, especially when a large audience, or one at a distance from the therapy room, is to view the therapy. The therapeutic uses of videotape replay have been outlined in Chapter 11, but videotape equipment is also invaluable as a training device. It can serve a number of purposes:

- Review by therapists of their own work.
- Review by supervisors of the work of their trainees.
- Demonstration of therapy techniques, as when the work of experienced therapists is reviewed by learners. Edited videotapes, some with commentary, are available from many centres.
- Review of the progress of therapist and family, when serial videotapes are made and kept for later use.
- Reviewing and learning from role-playing exercises undertaken as part of a training programme.

Kramer and Reitz (1980) described a design for the training of family therapists which used the videotape playback of role-playing exercises to groups of eight to ten students. Trainees were able to see themselves and other members of the group in a series of therapeutic situations, the complexity of which could gradually be increased. This led to sessions in which students learned to increase their 'personal awareness'. By such means students seen as aloof in therapy, or having recurrent difficulties in dealing with certain types of family, can be helped to overcome such problems.

Personal relationship problems which may be affecting a therapist's work – as when a therapist has to deal with someone who reminds him of his dominant father or of the sister with whom he feels rivalry – can be rehearsed and explored, for example, by setting up a role-played session with a critical supervisor. Students can explore their own appearance on the screen, watching a 'video portrait' of themselves, while being coached in expressing, through their appearance and behaviour, what they want convey to the group and, ultimately, to the families they treat.

Objectives

A teaching programme requires clearly defined objectives. The objectives set in teaching family therapy will depend on the model of family functioning and therapy used in the setting in which the teaching is to be done. There is a need for an explicit theory of how families change (Liddle, 1980). As therapists acquire clinical skills, they can start investigating other models and techniques and incorporate what they find helpful into their own practice.

Learning family therapy skills

Cleghorn and Levin (1973) defined three types of family therapy skills which must be learned. These are *perceptual*, *conceptual* and *executive* skills. This remains, to this day, a useful model.

Conceptual skills can be taught by various means. The McMaster group used a combination of a 'semi-programmed text': reading materials in which theoretical concepts were explained and tutorials in which the concepts the trainees had learned were integrated, and problems and issues which remained unclear were resolved. The concepts taught were naturally those upon which the McMaster model of therapy was based, but this approach could equally well be used to teach any other conceptual scheme.

At each stage, it is a good plan to test students' knowledge of what has been taught so far. Conceptual knowledge can be tested using multiple choice methods. If the trainee has not come to a satisfactory understanding of the relevant basic concepts, learning perceptual and executive skills may prove difficult.

Perceptual skills, like conceptual skills, can be learnt without seeing families in therapy. Instead, videotapes of real or simulated families, and role playing, can be used. If, for example, it were the McMaster model which was being taught, trainees would be asked to rate families on problem solving, communication, roles, affective responsiveness and involvement and behaviour control, taking into account the subcategories of each. Their responses would be discussed in the group and with the teacher. With practice and appropriate feedback, trainees' skills in perceiving the processes occurring in family groups improve.

Perceptual skills can also be learned by the use of 'scenarios', that is short, one- or two-paragraph summaries of families. After reading each of these, the trainees rate them according to the various categories being used. There must also be categories for no data or insufficient data, since it is important to know when additional information is needed.

Training in *executive skills* should be carried out principally while students work with families, although these skills can be practiced initially using simulated families, made up of groups of trainees. The supervisor watches through a one-way screen or on closed-circuit television and gives feedback. This may be done in breaks during therapy sessions, by using an intercommunicating telephone, or after sessions have ended. Alternatively, videotapes or, less satisfactorily, audiotapes of sessions may subsequently be reviewed.

Live supervision has the advantage that the supervisor can, when necessary, intervene during the session. When sessions are being recorded for later review, beginning students may get into difficulties if feedback is not available when things start to go wrong. For students with more experience, review of recordings can be satisfactory. Evaluation of executive skills may be achieved by observing videotapes of students' work and rating these according to specific criteria.

Liddle and Saba (1982) described a model for teaching family therapy at the introductory level. They drew a parallel between the process of therapy, using Minuchin's (1974) structural model and Haley's (1976) more strategic one, and that of training family therapists. Just as therapy may be viewed in stages (Haley, 1976), so may training. According to Liddle and Saba (1982), three stages characterize both therapy and training: *joining*, *restructuring* and *consolidation*.

Phase I, *joining*, requires the student 'to suspend... his existing view of reality' and to adopt, 'at least in experimental spirit, ideas about the etiology and treatment of human problems which are often quite alien to the student's previous training and experience' (Liddle & Saba, 1982, p. 65). Joining the training programme is thus seen as analogous to joining a family. This is the first stage of structural therapy, in which the therapist tentatively, but without being engulfed by the family's way of behaving and looking at things, becomes a member of the family group. The content of this phase has much in common with Cleghorn and Levin's (1973) stage of learning conceptual skills.

Phase II is that of *restructuring*. In structural therapy, this is the main change-producing phase of treatment. Similarly, the family therapy student, at this stage, is challenged 'to learn and experiment with new concepts from differing schools'. This has much in common with the learning of executive skills.

In phase III, *consolidation*, 'students are required to take personal and theoretical risks in integrating the various approaches into their professional identities'.

Liddle and Saba (1982) reported that the course, which introduced students to a variety of schools of therapy, had three main areas of impact:

- (1) It sparked student interest in clinical training in family therapy.
- (2) It affected the lives of some of the students, in that it made them more aware of their current families and their families of origin. Especially, after studying the work of Bowen, Boszormenyi-Nagy and Framo, students asked to be allowed to write family autobiographies.
- (3) It affected the students' views of human problems. One student is quoted as saying:

My eyes have been opened to a whole new way of viewing pathology. Clients are no longer isolates to me. I see them in relation to their environment which includes the family as well as myself, the therapist.

The content of training

Precisely, what is taught in any course of training will depend on the orientation of those teaching it. There are many schools of family therapy, and it is possible to teach students the theoretical bases of a variety of them. But

when actually teaching trainees to work with families it is necessary to use a specific, even if flexible, model. This need not be derived from one particular school of therapy, but may be an eclectic one derived from various sources. An example of such an approach was set out in Chapter 13.

So precisely what is taught will depend on the assessment and therapy model that is being taught. The paper by Figley and Nelson (1989) lists the 'top 100 generic skills' arising out of their survey of teachers of family therapy. Tomm and Wright (1979) were more specific in their listing of the 'functions', 'competencies' and 'skills' needed for each of the four stages of therapy: engagement, problem identification, change facilitation and termination.

Supervision

We have seen that expert supervision, especially live supervision, is a central feature of any good training programme for family therapists. Indeed the would-be student of family therapy might be well advised to avoid any 'training' centre that does not have a good system of supervision. This means that proper audiovisual aids are freely available with adequate supporting technical staff.

It seems that the term 'live supervision' was coined by Braulio Montalvo (1973). In addition to making some of the points about supervision which we have already discussed, he suggested that the supervisor and the trainee should define in advance the limits within which they will operate, including the situations when it is obligatory for the trainee to do as the supervisor says, and those in which the supervisor's suggestions may be modified, and that the supervisor should not unduly restrict the trainee's freedom to explore and operate within the family and that if this does happen the trainee should tell the supervisor so. He also recommended that the supervisor should endeavour to use procedures that fit the trainee's style and preferred way of thinking.

Montalvo (1973) also advised that the direction of therapy be worked out before each session and reviewed after it. The better the advance planning the less likely it is that the therapist and supervisor will have to consult during the session. The intensity of supervision and the frequency of interventions by the supervisor may be expected to lessen as the trainee gains experience.

Live supervision is best provided by having the supervisor watch through a one-way observation screen or on closed-circuit television. Some supervisors like to be able to communicate with their trainees by telephone, but an alternative is the 'bug-in-the-ear', a device which enables the supervisor to talk to the therapist while the latter is interviewing the family, but without the need for the ringing of a telephone. Its drawbacks are that the therapist cannot reply to what the supervisor says and may face the difficult task of listening to the 'bug' while not appearing discourteous to the family by

disregarding it. If either of these methods is used, it has been suggested by both Haley (1976) and Liddle (1980) that only one or, at the most, two ideas should be communicated to the trainee in the course of one call.

Another arrangement that can work well is for the trainee to leave the room during the session for one or more discussions with the supervisor. It is also possible for the supervisor to tell the therapist when to take a break to discuss progress, by a pre-arranged signal, such as a knock on the door (if there is no telephone intercom system). Whatever the plan, the family should be told about it in advance. Families seldom raise objections to having supervisors watch, and intervene if necessary, especially if they are told that in this type of therapy the input of another therapist, or a team, often enables them to be helped more effectively and quickly. When the situation is properly explained, most families are pleased to learn that more than one person is involved in helping them.

The process of supervision differs from that of therapy in that the supervisor must consider both the family system, and how the family may be helped to resolve its problems, and also the therapist/family system. It is this latter aspect that is the essence of family therapy supervision. A real danger that all family therapists face is that of getting involved emotionally with the families they treat. This can impede therapy or even make it ineffective. Expert supervision can help avoid this danger.

Quinn, Atkinson, and Hood (1985) offered an interesting model for the group supervision of advanced trainees. They call it the 'stuck-case' model. These authors established a special 'stuck-case clinic', for advanced trainees to bring families to when little or no progress was being made. They found it a useful way of bringing new thinking to difficult or 'stuck' families.

Ungar (2006) discusses the special challenges that supervision presents when postmodern methods are used and describes how he approaches his work as a 'postmodern supervisor'.

de Roma, Hickey, and Stanek (2007) have reported a study of the types of supervision used by trainees in marital and family therapy in the state of California. They seem to feel that their results contained both good news and bad news. The good news was that 38.9% of the sample used audiotapes and 57.4% used videotapes. The bad news was that 43% of the sample 'did not participate in observational practices'. However, recent literature seems to indicate the view that 'observational' supervision is generally considered desirable.

Learning to supervise

The importance of the supervision of family therapy is such that considerable attention has been paid to the process in the literature. Liddle, Breunlin, Schwartz, and Constantine (1984, p. 139), however, commented that

Although the literature on supervision is impressive, it lacks the vital component specifying how supervisors best acquire this knowledge.

Considerable clinical experience does not automatically qualify one to be a supervisor, but rather, just as the skills of family therapy can be taught, so also a separate and definable set of supervisory skills can and should be taught systematically to therapists who wish to be competent supervisors.

Liddle et al. (1984), in the paper from which the above is quoted, describe the ‘supervisor extern programme’ (SEP) at the Family Systems Program of the Institute for Juvenile Research in Chicago. The SEP comprises the following components:

- Live observation of supervision.
- A theory seminar.
- Opportunity for supervisors to receive feedback on their supervisory skills and styles (through videotape supervision and case discussions with trainees).
- Learning and support from peers.
- The practice of the supervisory role and skills at their primary place of work.

Liddle and his co-authors point out that the above list might be suited to any therapist training programme. There are, moreover, many principles common to therapy and supervision, for example, the need to set goals, think in stages, be sensitive to contextual cues, establish rapport (called joining by these authors) and challenge realities – all apply to both. Yet there are specific supervisory skills also, and the training system itself, and its components, requires that the supervisor has available an adequate conceptual map of the system.

Heath and Storm (1985) described a four-stage course in marriage and family therapy supervision. This is adapted from the scheme described by Liddle et al. (1984). It had four objectives:

- (1) To encourage student supervisors to adapt and use their therapy theories as supervision theories.
- (2) To facilitate the development of live supervision skills.
- (3) To have student supervisors become expert in supervising student therapists with a variety of theoretical orientations.
- (4) To provide student supervisors and student therapists with close and consistent supervision.

The course had two components, a seminar and a practicum. The seminar took up 2 hr per week and aimed to develop the supervisors’ conceptual skills. The practicum comprised four stages:

- (1) *Stage one.* During this stage, the supervisors, as a group, watched the live supervision of a student therapist by one of the authors of the article. The other instructor was with the trainee supervisors and helped them begin to think as supervisors, rather than as therapists.

- (2) *Stage two.* This was the stage of ‘individual participation’. The students watched the authors while they supervised family therapy, asking questions and discussing the rationale of what was done. Each was also assigned three therapists to supervise in the next stage.
- (3) *Stage three.* During this stage, the supervisors received live supervision of their supervision.
- (4) *Stage four.* This was the stage of independent supervision.

These two related schemes for training supervisors, though expensive in the time of the instructors, seem to offer the prospect of improving what has in the past been something of a hit-or-miss process.

Consultation

Consultation is another means whereby therapists may both improve their skills and receive help in treating families. It differs from supervision in two ways. There is no hierarchical distinction between a therapist and a consultant, and consultation is usually an occasional, rather than a regular event, though there is no fundamental reason why a therapist should not seek consultation, or a consultant offer it, on a regular basis.

Bullock and Kobayashi (1978) described a number of situations in which ‘live consultation’ may be helpful. These are:

- (1) Conflict between therapist and patient. The therapist may not be aware of this and the consultant may be able to intervene before the conflict escalates in a therapeutically unhelpful way.
- (2) When the therapist becomes ‘regulated’ by the family, and starts to behave in ways similar to the dysfunctional behaviour of the family.
- (3) When the therapist is drifting from the task. Therapists sometimes inadvertently stray from the course necessary to meet the goals and strategies which have been set out.
- (4) The ‘eureka’ effect. This term is used to describe a situation in which the consultant becomes aware of a therapeutic move which would better help the family towards its goals, than the strategy currently being used by the therapist.
- (5) When it appears that it may be helpful to create a therapeutic coalition. Thus the consultant may intervene to bring about an alignment of two parties against a third, when this seems likely to increase family members’ motivation.
- (6) When there is a misreading by the therapist of the family situation or the significance of members’ statements.

The above circumstances might also be reasons for intervention by a supervisor if one were involved. In most of them the therapist would probably be unaware of just what had gone wrong with the therapy. Consultation

is usually sought when unduly slow progress is being made. The consultant's task is to help discover what has gone wrong or, preferably, find a better approach than that used hitherto.

The responsibility to seek consultation when this is indicated is one of our ethical responsibilities. It is not an admission of failure or inadequacy, for no therapist can expect to succeed, unaided, with every family. On the contrary, it is a sign of a mature and well-trained professional who realizes that he or she has limitations and that good practice involves having consultants available and using them when necessary. The 'stuck-case clinic' (Quinn et al., 1985) is an example of how these situations may be tackled.

Max van Trommel (1984) suggests that there are three levels at which consultation can occur:

- (1) Expanding the field of the therapist but focusing on the family. Consultation initially places emphasis on the family with whom the therapist has reached a deadlock. This may be sufficient to free up the therapeutic process.
- (2) Expanding the field of the family. The progress of therapy may be impeded because of the relationship of the family with other systems. These may be the family of origin, a friend, a couple with whom the family is friendly, a school, a neighbourhood, an employer, a welfare system or the referring person or agency.
- (3) Expanding the field into a 'metadomain' to focus on the therapist/family system. The system with which the family has become 'inextricably entangled' need not, as van Trommel (1984) points out, be another person or organization but may be none other than the family therapist who is working with the family. The therapist/family system may, therefore, need to be addressed in consultation. If steps 1 and 2 do not lead to satisfactory progress, this area should be explored.

As therapists, we have the difficult tasks of both observing and participating in the systems of which we become part. van Trommel (1984) quoted Keeney (1982) who pointed out that 'there is no such thing as an observer-free description of a situation'. A system can only be analysed as a mutual interactional process between the system and some other 'functioning unity... for instance, the therapist himself' (van Trommel, 1984, p. 471).

van Trommel also describes a way of providing consultation to the 'family-plus-therapist'. This comprises the following:

- *A pre-session discussion.* The therapist provides basic information about the family, such as names, ages, who lives in the household, the aims of therapy and the strategies the therapist has used. Data about the content of the problem are not provided, since the consultation team (and this type of consultation is usually provided by a team) is concerned with a

higher level of abstraction than that of the family processes themselves. For the second part of the pre-session discussion, the therapist is absent, and the team draws up hypotheses about what has gone wrong with the therapist/family system.

- *A consultation session.* The interviewer, a member of the team, interviews the therapist-plus-family, using circular questions (Palazzoli, Boscolo, Cecchin, & Prata, 1980; Penn, 1982). The questions are designed primarily to elicit information about the functioning of the system under investigation. Questions are asked equally of therapist and family. The team may telephone-in advice or comments, and the interviewer may ask the team for advice.
- *An intersession break.* The therapist stays with the family. This emphasizes that it is the therapist/family system that is being investigated. Meanwhile, the interviewer and the rest of the team discuss the information obtained. An intervention is then formulated.
- *An intervention.* During this short session, the family and therapist are informed of the intervention.
- *A post-session discussion with team and therapist present.* The content of the intervention is not discussed, and this stage consists simply of a brief, general summing-up to conclude the procedure.
- *Present.* The content of the intervention is not discussed, and this stage consists simply of a brief, general summing-up to conclude the procedure.

van Trommel (1984) includes two examples of the above process, and also a discussion of it. Those considering using the approach he recommends should study his paper.

Integrating research and clinical training

In the early days of family therapy, there tended to be an emphasis on either the teaching of clinical skills or research. During the last few decades, however, universities and other teaching centres have sought to ensure that their graduates have both excellent clinical skills and also expertise in carrying out research or at least in understanding and applying the results of research in the field.

Jennifer Hodgson and her colleagues go so far as stating that ‘the future of the profession and practice of marriage and family therapy rests with those who promote the integration of research and clinical practice’ (Hodgson, Johnson, Ketring, Wampler, & Lamson, 2005). These authors go on to describe methods aimed at achieving this objective.

This issue is also addressed by, among others, Santisteban, Morales, Robbins, and Szapoznik (2006) in their paper entitled *Brief strategic family therapy: lessons learned in efficacy research and challenges to blending research and practice*.

Summary

Family therapy is taught to a wide variety of students, not all of whom aim to become specialists in this field. Increasing attention is being paid to defining what should be taught to students at different levels and to the setting of professional standards for marital and family therapists. Formal teaching, supervised clinical work, role playing and watching other therapists, live or on videotape, are all valuable components of training programmes. Modern training makes much use of the 'live' viewing of therapy, and for this, adequate audiovisual aids are essential. How necessary it is for therapists to explore their families of origin, and their current families, remains unclear. It may depend on the model of therapy to be used.

Well-defined objectives are necessary in training therapists, as they are in therapy. Means of assessing students' progress in meeting the objectives should be built into programmes. The content of training depends on the theoretical model to be taught, but it should cover all phases of therapy, from joining and assessment to termination and follow-up.

It is important for teachers to learn the specific skills of supervision. These are not the same as therapy skills. Therapists should also be trained to use consultation when it is needed. Marital and family therapies are complex undertakings and when progress is unsatisfactory, the seeking of consultation is one of our ethical responsibilities.

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Chapter 17

Research in Family Therapy

Imber-Black (2011, p. 1), then editor of *Family Process*, referred to ‘the vast cultural chasm of research and practice’ the so-called *research–practice gap* (Goldfried, 2010). Family therapy training prepares practitioners to become consumers of research so that research informs their practice. On the other hand, most family therapists practice based on the theoretical model in which they trained and their own clinical experience. Because of the ‘chasm’ described by Imber-Black, several researchers and scholars have considered how to help practitioners use research, and perhaps involve practitioners in research (Gurman, 2011).

Several kinds of research are available to family therapists. Research on the *efficacy* of family therapy interventions usually takes the form of randomized clinical trials (RCTs). In these kinds of studies, manualized interventions are provided to randomly assigned clients who experience one problem. This bears little resemblance to real-life therapy (Messer, 2001; Pinsof & Wynne, 2000). While tight controls permit researchers to make causal inferences, and RCTs provide useful analogues to real-life therapy, they have little *ecological validity* on their own.

Parry, Castonguay, Borkovec, and Wolf (2010) state the field has tried to integrate research and practice by incorporating research findings into *clinical practice guidelines*. However, the authors suggest such guidelines have little influence on therapists’ behaviour. Another approach has been to develop lists of *empirically supported treatments* (ESTs; APA Presidential Task Force on Evidence-Based Practice, 2006; Canadian Psychological Association, 1998; National Institute for Health and Clinical Excellence, 2012; The Office of Juvenile Justice and Delinquency Prevention, 2012). Indeed, the movement towards ESTs is predominant in counselling and psychotherapy. However, because ‘empirically supported’ usually means that the intervention has been validated in an RCT, its practical validity is questionable.

In this chapter, we will deal with several questions, the answers to which may help close the chasm between research and practice and make research more relevant to novice family therapists, instead of having one’s ‘eyes glaze over the moment that the issue of research is raised’ (Campbell, 2003, p. 51).

Why is family therapy research important?

Obtaining funding for mental health services is increasingly competitive. Those who provide financial support for services – government departments, insurance companies and employee assistance programmes – require that clinicians document the effectiveness of their services. Over a decade ago, Hawley, Bailey, and Pennick (2000) stressed the need for tailor research to funders' needs.

However, funders are not the only consumers of research. Sexton, Robbins, Holliman, Mease, and Mayorga (2003) note that policymakers and funders require broad information about the efficacy of programming, while clinicians need evidence about specific interventions and detailed process and outcome information.

Hawley et al. (2000), in a content analysis of research articles in major family therapy journals in the mid-1990s, found only 10% of articles addressed clinical outcome, 11% were on clinical process and few addressed the cost-effectiveness of family therapy. Sandberg, Johnson, Robia, and Miller (2002) found that family therapists do not participate in research because of shortage of time and financial resources and organizational constraints, but mainly because they find research irrelevant and do not feel a sense of involvement. While accountability requires research, educators and programme managers must make research more relevant and more convenient.

Is family therapy effective?

Family therapy effectiveness research was reviewed in a special issue of the *Journal of Marital and Family Therapy* (JMFT; Sprenkle, 2012). Earlier reviews (Pinsof & Wynne, 1995; Sexton et al., 2003; Sprenkle, 2002) established that family therapy is effective with a wide variety of problems, often more effective than individual therapy. Family treatment for adolescent substance abuse and family psychoeducation with schizophrenia showed robust outcomes.

This special issue of JMFT (Sprenkle, 2012) updated the research on family treatment for conduct disorder and delinquency (Henggeler & Sheidow, 2012), drug abuse (Rowe, 2012), internalizing child and adolescent disorders (Kaslow, Broth, Smith, & Collins, 2012), psychoeducation for psychiatric disorders (Lucksted, McFarlane, Downing, & Dixon, 2012), marital therapy for alcoholism (O'Farrell & Clements, 2012), couple distress (Lebow, Chambers, Christensen, & Johnson, 2012), relationship education (Markman & Rhoades, 2012), affective disorders (Beach & Whisman, 2012) and intimate partner violence (IPV; Stith, McCollum, Amanor-Boadu, & Smith, 2012). Clearly, family therapy is helpful, or at least promising, for each problem area.

Sprenkle (2012) distinguished between *efficacy studies* and *effectiveness studies*. While efficacy research (RCTs) alone is of questionable real-world

value, effectiveness research complements it by evaluating the impact of a treatment in community practice. Sprenkle (2012) rates the research in each area along 12 dimensions: the number of RCTs; research programme(s) of 10 years or more duration that allow the development of a research team and the accumulation of complementary investigations; the use of observation measures, as opposed to participant self-report; non-reactive dependent variables that can be objectively verified, such as incarceration or marital separation; documentation of treatment fidelity; diverse, non-Euro American participants; participants with comorbidities, which suggests that a treatment is more robust; follow-ups more than 1 year after treatment; cost-effectiveness studies; a focus on the mechanisms of change; studies by researchers other than professional associates; and transport to the 'real world'.

Based on these criteria, Sprenkle (2012) rated the research on conduct disorder/delinquency, drug abuse, psychoeducation for serious mental disorders, couple distress and alcoholism in the top tier of quality. He rated couple education in the second tier, and depression, IPV, child and adolescent internalizing disorders and chronic illness in the process of developing their research base. Sprenkle asserts that all areas have made methodological progress since the last review, that he is rating each area as a whole and there are methodologically rigorous studies within all the developing areas.

What makes family therapy effective?

Here we describe three approaches to research that can assist us to understand what contributes to the effectiveness of family therapy:

Qualitative accounts of clients' experiences of family therapy: the big picture

Qualitative research is an important source of evidence on the perspective of clients. Chenail, St. George, Wulff, et al. (2012) conducted a qualitative meta-synthesis, integrating the data of 49 qualitative studies on how clients experience family therapy, between 1990 and 2010.

Although these studies represented many theoretical approaches, there were no significant differences attributable to differences in theoretical approach. Clients identified therapists' balance and fairness, and sensitivity to helpful relationships within the family. Positive outcomes often relied upon a shared understanding of problems, and the resultant renewed sense of caring within the family. Family members want to be active participants in their therapy and appreciate it when therapists respond to their feedback.

The alliance in family therapy: a medium-range view

Friedlander, Escudero, and their colleagues have extensively researched the therapeutic alliance in family therapy (Beck, Friedlander, & Escudero, 2006;

Escudero, Friedlander, Varelac, & Abascald, 2008; Friedlander, Lambert, & de la Pena, 2008). They began by developing the System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, Horvath et al., 2006). The SOFTA improved on previous measures of the therapeutic alliance in family therapy, first, by basing measurement on observed behaviours instead of therapist or client self-report; and second, by focusing on important intrafamilial factors (i.e. *Safety within the Therapeutic System* and *Shared Sense of Purpose*), as well as the connection of family members to the therapist (namely *Engagement in the Therapy Process* and *Emotional Connection with Therapist*). These intrafamilial factors are roughly equivalent to cohesion and communication as dimensions of family functioning, which we discussed in Chapter 5. Friedlander et al. (2006) identified 44 observable behaviours linked to these intrafamilial and therapist–client factors.

Therapists can contribute to Shared Sense of Purpose by developing joint goals that are acceptable to all family members. Shared Sense of Purpose ratings depend a great deal on who attends the session, so it is advisable to include family members with this in mind. Safety within the Therapeutic System is strongly associated with treatment outcome. *Split alliances* (significant differences between family members on involvement with treatment) appear to be more the result of family members' different motivations for treatment than feelings about the therapist (Beck et al., 2006; Escudero et al., 2008). Friedlander, Lambert, Escudero, and Cragun (2008) note, as in individual therapy, family therapists often overestimate the strength of the alliance. Friedlander et al. (2008) found that coming to an initial session with a common purpose is a more powerful contributor to outcome than feelings of safety. Accordingly, a therapist should tailor his or her approach:

When family members express a common goal, offer to compromise, and demonstrate mutual respect in the first session, therapists can encourage more risk taking and expression of painful emotions. When, however, family members display reluctance or resistance to the therapeutic process—refusing to answer each other or responding sarcastically, avoiding eye contact, threatening to leave, and so on—therapists need to enhance the sense of safety by, for example, normalizing their experience, setting limits, redirecting blame, or forbidding hostile attacks. Then as comfort rises, the therapist should reframe the therapy goals in a way that everyone can agree to (p. 212)

Conversation analysis: a close-up

Conversation analysis (CA; Couture & Sutherland, 2006; Gale & Newfield, 1992; Healing & Bavelas, 2011; Sutherland & Couture, 2007; Tomori & Bavelas, 2007) describes the effects of therapy interactions, particularly how therapists use the conversation to create a therapeutic reality. Although there are some differences in how conversation analysts work, CA entails

analysing each utterance and each response, including pauses and non-verbal responses. CA focuses makes abstractions like 'working alliance' and 'safety' observable.

An early CA study by Gale and Newfield (1992) described a single-couple therapy session by well-known brief therapy author and presenter Bill O'Hanlon, which both O'Hanlon and the couple considered effective. Gale and Newfield described nine conversational practices and client responses, four of which O'Hanlon had not previously described. O'Hanlon's behaviour in session was consistent with the practice he had previously espoused in books and workshops.

Tomori and Bavelas (2007) analysed the conversational practices of two expert solution-focused therapists (Steve de Shazer and Insoo Kim Berg) and two client-centred therapists (Carl Rogers and Nathaniel Raskin), as seen on commercially available videotape. The researchers examined the therapists' first 50 utterances and the subsequent responses. The practices of therapists of both theoretical orientations were consistent with their espoused practice. Not surprisingly, the solution-focused therapists' utterances led clients to express desires for change and possible helpful actions approximately 80% of the time, while the client-centred therapists focused on clients' expression of problems approximately 80% of the time.

In the same research group, Healing and Bavelas (2011) conducted an experiment on how questioning facilitates change. The experimenter asked one group of interviewees about their performance on a neutral task using questions that presupposed they contributed to, or even controlled their performance. The other group was interviewed about the same neutral task, focusing on external factors affecting their performance. The researchers found that participants followed the interviewer's lead when explaining their performance. Those who were questioned with the assumption that they could exercise personal agency discussed their performance in terms of their own contributions, while those who were interviewed about external factors attributed their performance to them. Although this was an experiment, not a CA study, it demonstrated that a therapist's questions are not neutral. As Healing and Bavelas (2011, p. 46) state, 'All questions are "loaded questions"; the practitioner's choice is how to "load" them with presuppositions that will be useful to the client'.

Couture and colleagues (Couture, 2006, 2007; Couture & Sutherland, 2006; Strong, Busch, & Couture, 2008; Strong, Sutherland, Couture, Godard, & Hope, 2008; Sutherland & Couture, 2007) did CA with the work of Canadian psychiatrist and family therapist Karl Tomm. This research described how Tomm and the family overcame a therapeutic impasse (Couture, 2006), how Tomm used conversational practices to develop a working alliance (Sutherland & Couture, 2007) and how Tomm and the family jointly created receptivity for direct advice (Couture & Sutherland, 2006).

The potential of CA as a family therapy research method is still being realized. We have seen detailed description of how therapists can develop and maintain the working alliance, resolve therapeutic impasses, ask

questions that invite personal responsibility and give advice that is likely to be accepted. CA can determine if one's practice is consistent with one's espoused theory. Although this does not, in and of itself, tell us how a particular approach to therapy works, it can help us learn if therapeutic interventions are having their hypothesized effect. Combined with other methods (e.g. interpersonal process recall; Crews et al., 2005), CA can provide considerable evidence on how therapy works.

Is family therapy cost-effective?

Crane (2012) has led a research effort aimed at demonstrating the cost-effectiveness of family therapy. He and his associates have evaluated the economic value of family therapy in a large US health maintenance organization, one US state's Medicaid (health care for the financially disadvantaged) programme, a university training clinic staffed by students of various disciplines and a US health care insurer with nine million subscribers. Calculating the *medical offset effect*, family therapy reduced health care utilization by 21.5%, while individual therapy reduced usage by 10%. The reduction in utilization was even more pronounced among frequent users – closer to 50%. Frequency of urgent care visits, screenings and diagnostic studies such as laboratory and X-ray declined even more.

Family therapy was found to yield equivalent outcomes, in fewer sessions, with conduct-disordered youth, patients diagnosed with schizophrenia and depression and substance abusers. An approach that uses the client's support system and results in more efficient service lowers dropout rates (Crane, 2012).

How can practitioners be more involved in research?

Research–practice networks

One possible solution to the chasm between research and practice is to develop practice–research networks (PRNs). There are several examples of large 'top-down' PRNs in the United Kingdom and the United States (Parry et al., 2010) that focus on accumulating large databases of clinical information and can support experimental research.

On a more manageable scale for most family therapists, practice-based research can be done in community agencies or even by individual practitioners or small group practices. Campbell (2003) suggests that four affiliated private practitioners, starting a total of 100 new cases per year, could provide a rich source of practice-based evidence. Elliott and Zucconi (2010) provide guidelines for small-scale PRNs. They suggest using inexpensive and practical rating scales; collaborating with therapists and clients to select research questions and methods; focusing on manageable elements of therapy process and outcome (e.g. therapeutic alliance, client problem severity); increasing the scope of research as infrastructure develops; using a variety

of research methods (qualitative and quantitative; group and single case); and networking with other like-minded training sites. Qualitative methods like CA can contribute to the evidence base of family therapy.

Action research

Action research is an approach to inquiry that is accessible to most practitioners. It has much in common with reflective practice (Webber & Nathan, 2010) and continuous improvement (McKee, 2009). Action research is a qualitative method that entails self-reflection, systematic and concrete action to improve practice, documentation of accountability and dissemination of knowledge. It is a circular process focused on the question, ‘How can I improve my practice?’

As suggested by Kocha, Arharb, and Rumrilla (2004), action research begins with the identification of a practice dilemma. This could be a question about how to improve service delivery or a situation that presents a challenge to the practitioner’s sense of mastery. The researcher systematically observes and documents his or her actions as related to the practice dilemma. Next, the researcher refines the research question in consultation with colleagues, who offer critical feedback. Research questions can be expressed in terms of action for the practitioner (e.g. ‘How can I better deal with resistant families?’) or the organization (e.g. ‘How can we make our intake process more user-friendly to clients?’).

Third, the researcher must then decide the actions to be taken, taking into consideration the implications to self, clients and the organization. The plan should be specific and described in detail. The researcher may take multiple actions to test the hypothesis. Fourth, the researcher describes in writing the indicators of change, the data he or she will collect and how frequently.

Fifth, the researcher verifies that his or her interpretation of the data is credible. The researcher may use multiple sources of data and external indicators (e.g. client satisfaction ratings, client change data) and conducts member checks with colleagues who are in a position to offer an informed perspective. Sixth, the researcher disseminates the findings of the research, including implications for practice. This may occur internally (e.g. staff meetings) or at a professional conference or in a scholarly journal. In addition to providing valuable practice-based evidence, action research can assist practitioners to reflect on and improve their practice.

Summary

We began by describing the research–practice gap. We suggest that research is needed by family therapists. It documents that our practice is not only effective, but cost-effective, and provides significant guidance about how to improve it. Family therapy educators and managers can integrate research into practice settings.

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Chapter 18

Ethics and Family Therapy

All of us who practice family therapy are expected by our clients, our colleagues, the institutions in which we practice, those who refer families to us, and indeed the general public, to practice according to the highest professional standards and ethical principles. To assist us in this endeavour, the American Association of Marriage and Family Therapy has developed a Code of Ethics, the latest revision of which was promulgated on 1st July 2012. This is an important document to which all marriage and family therapists should pay heed. It can be obtained from:

AAMFT Ethics Committee
112 South Alfred Street
Alexandria, VA 22314
USA

It is also available online (ethics@aamft.org).

The ethical issues by which family therapists should abide are set out in the code as eight 'principles'. These are:

Principle I – Responsibility to Clients.

Principle II – Confidentiality.

Principle III – Professional Competence and Integrity.

Principle IV – Responsibility to Students and Supervisees.

Principle V – Responsibility to Research Participants.

Principle VI – Responsibility to the Profession.

Principle VII – Financial Arrangements.

Principle VIII – Advertising.

Many of the requirements that an ethical marital or family therapist should meet are those that are required of professionals in other helping professions, but family therapists sometimes find themselves confronted by ethical dilemmas peculiar to work with families. This is no doubt why being well informed on ethical issues is considered to be one of the 'skills' they need (Figley and Nelson, 1989).

Who is the client?

One of the dilemmas the family therapist may encounter is the question of who the client is. When a therapist is treating an individual adult, the answer

is simple. The client, or patient, is the person who comes for treatment. But when it is a family that is being treated the situation is not so simple. It is often not the family that presents for treatment but an individual member of it, and the family members may be unaware that they have a problem as *a family*. Yet the therapist may see the symptoms of the 'identified patient' as being embedded in the functioning of the family system.

In such cases, change in the family system may be necessary if the presenting symptoms are to be ameliorated or eliminated. This can involve the freeing up of communication within the family.

How is special confidential information to be handled?

In recent years legislation has been enacted in many jurisdictions restricting the dissemination of private, personal information. Such legislation aims to ensure that we can keep personal information to ourselves, or to a specified and limited number of people of our choosing. We even have a choice as to whether close family members may have certain information.

Yet the intent of such legislation may run counter to the aims of family therapy when these include the freeing up of communication within the family—as they often do.

This 'dilemma' need not present a problem, as long as it is acknowledged and addressed before treatment gets under way. The therapist should make sure all family members are aware of the legislation and what it means, and are willing to take part freely in discussing family and personal issues.

What are the risks and dangers that may follow from the free communication of 'sensitive' information?

In 1985, Wendorf and Wendorf reviewed the pre-existing literature on family therapy ethics (Wendorf and Wendorf, 1985). They found that the authors whose work they surveyed had identified a number of problem areas. They also expressed the view 'that the area of ethics (had not) kept abreast of the rest of the field in its appreciation for and utilization of systems principles as a conceptual base'. Among the possible problems the Wendorfs found in the literature they reviewed were:

- The potentially harmful effects of disclosure of extremely negative affect within the family.
- The possible undermining of authority as parental failings are brought out in therapy.
- The disclosure of personal sexual data.
- Divorce as a result of treating only one partner in a troubled marriage.
- Deciding who the patient is.
- Subordinating children's needs and goals 'to those of the more powerful adults in therapy'.
- When and to whom a therapist may reveal secrets told to the therapist in the course of treatment.
- The intrusion of the therapist's values into the assessment and treatment process without these being clarified for both therapist and patients.

- Whether, or when, it is justifiable to refuse treatment if all family members do not attend.
- Whether multigenerational aspects of each family's situation must always be considered.

Some of these issues have been mentioned above, and many are referred to also in the AAMFT Code of Ethics. However Wendorf and Wendorf (1985) went on to describe their own 'ethical base', which they believed was 'more systemic than that of previous orientations'. This was as follows:

We believe that the therapist's task is to help people become more competent in solving their problems as individuals and as systems. This problem-solving should always include the presenting problem but should also consider the problem in its broader patterns, or isomorphic transactions. In addition, this problem-solving should maintain a regard for the short- and long-term needs, growth, and welfare of the other individuals and subsystems that are involved in this mutually recursive system of influence. To be considered are the effects of actions both on and by the therapist and on and by the society in the system of family–therapist–society that forms the context in which family therapy occurs. (Wendorf & Wendorf, 1985, p. 447)

These authors suggested that family therapists tended to view particular problems non-systemically; that they addressed only the symptomatic behaviour interactions and overlooked the broader context of the behaviours; that they are non-systemic when they neglect to consider the extended family and other generations; and that they are non-systemic when they ignore the recursive effects of the therapy on the therapist and do not think systemically about the therapy context.

Wendorf and Wendorf (1985) proceeded to set out how they dealt with issues of family secrets; 'therapist deceptiveness' (the use of 'manipulations' such as paradoxical injunctions and reframings); and advocacy of particular values (e.g. feminist ones). Their contribution remains useful and their article is a resource well worth consulting, but achieving the aims set out in the quotation above is not a simple matter.

Informed consent

The issue of informed consent is the subject of the second paragraph under Principle I of the AAMFT Code of Ethics. Ensuring that all concerned have given their informed consent can help in dealing with some other ethical dilemmas. Informed consent can only be given once objectives have been agreed, the proposed treatment has been explained, and the risks, and possible side effects and complications, have been discussed with the family members.

According to Jensen et al. (1989) informed consent is 'more than just an ethical or legal obligation: inherent in the process of informed consent is the potential for the enhancement of the clinical work'. Informed consent, these authors believed, 'is particularly necessary where treatment can be hazardous, where it could have both negative and positive effects, where one treatment is not necessarily superior to another, and where full patient cooperation is necessary for the treatment success. All of these conditions are frequently met in the use of psychotherapy'. (Jensen et al., 1989, p. 379)

These authors point out that clarity in the therapist's mind as to who the patient is and in whose 'best interest' the therapist is acting is essential. What is in one person's best interests may be opposed to the best interests of other family members. Furthermore, the judgement of 'best interest' depends on the value systems of the family members and of the therapist. It may also be difficult, in many cases, to predict the effects, positive or negative, of family treatment.

These considerations underline the importance of discussing and agreeing the goals of therapy, as set out in Chapter 7. Without clearly established objectives, it is probably unethical even to start therapy. The objective-setting process is a good opportunity for the therapist to raise the questions of who is the patient, and in whose interests the therapy is to be undertaken. Possible side effects, including adverse ones, can also be discussed. Once all these issues have been put on the table and have been discussed and accepted, therapy can start.

Therapists' values

Values are 'enduring beliefs that specific modes of conduct or end-states of existence are personally or socially preferable to opposite modes of conduct or end-states of existence' (Rokeach, 1973). No form of psychotherapy can be value-free. We each have our ideas about how individuals, parents, children, adolescents, family groups, grandparents, employers and a myriad of others should behave and the roles they should play. To pretend otherwise is to deceive ourselves; so is pretending that we can keep our values totally separate from our therapy work. These values may assume more importance when we deal with families than when we are treating individuals.

In much of the literature on family therapy, therapists' values are downplayed. There are some exceptions, though. Kirschner and Kirschner (1986) made quite explicit their view of 'optimal family functioning' and Haley (1980) has long emphasized the importance of a proper hierarchy in the family.

The feminist approach

There is a substantial literature on the 'feminist' approach to family therapy. Feminist therapy aims 'to free both male and female clients from

destructive and unnecessary limitations derived from outmoded sex role constraints and an oppressive social system' (Chaney & Piercy, 1988, quoting Libow et al., 1982).

Chaney and Piercy (1988, p. 306) suggest that:

Feminist ideology may be useful in addressing some of the blind spots of more traditional therapies. For example, traditional family therapy may inadvertently give priority to the good of the family or relationship over the needs of the individuals, often the women.

What seems to be important is that we do our best to communicate our values to our clients as part of the contract- and objective-setting process. It should probably be regarded as unethical to start treatment with any deliberately hidden agendas, whether these be 'traditional', feminist or any other views of how families should function.

Confidentiality

It is unethical to reveal client confidences in all forms of therapy. The only exceptions are when the law requires us to do so or when revealing information is necessary to protect someone from harm, as when we learn of a person's intent to commit suicide or homicide. This rule applies as much in family therapy as in other forms of psychotherapy.

It seems that breaches of confidentiality are more common than might be supposed. According to Baker and Patterson (1990), based on their review of the literature, 'sharing clients' confidential information with family or friends is a serious ethical problem'. Engelberg and Symansky (1989) reported that, in the United States, violations of confidentiality and dual relationships are the commonest causes of professional liability claims against family therapists.

Baker and Patterson (1990) quote two examples of breaches of confidentiality:

Case 1. A family therapist comes home from work unusually depressed. When her husband inquires about the reason for her mood, she says that some clients, who are also family friends, have recently discovered that the wife has breast cancer. The therapist is upset and feels the need to process her own feelings of loss.

Case 2. Dr. Goodrich gets a phone call in the middle of the night. His wife awakens to hear him talking with a neighbour's teenage son who is suicidal. She wonders whether she should call the neighbour the next morning to see if she can help. (Baker & Patterson, 1990, pp. 296–297)

These authors consider that such breaches of confidentiality are associated with 'overlapping and sometimes inappropriately diffuse boundaries in the therapist's roles as professional and family member' (Baker & Patterson, 1990, p. 299). The danger of such information being unethically disclosed seems to be greater in small communities and where there is limited

availability of therapists. It is generally undesirable for us to treat families who are known to us socially but this may be inevitable in small communities or, in the United States, when Health Maintenance Organizations mandate that clients are treated by particular therapists.

The limits of confidentiality that apply should be spelled out early in the contact between therapist and family. The circumstances in which outside persons or agencies would need to be given information should be explained. A suitable time to do this is when the objectives of therapy are being discussed and a therapeutic contract is being developed.

Another important aspect of confidentiality is the question of what information may be shared within the family group. This has already been mentioned. It is not usually a problem when all family members are seen together, but it may be when subsystems of the family, or individual members, are seen separately. A problem may also arise when a family member fails to attend a session at which he or she is supposed to be present. Here we are dealing with therapeutic as well as ethical issues. The main *ethical* need is to ensure that all appropriate people know what the policies are and accept them. The *clinical* issues are another matter.

My practice is to tell children that what they tell me in individual sessions is confidential and will not be divulged to their parents, or to anyone else, without their consent, with certain exceptions. The exceptions are when I learn that a child (whether the one being interviewed or another) has been, or may have been, abused; and when I learn of something so serious, such as a child's intention to commit suicide, that I must divulge it. I do however promise to tell the child when I feel obliged to break a confidence and to advocate for him or her, as appropriate. This policy is also communicated to the parents to whom I explain that it is hard for children to speak freely if they feel that anything they say may be passed on to others, including their parents.

When parents are seen apart from their children, the situation is different. I undertake not to discuss the children in their absence without feeling free to share the content of the conversation with the children when this seems appropriate. On the other hand I acknowledge that there are some matters which are private issues concerning the parents and their relationship with each other. If an interview is to deal with marital or sexual concerns, I make it clear to the children that these are private matters about which they do not have a right to be informed. Whether they are told anything about them is their parents' decision. This is a way of defining, or strengthening, the boundary between the parental and child subsystems; in other words, a structural intervention.

It is not possible to be categorical about how to deal with other 'secrets' which may be revealed to the therapist by particular family members. These are clinical decisions. Sometimes it is appropriate for them to be 'kept' but in many cases they are features of dysfunctional systems. I therefore make it clear that I can give no guarantee that unsolicited 'secret' material will be kept confidential.

Ethical decision making

Zygmund and Boorhem (1989) described a process of 'ethical decision making' based on a model proposed by Kitchener (1984, 1985, 1986). These authors pointed out that:

Clinical decisions emerge from the interweaving of a complex set of circumstances consisting of the therapist's theoretical orientation; the idiosyncratic circumstances of the family; the personal values of the therapist that are often beyond awareness; the relationship between the therapist and the family; and the element of timing. These various factors cannot be reduced to a simple process of 'If A, then B'. (Zygmund & Boorhem, 1989, p. 271)

Which decision is ethically correct may depend on the circumstances of the case. Kitchener's model provides guidelines that therapists may use to evaluate their clinical decisions from an ethical standpoint. It proposes two levels of ethical reasoning:

- (1) The intuitive level.
- (2) The critical–evaluative level.

The *intuitive level* consists of a firm set of ethical beliefs concerning what is right or wrong, good or bad. Kitchener (1984) calls this 'ordinary moral sense'. Our ordinary moral sense depends on our experiences, ethical knowledge and level of ethical development. It is not a fixed, static set of beliefs but can change over time as we acquire new knowledge and have new experiences. It is a good day-to-day guide and individuals are more likely to act unethically if they ignore their moral sense than if they follow it. But it is not infallible, and it may not give us a clear signal as to what course of action to take in particular clinical situations. A further, important reason for not relying solely on intuition is that doing so does not provide us with a means of evaluating critically the decisions we make.

The *critical–evaluative level* is divided into three hierarchical, mutually exclusive levels of ethical reasoning:

- (1) Ethical rules. These are prescribed standards of behaviour. Zygmund and Boorhem (1989) cite as examples the Code of Ethical Principles of the American Association for Marital and Family Therapy (AAMFT) (recently revised as set out above) and the Ten Commandments. Unfortunately these codes tend to consist of general principles and do not give guidance as to how to apply them in practice. The AAMFT code says that family therapists 'are dedicated to advancing the welfare of families and individuals' but is silent on what we are to do when the needs of different family members are in conflict.

- (2) Ethical principles. The five principles that Kitchener (1984, 1985, 1986) stress are:
- **Autonomy.** This is the principle that individuals have the right to freedom of action, choice and thought as long as this does not compromise the rights of others. Even if we disagree with an individual's choice we must respect it if it causes no harm.
 - **Nonmaleficence.** This is doing no harm. Kitchener (1984) defined harm as engaging in activities with a high probability of hurting others; infringing upon the rights of others; and intentionally inflicting physical and psychological pain on others.
 - **Beneficence.** This is the concept of contributing to the health and welfare of others.
 - **Fidelity.** This is the principle of being faithful, keeping promises, being loyal and respecting others' rights. It is essential to all voluntary relationships such as therapeutic ones. Without it, it is not possible to establish meaningful relational bonds.
 - **Justice.** This is the principle that people should be treated equally, unless there is difference, or inequality, which is relevant to the issue in question. Thus the abused child and the abuser are different to an extent that fully justifies different treatment.

Ethical principles take precedence over personal and group values. An ethical principle must be upheld unless it is in conflict with other ethical principles. For example, if a person expresses suicidal intent the principle of nonmaleficence takes precedence over the principles of autonomy and fidelity—that is, the right to privacy.

- (3) Ethical theory. This is required when ethical principles are in conflict. Kitchener's (1984) two ethical theories are 'universalizability' and 'the balancing principle'. *Universalizability*, not a happy term, means that an act is ethical if 'it can be unambiguously applied to all similar cases' (Kitchener, 1984). Zigmond and Boorhem (1989) explain that this implies asking these questions:
- 'If I were in a similar situation, would I want my therapist to make this decision?'
 - 'If my family were in a similar situation would I want my therapist to make this decision?'
 - 'If other people were in a similar situation, would I want their therapist to make this decision?'

The *balancing principle* states that when ethical principles are in conflict, an ethical decision is one that produces the least amount of *avoidable* harm to all concerned, even if it limits the possible benefits.

Zygmund and Boorhem (1989) recommend the use of this model both in clinical situations and in classroom teaching and supervision.

Keeping informed and up to date

As we saw in the preceding chapter, therapists, and indeed the members of all the helping professions, have an ethical obligation to keep themselves informed about advances in their field. Just as a person with diabetes would not want to be treated by a physician who was unaware of recent advances in the treatment of that condition, or a person with arthritis of the hip would not desire to be operated on by a surgeon who does not know of the latest and most effective procedure for hip replacement, so those seeking family therapy will expect their treatment to be carried out by a therapist who is up to date and can offer them the benefit of the latest research in the area.

But this is a difficult area. Reliable information about which treatment is likely to be most helpful for particular family problems is scarce, despite the increasing amount of research data that are becoming available. Keeping up to date involves more than reading about the latest research findings. An ever-increasing variety of families and family problems are presenting to therapists. This means that a variety of treatment approaches are needed. Discussing ‘the new practice of family therapy’, Carlson et al. (2005, p. 11) suggest that the contemporary family therapist should possess:

- A solid grounding across diverse theoretical approaches.
- A broad repertoire of intervention approaches.
- The skill needed to carry out a comprehensive assessment of the family system.
- The ability to choose intervention strategies tailored to the individual family.

It is perhaps unfortunate that, even in the middle of this third decade of the twenty-first century, and when family therapy now has a history of 70-plus years, there is much to be learned about which approach is best for which family problem or situation. There also continues to be a relative lack of attention given to ethical issues in the family therapy literature.

Evidence-based clinical practice (Guyatt & Rennie, 2002; Patterson et al., 2004) is probably nowadays an ethical imperative. The principles of evidence-based practice were outlined in Chapter 17. Related to this is the ‘research-practice gap’ that has for long existed in marital and family therapy. This gap, Sprenkle (2003, p. 88) points out, ‘challenges our status as an ethical profession’. We are required to advance the welfare of our clients, but how, Sprenkle (2003) asks, ‘can we do that if most practitioners have insufficient information (on) which of our treatments are effective, which do little good, and which may cause harm?’

Ethical issues in family therapy research

Research in marital and family therapy also presents ethical issues. Regular clinical practice has the sole aim of providing help to the families that

present for therapy. In many research projects, however, there is an additional aim, that of achieving one or more specific research goals. These may be in conflict with the therapy process. It is therefore imperative that all research proposals are reviewed by the appropriate ethics committee. Universities, hospitals and other institutions in which research is carried out have such committees, which may approve or reject research proposals or, often, suggest modifications after which they are again reviewed.

Some of the ethical issues that may arise in relation to research studies are discussed by Lyness et al. (2005, pp. 307–309); Dahl & Boss (2005, pp. 76–78); and Mancini et al. (2005, p. 289–290).

Summary

Family therapy presents a number of special and ethical challenges. Deciding who the patient is, and whose best interests the therapist should be concerned with, can present major problems. Other issues are the choice of therapeutic approach; whether treatment should be contingent on all family members attending; and whether it should be mandatory to consider the extended family system and larger social systems.

The many imponderables make it particularly important that the therapist obtain informed consent. In doing so, the objectives of therapy should be agreed, the treatment approach explained and possible adverse effects discussed.

Therapists need to be as aware as possible of the values they bring to the therapy situation and they should share these with the family. The limits of confidentiality should be explained and carefully observed.

A scheme for ethical decision, proposed by Zygmund and Boorhem (1989) has been outlined. An ethical imperative is that we must keep up to date in our field, so that we can offer our clients the best currently available treatment.

The 2012 revision of the Code of Ethics of the American Association for Marital and Family Therapy provides helpful guidance on the general principles of the ethical practice in the field this book covers.

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Appendix

The following are some of the major family therapy journals, listed in the order in which they were founded. This list is not exhaustive and articles on family therapy topics are published from time to time in psychiatry, psychology, social work and other journals.

Family process

Family Process is the longest established and one of the most prestigious family therapy journals. It was founded in 1962, when family therapy was in its infancy, by two of the pioneers in the field, Nathan Ackerman and Don Jackson. For over 40 years now, it has been a major resource and has remained one of the foremost journals in the field. It appears quarterly and is published by Blackwell Publishing in the United States.

The journal of marital and family therapy

The Journal of Marital and Family Therapy is the official journal of the American Association for Marriage and Family Therapy. It was formerly the Journal of Marriage and Family Counseling and was founded in 1975. In its present form, it dates from 1979. It appears quarterly. With over 20 000 subscribers, it claims to be the best known and most influential family therapy journal in the world.

The journal of family therapy

The Journal of Family Therapy is published in the United Kingdom by Blackwell Publishing for the Association for Family Therapy and Systemic Practice. It is the foremost UK family therapy journal and aims to advance the understanding and treatment of human relationships in couples, families, professional networks and wider groups by publishing articles on theory, research, clinical practice and training. It was founded in 1979 and appears quarterly.

The American journal of family therapy

The American Journal of Family Therapy is described as ‘the incisive, authoritative, independent voice in an ever-changing field’. In addition to its general content, it includes the following regular sections:

- Family measurement techniques
- Family behavioural medicine and health
- Family law issues in family therapy practice
- Continuing education and training
- Book and media reviews
- Journal file
- International department

It is published in the United States by Routledge and appears five times a year. It was founded in 1979.

Contemporary family therapy: An international journal

Contemporary Family Therapy: An International Journal is published by Springer Science and Business Media. It presents the latest developments in theory, research and practice pertaining to family therapy with an emphasis on examining families within the broader socio-economic and ethnic matrices of which families and their members are a part. It is published quarterly and dates from 1979.

Journal of systemic therapies (formerly Journal of strategic and systemic therapies)

The Journal of Systemic Therapies focuses on post-modern and brief approaches to therapy. It is a practice-oriented journal, publishing case reports; accounts of therapeutic strategies; and theory and research in post-modern, brief and social constructionist approaches. It is a prime journal for narrative, solution-focused and collaborative practitioners, and would be of interest in readers who wish to learn more about these approaches. It is published quarterly by Guilford Publications.

Families, systems, & health (formerly Family systems medicine)

Families, Systems, & Health is a peer-reviewed, multidisciplinary journal that publishes clinical research, training and theoretical contributions in the areas

of families and health, with particular focus on collaborative family health care. Readers who wish to understand the dynamics of chronic and/or life-threatening health conditions on family interactions and family functioning will find this journal useful. It has been published since 1983, and is now published by the American Psychological Association.

The Australian and New Zealand journal of family therapy

The Australian and New Zealand Journal of Family Therapy is published by the Australian and New Zealand Journal of Family Therapy Association, Inc. It is reputed to be 'the most stolen professional journal in Australia' and is read by clinicians as well as by academics. It is 'a lively magazine that keeps its finger on the pulse of family therapy in Australia and New Zealand via local correspondents'. Four foreign correspondents report on developments in the United States and Europe. 'The Journal endeavours to retain the lightness of spirit and optimism that characterized early family therapy in Aotearoa/New Zealand and Australia.' Publication started in 1985. It was formerly the Australian Journal of Family Therapy.

The journal of family psychology

Primarily, a research journal, the *Journal of Family Psychology* 'offers cutting-edge, groundbreaking, state-of-the-art and innovative empirical research with real-world applicability in the field of family psychology'. It emphasizes family interaction research, system, assessment and intervention, and policy that aims to improve the quality of family life. Topics include couple and family processes, life stages, transitions, and stress and coping; health and illness across the family life cycle; couple and family diagnosis and assessment; couple and family intervention and prevention, family transitions (e.g. separation and divorce, remarriage and the stepfamily, adoption, and death); family violence; employment and the family; family and other systems; diversity; policy issues; family and system theories; family psychology education and training; and professional issues.

It has been published by the American Psychological Association since its inception in 1987. It is currently published six times a year.

The journal of feminist family therapy

The Journal of Feminist Family Therapy provides an international forum for the exploration of the relationship between feminist theory and family

therapy theory and practice. It is published in the United States by Haworth Press and has appeared quarterly since 1989. It aims to:

- Critique family therapy concepts from a feminist perspective with careful attention to cultural, class and racial differences;
- Apply a feminist-sensitive perspective to the treatment issues particular to women such as depression, agoraphobia, eating disorders, incest and domestic abuse;
- Explore the implications of a feminist approach to training and supervision in family therapy;
- Examine the field of family therapy and its organization and institutional structure from a feminist perspective;
- Describe clinical applications of feminist-informed treatment in family therapy.

The journal of family psychotherapy (formerly Journal of psychotherapy and the family)

The *Journal of Family Psychotherapy* is the official journal of the International Family Therapy Association. It is designed with the practicing clinician in mind. It publishes case studies, program reports (descriptions of effective or new treatment programs), and detailed descriptions of therapeutic strategies. It was founded in 1990 and publishes four times per year. The journal has several regular special sections: Family Therapy around the World, Family Therapy and Mental Health, Intervention Interchange, and Media Reviews. Each year includes a special issue, offering an in-depth exploration of a state-of-the-art and clinically relevant topic.

This is an excellent journal for readers interested in a broad range of approaches to family therapy, applied to a variety of settings.

The family journal: counseling and therapy for couples and families

The Family Journal: Counseling and Therapy for Couples and Families. This is the official journal of the International Association of Marriage and Family Counselors and is published in the United States by Sage Publications. *The Family Journal* advances the theory, research and practice of counseling with couples and families from a family systems perspective. It provides ‘groundbreaking, innovative scholarship for counseling researchers, educators and practitioners’. It appears quarterly and was founded in 1993.

The international journal of narrative therapy and community work

The International Journal of Narrative Therapy and Community Work has been published quarterly since 2002. In each issue, practitioners from a range of different countries discuss the ideas and practices that are inspiring them in their work, the dilemmas they are grappling with, and the issues dearest to their hearts. The first section of each issue revolves around a particular theme, while the second consists of a collection of practice-based papers on various topics. The journal has four issues per year and is published in Australia by Dulwich Centre Publications. It is the successor to the Dulwich Centre Journal.

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