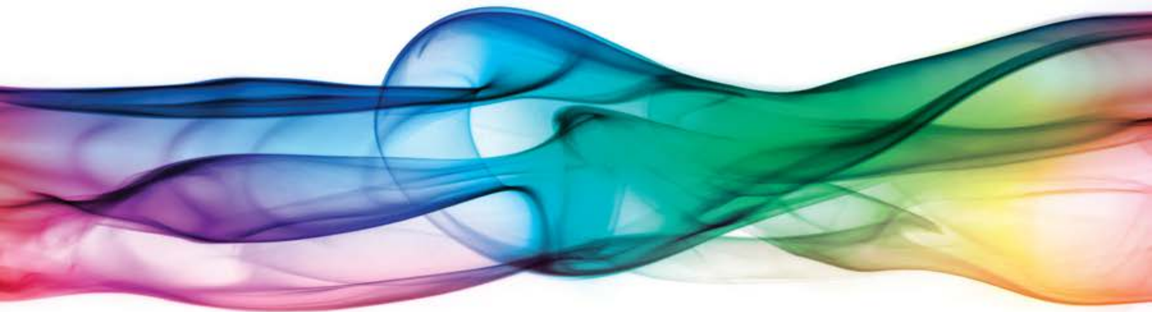
AN INTRODUCTION TO MARRIAGE AND FAMILY THERAPY

SECOND EDITION



EDITED BY
Joseph L. Wetchler & Lorna L. Hecker

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"This book provides a scholarly and practical approach to the advancements in the field of family therapy. Readers will benefit from discussions on the influence of gender, culture, spirituality, and sexual orientation. This well-conceived text is a must-read for those who are teaching, learning, and looking to expand their knowledge about family therapy approaches, research, and ethical issues."

—**Jennifer Hodgson,** *PhD, LMFT, Professor, East Carolina University; Former Chair, Commission on Accreditation for Marriage and Family Therapy Education*

"Drs. Wetchler and Hecker have recruited the top thinkers in family therapy theory and practice to share their knowledge of the field in this revised volume. This text presents critical and often overlooked information about both the history of family therapy and the field's most contemporary issues in a clear, easy-to-read manner. It is a perfect addition to any MFT's bookshelf, whether you are just orienting yourself to the world of family therapy or have been practicing for a lifetime."

—**Katherine M. Hertlein,** *PhD, Program Director, UNLV; Co-author,* The Couple and Family Technology Framework

"This second edition remains an engaging, pithy introduction to the rich history and practice of marriage and family therapy. The authors include as central concepts contextual issues of gender, race, culture, sexual orientation, and spirituality. They extend their focus into the future through topics such as the emergence of evidence-based therapy and common factors, and the role of marriage and family therapy in addressing critical clinical issues such as mental and physical illnesses, family violence, substance abuse, and sexual dysfunction. This is a perfect master's level text, but it is also for anyone who wants to know more about the breadth, depth, and trajectory of our evolving, dynamic field."

—**Fred P. Piercy,** *PhD, Professor of Marriage and Family Therapy, Virginia Tech; Editor,* Journal of Marital and Family Therapy

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and sexual orientation. This knowledge is the key to understanding what differentiates Marriage and Family Therapy from individual psychotherapy. Glossaries, case studies, tables, and figures appear generously throughout the text to present this information and give students a thorough overview to prepare them for their professional lives.

Joseph L. Wetchler, PhD, is Professor in the Marriage and Family Therapy Program at Purdue University Calumet in Hammond, Indiana. He was named a Legacy Scholar in 2013 by the Family Therapy section of the National Council on Family Relations for outstanding contributions to the field, and has been on the editorial boards of the most distinguished journals in the field.

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Second Edition

Edited by Joseph L. Wetchler and Lorna L. Hecker

NEW YORK AND LONDON

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Second edition published 2015
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
27 Church Road, Hove, East Sussex BN3 2FA

Routledge is an imprint of the Taylor & Francis Group, an informa business

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First edition published by Routledge 2003

Library of Congress Cataloging-in-Publication Data
Catalog record for this book has been requested

ISBN: 978-0-415-71949-0 (hbk)
ISBN: 978-0-415-71950-6 (pbk)
ISBN: 978-1-315-86733-5 (ebk)

Typeset in Bembo
by Apex CoVantage, LLC

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therapy supervision, family therapy for child and adolescent problems, couple therapy for substance abuse, and the self of the therapist. Dr. Wetchler has been a co-investigator on a large research grant funded by the National Institute on Drug Abuse to study couple therapy approaches for substance-abusing women. He regularly consults for social service agencies and therapists in private practice, and he maintains an active couple and family therapy practice in Northwest Indiana. Dr. Wetchler is a licensed marriage and family therapist in Indiana.

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ACKNOWLEDGMENTS

It has been a joy to edit the second edition of *An Introduction to Marriage and Family Therapy.* We have been surrounded by so many helpful and enthusiastic individuals that we remained equally enthusiastic about this project. We are especially indebted to the staff of Routledge Press for believing this book deserved a second edition and for persisting in pushing us to again take it on. We love your professionalism and editorial knowledge. We must give special thanks to our chapter authors. All of the authors from the first edition agreed to participate in the second edition, with the exception of Karen Rosen, who passed away prior to the start of this project. We were delighted when her longtime colleague, Sandra Stith, agreed to update the chapter, allowing them to have one more collaboration across time. Plus, we have had several newcomers to the field, many of whom are former students of ours, join the chapter teams to bring a sense of freshness and vitality. All of them brought their "A" game! Finally, we wish to thank our colleagues at Purdue University Calumet for providing us with a wonderful place to develop our Marriage and Family Therapy Program and for continuing to believe in our educational and scholarly efforts.

I (JW) want to personally thank the field of family therapy for bringing me a professional lifetime of joy and fulfillment. I am an unabashed fan! From the first time I read *Problem-Solving Therapy* as a master's-level intern to this very moment as I write these words I have had a love affair with this field. They say that if you love your job, you never work a day in your life. I have never worked a day in my life! I am especially lucky to have graduated from the Doctoral Program in Marriage and Family Therapy at Purdue University and the Post-Degree MFT Training Program at the Family Institute at Northwestern University. Both programs stimulated my thinking and pushed me further than I ever thought I could grow. With that, I thank my MFT mentors, Fred Piercy, Doug Sprenkle,

Wallace Denton, and Jerry Bigner. My career has been an effort to pay them back for all they have given me. With that, I am grateful to my longtime colleague and co-editor, Lorna Hecker, for her integrity, commitment to the field, and collaborative spirit. I also want to thank my family: my parents, Bernie and Jorie, and my sisters, Diane and Sherry, for their support and love. Plus, I thank my wife, Carole Schwartz, for her love, friendship, and support. I am the luckiest person alive! Finally, I dedicate this book to Carole's and my children, Jessica Lily, Jessica Marie, and Ryan. We are so proud of the adults you have become.

I (LH) also would like to acknowledge the spirit of marriage and family therapy, and all that it brings to those who study it. If you listen carefully to what our founding fathers and mothers had to say as you read this book, I think you will want to learn more. It is hard to resist the insights of those who brought a paradigm shift in mental health treatment. There is also an excitement in learning from these giants that never really leaves. As you become a family therapist, the great theoreticians live in your head, and their impact lingers in your thoughts, work, and memories. I have little embarrassment in admitting that when I first started studying family therapy, I stood in line at an AAMFT Conference to get Cloe Madanes's autograph. I want to acknowledge the trepidation and thrill I felt when I was in grad school as I slept in my car in Vancouver, British Columbia, so that I could afford the entrance fee to see Luigi Boscolo and Gianfranco Cecchin of the Milan group and be part of one of their reflecting teams! I acknowledge with little shame that I full-out ran to catch an elevator at an AAMFT conference so that I could be in proximity to John Gottman, one of my personal heroes. I do hope that readers and future leaders of the field grasp the depth of commitment of these many individuals and are as delighted to learn from these theorists as I have been. I hope they would believe they have been well represented in this book. I would like to acknowledge the support of my husband, Roger, and my always entertaining children, Aaron and Noah. Lastly, I would like to acknowledge my co-editor, Joe Wetchler, for understanding that to move the field forward, we must first look behind us.

INTRODUCTION

Welcome to the second edition of *An Introduction to Marriage and Family Therapy.* The first edition was published at the start of the 21st century and served as a summary of 20th-century family therapy. This edition not only presents the historical foundations of the field, but also summarizes the changes made during the first years of the 21st century. Some areas have remained the same, and some have changed drastically.

Family therapy remains an often-undernoticed branch of the mental health disciplines. Yet most behavior that follows us into adulthood developed within the context of our families of origin. Indeed, as you learn about family therapy, you will begin to understand how we recreate in our adult relationships the patterns that we learned in childhood. Family therapy departs radically from traditional mental health in that it looks to the family and the context in which it is embedded to understand mental health issues, rather than looking solely at an individual as the source of mental health problems. This was a dramatic shift from the more reductionist thinking of the early to middle 20th century. Yet another shift occurred in the field in the 1980s, when feminists led a revolt, claiming that family therapy had failed to address the larger social context in which families are embedded. They cited that the field had ignored the politics of gender and that all people in a family system, especially women, did not have equal power based on that larger social context. Soon after this tumultuous period, multicultural family therapists reminded us that ethnicity and race also play a factor in that context. Specifically, treatment models based on a two-parent Caucasian family often obscured and pathologized the issues faced by families of color, families in poverty, and single-parent families. In yet another revolution against the traditional psychodynamic therapy model on which psychology was founded, the inclusion of spirituality issues in family therapy has occurred.

Advocates cite that the majority of families believe in God and that the field had also ignored how this larger context influences and is influenced by families. The 21st century has brought a major revolution in how couples and families are viewed through a focus on lesbian, gay, bisexual, and transgender (LGBT) rights. For example, marriage is viewed no longer solely as the right of a man and a woman, but also as a right for same-sex couples. At the time of this writing, 17 states, plus the District of Columbia, have legalized same-sex marriage; the U.S. Supreme Court has overturned key sections of the Defense of Marriage Act; and judges in five other states have overturned those states' defense of marriage acts (all of which are pending review by a higher court). How we have viewed couples and families has changed drastically since the field of marriage and family therapy was founded.

In this book, you will learn about the revolution against traditional mental health treatment led by those who embraced systems theory and applied it to families. In addition, in response to the advocates of looking at larger systemic issues, you will learn about the contexts in which families are embedded—including gender, culture, spirituality, and sexual orientation. You will see departures from traditional psychology, but you will also see the integration of traditional psychology with family systems concepts, such as in Chapter 9, "Cognitive-Behavioral Therapies for Couples and Families." You may even learn about yourself and explore the contexts in which you grew up as you read through these chapters. This can be both an exhilarating and anxiety-provoking process, as we sometimes have to shift beliefs we hold near and dear in order to learn new ways of thinking. Last, you will see the results of one more rebellion within the field, led by social constructionist advocates. Chapter 7, "The Collaborative Language-Based Models of Family Therapy: When Less Is More," reflects yet another change in thought, termed *postmodernism*. This way of thinking is based on the belief that reality is socially constructed and that one person's worldview is as valid as the next person's. This view of therapy is collaborative and focuses on client language, not necessarily on the family system.

This book is organized into three parts. *Part I: Foundations of Marriage and Family Therapy* focuses on those components on which 21st-century family therapy is based. Chapter 1, "The History of Marriage and Family Therapy," revises several aspects of the history of the field to include a focus on the female founders, who were often excluded from earlier history chapters due to a patriarchal story of our field; a focus on the importance of the feminist, multicultural, and LGBT rights movements in our field; and the evidence-based practice model that dominates the present and future of our field. Chapter 2, "General Systems Theory, Cybernetics, and Family Therapy," presents the systems model that initially distinguished family therapy from the other mental health disciplines and continues to serve as the theoretical base for our field. Chapter 3, "Contextual Issues in Couple and Family Therapy: Gender, Sexual Orientation, Culture, and Spirituality," provides the largest theoretical shift in the field and the organization of the

book. In earlier overviews of the field, contextual issues chapters have mostly been included in the "Special Issues" sections. With the 21st century has come a long-overdue focus on the centrality of diversity and the importance of mental health care providers being culturally competent. Those of us in the helping professions must be trained to work with the vast array of diversity that encompasses the human and family experience. The implicit and explicit power entrusted to us requires that we do not maintain a monocultural view, but rather develop a lens that recognizes and privileges the strengths and competencies of those who are different than we are.

Part II: *Theories in Marriage and Family Therapy* presents the major theoretical models in our field. Each chapter focuses on the founders of the theory, the theoretical tenets, the key techniques, how the model focuses on diversity, and the underlying research that supports the approach. Plus, case examples are sprinkled throughout to bring the theories to life for the reader.

Next, specific treatment areas common to marriage and family therapists are discussed in *Part III*: *Special Issues and Topics in Marriage and Family Therapy.* This includes the ingredients to couple therapy, sex therapy, communication training, couple enrichment, and premarital counseling. Plus, special focus is given to family therapy approaches to the treatment of mental illness, physical illness, substance abuse, family violence, and divorce. The interface of ethics, the legal system, and client confidentiality in family therapy is often constant. These and other professional issues are covered in Chapter 15, "Ethical, Legal, and Professional Issues in Marriage and Family Therapy." One final question the reader should be able to answer after reading this book is "Does family therapy work?" Chapter 16, "Research in Marriage and Family Therapy," addresses this issue eloquently.

How is this text different from others in the field of family therapy? Most textbooks that detail the approaches to family therapy are written by only one or two authors. In this book, we have invited experts from each important area of family therapy to contribute chapters in their area of expertise. Thirty-two professionals from across the United States have come together to present their knowledge in the treatment areas in which they have expertise. This brings to the reader a blend of approaches and styles that is often lacking in other texts.

The intent of this book is to introduce the reader to the rich history and practice of marriage and family therapy. In this text, you will get a good but slightly distant look at important areas of family therapy. To fully understand each area, you would need to study it much more closely. We hope you will enjoy this opportunity to familiarize yourself with the field of marriage and family therapy. May this be the start of a lifelong fascination with a rich and wonderful profession.

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PART I

Foundations of Marriage and Family Therapy

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1

THE HISTORY OF MARRIAGE AND FAMILY THERAPY

Christi R. McGeorge, Thomas Stone Carlson, and Joseph L. Wetchler

The whole is greater than the sum of its parts.

Gregory Bateson

Welcome to *An Introduction to Marriage and Family Therapy.* This book serves as an introduction to and overview of the fastest-growing arm of the mental health field: marriage and family therapy. Perhaps this would be a good time to present a preliminary definition. **Marriage and family therapy** is a model of mental health treatment that takes a family perspective on emotional problems and psychopathology. It places individual pathology in a relational context and views treatment as encompassing the environment in which it is maintained—namely, the family. It is important to note that in more recent years, scholars have called for a more inclusive name for the field, "couple and family therapy," in an effort to more accurately reflect the varying types of couple and family relationships that receive services from family therapists.

The marriage and family therapy movement was started by several charismatic leaders who became disenchanted with the traditional individual-oriented mental health models (Guerin, 1976; Kaslow, 1980). For many of these clinicians, the psychoanalytic approach that dominated the field did not fit the patients nor the problems they treated. Marriage counselors and family therapists began experimenting with their new ideas in isolated pockets around the United States. In fact, with some notable exceptions in England, the marriage and family therapy movement was initially an American phenomenon.

Although one might think that the mental health field would have embraced these new approaches to treating emotional problems, in fact, the opposite occurred. Marriage and family therapists found themselves shunned by the mental

health establishment. Much of what they did was shared privately with trusted colleagues and students. Florence Kaslow (1980) reflects on the early family therapy movement:

> From 1950 to 1954 much work in family therapy took place underground. The ideas of the leaders were considered heresy and no platform was readily available to them at major professional conferences. Their writings were not welcome in the standard journals.
>
> (p. 93)

If anything, this initial rejection by the mental health field probably helped spark the revolutionary zeal of the original marriage and family therapists. John Elderkin Bell (1976), one of the founders of family therapy, beautifully summarizes his experience during this time:

> I began to be confronted by experienced psychotherapists and theoreticians who disapproved of my practice and were uncomfortable with my concepts. I learned that these critics were not to be won over easily by simple endorsements of working with the whole family, and usually answered their arguments by saying I would take their comments into account, as I did; but I also learned I could not fit older theories to my new experiences. I realized that, fundamentally, I had to find the rationale for family therapy from my own experiences, in private reflections on the actions of which I was a part. As a result, more and more I found myself avoiding the ideas and language of individual therapy and traditional group therapy. I found, also, the formulations and terms mastered for my university teaching on personality and abnormal psychology had little pertinence to my new activities.
>
> (p. 130)

Today, marriage and family therapy has gained acceptance by the mental health establishment and the laity in general. Family therapy is provided at most mental health centers and family service associations, and graduate degrees are available at universities across the United States and around the world. Marriage and family therapy was influenced by four major movements: early social work, the sexual reform movement, marriage counseling, and the family therapy movement. The following pages summarize their impact on the field.

Early Social Work

Although marriage and family therapy is a relatively new idea, working with families is not. The early social workers first pioneered interventions with marriages and families (Broderick & Schrader, 1991). The field of **social work**, a

branch of the mental health field that focuses on the impact of societal issues on human problems, grew out of the charity movements in Great Britain and the United States in the late 19th century (Nichols & Schwartz, 1998). The initial focus of the movement was to minister to the needs of the underprivileged. The first social workers proposed that effective interventions must begin with the family. As early as 1890, Zilpha D. Smith wrote to the mental health establishment:

> Most of you deal with poor persons or defective individuals, removed from family relationships. We deal with the family as a whole, usually working to keep it together, but sometimes helping to break it up into units and to place them in your care.
>
> (p. 377)

Perhaps the greatest early champion of family intervention was Mary Richmond. In her influential book *Social Diagnosis* (1917), she wrote about the importance of treating the family as a whole unit if one hoped to alleviate the problems of the poor. She believed that meeting with the family at the beginning of treatment and specifically intervening in their process was the best way to achieve lasting results. She also foreshadowed the family therapy movement in her ability to see family systems as nested in larger societal systems (Nichols & Schwartz, 1998). This led to interventions in larger units, such as neighborhoods, and government policies to effect change for families. It also led to a greater appreciation of the role of culture in one's family life.

Unfortunately, while social workers were some of the most influential pioneers in family intervention, when they joined forces with psychiatry in the 1920s they returned to a focus on the individual (Broderick & Schrader, 1991). Although, with notable exceptions, they did not play a dominant role in the initial development of either marriage counseling or family therapy, they were influential members of both movements from the 1960s onward. Social workers who have made valuable contributions to marriage and family therapy include Insoo Kim Berg, Betty Carter, Lynn Hoffman, Monica McGoldrick, Braulio Montalvo, Peggy Papp, Virginia Satir, Steve de Shazer, Richard Stuart, Froma Walsh, and Michael White. Many of the contributions of these influential social workers will be discussed in later chapters.

The Sexual Reform Movement

Following World War I, several Europeans and Americans participated in a movement to establish human sexuality as a science and to provide sexual education to the general population (Broderick & Schrader, 1991). At the forefront of this movement were Havelock Ellis of Great Britain and Magnus Hirschfeld of Germany.

In the late 1800s and early 1900s, Havelock Ellis wrote extensively on human sexuality, including sexual orientation, and provided counseling to people with sexual problems. He is considered one of the first scholars to write about same-sex relationships as a normal expression of human sexuality and is also credited with early attempts to explore and define a transgender identity. Although his practice consisted primarily of listening and providing readings, he would sometimes initiate women into his own version of non-demand sexual pleasuring (Broderick & Schrader, 1991). He felt he could do this without being controversial, as he was impotent for most of his adult life (Ellis, 1939). It is interesting to note that he restricted his practice to individuals and did not meet with couples. Although his methods could be considered simplistic and ethically questionable, he probably was helpful to several individuals in that, considering the times, a good proportion of the problems suffered by his clientele may have been related to a lack of education and Victorian views of sexuality as much as anything else.

Magnus Hirschfeld founded the Institute of Sexual Science in Berlin in 1918 and, together with August Forel and Ellis, founded the World League for Sexual Reform. His institute was a destination for physicians from all over the world who wished to learn more about human sexuality. His definitive book, *Geschlechtskunde* (*Sex Education*) (1930), reported his findings based on 10,000 questionnaires completed by men and women (Broderick & Schrader, 1991). He also founded the German Marriage Consultation Bureau, to provide counseling to German families and couples (Hirschfeld, 1940). Sadly, when Hitler came to power in Germany, he closed Hirschfeld's centers and turned them into institutions meant to evaluate couples for fitness to marry and reproduce.

Four American pioneers were instrumental in continuing the work of Ellis and Hirschfeld: Robert Dickinson, Alfred Kinsey, William Masters, and Virginia Johnson.

Robert Dickinson, a gynecologist, was active as a scientist and counselor in the area of human sexuality. He systematically sketched the pelvic area of each of his patients, both women and men, and he included several of these sketches in his landmark book, *Human Sex Anatomy* (1933). He also published his findings from thousands of interviews with his patients about their sexual histories and current practices (Dickinson & Beam, 1931, 1934). Further, he was one of the founders of the marriage counseling movement.

Alfred Kinsey, a professor at Indiana University, is typically the first person who comes to mind when we think about the history of human sexuality in the United States. He and his colleagues authored two of the most important and controversial books of the mid-20th century: *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and its companion, *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953). These publications created a whirlwind of both praise and criticism for their frank presentations of the sexual practices of a wide range of Americans.

William Masters and Virginia Johnson worked out of the Washington University Medical School in Saint Louis, Missouri. They conducted a vast body of scientific research in both the areas of sexual problems and treatment. Although written for professionals, their book *Human Sexual Response* (1966) was a popular success, selling more than 300,000 copies (Broderick & Schrader, 1991). However, it was their second book, *Human Sexual Inadequacy* (1970), that promoted and popularized the field of sex therapy. In 1978 the Masters and Johnson Institute (formerly the Reproductive Biology Research Foundation) was founded in Saint Louis, and here the pair continued to conduct research, provide professional trainings, and treat couples until the center closed in 1994.

Marriage Counseling

Marriage counseling, a form of therapy in which a clinician meets with both spouses together to resolve problems in their relationship, was virtually nonexistent within the mental health establishment during the early part of the 20th century. A person complaining about couple relationship problems would likely be seen in individual therapy by a psychiatrist, or psychologist, with his or her spouse being treated by another therapist. Although this may seem a bit naive, we must remember that the psychoanalytic model was the dominant approach at the time. It was through individual long-term therapy that clients transferred their past issues onto their therapists and subsequently worked through those issues. Having one's spouse in the room was thought to hinder the development of transference onto the therapist and was not advised.

Early marriage counseling became the domain of a variety of professionals outside the mental health establishment. Couples with marital problems were more likely to meet with a member of the clergy, a physician, or an educator to get some semblance of help. Broderick and Schrader (1991) recall:

> Marriage and premarriage counseling was often the auxiliary activity of a college professor. It was equally likely to be the auxiliary occupation of a range of other professionals, including lawyers, social workers, and physicians. One group of physicians that played a particularly central role in the early shaping of the field of marriage counseling were members of the growing specialty of obstetrics and gynecology.
>
> (p. 9)

In 1930, the first two marriage counseling centers opened in the United States (Broderick & Schrader, 1991). Paul Popenoe, a biologist specializing in human heredity, founded the American Institute of Family Relations in Los Angeles, California. He claims to be the first to coin the term *marriage counseling,*

which he translated from the German *Eheberatunsstellen,* the term used for marital consultation centers in Germany (Popenoe, 1975). That same year, physicians Hannah and Abraham Stone, finding themselves often providing marital counseling in their practice, officially opened the Marriage Consultation Center in the New York City Labor Temple. In 1932, they moved their operation to the Community Church of New York, where they ran an ecumenical marriage center for many years (Broderick & Schrader, 1991).

A third center, the Marriage Council of Philadelphia, opened its doors under the directorship of Emily Mudd in 1932. This historic institution was the first to conduct a continuing program of research on the marital process (Broderick & Schrader, 1991). The Marriage Council of Philadelphia exists today as the Penn Council for Relationships. It continues to be a major force in the marriage and family therapy field, training thousands of clinicians and publishing numerous papers and books.

In 1938, husband and wife David and Vera Mace formed the first Marriage Guidance Council in London. Their idea was to use a few professionals to train and supervise several paraprofessionals who could then provide counseling at a much-reduced cost to the numerous working-class families of England. By 1943, the council had become the National Guidance Council of Great Britain and regularly provided counseling to couples throughout the British Commonwealth (Mace, 1945, 1948).

Although the 1930s brought about the development of several important marriage counseling centers, the field remained on shaky ground. If marriage counseling was to survive, it needed a professional association to develop guidelines for training clinicians and to conduct conferences that presented the latest findings. In 1942, Lester Dearborn, Robert Dickenson, Gladys and Ernest Groves, Robert Laidlaw, Emily Mudd, Valerie Parker, and Abraham Stone convened to organize what would become the American Association for Marriage Counseling (AAMC). The organization became a reality in 1945, with Ernest Groves elected the first president (Mudd & Fowler, 1976).

Unfortunately, the field of marriage counseling was slow to develop. As late as 1960, the modal interview at the pioneering centers was still the one-on-one interview (Michaelson, 1963). Further, even up until the early 1970s, the field lacked a coherent body of scholarship (Gurman, 1973). Perhaps this is best explained by the fact that, as of 1965, only 25% of the members of the AAMC considered themselves to be primarily marriage counselors. For the rest, it remained an auxiliary activity (Alexander, 1968).

If the development of professional marriage counseling was somewhat sickly in the 1960s, its cure came in the form of the family therapy movement (Broderick & Schrader, 1991). The fields were a natural fit, as both took a relational approach to problem resolution. Family therapists' belief that individual pathology was best treated by working with the family was a perfect match to the marriage counselors' dictum to work with couples. The AAMC changed its

name to the American Association of Marriage and Family Counselors in 1970 and to the American Association for Marriage and Family Therapy (AAMFT) in 1979, to reflect this expanded perspective.

The Family Therapy Movement

Perhaps the greatest push within the field of marriage and family therapy came from the family therapy movement (Broderick & Schrader, 1991; Guerin, 1976; Kaslow, 1980; Nichols & Schwartz, 1998). The early family therapists were researchers and clinicians working with intractable problems such as schizophrenia and delinquency. Traditional individual models, such as psychoanalysis, play therapy, and client-centered approaches, were neither helpful nor applicable to these problems. The mental health field was restless and looking for new ways to treat these problems.

It is not surprising that family therapy had a stronger impact on the emerging field than marriage counseling. Historically, the mental health profession was built on treating pathological disorders. Even today, training in psychopathology and knowledge of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) are considered a crucial part of a clinical education. Often in marital problems there is no **identified patient**, or individual family member identified as having a specific problem; instead, there is a marital problem between two essentially healthy people. It has always been viewed within the mental health establishment, whether correctly or incorrectly, that it is more important to treat diagnosable problems than relational issues that cause extreme pain. This is supported by the large number of insurance companies that do not reimburse for couple therapy but will provide payment if one of the partners suffers from depression due to relational problems.

The family therapy movement started with a focus on the family as causing the patient's problem and eventually moved to a view of the patient's problem as part of a relational process among family members (Gale & Long, 1996; Guerin, 1976). This development made it a perfect fit with marriage counseling, since both place a strong emphasis on treating relational processes. Further, treating certain family problems involves working with the parents' relationship, and some children's problems have been found to diminish without treatment when the parents receive couples counseling (e.g., Bowen, 1978; Haley, 1987; Kramer, 1980).

Who actually founded family therapy is open to debate; however, the distinction can most likely be shared by four individuals: Nathan Ackerman, Murray Bowen, John Elderkin Bell, and Don Jackson (Nichols & Schwartz, 1998). Several other pioneers also played significant roles in the development of this movement. Gregory Bateson, Theodore Lidz, Ivan Boszormenyi-Nagy, Jay Haley, Salvador Minuchin, Virginia Satir, Carl Whitaker, and Lyman Wynne provided important contributions to this growing field. Further, in the 1980s

and 1990s, scholars such as Betty Carter, Steve de Shazer, Lynn Hoffman, Monica McGoldrick, Peggy Papp, Mara Selvini Palazzoli, and Michael White took the field in directions that its founders may never have imagined.

John Elderkin Bell

John Elderkin Bell (1913–1995), who was a psychologist at Clark University in Worcester, Massachusetts, began treating families in 1951. Although he may be considered the first family therapist (Broderick & Schrader, 1991; Nichols & Schwartz, 1998), he did not publish his ideas for several years. And because he neither developed a clinical center nor trained any students who would go on to become well known, many of his ideas remained on the periphery of the field.

Bell's most noteworthy contribution was a book, *Family Group Therapy* (1961), in which he described an approach to families based on the ideas of **group therapy**, a form of treatment in which individuals discuss their problems in a group setting, allowing them to receive support and feedback from other group members. Rather than thinking about a family as an **interactional system**, or a single unit in which all members interact as parts of a larger whole, Bell treated each family member as he would an individual group member. He would prod silent members to speak up and would encourage more dominant members to speak less often. Some of his ideas led to the early belief that family therapy was similar to group therapy, but there are many distinguishing characteristics.

First of all, group therapy brings several individuals together to form a temporary support group in which individuals work through their problems. Relationships between individuals often terminate when an individual leaves the group or the group disbands. On the other hand, family therapy operates on the assumption that the family in treatment has both a past and a future, as well as a current relationship. Issues from the past as well as future concerns of the family are often tied up in present issues. In a group of strangers with no connection other than the group, open discussion of feelings and issues is encouraged, since the therapist can handle and redirect any emotional fallout. Such complete disclosure may not be advisable in family therapy, however. In group therapy, issues are dealt with and the individuals then go to their respective homes; however, family members must spend the time together between sessions and acknowledge what was shared without a therapist to referee their conflicts (Nichols & Schwartz, 1998).

In addition, in family therapy, certain disclosures can have serious consequences for the emotional well-being of a family. For example, it would be very unwise for a therapist to encourage overwhelmed parents to admit to their young children that they wish they had never had them. Discussing this issue would be appropriate only if the children were out of the room, because it would certainly cause unnecessary pain for both the children and the parents and could foster relational problems regarding family trust.

A second difference relates to how a therapist approaches a group versus a family. In group therapy, the therapist brings together a group of strangers to develop a support network. Their initial relationship is with the therapist and then expands to the group. Group members do not have as big an investment in the other group members' problems and are willing to help the therapist in getting members to talk about their problems. In family therapy, the therapist is confronted with an organized system in which the members have a history of assuming specific roles and following a certain culture. Rather than getting support from other family members to help a member disclose an issue, the therapist may find that all members collude to keep the issue a secret. Further, the manner in which therapists talk to one family member may affect the success they have in developing relationships with the rest of the family. For example, Carl Whitaker (1976) believed it is important for family therapists to quickly develop a playful relationship with young children. When other family members observe the therapist being playful with the ones who are most vulnerable, it reassures them that the therapist is safe.

Nathan Ackerman

Nathan Ackerman was a dynamic individual who did much to introduce family therapy to the mental health profession. Originally trained as a child psychiatrist, he developed a method of family therapy that reflected his original psychoanalytic orientation. He believed that although a family may appear united, its members are often split into competing factions and coalitions—similar to how Freud saw the human psyche as caught in a battle among the components of id, ego, and superego.

In 1937, Ackerman became chief psychiatrist of the Child Guidance Clinic at the Menninger Clinic in Topeka, Kansas. He initially followed the traditional child guidance model in which a psychiatrist saw the child in therapy while a social worker consulted with the mother. He began to question this approach and, in the 1940s, experimented with having the same therapist treat both. It was also during this time that he became concerned with the legitimacy of the individual approach to mental illness and started to view mental illness as a family phenomenon. In 1950, he wrote "Family Diagnosis: An Approach to the Preschool Child" (Ackerman & Sobel, 1950), which some consider to be the article that started the family therapy movement (Kaslow, 1980).

Ackerman was a daring and innovative clinician who promoted the open and honest expression of feelings and the confrontation of issues within the family. He was known for his use of wit and charisma to enable families to develop new ways of relating; this was actually more closely related to modern family therapy approaches of changing family interaction than to the psychoanalytic and group format that dominated the early approaches. His style later evolved more fully through the work of his student Salvador Minuchin, whose **structural**

family therapy approach attempted to alter the organization of a family to enable the family members to solve their problems.

During the later part of the 1950s, Ackerman held many positions within this growing field. In 1955, he organized and chaired the first session on family diagnosis at the American Orthopsychiatric Association. Two years later, he opened the Family Mental Health Clinic at Jewish Family Services in New York City and joined the faculty at Columbia University. In 1958, he published *The Psychodynamics of Family Life,* which was the first book on the diagnosis and treatment of family relationships (Broderick & Schrader, 1991). In 1960, he founded the Family Institute (which was renamed the Ackerman Institute following his death in 1971). This institute continues to serve as a prominent center for training family therapists and promoting clinical innovation within the field. In the same year, together with Don Jackson, he founded the first journal in the field, *Family Process,* which continues to be one of the most influential and unifying journals in family therapy.

Palo Alto: Gregory Bateson, Don Jackson, Jay Haley, Virginia Satir, and the Mental Research Institute

During the 1950s, Palo Alto, California, became a foundational hotbed for the family therapy movement when two important projects—a study on schizophrenia under the directorship of Gregory Bateson, and the Mental Research Institute headed by Don Jackson—came together to have an impact that still affects the field today. It is difficult to document in a concise manner all the people who gained eminence through these projects, especially since many of them went on to influence the field differently than their original work in Palo Alto would have suggested. Still, besides Bateson and Jackson, this is where family therapy innovators such as Richard Fisch, Jay Haley, Cloe Madanes, Virginia Satir, Carlos Sluzki, Paul Watzlawick, and John Weakland got their start.

Gregory Bateson

Family therapy owes a major debt to Gregory Bateson, yet he was not a family therapist and was in fact opposed to therapeutic interventions of any kind. Bateson was an anthropologist with an interest in applying ideas from the emerging field of cybernetics to communication patterns in living organisms. **Cybernetics** is the science of communication and control in humans and machines. It looks at how humans and machines maintain stability through feedback. A good example is the way a thermostat maintains the temperature in a room. As the temperature rises, the thermostat receives this information and turns on the air conditioning. When the temperature drops to the desired setting, the thermostat receives this information and shuts off the air conditioning. This idea has been used to explain how a family member's symptoms may get worse to cool off an escalating family

crisis and subside once the crisis has settled down. For example, an adolescent might begin stealing to deflect attention from his or her parents' relational problems and then stop when their relationship improves.

In 1952, Bateson received a Rockefeller Foundation grant to study paradoxes in communication (Gale & Long, 1996). **Paradoxes** are statements that tend to disqualify themselves. For example, in a heterosexual relationship, a husband ordering his wife to be more spontaneous disqualifies his demands because she cannot behave spontaneously if she follows his orders, as the very root of spontaneity is to be free to act as one pleases.

Bateson invited two former students—John Weakland, an anthropologist and former chemical engineer, and Jay Haley, a communications major—to join him in this study. Their project was housed at the Veterans Affairs (VA) hospital in Menlo Park, California, and it was there that they developed an interest in the communication patterns of individuals with schizophrenia (Weakland, Watzlawick, & Riskin, 1995). Their initial concern was with the origin of schizophrenia. Because they were unable to get accurate descriptions of the history of their patients living with a diagnosis of schizophrenia or their families, they decided to study their communication patterns by interviewing them and taping their sessions (Weakland et al., 1995). They subsequently received a grant from the National Institute of Mental Health to study the effects of family therapy on individuals diagnosed with schizophrenia and their families.

During this period, Bateson invited Don Jackson, a psychiatrist at the VA hospital, to serve as a consultant to their project. Jackson later became a core member of the group and jointly authored a paper, "Toward a Theory of Schizophrenia" (Bateson, Jackson, Haley, & Weakland, 1956), that revolutionized the mental health profession's thinking about severe psychopathology. The paper posited that schizophrenic behavior is caused by paradoxical, or double-bind, family communication patterns in which verbal messages are often contradicted at the nonverbal level. For example, the team observed a situation in which a patient on the ward attempted to hug his mother when she visited him. Seeing her cross her arms and back away, he withdrew his gesture. The mother then admonished her son about how he should show more affection when she came to visit, which led to his having a psychotic episode after she left. The team believed that the only way a person continuously exposed to paradoxical messages could behave was through schizophrenic expression (Bateson et al., 1956). Although this paper garnered much discussion, it was primarily theoretical in nature. In fact, the team began to interview families with a member who was diagnosed with schizophrenia only around the time of the paper's publication. Haley candidly reflected (in Simon, 1992):

> When Bateson came up with the double-bind hypothesis, he had never seen a family. He developed it in 1954, and we didn't see a family until about 1956 or 1957. We wrote the double-bind paper in June 1956; it

> was published in September 1956—the fastest journal publication ever done, I think.
>
> (p. 5)

Although a theoretical paper of this type would not be published today without some form of clinical support, it influenced schizophrenia research, and therapy practices in general, for the next several decades.

Unfortunately, although the mental health establishment was uplifted by these ideas, the same may not be said for the families who had a member with a diagnosis of schizophrenia. Nichols and Schwartz (1998) provide a dissenting opinion on the double-bind theory:

> This 1956 double-bind paper proved to be one of the most influential and controversial in the history of family therapy. The discovery that schizophrenic symptoms made sense in the context of some families may have been a scientific advance, but it had moral and political overtones. Not only did these investigators see themselves as avenging knights bent on rescuing "identified patients" by slaying family dragons, they were also crusaders in a holy war against the psychiatric establishment. Outnumbered and surrounded by hostile critics, the champions of family therapy challenged the orthodox assumption that schizophrenia was a biological disease. Psychological healers everywhere cheered. Unfortunately they were wrong. The observation that schizophrenic behavior seems to fit in some families doesn't mean that families *cause* schizophrenia. In logic, this kind of inference is called "Jumping to Conclusions." Sadly, . . . families of schizophrenic members suffered for years under the assumption that they were to blame for the tragedy of their children's psychoses.
>
> (pp. 29, 30; italics in original)

Feminist family therapy scholars added to the critique of the double-bind theory by noting that almost all the examples that were used to illustrate this concept specifically blamed mothers for causing their children's schizophrenia, representing the gender bias that was present in many of the original theoretical developments in family therapy.

Bateson's subsequent books, *Steps to an Ecology of Mind* (1972) and *Mind and Nature* (1979), continue to have a major impact on family therapy theory and practice. However, true to his training as an anthropologist, he remained skeptical about therapeutic intervention. He often observed how anthropologists and missionaries accidentally destroyed the cultures they attempted to study or help, by teaching them the cultural practices of their home countries. Although these new gifts were typically valued by the host culture, they often did not fit with traditional practices and ended up destroying their society, an example of which could be the introduction of alcoholic beverages to Native Americans. Bateson's

greatest fear was that therapists would intervene too much with families and destroy their inherent strengths while attempting to resolve their problems. These concerns eventually led him to prefer the study of animal behavior over family therapy. He died in 1980 at age 76.

Don Jackson

Don Jackson was a brilliant psychiatrist and charismatic personality who impressed colleagues with his clinical insights. He was a major influence on many of the key family therapy figures of the time. While working at the VA hospital in Menlo Park, he served as a consultant to the Bateson project, and subsequently became a core member. Just before coming to the VA hospital, he had spent three years as a psychiatric resident at Chestnut Lodge under the supervision of Harry Stack Sullivan, who taught him about the interactional nature of psychosis (Guerin, 1976).

While working with Bateson on the communications project, Jackson founded the independent Mental Research Institute (MRI) in 1959, where he was joined by Virginia Satir (Broderick & Schrader, 1991). Although Bateson was more interested in research, the MRI team was more focused on family therapy. The MRI has served as one of the most influential centers for family therapy in the entire world. It was here that the strategic school of family therapy was founded (see Chapter 5), and as of 2001, the MRI has published over 60 research projects, more than 60 books, and more than 500 other publications (MRI, 2001). In 1959, Jackson published the paper "Family Interaction, Family Homeostasis, and Some Implications for Conjoint Family Therapy," in which he argued that conducting therapy with family members in combination was more effective than seeing them separately.

In 1960, Jackson joined with Nathan Ackerman to start up a journal, *Family Process,* and appointed Jay Haley as the first editor. The first issue was published in 1962, and *Family Process* continues to have an influential presence in the field.

The researchers at the MRI considered Don Jackson to be a talented diagnostician. Paul Watzlawick recalls that these researchers

> met with Don for many, many weeks for several hours per week, and we played him blind segments of structured interviews—that is, the couple's response to "How, out of the millions of people in the world, did you two get together?" We had 60 such examples which ranged from two to five minutes approximately. Don did not know the people. He had never seen them; we did not give him any information, not even the ages. Don would come up with the most incredibly concrete interchanges, of which, of course, he only had the verbal and paralinguistic parts; he did not see the facial expression and the body language or anything. He just listened to the tape. He would then say something as concrete as, "All right, if they have a son, he is probably delinquent. If they have a girl, she probably has some

> psychosomatic problem." He was right every bloody time. And we would say, "For God's sake, Don, how do you do it? What made you say this?" He would say, as if it was the most obvious thing in the world, "Well, because of the way they laugh here." We still did not know what was the thing that made him say it, but he was always right. I remember one funny incident in particular. We tried to get a control group of so-called normals, and we rounded up three normal couples. I remember one was a father and a mother, whose marriage seemed to be very much all right after something like 17 years. They had a 15-year-old daughter and she was doing well at school and there were no problems. So they qualified for our idea of normal. We played this particular part of "how did you meet" for Don, and for the first time Don said, "I don't know; to me they sound normal."
>
> (Weakland et al., 1995, p. 13–14)

In 1962, at the close of the Bateson project, Jay Haley and John Weakland joined Jackson at the MRI. In 1967, Jackson, along with Paul Watzlawick and Janet Beavin, published *Pragmatics of Human Communication* (Watzlawick, Beavin, & Jackson, 1967), which was the first book-length treatise on the interactional theories of the MRI. Jackson's premature death in 1968 deprived the field of a leader and an innovator; however, his name lives on through the ongoing accomplishments of the MRI.

Jay Haley

Jay Haley was one of family therapy's controversial and most influential leaders (Simon, 1992). With a master's degree in communications, he began as an outsider to the mental health establishment. Perhaps it was this outsider perspective that enabled him to so easily challenge the traditional psychoanalytic approach of the time and to focus on patterns of family interaction. In fact, none of the original members of the Bateson team held a degree in the mental health field (both Bateson and Weakland were anthropologists).

In addition to being one of the founders of the strategic school of family therapy, Haley served equally important roles as both a promoter and synthesizer of the ideas in family therapy and a critic of the mental health establishment (Simon, 1992). While a member of the Bateson project, he traveled to Phoenix, Arizona, to observe the work of Milton Erickson, a noted psychiatrist and hypnotherapist. Erickson practiced a brief form of hypnotherapy; patients from across the country then would work with him for a few weeks and return home with their problems resolved. It was through these observations that Haley and the other members of the MRI were able to develop **strategic family therapy**, a brief approach that focuses on observing and altering the interactional sequences in which a problem is embedded. Further, this association led to Haley becoming the chief chronicler of Erickson's work (e.g., Haley, 1973, 1985a, 1985b, 1985c).

During his tenure as the first editor of *Family Process,* Haley traveled around the country observing clinicians' work and encouraging them to submit articles to the new journal. During this period, he observed five family therapists conducting therapy and discussed with them how they conceptualized cases and why they intervened in the ways they did. These interviews, along with verbatim transcripts of their sessions, were published in book form as *Techniques of Family Therapy* (Haley & Hoffman, 1967). This book was the first to clearly show readers how family therapy was practiced. However, it was *Strategies of Psychotherapy* (Haley, 1963) in which Haley declared all-out war on the traditional mental health establishment by refuting such ideas as patient-therapist transference and therapist non-directiveness. He presented a therapy based on interaction, relational power, and therapist directiveness. His ideas continue to create controversy among students and mental health practitioners due to his direct and provocative writing style.

In 1967, Haley left the MRI to join Salvador Minuchin at the Philadelphia Child Guidance Clinic, where he helped develop structural family therapy (see Chapter 4), a form of therapy in which the therapist uses an organizational approach to treat families. He then moved on to co-found the Family Therapy Institute of Washington, DC, with Cloe Madanes, which he directed until 1994. He died in 2007 at the age of 83.

Virginia Satir

Virginia Satir, a social worker, was known for her unparalleled clinical intuition and capacity to see the unlimited potential that exists within all families. She is considered by many to be the founding mother of family therapy.

Satir was one of the original members of the MRI and served as the Director of Family Therapy Training. In 1964, she published *Conjoint Family Therapy,* which became the training manual for students learning family therapy at the MRI. During the mid-1960s, she left the MRI to join the human potential movement at the Esalan Institute in Big Sur, California, where she became one of the key founders of an approach to family therapy called **experiential family therapy**. In 1972, she published the influential book *Peoplemaking,* which marked an important shift in the field toward a more positive or strength-based view of family relationships.

Satir was a major force in popularizing the field of family therapy, through her warmth and charisma. Broderick and Schrader (1991) recall:

> Probably more than any other early founder, she was responsible for popularizing the movement. She had a flair for clear, nontechnical exposition and charismatic presentation that led her to address tens of thousands in person, hundreds of thousands through her books, and millions through the media.
>
> (p. 29)

In 1978, Satir founded the Avanta Network, which was dedicated to training therapists throughout the world to use her influential ideas. Following her death in 1988, the Avanta Network was renamed the Virginia Satir Global Network. The reach of Satir's work has extended far beyond the field of family therapy, as it has served as a model for peaceful relations throughout the world.

Lynn Hoffman

Like Virginia Satir, Lynn Hoffman was a social worker; however, her entry into the family therapy field was as an editor of some of the foundational books in the field. For example, she was employed by Satir to edit *Conjoint Family Therapy* and also worked as an editor for Don Jackson.

Her relationships with Satir and the opportunities she had to observe Satir's work led Hoffman to pursue a master's degree in social work and a career as a family therapist. She would later co-author the influential book *Techniques of Family Therapy* with Jay Haley in 1967. She also authored several other important family therapy books, including *Family Therapy: An Intimate History* (2002), which reflects her experience of having worked closely with some of the most influential figures in family therapy: Salvador Minuchin, Peggy Papp, Olga Silverstein, Mara Selvini Palazzoli, Harry Goolishian, Michael White, and David Epston.

More recently, Hoffman has taught courses at the Hunter School of Social Work in New York, the Ackerman Institute for the Family in New York, and Smith College in Northampton, Massachusetts. She currently works as an adjunct faculty member at St. Joseph's College in West Hartford, Connecticut, in the Marriage and Family Therapy program.

Murray Bowen

Murray Bowen was a child psychiatrist who specialized in treating children with psychiatric problems. After World War II, he served on the staff of the Menninger Clinic in Topeka, Kansas, which at the time was a bastion of the psychoanalytic movement. He was initially influenced by the writings of Frieda Fromm-Reichmann on the role of the "schizophrenogenic mother" in child psychosis. Fromm-Reichmann postulated that these mothers were needy, insecure women who smothered and overprotected their children to the point at which they had a schizophrenic break, an idea that has since been discredited and tied to the unfortunate history of mother blaming in family therapy.

In 1951, Bowen began hospitalizing children with schizophrenia and their mothers at the Menninger Clinic, hoping to observe and eventually treat this phenomenon. It was during this period that he began to question the psychoanalytic notion of schizophrenia as existing in the "head" of the patient and

began to assess the interactional dynamics of the mother/child relationship. His novel ideas about schizophrenia as an interactional disorder rather than an intrapsychic one drew the wrath of many of his colleagues at the clinic and eventually led to his departure (Wylie, 1992).

In 1954, Bowen moved to Washington, DC, to join the staff of the National Institute of Mental Health (NIMH), a creative wellspring for bright young mental health scholars who were interested in studying emotional phenomena that ran counter to traditional mental health ideas. During this period, he questioned whether the interactional pattern that maintained schizophrenia belonged solely to the mother/child dyad and began to examine the role of fathers in this relationship. He and his research team were able to hospitalize four entire families and study several others in the community. They found that these families engaged in a pattern in which the mother and child were unusually close and the father was distant; however, in times of stress, the alliance would shift to the father and child, with the mother at a distance. This finding led Bowen to study how these behavioral sequences were transmitted through the generations in families, which he called the **multigenerational transmission process**.

Bowen's desire was to develop a natural systems model of human behavior—a model that showed how all living systems behave according to innately programmed patterns. As the years passed, he turned more toward the field of biology and the natural sciences than to the traditional psychological models that pervaded the mental health literature at that time (Bowen, 1978).

In 1958, Bowen left NIMH to go to the Georgetown University School of Medicine, where he set up his family therapy training program. In 1967, he experimented with his ideas for altering entrenched multigenerational family patterns with his own **family of origin** (Anonymous, 1972). This was an important undertaking, as this experience was so profound for him that he mandated all his family therapy trainees have a similar experience with their own families. In fact, having family therapy students understand their own families of origin continues to be a hallmark of training in **Bowen systems therapy**, the family therapy approach that views problems as maintained through multigenerational patterns.

Throughout his career, Bowen showed a greater interest in theory than in therapy. He felt that too great of an emphasis on therapeutic technique led many therapists to replicate patterns that maintained their clients' problems because they did not understand the theoretical underpinnings of those problems (Bowen, 1978). His focus on theory was something of a novelty within the family therapy field, and it thus kept him rather separated and misunderstood (Wylie, 1992). Many of his key ideas are presented in *Family Therapy in Clinical Practice* (Bowen, 1978), a collection of his most important articles and presentations. Although he died in 1990, the ongoing work of the faculty at the Georgetown Family Therapy Center is his legacy.

Theodore Lidz

Theodore Lidz was a psychoanalytically oriented researcher interested in the role of families in the development of schizophrenia. At Johns Hopkins University in Baltimore, Maryland, he concluded that individuals with schizophrenia often came from homes with numerous family and marital problems (Lidz & Lidz, 1949). This certainly was a significant finding for its day and opened the door for other family models of severe mental illness.

After entering Yale University in New Haven, Connecticut, in 1951, Lidz began to study hospitalized individuals diagnosed with schizophrenia and their families more closely. Similar to Bowen, he questioned the role of the "schizophrenogenic mother" and emphasized the role of fathers in the process of mental illness (Lidz, Parker, & Cornelison, 1956). He also hypothesized that the parents' marital relationship was as important in the development of a child with schizophrenia as either of the parents' individual characteristics (Lidz, Cornelison, Fleck, & Terry, 1957). He introduced two dominant marital patterns, the first being **marital schism**, which occurs when husband and wife fail to accommodate each other, constantly attack each other, and compete for their children's affection. **Marital skew**, on the other hand, represents a pattern in which one spouse tends to be more dominant and the other is more submissive and dependent. Although these patterns were associated with schizophrenia in children, it must be noted that they also exist in families with no child pathology. Many couples who struggle with problems that are similar in structure to marital schism and marital skew will come to couple therapy but report no problems with their children. Lidz died in 2001 at the age of 90.

Lyman Wynne

Of all the founders of the field, perhaps none was so fully trained to become a family therapist and researcher as Lyman Wynne (Broderick & Schrader, 1991). Having earned both a medical degree in psychiatry and a doctorate in social relations from Harvard University in Cambridge, Massachusetts, he was easily able to move beyond the focus on the individual in mental health to a more contextual approach. In 1952, he joined the staff at the National Institute of Mental Health (NIMH) and began to meet with the families of patients with schizophrenia as part of the standard course of treatment.

Wynne believed that certain interpersonal characteristics pertained to "schizophrenic families." Specifically, he noticed that some people exhibited **pseudomutuality**, the loss of personal identity to maintain a sense of family togetherness. For example, family members would sacrifice important personal needs to maintain the façade of family harmony. For the family member with schizophrenia, this meant giving up a hold on reality to preserve peace in the family. He also noticed a different pattern in which some families

expressed **pseudohostility**, or the false expression of anger, to mask family members' needs for intimacy or deeper issues of conflict and alienation. In other words, they would have false fights to cover up more important areas of family conflict. He also noticed that "schizophrenic families" acted as if they were surrounded by a rubber fence; they remained impervious to interventions from outside agents. Typical therapist comments bounced off of them as if they were surrounded by rubber (Gale & Long, 1996; Wynne, 1961; Wynne, Ryckoff, Day, & Hirsch, 1958).

In 1954, Murray Bowen joined Wynne at NIMH. Although they worked in separate sections, they shared a fascination with the role of family phenomena in mental illness. During the 1956 and 1957 meetings of the American Psychiatric Association, Wynne and Bowen met with Don Jackson, Theodore Lidz, and Nathan Ackerman, which began a series of interchanges among these pioneering figures. In 1971, Wynne moved to the University of Rochester Medical School, where he conducted research on schizophrenia and families. He chaired the Department of Psychiatry from 1971 to 1977, and then served as professor of psychiatry until his retirement to emeritus status in 1998. Wynne died in 2007 at the age of 83.

Carl Whitaker

Of all of the charismatic founders of the family therapy field, Carl Whitaker is considered the most irreverent and colorful (Gale & Long, 1996; Nichols & Schwartz, 1998). He used an innovative approach to families that forced them to use their dormant creative powers to resolve their problems. He viewed therapy as a countercultural process in which clients and therapists need to be free to explore themselves apart from societal constraints (Whitaker & Ryan, 1988).

Perhaps Whitaker's belief that therapy promoted personal growth at the expense of societal expectations stemmed from his own tendency to operate outside of the mainstream. He began his medical career in obstetrics and gynecology; however, he left it for the world of psychiatry due to his growing concerns with the emotional lives of his patients. During World War II, he worked as a staff psychiatrist in the hospital at the Oak Ridge Plutonium Facility in Tennessee. It was there that he joined forces with John Warkentin, another innovative therapist and free spirit, and began experimenting with having two therapists interviewing a patient, bringing patients' relatives to sessions, and developing a creative approach to therapy. The flavor of Whitaker's work is apparent in a story in which a patient with schizophrenia threatened to kill him with a knife. The patient said, "You will never know when it will happen; you could be walking down the street, sleeping, going to the bathroom, and suddenly there I'll be!" Whitaker sincerely responded to the patient, "I want to thank you for giving me something else to think about at the urinal rather than worrying if I will get my shoes wet." It was this no-holds-barred,

irreverent attitude to therapy that characterized Whitaker's work throughout his life.

Following the war, Whitaker became chair of the psychiatry department at Emory University in Atlanta, Georgia. He brought Warkentin with him and hired a new colleague, Thomas Malone. It was here that Whitaker and Malone wrote *The Roots of Psychotherapy* (1953), which documented their new approach to the treatment of mental illness. This was a very provocative book for its time. The mental health establishment was aghast at their break from traditional psychiatric practice and not so subtly suggested that the team members receive therapy themselves. It was here that they experimented with seeing families of individuals living with schizophrenia, due to their disenchantment with the individual approach to treatment.

Some credit Whitaker for calling the first meeting of family therapy (Broderick & Schrader, 1991). At Emory, his staff would have a semiannual conference in which they would observe one another working with families of individuals living with schizophrenia and share their observations. In 1955, he invited Don Jackson and Gregory Bateson to participate. He recalls with typical aplomb that "[Jackson] was a 'brain' who sparked a lot of new thinking and [Bateson] was an elder statesman anthropologist—a sage who smelled of people" (Whitaker & Ryan, 1988). During this meeting, the group came to a clear definition of schizophrenia as a family phenomenon.

In 1965, Whitaker left Atlanta to join the Department of Psychiatry at the University of Wisconsin. It was here that he solidified his thinking about families and family therapy, and he named his approach **symbolic-experiential family therapy** (Whitaker & Keith, 1981) to represent the experiential form of encounter between therapist and client that operates at the symbolic level. In other words, the therapist interacts with the family at a metaphorical level to bypass their resistance.

As Whitaker's ideas were more creative than practical, he was not initially as well known as the other early pioneers; however, he was always respected by the leaders in the field. It was in his later years that he became a sage to the rest of the family therapy community and a fixture at conferences and workshops. His daring nature, creativity, and respect for the inherent strength of humans served as a model for other family therapists. Whitaker died in 1995 at the age of 83.

Philadelphia: Ivan Boszormenyi-Nagy, James Framo, and the Eastern Pennsylvania Psychiatric Institute

Across the country from Palo Alto, another important family therapy think tank was developing in Philadelphia. Although perhaps not as well known as the Mental Research Institute (MRI), the family therapists and researchers who worked at the Eastern Pennsylvania Psychiatric Institute (EPPI) have provided substantial contributions to the family therapy field.

Ivan Boszormenyi-Nagy

Similar to many of the early family therapists, Ivan Boszormenyi-Nagy was a psychoanalytically trained psychiatrist with an interest in schizophrenia. He founded the family therapy department at the EPPI to study the relationship between family process and psychosis. This became a major East Coast training institute that spawned numerous leaders in the field.

Boszormenyi-Nagy co-edited *Intensive Family Therapy: Theoretical and Practical Aspects* (Boszormenyi-Nagy & Framo, 1965), which was one of the first books on family therapy. More importantly, he wrote one of the first books on **transgenerational family therapy**, a school of therapy that believes that problems are maintained by patterns spanning several generations in families. That book was *Invisible Loyalties: Reciprocity in Intergenerational Family Therapy* (Boszormenyi-Nagy & Spark, 1973).

Boszormenyi-Nagy moved to Hahneman University in Philadelphia in 1980 after the EPPI was closed; he went on to become known as the founder of **contextual family therapy**, which focuses on the role of ethics in family relationships (Boszormenyi-Nagy & Krasner, 1986). He died in 2007 at the age of 86.

James Framo

James Framo was one of the few psychologists to gain a prominent role in the early days of family therapy. He initially gained national recognition at the EPPI, where he worked closely with Boszormenyi-Nagy.

Beginning in 1969, Framo served as the chief of the Family Therapy Unit at Thomas Jefferson University Hospital in Philadelphia, which is widely considered the first family therapy center in the United States. He is best known for developing the object relations approach to family therapy and for asking adult patients to bring their entire family of origin, no matter how far away, for intensive weekend marathon sessions to work on transgenerational issues (Framo, 1981).

Later in his career, Framo was a full professor at Temple University in Philadelphia and a distinguished professor of psychology at the United States International University (now known as Alliant International University) in San Diego, California. He died in 2001 at the age of 79.

Salvador Minuchin

Although Salvador Minuchin was not one of the founders of family therapy, he was an influential pioneer in the field (Wetchler, 1988). In fact, it is almost impossible to conceptualize the field of family therapy without Minuchin's contributions.

Minuchin was a child-oriented psychiatrist who came to the United States from Argentina. He initially worked under the tutelage of Nathan Ackerman, who taught him the rudiments of family therapy.

During the early 1960s, Minuchin worked with inner-city "delinquent youths" at the Wiltwyck School in New York. Here he faced the challenge of working with minority families who were not interested in insight and were more concerned with the real-world problems of keeping their children away from crime. He noticed that these families tended to be underorganized, with no one in charge. This posed a major problem, as traditional therapies did not seem appropriate for these families. He recalls:

> Like everyone else back then, I was thrashing around trying to find something that worked, since everything I had been trained to do—child psychiatry, play therapy, psychoanalysis—had shown itself to be ridiculously ineffective with the tough inner-city kids we were seeing.
>
> (Simon, 1992, p. 76)

Out of necessity, Minuchin developed a therapy that focused more on action than insight and was geared to help these families place the parents in a leadership position with their children. The results of this project led to the publication of *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). This book is especially noteworthy, in that it was one of the first family therapy texts to examine issues of culture, class, and race.

In 1965, Minuchin took over the directorship of the Philadelphia Child Guidance Clinic. There, joined by Braulio Montalvo, a colleague at the Wiltwyck School, and Jay Haley, from the Mental Research Institute in Palo Alto, he further refined his earlier ideas and developed structural family therapy, a form of treatment that applies organizational principles to family interaction. The goal of structural family therapy is to reorganize a family's structure so that parents can become effective leaders and resolve their children's problems. The ideas of structural family therapy were first presented in the groundbreaking book *Families and Family Therapy* (Minuchin, 1974), which continues to be the most popular family therapy text in the field (Nichols, 2013).

Among the programs Minuchin started was the Institute for Family Counseling in Philadelphia. This groundbreaking experiment involved training minority members from the community to work as paraprofessional family therapists with other minority families. Minuchin hoped that minority clients would be more open to the therapy process with therapists of similar backgrounds than they had been to the predominantly white professionals they had seen in the past. To accomplish a project of this nature meant that Minuchin and his colleagues had to present the ideas of structural family therapy in a straightforward manner, without using jargon. Their training manual was later published by Jay Haley as the influential book *Problem-Solving Therapy* (1987).

To gain legitimacy for this project among the professional community, Minuchin and his colleagues also provided intensive supervision for these paraprofessionals. They developed a new form of training called **live supervision**, in which a supervisor behind a one-way mirror observed the trainee conduct therapy and suggested interventions while the session was in progress. This form of training has been synonymous with family therapy supervision ever since.

In 1981, Minuchin founded Family Studies Incorporated in New York City, where he continued to train family therapists and became involved in the foster care system. Although he retired in 1996, Minuchin has continued to contribute to the field through the publication of a number of books. His most recent book is *The Craft of Family Therapy: Challenging Certainties* (Minuchin, Reiter, & Borda, 2013).

The Milan Group: Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Giuliana Prata

During the 1960s and early 1970s, family therapy was primarily an American phenomenon. This changed dramatically when a team of Italian family therapists burst upon the scene in the mid-1970s. The Milan Group, composed of psychiatrists Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Giuliana Prata, initially borrowed ideas from family therapists in the United States, but later became some of the foremost teachers to the family therapy community throughout the world.

Mara Selvini Palazzoli was an internist who became interested in the phenomenon of anorexia nervosa following World War II (Simon, 1992). She switched her specialty to psychiatry, as this disorder had physicians in Italy stumped. Selvini Palazzoli was sure that it was not a physical malady but an emotional disorder. The problem was how to treat it. Over time, she became one of the most prominent psychoanalysts in all of Italy; however, her frustration with the traditional psychoanalytic approach led her to the United States in 1967 to learn about family therapy.

Upon returning to Italy, Selvini Palazzoli formed a team of psychiatrists to experiment with family therapy in the treatment of anorexia and schizophrenia. The group split in 1971, but Selvini Palazzoli, Boscolo, Cecchin, and Prata remained. Their initial attempts at family therapy derived from a psychoanalytic perspective, but later drew their inspiration from the Palo Alto group, the text *Pragmatics of Human Communication* (Watzlawick et al., 1967), and the writings of Gregory Bateson. The group was interested not only in the interactional patterns in families but also in the interaction that existed between therapist and family. Their concern with therapists being co-opted by family patterns led to their development of a team approach to treatment, with two therapists interviewing the family in the room and two more therapists observing from behind a one-way mirror. The team would then meet without the family during the

middle of the session to discuss the first part of the therapy and devise an intervention for the second half.

As word of the Milan Group's ideas and clinical prowess spread, they were invited to present their work at an invitation-only conference at the Ackerman Institute in New York. The conference attendees included a veritable who's who of family therapy innovators. The somewhat skeptical audience was impressed with the Milan Group's team approach, use of paradoxical intervention, and flair for the dramatic. Family therapist Peggy Papp recalls:

> They turned everything into a theatrical presentation. With all their detailed questioning, they managed to take the hidden subjective life of the family and turn it into a heightened performance. Eventually each family's situation would take on the dimensions of a great opera.
>
> (Simon, 1992, p. 143)

Their "hit" presentation was followed by the eagerly awaited text *Paradox and Counterparadox* (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), which focused on the use of paradox in the treatment of severe psychosis and the use of their team format. Although this book was read worldwide, much of the Milan Group's theoretical impact came from an article they wrote in 1979 just before they disbanded, "Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session" (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). It was this article in which they moved away from paradoxical interventions and began to focus on the interactional process between family and therapist. They posited that the therapist was not an objective observer of a family's interactions, but that all hypotheses were due to the interaction between therapist and family. In other words, a feedback loop existed between the therapist's questions, the family's answers, and the subsequent questions the therapist would ask. Hypotheses were grounded not in fact, but rather in how useful they were for the therapist and family (Selvini Palazzoli et al., 1980). At this time, their approach became known as **Milan systemic family therapy** because of its focus on the interactional nature of the therapist-client relationship.

After the split, Boscolo and Cecchin held to the tenets originally presented in "Hypothesizing-Circularity-Neutrality" and focused on teaching their innovative approach. They referred to themselves as the Milan Associates, to differentiate themselves from the original group and Selvini Palazzoli's work. Selvini Palazzoli and Prata focused on a new method for treating psychotic processes in families. They referred to their approach as the **invariant prescription**, as they asked the parents in every family they treated to develop a secret alliance, separate from the other members, to break up the interactional patterns that existed in their families (Selvini Palazzoli, Cirillo, Selvini, & Sorrentino, 1989). Selvini Palazzoli died in 1999 at the age of 82 and Cecchin died in 2004 at the age of 71.

Feminist Family Therapy

By the late 1970s, it was evident that many of family therapy's basic assumptions were at odds with the principles guiding the feminist movement. Rachel Hare-Mustin's (1978) groundbreaking article "A Feminist Approach to Family Therapy" challenged many of the foundational theories and practices of family therapy as being inconsistent with and contradictory of women's rights to equality. For example, the systemic view of behavior as interactional can obscure the fact that women are typically the recipients of violence in couple relationships and that historically and currently women have less power to determine societal policy, and subsequently their own lives, than men do.

Also in 1978, Betty Carter, Peggy Papp, Olga Silverstein, and Marianne Walters founded the Women's Project in Family Therapy to study the issues of gender in families and family therapy. Walters explained the work of the Women's Project as "using the larger context of gender socialization to examine relationships, instead of an exclusively internal family system, provided us with the necessary tool to experiment with clinical revisions and adaptations" (1988, p. 9). This team was especially remarkable in that it brought together members with theoretical orientations in strategic, Milan systemic, structural, and transgenerational family therapies. The landmark book by the Women's Project, *The Invisible Web: Gender Patterns in Family Relationships* (Walters, Carter, Papp, & Silverstein, 1988), presented new ways of viewing families and conducting family therapy and challenged previously unexamined assumptions about the role of women and men in family relationships.

The work of Monica McGoldrick, Carol Anderson, and Froma Walsh was also central to advancing the feminist family therapy movement. In 1984, McGoldrick, Anderson, and Walsh organized the first Stonehenge Conference, which helped establish a network of female scholars who were committed to transforming the family therapy field through the integration of feminist principles. Prior to this conference, feminist women had often been forced to work in isolation. This meeting, as well as the second Stonehenge Conference in 1986, created crucial networks of support that led to many important collaborations that would influence the field for years to come. Betty Carter (1989) explained:

> Feeling isolated, vulnerable, severely criticized and unsupported, we each mushed alone or in our own small groups, until Monica McGoldrick, Carol Anderson, and Froma Walsh, also acting alone and unsupported, brought us and dozens of like-minded women together at the first Stonehenge Conference, in 1984. The results of the joyous meeting and the establishment of permanent networks of support and exchange among women family therapists have already made a permanent contribution to the field in the form of the many thoughtful articles, books and presentations that have flowed into the field since 1984.
>
> (pp. vii–viii)

In 1989, McGoldrick, Anderson, and Walsh edited the seminal *Women in Families: A Framework for Family Therapy*. The contributions of these feminist family therapists have forever altered the way family therapy is conceptualized and continue to challenge the field to acknowledge gender as a central organizing principle in families.

Betty Carter

Betty Carter was originally trained as a social worker and is known as one of the pioneers of the feminist family therapy movement. Among her many contributions, she is recognized as one of the first to integrate feminism in an existing family therapy theory. A Bowenian feminist therapist, she was known for her focus on issues of money and power in couple relationships. She believed that it was essential for women to have equal control over financial decision making. As Monica McGoldrick wrote at the time of Carter's death in 2012, "she used to say all the time, every woman who does not have financial control of her life is a man away from welfare" (McGoldrick, 2013, p. 3).

In 1977, Carter founded the Family Institute of Westchester (FIW) in Mount Vernon, New York, which she directed until 1997. The FIW is a postgraduate institute that trains therapists to use the Multi-Contextual Model of family therapy, which was developed by Carter. In 1980, along with her longtime colleague Monica McGoldrick, she published the groundbreaking book, *The Family Life Cycle: A Framework for Family Therapy,* which re-conceptualized the field's understanding of the family life cycle. The popularity of this book led to three more expanded editions, which highlighted the role of diversity and other contextual factors in shaping the family life cycle. The most recent edition is titled *The Expanded Family Life Cycle: Individual, Family, and Social Perspectives* (McGoldrick, Carter, & Garcia-Preto, 2011). It is interesting to note that while Carter and McGoldrick's work on the family life cycle is widely accepted, both Jay Haley and Murray Bowen were publicly critical of their ideas about the family life cycle framework as well as the idea that issues of gender and ethnicity were relevant to family therapy. Haley went so far as to write a scathing critique of their work in *Family Process* in 1981. Years later, McGoldrick recounted: "Haley wrote a nasty article on the right to choose your own grandchildren, saying that he rejected us as his grandchildren. He had nothing to do with us or our ideas" (Wyatt & Yalom, 2006). The reactions of Haley and Bowen were representative of the hostile climate that many of the founding feminist family therapists experienced.

Monica McGoldrick

Monica McGoldrick was originally trained as a social worker at Smith College in Northampton, Massachusetts, where she received an honorary doctorate in 1991 in recognition of her contributions to the field of family therapy. As a

feminist scholar, she has made significant contributions to the field on a wide range of topics, including culture, ethnicity, class, gender, the family life cycle, loss, and genograms. Her book *Genograms: Assessment and Intervention* (with Randy Gerson), originally published in 1985, set the standard for the use of genograms in family therapy. She is also known for her work in addressing issues of ethnicity and race in family therapy. In particular, her book *Ethnicity and Family Therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005) is widely considered a foundational text for training family therapists to work with racial and ethnically diverse families.

In 1991, McGoldrick co-founded the Multicultural Family Institute (MFI) in Highland Park, New Jersey, and she continues to serve as its director. MFI specializes in postgraduate family therapy training, research, and consulting with local organizations from a Multicultural Systemic perspective. MFI was founded on a commitment to social justice principles that involves addressing issues of racism, sexism, heterosexism, classism, and ableism. More recently, McGoldrick's scholarly work has contributed to the social justice movement in the field of family therapy. Her book *Re-Visioning Family Therapy* (McGoldrick & Hardy, 2008) challenges the field to make the broader issue of social justice central to the practice of family therapy.

The Multicultural Family Therapy Movement

Another important movement in the field was the effort by scholars to raise awareness of the larger contextual influence of racism in family therapy. In particular, this movement challenged the lack of training on racial diversity that family therapists were receiving and the overall lack of representation of people of color in the field. The efforts of those associated with this movement have led to some significant changes in the field, including increased attention to issues of race and ethnicity in family therapy training and research, efforts to increase the representation of people of color in family therapy training programs and academia (e.g., the AAMFT Minority Fellowship Program), and expanded understandings of systemic approaches to family therapy to include the impact of larger social systems on the lives of families and the therapy process. Scholars such as Rhae Almeida, Nancy Boyd-Franklin, Celia Falicov, and Kenneth Hardy have highlighted the importance of addressing how experiences of racism and discrimination directly influence the problems that racial minority families present with in therapy. These scholars have also argued that for white therapists, an important part of providing competent therapy to racial minority families involves exploring the privileges they themselves receive due to being members of the dominant race. While it is important to acknowledge the progress that these scholars have made, there is still work to be done to ensure that the multicultural movement remains central to the conceptualization and practice of family therapy.

The Lesbian, Gay, Bisexual, and Transgender Affirmative Family Therapy Movement

During the past two decades, a number of brave family therapy scholars have challenged the field's lack of acknowledgement and acceptance of the lesbian, gay, bisexual, and transgender (LGBT) community. For example, Joan Laird and Robert-Jay Green (1996) published the groundbreaking book *Lesbians and Gays in Couples and Families: A Handbook for Therapists,* which is recognized by many as the first book specifically written for family therapists on working with same-sex couples. In the early 2000s, Julianne Serovich, Janie Long, and Jerry Bigner shed light on (a) the dearth of scholarship in the field related to working with LGBT populations, (b) the homophobic and heterosexist biases that are present in family therapy practices, and (c) the desperate need for family therapy training programs to better prepare students to work with LGBT clients. In 2004, Ari Lev published *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families*, which extended the discussion to include the importance of considering the needs of transgender clients and their families.

Since that time, other scholars have joined Serovich, Long, Laird, Lev, Green, and Bigner to promote a more inclusive and affirming stance toward LGBT individuals, couples, and families. One outcome of this movement has been the effort to further develop and refine the practice of **LGBT affirmative therapy**, which is defined as "an approach to therapy that embraces a positive view of LGBT identities and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGBT clients" (Rock, Carlson, & McGeorge, 2010, p. 175).

Another important outcome of the LGBT family therapy movement has been a call to alter the name of the field from "marriage and family therapy" to "couple and family therapy" to be more inclusive of all types of couple and family relationships. While symbolic in nature, changing the name of the field would represent an acknowledgement that family therapists should competently and affirmatively work with all couples and, at the same time, recognize that some couples may not have the right to legal marriage. While the AAMFT continues to use the term "marriage" in its title, the AAMFT has released a series of position statements recognizing the rights of LGBT couples to competent and ethical treatment by family therapists. For example, the AAMFT added sexual orientation to the non-discrimination clause in its code of ethics in 1991 (AAMFT, 1991), and in October 2005 the board of the AAMFT adopted a series of official statements clarifying its values surrounding sexual orientation and same-sex relationships (AAMFT, 2005a, 2005b). In particular, the board reaffirmed the non-discrimination clause in its code of ethics, publicly acknowledged that an LGBT sexual orientation is not a disorder (by supporting the 1973 removal of sexual orientation from the *Diagnostic and Statistical Manual*), and publicly affirmed "the

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right of all committed couples and their families to legally equal benefits, protection, and responsibility" (AAMFT, 2005a, ¶ 1). Additionally, the AAMFT board released a statement entitled "What Is Marriage and Family Therapy?" declaring the AAMFT to be an open and inclusive organization and specifically inviting LGBT couples and families to seek out the services of marriage and family therapists (AAMFT, 2005b).

Social Constructionist Family Therapy: Michael White, Steve de Shazer, Harlene Anderson, and Harry Goolishian

The late 1980s through the 1990s marked a radical shift for family therapy. Following the ideas of the Milan Group that hypotheses arise through the interaction between family and therapist, some clinicians began to question whether any therapist could objectively diagnose a family and intervene in its processes separate from the therapist's values and worldview. **Social constructionist family therapists** believe that therapists should not take an expert position, relying instead on the expertise of families to solve their own problems. They believe that reality is not an objective phenomenon; instead, it is subject to the interpretations of various groups. This means that all ideas about how a family should look, or how it should solve its problems, are subjective. Therefore, social constructionist family therapists do not tell families how to change, but rather help them find their own solutions (Wetchler, 1996). The social constructionist movement has had a significant impact on the field and led to the development of a number of family therapy theories, including narrative therapy, solution-focused therapy, and collaborative language systems.

Michael White

Michael White was an Australian family therapist who is best known for his critique of the marginalizing effect that diagnoses had on the lives of families and individuals (White, 1995; White & Epston, 1990). With his colleague David Epston, he developed **narrative therapy**, which helps clients challenge their views of themselves as the problem and helps them develop preferred alternative stories about themselves based on their own values, strengths, and lived experiences. Additionally, White's approach highlighted the role that culture plays in shaping people's experiences of themselves and the way they give meaning to the problems in their lives. Perhaps the most well-known practice of narrative therapy is externalizing conversations, which involves naming the problems that clients present with in therapy as existing outside of themselves in order to help them separate themselves from negative stories.

In 1983, White, along with Cheryl White, founded the Dulwich Centre in Adelaide, Australia, which serves as a therapy and training center as well as a publishing house for narrative ideas. He then traveled the world, training therapists

in the use and practice of narrative therapy. He also authored a number of influential books outlining the practice of narrative therapy, including *Narrative Means to Therapeutic Ends* (White & Epston, 1990) and *Maps of Narrative Practice* (White, 2007). Sadly, he died suddenly in 2008 at the age of 59; however, his ideas continue to influence the field through the work of the Dulwich Centre and the many therapists he trained throughout the world.

Steve de Shazer

Steve de Shazer, along with Insoo Kim Berg, developed **solution-focused therapy**, which de-emphasizes problems and focuses on the role of solutions in treatment (de Shazer, 1985, 1988). Similar to the work of the Mental Research Institute, de Shazer's ideas initially stemmed from the teachings of hypnotherapist Milton Erickson. In fact, de Shazer's ideas were originally considered to be a form of strategic therapy. However, he did not look at interactional sequences that maintain a problem. Instead, he worked with families to identify exceptions to the problem and have them utilize these exceptions in solving their problem. Because his approach focuses on solutions rather than problems, it tends to require fewer sessions than traditional therapies and is thus considered a brief form of family therapy.

Solution-focused therapy represented a radical shift for the family therapy field. In 1978, de Shazer and Berg founded the Brief Family Therapy Center in Milwaukee, Wisconsin, where many of the practices associated with solution-focused therapy originated. De Shazer wrote extensively on these ideas throughout the course of his career and published many books, including *Putting Difference to Work* (1991) and *Clues: Investigating Solutions in Brief Therapy* (1988). He died in 2005.

Harlene Anderson and Harry Goolishian

Harlene Anderson and Harry Goolishian played an instrumental role in shifting the family therapy field toward a more social constructionist framework. They were among the first to question the utility of a systems-based approach to family therapy and, in particular, argued that systems theory led therapists to be too directive and take an expert-based approach in their work with families. They were particularly influenced by the postmodern idea that challenged the notion of a universal truth and encouraged family therapists to take a "not knowing" approach in their work with families.

Anderson and Goolishian developed the **collaborative language systems** (CLS) approach to family therapy, which emphasizes that "human systems are language-and-meaning-generating systems" (Anderson, 1997, p. 324). In particular, they suggested that problems experienced by families are created and maintained by the ways in which the family members give meaning to and

talk about the problem. Therefore, they argued that through simply engaging in conversations with clients, from a not knowing position, about the language that they use to describe their problems, therapists can facilitate natural change in therapy.

In 1978, Anderson and Goolishian, along with Paul Dell and George Pulliam, co-founded the Houston Galveston Institute, a training and therapy center, to advance their collaborative approach to therapy. Although Goolishian died in 1991, Anderson has continued to develop these ideas in a number of scholarly publications, most notably in *Conversation, Language, and Possibilities: A Postmodern Approach to Therapy* (1997) and *Collaborative Therapy: Relationships and Conversations That Make a Difference* with Diane Gehart (2006).

Evidence-Based Family Therapy: Sue Johnson and Les Greenberg

Evidence-based family therapy represents a movement that, toward the end of the 20th century, critiqued the traditional view of therapy as an art or craft and emphasized the need for therapeutic approaches to demonstrate effectiveness through the use of research methods (Nichols, 2013). This movement was focused on the importance of defining and measuring clear therapeutic outcomes and often involves the use of treatment manuals to standardize the therapy process. Examples of evidence-based family therapies are functional family therapy (FFT), developed by James Alexander; multidimensional family therapy (MDFT), created by Howard Liddle; integrative behavioral couple therapy (IBCT), developed by Neil S. Jacobson and Andrew Christensen; and emotionally focused therapy (EFT), by Sue Johnson and Les Greenberg. Of all of the evidence-based approaches to family therapy, EFT is considered the most widely researched and used.

Sue Johnson and Les Greenberg

Sue Johnson and Les Greenberg, co-founders of **emotionally focused therapy** (EFT), have had a significant impact on the further development of the field of couple and family therapy. EFT was developed in the early 1980s as an approach to couple therapy that combines systemic principles with experiential understandings of the important role of emotions in creating change in therapy. Later, Johnson would further refine EFT to include the role of attachment in adult relationships. EFT is a standardized approach to therapy that relies on research to demonstrate its effectiveness. The research outlining the effectiveness of EFT illustrates that 70% to 73% of the couples who are provided this therapy move "into recovery from distress," while 86% to 90% report "significant improvement" (Johnson & Wittenborn, 2012, p. 19). Johnson, along with her colleague Andrea Wittenborn, state that "these results have yet to be surpassed by any other form of couple intervention" (2012, p. 19).

Johnson and Greenberg are clinical psychologists who each direct clinical centers in Canada. Johnson is the director of the Ottawa Couple and Family Institute and the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). Greenberg is the director of the Emotion-Focused Therapy Clinic at York University in Toronto. They have both written extensively on the practice and effectiveness of EFT; their definitive book in this regard is *Emotionally Focused Therapy for Couples* (Greenberg & Johnson, 1988).

Summary

The field of marriage and family therapy has its roots in four sources: early social work, the sexual reform movement, marriage counseling, and the family therapy movement. Although early social work and the sexual reform movement served as influences, it was the push within marriage counseling and family therapy that organized the field. Perhaps the greatest impetus for growth came with family research on schizophrenia in the 1950s.

Initially, much of the growth in the field was due to charismatic leaders who rebelled against the typical mental health establishment. Early marriage counselors, such as Paul Popenoe and Hannah and Abraham Stone, and early family therapists, such as John Elderkin Bell, Nathan Ackerman, Don Jackson, Virginia Satir, and Murray Bowen, fought numerous battles to have their ideas accepted. The feminist, multicultural, and LGBT affirmative family therapy movements continue to challenge how we view, treat, and define families. Scholars such as Rhea Almeida, Betty Carter, Robert-Jay Green, Kenneth Hardy, Monica McGoldrick, and Julianne Serovich remind us of the vital need to continue to work to make the field more inclusive and affirming of all individuals, relationships, and families.

Suggested Readings

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Glossary

Bowen systems therapy: A form of transgenerational family therapy, founded by Murray Bowen, that views patterned behavior as being innate in all of nature.

collaborative language systems: An postmodern approach to family therapy, founded by Harlene Anderson and Harry Goolishian, that views families as language-and-meaning-generating systems.

contextual family therapy: A form of transgenerational family therapy, founded by Ivan Boszormenyi-Nagy, that focuses on the role of ethics in family relationships.

cybernetics: The science of communication and control in humans and machines.

emotionally focused therapy (EFT): An evidence-based approach to therapy, founded by Sue Johnson and Les Greenberg, that is based on the role of attachment in adult relationships to help couples strengthen their emotional bonds.

evidence-based family therapy: A movement within family therapy that emphasizes the need for therapeutic approaches to demonstrate effectiveness through the use of research methods.

experiential family therapy: A school of family therapy that focuses on human emotions and growth rather than interactional sequences.

family of origin: The family in which an individual is raised.

group therapy: A form of treatment in which individuals discuss their problems in a group setting, allowing them to receive support and feedback from the group members.

identified patient: An individual family member identified as having a specific problem and who, in fact, is representative of a larger family problem.

interactional system: A single unit in which all members interact as parts of a larger whole.

invariant prescription: A technique in which a couple is instructed to form a secret alliance separate from the other family members to break up the interactional patterns that exist in their family.

LGBT affirmative therapy: An approach to therapy that embraces a positive view of LGBT identities and relationships while also addressing the negative influences that heterosexism has on the lives of LGBT individuals, couples, and families.

live supervision: A form of training in which a supervisor behind a one-way mirror observes the trainee conduct therapy and suggests interventions while the session is in progress.

marital schism: A dysfunctional relationship pattern in which husband and wife fail to accommodate each other, constantly attack each other, and compete for their children's affection.

marital skew: A dysfunctional relationship pattern in which one spouse is always dominant and the other is submissive and dependent.

marriage counseling: A form of therapy in which a clinician meets with both spouses together to resolve problems in their relationship.

marriage and family therapy: A model of mental health treatment that takes a family perspective on emotional problems and psychopathology.

Milan systemic family therapy: A form of therapy, founded by Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Giuliana Prata, that focuses on both the interactional nature of the family and the therapist-client relationship.

multigenerational transmission process: A process by which behavioral sequences are transmitted through several generations within a family.

narrative therapy: A social constructionist family therapy, founded by Michael White, that helps clients challenge their views of themselves as the problem and helps them develop alternative stories about themselves based on their strengths.

paradox: A statement that tends to disqualify itself. For example, a husband ordering his partner to be more spontaneous disqualifies his demands, because his partner cannot behave spontaneously if she follows his orders.

pseudohostility: The false expression of anger to mask family members' needs for intimacy or for help with deeper issues of conflict and alienation.

pseudomutuality: The loss of personal identity in an attempt to maintain a sense of family togetherness.

social constructionist family therapists: This school of family therapy believes there is no objective reality, and that reality is subject to the interpretations of various groups. This means that all ideas about how a family should look, or how it should solve its problems, are subjective. Therefore, social constructionist family therapists do not tell families how to change, but rather help them find their own solutions.

social work: A branch of the mental health field that focuses on the impact of societal issues on human problems.

solution-focused therapy: A social constructionist family therapy, founded by Steve de Shazer and Insoo Kim Berg, that helps clients solve their problems by identifying naturally occurring opportunities within their lives and helping them utilize them.

strategic family therapy: A brief approach, founded by the members of the Mental Research Institute, that focuses on observing and altering the interactional sequences in which a problem is embedded.

structural family therapy: An approach, founded by Salvador Minuchin, that alters the organization of a family to enable its members to solve their problems.

symbolic-experiential family therapy: A specific form of experiential family therapy, founded by Carl Whitaker, in which the therapist attempts to have an experiential form of encounter with the client, operating at the symbolic level in order to bypass client resistance.

transgenerational family therapy: A school of therapy that believes that problems are maintained by patterns that span several generations in families.

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2

GENERAL SYSTEMS THEORY, CYBERNETICS, AND FAMILY THERAPY

Lorna L. Hecker, Grace Ann Mims, and Shelly R. Boughner

> "But I don't want to go among mad people," Alice remarked.
>
> 'Oh, you can't help that," said the Cat: "we're all mad here. I'm mad. You're mad."
>
> "How do you know I'm mad?" said Alice.
>
> "You must be," said the Cat, "or you wouldn't have come here."
>
> Alice didn't think that proved it at all; however, she went on. "And how do you know that you're mad?"
>
> "To begin with," said the Cat, "a dog's not mad. You grant that?"
>
> "I suppose so," said Alice.
>
> "Well, then," the Cat went on, "you see, a dog growls when it's angry, and wags its tail when it's pleased. Now I growl when I'm pleased, and wag my tail when I'm angry. Therefore I'm mad."
>
> Lewis Carroll
> *Alice's Adventures in Wonderland*

Family systems theory allows family therapists to examine the context in which individuals live. It is this context that shapes meaning in the lives of individuals, couples, and families. Whereas individual psychology has traditionally focused on the mind as the source of mental illness, family therapy focuses on the family

system as the source of problematic behaviors. As Alice quickly found in encountering the Cheshire Cat and others in Wonderland, mental illness can be defined by one's surroundings, or context.

In this chapter you will learn about general systems theory and cybernetic theory and the application of these theories to families. Following is a look at how these two theories came to be.

Reductionism vs. Holism

As early as the 1920s, scientists from many disciplines began to question the usefulness of **reductionism** in science. Reductionism is a theory or procedure that reduces complex data to simple terms. Reductionism is a powerful tool for understanding reality by breaking complex identities down into constituent parts, allowing significant insight into how things work.

Reductionism asks us to think about things mechanistically, or as a machine. A machine is built up from distinct parts and can be reduced to those parts without losing its machinelike character. This idea is called *Cartesian reductionism.* The success of reductionism in science cannot be ignored; most of modern science and technology is the result of reductionism.

However, this notion that everything is reducible to machinelike parts does not generally apply to complex (real) systems. One cannot reduce complex systems; reductionism limits our ability to understand complexity. The human brain similarly displays unique properties that are unrecognizable in a reductionist study of neurons and transmitters. In some sense, then, the whole is more than the sum of its parts. The same is true in understanding human beings and mental illness. Gregory Bateson (1972) pointed out that to understand a mentally ill person, one should look at the web of family communications with which that person lives.

In order to understand families, we cannot reduce them to their distinct parts. That is, we cannot study families by looking at individual members. In order to understand families, we must study the family members in relationship to one another. It is this relationship between family members that makes each family unique. When studying families, it was found that using a reductionist approach was not helpful, and that a more holistic approach better captured the complexity of families (Bateson, 1972). Although many people advanced our thinking toward a more holistic approach in mental health, three historic figures in particular were perhaps most influential in paving the way for our modern notions of family therapy. The first of these was Ludwig von Bertalanffy (1968), a biologist who developed **general systems theory**. General systems theory focuses on the relationship and interaction between the objects in a system. It provides a model for understanding living systems that is focused on how apparently unrelated events or phenomena can be seen as interrelated parts or components of a larger whole or system. The second important scientist, Norbert Wiener (1954), advanced cybernetic theory. **Cybernetics** is a term derived from the Greek word *kubernetes,* which means "steering" or "governing." Cybernetics was used to describe Wiener's

theory of communication and control. According to this theory, humans (as well as machines) attempt to control entropy (disorganization) in systems through feedback that influences future performance. Cybernetic theory considers the organization of systems and the mechanisms that regulate the system's functioning. Third, one of the most influential thinker in the field of family therapy, Gregory Bateson (1972), an anthropologist, was the person most responsible for applying both general systems theory and cybernetic theory to families.

The integration of general systems theory and cybernetics theory as applied to families shall be referred to in this chapter as systems theory. Learning about systems theory not only means studying new terms and concepts but involves a **paradigm shift** (Kuhn, 1962)—which is a shift in thinking similar to the change in thinking that occurred when Galileo proposed that the earth revolved around the sun, challenging the commonly held belief that the earth was the center of the universe. A **paradigm** is a model or conceptual scheme through which people make sense of such things as "reality" or "the world." Each paradigm provides a particular way of viewing and understanding its subject, along with corresponding methods for gaining this understanding. When family therapy originated, it provided an entirely new approach to viewing and understanding people, an approach that contrasted greatly with individual-oriented paradigms. Systems theory is a scientific paradigm applied to both biological and social systems. In this chapter, systems theory is applied to families.

The basic **tenets** of systems theory include the following (adapted from Minuchin, 1985):

1. Any system is an organized whole; objects within the system are necessarily interdependent.
2. The whole is greater than the sum of its parts.
3. Systems are composed of subsystems.
4. Patterns in a system are circular rather than linear.
5. Complex systems are composed of subsystems.
6. Systems have homeostatic mechanisms that maintain stability of their patterns.
7. Evolution and change are inherent in open systems.

Let us take a close look at each of these and what it means in the case of family therapy.

Any System Is an Organized Whole; Elements Within the System Are Necessarily Interdependent

What Is a System?

A **system** is a set of elements standing in interaction. Each element in the system is affected by whatever happens to any other element. Systems are composed of three elements: objects, attributes, and relationship among the objects within an

environment (Littlejohn, 1978, p. 31). Within a family, the "objects" are the family members. Attributes may include goals, energy, attitudes, ethnicity, and other characteristics of the family. The "relationship among objects" is how family members communicate with one another. The environment includes the surroundings that simultaneously shape and are shaped by the family. For example, the community in which a family resides, or the social class to which a family belongs, would provide the family with particular opportunities or limitations and would also reflect the family's participation as members of the community or social class. The success of the family depends on the existence and connection with other family members. Family therapists are most concerned with the relationship between the "parts" or family members (see Figure 2.1). Interaction (communication) among the parts reflects the dynamic nature of families. The study of the family must begin with a look at the relationships and interactions among family members.

What Is a Family System?

Our society has historically defined family in a fairly restricted fashion. We may think of the typical American family consisting of a mother, a father, and their children. Although this **nuclear family** form is prevalent in depictions of families in movies or on television programs, and although it is still the dominant form, it is not the only form that family therapists will encounter by any means.

One person's definition of a family may not look like a family to another. Perhaps you come from a traditional nuclear family. Or you may come from a stepfamily, foster family, single-parent family, cohabiting family, three-generation family, kinship family, or grandfamily, as well as a family in which one or more of your parents is gay. Couples without children are also families.

Fortunately, systems theory encompasses all types of families and examines the relationships among people, their attributes, and their environments. From a systems-theoretical perspective, a family is a small group of closely interrelated and interdependent individuals organized into a unit with specific purposes, functions, or goals. Thus a **family system** includes the unique attributes of the family members and the relationships between family members, as well as the family members themselves. Family systems also include **extended families**, or relatives of those making up the primary nuclear family.

We all grow up in some type of a family system. The family you grew up in is referred to as your **family of origin**. Some people who do not have family-of-origin support or extended families may make up their own family configurations based on friendships; this is termed a **family of choice**.

The Impact of Suprasystems

Larger systems also impact the family system. Unfortunately, until recent years family therapy often ignored the impact of the larger system on the family. Larger systems, or **suprasystems**, impacting families include cultural, political,

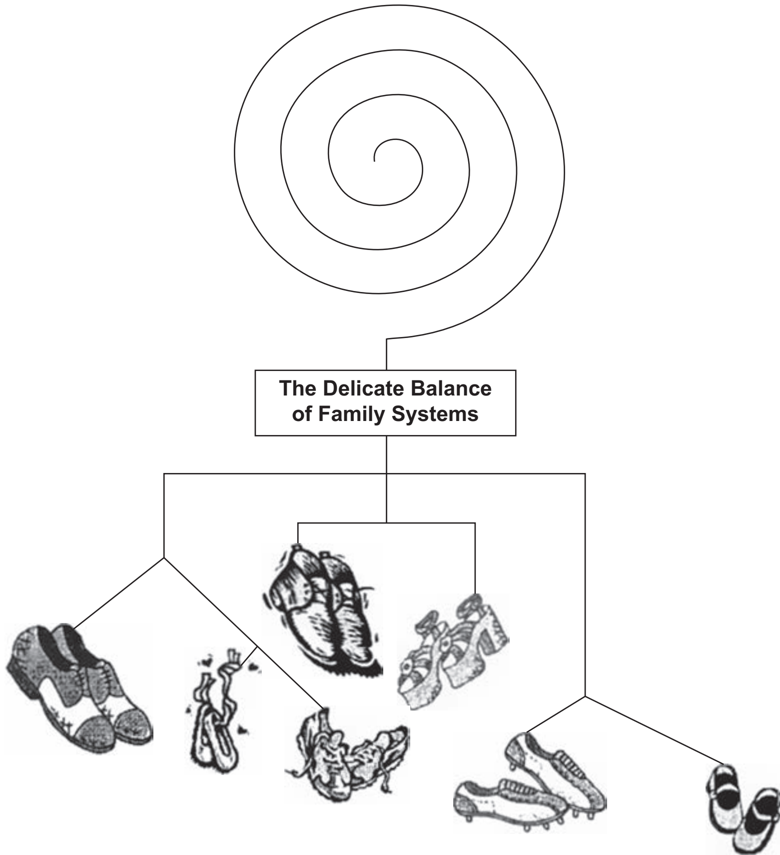

FIGURE 2.1 Understanding Interdependence. Virginia Satir encouraged people to think of families as interdependent systems and imagine them as hanging mobiles. Perhaps you had a mobile as a child that had airplanes or shapes or planets on it. Instead of objects, visualize each person hanging from the mobile. Now imagine that the wind blows a bit. Interdependence is illustrated each time one person on the mobile moves. When one person on the mobile is impacted by the wind, it impacts all the others in the mobile, and they in turn also move. The mobile is more than each hanging object; it is also the delicate balance of each part with the others. This illuminates the systems-theoretical concept that a change in one part of the system affects all parts of the system.

and economic contexts, environment (social and physical), and any other contextual systems that impact the daily workings of the family—school, ethnicity, religion, culture, community, and so on (see Figure 2.2).

For example, some people find it difficult to understand why some women remain in abusive relationships. Yet if the impact of the larger systems on a woman in an abusive relationship are taken into account, we may find that culture dictates that she stay—her ethnicity and/or religious background may

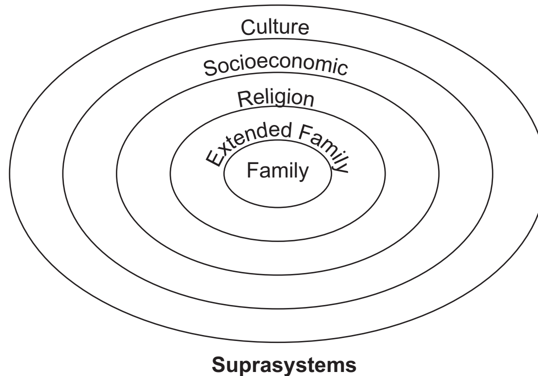

FIGURE 2.2 Larger Systems Impact the Family

place pressure on her to remain in the marriage, for example. In addition, because of political and economic constraints, women in our society generally have fewer economic opportunities than men do. Perhaps a woman in an abusive relationship has few ways in which she can support herself and her family without the income of her abusive partner. Many larger systemic factors may be influencing this woman to stay in an abusive situation. An abused male partner may face his own unique suprasystemic factors, such as societal shaming for allowing a woman to beat him; thus he also develops a cloak of secrecy and reasons to tolerate the abusive situation.

Context Alters Meaning

Those who practice family systems theory examine the context of individuals and their families in order to fully understand a problem. Context alters meaning. A reductionistic paradigm would cause one to assume the problem exists alone; a holistic family systems paradigm explores the context of the problem within family and social relationships. Because the parts of a system are interdependent for survival, family therapists look at this context and examine the relationships of those in the family system.

Let's say you begin seeing a client who wishes to reduce his obsessive behaviors, which include inspecting light switches, electrical sockets, and fire alarms several times daily. You learn he is driving his wife to the point of desperation because of his incessant checking behaviors and his inability to keep a job due to his compulsivity. In addition, he continually checks their children in the night just to be sure they are breathing. This client, if seen individually, might be diagnosed with obsessive-compulsive disorder. Yet after learning that his first wife and children died in a house fire, you consider his behaviors in light of this information. His behaviors make further sense when

you examine his present relationship and learn that his wife occasionally has too much to drink (she tries to "loosen up" with alcohol in response to his hypervigilant behaviors) and has fallen asleep holding a lit cigarette; on one occasion, they had to throw a smoldering couch cushion out of their home. All the behaviors viewed as problematic in this case make sense in the context of the relationship system.

Interdependence

Systems (or subsystems) are interdependent and do not exist in isolation. Interdependence may be thought of as every part of the system having an effect on every other part of the system. Change in one part of the system will result in change in another part of the system. Capuzzi and Gross (1999) describe the interrelatedness of systems using the metaphor of the ripple effect seen when a rock is thrown into a pond. At first, the ripple will be very small, but eventually it spreads throughout the entire pond. For example, if a teenage girl becomes pregnant, the event will probably impact not only the girl, but also the baby's father, as well as the parents of both; perhaps the girl's grandparents will be involved in helping care for the baby while she finishes high school or attends college; the social welfare system may become involved if the family needs assistance; and so on. There is a ripple effect from this event. Because family systems therapists believe in interdependence, they believe that change in one family member necessitates change in other members.

The Whole Is Greater than the Sum of Its Parts

A concept related to interdependence within systems theory is that the whole is greater than the sum of its parts. Consider: One could study hydrogen and oxygen in isolation from each other forever yet never discover water. Hydrogen and oxygen must interact before water can be achieved (Bellinger, 2000). In a human example, although a team may have very good baseball players, they may not be a winning team unless they have just the right mix of players. The combined skills of the players and their ability to work together shows synergy, or what is often referred to as nonsummativity. **Nonsummativity** is the assertion that a system is its own entity, one that is greater than the mere sum of its parts; this is often illustrated using the equation 1 + 1 = 3. If a system has two people, then it has three parts. Each person in the system is one part, and the interaction between them is the third. Within families, although several individuals make up a family, the family system takes on a life of its own when the family gets together. Each family has its own "personality." The sum—the relationships among members—is greater than simply the contributions of individual family members.

Patterns in a System Are Circular Rather than Linear

Feedback

Feedback in a family system is the process by which the input of each family member leads to a more complex, systems-oriented output. In other words, the output is not individually determined but determined by the contributions of all. With systems feedback, we assume that the malfunction of any one person is caused not by an intrapsychic breakdown, but by failure of the system itself to function properly. Typically, one person is labeled by the system as the problem. Family therapists call this person the **identified patient**, or IP. Family therapists see this person as the symptom bearer for dysfunction in the family system.

Feedback loops are the cycles by which individuals influence one another's actions. The impact that a behavior has on the system and the response of the system to that behavior are viewed in terms of positive and negative feedback. "Positive" and "negative" are not value judgments about the behavior; rather they indicate whether a change has occurred in the system. A positive feedback loop reinforces itself. If a change has occurred and has been accepted by the system, a positive feedback loop has occurred. The status quo was not maintained, so the process is referred to as positive feedback. Negative feedback, on the other hand, can lead to nearly stable behavior with gentle fluctuations, similar to a thermostat that maintains a certain room temperature. If a couple get into a fight, but each goes to a different part of the house to cool off so that they avoid saying hurtful things to each other, negative feedback has occurred. The couple became aware that the "temperature" was getting higher in the relationship than was comfortable, so they took action to correct the situation to maintain a comfortable stance with each other. Evaluating the usefulness of positive or negative feedback loops must be done contextually. Both processes may refer to something that is either helpful or not helpful to the family.

The entire system is governed by feedback loops which perform regulation and control; negative feedback tends to stabilize systems, while positive feedback tend to destabilize systems. Positive feedback may give way to pronounced change behaviors, while negative feedback counters the volatile change of positive feedback. Together, negative and positive feedback can produce system equilibrium.

Negative Feedback Example. Maria and Julio, a couple, present for couple therapy. Their primary complaint is low sexual desire. The therapist learns that whenever Julio begins to exhibit sexual interest in Maria, which he expresses by asking her whether she wants to "get it on" or "do the horizontal mambo," Maria becomes anxious. When Maria becomes anxious, she tends to do things that turn Julio off, such as talk incessantly, bite her nails, and smoke more cigarettes. The level of sexual desire remains low. In this example, the output (sexual interest) of one object of the system, Julio, becomes the input of the other object, Maria. Maria's output (doing unattractive things) becomes Julio's input (Maria's unattractive behaviors decrease Julio's sexual desire). The result

is that no change occurs. The more sexual interest Julio displays, the more anxious Maria becomes, and thus the more she engages in behaviors that turn Julio off. No matter how sexually turned on Julio becomes, the result is always the same: low sexual interest on the part of both spouses. This is an example of negative feedback—the input led to output that leads to input that maintains the status quo.

Positive Feedback Example. Dwayne is jealous and suspicious of his wife, LaShonda. When LaShonda has a business lunch with a male colleague, Dwayne becomes suspicious and distrustful of LaShonda. Dwayne's jealousy makes LaShonda defensive and antagonistic; she tries to conceal innocent things from Dwayne to avoid arousing his jealousy. Yet her defensiveness and efforts at concealment only fuel Dwayne's jealousy. The more jealous Dwayne becomes, the more defensive and surreptitious LaShonda becomes. Thus, Dwayne becomes more and more jealous. Here Dwayne's output, jealousy, becomes input for LaShonda: she responds with defensiveness. LaShonda's output (defensiveness) becomes input for Dwayne, who responds with increased jealousy. The result is that an original small jealousy is magnified and becomes raging jealousy.

Distinguishing Between Positive and Negative Feedback. Whenever Ben begins to become angry, it makes his partner Norman become more detached. The angrier Ben becomes, the more detached Norman acts. If Norman's detachment has the result of cooling Ben down, we would have an example of negative feedback: As Ben becomes angry, Norman backs off and this decreases Ben's anger, and soon neither partner is angry (the feedback system eliminates the anger). If, on the other hand, Norman's detachment just makes Ben angrier, we have an example of positive feedback: the angrier Ben becomes, the more detached Norman becomes, and Norman's increasing detachment and coolness fuels Ben's anger, so that Ben's anger continues to escalate (the feedback system magnifies the anger).

Stability/Adaptability

Change is something that families must embrace at times and avoid at other times. In order to avoid disintegration and chaos, a system must balance stability with adaptability. A system's ability to remain stable in the context of change and to change in the context of stability is central to its survival. A system has two mechanisms that operate simultaneously to achieve this balance. **Morphostasis** is a system's tendency toward stability or a steady state. The system must engage in regulation and control as well as manage its position in the supra-system. Such regulation and control contribute to order and to a state of dynamic **equilibrium** for the system. At the same time, the system has a mechanism that allows for growth, creativity, innovation, and change, called **morphogenesis**. Becvar and Becvar (1996) describe

these as two sides of the same coin. Keeney (1983, p. 70) illustrates the interrelatedness of morphostasis and morphogenesis with his statement "change cannot be found without a roof of stability over its head. Similarly, stability will always be rooted to underlying processes of change" (as quoted in Becvar & Becvar, 1996).

Linear vs. Circular Causality

As in the previously noted negative and positive feedback examples, input in a family system leads to output that is fed back into the system, thus becoming input to the family's or couple's next output. This circular process is important in understanding family systems. In family systems thinking, a circular process is involved in the feedback model of causality. Viewing reality from this circular model of causality means that events are multicausal and reciprocal. Circular causality is very different from how our society typically understands events. Most of us are trained to think in terms of **linear causality**, or *A causes B* (see Figure 2.3). You can make the paradigm shift from linear to circular thinking by thinking about two or more people rather than one. Whenever we describe a person, we are also describing one part of an interaction. For example, if we describe the father in a particular family as "controlling," we can't stop with that "one-way" (i.e., linear) description of the interaction. Systems thinkers also want to understand what the father is reacting to—perhaps a teenage son whose behavior the father believes is "careless." Now we can broaden our descriptions to include a "two-way" interaction. When the son behaves carelessly, the father becomes controlling; the more controlling the father becomes, the more careless the son becomes. Understanding the reciprocal component of any interaction is central to circular, systemic thinking. This is often more formally referred to as **circular causality** (see Figure 2.3). A's behavior is the logical outcome of B's behavior, and B's behavior is the logical outcome of A's behavior. In this case, the son's carelessness is the outcome of the father's overcontrolling behaviors, and the overcontrolling behaviors are a function of the son's carelessness. Both influence and are influenced by each other simultaneously.

Consider circular causality in terms of a coin (see Figure 2.4). The father's "controlling" behavior is related to the son's "careless" behavior in that both behaviors can be described as different approaches to risk taking (the coin). One side of the coin represents minimum risk taking, while the other side of the coin represents maximum risk taking. One way circular causality concepts are utilized

FIGURE 2.3 Linear vs. Circular Causality

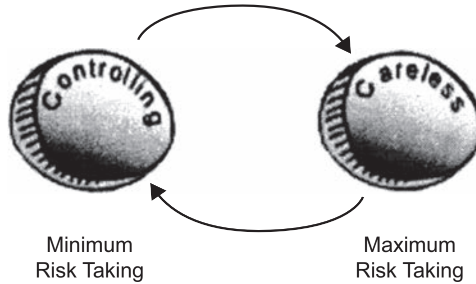

FIGURE 2.4 Circular Causality. This figure represents two sides of the same coin. The father takes minimum risks; the son takes maximum risks. The more careless the son becomes, the more controlling the father becomes in his efforts to protect his son. The more controlling the father becomes, the more the son rebels by taking more risks. The more the son rebels, the more the father controls the son, and so on, causing a vicious cycle. This mutual influence is called circular causality.

in family therapy practice is through **positive connotation** (see Box 2.1 for further explanation of positive connotation).

Family therapists understand relationships from a circular causality perspective. If a woman comes to therapy complaining that her husband just watches television and does little with the children, we might think that her husband's behavior is causing her unhappiness (linear causality). But with circular causality in mind, we look further and examine the relationship pattern. We might find that in the past, when the husband has become more involved in chores and interaction with his wife, she has criticized his performance. Therefore, he has withdrawn in response to this criticism. The more the husband withdraws, the more lonely and unsatisfied the wife feels, and the more she complains. The more she complains, the more he withdraws into the solace of television programs, and so the reciprocal process continues.

BOX 2.1. Putting Theory into Practice: The Art of Positive Connotation

One final helpful tip for understanding systems theory is to utilize the art of positive connotation. As in the case presented involving a father and son, if we want to influence the interaction between father and son we will need to alter the connotation of each of their behaviors so that they can think differently about their interactions. For example, if we continue to call the father "controlling" and the son "careless" then we are discounting the positive intentions each one has toward the other. As an alternative, we might say that the father is frightened about his son's safety and would be devastated and unable to forgive

himself if anything were to happen to his son. The son now can view his father as deeply concerned for him, which allows the son to respond to his father differently than when he believed his father was trying to control him. Similarly, the therapist can remind the father that he had to take risks in order to attain the success he has in life; likewise, his son is taking risks. If the therapist reframes the son's "carelessness" as an attempt to learn how to take risks, the father may see him as capable and behaving in a way that ultimately could lead to success in his adult life. The therapist could then encourage the father to teach the son methods of risk taking that are likely to have good results.

Positive connotation is central to the work of family therapy as we seek to understand a system and how each part affects and is affected by every other part. The use of positive connotation helps us have empathy for a family rather than blaming or criticizing particular family members or the entire family. Systems theory views a problem as an indication that something is not working effectively within the family structure or process. A *structural symptom* points to problems in the system's hierarchy, boundaries, subsystems, rules, and so on. A *process symptom* points to problems in the family interaction, such as emotional reactivity and ineffective communication. The goal is to understand the context within which a problem fits, examine the patterns maintaining that problem, and then change the context.

Complex Systems Are Composed of Subsystems

Within a family system are smaller, self-contained, but interrelated **subsystems**. For example, parents in a family constitute a **parental subsystem** that has its own set of rules, boundaries, and goals. The same parents may also be married and form yet another subsystem known as a **spousal subsystem**. Brothers and sisters, stepbrothers and stepsisters, half-brothers and half-sisters all are different formations of the **sibling subsystem**. The concept of hierarchy (as you shall see in Chapter 4 on structural family therapy chapter) refers to the fact that any complex system is also a subsystem of a higher-order system. For example, the local school district, religious community, medical community, and business community are subsystems of the larger community for each town or city in the United States. Just as cities have within them subsystems, so do families.

One other subsystem is the **personal subsystem** and its components. Each person has biological, cognitive, emotional, and behavioral components that constitute the individual (Kantor & Lehr, 1976) and impact the other subsystems and systems, and conversely these systems impact the individual's personal subsystem.

Systems Have Homeostatic Mechanisms That Maintain Stability of Their Patterns

Family Patterns

All systems exhibit patterns that are recursive in nature. Patterns are habitual, redundant ways of behaving and communicating in relationships. Systems are made up of interactional patterns that tend to repeat themselves. All systems want to maintain equilibrium or a steady state. As a result, these patterns lead to predictability that an interaction will end the same regardless of the way it began—regardless of the topic or content (i.e., input) of the interaction. For example, most teens could predict how their parents would react to them staying out all night without calling home. These teens understand how their family system would show a pattern they are likely to be able to predict. Another salient example is when a family member or partner just has to give you a "look" and it seems to start an argument. The "look" itself is a predictor of an interactional pattern, reflecting circular causality. All systems have patterns of interaction that can become predictable over time. **Homeostasis** in a family is the desire to maintain stability or the status quo. Humans tend to like predictability; this predictability lends itself to homeostasis.

Rules and Roles

Family rules and roles help maintain stability. **Family rules** are understandings or agreements in families that organize the family members' interactions. Rules may be overt or covert. Examples of **overt rules** are "In our family, we go

to church every Sunday" and "Those who do not do their chores do not get their allowance." **Covert rules** are those that are implied but not overtly stated, such as "Never challenge your mother" and "Don't have sex until you are married."

Family **roles** are individually prescribed patterns of behavior reinforced by the expectations and norms of the family. These roles may be defined by gender, by talents, by abilities, and so on. A father's role may be to stay up late with sick children because he can manage on less sleep than his wife. Roles can be about tangible tasks, or they can be more about ascribed traits, such as the role of the "black sheep," the "clown," or the "achiever."

Boundaries

Boundaries are the defining parameters of both individuals and systems. A system boundary may be thought of as the point at which data (e.g., output) flow from one system into another (e.g., input). In family systems theory, boundaries determine who is part of and who is not part of a particular system. Boundaries may separate subsystems, generations, or the identity of families.

The degree to which data are free to flow from one system to another defines the **permeability** of the boundary. A permeable boundary allows data to flow freely, resulting in an open system. An impermeable boundary is one that strictly controls (or even refuses) the acceptance or dispensing of data, resulting in a closed system.

In family systems it is sometimes difficult to distinguish between subsystems, which may point to either a lack of boundaries or **diffuse boundaries**. For example, it is not uncommon to see a child as part of a parental subsystem. A child may have been "parentified" because he or she is the oldest and is expected to take care of younger siblings with little consideration for his or her needs by the parents. Or perhaps one parent is not functioning in the parental role, as may be the case if one parent is struggling with substance abuse. In such a case, a child may try to fill the role and become part of the parental subsystem. In other instances, **rigid boundaries** exist and family members are so separate that it is difficult to tell that members are part of the same family. For example, there may be little communication between parents and children, as depicted in the saying, "Children are to be seen and not heard!" See Figure 2.5 for a continuum that demonstrates the range of family boundary variations.

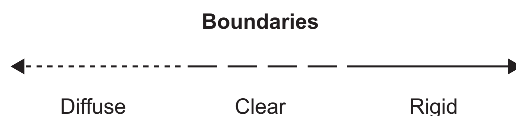

FIGURE 2.5 The Range of Possible Boundaries Within a Family

Evolution and Change Are Inherent in Open Systems

Systems can be closed or open. **Closed systems** have no interchange with their environments. For example, machines are closed systems. They do not exchange energy with the environment. Consider a windup alarm clock. The system of this alarm clock is closed. The alarm clock does not exchange energy with its environment. Without the help of a human hand to wind it, it will stop running. **Open systems** exchange matter, energy, or information with their environments. Most biological and social systems are open systems. Plants are an example of open systems. The environment provides the plant with moisture and food, and the plant provides the environment with oxygen. Each influences the other.

Family systems are open systems. "An open system is a set of objects with attributes that interrelate in an environment. The system possesses qualities of wholeness, interdependence, hierarchy, self-regulation, environmental interchange, equilibrium, adaptability, and equifinality" (Littlejohn, 1983, p. 32). Families have constant interchange with their environment. Values encouraged at school, work, or religious institutions influence values at home, and vice versa. For example, a child comes home from school one day making fun of a schoolmate for being different. The parents respond with a discussion of tolerance and compassion for those who are different; the child, in turn, goes back to school and shares these ideas with other children, who then filter this information to their families.

Families influence their environments; at the same time, those environments influence the families. A family's **adaptability** is its ability to adjust its patterns in response to changing conditions, such as developmental or situational crises or occurrences. For example, a family that makes curfew later for a teenager who has been responsible but desires to stay out a little later is showing adaptability to the child's changing developmental needs. Families must change and restructure themselves in order to survive and thrive. **Equifinality** is the ability of a family to achieve similar goals, but in different ways. For example, not all parents parent alike. Yet families with different parenting styles may have children who behave in an acceptable manner. This illustrates the ability of family systems to achieve the same goals, but by various routes. The opposite of equifinality is **equipotentiality**. Equipotentiality occurs when the same cause can produce different results. Both equifinality and equipotentiality refer back to the notion that there are no single causes or effects in systems theory.

Sometimes families minimize interchange with their environment, especially if that environment is seen to threaten the integrity of the system. For example, the Amish have strong boundaries between the outside world and their world in order to preserve their cultural and religious ideals. On the negative side of a closed system, some families may wish to protect a secret, such as physical or sexual abuse, and thus avoid the outside world so that no one will know what is occurring in the family (see Figure 2.6).

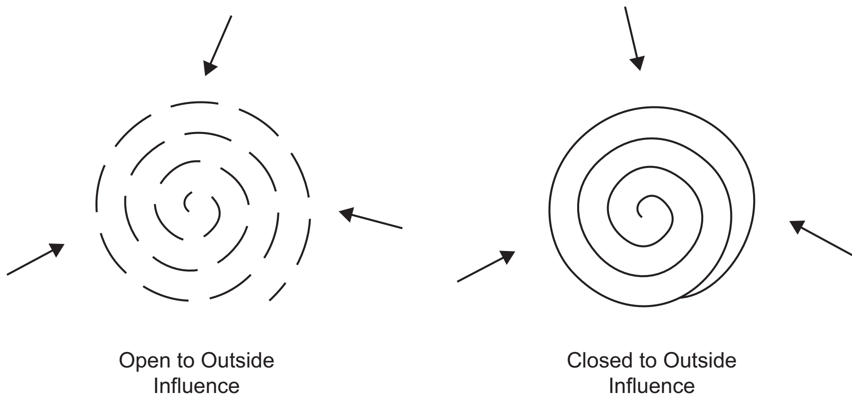

FIGURE 2.6 Open and Closed Family Systems

A system at either extreme (totally open/totally closed) is in maximum disorder and disintegration, referred to as **entropy**. A system must find a balance of permeable boundaries so that it can be open to receive the information it requires to survive and shut out information that threatens the system's integrity. Such a balance is called **negentropy**; it indicates a system at maximum order. Typically, family therapists encounter families in a state of entropy, and it is their job to help restore negentropy to the family system.

Information Exchange

Open systems exchange information with their environment. Families exchange information through behavior and communication. All behavior is communication, and it is impossible not to communicate (Watzlawick, Beavin, & Jackson, 1967). Even as you are sitting reading this book right now, you are communicating to those around you—perhaps you are showing that you are studying (by your silent reading), that you are bored (by yawning), or that you are interested (by the look on your face as you read). Communication serves as input and output in the system.

There are two types of communication: digital and analogic. **Digital communication** is the verbal mode of communication: the spoken word or content of the communication. **Analogic communication** is the combination of nonverbal communication mode (e.g., vocal tone, vocal inflection, gestures, facial expression, and body posture) and the context of the message. Analogic communication is of more interest to family therapists, because this communication tells us about interpersonal relationships.

In a family therapy session, the therapist is typically looking at the **process** of communication and trying to decipher what it means regarding the family

relationships. The **content** of what is said is much less important than how it is said.

For example:

- If someone says, "Hey, we should get together sometime," in a cheery tone with a friendly smile, you would probably consider that an invitation to do something fun with this person.
- If someone says, "Hey, we should get together sometime," with little passion or interest in his or her voice while looking away, you might think he or she is being polite but is uninterested in truly getting together.
- If someone says, "Hey, we should get together sometime," from behind bars as you are walking down a prison aisle, you might interpret this message in an altogether different way.

The digital communication (content) is the same in all three examples, but the analogic communication is different.

If the process and content of the message are not *congruent,* a **double message** can occur. If someone says, "You really look nice today," but rolls his or her eyes sarcastically while saying it, you are receiving a double message. Communication is key to any form of psychotherapy.

Family therapists look to communication to regulate the family system. Although content is important for the family therapist to consider, he or she will be continually monitoring the communication process of the family, since this is where input and output in the system occur.

From Systems Theory to Family Therapy Theories

Systems theory is the foundation for understanding the majority of family therapy theories presented in the remainder of this book. This theory is provided as the starting point for an important paradigm shift from linear to circular thinking, so that when you conceptualize a family you will focus on the family members' interrelatedness and their interactions rather than on the individual family members. In addition, systems theory helps us understand the tremendous balancing act families must perform to achieve being close and yet separate, stable yet adaptable, open yet closed, and the same yet different—all at the same time. Finally, systems theory orients us to discover the context of any family problem or symptom to give it meaning and understand its function for the entire system.

Each model of family therapy presented in this book represents an emphasis on a different part of systems theory, with the exception of the social constructionist theories presented in Chapter 6, and to a lesser extent, the cognitive behavioral theories discussed in Chapter 8. For example, structural family therapy attends to the family structure by looking at its rules, boundaries, and hierarchies.

Strategic family therapy attends to interactional patterns and positive feedback mechanisms. Because each theory emphasizes a different part of a family's process or structure, unique interventions from each theory are designed to impact various aspects of the family system. Some models of family therapy emphasize the importance of having all family members in the room; others believe that there is a ripple effect with the system, so having all family members in therapy together is unimportant. The latter believe that changing one or more family members will create change in the entire system. It may help to think of this emphasis on various family therapy theories or models from the systems-theoretical viewpoint of equifinality: since similar outcomes may have different origins, family change can occur through many different types of family therapy.

Whatever the theoretical model of treatment chosen, family therapy typically has the following hallmarks:

- No family member is singled out as the patient or "sick one."
- Family therapists usually see families conjointly rather than individually.
- Diagnosis and goals are based on the family, not on individuals.

This chapter has introduced you to family systems theory, which was derived both from general systems theory and cybernetic theory. Systems theory was derived from a revolt against the reductionist thinking that permeated science in the early 20th century. It provided science with a more holistic way to look at complex phenomena. Gregory Bateson, basing his work on the ideas of Norbert Wiener (1954) and Ludwig von Bertalanffy (1968), did much to bring these theories to the forefront of families and was a pioneer in understanding mental illness in the context of the family system.

Glossary

adaptability: The ability of a (family) system to change its patterns concurrent with changing conditions.

analogic communication: Communication not with words, but via nonverbal, paraverbal, and contextual aspects of interaction. Analogic communication has connotative meanings. In family therapy, it is the *process* of communication.

boundaries: Abstract or physical dividers between or among systems and subsystems. Boundaries define who is part of and who is not part of a particular system.

circular causality: Refers to a nonlinear, circular sequence of events whereby one event modifies another event, which in turn modifies another event, which eventually modifies the original event.

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closed system: A system that has no interchange with its environment.

content: Spoken or written words; in communication, what is said. *See* DIGITAL COMMUNICATION.

covert rules: Rules that are implied but not overtly stated.

cybernetics: The science of communication, control, and feedback; the study of the self-regulating properties of systems.

diffuse boundaries: Boundaries that are overly permeable. In families, diffuse boundaries cause distances to decrease and roles to become blurred.

digital communication: Verbal mode of communication, with denotative meaning. Digital communication takes place via spoken or written words.

double message: Occurs when the process and content aspects of a message are not congruent.

entropy: A system's tendency to move toward disorganization.

equifinality: The principle that similar outcomes may result from different origins. In family systems theory, this refers to the ability of a family or families to achieve similar goals in different ways.

equilibrium: Balance in a system that keeps it stable.

equipotentiality: The ability of the same process to produce different results.

extended family: Relatives of those making up the primary nuclear family.

family of choice: Individuals outside of one's biological family that one chooses to also consider family.

family of origin: The family one grew up in.

family rules: Understandings or agreements in families that organize the family members' interactions.

family system: Includes the family members, the unique attributes of the family members, and the relationships among the family members.

feedback: Any reciprocal flow of influence.

feedback loop: A circular causal process in which a system's output is returned to its input.

general systems theory: A theory that defines relationships of objects or individuals within biological, economic, or physical systems.

homeostasis: Occurs when a system maintains stability or the status quo. Refers to the tendency of families to develop recurring interactional patterns to maintain stability and balance.

identified patient: The symptom bearer for dysfunction in the family.

linear causality: The idea that one event is the cause and another is the effect.

morphogenesis: The tendency of a system to evolve and to change its structure; refers to constructive, system-enhancing behaviors.

morphostasis: The tendency of a system to retain its organization or to maintain the status quo.

negentropy: Emergence of organizational patterns.

nonsummativity: The assertion that a system is a separate entity greater than the sum of its parts. A synergistic effect that occurs in systems.

nuclear family: A family consisting of a father-mother-child (or mother-father-children) triad.

open system: A system that exchanges matter, energy, or information with its environment.

overt rules: Rules that are stated.

paradigm: A model or conceptual scheme through which people make sense of their reality or world.

paradigm shift: A shift in thinking when one conceptual worldview is replaced by another.

parental subsystem: The executive functioning unit of the larger family system; it can include parents or parental figures.

permeability: The degree to which data are free to flow from one system to another through boundaries.

personal subsystem: Systems are composed of individuals. Each person has a system that includes his or her biological, cognitive, emotive, and behavioral components, making that individual a subsystem of the larger system. The individual impacts the family system, and the family system impacts the individual, including his or her biology, cognitions, behaviors, and emotions.

positive connotation: Occurs when a therapist relabels a behavior positively so that the family can see the symptom in a new light.

process: How one communicates and the context in which one communicates. Process gives one information on how to interpret content. *See* ANALOGIC COMMUNICATION.

reductionism: A theory or procedure that reduces complex data to simple terms.

rigid boundaries: Boundaries that are impermeable, making communication across subsystems difficult.

roles: Individually prescribed patterns of behavior reinforced by expectations and norms (of the family).

sibling subsystem: A family subsystem made up of the siblings of the family.

spousal subsystem: A family subsystem made up of the two spouses.

subsystems: Smaller, self-contained, but interrelated systems within a (family) system.

suprasystems: The larger systems that surround a (family) system.

system: An entity that maintains its existence through the mutual interaction of its parts.

tenets: Principal beliefs or doctrine.

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3

CONTEXTUAL ISSUES IN COUPLE AND FAMILY THERAPY

Gender, Sexual Orientation, Culture, and Spirituality

Lindsey M. Weiler, Kevin P. Lyness, Shelley A. Haddock, and Toni Schindler Zimmerman

Rather than gender being a peripheral issue, gender is the basic category on which the world is organized.

Rachel T. Hare-Mustin
Women and Families

Having GLBTQ members in families does not make them inherently problematic; in fact, the problems faced by these families are mainly reflective of the heterosexist, homophobic world in which they live.

Jerry Bigner and Andrew Gottlieb
Interventions with Families of Gay, Lesbian, Bisexual, and Transgender People

Cultural identity has a profound impact on our sense of well-being within our society and on our mental and physical health.

Monica McGoldrick, Joe Giordano, and Nydia Garcia-Preto
Ethnicity and Family Therapy

A system of values and shared beliefs that transcends the limits of family members' experience and knowledge enables better acceptance of the inevitable risks and losses in living and loving fully.

Froma Walsh
Spiritual Resources in Family Therapy

Increasingly, scholars and practitioners have given attention to contextual issues in the practice of couple and family therapy. In the past two decades, issues of **gender**, **culture**, and **spirituality** have emerged as critical therapeutic considerations (McGoldrick & Hardy, 2008; Nichols, 2013; Walsh, 2009, 2011). Much of the discussion about gender and culture has been driven by the feminist critique of the field (Leslie, 1995). More recently, issues of sexual orientation have finally "come out of the family therapy closet" (Nichols, 2013, p. 219). Advances in tolerance and acceptance have allowed this issue to emerge as an important context from which to view individuals and families.

Historically, one of the primary criticisms of family therapy was the failure of family therapy to see relationships *in context* (Taggart, 1985). Fortunately, as family therapy has evolved, therapists have come to recognize the powerful influence that context has on individuals and their relationships. Individuals and families live in a society in which contexts such as gender, sexual orientation, culture, and spirituality are important and life shaping. To ignore the influence of these issues is to do a disservice to families. For instance, a large body of literature shows that egalitarian couples are more satisfied in their relationships (Gottman & Silver, 1999; Larson, Hammond, & Harper, 1998; Rabin, 1996; Schwartz, 1994; Steil, 1997) and that spiritual rituals can improve health and healing (Hill & Pargament, 2003; Koenig, McCullough, & Larson, 2001; Walsh 2009). On the other hand, negative consequences occur when individuals develop intimate relationships based on **power** differentials (e.g., Canary & Stafford, 1992; Erickson, 1993; Gottman, 1991; Rabin, 1996) or hold harmful religious beliefs regarding homosexuality (Long & Andrews, 2011).

Many scholars argue that contextual issues should be overarching principles that are infused throughout all models of individual, couple, and family therapy. One direction the field has taken is to look at contextual issues as **metaframeworks** (Breunlin, Schwartz, & Mac Kune-Karrer, 1997). One way to think about a metaframework is as an umbrella. The domains of gender, sexual orientation, culture, and spirituality can each be seen as an umbrella that "covers" all of the other theories of marriage and family therapy. Therefore, it is important to think about each domain regardless of whether you are working from a solution-focused, structural, or narrative perspective (see Figure 3.1).

Couple and family therapists (CFTs) should view each chosen theory under the umbrella of gender, sexual orientation, culture, and spirituality to promote competence and provide protection from biases. Not only should CFTs use the umbrella, but they should keep it fully open, bringing these issues into therapy directly. An open umbrella attends to, and brings, the issues to the forefront of therapy. On the other hand, a closed umbrella encourages stereotypes by supporting the status quo, and it contributes to the continued discrimination of individuals and families based on gender, sexual orientation, culture, and spirituality. All therapists' behaviors lie somewhere along a continuum of closed to

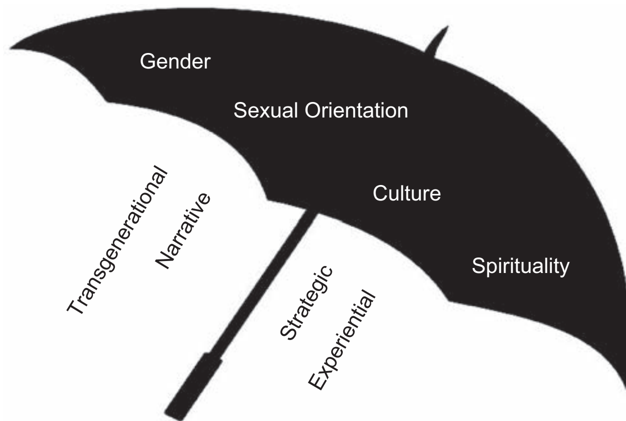


FIGURE 3.1 The Umbrellas of Gender, Sexual Orientation, Multiculturalism, and Spirituality

open umbrellas, and our hope is that all therapists will feel confident with an open umbrella.

In this chapter, you will become familiar with the history of our field's struggles with opening the umbrella, with assessment techniques and interventions for addressing these issues, and with research that relates to each area.

Gender

Gender refers to "the psychological, social, and cultural features and characteristics that have become strongly associated with the biological categories of male and female" (Gilbert & Scher, 1999, p. 3). Elijah Nealy (2008) describes gender similarly, as composed of the following: one's biological sex, social expectations of gendered acts within his or her gender role, and one's self-conception of his or her gender identity. There is a growing body of literature that provides support for a definition of gender that is understood as a continuum. As therapists, viewing gender on a continuum allows us to challenge the gender binary (i.e., female vs. male) that marginalizes individuals who fall somewhere in the middle. **Transgender** refers to individuals whose gender identity is different from the gender socially assigned to them because of biological sex (Morrow, 2008). However, as Arlene Istar Lev (2004) highlights in her book *Transgender Emergence,* the term "transgender" should not be confused with **transsexual**. She quotes a transsexual client who stated: "I'd rather get wet than be under [the transgender] umbrella" (p. 6). Thus, it is necessary to speak with our clients about their self-identified meaning of gender.

There is perhaps no place in American society where dichotomous gender expectations are more prevalent than in the family (Haddock, Zimmerman, &

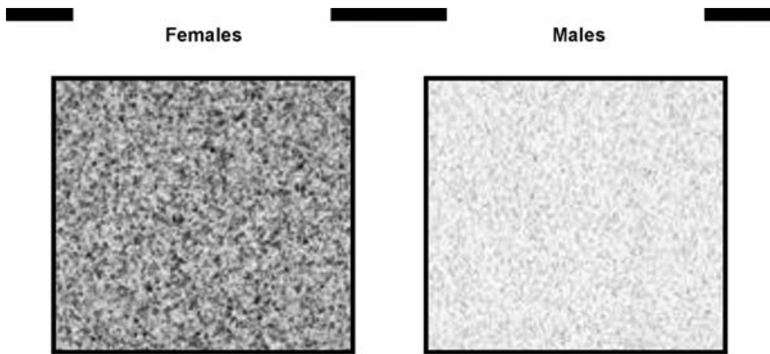
Lyness, 2003). Our society is filled with gender messages about who we should be and who we should not be. For example, men are typically assigned the *public sphere* of work, and women are assigned the *private sphere* of homemaking, child care, and maintaining family relationships. Within this viewpoint, each gender is also expected to have qualities that will help them in these spheres (e.g., men should be stoic and women should be nurturing). These gender messages often serve to keep people stuck in a "gender box" and increase power differentials between men and women. See Box 3.1 for an exercise in gender stereotypes. Also see the Fairness for All Individuals through Respect (FAIR) website (www.fair.chhs.colostate.edu) for additional exercises in the "Big 8" social identifiers that influence a person's social standing.

Many of these gender messages also tell us who we should be within our relationships and our families. For example, men are seen as less emotional, even though they may have the same internal experiences as women (Gottman & DeClaire, 1997), and women are often socialized to believe good mothers should not work, yet a mother who works may have positive effects on children (Crosby, 1991; Galinsky, 1999). Similarly, couple and family therapy theories have been guided by these messages about what is appropriate within the family. For example, when a heterosexual couple seeks therapy and the female partner assumes more responsibility for making changes, many therapists perpetuate this cycle by expecting more of the woman and allowing the man to take on a lesser role (Almeida, Dolan-Del Vecchio, & Parker, 2008). It is critical to question these societal ideals about what is believed to be normal, especially as we embrace a more fluid definition of gender roles. Recently, scholars have argued for a shift toward gender reconstruction in which heterosexual, lesbian, and gay couples can work toward meaningful, flexible definitions of who they are along the gender continuum (Prouty & Lyness, 2011).

The Feminist Critique of Couple and Family Therapy

The feminist critique of family therapy began in the 1970s (Hare-Mustin, 1978; Humphrey, 1975), and Hare-Mustin's article in particular was seen as an impetus for heated dialogue within the field. This article not only challenged the theories of family therapy, but also served to challenge the very definition of the family. In fact, much of the early feminist critique focused on the traditional definition of the family. The family was traditionally defined in family therapy as it was in the larger society; that is, men should be in the public sphere and women in the private sphere. In this type of family, the power of the man is guaranteed by societal expectations that he will be older, more educated, of higher social status, and more economically viable than his female partner (Hare-Mustin, 1978). By not challenging this definition, the family therapy field devalued women and "women's work" and supported harmful power imbalances. Because family

BOX 3.1. In the Box/Out of the Box Exercise



In small groups, brainstorm traits, characteristics, attitudes, and/or behaviors that society encourages for each gender. These are "in the box" items. For example, "in the box" traits for females might include nurturing, emotional, passive, and want children, while "in the box" traits for males might include aggressive, rational, enjoy sports, and unemotional. Come up with as many traits for each gender as you can. Often these are stereotypes that govern behavior.

The next step is to discuss what consequences women and men experience for stepping "out of the box." Consequences might include what others would say (e.g., a woman who is "out of the box" is referred to as a "bitch," while a man who steps out of the box might be called a "wimp" or "fag") or personal consequences (e.g., feeling strange or empowered). Consequences can be both positive and negative. Explore the following: What are the benefits of stepping "out of the box"? What are the benefits of staying "in the box"?

Next, consider the benefits and consequences of "in the box" versus "out of the box" behavior for couples and families. For example, "in the box" behaviors encourage women to have less say about major aspects in their lives (e.g., finances, careers) and encourage men to feel overly responsible for breadwinning and underinvolved in parenting.

Finally, consider how couples need to find a "common gender box" where they can interact with less constraint and conflict. Examples of "common box" behaviors include interdependence, assertiveness, and a sharing of major life responsibilities (e.g., child care).

Source: Adapted from Creighton and Kivel (1992).

therapy focused on building families that conformed to the traditional model, family therapy itself was seen as supporting male power and privilege and pathologizing families that did not fit this mold.

Family therapy has been criticized by feminists for its adherence to theories of **circular causality**. In particular, Taggart (1985) raised the question of whether circular causality and traditional forms of systems theory inhibited the development of gender equity in family therapy. Circular causality, neutrality, and complementarity fail to account for imbalances of power within relationships. That is, it is assumed that each part of the system carries the same weight in contributing to problems and to change; that patterns of behavior are mutually reinforcing; and that roles are equal though different. Yet, they bypass questions of responsibility and the possibility of external influences, such as cultural beliefs about gender behavior (Nichols, 2013). In fact, within many relationships, each partner does not have the same options for behavior, due to differences in power. This is particularly salient within the family, where traditional roles give one partner all the power. For example, when one partner has all, or much, of the economic resources within the relationships, he or she has the most power. A severe example is in cases of intimate partner violence, in which men have more physical power than women do (Benokraitis, 1999; Bograd, 1999). For example, women are more likely than men to be assaulted by an intimate partner, experience sexual violence, and be subjected to abuse of power and control (Coker et al., 2002). Power has been a key issue in the feminist critique, particularly in challenging how the field views therapy.

Relatedly, early family therapists attempted to remain neutral so as not to impose their ideals of family functioning on others, a concept referred to as **therapeutic neutrality** (Bograd, 1986). One criticism of neutrality is that it can result in supporting the status quo. In other words, not taking a stand against power imbalances and gender inequity can result in silently supporting it. As such, feminist-informed family therapy seeks to bring about changes to reduce or eliminate such inequities. Brimhall and Butler (2010) discuss the evolution of neutrality and argue for a more balanced approach. That is, attending to family dynamics in lieu of gender socialization would be a mistake, and believing that gender socialization is not influenced by family dynamics is equally erroneous.

Since the feminist critique of family therapy began, much has changed in family therapy. Many introductory graduate texts for family therapy have sections discussing either the feminist critique and/or gender sensitivity in practice (e.g., Becvar & Becvar, 2013; Goldenberg & Goldenberg, 2000; Nichols, 2013).

A Note About Feminism

Feminism has multiple definitions and complexities. However, at its core is "a recognition of women's subordination and inferior social position, an analysis of the forces that maintain it, a commitment to changing it, and a

vision of future equality between men and women" (Avis, 1986, p. 221). One does not have to be female to agree with or practice feminist principles. However, not paying attention to issues of gender in therapy will result in less effective therapy (Gottman & Silver, 1999; Schwartz, 1994). It is important to point out that men as well as women benefit from such a model (see Bograd, 1991). Indeed, couples who demonstrate flexibility within their gender roles are more likely to fare better (Knudson-Martin & Laughlin, 2005). Power imbalances within relationships have been linked to lack of intimacy and engagement for both partners (Horst & Doherty, 1995; Rabin, 1996; Steil, 1997). Feminist-informed family therapy is necessary for effective therapy, as well as for balanced and collaborative relationships (Gottman & Silver, 1999; Rabin, 1996).

Gender and the Practice of Couple and Family Therapy

A gender-aware approach to therapy includes the following:

- Recognition of *oppression* based on gender, race, and class (McGoldrick, Giordano, & Garcia-Preto, 2005; McGoldrick & Hardy, 2008)
- Valuing the *female perspective* (Gilbert & Scher, 1999; Whipple, 1996) and focusing on *women's empowerment* (Haddock, Zimmerman, & MacPhee, 2000; Rader & Gilbert, 2005)
- Reducing *power* differentials between clients and therapists (Gilbert & Scher, 1999; Haddock et al., 2000; Whipple, 1996)
- Promotion of *egalitarian* relationships (Worell & Remer, 2003)
- Ongoing therapist *self-examination* of values (Mac Kune-Karrer & Weigel Foy, 2003; Prouty & Lyness, 2011)
- Identifying clients' *internalized societal and familial sex-role messages* and *beliefs* (Worell & Remer, 2003)
- Challenging and replacing *sex-role stereotypes* (Worell & Remer, 2003)

Gender-aware or gender-informed therapy seeks to value all clients' experiences while seeking to reduce power differentials, both within couples and within the therapeutic system. In exploring specific ways to work with clients from a gender-aware perspective, there are two major areas of focus: assessment and intervention. Throughout assessment and intervention with couples and families, therapists have an obligation to be aware of how gender is affecting the presenting problems. One way to help therapists focus their attention is through the Power Equity Guide (see Haddock et al., 2000; Haddock & Zimmerman, 2001), a tool to highlight feminist-informed approaches to summarizing the therapeutic approach, treatment planning, and evaluating therapists within supervision.

Assessment

Many authors have noted the importance of assessing gender dynamics in the initial stages of couple and family therapy (Breunlin et al., 1997; Haddock et al., 2000; Patterson, Williams, Grauf-Grounds, & Chamow, 1999; Rabin, 1996). Knudson-Martin and Laughlin (2005) suggest that "family therapists will be unable to effectively promote individual and relational health unless they recognize and counteract the often nearly invisible ways that gender influences interpersonal processes" (p. 103). To gauge the extent of gender issues, a therapist might begin by examining the following series of questions recommended by Rabin (1996):

- In what ways do the presenting problems reflect gender power issues?
- How does each partner define equality, and to what extent are the partners in agreement about these definitions?
- To what extent does each partner perceive the other as a real friend?
- To what extent does the relationship empower both partners?
- To what extent is the communication work of the relationship equally shared?
- To what extent have the couple developed a shared ideology fostering their relationship?

Additionally, Patterson and colleagues (1999) note that conflict can arise if partners were raised in different gender backgrounds. For example, a man who grew up in a more egalitarian family may clash within a relationship with a woman from a family with more traditional gender expectations. To assess gender roles and expectations stemming from one's family of origin, therapists can explore each partner's **genogram**. In doing so, therapists explore intergenerational patterns related to roles, relationships, and power. When discussing familial influences on gender, it is also important to consider these issues within the client's culture, including **race** and **ethnicity** (McGoldrick et al., 2005). For example, it may be important to include non-nuclear family members of African American clients, as they may significantly contribute to the family system (Watts-Jones, 1997).

Furthermore, therapists should assess couple interactions for gender and power themes, including family dynamics such as who opens the conversation, who chooses the topic, who interrupts whom, who talks more, who pays for the session, and who decides whether there will be a next session (Rabin, 1996). However, it is critical that the therapist evaluate such roles within the context of the couple and family, by investigating how each partner perceives and experiences the fairness, or lack thereof, within the relationship. Each of these areas can reveal power dynamics in a relationship, although initial hypotheses should always be tentative.

In *Metaframeworks: Transcending the Models of Family Therapy* (Breunlin et al. 1997), the authors propose that all families fit into one of five transitional

TABLE 3.1 Transitional Gender Positions Continuum

Position	*Goals*	*Interventions*
Traditional	Promote gender awareness	• Question rigid gender expectations
Gender-aware	Amplify experiences of gender imbalance	• Question explanations that justify patriarchy • Support increasing awareness
Polarized	Decrease polarization and encourage balanced roles	• Question adherence to narrow definitions • Validate individual experiences • Encourage balancing extreme positions
In transition	Amplify changes toward egalitarian roles	• Support and validate beliefs • Discuss consequences of change • Clarify new roles
Balanced	Support egalitarian roles and expand changes into other social areas	• Discuss consequences of beliefs • Examine potential social traps • Discuss impact of lack of social support

Source: Adapted from Breunlin et al. (1997), pp. 250–251.

positions in the evolution of gender balance, falling along a continuum from *traditional* to *balanced* (See Table 3.1). Families existing with a gender-based paradigm may face negative consequences, such as greater family dysfunction or intrafamilial abuse (Haddock et al., 2003). Therefore, it is critical that therapists address power differentials and any gender-based negative influences on children.

Intervention

The context of gender should be used as a lens for choosing and implementing therapeutic interventions (Haddock et al., 2003). As noted in Table 3.1, Breunlin et al. (1997) make specific intervention suggestions for clients at each of the five transitional stages. It is important to be explicit (i.e., to have one's umbrella wide open) in pointing out these connections in clients' lives (Breunlin et al., 1997; Haddock et al., 2000; Whipple, 1996). Knudson-Martin and Laughlin (2005) suggest an approach in which therapists view themselves as mediators between clients and the larger society. Having explicit conversations about gender inequities is one way to help clients feel confident navigating rigid expectations.

Empowering and valuing women is a consistent theme in gender-aware therapy (Brown, 1994; Haddock et al., 2000). In fact, the empowerment model of power-sharing in therapy sessions has been empirically validated as distinct from other therapeutic techniques (Rader & Gilbert, 2005). One way of empowering clients is to help them explore all the options available to them, including nonstereotypical ones (McGoldrick & Hardy, 2008). Haddock et al. (2000) recommend that therapists encourage female clients to be attentive to self-care, to be assertive and independent, to pursue personal time, and to develop support systems.

It remains important to be gender aware when working with men, as well (Font, Dolan-Del Vecchio, & Almeida, 1998; Green, 1998). Therapists should help male clients be more attentive to relationship maintenance, to be more emotionally expressive, and to be more vulnerable in relationships (Haddock et al., 2000). As men learn to expand their roles within the family, space is created for women to be able to change their roles. One way of helping men expand their roles is to empower them to develop an identity away from the *patriarchal male code* and toward a *partnership code* (Almeida et al., 2008). For example, therapists can help men move from the traditional "in the box" message to avoid child care toward a partnership stance in which both partners share caregiving responsibilities and value each other's work (Almeida et al., 2008; Haddock, Zimmerman, Ziemba, & Current, 2001; Schwartz, 1994). See the webpage "Family and Work" (www.workandfamily.chhs.colostate.edu/) for more information on how couples can manage work and family balance.

Relatedly, Shepard and Harway (2012) propose a style of couple therapy that is sensitive to the fears, expectations, and vulnerabilities that men may bring into the therapy room. In particular, therapists should avoid shaming the male partner and instead use language that highlights his strengths, desire for intimacy, and gender role restructuring. Highlighting strengths and reframing the male partner's behavior through the lens of gender socialization is one way to encourage affective expression in therapy, which has been recommended to help couples develop intimacy (Ganley, 1991; Haddock et al., 2000).

To reduce gender imbalances, Breunlin et al. (1997) suggest using universal statements about gender (e.g., "It is painful when family members experience limitations," p. 259), directives about behavior (e.g., "Would the two of you think about how you prepare your daughters for adulthood?" p. 260), and questions about gender in the family (e.g., "What does each of you think about the way responsibilities and decisions are shared in your house?" p. 260). Breunlin et al. (1997) and Roberts (1991) also recommend using *circular questions* (Selvini-Palazzoli, Cecchin, Prata, & Boscolo, 1978; Tomm, 1987) as gender interventions. Circular questions are useful in allowing people to take another person's perspective in looking at themselves. See Box 3.2 for some suggestions to use with gender, sexual orientation, culture, and spirituality.

Next, an imbalance of power is one of the most important issues to deal with in considering gender in therapy. Haddock and colleagues (2000) discuss several

BOX 3.2. Circular Questions About Gender, Sexual Orientation, Culture, and Spirituality

In small groups, ask one another the following questions to expand your understanding of gender, sexual orientation, culture, and spirituality. Think about how to use these in therapy.

- In terms of relationships generally:
  - "Who in your family of origin taught you the most about being a man or woman?"
  - "What did your parents model for you about gender relationships and sexual orientation in their interactions?"
- In terms of differences in behavior:
  - "Who would you consider to be the most stereotypically feminine in your family of origin? Masculine?"
  - "Who gave you the most messages about what it was to be 'a man' or 'a woman'?" About what it is to be White or Black or Latino? About what it is to be of your religion? About what it means to have a sexual identity?"
  - "Who in your family of origin most approves of you as a man/woman? As gay or straight? As spiritual? As a member of your culture? Who least approves?"
- Explanation questions:
  - "What is your explanation of why society seems to ascribe different behaviors to different genders? Sexual orientations? Races? Religions?"
- Differences related to hypothetical circumstances:
  - "If your mother (father) had worked outside of the home (or had not), how do you think your family relationships might have been different?"
  - "If your parents were gay (or not), how do you think your family relationships might have been different?"
  - "If you had been born a different gender or with a different sexual orientation, how do you think your life would have been different as a child? What if you had been born a different race?"
  - "If you were a different gender, how do you think your style as a therapist would be different? What if you identified as LGBT (or not)? What if you were a different race or had different spiritual beliefs?"

- Normative comparison questions:
  - "Do you think your family was more or less flexible about gender roles than other families? Would others in your family agree with you?"
  - "Did you learn similar things about your race as other children in your neighborhood, or did you learn different things within your family? How about regarding gender? Sexual orientation? Religion/spirituality?"
- Conservative needs questions:
  - "Assume there are reasons for your family to continue its patterns around gender, sexual orientation, culture, and spirituality. What would they be?"
- Process interruption questions:
  - "What part of you is most comfortable talking about these topics? Least?"
  - "If we were to stop this discussion, what would your reaction be?"

Source: Adapted from Roberts (1991).

dimensions of power within the family to which the therapist must attend including decision making; communication and conflict resolution; work, life goals, and activities; housework; finances; sex; relationship maintenance; abuse and violence; and parental responsibility and parental style. To broach power issues in these domains, Parker (1997) recommends four strategies: (1) structuring the session for consciousness raising; (2) boldly naming power issues; (3) indirectly raising the power issues; and (4) meeting with partners separately to raise the issues. Additionally, Almeida and colleagues (2008) discuss the concept of **critical consciousness** and provide guidelines for structuring therapy sessions to raise issues of power and privilege for discussion and analysis. For example, to raise critical consciousness regarding finances, the therapist might directly ask (Almeida et al., 2008, p. 28):

- "Are you employed?"
- "Do you work out of the home?"
- "How much money do you earn?"
- "How are the resources allocated?"
- "Who makes decisions?"
- "How are the household and family-care responsibilities distributed?"

To enhance the effects of raising critical consciousness, it is much more powerful if the couple (as opposed to the therapist) can identify the consequences

of current power differentials within their relationship. One way to encourage identification of these consequences is to first have the couple apply concepts of power and control to a movie or book. Encouraging clients to first be critically aware of power differentials *outside* their personal relationship may decrease defensiveness (Almeida et al., 2008). After they apply their knowledge of power and control to an outside relationship, the therapist can ask the clients to be critically aware of their own patterns and consequences of power issues (e.g., in the area of finances).

Gender also plays a role in how therapists perceive clients. Therapists can perpetuate gender issues by (a) treating behavior that is consistent with patriarchal male code as normal or healthy; (b) expecting women to assume more than half of the responsibility for making changes; (c) minimizing the seriousness of abusive behavior committed by men; and (d) minimizing differences in a way that pretends we all share the beliefs of White heterosexual males without disabilities and from upper-middle-class backgrounds (Almeida et al., 2008, pp. 70–71). One way of interrupting these patterns is for therapists to monitor their expectations for women's emotional expression in therapy. When a therapist assumes a female client will express herself in a certain way, he or she is inadvertently subscribing to stereotyped modes of female expression (Gehart & Lyle, 2001). This is especially damaging for women who are more "out of the box." Instead, the therapist should avoid inaccurate assessments, adjust the level of intimacy within the therapeutic alliance, and choose interventions that engage the client at her comfort level (Gehart, 2014).

Gender is a critical part of couple and family therapy; gender is inescapable because people are gendered and our society is gendered. To ignore gender in therapy is to do an injustice to all individuals. The interventions described above focus on making gender and power dynamics an explicit part of therapy. If therapists do not address gender in their work, they are, in effect, supporting the status quo of gender inequality, which is problematic for everyone.

Case Study

Tim (age 28) and Julie (age 31) are a Caucasian, middle-class couple. They have a two-year-old daughter, Jesse. Julie works full-time as a physician's assistant, and Tim works full-time as a real estate agent.

Tim and Julie have come to therapy because of an increasing number and intensity of arguments that are causing difficulties and a loss of emotional closeness. Julie reports that she is frustrated because "right at the time that Tim should be cutting back at work to spend more time with his daughter," he has begun working late almost every night. She is exhausted and angry because she is doing the bulk of the child care and

housework. She says that the "straw that broke the camel's back" was Tim telling his parents, without consulting her, that they could spend the holidays with them. Tim reports feeling as if Julie doesn't even notice him: "She is so wrapped up with Jesse all the time." He says that when he does get time with Julie, she is angry, is emotionally unavailable, and lacks interest in sex. He believes Julie does not understand that he can't cut back his hours at work—"We need the money I earn now more than ever."

Using the gender umbrella, the therapist recognizes the gender and power dynamics that are underlying the couple's marital difficulties. Her assessment of the couple's difficulties includes the influence of the social context that defines men as primary breadwinners and women as primary caretakers, and she identifies the couple as traditional along the continuum of gender positions. She brings up the topic of gender and explores with the couple the possible influences of gender socialization on the presenting problem. She uses circular questions (see Box 3.2) to explore whether Tim's increased focus on work is related to pressures that he be the primary breadwinner for his family. She makes efforts to validate the internal struggles of both Tim and Julie.

Following a collaborative exploration of the influence of gender socialization on the behaviors of each partner through a genogram, the therapist normalizes that many couples encounter similar difficulties after the birth of their first child. She then overtly states that these gender messages can be harmful to individuals and their relationships, inviting the couple to consider some of these negative effects (e.g., loss of intimacy and friendship in marriage, a compromised emotional connection between father and child). She also encourages the couple to consider the benefits of resisting these messages, and she invites both partners to articulate what they would like their marriage to "look like."

Based on this information, the therapist assists the couple in collaboratively setting the following goals: (a) to involve Tim more in the parenting of his daughter, (b) to divide household labor equitably between Tim and Julie, (c) to allow Julie time for self-care, (d) to develop skills for negotiating decisions together, (e) to promote intimacy through shared meaning, and (f) to share financial responsibility for the family.

Recent Research

Due to space limitations, we will briefly highlight recent research on gender issues in couple and family therapy.

While not a research study, Knudson-Martin's (2013) article titled "Why Power Matters: Creating a Foundation of Mutual Support in Couple Relationships"

provides a thorough summary of recent research on gender and power in couple relationships.

Another thorough research review (Blow, Timm, & Cox, 2008) focuses on whether gender-matching of the therapist and client affects couple and family therapy outcome. Findings indicated that gender-matching does not typically affect outcomes, except for adolescent males in some cases.

Gender differences continue to be of interest to researchers. Some recent research has failed to find significant gender differences in areas related to couple and family therapy (e.g., awareness of relational problems, Moynehan & Adams, 2007; clinicians' attitudes about the use of emotion in therapy, Suarez Pace & Sandberg, 2012). Conversely, Whiting, Oka, and Fife (2012) found gender differences in appraisal distortions in cases of intimate partner violence. Williams and Knudson-Martin (2012) utilized grounded theory methods to explore ways that gender and power issues are addressed in the literature on infidelity, finding that gender and power are often obscured in that literature. In another type of content analysis, Winston and Piercy (2010) explored gender and diversity topics taught in accredited MFT educational programs, finding high levels of commitment, transparency, and experiential learning methods at both master's and doctoral levels.

Recommended Readings

Interested readers are encouraged to read the following articles on the feminist critique: Bograd (1986), Goldner (1985), Hare-Mustin (1978), and Taggart (1985), as well as the books *Women in Families: A Framework for Family Therapy* (McGoldrick, Anderson, & Walsh, 1989) and *Feminist Perspectives in Therapy: Empowering Diverse Women* (Worell & Remer, 2003). *Re-Visioning Family Therapy: Race, Culture, and Gender in Clinical Practice* (McGoldrick & Hardy, 2008) is highly recommended for content on both gender and culture. *Couples, Gender, and Power: Creating Change in Intimate Relationships* (Knudson-Martin & Rankin Mahoney, 2009) provides another useful exploration of gender and power dynamics in couple therapy.

Sexual Orientation

Each of the contextual issues discussed in this chapter has been uniquely neglected in the literature and training of couple and family therapists, and sexual orientation is no different. In fact, our consciousness of gay and lesbian rights has been awakened only in the last 15 to 20 years. When Laird and Green released their handbook for therapists, *Lesbians and Gays in Couples and Families,* in 1996, this marked the beginning of a heightened recognition of sexual orientation as a key contextual issue among CFTs (Nichols, 2013). Since then, an updated publication edited by Bigner and Wetchler (2012) was released, the *Handbook of LGBT-Affirmative Couple and Family Therapy,* which serves as the most important,

comprehensive text of its kind. Several other publications also have added significantly to the literature: in 2005, Stone Fish and Harvey published *Nurturing Queer Youth: Family Therapy Transformed,* and in 2006, *Interventions with Families of Gay, Lesbian, Bisexual, and Transgender People: From the Inside Out,* edited by Bigner and Gottlieb, was published. Even so, the research on lesbian, gay, bisexual, and transgender (LGBT) families is significantly lagging.

Historically, there has been confusion among students and therapists surrounding the definition of **sexual orientation**, and in particular how it relates to definitions of gender and gender identity. To clarify, sexual orientation is distinct from a person's gender identity. Rather, it is one's sexual identity in relation to the gender to which he or she is primarily attracted. Sexual orientation should also be viewed on a continuum. As outlined by Morrow (2008), **gay** refers to people (male or female) whose primary intimate attractions are toward others of the same gender; **lesbian** refers to women whose primary attractions are toward other women; **bisexual** refers to men or women who are attracted to both men and women. Gay is also commonly used to describe male homosexual individuals. Furthermore, transgender couples may consist of two transgender individuals or one trans-identified person and one non-trans-identified person (Nealy, 2008). Throughout the following discussion, "LGBT" refers to members of these **sexual minority populations**.

Akin to issues of gender, culture, and spirituality, identifying as LGBT is *not* inherently a clinical issue, nor should therapists assume that a gay couple seeking therapy wants to talk about issues such as coming out or creating families of choice (Green & Mitchell, 2008). In fact, many LGBT families are functioning as well as, or better than, heterosexual families (Gartrell & Bos, 2010; Gottman et al., 2003; Peplau & Fingerhut, 2007). Thus, the charge to CFTs is to be familiar with the unique challenges that LGBT families may face (Green & Mitchell, 2008), to understand their own comfort level, biases, and values about sexual orientation (Godfrey, Haddock, Fisher, & Lund, 2006), and to examine the degree of heterosexist bias in family theories (Long & Serovich, 2003). McGeorge and Carlson (2011) propose a three-step model for heterosexual therapists to become more aware of their heteronormative assumptions and to explore privilege and identity. They offer self-reflection questions to explore each of these areas.

A recent article in the *Journal of Marital and Family Therapy* examined CFT student beliefs about their level of competence in working with LGBT clients (Rock, Carlson, & McGeorge, 2010). The authors found that 60.5% of participants had received no training on affirmative therapy practices and about 63% reported no training on LGBT identity development models. Although students reported low levels of homophobia and moderate levels of understanding heterosexism and discrimination, they also indicated lower perceived competency in therapeutic skills when working with LGBT-related issues (Rock et al., 2010). Thus, there is a need for increased training regarding LGBT contextual issues.

Sexual Orientation and the Practice of Couple and Family Therapy

When working with LGBT couples and families, there are a number of unique, potentially challenging, issues that all therapists should be aware of. It is important to note that when coupled with other contextual issues outlined in this chapter (gender, spirituality, culture), multiple layers of stigma may be present (Long & Andrews, 2011; Nealy, 2008). For example, Asian American men are often stereotyped as being weak or nerdy (Pyke & Dang, 2003) and if an Asian American man also identifies as gay, the stereotype of being emasculated can permeate his life (Eng, 1997). Further, Long and Andrews (2011) highlight the importance of considering the unique minority status of interracial LGBT couples. Therefore, each contextual issue should be considered in light of the others.

Perhaps one of the most prominent issues faced by LGBT clients is that they are vulnerable to marginalization and discrimination. Unlike their heterosexual counterparts, LGBT clients are likely to face this prejudice not only from other people, but also from institutions outside the relationship (e.g., school, church, government) (Green & Mitchell, 2008). In particular, antigay attitudes, societal oppression, and internalized homophobia create **minority stress** for LGBT individuals (Giammattei & Green, 2012; Meyer, 2003). Therapists should be wary of assuming that the experience of minority stress is similar across all LGBT families. For example, bisexuals in same-sex relationships often face prejudice from both heterosexual and LGBT communities (Dodge & Sandfort, 2007). Therapists must be aware of the prejudice that exists within a client's family, work, school, medical care, insurance, religious, and legal systems. For example, it was not until 2003 that homosexuality was decriminalized by the U.S. Supreme Court, and as of August 2013, only 13 states plus Washington, DC, legally recognize same-sex relationships. Discrimination based on sexual orientation continues to contribute to increased feelings of marginality and extraordinary vulnerability (Green & Mitchell, 2008).

Second, the process of **coming out** is unique to each individual and may or may not entail significant challenges. It may be a continual stressor throughout a person's life (Johnson & Colucci, 1999; Morrow & Messinger, 2006) and may occur at multiple levels (i.e., self, family members, friends, coworkers, professionals). CFTs may encounter the coming-out process at multiple levels, as well, such as an individual who is seeking support in coming out to her friends, or two parents whose child recently came out. For some young people, the burden of coping with the coming-out process can be extremely overwhelming and may present as acting out, suicidal ideation, or family conflict (LaSala, 2010).

Third, **relational ambiguity** is not unique to LGBT clients except in one major way. Many LGBT couples lack a socially endorsed and legally framed relationship, in which the relationship is established by a ceremony, governed by statutes for legal marriage, approved by important others (e.g., families of origin),

and demarcated with formal termination proceedings (i.e., divorce) (Green & Mitchell, 2008, p. 667; Lyness, 2012). Furthermore, LGBT individuals are surrounded by a heterosexual culture with specific rituals (e.g., prom, wedding showers) and language (e.g., boyfriend-girlfriend, husband-wife) that is exclusionary (Nealy, 2008). For some, they also cannot rely on their parents or families as role models in relationships similar to their own. Therefore, questions about when the commitment began, how it will progress, and options for ending it remain unanswered.

Lastly, CFTs should be aware of LGBT clients who have distanced from their family of origin for a variety of reasons, including antigay prejudice. Certainly many LGBT clients have close, caring relationships with family members. Yet, for clients marginalized by their family, **families of choice** can provide emotional and instrumental support (Weston, 1991). Neglecting to see a couple's families of choice as important and influential is a serious oversight on the part of the therapist (Green & Mitchell, 2008). Similarly, many LGBT couples wish to have children and may face legal barriers to doing so. Part 4 of Laird and Green's (1996) handbook for therapists working with LGBT issues specifically highlights the journey to parenthood for gay and lesbian couples and should be compulsory reading for all therapists. Similarly, Long and Andrews (2011) review the unique barriers that exist for families wishing to start a family, such as lack of health care benefits.

Assessment

As part of the initial and ongoing assessment of the family's presenting problem, therapists should determine the extent to which the problem is connected to the unique challenges facing LGBT individuals (Green & Mitchell, 2008). Similar to when working with gender issues, therapists should seek collaboration with their clients when discussing issues related to sexual orientation. In discussing past, present, or future coming-out processes, therapists should remain curious about the extent to which the process is distressing. In assessing minority stress, therapists should seek to understand the level of societal antigay prejudice and internalized homophobia and traditional gender norms present within their clients (Green & Mitchell, 2008). To assess relational ambiguity, the following questions may be helpful to the couple and the therapist (adapted from Green & Mitchell, 2008):

- "What does it mean to be a couple? What does it mean for you, as a couple?"
- "What is the history of your relationship?"
- "What are the agreements in your relationship about monogamy and/or safe sex?"
- "How are decisions made about who is responsible for finances, household chores, child care? Are you satisfied with the current arrangement?"

- "What are the obligations you have for each other in terms of illness, injury, disability, or death?"
- "Are you viewing this as a lifetime commitment? What steps have you taken to prepare legal documents?"

To evaluate the couple's and family's social support, Green and Mitchell (2008) recommend using a basic sociogram that includes concentric circles beginning with the couple, then including a few close friends, followed by circles for other supports and the larger community. Through this process, therapists can assess the level of support, and families may be able to identify a number of individuals in their families of choice.

Nealy (2008) states that LGBT clients need therapists who are (a) nurturing, accepting, and nondiscriminatory and (b) sensitive to the diversity and variety of relationships in the LGBT community. Certainly, each relationship and situation is unique to that couple or family. Green and Mitchell (2008) also recommend that therapists "function as a celebrant and witness of constructive lesbian and gay relationships, acknowledging their legitimacy and worthiness of equal support" (p. 666), also known as **LGBT-affirmative therapy**, which Malyon (1982) defines as follows:

> Gay-affirmative psychotherapy is not an independent system of psychotherapy. Rather, it represents a special range of psychological knowledge which challenges the traditional view that homosexual desire and fixed homosexual orientations are pathological. . . . . This approach regards homophobia, as opposed to homosexuality, as a major pathological variable in the development of certain symptomatic conditions.
>
> (pp. 68–69)

Throughout the assessment, therapists should remain aware of how society's negative attitudes contribute to the problems LGBT families face and should be willing to stand with them as allies.

Intervention

Before moving into our discussion on intervention, it is critical to note that **reparative therapy** is not acceptable or ethical in the treatment of LGBT clients. As noted by the American Association of Marriage and Family Therapists (AAMFT) in regard to reparative therapy, "the association does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for such therapy. AAMFT expects its members to practice based on the best research and clinical evidence available." As such, in 2012, California was the first state to enact a law that prohibits licensed therapists from providing reparative therapy to minors, followed in 2013 by New Jersey. Other states, including Massachusetts,

Pennsylvania, Ohio, New York, Washington, and Illinois as well as the District of Columbia are considering similar legislation (www.nclrights.org/bornperfect-laws-legislation-by-state/). McGeorge, Carlson, and Toomey (2013) found that family therapists who believed that conversion therapy was ethical were significantly more likely to hold negative beliefs about LGBT individuals.

Within our discussion, we highlight a few effective tools for intervening with LGBT contextual issues. First, Mitchell (2012) highlights three therapeutic goals in working with families experiencing the coming-out process in her chapter "Coming Out to Family": "sustaining the self of each family member, respecting and handling different agendas, and holding the hope and remembering the love" (p. 133). In cases of a youth's coming out, it is also important for therapists to consider the loss of the parents' heterosexual paradigm, perhaps applying a grief and loss perspective (Tanner & Lyness, 2003). For additional information on helping families adjust to a gay or lesbian child, see the book *Coming Out, Coming Home* (LaSala, 2010).

Second, due to the great likelihood that LGBT clients have, are currently, or will experience discrimination and prejudice, the next intervention is designed to help clients detoxify personal issues while discussing the misuse of societal and familial power in LGBT relationships (Almeida et al., 2008). It involves the use of a power and control wheel designed to validate the clients' personal experiences, as well as heighten all family members' critical consciousness regarding the abuse of power within the public and family contexts (see Figure 3.2).

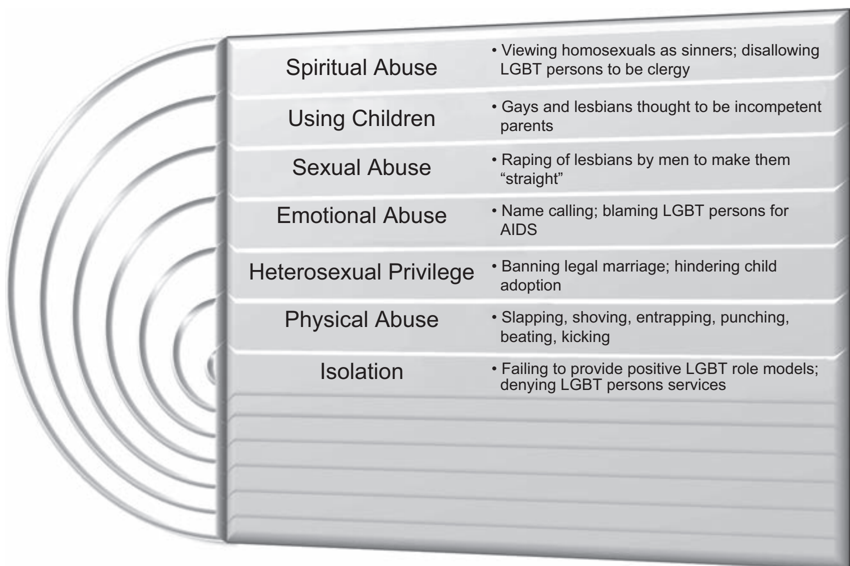


FIGURE 3.2 A Power and Control Wheel

Source: Adapted from Almeida et al. (2008), p. 31.

Third, Robert-Jay Green discusses how therapists can help gay and lesbian couples cope with minority stress in his chapter in *Re-Visioning Family Therapy: Race, Culture, and Gender in Clinical Practice* (McGoldrick & Hardy, 2008) and in his chapter with Valory Mitchell in the *Clinical Handbook of Couple Therapy* (2008). Table 3.2 outlines the risk factors for minority stress, potential couple problems, possible therapeutic interventions, and the identified outcome goals.

The final interventions are designed for LGBT clients who wish to start a family. As White and Epston (1990) noted, "individuals and families often seek therapy when their lived experiences contradict the dominant narrative about them" (as cited in Muzio, 1996, p. 367). Therefore, therapists may see LGBT clients prior to creating a family or at other transitional times in the family life cycle, both of which have important implications for intervention. For example, a couple contemplating adoption may face barriers of non-gay-affirming agencies, whereas a couple in the waiting phase may be coping with anxiety and doubt (Gianino & Novelle, 2012). In some cases, therapists can help clients create life-cycle rituals. For example, Muzio provides an example in which a lesbian couple held a naming ceremony after the birth of their child, which included playing representative music, stating the child's full name while the nonbiological

TABLE 3.2 Successful Coping with Minority Stress for LGBT Families

Risk Factors	*Potential Couple Problems*	*Therapeutic Interventions*	*Outcomes*
Antigay prejudice in the community and larger society	• Internalized homophobia—fear and ambivalence about committing to a same-sex couple relationship • Partner conflicts over how "out" the couple will be with family, at work, and in the community	• Externalizing the homophobia—viewing societal ignorance and prejudice as the problem • Negotiating any "outness" conflicts between partners based on realistic constraints or dangers	• Self-acceptance of lesbian/gay identity • Comfort committing to a same-sex relationship • Maximizing involvement in social contexts in which the couple can be out
Lack of normative and legal template for same-sex couplehood	• Relational ambiguity • Insecure attachment in current relationship	• Exploration and collaboration about what being a couple means to them • Creating legal documents	• Commitment clarity (operating as a team, primary commitment to each other, longer-term planning ability, secure attachment)
Lack of social support for the couple relationship	• Social isolation • Lack of couple identity in a defined community • Lack of support system	• Coaching to build families of choice	• Embedded couple identity and community of care (social network, reciprocity of emotional and instrumental support)

Source: Adapted from Green (2008); Green & Mitchell (2008).

mother held her, and lighting candles while making wishes. Such experiences are powerful, and "the rituals give voice to struggles and joys that are disallowed or discounted by the dominant culture" (Muzio, 1996, p. 366).

Working with clients to successfully navigate the unique challenges that LGBT families face is critical. While societal and legal barriers exist, therapists can walk with LGBT clients on their journey toward healing, health, and hope. Examining presenting problems with an open umbrella will not only validate the experience of LGBT clients, but also interrupt the denial and neglect of these issues that has existed in the field.

Case Study

Roger (age 32) and Ben (age 35) are an interracial middle-class couple. Roger is African American and Ben is Caucasian. Roger works full-time as a chemical engineer, and Ben works full-time as a writer.

Roger and Ben came to therapy because they feel distant and lonely in the relationship. Roger reports that he is concerned about the status of their relationship. He reports feeling as if "we're not even a couple, except in the privacy of our own home." Roger feels especially frustrated since his coworkers at the lab started excluding him from certain social functions after he came out. He reports feeling angry when Ben doesn't appear to understand. Ben believes Roger is overreacting and exaggerating the discrimination he is facing at work. Ben states that he is also unsure of the relationship because Roger doesn't want to define the relationship: "I just wish Roger would understand how important a ceremony is to me."

With an open sexual-orientation umbrella, the therapist recognizes two key processes underlying the couple's presenting problems. He recognizes that Roger is feeling minority stress, whereas Ben is feeling relational ambiguity. The therapist's assessment of the presenting problem also identifies Roger's ethnicity as a probable additional layer of minority stress. In collaborating with the couple, the therapist uses some of the therapeutic interventions in Table 3.2. For example, he walks Ben and Roger through an activity that helps them identify how they each see prejudice and homophobia in their own lives and how they view and define their relationship. Through these discussions, the therapist explores whether Ben is underreacting to the minority stress Roger is experiencing due to Ben's dominant culture status and whether Roger is resisting commitment within the relationship. The therapist normalizes both experiences and works toward increased understanding and compromise, which will likely result in Ben and Roger feeling closer to each other.

Recent Research

Numerous research studies have been published exploring training and measurement issues in working with LGBT families (Carlson, McGeorge, & Toomey, 2013; Henke, Carlson, & McGeorge, 2009; McGeorge & Carlson, 2011; McGeorge et al., 2013; Rock et al., 2010). Similarly, Godfrey et al. (2006) published research on training issues for working with LGBT populations. Other recent research has explored relationship dynamic issues like outness and relationship satisfaction (Knoble & Linville, 2012), gay men's experiences of societal non-support and coping through families of choice and therapy in Alaska (Blumer & Murphy, 2011), and outcomes involved in inviting LGBT clients' partners into substance abuse treatment (Senreich, 2010).

Two recent content analyses have focused on LGBT issues in the couple, marital, and family therapy literature. Blumer, Green, Knowles, and Williams (2012) found that only 9 of 10,739 articles over a 22-year span addressed transgender issues, while Hartwell, Serovich, Grafsky, and Kerr (2012) found that articles with LGBT content are increasing in couple and family therapy journals, indicating a 239% increase over the study period of nearly 15 years.

Recommended Readings

The *Handbook of LGBT-Affirmative Couple and Family Therapy* (Bigner & Wetchler, 2012) is the most comprehensive text for working with couples and families from an LGBT-affirmative perspective. *Relationship Therapy with Same-Sex Couples* (Bigner & Wetchler, 2004) is also an excellent resource. Other excellent reads include *Nurturing Queer Youth: Family Therapy Transformed* (Stone Fish & Harvey, 2005) and *Interventions with Families of Gay, Lesbian, Bisexual, and Transgender People: From the Inside Out* (Bigner & Gottlieb, 2006).

Culture

Our field has also had some debate over how to define *culture, ethnicity,* and *race*. McGoldrick, Garcia-Preto, Hines, and Lee (1991) refer to ethnicity as "a concept of a group's 'peoplehood' based on a combination of race, religion, and cultural history, whether or not members realize their commonalities with one another" (p. 547). At a more general level, others have talked about and defined the word "culture." Falicov (1995) provides perhaps the best multidimensional definition of "culture":

> shared world views, meanings and adaptive behaviors derived from simultaneous membership and participation in a multiplicity of contexts, such as rural, urban or suburban setting; language, age, gender, cohort, family configuration, race, ethnicity, religion, nationality, socioeconomic status,

> employment, education, occupation, sexual orientation, political ideology; migration and stage of acculturation.
>
> (p. 375)

This definition is much broader than an ethnicity-focused one in that it allows for the examination of a multitude of variables. This broad definition of culture has led to the widespread adoption of a **multicultural perspective** (e.g., Almeida et al., 2008; Breunlin et al., 1997; McGoldrick et al., 2005).

So why is a multicultural framework important in therapy? The United States is one of the most ethnically and culturally diverse nations in the history of the world (McGoldrick et al., 2005). A multicultural perspective validates the variety of ways that culture influences our humanity (Breunlin et al., 1997). Each of us fits into different levels of culture—different ages, educational levels, social class, race, ethnicity, sexual orientation, **religion**, and ability. Each person is raised in a number of cultural subgroups, and each person draws selectively from these groups' relative influences (Falicov, 1995). Culture also provides us with guidelines on how to behave, think, and interpret situations (Goodenough, 1999); thus it is imperative that couple and family therapists attend to issues of culture. To ignore multicultural influences is to legitimize only one reality—that of the dominant culture.

Family therapy has been accused of holding monolithic views of the family based upon ideals of the majority culture (Breunlin et al., 1997; Preli & Bernard, 1993), but, as McGoldrick (1998) notes, "all families, not just 'minorities' are seen as embedded in and bounded by class, culture, gender, and race. Moreover, how a society defines gender, race, culture, and class relationships is viewed as critical to understanding how *all* family processes are structured" (p. 17, italics in original).

It is also important that therapists, and majority-group therapists in particular, understand the role of prejudice and discrimination in our culture. The first ethical issue listed in the AAMFT *Code of Ethics* is that "Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status" (AAMFT *Code of Ethics,* 2012, paragraph 1.1). At another level, the *Code of Ethics* specifies that CFTs cannot practice outside of their competence. Therapists need to understand issues of culture so that they do not practice outside their realm of knowledge (Thomas, 1992).

Prejudice and discrimination are by definition a fact of life for minority groups. To be truly effective in working with clients who are members of minority groups, therapists should be aware of the levels of prejudice and discrimination in society and the effects that they have on those clients. However, a multicultural approach needs to include more than just sensitivity training in order to be relevant (Preli & Bernard, 1993); a truly relevant approach helps

majority-culture therapists understand their own experience from a cultural perspective.

Culture and the Practice of Couple and Family Therapy

There are many things to consider when working with families from a multicultural perspective. One is that families are unique within cultural groups (Gladding, 1998; Hanna & Brown, 1995). Family therapists should distinguish among a family's patterns that are universal and common to a wide variety of families, patterns that are culture specific, and patterns that are idiosyncratic to that particular family (Goldenberg & Goldenberg, 2000). One must be wary of broad generalizations and cannot assume that the stereotypes of one culture accurately describe the clients one is working with (Becvar & Becvar, 2013). One way for therapists to increase their understanding of families from a multicultural perspective is to learn as much as possible about a variety of cultural groups. Two particularly useful resources in exploring the impact of culture, race, and ethnicity on families are *Ethnicity and Family Therapy* (McGoldrick et al., 2005) and *Re-Visioning Family Therapy: Race, Culture, and Gender in Clinical Practice* (McGoldrick & Hardy, 2008). These are perhaps the most comprehensive explorations of ethnic families available to family therapists. However, the authors caution that therapists should not feel as if they have to know everything about every ethnic group; of primary importance is an awareness of difference and similarity.

Because family therapists cannot know everything about every family type (though therapists should always strive to learn more about diversity), there are some general guidelines that are perhaps even more important to consider. One guideline set forth by Hardy and Laszloffy (2008) is that therapists should have *racial sensitivity,* which these authors state is "the ability to recognize the ways in which race and racism shape reality" and "involves using oneself to actively challenge attitudes, behaviors, and conditions that create or reinforce racial injustices" (p. 227). In contrast, a detriment to working with clients of diverse backgrounds is a *pro-racist ideology* that promotes the superiority of Whites and reinforces the racial status quo (Laszloffy & Hardy, 2000). In trying to promote greater racial sensitivity, Hardy and Laszloffy (2008) recommend that therapists do the following:

- Become aware that race matters.
- Recognize the existence of a pro-racist ideology.
- Enhance cross-racial experiences.
- Explore one's own racial identity.
- Challenge pro-racist ideology first in oneself and then in others.
- Persist in spite of criticism or rejection.

A similar concept is **cultural sensitivity**. One way for therapists to develop cultural sensitivity is to maintain a stance of curiosity and take a one-down

position with clients, so that clients may articulate their cultural experiences. However, it should not be assumed that it is the client's responsibility to teach his or her therapist about a particular culture. Another way to develop cultural sensitivity is to make diverse connections in your personal life (Nichols, 2013).

In addition to assessing one's own racial and cultural sensitivity, Falicov (1995) states that it is important to view existing theories, practices, and beliefs through a *cultural lens.* She asserts there are four parameters that therapists should keep in mind as they assess families and plan interventions: *ecological context, migration and acculturation, family organization,* and *family life cycle.* Ecological context includes a family's community, work, living conditions, school environment, and so on. Migration includes if and when a family migrated and whether that migration was forced or voluntary. Family organization refers to how a family is arranged according to its "cultural code," which influences family hierarchy, values, communication styles, and emotional expressivity. When family life cycle is viewed through a cultural lens, therapists look at what is appropriate to a particular culture. Established norms and developmental processes may not fit for some cultures, but therapists should be wary about assuming health or pathology based on norms that may be incongruous with the culture at hand.

Assessment

Having a multicultural perspective while assessing families is very important. It is particularly important to keep this perspective in mind when the client's culture is different from that of the therapist, so that the therapist does not misinterpret culturally based behavior as pathological (Breunlin et al., 1997; Hanna & Brown, 1995; Patterson et al., 1999). For example, in an Arab American family, children may be discouraged from individualistic pursuits, and major decisions, such as choosing a partner or career, may be considered in light of family expectations (Abudabbeh, 2005). A non-Arab therapist seeing an Arab American family might interpret pathology where there is none, if she or he is not sensitive to potential patterns of Arab American families.

Therapists of similar racial or ethnic backgrounds to their client should assess the degree of fit between them regarding immigration and acculturation status, economics, education, ethnicity, religion, gender, age, race, majority/minority status, and regional background (Breunlin et al., 1997). Each of these areas may affect values and behavior, and, unless each is assessed, therapists may assume more similarity than actually exists. There are advantages and disadvantages to being in the same cultural group as your client (McGoldrick & Giordano, 1996). One potential disadvantage of identifying with the same group is that you may believe that you understand your clients fully even though you may differ greatly.

Hanna and Brown (1995, p. 101) offer a number of questions for therapists to ask their clients in assessing cultural factors:

- "How does your racial/cultural/religious heritage make your family different from other families you know?"
- "Compared to other families in your cultural group, how is your family different?"
- "What are the values that your family identifies as being important parts of your heritage?"
- "At this particular time in your family's development, are there issues related to your cultural heritage that are being questioned by anyone?"
- "What is the hardest part about being a minority in U.S. culture?"
- "When you think of living in America versus the country of your heritage, what are the main differences?"
- "What lessons did you learn about your people? About other peoples?"
- "What did you learn about disloyalty?"
- "What were people in your family really down on [i.e., what did they dislike]?"
- "What might an outsider not understand about your racial/cultural/religious background?"

Many of these questions should be modified based upon the majority/minority status of the client and the degree of match between therapist and client. Further, the therapist need not attempt to become an expert on ethnicity in general, but should seek complete understanding of how his or her clients experience their culture.

Also important to assessment are exploring the importance of culture with clients (McGoldrick & Giordano, 1996) and considering cultural background when evaluating other assessment materials (e.g., assessment instruments such as the Dyadic Adjustment Scale), since behaviors may have different meanings within different cultures (Patterson et al., 1999). Once again, power comes into play, as different cultural groups experience different levels of power in society. Being aware of and assessing power dynamics within the family, and of the family within society, is vitally important (Patterson et al., 1999).

One of the more ignored aspects of culture in family therapy has been social class and poverty. Often more differences exist within a cultural group based upon class than across cultural groups of the same class. Every cultural group has social class divisions (Goldenberg & Goldenberg, 2000), and therapists should assess and attend to these factors as well. In particular, social class often determines access to power within society (Goldenberg & Goldenberg, 2000). *Bread and Spirit: Therapy with the New Poor* (Aponte, 1994) provides an excellent resource for family therapists working with clients facing poverty.

One final way to conceptualize assessment from a multicultural perspective is to assess constraints (Breunlin et al., 1997). Many families are constrained by their culture, and many families feel particularly constrained when coming to therapy. The therapist can open room for unexplored opportunity. Hines and

Boyd-Franklin (1996) illustrate one way prejudice and discrimination affect African American couples:

Usually, African American women initiate the therapy process. Therapists may get frustrated with women who express intense dissatisfaction yet resist change in dysfunctional relationships. These women's discontent, however, frequently is coupled with empathy for their husband's frustration and sense of powerlessness in society, as they are aware of the torment that generations of racism have caused for both African American men and women (p. 70).

Intervention

One simple intervention for attending to cultural contextual issues is that of making culture the central metaphor for therapy (Laird, 1998). Culture as a metaphor for therapy implies understanding people within their own context. This helps clients and families by empowering them to change within their context and to change their context, while recognizing that context can provide both opportunity and constraint. McGill (1992) spells out the core metaphors and themes of different cultural stories. For example, one core metaphor for Native Americans is harmony with nature. Metaphor in general can be an excellent way of introducing topics from within a client's perspective (see Lyness & Thomas, 1995, for an illustration of using metaphor within a narrative framework).

CFTs need also to validate and strengthen cultural identity. When families are under stress—as client families typically are—their sense of identity can become diffuse. Therapists can foster a sense of identity by strengthening the sense of cultural heritage, helping the family find resources in that identity (McGoldrick & Giordano, 1996). Similarly, therapists need to support client support systems from a cultural perspective. Some families are disconnected from traditional support systems, and therapists need to be aware of ways to connect individuals and families with support in the community (e.g., community organizations and supports such as El Centro or Lambda centers) (McGoldrick & Giordano, 1996).

Perhaps one of the most important interventions from a multicultural perspective is to move beyond polarizing discussions (McGoldrick & Giordano, 1996). When families are polarized, they are constrained from other options. Black-versus-White or male-versus-female polarizations keep people stuck. Therapists can also serve as "culture brokers" (McGoldrick & Giordano, 1996, p. 23) who help the family identify and resolve cultural conflict. Conflicts can exist intrapersonally and within the family regarding cultural background, including pride in some aspects and shame about others. Therapists need to notice and address such polarizations. For example, in families with generations at different levels of acculturation, the different generations may become polarized. The therapist should try to validate the older and younger generations together, to reduce polarized discussion (see the case study).

Within the last decade, one of the most comprehensive multicultural approaches to therapy was introduced, *The Cultural Context Model,* which "revises the endeavor of family therapy to include the pursuit of justice at every level" (Almeida et al., 2008, p. 6). The model includes a multi-family component, as well as unique combinations of children's programming and individual and couple sessions (see Chapter 3 of *Transformative Family Therapy: Just Families in a Just Society* by Almeida et al., 2008, for a complete description). For working with one couple or family at a time, the following basic tenets of the model (Almeida et al., 2008, p. 6) are helpful:

- Inviting clients' critical awareness of diversity and power
- Emphasizing how hierarchies of power, privilege, and oppression perpetuate suffering
- Experientially demonstrating the link between fairness and relational feeling
- Expanding the therapeutic encounter to include a community with critical consciousness
- Defining empowerment in collective, rather than individual, terms
- Linking social activism to therapy as a means of empowering families
- Inviting and embracing systems of accountability for clients and therapists
- Creating a basis for developing authentic relationships across diverse communities
- Helping people think about ways to connect past, present, and future legacies

Like issues related to gender and sexual orientation, cultural issues should be addressed regardless of the therapeutic model. Many of the interventions suggested for a gender-aware therapy, particularly including attention to power dynamics, are equally useful in multicultural therapy. Additionally, as with issues of sexual orientation, it is important to recognize issues of minority stress when working with individuals outside the dominant culture. The most important intervention from a multicultural perspective is to maintain a collaborative stance with the clients. By maintaining collaboration, therapists can avoid pitfalls of power and can empower families to change.

Case Study

Lupe (age 42) is seeking therapy because she is concerned about her daughter, Rose (age 14). Lupe is divorced from Rose's father, Manuel. Lupe does not believe that Manuel would be a resource for helping Rose at this time. Lupe was born in Mexico but immigrated to the United States when she was an adolescent.

Lupe reports that Rose has been getting into trouble—breaking curfew, getting poor grades, skipping school, and dating older boys. Lupe also expresses disappointment that Rose spends most of her time away from home and does not eat meals or attend church with her. Lupe is concerned that Rose will not be able to find a suitable husband if she does not start "acting like a lady." Rose claims that her mother "just doesn't want me to have friends" and is "trying to keep me her little girl." Rose argues that she is not doing anything that her friends are not doing, adding that her mother just does not understand how difficult it has been for her to make friends and fit in at her school. Rose says that she does not spend more time with Lupe because "it is boring to hang out with Mom" and "church is stupid."

While listening to Lupe and Rose share their perspectives, the therapist recognizes that the mother and daughter are experiencing common difficulties with emancipation. However, using a cultural umbrella, she seeks to understand these difficulties within a cultural context. For instance, does the daughter feel as though she must deny her cultural beliefs and practices to "fit in" at a school that is predominantly White? Is Rose's "pulling away" from her mother influenced in part by pro-racist messages that her culture's ways are inferior? How are different levels of acculturation influencing the emancipation process?

The therapist collaboratively explores these questions with Lupe and Rose. Using culture as the central metaphor of therapy, she helps Lupe and Rose understand their difficulties within a cultural context, providing a means for reconnection and commonality. She helps Rose reconnect with her cultural background by encouraging her involvement in a youth group at her church, where she can interact with people her own age. The therapist also explores the racism that Rose encounters at school and facilitates a *critically conscious* activity in which Lupe and Rose overtly discuss issues of power and privilege as it relates to Latina culture.

In addition, the therapist inquires about the process by which daughters emancipate within the Mexican culture. As a result of these efforts, Lupe and Rose decide that, when Rose turns 15 years old, they will hold a *quinceañera*—a Mexican tradition that marks a girl's passage into adulthood and renews baptismal vows in the Catholic Church. One significant part of this tradition is the father-daughter dance; this will provide a way for Rose to reconnect with her father. Recognizing that it is time to plan the *quinceañera* allows Lupe to realize that her daughter is becoming a woman. Her daughter's enthusiasm for the ceremony alleviates some of her fears about Rose "losing her way" in the dominant culture.

Recent Research

A great deal of recent research focuses on cultural or ethnicity factors in family therapy, including several content analyses (see Seedall, Holtrop, & Parra-Cardona, 2013, for a look at diversity, social justice, and intersectionality trends in C/MFT journals, and Hernandez & Curiel, 2012, for a content analysis on Latino diversity in the family therapy literature). Bermudez, Kirkpatrick, Hecker, and Torres-Robles (2010) asked Latinos how much they agreed with various statements taken from MFT literature on Latino families. Findings indicated that Latinos agreed with most statements about familism and personalism, but were mixed regarding sense of hierarchy, spiritualism, and fatalism. Bermudez et al. (2010) also found that the Latinos in their sample were likely to seek help from MFTs as well as other mental health professionals. Another piece of focusing on cultural and ethnicity factors is increasing in focus on international family therapy. Crane (2013) provides an introduction to a special issue of *Contemporary Family Therapy* on international developments in family therapy, while others have described how research is being implemented to inform practice with diverse populations (for a description of community-based applied research with Latino immigrant families, see Baumann, Rodriguez, & Parra-Cardona, 2011, and for a social justice agenda for family therapy research and practice, see Imber-Black, 2011).

Therapist-client matching is another area of recent research. Pakes and Roy-Chowdhury (2007) explored cross-cultural therapy using discourse analysis, and Horst et al. (2012) looked at the importance of matching ethnicity/race between therapist and client in couple therapy for domestic violence. On a similar note, Seshadri and Knudson-Martin (2013) explored how couples manage interaction and intercultural differences, while Bell-Tolliver, Burgess, and Brock (2009) explored strengths in African American therapists working with African American families.

Bermudez and Stinson (2011) explored conflict resolution styles in Latino couples, researching the roles of gender and culture. Carneiro (2013) explored intersections of culture and religion by looking at the role of Christianity in therapy with Latino families. To further explore ethnicity, Awosan, Sandberg, and Hall (2011) researched the experience of Black clients in marriage and family therapy, and Hall and Sandberg (2012) looked specifically at African American clients who overcame barriers to engage in family therapy, using a qualitative lens. Finally, several recent articles looked at ways to build cultural competence among therapists (Dupree, Bhakta, Patel, & Dupree, 2013; Esmiol, Knudson-Martin, & Delgado, 2012; Seponski, Bermudez, & Lewis, 2013).

Recommended Readings

There are many helpful books that the interested reader should consider. The two most comprehensive books are *Ethnicity and Family Therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005), and *Re-Visioning Family Therapy: Race, Culture,*

and Gender in Clinical Practice (McGoldrick & Hardy, 2008). There are also more culturally specific volumes, including Celia Jaes Falicov's recent update to *Latino Families in Therapy* (2013), and Nancy Boyd-Franklin's *Black Families in Therapy: Understanding the African American Experience* (2006) describes well the issues of working with African American families. Karis and Killian (2008) explore working with intercultural couples.

Spirituality

In the past, religion and spirituality were often considered only under the umbrella of culture (see Breunlin et al., 1997, for an example). However, interest has grown over the past two decades regarding spirituality and religion in clinical practice as a unique context (Harris, 1998; Prest, Russel, & Souza, 1999; Stander, Piercy, Mackinnon, & Helmeke, 1994; Walsh, 2009).

In one form or another, spirituality and religion have been a part of our field for many years (Humphrey, 1983). In fact, pastors and ministers were some of the earliest CFTs (see Helmeke & Bischof, 2011, for a review of the history of integrating spirituality in therapy). Yet in general, we have attempted to maintain a *secular* outlook, keeping religion and therapy strictly apart. Despite the perceived separation, a large number of counselors identify as Christian and believe that part of their job requires counseling in religious beliefs (Wylie, 2000). The American Association of Christian Counselors had approximately 18,000 members in 2000, and by 2013, the number nearly tripled, to 50,000 members (AACC, 2013). By contrast, the AAMFT represented about 23,000 members in 2000 and currently represents the interests of over 50,000 therapists. Clearly, a clinical interest in religion and spirituality exists and seems to be growing.

Religion has been defined as "an organized belief system that includes shared, institutionalized, moral values, practices, involvement in a faith community, and for most, belief in God or a Higher Power" (Walsh, 2009, p. 5). Over 80% of Americans identify as Christian, with nearly half identifying as Protestant (e.g., Baptist, Methodist, Lutheran) (Gallup, Inc., 2008). Sixty-two percent of individuals in the United States say they are members of a church or synagogue. The non-Christian population in the United States has grown from 3.6% in 1900 to nearly 15% in 2000 (Gallup, Inc., 2002); it is expected to continue to grow. The percentage of Americans who identify as Jewish is 2%; Islam, Hinduism, and Buddhism each are currently at 1%.

In contrast, *spirituality* is "a dimension of human experience involving transcendent beliefs and practices" (Walsh, 2009, p. 5). Spirituality can be experienced either within or outside organized religion; it is more often seen as a general construct that does not necessarily have to do with a specific Higher Power. In fact, some define it as a sense of connection to others, the world, and the universe (Walsh, 1999). According to one model, spirituality has four

elements: (a) the cognitive, wherein spirituality prompts us to reflect upon our lives, our relationships, and the meaning we give to experiences; (b) the affective, wherein spiritual beliefs help people experience a sense of safety and security, confidence and hope, and belonging and connection; (c) the behavioral, wherein spiritual experiences and beliefs lead to lifestyle choices; and (d) the developmental, wherein beliefs are transmitted through religious affiliations, values, and beliefs in the family of origin and continue to evolve over the life span (Haug, 1998).

According to Bibby (2002) and Miller and Thoresen (2003), there has been a growing interest in spirituality as people seek meaning, harmony, and greater connections. Despite a decrease in formal denominational affiliation and congregational membership (Lindner, 2008), there has been an increase in **pluralism**, which involves energetic engagement with diversity and relationship with a common society of diverse faith groups (Eck, 2006). It also involves working together for a common good (see the website of Harvard's Pluralism Project, www.pluralism.org).

Spirituality and the Clinical Practice of Couple and Family Therapy

Couple and family therapy's exploration of spirituality is a relatively recent phenomenon (Harris, 1998; Prest & Keller, 1993; Walsh, 2009). In the past, the field has been interested in establishing a scientific authenticity that has interfered with the embracing of spirituality—a decidedly unscientific pursuit. In addition, the field has steered away from spirituality because of rigid conceptions of spirituality and religion as requiring evangelism.

In part, this has been due to therapists attempting to be attentive to power issues—telling clients how to live their spiritual lives was seen as a potential abuse of power (Prest & Keller, 1993), and some therapists feared that talking about religion would be considered proselytization (Carlson, Kirkpatrick, Hecker, & Killmer, 2002). Indeed, it is helpful to be aware of power differentials and to have an understanding of the varieties of spiritual experience within ourselves, families, and society (Ross, 1994; Stewart & Gale, 1994; Walsh 2009). However, spirituality is a contextual issue that should no longer be ignored.

Walsh (2009) refers to religion and spirituality as a "wellspring for health, healing, and resilience" (p. 31). She states that many couples and families who seek therapy are seeking deeper meaning and connection, not simply a reduction of their symptoms. Clients may attend therapy for deep spiritual wounds or as a result of normative life transitions (e.g., death of a parent, birth of a child). These clients may benefit from a direct integration of spirituality; yet, clients often report feeling uncomfortable bringing such issues to the therapeutic conversation (Walsh, 2009). Therapists, however, can create an environment in which it is safe to discuss issues of religion and spirituality.

Despite the therapist's responsibility to create a safe environment for all topics, most CFTs are not formally trained to incorporate issues of religion and spirituality into therapy. A study by Carlson and colleagues (2002) found that although many CFT graduate students value the role of spirituality and religion in their own lives, they feel constrained from discussing spirituality in their professional lives and fewer than half had any training regarding spirituality. Interestingly, eight years later, student therapists and CFT faculty members continued to see a great need for education regarding the integration of spirituality in clinical practice (Carlson, McGeorge, & Anderson, 2010). To overcome many of the constraints communicated by therapists, Walsh (2009) recommends three approaches. See Table 3.3 for her recommendations, as well as examples of how to implement them.

It is important to note that some individuals have been hurt by, or exiled from, religious communities. Some religions espouse patriarchy, sexism, and heterosexism (Walsh, 2009). Some religions promote negative messages about, or overtly discriminate against, LGBT families, which may compound the level of minority stress for LBGT individuals (Rostosky, Johnson, & Riggle, 2012). Furthermore, some religious fundamentalists promote traditional gender expectations in which women are considered second-class citizens. In cases of domestic violence, the message to women in some religions is that they must not be a "good-enough" wife. It is important to note that most religions do not condone domestic violence.

TABLE 3.3 Overcoming Constraints to Integrating Spirituality

Constraint	*Recommendation*	*Examples*
Spirituality is not the proper domain of mental health professionals	Build connections and collaborations between secular and sacred domains	• Link couple and family therapists with clergy and lay leaders to provide a pre-marital program to couples in the community (see Stanley et al., 2001). • Collaborate with a religious community to provide family mentorship in which parish families invest in a relationship with a struggling family (McRae & Walker, 2007).
Risk of therapists influencing or proselytizing vulnerable individuals	Foster collaboration and empowerment with clients	• Gain awareness of one's own beliefs and recognize that one's pursuits (or lack of) within therapy influence the relationship, process, and outcome (Walsh, 2009). • Respect clients by not avoiding a discussion of their values, practices, and concerns (Walsh, 2009).
Skepticism that spirituality can influence mental health	Seek opportunities to learn about the integration of science and spirituality	• Read the following: Hill & Pargament, 2003; Koenig, 2005; and Koenig et al., 2001.

Source: Adapted from Walsh (2009).

Fortunately, for many, religion and spirituality are a great source of strength. Research on healthy families consistently shows that spiritual beliefs and practices are key ingredients in healthy functioning (Koenig et al., 2001; Stinnett & DeFrain, 1985; Thomas, 1992; Walsh, 2009). Religion and spirituality can also be sources of support for LGBT families (Rostosky, Dekhtyar, Cupp, & Anderman, 2008). Helping people cope with negative life experiences through spirituality inevitably provides an opportunity to give meaning and ritual to daily life while promoting healthy relationships, service to others, and resilience (Koenig et al., 2001; Pargament, 2007; Walsh, 2009).

Assessment

Assessment of spirituality and religion within the family is vital to incorporating spirituality in clinical practice. An initial assessment in individual, couple, and family therapy may begin with identifying whether the client is affiliated with a specific faith tradition and/or transcendent values (i.e., spirituality) (Walsh, 2009). Following this identification, the therapist may inquire about the role of religion and/or spirituality in the clients' lives. For example, it is helpful to gather a spiritual history of each partner, asking questions such as "How did your parents and families express spiritual beliefs?" "Do you recall any significant experiences (positive or negative) while growing up that had to do with religion?" and "Is your current spiritual orientation the same or different from that of your family?" (Hodge, 2005a, 2005b; Sperry, 2001).

Walsh (2009) then suggests a series of questions to identify religious/spiritual sources of distress (e.g., "Have religious convictions contributed to suffering or oppression?" "Has adversity wounded the spirit?") and resources (e.g., "How do you find spiritual nourishment, connection, strength, meaning, or inspiration?" "How have your spiritual resources supported personal and relationship well-being?"). After gaining an understanding of the role of religion and/or spirituality within the clients' lives, the therapist may want to further assess the role of spirituality within the family's dynamics. Raider (1992) suggests four general areas in which to assess spirituality. Table 3.4 illustrates some specific assessment questions for each area.

Finally, it is also important to assess the degree of fit between therapist and client regarding belief systems (Anderson & Worthen, 1997; Breunlin et al., 1992; Haug, 1998; Rotz, Russell, & Wright, 1993). When beliefs are similar, such beliefs may be a source of therapeutic strength (Anderson & Worthen, 1997). In the case of a lack of fit, these differences should be processed. For example, if a therapist is Catholic and has clients who are Muslim, these differences should be acknowledged and made explicit. Regardless of fit, spirituality can be integrated successfully into intervention.

TABLE 3.4 Examples of Spirituality Assessment Questions

Dimension of Family Functioning	*Questions*
Family structure	• To what extent does the family's religion specify rules and norms concerning marriage, divorce, contraception, fidelity, etc.? • To what extent does the family's religion specify sex roles? • To what extent does the family's religion value family life?
Family processes	• What is the religious orthodoxy of each member of the family? Are the members of the family similar to one another? • To what extent does the family's religion emphasize emotional closeness, nurturance, and intimacy among family members? • To what extent does the family's religion influence the family's capacity to tolerate diversity and different points of view?
Boundaries	• To what extent does the family's religion influence family rules, norms, and expectations that determine family members' behavior? • To what extent does the family's religion influence family morals, values, and ethical positions? • To what extent does the family's religion influence the family's boundaries within the neighborhood and community?
Family system equilibrium	• To what extent does the family's religion emphasize tradition, order, and stability? • To what extent does the family's religion shape the family's identity? • To what extent does the family's religion prescribe family rituals characterized by repetition, stylization, and order?

Source: Adapted from Raider (1992).

Intervention

As in working with clients regarding gender, sexual orientation, and cultural contexts, a collaborative therapeutic stance is important in working with clients regarding spirituality and religion. Joanides (1996) notes that adopting a collaborative approach reduces the tendency to mislabel religious issues as pathological, prevents the therapist from misinterpreting subtle religious issues as irrelevant to therapy, and helps keep therapists from inadvertently imposing their worldview on client families while allowing a broader and deeper discussion of the family's religious and spiritual experiences.

Moreover, therapists must be aware of their own religious beliefs and values when intervening with clients. In particular, religiously or spiritually sensitive therapists should have respect for the "ethic of religious autonomy" (Stander et al., 1994, p. 31). Spiritually sensitive therapists should also pay attention to clients' personal struggles to grow religiously, yet approach potentially religious

issues (e.g., divorce, abortion, sexual orientation, etc.) without allowing their own struggles to interfere with the therapy (Stander et al., 1994).

Keeping the spiritual umbrella closed may create a situation in which intervention occurs in the absence of complete information about the context. For example, in a recent article, Simonic, Mandelj, and Novsak (2013) present information on religion-related emotional abuse and discuss the complex role that religion, including transgenerational influences, can play in perpetuating abusive family relationships. In this case, not understanding the role of religion may result in inappropriate care. Whenever religion or spirituality has been harmful to clients, therapists must attend to these hurts and provide opportunities for healing.

Additionally, therapists should seek to use religion and spirituality as a resource in therapy. Many religious practices, including prayer, meditation, and rituals, can be fostered and explored with families (Imber-Black & Roberts, 1992; Roberts, 1999; Walsh, 2009). For example, Senter and Caldwell (2002) suggest that therapists working with women who are trying to leave an abusive relationship utilize the woman's spiritual beliefs as a resource. Similarly, Marsh and Dallos (2001) suggest that clinicians utilize prayer and meditation as tools for couples seeking to manage anger and conflict. With an intervention that is religious or spiritual in nature, it is important to work collaboratively with the client to ensure that the practice (e.g., prayer, worship) is significant and meaningful to him or her.

To promote the strengths and healing that spirituality can provide outside of a specific religion, therapists can help clients seek alternative ways to build strength, resilience, and hope. For example, the book *Rituals for Our Times: Celebrating, Healing, and Changing Our Lives and Our Relationships* (Imber-Black & Roberts, 1992) explores nonreligious ways to build rituals in family life. Additionally, 12-step programs such as Alcoholics Anonymous are built upon essentially Christian ideals (confession, service to others) but stripped of religious trappings and boiled down to their essential spirituality (Berenson, 1990; Walsh, 1999). This approach to spirituality has been healing for many people, and CFTs might find ways to incorporate 12-step principles into their practice as a way of increasing spirituality.

Another positive aspect of utilizing spirituality is in the encouragement of faith-based activism (Walsh, 1999) and justice-seeking spirituality (Perry & Rolland, 2009). Walsh reports that resilience often stems from individuals gaining strength from collaborative efforts to right wrongs or bring about change. Therapists can promote this sense of strength by drawing on the tenets of their clients' beliefs to "give back" or show "mercy and justice." For example, Judaism promotes *tikkun olam,* which is the repair of the world (Perry & Rolland, 2009). Given the potential societal and therapeutic benefits of social justice activism, therapists should seek opportunities for their clients to engage in such activities (Perry & Rolland, 2009). Others have also espoused the benefits of service (e.g., Doherty, 1995).

Further resources are available for learning about the use of spirituality in therapy. One such resource for therapists and clients is *Care of the Soul: A Guide for Cultivating Depth and Sacredness in Everyday Life* (Moore, 1992). Also, *Spiritual Resources in Family Therapy* (Walsh, 2009) goes into great depth on many of these topics.

Case Study

Sue (age 43) and John (age 45) have recently decided to get married. Both have two children from previous marriages. The couple sought therapy in preparation for blending their families. They are primarily concerned about how to manage their difference in spiritual beliefs—whereas Sue and her children are Catholic, John identifies as atheist, and his children do not attend church. John states he is spiritual in that he finds purpose and meaning in building connections with others. They state that their concerns came to a head when Sue's mother passed away, about a year ago. Although Sue and her children are managing their grief in a healthy way, Sue and John have trouble talking about the conflict and hurt that remains.

Sue reported feeling neglected by John: "I just needed him to accept my beliefs for once." She stated that initially the only relief she felt from her intense grief was to think of her mother in heaven. Sue also expressed that as a result of her mother's death, she had increasing concern for John's and his children's salvation. John stated that when Sue's mother died, he was forced to "walk on eggshells" to avoid an argument about God. He expressed a desire to be supportive of Sue, but stated, "I could do nothing right. I'd say her mom's in a better place—she'd be pissed. I'd say 'I love you'—she'd be pissed."

The therapist normalizes that many stepfamilies encounter difficulties in blending their families. He empathizes with both Sue and John, and he commends them for seeking therapy. He states that differences in faith can present challenges but that many couples have found ways to effectively manage them. As he listens to their story, he begins to conceptualize their situation through an assessment of their spiritual distresses and resources. He also assesses the meaning that Sue and John give to death, and he inquires about rituals around death in each of their own families of origin.

After a thorough assessment of the couple's situation and beliefs, the therapist makes several recommendations and seeks their collaboration. First, he discusses the possibility of accepting and honoring multiple realities (i.e., more than one faith) and encourages each partner to learn about the other's belief systems. He encourages the couple to also explore any negative views they may hold about each other's faith and to consider each other's feelings regarding the denial of their beliefs. For instance,

he invites John to consider the pain and fear that Sue may feel as she thinks about John's salvation, while he invites Sue to explore her negative views of atheism and how they may hinder her openness to celebrate more than one type of spirituality.

The therapist also encourages the couple to explore various options for managing these differences. For instance, he helps them consider (a) celebrating all the rituals of both of their families, and exposing their children to both spiritualities; (b) developing their own rituals; and (c) one of them adopting the religion of the other. In exploring these options, he recommends that, to gain additional perspectives, the couple interview other couples who married despite differences in faith.

Recent Research

A few recent research articles have focused on training in spirituality and family therapy. Carlson, McGeorge, and Anderson (2010) compared couple and family therapists' beliefs to those of educators. Therapists were more likely to believe that spirituality plays an important role in both personal and professional identities, though both groups believed that training in spirituality and clinical practice was important. McNeil, Pavkov, Hecker, and Killmer (2012) explored marriage and family therapy graduate students' satisfaction with training regarding religion and spirituality. The researchers found that satisfaction with training was related to whether a course was offered and to perceived need for such training, as well as to overall levels of religiosity and spirituality. Hodge (2005c) offers qualitative assessment tools for spirituality assessment to address a perceived lack of training in this area, while Limb and Hodge (2009) explored spirituality using spiritual ecograms with Native American families and children. Finally, several recent studies have focused on the role of spirituality and religion as coping mechanisms (e.g., in dealing with disasters, Hackbarth, Pavkov, Wetchler, & Flannery, 2011; in dealing with diabetes, Cattich & Knudson-Martin, 2009, and Houston-Barrett & Wilson, 2012).

Summary and Conclusions

As the field of couple and family therapy has matured, therapists' ability to address issues of gender, sexual orientation, culture, and spirituality have improved. Each of these contextual issues plays a role in the everyday life of every member of our society, in both positive and negative ways. There are clear benefits to addressing power and equality in relationships, to addressing power and equality in society, and to addressing issues of power in the larger sense (i.e., a Higher Power).

It is vital that therapists continue to address these issues in their practice. As CFT continues to develop, we are recognizing that to ignore these factors is unethical.

Our hope is that your umbrella is a bit more open now, and that as you continue learning about couple and family therapy, you always keep in mind how gender, sexual orientation, culture, and spirituality affect families and CFT theories.

Recommended Readings

The most comprehensive book in this area is *Spiritual Resources in Family Therapy* (Walsh, 2009).

Glossary

bisexual: A term that refers to men or women who are attracted to both men and women.

circular causality: A nonlinear, reciprocal sequence of events whereby one event modifies another event, which in turn modifies another event, which eventually modifies the *original* event. In linear causality there is a single cause-and-effect relationship; in circular causality, events, behaviors, and interactions are seen as mutually influencing one another (through feedback loops). In families, each member is influenced by every other member of the family system in a never-ending cycle. Families affect individuals and individuals affect their families in a recursive manner.

coming out: A person's process of self-disclosure of his or her sexual orientation.

critical consciousness: The awareness of the political foundation of relationship patterns.

cultural sensitivity: Knowledge, awareness, and acceptance of other cultures.

culture: A shared worldview and behaviors that come about by belonging to and participating in a specific contexts, such as age, gender, family configuration, race, ethnicity, religion, socioeconomic status, geographic location, employment, education, sexual orientation, and/or political ideology.

ethnicity: A way to describe people who have a common ancestry and shared values, customs, and rituals, frequently based on a combination of race, religion, and cultural background.

families of choice: Persons or a group of people an individual sees as significant in his or her life. The family of choice may include none, some, or all of his or her biological family members.

feminism: The realization of women's subordination and inferior position in society, understanding how this position is maintained in society, and a commitment to moving from this position to one of equality.

gay: A term that refers to people (male or female) whose primary intimate attractions are toward others of the same gender.

gender: The characteristics that are associated with the biological categories of male and female. These characteristics include social, cultural, emotional, and psychological aspects.

genogram: A pictorial display of an individual's family composition, family relationships, and other intergenerational patterns.

lesbian: A term that refers to women whose primary attractions are toward other women.

LGBT-affirmative therapy: An approach to therapy that holds a positive view of LGBT identities and relationships. It also addresses the negative influences of prejudice and discrimination that result from homophobia and heterosexism.

metaframework: An overarching conceptual framework or principle that helps explain underlying phenomena or patterns.

minority stress: Stress experienced by minority individuals (e.g., LGBT individuals) as a result of social stigmatization and discrimination.

multicultural perspective: An approach to therapy that recognizes culture as a metaframework and that utilizes a multidimensional definition of culture.

pluralism: A commitment to, and active engagement with, the diversity of religious belief systems co-existing in society. Does not require one to leave behind his or her personal beliefs but recognizes and accepts the diversity of religious beliefs.

power: The ability to impose one's will on others. Those who have power are seen to have influence and authority. Power is involved in hierarchy and typically derives from both tangible (e.g., money) and intangible (e.g., love, interest) resources. Power is also often ascribed to specific roles, often by gender.

race: Often serves as a basis for differential treatment. This treatment is a social construction, meaning it is not merely based on biology or inherited physical characteristics but in fact is the basis for hierarchy in our society.

relational ambiguity: A feeling of uncertainty regarding the definition of one's relationship.

religion: An organized and agreed-upon belief system that involves beliefs about God or a Higher Power. Religion typically involves institutionalized beliefs, a shared community, and shared rituals.

reparative therapy: Also called conversion therapy. A term for therapeutic approaches aimed at changing one's sexual orientation from homosexual to heterosexual. Organizations such as the American Psychological Association have identified such practices as unethical and inappropriate.

sexual minority populations: Individuals who identify as gay, lesbian, bisexual, or transgender.

sexual orientation: One's sexual identity in relation to the gender to which he or she is attracted. Sexual orientation should also be viewed on a continuum.

spirituality: An overarching and more general construct referring to transcendent practices and beliefs. Spirituality does not necessarily have to do with a specific Higher Power.

therapeutic neutrality: In systems theory, the therapist focuses on the processes of relationships. Therefore, a neutral family therapist would not see any one family member as causing the problems and would be unable to align with any one family member on any issue, due to a belief in circular causality.

transgender: A term referring to individuals whose gender identity is different from the gender commonly socially assigned to them on the basis of their biological sex.

transsexual: A term referring to individuals who do not identify with the sex they were born with and change their sex through use of medical intervention.

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PART II

Theories in Marriage and Family Therapy

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4

STRUCTURAL FAMILY THERAPY

Jared A. Durtschi and Joseph L. Wetchler

> Minuchin: What is the problem? . . . So who wants to start?
> Mr. Smith: I think it's my problem. I'm the one that has the problem . . .
> Minuchin: Don't be so sure. Never be so sure.
>
> Salvador Minuchin
> *Families and Family Therapy*

During the late 1960s, an Argentine-born psychiatrist named Salvador Minuchin challenged patients, family members, and mental health professionals to view emotional problems from a family perspective rather than an individual one. His clinical flair and personal charm enabled him to seduce families to change in an often startling and provocative fashion. However, although his methods were certainly dramatic, they were based on solid theoretical tenets.

Structural family therapy views families and emotional distress from an organizational perspective: Individual problems are maintained not through personal pathology, but rather through flaws in a family's organizational design. Structural family therapists do not attempt to resolve an individual's problems as much as they work to alter the family's organizational structure. After this family structure has been altered, it allows family members to relate to one another in new ways that enable them to solve their problems themselves (Minuchin, 1974; Minuchin & Fishman, 1981).

Major Figures in Structural Family Therapy

In the early 1960s, Salvador Minuchin joined the staff of the Wyltwick School, in upstate New York, to work with juvenile delinquents. It was here that he discovered the limits of a traditional psychotherapy background. Basically, he found that

insight-oriented, individual approaches did not work with a non-motivated teenage population. Physically active boys who were cut off from their feelings tended to be highly resistant to the quiet reflection required for individual therapy. Further, talking about feelings and problems often seemed futile when parents were concerned with stopping their child's violent behavior. With colleagues Braulio Montalvo and Bernice Rosman, Minuchin developed an action-oriented approach that utilized a family perspective to treatment (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967).

Based on his success at the Wyltwick School, Minuchin moved on to become the director of the Philadelphia Child Guidance Clinic. From its humble beginnings as an inner-city child guidance center, under Minuchin the Philadelphia Child Guidance Clinic grew to become one of the foremost centers for family therapy training in the 1970s and early 1980s (Nichols & Schwartz, 1998). With Montalvo and Rosman from the Wyltwick School, Minuchin joined forces with Jay Haley, Harry Aponte, Charles Fishman, Jorge Colapinto, Cloe Madanes, and Marianne Walters to develop and refine structural family therapy.

In 1976, Minuchin resigned as director of the Philadelphia Child Guidance Clinic, but he remained the director of training until 1981. From there he moved to New York City to start his own small center, Family Studies Inc., with colleagues George Simon and Wai-Yung Lee. Following his retirement in 1996, the center in New York City was renamed the Minuchin Center for the Family. Currently, Minuchin lives in Florida, and at 92 years young, he is in the process of publishing a new book on training in family therapy, and he continues to consult and supervise at a local clinic one day a week (C. Fishman, personal communication, September 12, 2013).

Although the pioneers at the Philadelphia Child Guidance Clinic have since moved on, several members of the original team and its students continue to make notable contributions to the structural family therapy literature. Montalvo, Colapinto, and Aponte are considered elder statesmen within the family therapy community, and second-generation structural family therapists Fishman and Simon have continued to develop the theory (e.g., Fishman, 1993, 2004; Simon, 1995). Haley and Madanes developed their own school of strategic family therapy (see Chapter 5), and Walters became a major figure in the feminist family therapy movement (see Chapter 3).

Theoretical Concepts of Structural Family Therapy

Family Structure

Like other schools of family therapy, structural family therapy focuses on the role of context in maintaining and solving individual problems. It is unique in its focus on family organization and the active role assigned to the therapist as an agent of change (Colapinto, 1991). In fact, it is from this view of the family as

an organizational entity that the theory derived the name "structural family therapy." Minuchin and Fishman (1981) state: "The family is a natural group which over time has evolved patterns of interacting. These patterns make up the family structure, which governs the functioning of family members, delineating their range of behavior and facilitating their interaction" (p. 11).

Structural family therapists believe that problems are maintained, not caused, by a dysfunctional family organization. Therefore, they are less concerned with the root cause of the problem than they are with how the family is structured in its attempts to solve the problem. Rather than focusing on the history of the problem, structural family therapists are interested in present-centered issues such as who is in charge, which family members are in **alliance** and which are in conflict, how much personal space exists for family members to assume responsibility for their actions, who has power over whom, and how much flexibility exists for family members to change roles in new and different situations.

Structural family therapists view families similarly to how an organizational consultant looks at a corporation. Every family has an unspoken structural flowchart that shows who is in charge and the responsibilities of each member. Various family structures dictate the patterns in which families communicate (Aponte & VanDeusen, 1981). The manner in which a family is organized affects who takes the leadership role in specific situations and who talks to whom about certain subjects. For example, in many families the parents are in charge of setting limits on their young children's behavior; they discuss and set the rules and values for raising their children. However, although these children are excluded from disciplinary discussions, they may be included in family decisions about where they will go on family outings.

When a family comes to therapy, a structural family therapist assesses how the family organizes itself regarding solving the problem. Does an effective leadership pattern exist in dealing with this problem? Do people talk directly to one another about the problem, or are others inappropriately involved as mediators? Are problems maintained because certain family members are in secret alliance against other family members? Are some people unable to solve their own problems because other family members intrude on the resolution process? Is the family flexible enough that the family members can change their organization to solve the problem, or do they attempt to resolve it with an outmoded structure? The answers to these types of questions about a family's organization enable structural family therapists to develop treatment plans and interventions to meet a family's specific needs.

All families have a variety of structures to handle different situations (Minuchin, 1974). For example, although the mother and the father might handle the majority of housework in a family, some of the older children might have to assume more of this responsibility if a parent develops a serious illness. As the parent recovers, he or she can return to the position of authority, or perhaps the family

members might renegotiate their roles around who handles which responsibilities at home. Similarly, it is important for various subgroups to handle different tasks. One parent and child might be the best subgroup to work on problems with math homework, whereas the two brothers who share a room might be the best subgroup to decide on what posters they hang on their walls (of course, parental supervision might be necessary in this process).

Family Competency

At the heart of structural family therapy is a fundamental belief in the basic competency of families (Simon, 1995). Problems exist not because of a core dysfunction in the family, but rather because the family is unable to access a workable structure to solve the problem. As Minuchin states (in Minuchin & Nichols, 1993):

> When families come to me for help, I assume they have problems not because there is something inherently wrong with them but because they've gotten stuck—stuck with a structure whose time has passed, and stuck with a story that doesn't work.
>
> (p. 43)

According to this theory, all families have the potential to solve their own problems. In fact, the ability to access appropriate structures usually already exists in their repertoire. It is the therapist's task to convince families to risk searching for alternatives they already possess (Simon, 1995).

Boundaries and Subsystems

In keeping with its organizational approach, structural family therapy focuses on the structure of the entire family system, as well as smaller **subsystems**, or groupings of family members concerning specific tasks. For example, husbands and wives form the spouse subsystem, which provides mutual support, sex, and companionship, as well as the parental subsystem, which makes executive decisions about child rearing, discipline, and nurturance. Children, on the other hand, form the sibling subsystem, in which they learn about mutual cooperation, peer problem solving, and how to support one another (Colapinto, 1991). Other relevant subsystems from the larger family system may include a divorced couple who continue to coparent their children, or a spouse and his or her paramour, or a grandmother and a grandchild, or an adult child who has moved back in with the parents. Other subsystems can serve a temporary function, as when a father and a daughter work on a school project together or a mother coaches her son's Little League team.

Individuals are a subsystem unto themselves as well as being members of numerous other subsystems. In fact, all subsystems belong to even larger subsystems. For

example, the family is a subsystem of the extended family and the community in which it lives. The term **holon** refers to a subsystem that is both a system in its own right and a subsystem of a larger system. "Every holon—the individual, the nuclear family, the extended family, and the community—is both a whole and a part, not more one than the other, not one rejecting or conflicting with the other" (Minuchin & Fishman, 1981, p. 13). Structural family therapists would say that an individual's identity is formed by being a member of numerous subsystems. Within such various roles as spouse, parent, employee, lover, and child to one's own parent, we develop different aspects of personality and develop a sense of self.

Boundaries are the rules that govern who is included and excluded from a specific subsystem. It is as if these rules form an invisible fence around each group and define its membership. However, these subsystems do not exist in isolation; following the idea of holons, they are in constant interaction with other subsystems within a family. **Clear boundaries**, those boundaries that successfully enclose a subsystem yet enable communication with other subsystems, are important for optimum family functioning (see Figure 4.1). "They must be defined well enough to allow subsystem members to carry out their functions without undue interference, but they must allow contact between the members of the subsystem and others" (Minuchin, 1974, p. 54). The composition of a subsystem is not as important as the clarity of a subsystem's boundaries. Therefore, optimum functioning in one family might include two parents working together to run the family; while the **executive subsystem**, the subsystem that takes the leadership role, in another family might be composed of a mother and a grandmother; and a third family might have a **parental child**, an older child with occasional family leadership tasks, who takes charge of the younger children while the parents are at work. Because this is an organizational model, the emphasis is on the successful functioning of a family as opposed to how a family "should" look.

In fact, the clarity of a family's boundaries is an extremely useful parameter for assessing family functioning. Some families have highly **enmeshed boundaries**.

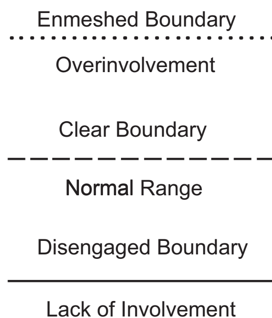

FIGURE 4.1 Boundaries

In such families, there is little autonomy between individuals and other subsystems (see Figure 4.1): It is as if there is no internal support structure for the family, and it is impossible to develop effective subsystem productivity, because everyone keeps intruding in everyone else's business. Children's issues become confused with marital issues, and no one has a sense of self, because it is impossible to tell where one person ends and another begins. Minuchin and Fishman (1981) present a brief example of a dysfunctionally enmeshed system:

> The therapist presses a diabetic girl's wrist. "Do you feel this?" he asks the parents.
>
> "Yes, I do," the father says, indicating his own wrist. "Here. It feels like pins and needles."
>
> "I have very poor circulation today," the mother says, apologizing for not sharing the experience.
>
> (p. 142)

How could a father actually believe that he felt a therapist squeezing his daughter's wrist, and why would a mother believe she should have felt it? Enmeshment at this level is extremely rare. Yet this situation happened in a family in which a diabetic child had to be hospitalized numerous times for diabetic acidosis even though the child received regular doses of insulin. This type of enmeshment is not typical of families with diabetic children, but it was found in several of the families Minuchin, Rosman, and Baker (1978) treated for **psychosomatic diabetes**, cases of diabetes that consistently have to be hospitalized even though the child is on insulin. Although the diabetes is physiological in nature, the flare-ups are thought to be due to psychological or family issues.

Of course, enmeshed boundaries can also be appropriate in certain situations. Parent-infant relationships must be enmeshed, because babies have no way of fending for themselves and are dependent on their parents' abilities to understand their needs based on the tiniest shift in expression. Further, parents must be thoroughly involved in all aspects of their baby's life until their child begins to function autonomously. Until that time, they must feed, clothe, bathe, diaper, and nurture their young one. At the opposite end of the spectrum are **disengaged boundaries**, which successfully enclose a subsystem but are impermeable to outside information (see Figure 4.1). Families with disengaged boundaries are often closed off from the rest of their community. They do not discuss their problems with others and do not voluntarily partake of outside services such as counselors or family-life educators. Again, a disengaged family structure can often be quite helpful. Many families believe that parents should promote autonomy in their teenage children. For example, many parents give their teenagers chores to do on their own and let them make their own decisions about how to spend their allowance. An extremely disengaged boundary between the

parents and child, on the other hand, might result in parents having absolutely no idea where their teenagers go when they leave home, who their friends are, or how they are doing in school. In sum, enmeshed, disengaged, and clear boundaries can each be helpful or harmful, depending on the context. It would be inappropriate to assume that one type of boundary was always limiting or preferred.

Many families show a mixture of boundaries within their organization. Minuchin, Rosman, and Baker (1978) found that several of the families with an anorexic child that they treated had highly enmeshed internal boundaries and overly disengaged external boundaries. Although it was virtually impossible to distinguish the child's issues from the parents', these families were particularly immune to professional intervention. Trepper and Barrett (1989) report a similar phenomenon in incest families in which no sexual boundary exists between the perpetrator and the child; however, these families are so secretive that often no one reports the abuse until several years have passed.

Structural family therapists are also aware that it is useful for families to use multiple types of boundaries at different times. Further, it is desirable for boundaries to change according to different situations. For example, consider a young teenage daughter with an enmeshed boundary between herself and her recently divorced mother and with a disengaged boundary between herself and her mother's new boyfriend. Through the divorce, it seemed to the daughter like a good idea to be extra close to her mother yet to keep a safe emotional distance from her mother's new boyfriend. As the daughter learned to trust the mother's new boyfriend, the boundary between them gradually became more open, whereas the boundary between mother and daughter eventually became somewhat more closed as the stress from the divorce decreased. Thus, boundaries at different developmental points serve various functions, and boundaries become problematic when they do not allow the desired change to occur. Changes in boundaries between family members—and between family and outside systems, such as the parental subsystem and the school subsystem—can allow structural changes that result in all members of the family benefiting individually and collectively.

Hierarchy

Hierarchy refers to a boundary that distinguishes the leadership subsystem from the rest of the family. Structural family therapists believe that an individual, or a group of family members, must assume the leadership role for a family to successfully resolve a given task. Those members within the leadership hierarchy have more power in the decision-making process than the rest of the family. For example, parents typically have a greater role in determining their young children's bedtimes than do the children themselves. Although young children may have input in some situations, such as asking for later bedtimes to watch special television programs, it is still up to the parents to make the final decision. The term

parent–child hierarchy refers to the specific boundary that demarcates the parents' responsibility in child-rearing issues. Figure 4.2 shows a diagram of a parent–child hierarchy with a clear boundary, where F = father, M = mother, and C = child.

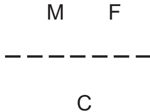

FIGURE 4.2 Parent-Child Hierarchy with a Clear Boundary

As families use different structures to meet the demands of different situations, they must also have different hierarchical arrangements. Typically, the person who is responsible for a specific task assumes the leadership function for that task. The father might be at the top of the hierarchy for cooking meals if he is in charge of preparing supper, and the mother would assume the leadership function for mowing the lawn if she is in charge of yard work. Children also can assume leadership roles. For example, an older son (OS) might take care of the younger children (CC) while a single mother is out but then relinquish that role when she returns. Figure 4.3 shows various hierarchical arrangements.

No hierarchical arrangement is written in stone. In fact, families must often rearrange their structure to meet the demands of specific crises. For example, if a father is recovering from a heart attack, the grandmother might care for him and the children while the mother is at work. Children might receive increased responsibilities for chores and meal preparations following a divorce. When a family fails to appropriately change its leadership hierarchy in times of crisis, severe problems can arise. A family that is lost in the woods would be wise to let the son who is an Eagle Scout be in charge of getting everyone to safety instead of relying on the parents—the usual leaders—if the parents have minimal outdoor skills. Then, when the family returns to civilization, the parents can again assume primary responsibility.

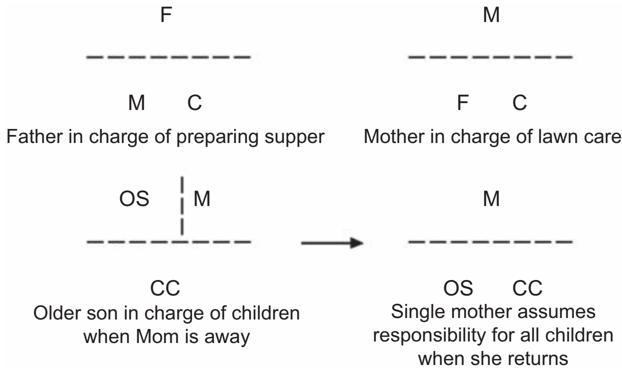

FIGURE 4.3 Typical Hierarchical Arrangements in Families

Problems arise when families fail to adopt a functional leadership subsystem. For example, a parent-child hierarchy may be so enmeshed that the parents are unable to apply appropriate punishment when their children misbehave. The parents may be so concerned about losing their children as friends that they fail to set appropriate limits. In other families, the boundary between parents and children might be so disengaged that, although effective rules exist, the parents are unable to respond to their children's personal and emotional concerns. A crisis can develop because the parents are unaware that their child has a problem. This sometimes happens when parents do not monitor their child's school performance until they discover that he or she has to repeat a grade. In this case, the family must open the lines of communication. Perhaps the parents might create a study time at home, have the child show them his or her work, do homework with the child, or have the school send progress notes to keep them aware of the child's in-class behavior and performance.

Alliances, Coalitions, and Triangles

In everyday life, many tasks are more easily accomplished when family members collaborate. For example, a mother and her daughters raking the leaves and a father and his sons washing the dishes often make the chores go faster. An alliance exists when two or more family members join together to handle a specific problem. Family alliances are typically known to most members and are generally viewed positively. For example, everyone in the family usually knows if two brothers like to go fishing together, or that Mom and Dad work together on paying the bills.

Alliances often shift as family members deal with various tasks. Alliances can exist across family hierarchies and are not limited by a particular subsystem. In fact, each new alliance is a new subsystem. Mom and Dad may be the most effective team to work on parenting issues; however, Dad and the two daughters, who share a mutual interest in rare stamps, might be better suited for having a joint hobby of stamp collecting. Expecting Mom to join in simply because she and Dad are part of the "parenting" alliance would probably diminish the joy for everyone involved. Then again, Mom and Dad would probably most enjoy a night out together without the children, and the kids would feel stifled if their parents regularly intruded on their playtime.

A **coalition** exists when two or more family members join forces against one or more of the others. This usually happens when two family members have a disagreement and a third member joins forces with the seemingly weaker member to balance the score (Aponte & VanDeusen, 1981). Besides being adversarial, coalitions tend to be secretive in nature. In fact, coalitions are most likely to exist when family members are unable to openly discuss a particular problem. The more overt a coalition is, the easier it is to resolve. For example, families can easily recognize and handle situations in which the big sister punches the middle son for breaking the youngest son's toy. It is clear to everyone that

the big sister is defending her youngest brother. It is an entirely different matter if the big sister consistently breaks one of Dad's possessions every time Dad wins an argument with Mom. Dad may not even be aware that his daughter has aligned with Mom against him. This is especially problematic if Mom and Dad do not discuss the problems in their relationship that led to the daughter becoming Mom's champion.

A **triangle** is a specific type of coalition in which two family members join forces against someone else. The previous example characterizing Mom, Dad, and the child who is Mom's champion is a coalition, but it can also be more broadly thought of as a triangle. Although triangles within a subsystem can be relatively benign and are often easily handled, they can be especially problematic when they exist across generations. A **cross-generational coalition** is a specific type of triangle in which two family members from different generations ally against a third member. Cross-generational coalitions typically arise when a power imbalance that cannot be mediated by discussion exists between two family members. The weaker member typically joins forces with a family member of a different generation to balance the power discrepancy.

A common type of cross-generational coalition is when a parent-in-law and a spouse ally against the other spouse. The weaker member typically joins forces with a family member of a different generation to balance the power discrepancy. Problems between an in-law and a spouse may result from one spouse complaining to his or her parent about his or her spouse's behavior. The parent then retaliates by openly criticizing that spouse. This pattern, although highly uncomfortable for the members of the triangle, is not as uncomfortable as the two spouses dealing with the core issues in their relationship. Unfortunately, although this type of interaction balances the power in the family, it does not resolve the core problem. In fact, once started, cross-generational coalitions often maintain the problem. The only way for a problem such as this to be resolved is for the two spouses to openly discuss with each other the problems in their relationship.

Another type of cross-generational coalition exists when a parent and a child join forces against the other parent. Typically, one parent allies with the child against the other parent; however, another pattern involves both parents attempting to enlist the child in a coalition against the other. Such involvement of a child in a parental dispute can be highly stressful for the child, because to ally with one parent automatically earns the disfavor of the other parent; the child must constantly walk a fine line between the needs of each parent (Minuchin, 1974).

A third type of cross-generational coalition is called **detouring**, in which the parents shift their focus to one child every time a problem arises between them. This action happens so fast that the parents may not be overtly aware of the problem between them and simply assume they have a problem child. Minuchin, Rosman, and Baker (1978) explicitly revealed this pattern in a

landmark study of psychosomatic diabetics, or diabetic children who had to be consistently rehospitalized for diabetic acidosis despite being on insulin. Hospitalization is usually rare once treatment for diabetes has begun, yet these children constantly returned with no organic reason for their crisis. For the purposes of this study, the parents and child all had intravenous blood sampling units attached to their arms, from which blood samples were unobtrusively taken at specific intervals over the course of a three-stage experiment. These were later evaluated for the concentration of free fatty acids (FFA) in the bloodstream. Although certain amounts of FFA are normal, the buildup of FFA is a precursor to ketoacidosis in diabetics. Ketoacidosis is a life-threatening condition that can develop in response to deficient insulin, resulting in cells being unable to absorb the sugar needed for energy. FFA levels are also known to rise when an individual is under stress. During the first stage of the experiment, a researcher elicited and maintained an argument by the parents while the child watched from behind a one-way mirror. In the second stage, the child was brought into the room to help the parents resolve the problem. In the third stage, the discussion ended and the family met with a researcher who debriefed everyone and made sure the experiment had no undesirable effects.

The psychosomatic diabetic families showed the most striking physiological examples of detouring compared to normal diabetic families and physiologically and emotionally normal families. During the parent argument stage, both the parents and the child showed highly elevated FFA levels. When the child entered the room, the parents' levels dropped markedly as they focused on the child, yet the child's levels continued to rise. Afterward, the parents' FFA levels continued to drop while the child's were still on the rise.

In contrast, in the normal diabetic families the parents showed a small rise in FFA during the parent argument stage, while the child showed none at all. The child's FFA rose slightly when he or she entered the room, while the parents' returned to normal. Afterward, both the parents' and the child's FFA levels were maintained at the normal level. The reason for the lack of change in FFA levels in the normal diabetic families is that disagreement was not a major form of stress for these families. For the psychosomatic families, however, parental disagreement was very stressful and was detoured onto the diabetic child, who carried the brunt of the family anxiety (Minuchin, Rosman, & Baker, 1978).

Normal Family Development

Minuchin (1974) claims that no single family structure is indicative of health; however, the best sign of functionality is a family's ability to change its structure to meet the demands of various life stages or family crises. Change, transitions, and problems are a part of life, and dealing with them often requires families to make organizational shifts (Nichols & Schwartz, 1998). This is certainly true

for life cycle development. Specific structures are idiosyncratic to individual families, yet we can make some general assumptions.

The primary task of a newly married couple is to develop both external and internal boundaries that define them as a spousal system. Initially, each will attempt to shape the couple according to the rules he or she learned in his or her family of origin. This includes what they eat, when they eat, what they do for fun, when they make love, how many children they have, whether they go to church, and many more decisions both large and small. Through discussion, they develop the rules and procedures that define them as a couple, some of which will be similar to their families of origin and others of which will be unique. It is the ability to successfully negotiate these rules that creates a boundary that separates them from their families of origin. Although healthy couples should always maintain the option of returning to their families of origin for advice and help, they must now depend primarily on each other for decision making and problem solving.

Internally, the new couple must also learn to accommodate each other and to develop internal boundaries. As they develop their rules, each must learn to compromise and recognize when the other has a better idea. Further, they must also negotiate rules that enable each to maintain a unique personhood. Although the couple may choose to do some activities jointly, such as going to church and going to the movies, they may do other activities separately—for example, one may enjoy going to the gym while the other enjoys fishing. Couples are constantly renegotiating their internal boundaries as they change jobs, get promotions, develop new interests, and meet new friends.

The birth of children leads to the development of a parent-child hierarchy, a parental subsystem, and a sibling subsystem. The parents need to open the boundary of their couple system to include their newborn children. Failure to accommodate their children's needs could lead to serious developmental problems for their offspring. Further, the parents need to work jointly in formulating decisions that affect their children without pulling them into the parents' problems.

The type of boundary that exists within a parent-child hierarchy changes as children mature. For example, an infant requires a well-defined hierarchy with an enmeshed boundary. Young children are totally dependent on their parents' decisions regarding their well-being. Further, parents need to be highly in tune to the most subtle clues, because young children lack the verbal ability to fully express their needs. On the other hand, the hierarchy between parents and normal adolescents becomes more egalitarian and less enmeshed as teenagers show increased responsibility and decision-making ability.

It is important that clinicians not mistake growing pains for pathology (Minuchin, 1974; Nichols & Schwartz, 1998). A heightened degree of stress and anxiety accompanies all life cycle transitions. The important issue is whether a family can modify its existing structure to meet the developmental changes.

Nichols and Schwartz (1998) remind us, "Although no clear dividing line exists between normal and abnormal families, we can say that normal families modify their structure to accommodate to changed circumstances; pathological families increase the rigidity of structures that are no longer functional" (p. 249).

Pathology and Behavior Disorders

If structural family therapy defines "normality" as a family's ability to change its structure to solve a specific problem, then at the most basic level pathology exists when a family is unable to alter its structure to handle an existing crisis. No family structure is a panacea; every family structure has strengths and weaknesses. For example, consider a cohabiting couple in treatment who want to stay together and alter their family structure in the aftermath of an affair. In conjunction with the therapist, the couple may decide it is most helpful to develop disengaged boundaries from the paramour in regard to all forms of contact and communication, whereas the boundary between the couple may need to become much more open. Likewise, although having every member of the family involved in decision making can ensure a certain degree of unity for certain situations, such as going on a family outing, it can be cumbersome and even dangerous when an emergency arises and an immediate decision is necessary. Then, having a subsystem choose the path of action may be the most expedient route.

Families must not only possess the ability to change their structure, but also have the wisdom to recognize when they should not change it (Colapinto, 1991). A stable structure is often the best solution for many problems. For example, in many cases of childhood rebellion, the best strategy is for the parents to continue to take charge and punish the misbehavior. Although the child might be angry about the punishment, this does not mean that the parents should not hold firm. In fact, altering their structure and giving in to the child may give the message that no offense was committed or that the child can get his or her way by simply having a tantrum.

Most important, structural family therapists do not see a one-to-one relationship between specific family structures and individual symptoms (Aponte & VanDeusen, 1981). That is, although certain family structures may be associated with higher risks of problem behaviors, the structures do not cause the behaviors. For example, cross-generational coalitions have been implicated in both **anorexia nervosa** (Minuchin et al., 1978) and adult male substance abuse (Stanton, Todd, & Associates, 1982). It is not viewed as atypical when a girl starts to diet because she is concerned about her looks or when a person experiments with drugs. These situations happen all the time in families. From a structural perspective, many families find ways to handle these situations before they become problems. Other families, however, cannot find alternative family structures to nip these problems in the bud or to create an appropriate parent-child hierarchy in which

both parents work together to deal with their anorexic or substance-abusing child.

In essence, structural family therapy provides a highly optimistic view of families. Individual symptoms are due not to dysfunctional or punitive families, but rather to an inability to access a workable structure. Even long-standing problems can be solved if the family can find a workable organization. This does not mean that family members are not capable of doing terrible things to one another, or that they are absolved of taking responsibility for their actions. For example, Trepper and Barrett (1989) believe that it is a crucial part of treatment for fathers who sexually abuse their children to take responsibility and apologize for their actions as an initial part of treatment; however, long-term change is maintained only if these families are able to develop an appropriate boundary between the parent and child generations. Further, much structural renegotiation needs to happen within the spousal subsystem, especially in terms of opening up boundaries around communication and problem solving.

Alignments and coalitions are a normal part of family life. A father and a daughter might secretly unite to throw a surprise party for the mother, or younger siblings might occasionally ally against the older brother who always watches the same television shows. The important point is that alliances and coalitions can shift to different members when appropriate (Aponte & VanDeusen, 1981). Although father and son might be the best twosome for discussing football, Dad and Mom would still be the most appropriate alliance for handling parenting issues.

Alliances and coalitions become problematic when they remain inappropriately stable across time. Let us return, for example, to the father/son who enjoy discussing football. Perhaps a wider view of the family reveals a power imbalance between the mother and the father in which their inability to communicate leads to the mother typically making the family decisions. The father, being lower in the marital hierarchy, begins to rely on the son more for emotional support than as someone to discuss football with. The father-son alliance now has the makings of a cross-generational coalition, especially if the son begins to challenge the mother on behalf of the father. Another variation of this problem is when the parents become ineffective disciplinarians because they cannot agree on how to deal with the son. Each time the mother wants to punish the son for his mistakes, the father takes the son's side. Problems such as these can be dealt with by forming a more solid parent-child hierarchy and having the parents become more open and egalitarian in their relationship with each other. Another option is to create a mother-son alliance that enables them to develop a positive relationship. One single alternative structure is never perfect for solving all problems. Fortunately, many options are available. The most important consideration when selecting a structural treatment option for a given family is its fit with that specific family.

Goals of Structural Family Therapy

Structural family therapists believe that problems are maintained by dysfunctional family structures. Therefore, the primary goal is to help the family develop a new structure. Problem resolution is a by-product of change, as new, more appropriate structures lead to effective problem solving (Aponte & VanDeusen, 1981). First-order change is when a specific behavior within a system changes, whereas second-order change is when the entire family system and family structure is fundamentally changed. Second-order change is believed to be more lasting. Changing the family structure—involving boundaries, hierarchy, coalitions, alliances, triangles, and so forth—is second-order change. In other words, the goal of structural family therapy is to bring about second-order change in the family structure that can lead to preferred outcomes.

Families with problems are viewed not as inherently flawed but rather as suffering from an inability to switch to a more functional family structure. One of the core assumptions of structural family therapy is that all families possess the ability to change (Simon, 1995). Therefore, it is the therapist's responsibility to help them find a more appropriate structure. At that point, the family will begin generating potential solutions.

Structural family therapy is a process-oriented model, opposed to focusing on specific content. The therapist focuses more on altering the family's transactions than on solving specific problems. Once the family structure has changed, the family members individually and the family collectively are more able to realize their desired goals, based on a belief that no therapist has the ability to know what the most effective solution for a family is. The therapist's role, then, is to change the process by which problems are solved. In fact, focusing on the content of a family discussion more than likely will hinder the change process. This is because a therapist who becomes bogged down deciding who is right and who is wrong in a family negotiation has probably been made part of a triangle in a role usually reserved for another family member. It is hard to maintain clinical objectivity when a therapist takes sides on an issue (Minuchin & Fishman, 1981). Further, it can be difficult to focus both on content and on the process involved in changing a family's structure. Some examples of how to assess family process and family structure are included below, in the discussion of structural diagnosis.

Family assessment typically involves asking questions about how a family attempts to resolve its problems and observing the family members in action. Using that information, the therapist generates a **family map** in which he or she diagrams the family's current dysfunctional structure. From there, the therapist can develop a more suitable alternative structure. For example, Wetchler (1992) describes a family in which a son consistently missed school due to a psychosomatic stomach ailment. The boy lived with his mother, but his stepmother made most of the decisions concerning his health and school attendance. The family's structure had the stepmother at the top, providing most of the leadership

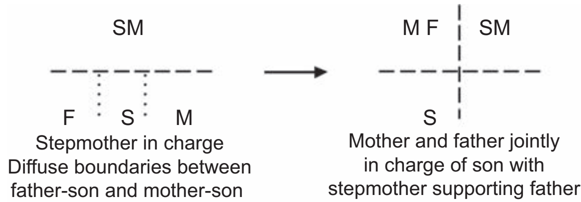

FIGURE 4.4 Change from Nonfunctional to Functional Hierarchy in Family of Boy with Stomach Pain

for the son, and the son at the next level, in between his two divorced parents who ineffectively argued about how to care for him. Most of the communication between the biological parents was carried out by the son, because the two did not speak to each other (see Figure 4.4). The goal of this therapy was to create an appropriate parent-child hierarchy, with the two biological parents deciding how to handle their son's stomach problems and lack of school attendance and with the stepmother off to the side as a support to the father. Having the parents negotiate a set of rules and consequences while the son stayed out of their discussions took several sessions. The parents' initial response was to pull the son, or the stepmother, into their discussions when they began to disagree with each other. The results of the intervention were that the parents agreed to have the son live with the father and stepmother and that he was not to miss school unless he had a fever. The parents had to punish the boy for not attending, but he eventually went back to school and had perfect attendance.

Structural Family Therapy Techniques

Structural family therapy techniques tend to be action focused rather than insight oriented (Minuchin & Fishman, 1981). This is consistent with structural family therapy's original development as a model for treating families with adolescents in the context of poverty and needing practical help with challenging problems. Many of these children had no interest in discussing their problems, and the families did not have the luxury of long-term discussions about their problems' possible origins. They needed to take action quickly. When parents are confronted by a son threatening them with a knife, they need to know how to safely convince their son to hand over the knife. Discussions about insight are better left for more calm and reflective times.

Joining

Families are often anxious when they begin therapy. They wonder whether their therapist will understand them or blame them for their problems. They worry about how much to reveal about themselves and whether they can trust their

therapist with this information. They ask themselves questions such as "Will my therapist like me?" "Will my therapist blame me for these problems?" "Will my therapist think I am crazy?" and "Can this therapist really help us?" All of these concerns are valid, and all must be addressed before a therapist can help a family change.

Joining is the process in which family therapists let their clients know that they understand them and are working to help them (Minuchin & Fishman, 1981). A primary rule of structural family therapy is that therapists should first join with their families and only then attempt to restructure them (Minuchin, 1974). No therapeutic plan, no matter how brilliant, will ever be effective if a family does not trust its therapist.

Joining includes such behaviors as making a family feel comfortable, listening to the concerns of all members, understanding each member's opinions and feelings, and treating everyone with respect. Joining is helped by validating, empathizing with, and normalizing the family's experiences, as well as suspending judgment and blame of the family and its members. This process goes beyond the bounds of simple courtesy to include the understanding of a family's rules and unique structure. For example, a therapist should not undermine a parent's credibility in front of a child and should treat important family members with extra respect.

Further, it is helpful for therapists to support a family's unique cultural values without creating stereotypical expectations. Normal families can engage in a wide array of religious, educational, sexual, marital, and behavioral practices. In some cases, a family's uniqueness may enable its members to solve certain problems that other families might struggle with. It is problematic for therapists to assume that all African Americans have the same parent-child relationships, or that all Catholics have the same religious beliefs. In fact, stereotyping of families by therapists often leads to a family feeling misunderstood and wanting to withdraw from therapy. As an example of therapists being flexible and adapting to clients' cultural and family values, in Charles Fishman's current practice of structural family therapy in New Zealand among the Maori people, prayers and songs are offered in most sessions, to honor their traditions and preferences (C. Fishman, personal communication, September 12, 2013).

Accommodation

Accommodation, sometimes referred to as mimesis, is the manner in which a therapist adapts his or her behavior to fit a specific family (Minuchin, 1974).

Therapists should not only understand the importance of family uniqueness, but also respond to their clients in ways that demonstrate this understanding. This means that therapists should adjust their language, body posture, and pace to be consistent with a given family's mode of operating. For example, a boisterous family in which everyone interrupts one another would probably drown out a quiet therapist. That therapist would probably have to speak louder and

block interruptions in order to be heard. On the other hand, behaving in a loud and directive manner might seem overbearing to a soft-spoken and thoughtful family. Likewise, a therapist will need to adjust his or her style to fit with a more jovial or depressed family.

Of course, all therapist accommodations must stay within the style and culture of that given therapist; a therapist should never act as if he or she is a fellow member of a client's in-group when that is not the case. For example, it would be rude and disrespectful for a therapist to substantially alter his or her own dialect to match a family's; however, it would make sense to talk a bit faster if that family seemed bothered by the therapist's "slow" pace.

Accommodation also means knowing when to challenge a given family and when to hold back. For example, one therapist found that one of her families failed to do a homework assignment every time she encouraged them. However, they always rose to the challenge when she questioned whether a given assignment was a bit beyond their abilities. Would this type of challenge work for every family? Definitely not! Structural family therapists must learn from each family how to get the best results (Minuchin & Nichols, 1993).

Finally, accommodation even pertains to the words a therapist uses to explain a concept to a family. For example, a mother who attributes her daughter's bad behavior to depression may benefit from the daughter's behavior being reframed as "bossy" or "rude"—it would help her recognize that these behaviors need to be punished. Similarly, Minuchin, Rosman, and Baker (1978) once had to describe a girl's refusal to eat as disrespect, rather than anorexia, to encourage her parents to enforce rules regarding her eating habits. The important thing to remember is that every family is different. What works for one family may be totally inappropriate for another. It is through joining and accommodation that clinicians learn to tailor therapy to meet an individual family's needs. Joining is also the foundation upon which all the structural interventions are founded. If the therapeutic relationship is weak, the interventions are not likely to work.

Structural Diagnosis

Structural diagnosis is the process by which a therapist identifies the dysfunctional family structure that maintains an individual's symptoms. It is within the assessment process that structural family therapists expand the idea of individual pathology to a focus on family transactions. Families are typically unable to describe their problematic structures. Therefore, therapists have to discover them over the course of several sessions. It is through interacting with families, asking questions, and making observations that therapists come to understand a family's structural makeup. As Minuchin (1974) states:

> Family structure is not an entity immediately available to the observer. The therapist's data and his diagnoses are achieved experientially in the process of joining the family. He hears what the family members tell him about the way that they experience reality. But he also observes the way that family members relate to him and to each other. The therapist analyzes the transactional field in which he and the family are meeting, in order to make a structural diagnosis.
>
> (p. 89)

It is usually helpful for therapists to ask questions—such as who is close to whom, how do the mother and father differ in terms of parenting styles, and who has the greatest say in making decisions—to get an initial sense of a family's structure. However, the way family members describe their behavior and how they act can be two different things. It is often helpful for therapists to observe family interactions. For example, if a child repeatedly sits next to one parent, while the other parent sits across the room, the therapist might infer that a coalition exists. Or if every time the parents discuss a disagreement, they either change the subject to the identified patient or the child distracts them by becoming disruptive, the therapist might assume that a detouring maneuver is taking place. Both verbal and observational cues are important in understanding a family structure.

A good structural diagnosis should not only contain the dysfunctional pattern, but should also have a hypothesized alternative structure to resolve the problem. For example, if a therapist believes that a teenage boy's drug use is maintained by a cross-generational coalition with his mother against his father, then an alternative structure might propose shoring up the parental subsystem and creating a parent-child hierarchy. As an alternative, a therapist might propose developing an alliance between the father and the son by having them engage in more activities together, such as washing the car, playing catch, or doing homework together.

No structural diagnosis is written in stone. In fact, further sessions may reveal that a different structure is, in fact, the dysfunctional one. A clue that a therapist's diagnosis is faulty is when a proposed alternative structure begins to develop, yet this fails to improve the problem. In these cases, the therapist needs to do additional family process assessment, make a new structural diagnosis, and resume the process of creating an alternative structure.

Restructuring

Structural family therapy is a process-oriented rather than content-oriented treatment approach. **Restructuring** refers to helping the family find a more appropriate structure for solving its problems. Although the family's goal might

be to get a child to stop stealing, the structural family therapist helps family members reorganize their transactional patterns so that they can successfully solve the problem themselves.

Although families are capable of developing numerous types of structures, they will limit themselves to those that feel most comfortable or are most useful. Some families begin repeating these structures even though they no longer work. It is not that the family members are not trying to solve the problem; it is more that they are attempting to solve the problem in the "same old way." In many cases they might be putting forth superhuman effort. The problem is they need a different structure to be successful. As Minuchin (1974) states: "Families with chronic dysfunctional patterns can be helped only by changing those patterns. The pain can be reduced only when the family's functioning improves" (p. 139).

Although joining and accommodation help the family feel understood and cared for, they are not enough to bring about change. Restructuring requires that a therapist be active and directive. Old patterns die hard. Therefore, clinicians must be willing to take charge of the therapy to ensure that families change their structures. Remember, it is not that families do not want to change; rather, it is that they are trapped in a structure that does not allow them to solve their particular problem. Even in therapy, they will initially try to maintain their old ways of doing things. It is the therapist's job to challenge the old structure in such a way that the family is compelled to try a different way of interacting (Colapinto, 1991). It is here that the relationship between joining and restructuring is most obvious. It is scary to try out new structures, and no family will follow a leader if its members do not feel safe with him or her. It is through joining that a therapist and family form a safe, emotional bond that enables them to face the challenge of restructuring relational patterns.

Enactment

Enactment involves having family members engage in their problematic behaviors in the therapy room. Dating back to his early work with families of inner-city adolescents, Minuchin and colleagues (1967) believed that many people provide inaccurate accounts of their behavior. Their retelling of events is often colored by their own perceptions. Further, different individuals have different accounts of events, which often lead to heated arguments over who is right or wrong. To bypass this, Minuchin had family members enact their behaviors as a way of showing the therapist the sort of thing that would happen at home. For example, a structural therapist might ask family members to talk among themselves about how to solve the problem of their son's truancy. This allows the therapist to observe the problematic structure as it actually unfolds. Minuchin and Fishman (1981) state:

> When the therapist asks the family questions, the family members can control what they are presenting. In selecting what material to communicate, they frequently try hard to put their best foot forward, as it were. But when the therapist gets the family members to interact with each other, transacting some of the problems that they consider dysfunctional and negotiating disagreements, as in trying to establish control over a disobedient child, he unleashes sequences beyond the family's control. The accustomed rules take over, and transactional components manifest themselves with an intensity similar to that manifested in these transactions outside of the therapy session.
>
> (pp. 78–79)

Enactments are a valuable tool, both as a wonderful means of developing a structural diagnosis in the assessment phase and as a tool to help restructure a family's behavior as it unfolds in the therapy room. As therapists observe a dysfunctional transaction, they can invite other members to participate or they can block an individual from dominating the discussion. For example, a structural family therapist might disrupt an ongoing triangle involving the parents and a delinquent son by having the parents talk together about how to effectively discipline him, blocking the son's interruptions.

Structural therapists also use enactments to support and encourage individual family members to express their views. For example, Minuchin and Fishman (1981) describe a situation in which they used an enactment to help a mother form an effective parent-child hierarchy with her daughter. As the daughter began misbehaving in the session, the therapist asked the mother to control the girl's behavior. When the mother's efforts proved fruitless, the therapist moved his seat next to the mother's and pushed her to continue confronting her daughter until she behaved appropriately. The therapist then complimented the mother on her ability to effectively discipline her daughter, as a means of reinforcing her behavior.

Certainly, encouraging a person to take a strong stand with his or her family members can be risky and anxiety producing. Let us caution you that interventions such as this are not done in isolation. In this case, the therapist and the mother must have already had a trusting relationship, or else the therapist could never have pushed her to discipline her child. Further, the therapist had to have faith in the mother's inherent ability to be successful. Finally, the therapist would have to be willing to continue this intervention for however long it took for the mother to be successful. Ending this intervention with the mother failing to control her child could have deeply affected her confidence in ever being able to manage her daughter and could have led the daughter to conclude that her mother was an ineffective parent.

Practically speaking, these interventions are often best accomplished when the therapist has diagnosed the family structure and patterns and has briefly worked

with the family members separately to try to set them up for success. For example, the therapist could meet one-on-one with the mother to discuss how she wants to handle the child and prepare her for a variety of likely scenarios with the child. Such preparation with various family members and subsystems increases the chances of a successful intervention. No intervention is as easy as it looks; it takes a well-trained therapist to successfully intervene in people's lives.

Boundary Marking

Boundary marking is a technique for creating new subsystems within a family. A therapist might want to create a boundary by having the parents work together without their children's interruptions or open a disengaged boundary by helping a distant father become involved with his children. It is through boundary marking that therapists create new structures that enable families to solve problems.

Boundaries can be established through various means. For example, a therapist might disrupt a cross-generational coalition by having the over-involved father and the distant mother negotiate rules for parenting their child. The therapist would then block the child's attempts to interrupt the parents' conversation and refocus the parents when they try to involve the child. An even simpler intervention would be to ask the child to leave the room while the therapist and parents discuss how to discipline the child. The walls of the office would then serve as a boundary between parents and child. The therapist could then meet with the child alone to discuss any concerns with the new rules the parents were implementing.

Even assigning different tasks to different subsystems can be an effective way to mark a boundary. For example, Wetchler (1990) relates the case of a single-parent family in which the teenage son refused to leave his room. The therapist created a parent-child boundary by (a) assigning the son the task of finding a job and (b) giving the mother the task of monitoring his behavior to make sure that he searched for a job and to enforce rules regarding how many applications he must complete in a day. The enmeshed boundary between mother and son was altered so that the son worked alone on his task of finding a job. He practiced interviewing skills, found job openings on his own, collected applications, and applied for jobs. His mother monitored his progress by having him show her a specific number of completed job applications each week and setting up a series of rewards and punishments, depending on whether he successfully met his quota.

Therapists can also manipulate the space in the treatment room to establish boundaries (Minuchin & Fishman, 1981). To help a disengaged father become closer to his son, the therapist might ask him to sit next to the boy while they plan a father-son outing. Further, the therapist might ask the mother to observe their conversation from the opposite end of the room as an additional means of

marking the boundary surrounding father and son. Some therapists have found it useful to make this idea of boundaries in families more tangible by using concrete examples of something in the therapy room, such as opening and shutting window blinds or a door to demonstrate current boundaries in contrast with preferred boundaries.

Unbalancing

Unbalancing is a technique in which a therapist temporarily sides with a specific individual, or family subsystem, to induce change. Sometimes a family's structure is so rigid that the members are unable to change through discussions or new actions on their part. No matter what they do, they go back to behaving in the same problematic way. In these situations, a structural family therapist might use his or her influence to help a specific member behave differently for long enough to generate a new structure (Minuchin & Fishman, 1981). For example, unbalancing could be used in a marital case in which the spouses are unable to successfully renegotiate their relationship because one spouse holds an inordinate amount of power. Whether this is due to family-of-origin issues, gender stereotyping, or an imbalance of income that the spouses generate for the family, it seems that the more powerful spouse dominates the discussion and that the less powerful spouse always gives in. In this situation, the therapist might support the less powerful spouse to continue to assert his or her needs in spite of the cues from the more powerful spouse to stop talking. For example, the therapist might sit next to the less powerful spouse during the negotiations, or he or she might keep encouraging the less powerful spouse to continue talking. In more extreme cases, the therapist might actually confront the more powerful spouse about the need to listen to his or her mate.

Unbalancing techniques could also be used to help parents take charge of their child. The therapist might meet with the parents alone to help them develop a plan, or he or she could sit with them when they confront their child. Even simple statements such as "Because you are the parents, I will support your rules" can have great power to help change an inadaptive family structure.

Needless to say, an unbalancing technique could never work unless the therapist is strongly joined with all members of the family (Minuchin, 1974). It is only through the development of a good relationship that a family member could tolerate the therapist temporarily taking sides against him or her. All family members need to feel safe in knowing that although their therapist may temporarily stand against them, he or she will eventually return to support them. In fact, whenever a therapist sides with one family member against another, he or she must always return to side with the opposed member so that that person will feel supported. Failure to follow through with this important component could lead to either that member or the entire family dropping out of treatment. Needless to say, unbalancing is a highly sophisticated technique that should be done only either by an advanced clinician or under the supervision of a senior family therapist.

Enhancing Family Strengths

A core belief in the inherent strength of families underlies structural family therapy (Simon, 1995). If therapists approach families as if they are basically dysfunctional, they will find only problems and will fail to see potential resources within the family that can be used to solve their problem. Structural family therapists **enhance family strengths** when they help the family identify these hidden resources and promote their use in resolving the problem (Minuchin & Fishman, 1981). Through altering its structure, a family is usually able to solve its own problems.

When a therapist encourages a couple to discuss solutions to their marital problems, or pushes a parent to discipline a child, there is an inherent message that these individuals are *capable of being effective.* This is a very powerful message. Therapists should genuinely believe that families have the ability to overcome problems and make lasting changes. A therapist's attitude of hope and confidence in each family should be palpable in all interactions with that family. Often families in crisis are able to identify only their faults. Helping them view themselves as competent people can create a world of new solutions. For example, in the case of the teenage son who never left his room, Wetchler (1990) strengthened the emerging boundary between parent and child by having the boy develop numerous ways to solve his problem while his mother observed. At the end of the session, both the mother and the son agreed that he had the potential to get out of his room and get on with his life. In fact, the son was later able to use these ideas to obtain a job and to eventually earn a promotion.

Structural Family Therapy in Diverse Families

Structural family therapy began as a mode of treating low-income African American and Latino families that were concerned about their adolescents' behaviors involving violence, substance use, and other illegal activities. The initial focus was necessarily on action and change, not long-term therapy based on insight and reflection. These families required a treatment that could produce relatively quick, large, and comprehensive change that could meaningfully redirect the expected trajectory for child and family.

Diversity has long been respected as an important feature of the practice of structural family therapy. Some clinical approaches have espoused the need to become an expert on African American, Jewish, or Latino culture prior to being able to provide quality services to them. Other approaches state that one can never know everything about a given culture, and therapists should thus assume that they know nothing that may be applied to their clients. From the earliest days in the development of structural family therapy, Braulio Montalvo discussed the "informed one-down" position. The informed one-down position is a very

respectful position that proposes that the family is the expert on the family's culture, whereas the therapist is the expert on family systems, structure, development, and change. The structural family therapist then applies these structural family therapy principles to help the family in the context of their unique culture (C. Fishman, personal communication, September 12, 2013).

Structural family therapy can be applied to a wide variety of additional relational contexts, including single-parent families, same-sex couples, cohabiting couples, stepfamilies, and families of choice. The same theoretical assumptions remain for the application of structural family therapy in these additional types of families and couples; namely, that the organizational structure of the family in its current form is not conducive to allowing the family members to solve their own problems and live their preferred lives. Furthermore, the same clinical goals and techniques of structural family therapy can also be applied to working with couples and families from different cultures and different family types, while being sensitive to the unique culture and context of each family. Perhaps a reflection on the ubiquitous changes to family life and structure in the United States would be helpful as therapists consider the typical family structures of our day (see Cherlin, 2010, for more details on the studies reported here). First, the median age at first marriage is higher than in the past, at 27.4 for men and 25.6 for women (U.S. Bureau of the Census, 2009), meaning that couples usually form long before an official marital relationship begins. The lifetime probability of divorce is between 40% and 50% (Stevenson & Wolfers, 2007), meaning sooner or later many families must adjust to structural changes associated with divorce. In relation to fertility, in 1950, only 4% of all children were born outside of marriage, whereas by 2007, 39.7% of all children were born outside of marriage (U.S. National Center for Health Statistics, 2009a). It is important to note that about half of these unmarried women who gave birth were cohabiting with the fathers of the children (Kennedy & Bumpass, 2008). The average number of children for a woman in the United States is 2.10 (U.S. National Center for Health Statistics, 2009b). Currently, multipartner fertility—that is, having children with more than one partner—occurs at a rate of 36% among all couples and 59% for those who are unmarried (Carlson & Furstenberg, 2006). Thus, family systems are more likely to have multiple partners, and multiple sets of children, yielding more complex family structures. The overall percentage of children who do not live with both parents together is 40% (Ellwood & Jencks, 2004). Other unique family structures include committed couples who live apart. Approximately 6% to 7% of adults say they have a romantic partner but do not live with that person, meaning that many couples are "living apart together" (Strohm, Seltzer, Cochran, & Mays, 2009). In 2005, grandparents were the primary caregivers for 21% of preschool-aged children whose mothers were employed (U.S. Bureau of the Census, 2008). These reports suggest that there is great diversity in the types of family structure that may present in therapy.

Same-sex couples are also becoming more visible. Surveys completed in California identified 37% to 46% of gay men were cohabiting with a partner, as were 51% to 62% of lesbians (Carpenter & Gates, 2008). These rates of partnership of same-sex couples are quite close to the rate of partnerships among heterosexual couples (62%) in California. The 2000 census reported that same-sex partners commonly are raising children, with 33% of lesbian couples and 22% of gay couples doing so.

Scholars and clinicians are beginning to forge ahead in the application of structural family therapy with these more diverse family structures. For example, Greenan and Tunnell (2003) have written an informative book on the unique aspects of applying structural family therapy with gay men, couples, and parents. Their book focuses on gay couples' unique strengths and challenges, strategies for joining, how to demonstrate sensitivity to particular issues often confronting gay couples in our culture, and the implementation of structural techniques with this population. Structural family therapy with a gay or lesbian couple would follow the exact same process as structural family therapy with a heterosexual couple or family.

There are many examples of diverse family structures for which structural family therapy can be quite helpful. For example, consider a gay couple where one partner is openly gay with friends, colleagues, and family, and is frustrated that the other partner is less open about this. In this structure, the boundaries distinguishing the spousal subsystem from friends, colleagues, and family are disagreed upon between partners.

For another example, consider a divorcing couple who are splitting time with their children. Both parents feel bad for the suffering of their children as a consequence of the divorce. Thus, neither parent enforces rules or applies punishments for the children, in an ill-fated attempt at protecting their children from the difficult aspects of divorce and keeping his or her time with the children positive. Each parent also sometimes speaks negatively of the other parent in front of the children, pulling them into the parents' conflict. Structural family therapy can help parents learn to better coparent, enforce rules, decide upon common rules and consequences that will be consistent between homes, and stop speaking negatively of each other in front of the children.

As another example, consider a household headed by two grandparents, where the father left long ago and the children's mother recently lost custody due to her continued drug use. The grandparents are having a difficult time raising their grandchildren as they struggle to transition from their previous role of "grandparents" to their new role of "parents." The boundaries, hierarchy, and interactional patterns all likely need to shift to create a structure that can allow the family to succeed.

Finally, consider a heterosexual cohabiting couple, where she already has two young children. He enjoys playing with the kids, but takes on very little

responsibility for them; it is the mother who cares for all their needs. The romantic relationship is suffering, because she sees him as lazy and immature and he sees her as a "control freak" who never has time to focus only on him. A structural family therapist would look at what organizational structure in this family can be amended to help this couple improve their romantic relationship.

Evaluating Structural Family Therapy

Beginning with his early days at the Wyltwick School, Minuchin showed a commitment to testing his theories through research (e.g., Minuchin et al., 1967). His studies on psychosomatic children and delinquents, and Stanton, Todd, and Associates' (1982) work with people addicted to drugs, are excellent examples of the effectiveness of structural family therapy (Nichols & Schwartz, 1998).

Structural family therapy appears to be a promising means of treating several childhood and adolescent problems. Further, it shows great potential in treating young adults addicted to drugs who remain in close physical contact with their families of origin. In his book *Families of the Slums,* Minuchin and colleagues (1967) found that structural family therapy was effective in seven of the eleven cases they treated at the Wyltwick School. Although they did not use a control group in their study, they found their results compared favorably to the 50% success rate that existed at Wyltwick during that time. Although readers are cautioned that the small number of cases actually treated at Wyltwick limits interpretations of overall effectiveness, the results invite further analysis and help support the results found in more comprehensive studies.

In a most impressive study of structural family therapy, Minuchin, Rosman, and Baker (1978) summarized the results of treating 53 cases of childhood anorexia nervosa. They found that 43 children with anorexia symptoms "recovered," 2 were "improved," 3 showed "no change," 2 "relapsed after showing initial improvement," and 3 "dropped out of the study." Even though the researchers did not use a control group (due to ethical considerations), the 90% improvement rate for children who remained in the study (43 "recovered" and 2 "improved") is extremely compelling when compared to the typical 30% mortality rate for this disorder (Nichols & Schwartz, 1998).

Finally, the work of Stanton, Todd, and Associates (1982) showed structural family therapy to be a highly effective treatment for 19- to 30-year-olds addicted to drugs. These researchers compared structural family therapy to both a family placebo treatment and individual therapy and found that the level of positive change in the structural family therapy group was twice that in the other two treatment groups; these changes persisted for up to one year after therapy. A particularly notable aspect of these results is that clients were young adults, ranging in age from 19 to 30, yet the primary intervention of placing the parents in charge of the child, limiting the drug use, was effective even for young adults.

Case Study: Structural Family Therapy with a Single Mother and Two Daughters

This section describes how a structural family therapist treated a distressed family. It should be noted that the organizational structure of this family contributed to the family's problems and the individual members' symptoms. When the organizational structure of the family improved, individual symptoms also improved. Structural family therapy is an ideal approach to treating entire families from a systemic perspective. In structural family therapy, the primary goal of assessment is to identify the organizational structure of the family, and the primary goal of treatment is to change the family structure in a way that allows the family to solve its own problems.

In this family, the mother, who was working as an accountant, was still coping with a difficult divorce that had been finalized for two years. She had had many signs of serious depressive symptoms ever since the divorce, including low energy, depressed mood, weight gain, fatigue, and feelings of worthlessness.

The older daughter, age 21, had never moved away from home and was attending the local university. She worried excessively about her mother, as well as about her sister's bad behavior at school. What bothered her primarily, however, was that she had to do virtually all the household cooking and cleaning, which she perceived as unfair. She developed a strong compulsion to constantly clean the house.

The younger daughter, age 14, had gotten pretty good grades prior to the divorce, but since the divorce, she had begun failing many of her classes. She had also been suspended a couple of times for cheating and for getting into a fight with another girl. Although the family had had very little contact with the father since the divorce, it was learned that he was in the military and had been the disciplinarian and family leader. The mother's initial complaint on the phone intake was regarding her daughters' conflict; she requested help dealing with her children.

When the mother made the initial call to the clinic, the therapist requested that the entire family come for the initial session. The mother asked whether it would be okay if only she came, because she was unsure whether her two children would be willing to come. The therapist told her that it was very important that she inform her entire family that they would all need to come to family therapy together. If changes were going to happen that could benefit the entire family, then the entire family would need to come to the first session. The therapist hypothesized that the mother perceived limited power in herself and that one or more of

the children may have nearly as much power in the family hierarchy as she did.

(It is common for structural family therapists to request the entire family to attend the first session, so that they can assess family interactions, patterns, alliances, coalitions, boundaries, hierarchy, and so forth. For many therapists, it is common to work primarily with only one parent or one child. However, when the entire family is present, important family dynamics are readily observable and it is much easier to diagnose the problem than when working with only a single member of the family.)

All family members came to the first session, which was also a part of the treatment, to empower the mother to be the leader in the family. Upon arriving, the mother and the younger daughter sat close together, while the older daughter sat across the room from them. Because of this, the therapist initially hypothesized that the mother and younger daughter might be in a cross-generational coalition against the older daughter.

To further assess the family structure, the therapist asked each member of the family to describe what was going on in the family. The older daughter spoke first, saying that her mother never did any cooking or cleaning and just "moped" around the house all day. The younger daughter defensively replied that her mother had been depressed and lonely since her divorce a few years ago. She angrily continued that there would not be any problems if her sister would just leave her and their mother alone and stop complaining about how dirty the house was. The mother weakly stated that it had been really hard for her to take care of her family as a working single mom.

From just this simple exchange among family members, a great deal of family structure information was gleaned. The therapist had more evidence that the mother and the younger daughter were in a cross-generational coalition against the older daughter, as evidenced by the younger daughter defending the mother and the oldest daughter verbally attacking the others. The therapist also hypothesized that the older daughter may have assumed more of a leadership role in the family, filling the void left by the father while the mother struggled with depressive symptoms.

The older daughter appeared frustrated and angry as she reported that she had to do all the cleaning and cooking because no one else did any household work. The younger daughter and the mother frequently interrupted her, complaining that she was so obsessed with having a perfectly clean home that they could never relax. The conversation quickly became heated, revealing a strong alliance between mother and younger daughter. The mother began to cry, stating that she just did not know what to do

anymore and that things had been out of control for a while. The younger daughter snapped at the older daughter, “Look what you did!” The older daughter rolled her eyes, appearing annoyed. From this interactional sequence, it appeared that the older daughter might hold more power than the mother and younger daughter. The therapist then asked a variety of questions, further assessing for current family structure. This line of questioning made it apparent that there was an alliance between mother and younger daughter, that the older daughter was on the outside of this close alliance, and that conflict between the older daughter and the mother almost always involved making the younger daughter part of a triangle. The older daughter showed signs of being parentified and of not really enjoying this role of caring for her mother and sister. The primary interactional pattern that the therapist observed as the family spoke and argued was that the older daughter brought up concerns, the younger daughter defended herself and their mother, and the mother would disengage further from the older daughter and was comforted by the younger daughter.

In the second session, further assessment information was gathered, largely confirming most of what had been observed and hypothesized in the first session. The therapist gained more background information about the family members and their history, and treatment goals were set to improve problematic family relationships and individual symptoms.

In the third session, the therapist wanted to help the family members understand their current family structure and how it was interfering with their ability to make the desired changes they had set forth in their treatment plan. To help make the abstract idea of family structure, processes, and patterns more concrete, the therapist drew a picture diagramming the family structure, showing the younger daughter and mother very close together, with a circle around them representing how close they were. The older daughter was drawn above them, representing that she often took more leadership responsibility in the family, but she was drawn far off to the side, separated from the others by a thick line. The therapist asked whether this fit with how the family members saw themselves, or whether any of them would change anything about it. All three were very interested in this and agreed that this seemed to characterize their family. The therapist then intentionally kept pointing at the diagram and talking about how “this” was the problem, thereby externalizing the problem from the individual family members and blaming the structure. In this type of structure, the therapist explained, it would be very common for the outsider (the older daughter) to become anxious and concerned about the other family members. It would also be very difficult

for a parent in this lower position of power to feel unhappy with the situation. It would also not be surprising if a younger daughter who did not have a parent closely monitoring her progress at school saw her grades deteriorate. The family members discussed for a while how this structure was currently affecting their individual symptoms of depression, anxiety, and poor grades. They also discussed how this structure made it difficult for them to have the type of family and relationships within their family they longed for. The older daughter stated that she wanted to get a flyswatter and smack that piece of paper with the family structure diagram, and the family laughed. She recognized that this family structure was not helping anyone.

The fourth session was spent discussing possible alternative structures the family would prefer. The daughters stated that they wished they did not have to fight all the time; they wanted to be close again. The mother was concerned that she had not realized how failing to be the leader in the family might negatively impact her daughters and herself; she wanted to be the leader. The therapist then had the family members draw what they would like their family structure to be.

In the fifth session, the therapist asked the mother and the younger daughter to sit close together at one end of the room, while the older daughter sat alone in the far corner. The therapist asked each family member to share what it felt like to be sitting in these positions, and what it meant for their family. The older daughter cried that she did not like being on the outside so much, and then the mother and the younger daughter also cried, expressing concern that such a big rift had developed between them. The therapist then asked the mother how she would like her family to be arranged. The mother asked her two daughters to sit close together, and she sat down in front of them and raised her chair up a few inches higher. The therapist then asked each family member what she thought about these new positions, and each family member was much more comfortable with this arrangement. The therapist processed with the family members what might be different if they each assumed different positions in the family (those indicated by their new seating arrangement) and whether this was something they wanted. The therapist asked the family members to think about what each person could do to contribute to this preferred family structure.

In the sixth session, each family member reported that they had not only thought about what they could do differently, but actually began doing some things differently already. The mother had woken up earlier and made breakfast for her daughters, something she had not done in years. The

older daughter reported that she took her younger sister to get their hair done together, and then they went out to eat dinner together. The younger daughter reported that she loved that her mom made breakfast and that she got to spend some time with her sister. She also shared that she had helped clean the kitchen a few times. The therapist processed each of these changes and congratulated all three family members on their progress toward their goals. The therapist then met individually with the mother to determine what rules, chores, and consequences she wanted to establish for her family. They also discussed how to handle misbehavior from her daughters. The therapist then met with only the two daughters, discussing with them the importance of building their relationship, spending time together, and being respectful and obedient to their mother. At the end of the session, they all met together, and the mother shared the new chore chart, rules, and consequences with her daughters.

In the seventh session, it turned out that although there had been a few problems with the younger daughter complaining about chores, the mother had enforced the punishment of her needing to do additional chores for complaining, and the older daughter was very grateful to have the whole family assisting with the cooking and cleaning.

In the eighth session, the older daughter noted that her excessive worrying about cleaning the house had begun to dissipate. The mother also reported in a one-on-one session with the therapist that she was feeling much better about herself in the leadership role she had taken for the first time in her family. She also was also more relaxed, because the frequency of conflict and bickering had dramatically decreased.

Session twelve was the family's last session after a new family structure had been developing for the past four weeks. The therapist expressed confidence that with this new structure the family would be able to develop warm, trusting relationships. The mother found that although she still struggled with depressive symptoms, they had become much less intense, and some days she did not feel depressed at all. She had begun developing new hobbies and making new friendships with other adults. The older daughter realized that she really wanted to move out of the house, not because she wanted to run away from her family, but because she felt confident that they would be okay without her caring for them. The younger daughter's grades improved, as did her behavior at school and at home. At the end of the session, the therapist gave the clients a flyswatter as a parting gift to remind them of the wonderful changes they had made, and to "swat" that old structure away if it tried to sneak back into their family.

Summary

Structural family therapy takes an organizational approach to families. It focuses on altering dysfunctional hierarchies, boundaries, coalitions, and triangles. Its most important tenet is that a specific family structure can be called "dysfunctional" only if it keeps a family from solving a particular problem. As a result, this family therapy takes a present-centered and problem-focused stance to treatment. It appears to be most effective with childhood and adolescent problems, especially substance abuse, delinquency, and psychosomatic problems such as anorexia nervosa. Less information is available on its use with couple and marital problems.

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Glossary

accommodation: The manner in which a therapist adapts his or her behavior to fit a specific family. For example, a therapist might talk more quickly with a fast-talking family and more slowly with a slow-talking family to fit their individual styles.

alliance: When two or more family members join together to handle a specific problem.

anorexia nervosa: A disorder, primarily found among young women, in which people starve themselves to dangerous levels under the mistaken idea that they are overweight.

boundaries: Abstract or physical dividers between or among systems and subsystems. Boundaries define who is part of and who is not part of a particular system or subsystem.

boundary marking: A technique for creating new subsystems within a family.

clear boundaries: Boundaries that successfully enclose a subsystem yet enable communication with other subsystems. Clear boundaries are often important for optimum family functioning.

coalition: When two or more family members join forces against one or more family members.

cross-generational coalition: A specific type of triangle in which two family members from different generations ally against a third member.

detouring: A defensive pattern in which the two parents shift their focus to one child every time a problem arises between them that they are unable to handle.

disengaged boundaries: Boundaries that successfully enclose a subsystem but are impermeable to outside information.

enactment: A technique in which a therapist has family members engage in their problematic behaviors in the therapy room to assess their family structure. Enactment can also help restructure family interactions as they are occurring.

enhance family strengths: A technique in which a therapist helps a family identify hidden resources and promotes use of those resources in resolving the problem.

enmeshed boundaries: Boundaries that impart little autonomy between individuals and other subsystems.

executive subsystem: The subsystem within a family that takes the leadership role. In most cases, this is typically the parents.

family map: A diagram of a family's current (dysfunctional) structure.

hierarchy: A boundary that distinguishes the leadership subsystem from the rest of the family.

holon: A subsystem that is also a system in its own right. For example, in a family with children, a marriage is both a system in its own right and a subsystem of the family.

joining: The process in which therapists let their clients know that they understand them and are working to help them.

parental child: An older child with occasional family leadership tasks.

parent-child hierarchy: The specific boundary that demarcates the parents' responsibility in child-rearing issues.

psychosomatic diabetes: Cases of diabetes that consistently have to be hospitalized even though the child is on insulin.

restructuring: A therapeutic technique to help a family find a more appropriate structure for solving family problems.

structural diagnosis: The process by which a therapist identifies the dysfunctional family structure that maintains an individual's symptoms.

structural family therapy: A family therapy theory that views emotional distress from an organizational perspective. Individual problems are maintained not through personal pathology, but rather through flaws in a family's organizational design.

subsystem: A grouping of family members to accomplish specific tasks.

triangle: A specific type of coalition in which two family members join forces against a third member.

unbalancing: A technique in which a therapist temporarily sides with a specific individual, or family subsystem, to induce change.

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5

STRATEGIC FAMILY THERAPY

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> A strategic therapist must have a strategy. The issue is choosing the strategy that is best suited to each different kind of problem.
>
> Cloe Madanes
> *Behind the One-Way Mirror*

Strategic family therapy is an approach that is associated with many different individuals and groups in the field. Although these schools of strategic therapy have many similarities, they also have a number of differences. In this chapter, we focus on two of these schools: the Mental Research Institute (MRI) approach, which was founded on the West Coast by Fisch, Weakland, and Watzlawick in the 1960s, and the Washington School, which was founded by Jay Haley and Cloe Madanes at the Family Therapy Institute on the East Coast in the 1970s. Additionally, we briefly discuss how the strategic approach has been integrated into several current evidence-based family therapy models.

We will introduce you to the major proponents of the strategic therapy approach and to its basic theoretical concepts, views of pathology, and techniques. We will also cite relevant research to familiarize you with the effectiveness of this approach. Then through case examples, we will illustrate how therapists might actually apply strategic therapy principles in working with clients.

Major Figures in Strategic Therapy

The two primary schools of strategic therapy have common roots. They are an outgrowth of a research project headed by Gregory Bateson in Palo Alto, California, in the 1950s and 1960s. Bateson, who is sometimes considered the grandfather of

family systems theory, conducted a research project that applied ideas from **cybernetics** and **systems theory** to the study of communication. The project evolved into a study of communication patterns common to schizophrenics and their families and produced the seminal concept of the **double bind** theory of **paradoxical communication**, which was highly controversial. Haley and Weakland were among the researchers working on this project, along with Don Jackson. Some of the thinking that emerged from this research project was subsequently applied to treating clients when the Mental Research Institute was founded by Jackson, who was joined by Fisch, Weakland, Watzlawick, and Haley, among others.

Strategic therapy was also largely influenced by the unique therapeutic approach of Milton Erickson, whom some consider the father of strategic therapy. Haley and Weakland visited Erickson many times over a period of 17 years to record his thoughts and study his work (Haley, 1985). At that time, Erickson was considered a maverick in the field of psychiatry because he tended to use **hypnosis** and **paradoxical interventions**. He was also considered unconventional because he viewed symptoms as resulting from clients' failure to take action or from their taking the wrong action when confronted with difficulty. He used many different techniques to help people resolve their problems and believed that action often preceded understanding, rather than the other way around.

Although work at the Brief Therapy Center at the MRI continues, and the therapeutic approach conceived there continues to evolve, Haley left the MRI in the mid-1960s to work with Salvador Minuchin and Braulio Montalvo at the Philadelphia Child Guidance Clinic, where **structural family therapy** was developed (see Chapter 4). There he met Cloe Madanes, a clinician from Argentina, and after working and learning with the leaders of the Philadelphia Child Guidance Clinic for several years, Haley and Madanes started the Family Therapy Institute in the Washington, DC, area in the 1970s. There they developed and refined their own approach to strategic therapy, which has commonality with both the MRI model and structural family therapy. The Haley-Madanes approach to therapy is sometimes referred to as the Washington School of strategic therapy. After leaving the Family Therapy Institute in the 1990s, Haley moved to the San Diego area and, in collaboration with Madeleine Richeport-Haley, wrote his final book, *Directive Family Therapy* (Haley & Richeport-Haley, 2007). At the time of his death, he was also a Scholar in Residence at California School of Professional Psychology at Alliant International University.

More recently, strategic family therapy has had a strong influence on several evidence-based treatment approaches—for example, brief strategic family therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003), multidimensional family therapy (MDFT; Liddle & Hogue, 2001), functional family therapy (FFT; Alexander & Parsons, 1982), and multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Each of these treatment approaches, which were developed for youths with behavior problems, integrates both structural

family therapy (see Chapter 4) and strategic therapy (Szapocznik, Schwartz, Muir, & Hendricks Brown, 2012), along with various other interventions, in unique ways to treat behavior problems in a family setting (Henggeler & Sheidow, 2012).

Theoretical Concepts

Theory is a provisional **conceptual map** that helps therapists understand and treat problems. It is a tool that allows therapists to integrate observation and action in a consistent way. At the same time, theory is an "acknowledged over-simplification" (Keim, 1999) of complex processes, which is in part what makes it useful in working with families. What therapists believe about the nature of problems and about how people change strongly influences the kind of information they pay attention to, whom they see in treatment, and what interventions they use. It helps them make these decisions in a consistent, timely way in the face of myriad information that clients often provide.

A Focus on Interactions

Similar to other schools of family therapy, strategic therapy subscribes to the **interactive view of problems**, which explains behavior in terms of what happens between people rather than within them (Fisch, Weakland, & Segal, 1982; Haley, 1976). In addition, strategic therapy focuses on the social context of these interactions (Haley & Richeport-Haley, 2007). When strategic therapy was initially developed, it was considered revolutionary because traditional **psychoanalysis** was the mainstream approach to treating mental disorders at the time. From the interactive perspective, problems and their treatment are viewed in terms of what happens between the identified client and his or her primary social context—the family. A focus on communication and interaction within the family and its social context leads to an emphasis on what is happening in the present rather than what happened in the past. Therapists attempt to obtain a step-by-step account of what happens between people regarding the presenting problem and to help clients move from unsatisfactory sequences of interaction to satisfactory ones.

In addition to placing emphasis on the interactions between the **identified patients** and their social systems, MRI strategic therapists also tend to pay close attention to what is being said and done to try to resolve the problem (Weakland & Fisch, 1992). According to this approach, problems are a result of attempts to change a real or imagined difficulty. Attempted solutions sometimes become the problem; families get stuck in **vicious cycles** involving some inappropriate behavior and well-intentioned efforts to get rid of it. In other words, MRI strategic therapists tend to view problems as resulting from applying a solution that does not work and continuing to do more of the same despite undesirable results. Therefore, interventions tend to interrupt the continuation of the

misguided solution behavior: "Since one cannot just cease any given behavior, such interventions often involve the prescription of some new alternative behavior, but the crucial element remains stopping the performance of the attempted solution" (Weakland & Fisch, 1992, p. 309).

The Washington School's Map

The Washington School is noted for describing problems in terms of what is called the **PUSH system**—protection, unit, sequences of interaction, and hierarchy (Keim, 1999). PUSH is a helpful way for therapists to describe presenting problems because it emphasizes solutions rather than causes.

Protection

With the exception of abuse, Washington School therapists often view symptoms as motivated at some level by a desire to help a loved one. In other words, symptoms serve a protective function: either to stabilize the family or to help a family member who is experiencing difficulty (Madanes, 1984). For example, a child's symptom may be viewed as providing an opportunity for parents to behave competently in their parental role as an alternative to focusing on a failure in another area of life. If it is suspected that a child's symptom serves a protective function, the therapist may substitute a sequence of interaction for the family that serves the same purpose without necessitating the symptom.

Viewing problems as unsuccessful attempts to help is useful for therapists for two main reasons. First, a therapist who believes that problem behavior is positively motivated tends to view the client in a positive light and to intervene in a much more empathic manner than a therapist who believes that a client is negatively motivated. Second, a therapist who views problematic efforts as protection is open to investigating issues and relationships that may otherwise be overlooked.

Unit

When viewing problems interactionally rather than intrapsychically, the preferred unit of focus is the **triangle** (see Chapter 10). In other words, when working with a problem that seems to be between two spouses, from this perspective a therapist would be curious about the possible involvement of a third person, such as an in-law or a child. The therapist would also consider the role that a third person may play in the solution to the problem and the impact of change on this third person. In either case, therapists from the Washington School also tend to view themselves as a new point in a triangle and to thus consider their own effect on a two-person relationship (Haley, 1976). Similarly, therapists using BSFT focus on the family's patterns of interaction (Szapocznik et al., 2012).

Therapists using BSFT are encouraged to consider the possibility that an adolescent may engage in substance abuse or risky sexual behavior in an effort to draw his or her parents' attention away from their conflict with each other. This kind of behavior is known as *triangulation* because the adolescent is inserting himself or herself (or is inserted) into the conflict between the parents. The BSFT counselor seeks to identify the patterns of family interactions that are associated with the adolescent's behavior problems.

Sequence of Interaction

For Washington School therapists, the sequence of interaction is crucial to conceptualizing the presenting problem. The sequence of interaction not only describes the problem but points the way to a solution. In general, negative escalating sequences of interaction are replaced with soothing ones; thus, a preferred sequence replaces a destructive one. Further, within the interactional frame of reference, solving one problem sequence may result in a change in other sequences. For example, a father and a mother who learn to be more effective parents may also learn to deal more effectively with their differences regarding financial issues.

Hierarchy

From the Washington School perspective, people who have a history and a future together follow organized ways of behaving with one another. When people are organized together, they form a status, or **power ladder**, where each has a place with someone above and someone below. In the marital hierarchy, for example, there is a balance of influence between spouses, with each spouse contributing equivalently and each spouse open to the influence of the other. In the parental hierarchy, parents are in charge of children. Strategic therapists pay attention to the degree to which the people involved in the problem interact in age- and role-appropriate ways (Haley, 1976).

Dysfunction is viewed as a manifestation of an **incongruent hierarchy**. In other words, people are not behaving in age- or role-appropriate ways toward one another. For example, although by their position parents may be leaders of the family, children—through their repetitive misbehavior—may, in effect, be in charge of the parents. Further, the helplessness of a drug-addicted husband may be both a source of power in relation to his wife and, at the same time, a source of weakness. To the extent that the couple's marital life is organized around his addiction, he is powerful; to the extent that he is incapable of fulfilling his adult role in the family, he is weak relative to his wife (Madanes, 1984). Washington School strategic therapists assess the family's hierarchical arrangement by carefully observing the family's interactions: Who speaks first? Who interrupts whom? Who tells whom what to do? Around whom does the family seem to be organized? Whose opinion

is discounted? When the presenting hierarchy results in patterns of behavior that are problematic for a family, a strategic therapist tries to correct this hierarchy and reorganize the family so that family members interact in ways that are appropriate to their relationship. An example of this would be if children are making decisions for the family that would be best made by the parents, a strategic therapist will work with the parents to reestablish their place in the hierarchy.

Client Position

A key concept from the MRI perspective is **client position**, a term that refers to strongly held beliefs, values, and priorities that determine how clients behave. These are values that the client is committed to and that have likely been made public, similar to a politician's platform (Segal, 1991). For example, parents' position on why their children misbehave usually determines their response. If a father who expresses concern that his son is having difficulty adjusting to a new school takes the position that his son misbehaves because his son is sad, the father may tend to be overly gentle rather than enforce consequences. On the other hand, a father who describes his son as "lazy" probably takes the position that his son misbehaves because he is bad, and therefore he might tend to be overly punishing.

Why is it important to understand the client's position with regard to the problem, therapy, or the therapist? Much of the success of strategic therapy depends on the therapist's ability to persuade the client to do something differently. If therapists want to successfully influence clients, they must understand their clients' positions. Knowing their clients' positions allows therapists to frame their suggestions in ways that clients are most likely to accept or respond to. For example, clients who view themselves as caregivers will be more motivated to undertake tasks that are framed as self-sacrificing and constructive than tasks framed as self-care (Fisch et al., 1982). In order to assess their clients' positions, when clients talk about problems, themselves, or therapy in general, therapists pay attention to their specific wording, tone, and emphasis.

Symptoms as Metaphors

> A therapist can focus on concrete facts, observations, and information, or he can be interested in covert, implied, or indirect references.
>
> (Madanes, 1984, p. 145)

Strategic therapists from the Washington School may sometimes view presenting problems as **metaphors** for the actual problem (Haley, 1976; Haley & Richeport-Haley, 2007; Madanes, 1981). For example, the marital problem presented by a couple may be both the focus of fighting and a way of avoiding conflict in another area. A child's refusal to go to school may be viewed as a metaphor for the mother's difficulty finding a job. The strategy the therapist develops to solve

the family's problem is based on the therapist's thinking about what sequence of interaction might be able to replace another sequence of interaction. The therapist may think in terms of the symptom as metaphor yet choose to take a direct approach to therapy and focus on the symptom that is presented, or the therapist may choose to respond to the metaphor.

Problem Development, Pathology, and Normalcy

Both schools of strategic family therapy view deviant behavior in an individual as a social phenomenon reflecting a dysfunction in the system. Strategic therapists do not see problems as arising randomly; problems often occur at times of family change and normal biological transitions. **Family life cycle transitions** may require a major shift in personal relationships (Haley, 1973; Weakland, Fisch, Watzlawick, & Bodin, 1983). The therapist's role is to facilitate healthy change as families adapt to these transitions (Haley & Richeport-Haley, 2007). Symptomatic behavior is viewed not as pathological but rather as unfortunate behavior that makes sense given the client's social context. For example, the symptom of depression is viewed as logical in a dysfunctional context. Strategic therapists avoid labeling their clients' behavioral disorders. Labeling clients' thoughts, feelings, or actions (diagnosing) is viewed as an obstacle to resolving their problems because it tends to give clients the sense that their problems are deep-rooted and fixed, rather than fluid and contextual.

From the view of the Washington School, symptoms are described as communicative acts that have a function within the family system. In essence, they are "a style of behavior adaptive to the ongoing behavior of other people in the system" (Haley, 1976, p. 98). The communication of the identified patient is functional within the system. In order for the identified patient's communication to change, the situation or family system must change.

Further, when an individual has a symptom, it may be an indication that the family has a confused hierarchical arrangement. Every family organizes itself in a hierarchical fashion in which the rules are worked out about who is primary in status and power and who is secondary. A hierarchy may become confused if no one knows exactly who is in charge. It may also become confused because a person at one level of the hierarchy consistently joins with a member at another level against a peer, thus forming a dysfunctional coalition. For example, one parent may consistently take the side of a child against the other parent. When the hierarchy is confused, repetitive dysfunctional sequences of interaction develop that stabilize the system. Pathology is defined as a rigid, repetitive sequence of a narrow range of interaction. Pathological behavior develops when the repetitive sequence of interaction confirms two opposite hierarchies at the same time or when the hierarchical arrangement fluctuates. Therapeutic change introduces greater diversity into the system by expanding behavioral options. Often, these new or novel changes will result in different behaviors than the repetitive ones found before the changes were made.

In addition, from the Washington School perspective, symptoms are viewed as inevitable in every family, based on the way the family develops over time (Haley, 1973). Therapists must be sensitive to family life cycle stages (e.g., young adult, marriage, having children) and the tasks common to different ages and stages. Clients may have difficulty as they try to adjust to the changes required when moving from one life cycle stage to another. Thus, therapists help clients move from one stage of life to another. It is helpful for therapists and clients alike to know that problems are normal challenges faced by people going through similar life cycle stages rather than indicators of pathology (Keim, 1999).

The MRI approach does not try to impose any standards on clients (Heath & Ayers, 1991). Nor is there an ideal standard of family structure or communication. From the MRI perspective, dysfunction is not viewed as an aspect of the system's organization that requires fundamental changes. Instead it is believed that fairly minor changes in behavior are often enough to initiate progressive developments in a positive direction. As in the Washington School, the MRI approach is also nonpathological in that clients are viewed as caught up in unhelpful (for the clients) interactional patterns.

Further, problems are likely to develop when ordinary difficulties are either overemphasized or underemphasized. Over- or underemphasis of life's difficulties may depend on general cultural attitudes as much as on personal or family characteristics. For example, normal adolescent limit testing may become a problem when incidents are blown out of proportion by the parents and the adolescent is inappropriately punished or lectured.

In addition, inappropriate handling of life's difficulties is often multiplied by the interactions between various family members. Once the difficulty is seen as a problem, behaviors that are designed to resolve the problem may inadvertently serve to intensify the difficulty. Thus, the cure becomes worse than the disease. Although potentially disturbing and painful, symptomatic behavior can have its advantages or payoff. For example, symptoms can provide leverage in controlling relationships (e.g., they may organize the family). However, this potential function of the symptom is not considered a major factor in the change process by the MRI school of strategic therapy and should not be a focus of therapy. Instead, therapy should focus on the specific actions needed to solve the problem (Haley & Richeport-Haley, 2007.) Resolution of problems primarily requires a substitution of behavior patterns that disrupt the vicious cycle that has developed around the initial life difficulty.

Goals of Therapy

> The long-term goal of treatment should be the immediate goal.
>
> (Haley & Richeport-Haley, 2007, p. 36)

Another revolutionary perspective adopted by the developers of strategic therapy is that therapeutic interventions focus on resolving those problems that are most stressful for clients. Although considered mainstream thinking today, this approach

went counter to the mainstream thinking during the '60s and '70s which was dominated by psychoanalysts who focused on uncovering the **subconscious roots of problems**. The goal of the initial therapeutic interview from a strategic therapy perspective is to negotiate a presenting problem that can be defined in clear, solvable behavioral terms. The therapist negotiates a detailed behavioral statement of the problem and goals for therapy in order to check outcome and determine whether therapy has been successful.

In focusing on the presenting problem, strategic therapists tend to emphasize the importance of behavioral change rather than change in feelings or insight and, as a result, **brief therapy** tends to occur. In fact, the belief is that change can happen without understanding and that self-understanding does not necessarily produce change. Thus, the primary goal of therapy is to solve the presenting problem by getting clients to do something different rather than getting clients to express their feelings or to understand their problem better. In addition to changing behavior, strategic therapists may also try to get clients to look at their problems differently. This may entail **redefining the problem** so that it is viewed as simply one of life's many difficulties (Weakland & Fisch, 1992). This reframing is a seen as a potent intervention that carries within it the command to change (Haley & Richeport-Haley, 2007).

Strategic Therapy Techniques

The strategic therapist first joins with the family and collects information about the presenting problem, the goals for change, and interactions that maintain the symptomatic behavior. With this information, the therapist then develops a plan (strategy) for solving the presenting problem. The **strategy for change** may include giving the family (or individual) one or more **directives** or tasks with the intent of changing the problematic interactional sequence. Informing the choice of directive from the Washington School point of view might be the sense of hierarchy and triangles involved in the problematic interactional sequence. The choice of directive from the MRI point of view is informed by knowledge of ineffective solutions that the family has tried or the clients' position.

After the therapist gives a directive designed to shift interactions, he or she assesses the family's response to the directive and plans a new theraputic change depending on that response. If the directive does not produce the intended result, the therapist may need to change the strategy or to develop a different way of implementing the strategy. This process continues until the presenting problem is solved.

Whom to Invite to the Session

Strategic therapists practicing from the Washington School perspective prefer to work with all the individuals involved in the problem (Haley, 1976). For example, if the identified client is an adolescent, the whole family would be engaged in treatment from the beginning. If instead marital problems are the focus, both

the husband and the wife would be asked to attend the first session of therapy. Seeing everyone who is involved in the problem helps the therapist understand the problem and the social situation that maintains it. It is believed that clients are incapable of accurately reporting their own social system. In contrast, MRI strategic therapists tend to direct their therapeutic efforts toward whoever is most motivated to see change happen instead of routinely seeing all members of a family (Weakland & Fisch, 1992).

The Role of the Therapist

Strategic therapists actively take charge of what happens in the sessions. The therapist decides how therapy should be conducted, including whom to invite to the sessions, who will be asked to speak about the problem first, and what interventions to apply (Haley, 1976). In both the MRI and the Washington School approaches, therapists tend to remain outside the family system (i.e., maintain distance from the family) and avoid directly challenging the family's defenses. Thus interventions are viewed as the therapist taking action on behalf of the family. Further, they do not stress using or eliciting the expression of the client's or the therapist's feelings.

Strategic therapists observe the family's interactions and mood and, rather than commenting on what is occurring in the session, develop **hypotheses** about what maintains the problem, based on the information collected. Therapists direct the session based on these hypotheses as well as their own thinking about what brings about change. For example, a therapist may purposely speak to the leader of the family first, to show differential respect to the member who has the most power to bring the family back to therapy. In taking leadership of the therapeutic process, the strategic therapist also takes full responsibility for solving the presenting problem (Haley, 1976; Weakland & Fisch, 1992).

Strategic therapists create the change necessary to solve the presenting problem by giving directives. Giving directives may involve telling people what to do directly or implicitly—by vocal intonation, body movement, well-timed silence, or commenting on something a client has said or done (Haley, 1976).

The Therapist-Client Relationship

Although the therapist is in charge of the session, the relationship between therapist and client is hierarchically balanced, because the client has hired the therapist and is therefore the boss, yet the therapist has special training and is in the position of expert (Keim, 1999). Essentially, the **therapist–client clinical contract** forms the basis of the relationship.

Another aspect of the therapist–client relationship is the **therapeutic alliance**. Although developing a positive therapeutic alliance for its own sake is not a goal of strategic therapy, a strong therapeutic alliance is an important aspect of creating

a cooperative atmosphere, one in which the client and the therapist work together to solve the presenting problem. The therapist must establish a trusting relationship with the client in which the therapist is viewed as being helpful and on the side of the client (Haley, 1976). Strategic therapists encourage and compliment clients, eliciting their cooperation in doing the tasks and following the directives they give them (Haley & Richeport-Haley, 2007).

Toward this end, a strategic therapist is concerned with understanding the client's beliefs, values, priorities, and feelings, as well as conveying understanding and empathy, which is critical to developing a strong therapeutic alliance. A therapist must be able to communicate to clients that they have been heard, understood, and respected (Fisch et al., 1982). Therefore, the **joining** process would probably look much the same for a strategic therapist as for other schools of family therapy (e.g., structural) in which the therapist uses empathic communication to build rapport with the client. Along the same lines, strategic therapists tend to highlight clients' strengths rather than their liabilities, which empowers the clients to make change quickly and not feel overwhelmed by pathology.

The MRI school stresses the importance of the therapist maintaining **therapeutic maneuverability**. In other words, therapists try to maintain their ability to determine whom to see in therapy, what questions to ask, and the timing and pacing of treatment. When a client will not include his or her spouse in treatment or will not discuss certain topics, for example, the therapist's maneuverability is reduced (Segal, 1991). Treatment success depends on clients providing concrete information and therapists getting clients to carry out suggestions or tasks. To be successful, therapists need to be in charge of the therapeutic process.

In addition, strategic therapists tend to discourage clients' dependence on them and instead stress clients' strengths and ability to take charge of their own problems. An assumption is that clients come to therapy feeling discouraged and incompetent after trying unsuccessfully to solve their problems. Highlighting clients' strengths reinforces their sense of competence, and they become empowered to try something new or to resurrect healthy behavior that had been attempted in the past but perhaps forgotten.

The First Session

Although perhaps not a technique per se, much is written about the first session in strategic therapy literature since it is a critical first step in establishing a working client-therapist relationship and in collecting information needed for developing a strategy. In other words, the first session sets the stage for treatment. Therapy that begins well will more likely end well (Haley, 1976). Haley recommends beginning therapy by inviting the entire family to the initial interview and following a highly structured approach that has four stages: a social stage, a

problem stage, an interaction stage, and a goal-setting stage. The goal of the **social stage** is to help everyone relax. The therapist greets everyone and tries to make each person feel comfortable and welcome as he or she observes how the family interacts. During the **problem stage**, the therapist tells the family what is already known, explains why the entire family was invited to the session (to get everyone's perspective about the problem), and asks each person to give his or her perspective about the problem. Strategic maneuvering begins with the decision about which person to turn to first at this point. The therapist considers such factors as who has the most power to bring the family back to more therapy sessions, who is most concerned about the problem, and who is least involved. During this stage, the therapist is observing the family's interactions with the intent of assessing interaction sequences and family structure (triangles and hierarchy). After each person has had a chance to express his or her point of view, the therapist invites the family members to talk among themselves about how they view the problem **(interaction stage)**, which provides the therapist an opportunity to observe their interactions regarding the problem. After the family members have had a chance to interact with one another, the therapist negotiates a reasonable, clear statement of the changes the family wants to make **(goal-setting stage)**. The therapist may end the first session by giving a directive that can be done as **homework** to be completed before the next session. This may be a simple task that keeps the family involved with the therapy until the next session.

From the MRI perspective, the primary aim of the initial interview is to gather information—about the problem, about how the problem is being managed, about the clients' goals, and about the clients' positions and language (Fisch et al., 1982). When the problem is stated in vague terms, such as "Mom is depressed," the therapist helps the clients define a concrete, behavioral goal, perhaps by asking, "What will be a sign that things are getting better?" Once the problem and the goals have been defined clearly, the therapist asks what the clients have done so far to try to solve the problem. The therapist wants to have an understanding of what people say and do to solve the problem and who is involved. In this way, the therapist can get an understanding of the attempted solutions that may be maintaining the problem. Getting the clients' cooperation in letting go of their solution may be a challenge.

As has already been discussed, understanding the clients' position is critical to gaining their cooperation. The therapist notices the clients' wording and tone in relation to the presenting problem, treatment, and the therapist. For example, do clients view themselves and their situation as unique or commonplace? Do they view the identified patient as mad, sad, or bad? Do they view themselves as angry, frustrated, or hurt? Making an accurate assessment of the clients' positions on these and other matters related to the presenting problem will help the therapist decide on the best approach to take with the clients in terms of strategies to use and ways to deliver them.

Reframing

A basic tool of both schools of strategic family therapy is **reframing** problematic behavior in order to solve the presenting problem. Reframing is an especially important core technique in FFT (Henggeler & Sheidow, 2012). Getting clients to let go of their own solution to the problem and to try a new approach that may seem uncomfortable at best, or bizarre at worst, is an important step to solving the presenting problem (Fisch et al., 1982). Changing the meaning of the problem or reframing the situation is often an important first step, because sometimes the way a problem is viewed helps keep clients stuck. The therapist must listen carefully to the words a client uses to describe a problem to understand the client's view of it. For example, does a wife talk about her husband who does not have a job as if he were depressed and therefore deserving of pity? Or does she talk about him as if he were lazy and therefore deserving of disrespect and criticism? Reframing involves altering the client's experience of a situation in a way that fits the facts of the situation but changes the meaning of the situation in a way that invites the client to change his or her response to the situation (Watzlawick, Weakland, & Fisch, 1974). In essence, the therapist uses language to give new meaning to a situation. When new meaning is given to a situation, this new meaning necessitates the development of new, more congruent action (Haley & Richeport-Haley, 2007).

The change in meaning may be directed toward a behavioral sequence of interactions, the client's perception of what is causing the problem or who is responsible, the client's perception of the seriousness of the problem, and/or the client's perception of the solution to a problem. Sometimes the weak are relabeled as powerful and the powerful as weak (Madanes, 1984). In the case of parents who are convinced that their child is not going to school because he or she is depressed and therefore too sad to be forced to behave appropriately, reframing the child's behavior as laziness or rebelliousness rather than depression may help the parents take action.

Directives

Directives are techniques the therapist uses to help the family change. A hallmark of strategic therapy is that each therapy is individually created depending on the presenting problem and how the family views it. Unique directives are developed to help clients solve the presenting problem. In addition to bringing about change, a directive may also serve the purpose of providing more information to the therapist. When the therapist tells the family what to do, whether or how family members respond gives the therapist information about how the family interacts and/or how family members respond to the changes sought. In a sense, everything a therapist does can be considered a directive (Haley, 1976). For example, when a mother is explaining in session how she talks to her daughter

about the problem, and the therapist nods, smiles, or says "Tell me more," the therapist is encouraging certain behavior. If a client says or does something that the therapist does not think is helpful, she or he may tell the client to stop or simply turn away from the client and change the subject. Telling the client to stop is an **explicit directive**; turning away and changing the subject is an example of an **implicit directive**.

When giving an explicit directive, the first step is to motivate the family to follow it (Madanes, 1981). The way therapists motivate their clients depends on the therapist-client relationship, the nature of the task, and family dynamics. Haley (1976) suggests that therapists give directives that go directly to the goal. If such a direct approach does not work, therapists can use another approach to motivate the family toward the goal. Developing a clear problem and goal for therapy makes it easier to design directives. There are two basic types of explicit directives: (1) **straightforward directives**, or those the therapist hopes the client will do, and (2) **indirect directives**, or directives the therapist hopes the client will rebel against and not do. Strategic therapists highlight the success that will come with following these directives and provide assurance that these directives will meet the therapeutic goals (Haley & Richeport-Haley, 2007).

Often strategic therapists give directives that are to be carried out at home between sessions. This approach helps keep the family engaged with the therapy over the course of the week (Haley, 1976). Family members end up thinking about the therapy and whether they will do the task prescribed and, if not, how the therapist will respond. When therapists assign homework, they should be precise and include all the members of the family if possible. The assignment may be rehearsed in the session. The therapist should ask for a verbal report about the assignment during the next session.

Straightforward Directives

Therapists give a straightforward directive to help clients change interactional sequences and/or hierarchical structure (Haley, 1976). They give these kinds of directives when they think that they have enough power to get clients to do what they want them to do. These **compliance-based directives** may be in the form of advice, explanations, information that the family lacks, or suggestions that promote open communication. They may also take the form of coaching parents on how to control children, establish family rules and consequences, and redistribute jobs and privileges among family members. Therapists may simply ask clients to stop doing something they are doing that is unproductive or to begin to do something they are not doing. For example, a therapist may ask parents to follow through with consequences or to stop reminding their teenage son to do his homework. With minor problems, helping clients change in this way may be fairly easy. However, with more serious or with chronic problems, a straightforward directive often needs to accompany other messages or other

actions in order to obtain the client's cooperation. For example, the therapist may need to raise clients' anxiety about the problem to motivate them to cooperate, or the therapist may need to enlist the help of other family members. The therapist may describe the task as small or as a major undertaking, depending on the situation. In general, directives should be clearly stated rather than suggested. If possible, a directive should involve all family members participating in therapy, to put emphasis on the family unit as a whole. As discussed, the MRI school recommends taking into account the clients' position when giving a directive.

Typically, strategic therapists will help family members **negotiate and contract** with one another to reach agreements (Madanes, 1990). The therapist helps family members express their preferences and compromise with one another about money, rules, relatives, leisure time, and sex. They may develop a contract that formalizes agreements and encourages family members to respect the terms agreed upon.

Indirect Directives

Strategic therapists give indirect directives when they think they might not have the power to gain the cooperation of family members to follow a straightforward directive or if the family is resistant to change despite asking for help with a problem (Haley, 1976). These directives are sometimes called **paradoxical directives**. Both Washington School and MRI strategic therapists use therapeutic paradoxes when appropriate. Therapeutic paradoxes are seemingly illogical interventions that appear contradictory to the goals of therapy, yet are designed to achieve the goals of therapy. When the client proves the therapist wrong and makes changes, the therapist might act surprised or confused or might suggest that the change is probably temporary. It is important that these directives be given in a thoughtful, respectful manner, and in a way that makes sense in the therapeutic context.

Prescribing the symptom is one type of therapeutic paradox that has several variations. Basically, the family is told to continue having the problem behavior, sometimes in such a way that it exposes family interactional sequences that maintain the problem (Haley, 1976). The therapist may also prescribe where, when, and how the symptom will happen. For example, the therapist may encourage a couple who regularly fight in unproductive ways to practice fighting at a certain time every evening, in a specified manner, and in a particular room in the house. Or the therapist may encourage a depressed husband to continue to be depressed because his wife needs someone to care for.

Madanes (1984) developed several variations on prescribing the symptom, many of which are done in a playful way and may be practiced in the session and then given as homework. In one variation, the therapist prescribes the symptom in such a way that it shifts the hierarchical arrangement of family members. For example, a parent might be asked to encourage the child to purposely have the

presenting problem instead of trying to prevent it; thus when the child has the symptom, he or she becomes compliant and the parent is in charge. In this example, in addition to shifting interactions between parent and child regarding the symptom, prescribing the symptom also realigns the incongruent hierarchy between parent and child. In another variation, family members are directed to behave in ways that represent what the therapist thinks is the function of the symptom. For example, if the therapist believes that the 3-year-old child's misbehavior is an attempt to get the parent to provide nurturance, the therapist might ask the parent to rock and hold the child three times a day at predetermined times and for a specific length of time.

Restraining change or asking the clients to go slowly is a paradoxical intervention frequently used by MRI strategic therapists (Fisch et al., 1982). This intervention might be used when clients are anxious and impatient about solving the presenting problem and apt to rush assignments, or when clients see improvement as having negative as well as positive consequences. It might also be used when the therapist suspects that a client might be thrown by a temporary setback or a lapse into old behaviors (Segal, 1991). The client may be encouraged not to change or to change slowly because change might have negative effects for someone in the family. A critical determinant of the success of this intervention is the therapist's skill in offering a believable rationale for suggesting that the client go slowly. This directive will most often be given early in the treatment, perhaps in the first session, particularly with clients who are trying too hard to solve the problem. Another appropriate time to use this intervention is when a client comes to a session feeling elated after experiencing definite, welcome improvement. In this event, a therapist may want to avoid indicating overt optimism and instead caution the client to go slowly, perhaps because changing too fast might be dangerous or scary. In fact, the therapist might even encourage the client to have a relapse (i.e., prescribing the symptom). This tactic is useful because if the therapist is relatively uncommitted to changing the client quickly, it takes away the sense of urgency to solve the problem and puts implicit pressure on the client to cooperate with any suggestion the therapist may give.

Prescribing a symbolic act is an intervention that might be used if a client is engaged in compulsive self-destructive behaviors (Madanes, 1990). Because self-destructive behaviors are often performed in an attempt to punish someone else who does not provide enough love and attention, asking the client to perform a repetitive action that is symbolic of the self-destructive act may symbolically punish that person without actually being self-destructive. For example, a bulimic client may be encouraged to mash up all her favorite foods with her hands and, in the presence of the other family members, flush it down the toilet.

The **pretending technique** is a therapeutic intervention that originated from the Washington School of strategic therapy (Madanes, 1981). When prescribing the symptom is impractical or ethically inappropriate, the therapist may direct the client to pretend to have the symptom. For example, a child may be

asked to pretend to have the symptom each evening, and the parents may then be asked to criticize the child's performance (i.e., make sure the behavior is accurate) and then behave the way they usually do when the child has the symptom. This strategy might be used when the therapist hypothesizes that the symptom has a function in the family and that pretending to have the symptom can fulfill that function, eliminating the need to actually have the symptom. Asking a symptomatic client to pretend to have the symptom also makes a seemingly involuntary behavior become voluntary. In addition, pretending to have the symptom provides the opportunity for the family to respond differently to the symptom, thus interrupting patterns of interaction that have developed concerning the symptom. For example, the therapist may arrange for a daughter who has stomachaches (in order to get love and attention from her mother) to pretend to have a stomachache and for the mother to comfort her.

Ordeal

An **ordeal** is an intervention that directs clients to do something that is mildly disagreeable yet also good for them in response to engaging in symptomatic behavior (Haley, 1984). These interventions are based on the premise that if it is more difficult for a person to have a symptom than to give it up, the person will likely give up the symptom. There are two types of ordeals: straightforward and paradoxical. When the therapist prescribes a **straightforward ordeal**, he or she requires that each time the symptom occurs the client must go through a specific ordeal. For example, when a symptom occurs during the day, a client may be directed to get up in the middle of the night to do something distasteful but healthy (e.g., write or exercise). In a **paradoxical ordeal**, the therapist directs the client to have the symptom at a time when he or she might rather be doing something else. For example, a client who is troubled by ruminations during work hours may be directed to get up an hour early each morning to ruminate for a specific amount of time. An ordeal may also involve more than one person. For example, a couple who are having problems getting past an extramarital affair may be directed to conduct a ritualized ordeal together that is designed to make the offender suffer appropriately.

When ordeals are used skillfully, they can aid in problem resolution. The problem must be clearly defined, the client must be very motivated to get over the problem, an appropriate ordeal must be selected, and a rationale that makes sense must be given to the client. Generally, the therapist directs the client to continue the ordeal until the problem is solved.

Diversity Issues Addressed in Strategic Therapy

While Haley recognized that the social context is an important element in therapy and can be useful in solving problems (Haley & Richeport-Haley, 2007), traditional strategic therapy does not delve into cultural influences. Haley believed

that exploring cultural roots was a practice used by earlier, psychoanalytic therapists. Strategic therapy, instead, focuses on the structural similarities of all people rather on a particular issue related to culture. Haley and Richeport-Haley wrote, "exploration of cultural differences often prolongs therapy unnecessarily" (2007, p. 6). Due in part to the lack of focus on issues of diversity and the focus on hierarchical, often patriarchal family structures, strategic therapy (and others of the Milan school) came under fire in the 1980s and 1990s from feminist scholars and those expressing a social constructionist position (Vetere, 2001).

However, each of the integrated treatment models has paid particular attention to the effectiveness of its treatment programs with diverse clients. In fact, BSFT was developed specifically for Cuban families in Miami, and most of the original work in developing this treatment approach was conducted with Hispanic families (Szapocznik et al., 2012). BSFT effectiveness research indicates that the model is equally applicable to African Americans, Hispanic Americans, and White Americans. Furthermore, each of the evidence-based models that were influenced by strategic therapy has been tested with high rates of ethnic minority families.

Relevant Research

Although research on the effectiveness of strategic therapy as a stand-alone treatment is limited, more recently research in which strategic therapy is included in an integrated approach has led to programs such as BSFT, MDFT, FFT, and MST being tested in numerous randomized clinical trials evaluating the efficacy and effectiveness of the models. These studies have led the U.S. Department of Health and Human Services to include BSFT, MDFT, and MST in its "model programs" and in the National Registry of Evidence-Based Programs and Practices (NREPP; http://nrepp.samhsa.gov/viewintervention.aspx?id_151). In addition, BSFT, MDFT, MST, and FFT have all demonstrated favorable decreases in antisocial behavior in randomized control trials among conduct-disordered or delinquent adolescents, and results have been replicated across at least two research teams (Henggeler & Sheidow, 2012).

There have been a few instances in which pure strategic therapy outcome has been tracked more systematically. For example, in one study follow-up, telephone interviews were conducted three to six months after treatment ended with 97 clients treated from the MRI perspective for an average of seven sessions. These clients had sought therapy for a wide range of problems. Interviewers found that 40% of these clients said they had experienced complete symptom relief; 33% said they had had considerable but not complete relief; and 27% said there had been no change in their symptoms, which represents a 73% success rate (Watzlawick et al., 1974).

Haley (1980) reported on the outcome of his model with schizophrenic young adults who had issues with leaving their families of origin. He and his colleagues

treated schizophrenic young adults who had been hospitalized for the first time. He used rehospitalization as a measure of whether therapy helped the clients. In two to four years after completing therapy, 3 of the 14 clients tracked had been rehospitalized, and 1 had committed suicide, which represents a 71% success rate. Madanes (1995) reported on the outcome of her work with a large sample of male adolescent sex offenders. She and her colleagues obtained two-year follow-up information for 72 of the 75 adolescents treated. Of these individuals, 4 had reoffended, which represents a 96% success rate.

Case Studies

Case Study 1: A Case of Mismatched Confrontational Styles

Tom and Susan Jones, parents of Beth, age 14, were referred to family therapy by Beth's school counselor because she had been disrespectful to teachers and cutting class. Beth was also confrontational at home and seemed to enjoy having arguments with her parents.

The whole family (Tom, Susan, Beth, and two younger children) was invited to the first session in order for the therapist to hear everyone's description of the problem and to see the family in action. The therapist listened carefully to all family members and made them feel comfortable, heard, and supported. When the therapist met with Tom and Susan alone, they confessed that they were afraid Beth was turning into an evil person and that her teacher had said that her behavior in class was completely unacceptable and that she was considering referring her to an alternative school. They felt guilty, frustrated, and powerless to change Beth's behavior.

Based on the family's description of events, the therapist hypothesized that the family had a confused hierarchy in which Beth acted as though she had authority over the adults, and the adults behaved as if they were arguing with a peer. A vicious cycle was repeated several times each week with increasing intensity. When Tom or Susan asked Beth to do something, she would talk back. When the parent tried to explain or insist, Beth would become even more belligerent, leading to a screaming match or slammed doors.

First, it was necessary to shift Tom and Susan's position that Beth was an "evil person" and that they were at fault. The strategy chosen to accomplish this task was a reframing. Tom and Susan were told that this kind of problem often occurs when parents and children have different confrontational styles. They were told that most parents are outcome

oriented in their confrontational style, as they themselves were, and children are sometimes process oriented. That is, for children who are process oriented, winning an argument means controlling the process and keeping the argument going if they so choose, while parents are interested in the outcome—getting the child to behave appropriately. The therapist told Tom and Susan that although they were doing what normally works with children, parents with a child who has this kind of confrontational style need to do something different.

Once Tom and Susan accepted this reframing, they were able to relax and to consider changing the way they responded to Beth. The focus shifted from "Who is at fault?" to "What can we do about it?" Tom and Susan were given the homework assignment of observing the degree to which Beth was invested in determining the process of their arguments by controlling the timing, the content, or the mood of their confrontations. This homework assignment began to shift the parent-child hierarchy by putting the parents in charge, because they became observers of their child's behavior and knew something that Beth did not know.

The therapist then began to help Tom and Susan change their behavior in response to Beth. Their task was to prevent Beth from controlling the timing, content, or mood of their confrontations and conversations. They were asked to describe a typical argument and to think of process-sensitive strategies that would allow them to control the conversation. The goal of this straightforward directive was to strengthen the appropriate hierarchical arrangement, in which parents are in charge of children and competent enough to think of their own solutions.

The next series of steps focused on helping Tom and Susan change their interactions with Beth. After each session, the parents left with a homework assignment to try a strategy they had developed to take charge of the conversation (straightforward directive). They were also asked to record the results of their efforts, so that adjustments could be made during the next session. For example, the parents were asked what kind of mood they wanted to have during confrontations with Beth. They said that they would like to stay calm and caring, yet firm. With coaching from the therapist, they decided that they would help each other remain calm when talking to Beth by holding hands when the intensity began to rise. The therapist congratulated them on every small success, and they became more confident in their ability to control the mood of their conversations with Beth. Once they began to do this consistently, the focus shifted to developing a process-sensitive system of rules and consequences. Tom and Susan were directed to develop a basic list of rules and consequences and ways to time their delivery in the most effective

manner. Beth slowly became more amenable to their efforts to discipline her, as well as a competent student.

Case Study 2: The Anxious Job-Seeker

Allen, a young man, came to therapy because he had trouble obtaining a job in his chosen field after graduating from college. His resume was strong and he was called in for interviews, but they went poorly and he did not receive a job offer. He became so nervous when he was called for interviews that he had recently begun to avoid them and to withdraw his applications.

The therapist's first task was to clearly understand the problem and what the young man was doing in his attempts to deal with the problem. The therapist asked specific questions about the problem, the solutions the young man had attempted, and who was involved in the problem and its solution. The therapist discovered that the nervousness was experienced in a rapid heart rate, flushed face, and trouble concentrating. The therapist asked about variations in the state of this nervousness and times when it did not occur.

The therapist learned that the young man was also living on his own for the first time after his parents requested that he move out after graduation. They were helping support him only until he found a job. He reported that he felt more support from his mother than his father, who was becoming impatient with his extended job search.

After the initial session, the therapist began to surmise the young man's situation. The client admitted that he was often discouraged about his job chances even though he sent out multiple applications each week. His father was adamant the young man should be aggressive in his job search, and as a result he often sent out applications to jobs in which he was not interested or for which he was not qualified.

The young man also held that it was wrong for him to be nervous, and he was skeptical about the possibility of success in finding employment. To cast doubt on this position, the therapist reframed his skepticism as healthy skepticism. She cited the bad economy and the high unemployment figures of a recent report. The therapist cautioned him to be careful not to put too much stock in his father's demands because of the risk of over-reaching, which could result in a bad setback. In effect, the therapist was issuing a paradoxical directive to the young man by suggesting that he go slowly, which was counter to his efforts to correct the problem by trying harder in response to the advice of others.

The therapist also suggested that improvement may have mixed blessings. She encouraged the young man to be more thoughtful in pursuing his goal of finding employment, because success could have

some disadvantages that may not have occurred to him yet. She asked him to think about what those disadvantages might be. After some discussion, she then offered another possible problem: he had suggested that a certain amount of anxiety goes along with interviewing even if the person is perfect for the job. Thus, the therapist reframed the problem as normal and again confirmed the need to go slowly because pursuing a career could have some disadvantages.

The therapist also suggested that it might be difficult to distinguish between the kind of anxiety that is natural and useful in an interview situation and the kind of anxiety that is not. To help the young man further part with his attempted solution, the therapist made an implicit suggestion to deliberately try to throw an interview. He suggested that he might dress poorly, maintain minimal eye contact, and deliberately change the subject from a discussion of the position. However, the dilemma was posed that trying to throw the interview might actually lead to the beginning of improvement, which could have a snowball effect—leading to even more improvement, possibly putting him on a road that he does not really want to be on. The client was then given the homework task of thinking about the dangers of change. When, during the next session, the client reported that he had experienced some improvement in his most recent interview and had been called back for a second one, the therapist resisted the urge to be optimistic and instead said that he shouldn't attach too much meaning to that improvement. She focused on what advantages there were to remaining unemployed, specifically identifying the continued support of his parents. After a few sessions the client terminated, and in a follow-up interview several years later reported that he had become a successful businessman.

Recommended Readings

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Glossary

brief therapy: An approach to therapy that maintains a focus on the present rather than the past and on solving the presenting problem as quickly as possible.

client position: Beliefs, values, and priorities that clients hold that are related to the presenting problem.

compliance-based directive: A directive that the therapist expects the client will follow.

conceptual map: A mental model that represents how an individual perceives reality and by which an individual is guided.

cybernetics: A scientific discipline interested in the interrelationship between stability and change.

directive: An encouragement by the therapist to the client to think or act in a certain way.

double bind: A communication in which an individual is given two mutually exclusive messages by another person to which any response will inevitably result in a failure to please.

explicit directive: A request of the client by the therapist to do something that the therapist thinks will lead to change.

family life cycle transition: Phases in the family developmental evolution that mark periods of change—primarily when a member enters or exits the family.

goal-setting stage: The final stage of the initial session, when strategic therapists help family members set goals for therapy.

homework: Activities or tasks relating to the presenting problem that the therapist asks the client to do between sessions.

hypnosis: A technique in which a person is put into a trance or dreamlike state.

hypotheses: The ideas and/or guesses that a therapist makes regarding what maintains the presenting problem.

identified patient: The person who is viewed by the family as the focus of therapy; the person who has a problem or is a problem for the family.

implicit directive: An attempt by the therapist to indirectly influence the client's behavior—for example, by changing the subject when the topic seems counter-productive to the goals of therapy.

incongruent hierarchy: A term used to describe families in which family members do not behave in age- or role-appropriate ways in relation to one another.

indirect directive: A task that implicitly influences the client's positive change.

interaction stage: The third stage of the initial session, in which strategic therapists ask family members to discuss their various points of view about the problem so that they can observe how the family interacts regarding the problem.

interactive view of problems: The belief that problems are maintained by the repetitive negative interchanges of family members.

joining: A therapeutic skill of establishing rapport with clients in which therapists develop a personal relationship with families, thus becoming accepted, trusted helpers.

metaphor: Symbolic language or behavior that links two events, ideas, or characteristics (or their meanings).

negotiate and contract: A process by which the therapist helps families reach a satisfactory agreement regarding specific goals or changes in behavior.

ordeal: A therapeutic technique in which the client is asked to do a set of tasks that is appropriate for the problem but causes distress that is equal to or greater than the problem.

paradoxical communication: A set of contradictory messages.

paradoxical directive: A therapeutic task that seems contradictory to the goals of therapy whereby family members change by either accepting or rejecting the therapist's suggestion.

paradoxical intervention: When the therapist directs clients to continue their symptomatic behavior.

paradoxical ordeal: A therapeutic technique in which the client is instructed to go through the experience of having the symptom at a time or place that is different than when he or she might ordinarily have the symptom.

power ladder: The relative influence each family member has in relation to other family members.

prescribing a symbolic act: A type of directive in which the therapist asks a client to do something that represents the symptom.

prescribing the symptom: A strategy in which the therapist asks the client to have the symptom, which forces the client either to rebel against the prescription or to obey, thus putting the client more in control of the symptom.

pretending technique: When the therapist directs a client to pretend to have a symptom, thereby putting the symptom more under the client's control.

problem stage: The second stage of the initial session, in which strategic therapists ask each family member to share ideas about the problem and his or her involvement in it.

psychoanalysis: A form of therapy usually accredited to Sigmund Freud in which the patient's past and unconscious inner life is the focus of treatment.

PUSH system: A way of viewing a family system used by some strategic therapists who think about (1) how a symptom might be protective of someone in the family (**p**rotection), (2) who is involved in maintaining the problem (**u**nit), (3) what behavior patterns are involved in maintaining the problem (**s**equences of interaction), and (4) what is the power structure of the family (**h**ierarchy).

redefining the problem: Changing the client's belief about the problem.

reframing: Using language to give new meaning to a situation and thereby helping clients see their situation in a new way, which may entail developing a more positive interpretation of the problem.

restraining change: A type of paradoxical directive in which the therapist discourages change, often citing the drawbacks of improving.

social stage: The first stage of the initial session, in which strategic therapists greet family members and try to make them feel comfortable.

straightforward directive: A task given to a client that the therapist hopes he or she will do because it encourages the client to correct the presenting problem.

straightforward ordeal: When the client is instructed to go through a specific ordeal (something he or she should do more of anyway) each time the symptom occurs.

strategy for change: A plan or approach for solving the presenting problem.

structural family therapy: The approach, developed by Salvador Minuchin and his colleagues, that focuses on how families operate (structure and communication patterns).

subconscious roots of problems: Problems that stem from feelings or motivations that are outside a person's awareness and therefore based in the subconscious.

systems theory: A theoretical framework that suggests individuals in a system affect and are affected by one another and cannot be understood without understanding the interrelationships.

therapeutic alliance: A collaborative working relationship between therapist and client.

therapeutic maneuverability: A technique in which therapists maintain their ability to take action.

therapist-client clinical contract: When the therapist and the client together negotiate an agreement related to the presenting problem and goals for change.

triangle: A three-person system that develops when stress between two people becomes so great that a third person is drawn into the conflict to decrease the tension.

vicious cycle: A destructive, repetitive pattern of interaction.

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6

MILAN SYSTEMIC THERAPY

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> Milan therapy brings the future—or rather, many possible futures—into the present, and allows clients to choose the ones they prefer. The possibility of a future not determined by necessity, but open to sometimes unpredictable choices, gives clients hope; it helps them . . . embark on a new journey.
>
> Luigi Boscolo
> *The Times of Time*

Theories are, by definition, works in progress. Nowhere is the evolving nature of therapy models more apparent than in the Milan approach. Indeed, its numerous revisions over time represent perhaps its most obvious characteristic. Based initially on the ideas of the early Palo Alto Mental Research Institute group, with its emphasis on family rules and **homeostasis**-seeking interactive patterns, the Milan approach has itself undergone continuous change in its history (Goldenberg & Goldenberg, 2013; Campbell, Draper, & Crutchley, 1991).

After a decade of work together, the four original Milan team members separated into two autonomous groups (Selvini Palazzoli and Giuliana Prata; Luigi Boscolo and G. F. Cecchin) in 1979, each pair pursuing differing emphases in their systemic thinking and practices. Selvini Palazzoli and Prata (separately since 1982) have engaged in family systems research, particularly directed at developing techniques for interrupting the destructive games they believe psychotic individuals and their families play. Selvini Palazzoli's work at this stage, carried out in collaboration with a group of colleagues, is called *Family Games* (Selvini Palazzoli, Cirillo, Selvini, & Sorrentino, 1989); in it she proposes a **universal strategic intervention** designed to break up repetitively resistant patterns

in families with severely disturbed members. In the early 1990s Selvini Palazzoli abandoned this strategic approach and returned to long-term insight-oriented individual therapy until her death in 1999.

On the other hand, Boscolo and Cecchin began training family therapists worldwide and have continued to elaborate their own systemic ideas. Departing from strategic techniques, they have developed a more **collaborative** therapeutic intervention style based on the interviewing process itself, particularly the use of circular questioning. Consistent with those views, their most recent efforts have been directed at fine-tuning such questioning techniques. In seeking to advance a new **systemic epistemology**, Boscolo and Cecchin (Boscolo, Cecchin, Hoffman, & Penn, 1987) became central players in advancing the approaches of **constructivism** that are now popular in the postmodern approaches in the family therapy field. Their work together ended with Cecchin's sudden death in 2004. This collaborative evolution of systemic therapy continues to be developed in Europe by Bertrando (2007), who was trained in Milan by Boscolo and Cecchin and collaborated with them through the 1990s. Incorporating ideas from both systemic and postmodern theories, Bertrando calls his synthesis dialogic therapy. He describes a dialogic therapist as someone whose therapy is guided by systemic hypotheses but who also works in a more collaborative manner, in dialogue, to produce a hypothesis actively created by both therapist and clients.

In the United States, the Milan team found a particularly receptive audience among some members of the Ackerman Institute for Family Therapy in New York, particularly Peggy Papp (1983), Peggy Penn (1982), and Joel Bergman (1985). Lynn Hoffman, formerly at Ackerman, relocated to Amherst, Massachusetts, and now subscribes to a social construction viewpoint (Hoffman, 2002). Elsa Jones (1993), as well as David Campbell (1999) and Campbell, Draper, & Crutchley (1991) in England, are enthusiastic supporters of the Milan viewpoint. In Canada, Karl Tomm of the University of Calgary is a leading interpreter of the Milan (and post-Milan) systemic approach. Elaborating on the Milan group's collaborative techniques and constructivist epistemology, Tomm (Tomm, 2003; Strong, Sutherland, Couture, Godard, & Hope, 2008) incorporates an ethical dimension to his interview approach that is designed to enhance healthy interpersonal patterns (HIPS). He pays special attention to the institutional definitions of family problems and proposes therapists have a responsibility to not only monitor the influence their inquiry has on families, but also promote social justice.

Main Proponents and Theoretical Concepts

Like many well-known therapists in the family therapy field, Mara Selvini Palazzoli was initially trained as a psychoanalyst. In 1967 she became the leader of a group of eight fellow psychiatrists—including Luigi Boscolo, Gianfranco Cecchin,

and Giuliana Prata—to treat families of severely disturbed children, many of whom were suffering from **anorexia nervosa**. However, their initial efforts to apply psychoanalytic concepts to the family proved to be very time consuming and produced limited results (Selvini Palazzoli, 1974). Turning to the published accounts of the works of the Palo Alto group, particularly the book *Pragmatics of Human Communication* (Watzlawick, Beavin, & Jackson, 1967), Selvini Palazzoli, Boscolo, Cecchin, and Prata formed a study group to better understand strategic theories and techniques in the hope that such an outlook would lead to better interventions in families with entrenched patterns of interaction.

In 1971, these four split from their analytic colleagues. They established the Milan Center for the Study of the Family in order to work more exclusively with family systems. Although Watzlawick was their major consultant in these early years and visited them periodically in Italy, they gradually developed their own theory and set of strategic intervention techniques over the next decade (Boscolo et al., 1987). They published their first article in English in 1974 (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1974), introducing a team approach along with a set of powerful and innovative intervention techniques, such as positive connotation and therapeutic rituals (both described in detail later in this chapter), designed to overcome the paradoxical interactive sequences that deadlocked families and resulted in therapeutic impasses. What is now referred to as the "classic" Milan approach quickly captured the imagination of family therapists around the world. Working with families that exhibited a wide range of the most severe emotional problems, they reported particular success in treating anorexic children as well as schizophrenics with their team approach.

By 1980, the four were beginning to de-emphasize the use of therapeutic paradoxes, and a landmark paper, "Hypothesizing—Circularity—Neutrality: Three Guidelines for the Conductor of the Session" (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980), revealed their thinking to be moving in a systemic direction and away from strategic techniques. They contended that **hypothesizing**, a continual interactive process of speculating and making assumptions about the family situation, provides a guide for conducting a systemic interview. They stressed that this guide to the family system is neither true nor false but is useful as a starting point. Hypothesizing allows the therapist to search for new information, identify the connecting patterns that sustain family behavior, and speculate on how each participant in the family contributes to systemic functioning. Beginning with the family's first telephone contact and continuing throughout the therapeutic process, hypothesizing represents therapeutic formulations regarding family functioning and is carefully constructed to elicit a picture of how the family is organized around the symptom or presenting problem. When asked for a description of the problem at the start of the first interview, the family might point to the symptom bearer as the one with the problem. The Milan therapist will ask, "Who noticed the problem first?" This redefines the problem as relational—the problem does not exist without a "noticer," and thus it does

not belong to one person alone. Moreover, the problem is depicted as an event between two or more family members, thus involving the wider family system (Boscolo et al., 1987). Thus, hypothesizing permits the therapist to present a view of the family's behavior that is different from the family's own established self-picture. The therapist is offering a conceptualization—of the family's communication patterns, the meaning of a family member's symptoms, the way in which the family organizes itself to deal with problems, and the family game. In doing so, the therapist identifies himself or herself as an active participant, someone who does not necessarily have all the answers but, with his or her unique view of the family's reality, intends to open the family up to considering a new perspective on their lives.

As Burbatti and Formenti (1988) contend, *the goal of therapeutic hypotheses is change, not truth.* In the Batesonian tradition, hypothesizing offers information, allowing the family members to choose whether to accept or reject the therapeutic message from an active therapeutic partner. If, instead, the therapist were simply a passive observer, the Milan group believes the family would impose its own punctuations and resume its own games; little if any new information would be forthcoming to initiate change, and the system would tend toward entropy. Hypothesizing, on the other hand, offers a structured viewpoint, organizing data provided by the family and encouraging the family members to rethink their lives and together begin to form new hypotheses (e.g., regarding previously denied coalitions) about themselves and their interactions.

Neutrality is different from noninvolvement; it means the therapist is interested in, and accepts without challenge, each member's unique perception of the problem (although the therapist does not necessarily accept the problem itself). No one family member's view is seen as more correct than any other view. Thus, each family member may repeatedly experience the therapist being allied with one or another member as that person's views are elicited, but never allied solely with any one participant. To combat what he perceived was a widespread misunderstanding that neutrality demonstrated coldness or aloofness, Cecchin (1987) characterized the notion of neutrality as **curiosity**. The curious therapist is open to numerous hypotheses about the system and invites the family to explore those that increase the number of options or possibilities for the changes its members seek.

When Milan therapists speak of **circularity**, they are referring both to interactional sequences within the family and, because the therapist is part of the system, to the therapist's interactional relationship with the family. The therapist's hypotheses lead to questions, and the family's responses lead to refined hypotheses and new questions, all leading to changes in the family's belief system. As Selvini Palazzoli et al. (1980) define it:

> By circularity, we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the

> information he solicits about relationships and, therefore, about differences and change.
>
> (p. 3)

Circular questioning, destined to be a significant influence on future therapists, has become the cornerstone of Boscolo and Cecchin's later modifications of the original systemic outlook. Circular questioning involves asking each family member questions that help address a difference or define a relationship between two other members of the family. These differences are intended to expose recursive family patterns. These interviewing techniques will be defined and illustrated later, but for now it will suffice to state that the therapist is trying to construct a map of the interconnections among family members and is assuming that asking questions about differences in viewpoints is the most effective way of creating such a map (Campbell et al., 1991). One major gain is that each family member is continually exposed to the ideas and opinions of the others throughout the therapy.

After Selvini Palazzoli, Boscolo, Cecchin, and Prata separated, Selvini Palazzoli and a new set of associates (Selvini Palazzoli et al., 1989) began to elaborate on the concept of **family games**, the destructive, collusive parent-child patterns they believe psychotic individuals and their families engage in. She and her colleagues made the controversial recommendation that family therapists offer a solitary prescription or task to the parents. Selvini Palazzoli proposed that this universal or **invariant prescription** be applied to all families with schizophrenic or anorexic children. Their intervention techniques at this stage represent a return to some of the Milan group's earlier strategic and structural ways of working (Simon, 1987).

In the early 1990s, Selvini Palazzoli reinvented her therapy once more, this time abandoning any form of short-term strategic therapy (invariant prescription included) for long-term therapy with patients and their families. Thus she came full circle, beginning with psychodynamic roots, then abandoning any concerns with the individual to focus on family patterns, and finally returning to long-term therapy that emphasized insight and focused again on the individual. This therapy revolved around the denial of family secrets and suffering over generations. In this way, it was linked conceptually to her former models (Nichols & Schwartz, 2001).

Following the original group's split in 1979, Boscolo and Cecchin continued to elaborate their own systemic ideas and have developed a more collaborative therapeutic intervention style based on the interviewing process itself, particularly the use of circular questioning. Unlike Selvini Palazzoli's direct, take-charge therapeutic style, in which parents are offered prescriptions, Boscolo and Cecchin's efforts emphasize neutrality as a way of quietly challenging an entire family to reexamine its epistemology. In effect, the therapist temporarily joins the family, becoming part of a whole system from which he or she can begin to offer

information and perspectives on reality. In essence, the therapist and the family members influence each other, producing the opportunity for change as a by-product.

Boscolo and Cecchin argued that perhaps it is better to do away with the concept of family systems entirely, and rather to think of the treatment unit as a meaning system in which the therapist is as active a contributor as anyone else. Any intervention, then, should not be directed at a particular outcome but rather be seen as perturbing the system, which will then react in terms of its own structure. Consistent with postmodern ideas, therapists do not have the answers but, together with the family, can co-construct or co-evolve new ways of looking at the family system, creating the possibility of new narratives or versions of reality that are less saturated with past problems or past failed solutions. For example, Cecchin (Cecchin, Lane, & Ray, 1993) has suggested that in addition to remaining curious, the therapist should maintain an attitude of **irreverence**. By this, Cecchin means the therapist should not become too attached to any model or belief and should help families become more irreverent toward the beliefs that constrain them (Nichols & Schwartz, 2001).

Karl Tomm, in a series of papers (1987a, 1987b, 1988), has elaborated on these ideas, arguing that the therapist should carry out continuous **interventive interviewing**. More than simply seeking workable interventions, Tomm (1987a) urges therapists to attend closely to the interviewing process, especially their own intentionality, adopting an orientation in which everything an interviewer does and says—and does not do and say—is thought of as an intervention that could be therapeutic, nontherapeutic, or countertherapeutic.

Tomm adds **strategizing** to the original set of Milan techniques of hypothesizing, circularity, and neutrality. His circular questions are carefully constructed—not simply for information-gathering purposes, but also as a change-inducing technique (Slovik & Griffith, 1992). Strategizing refers to a therapist's ongoing cognitive activity—evaluating the effects of past therapeutic actions, developing new plans of action, anticipating the consequence of possible interventions, and deciding, moment to moment, how to achieve maximum therapeutic influence most effectively. More specifically, Tomm is interested in the kinds of questions a therapist asks to help families extract new levels of meaning from their behavior, in the service of enabling them to generate new ways of thinking and behaving on their own.

Of greatest relevance are what Tomm (1987b) refers to as **reflexive questions**. Intended to be facilitative, reflexive questions are designed to move families to reflect on the meaning they extract from their current perceptions and actions and to stimulate them to consider alternative options. For example, the therapist may suggest a useful course of action by asking, "What would happen if you told her when you were hurt or angry instead of withdrawing?" The client is given the idea and invited to speculate on the implications of acting on it. These questions are described in more detail later.

Normal Family Development

Because the Milan team was closely associated with the MRI group in its early stages, they share a **nonnormative stance** toward family development. By nonnormative, MRI therapists mean that "we use no criteria to judge the health or normality of an individual or family. As therapists we do not regard any particular way of functioning, relating, or living as a problem if the client is not expressing discontent with it" (Fisch, 1978, p. 109). This relativism has deep roots (Nichols & Schwartz, 2001). As early as 1967 Don Jackson wrote an essay called the "Myth of Normality," cautioning against taking any position regarding how families should behave.

The Milan associates strive to maintain a nonnormative posture through their attitude of neutrality or curiosity (Cecchin, 1987) regarding families. They aspire to no preconceived goals or normative models for their client families. Instead, by raising questions that help a family examine itself and its belief system, they trust that the family will reorganize on its own in a better way, even if that does not conform to some normative map (Nichols & Schwartz, 2001). However, despite their rejection of normative goals, Boscolo and Cecchin imply that healthy families are resourceful enough to modify beliefs and attitudes that do not work, and that this flexibility is needed not only with everyday difficulties but also to navigate transitional periods in the family's development.

Selvini Palazzoli and her colleagues came closer to a normative blueprint of family functioning, although this is not explicitly stated. Their hypotheses about family games involve any number of covert **cross-generational alliances**, so one could infer that they believe families should have clear generational **boundaries**. Nichols and Schwartz (2001) caution against making this inference, however, since normality is not always the converse of abnormality.

Pathology and Behavior Disorders

The Milan team's explanation of problematic behavior parallels the group's evolution. The team's first book, *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction* (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), reveals the strong influence of **cybernetics** on their thinking. Dysfunctional families exhibited paradoxical behavior—the moves each member of the system made seemed to keep change from occurring. As Tomm (1984a) observed, it was as though the family was asking the therapist to change its symptomatic member at the same time that it was insisting the rest of the family was fine and had no intention of changing.

For example, in this early work, the Milan group focused on the rules of the game in psychotic families—tactics by which family members struggle against one another as, together, they act to perpetuate unacknowledged family games in order to control one another's behaviors. That is, the Milan group conceptualized the

family as "a self-regulating system which controls itself according to the rules formed over a period of time through a process of trial and error" (Selvini Palazzoli et al., 1978, p. 3). The symptoms in a family member, then, were not accidental, but were "skillfully fabricated to achieve particular systemic purposes" (Seltzer, 1986). A schizophrenic individual, trapped by these family rules, is powerless to effect change. That is, the rules of the family's game, rather than any individual input, define and sustain his or her family position and pathology.

Recognizing from a systems perspective that it is impossible for a part to change without a complementary change in the whole, the group began to design interventions in the form of **counterparadoxes** directed at breaking up such contradictory patterns, thus freeing up the family to change. Selvini Palazzoli, in her work *Family Games* (Selvini Palazzoli et al., 1989), describes her experiments with interventions, such as the invariant prescription, designed to disrupt these pathological family games. Most recently Selvini Palazzoli focused her research on intergenerational secrets as the source of symptomatic behavior in families.

Boscolo and Cecchin's thinking moved away from the MRI version of families as self-correcting systems governed through rules; the pair began to regard systems as evolving and unfolding rather than as seeking a return to homeostasis. Extrapolating from Bateson's (1972) work, they theorized that dysfunctional families are making an "epistemological error"—they are following an outdated or erroneous set of beliefs or maps of their reality, which is why they appear to be stuck or in homeostatic balance. Put another way, a family that is having problems has adopted a set of beliefs that does not fit the reality in which it is living. In effect, the family is being guided by a map that is out-of-date.

According to this new perspective, the family's beliefs about itself are not the same as the actual behavior patterns of its members, so that they only gave the impression of being stuck; in reality their behavior was changing continuously. Boscolo and Cecchin decided they needed to help families differentiate between these two levels—meaning and action. Therapeutically, they began to introduce new information, new distinctions in thought and action, carefully introducing differences into the family's belief system. Relying on circular questioning to present differences for the family to consider, the pair attempted to activate a process in which the family creates new belief patterns and new patterns of behavior consistent with those beliefs.

Techniques

Long Brief Therapy

Two distinguishing characteristics of classic Milan systemic family therapy have been its **spacing of therapeutic sessions** and its use of a team of therapists who work together with a family. The original Milan team method has been

described as "long brief therapy" (Tomm, 1984a), since relatively few sessions (generally about 10) were held approximately once a month and thus treatment might extend up to a year or so. Initially, this unusual spacing of sessions was instituted because so many of the families seen at the Milan Center had to travel hundreds of miles by train for treatment. Later, the therapy team realized that their interventions—often in the form of paradoxical prescriptions aimed at changing the way an entire family system functioned—took time to incubate and finally take effect. Once the frequency was determined, the therapists did not grant an extra session or move up a session to shorten the agreed-upon interval. Such requests by families were seen as efforts to disqualify or undo the effects of a previous intervention (Selvini Palazzoli, 1980). The early Milan group was adamant in its determination that the therapist not submit to the family's "game" or become subjugated to its rules for maintaining sameness and controlling the therapeutic relationship. Even under pressure from the family, these therapists would remain unavailable in the belief that a request for an exceptional meeting actually meant the family was experiencing rapid change and needed the time to integrate any subsequent changes in family rules.

During most of the 1970s, the members of the Milan group worked in an unconventional but consistent mode developed from their strategic-based research. The entire family was seen together by one or sometimes two therapists (typically a man and a woman), while the remainder of the team watched from behind a one-way mirror to gain a different perspective. From time to time during the session, the observers would summon one of the therapists out of the room to change therapeutic direction; while conferring with the therapist, they would make suggestions, share opinions, provide their own observations, and often issue directives that the returning therapist could then share with the family. When the therapist rejoined the family group, he or she discussed what had transpired with the **observer team**, and assigned the family members a task, usually a paradoxical prescription. Sometimes such an intervention took the form of a paradoxical letter, a copy of which was given to every family member. In the event that a key member missed a session, a copy of the letter would be sent by mail, frequently with comments (again, often paradoxically stated) regarding his or her absence. Prescriptions took the form of opinions (e.g., "We believe Father and Mother, by working hard to be good parents, are nevertheless . . . ") or requests that certain behavioral changes be attempted by means of rituals carried out between sessions (e.g., "The immediate family, without any other relatives or outsiders, should meet weekly for one hour, with each person allowed fifteen minutes to . . . "). By addressing the behavior of all the members, the therapists underscored the connections in the family patterns. Prescriptions usually were stated in such a way that the family was directed not to change for the time being. Thus, the therapist might say, "I think the family should continue to support Selma's behavior for the present" (Selvini Palazzoli et al., 1978).

Structured Family Sessions

The classic Milan therapeutic interview format was divided into five segments: the presession, the session, the intersession, the intervention, and the postsession discussion. Family therapy would begin with the initial telephone call from the family. The team member who took the call would talk to the caller at length, recording the following information on a fact sheet.

- Who called?
- Who referred the family?
- What is the problem?
- How disturbed is the caller's communication?
- What tone of voice is used?
- What is the caller's attitude regarding the forthcoming treatment?
- What special conditions, if any, does the caller attempt to impose?

These intake issues would then be discussed with the entire team in the presession, prior to the first interview, in a lengthy and detailed way, and the various team members would propose tentative hypotheses regarding the family's presenting problem. Particularly noteworthy is the fact that the referring person or agency was kept involved throughout treatment, a recognition of his or her part in the **larger system**.

In a similar fashion, such team conferences occurred before each subsequent session, as the group met to review the previous session and to strategize for the upcoming one. All of these tactics affirmed the Milan therapists' belief that family and therapist(s) are part of one system. During the session itself, a major break in the family interview (the intersession) would occur so that the observer team could have an active discussion with the therapist out of hearing of the family, during which hypotheses would be validated or modified. The therapist would then return to offer the team's intervention (usually a prescription or a ritual) to the family. The team postsession discussion would focus on the family's reaction to the intervention and also provide a chance to plan for the following session (Boscolo et al., 1987).

This early version of the Milan model was more concerned with family processes than with family structure. Members of dysfunctional families were seen as engaging in self-perpetuating games in which members tried to control one another's behaviors. The identified problem was seen as serving the system in the best way possible at the moment. Since the family members, through their communication patterns, maintained the system's rules and thus perpetuated the transactions in which the symptomatic behavior was embedded, the therapist tried to change the rules in order to change that behavior (Selvini Palazzoli et al., 1978).

As the Milan therapeutic procedures changed over time, the classic method—male and female cotherapists, two team members behind the one-way mirror—was

amended so that a single therapist was likely to work with the family while the rest of the team (often students learning the technique) observed. The observers were free to call the therapist out of the room to share ideas and offer hypotheses. The **five-part session** division (presession, session, intersession, intervention, and postsession discussion) has been maintained by and large, although the fixed month-long interval between sessions has become more flexible, depending upon feedback from the family and consultants. Generally speaking, a 10-session limit extended over an indeterminate period of time still qualifies the approach as long brief therapy (Jones, 1993).

Interviewing Techniques

Two early Milan therapeutic interventions included the use of **positive connotation** and ritualized prescriptions.

Positive connotation is a form of **reframing** the family's problem-maintaining behavior in which symptoms are seen as positive or good because they help maintain the system's balance and thus facilitate family cohesion and well-being. By suggesting a good reason for behavior previously viewed as negatively motivated (e.g., "Your child refuses to go to school because he wants to provide companionship for his lonely mother"), the systemic therapist is indicating to the family that the unwanted symptomatic behavior may actually be desirable. Instead of being considered "bad" or "sick" or "out of control," the symptomatic child is considered to be "well intentioned" and behaving volitionally. Note that it is not the symptomatic behavior (school refusal) that is connoted to be positive but rather the intent behind that behavior (family cohesion or harmony).

All members of the family are considered to be motivated by the same positive desire for family cohesion, and thus all are linked participants in the family system. Because the positive connotation is presented by the therapist as an approval rather than a reproach, the family does not resist such explicit confirmation and accepts the statement. As a result of reframing, the symptomatic behavior is now viewed by the family as voluntary, greatly enhancing the possibilities for change. However, the positive connotation has implicitly put the family in a **paradox**: Why must such a good thing as family cohesion require the presence of symptomatic behavior in a family member?

One other important function of positive connotation deserves mention: it prepares the family for forthcoming paradoxical prescriptions. That is, when each family member's behavior is connoted as positive, all view one another as cooperative and thus they are more willing to join in complying with any tasks they may be assigned by the therapist, reducing family resistance to future change. If the therapist adds a **no-change prescription** (also known as a paradoxical intervention) ("And because you have decided to help the family in this way, we think that you should continue in this work for the time being") (Tomm, 1984b, p. 266), an additional paradox of "no change in the context of

change" further increases the impact of the intervention. The seemingly innocuous phase "for the time being" implies that the current family pattern need not always occur in the current manner, leaving open the possibility of future spontaneous change. The family is left to resolve the paradoxical absurdities on its own.

Family rituals, such as weddings, birthday parties, baptisms, bar and bat mitzvahs, graduations, and funerals, often play a central role in a family's life. Such transitions are designed to mark and facilitate family developmental transitions and changes. Therapeutically, rituals may be designed to intervene in established family patterns, promoting new ways of doing things, which in turn may alter thoughts, beliefs, and relationship options (Imber-Black, 1988). Rather than offer a direct prescription, which the family may fear or resist or otherwise oppose, ritualizing the prescribed behavior offers a new context and is thus more likely to be carried out by the family. Rituals usually are assigned in paradoxical prescriptions describing in detail what act is to be done, by whom, when, and in what sequence. Typically, carrying out the ritual calls for the performance of a task that challenges a rigid and covert family rule (see Box 6.1).

Therapeutic rituals address aspects of family relationships that the therapist or team hypothesizes to be significant for family functioning, based on the team's view of the family's current difficulty. Generally, therapeutic rituals are ceremonial acts proposed by the therapist in a tentative way as suggestions or family experiments and are not expected to become a permanent part of family life. The therapist does not insist the ritual be carried out but only indicates that he or she believes the gesture may be useful.

Box 6.1. Family Ritual Example

Family rituals have many uses. One example is using family rituals for a case in which parents are inconsistent or competitive with each other in an attempt to maintain behavioral control of a disruptive child. The therapist may suggest a "ritual" wherein the mother takes full charge of discipline on odd days (with the father observing and taking exact notes on the ensuing mother-child interaction) and the father takes charge on even days (with the mother playing the opposite role); each is directed to carry out the assigned roles for a certain number of days and to behave "spontaneously" for the remaining days of the week. Carrying out the ritual clarifies differences in approach for the parents and provides greater awareness of how their differences can cause confusion in their child. It thus highlights the importance of two-parent consistency as a goal if the child is to achieve the comfort level necessary to abandon the disruptive behavior.

Generally speaking, the purpose of a ritual is to provide clarity where there might be confusion in family relationships; clarity is gained by the family's enactment of the directive (Tomm, 1984b).

In a 10-year evolution of their own therapeutic approach, Selvini Palazzoli and Prata (Prata, 1990; Selvini Palazzoli et al., 1989) sought to avoid end-of-session rituals tailored for each new family by specifically searching for a universal or invariant prescription that would fit all families. The invariant prescription is a ritualized sequence of directives families must follow if the therapist is to help them interrupt their dysfunctional interactions.

This ritualized prescription is based on their six-stage model of psychotic family games. Selvini Palazzoli (1986) contends that a single process takes place in all schizophrenic and anorexic families, beginning with a stalemated marriage (stage 1) in which a child attempts to take sides (stage 2). Eventually drawn into the family game, the child erroneously considers the actively provoking parent to be the winner over the passive parent, siding with the perceived "loser." The subsequent development of disturbed behavior of symptomatology in the child (stage 3), requiring parental attention, presents a demonstration to the passive parent of how to defeat the "winner." Instead of joining the child, however, the passive parent or "loser" sides with the "winner" parent (stage 4) in disapproving of the child's behavior. The child, in this scenario, feels betrayed and abandoned and responds by escalating the disturbed behavior, determined to bring down the "winning" parent and show the "loser" what can be done (stage 5). Ultimately, the family system stabilizes around the symptomatic behavior (stage 6), all participants resorting to "psychotic family games" as each family member tries to turn the situation to his or her advantage.

To break up the game, it is suggested that therapists offer a solitary prescription or task by which the parents mysteriously disappear for a limited time. Selvini Palazzoli proposed that the invariant prescription be applied to all families with schizophrenic or anorexic children. As indicated earlier, Selvini Palazzoli later abandoned this idea.

Boscolo and Cecchin, on the other hand, focused on developing the three landmark intervention strategies—hypothesizing, circularity, and neutrality—developed near the end of the original Milan group's collaboration. Circular questioning in particular has become the cornerstone of Boscolo and Cecchin's later modifications of the original systemic outlook. Further refinements have been offered by Penn (1982, 1985) and Tomm (1987a, 1987b).

Underscoring the notion of feedback loops, circular questions enable the therapist to construct a map of the interconnections among family members. More specifically, rather than rely on a free-form set of therapeutic questions based loosely on previously formulated hypotheses, Boscolo and Cecchin refined questions that (1) probed differences in perceptions about relationships (e.g., "Who is closer to Father, your daughter or your son?"); (2) investigated degrees of difference (e.g., "On a scale of one to ten, how bad do you think the fighting

is this week?"); (3) studied now-and-then differences (e.g., "Did she start losing weight before or after her sister went off to college?"); and (4) sought views of family members on hypothetical or future differences (e.g., "If she had not been born, how would your marriage be different today?") (Boscolo et al., 1987, p. 11). The idea was to search for mutually causal feedback chains underlying family interactive patterns and to incorporate these findings into systemic hypotheses, which in turn would form the basis for asking further circular questions, leading to further refined hypotheses, and so forth. What is particularly ingenious about this technique is that it allows very little room for a refusal to answer, because questions are given in multiple-choice format.

The technique focuses attention on family connections rather than individual symptomatology by framing every question so that it addresses differences in perception by different family members about events or relationships. Asking a child to compare his mother's and his father's reactions to his sister's refusal to eat, or to rate each one's anger on a 10-point scale, or to hypothesize what would happen if they divorced—these are all subtle and relatively benign ways to compel him to focus on differences. By asking several people the same question about their attitude toward the same relationship, the therapist is able to probe more and more deeply without being directly confrontational or interrogating the participants in the relationship (Selvini Palazzoli et al., 1980).

Family members reveal their relationships with each other through both verbal and nonverbal communication. Information about the family can be found in the different meanings each participant gives an event. Such differences in turn reflect differing views of family relationships. Circular questioning aims to elicit and clarify confused ideas about family relationships and to introduce information about such differences back to the family in the form of new questions.

Such **triadic questioning** (addressing a person about the relationship between two other people) often produces change in the family in and of itself, as well as provides information to the therapist. Along the way, families learn to think in circular rather than linear terms and to become closer observers of family processes. Another family member's perspective may prove enlightening when compared with one's own view of an event or relationship. Circular questioning always addresses significant family issues and not trivial or irrelevant differences. Such questions need to be guided by hypotheses, because hypotheses give order and coherence to the therapist's pattern of circular questioning (Tomm, 1984b) (see Box 6.2).

"Neutrality" refers to the therapist's efforts to remain allied with all family members, avoiding getting caught up in family coalitions or alliances. Such a position, typically low key and nonreactive, gives the therapist maximum leverage in achieving change by not being drawn into family games or appearing to side with one family member against another. More concerned with curiosity about how the family system works than with attempting to change it, the neutral therapist assumes that the system the family has constructed makes sense; the

family could not be any other way than it is at the moment. By not offering suggestions as to how the family should be, the therapist activates the family's capacity to generate its own solutions (Boscolo et al., 1987).

BOX 6.2. Reflexive (Change-Inducing) Circular Questions

Reflexive (change-inducing) circular questions are intended to facilitate the therapeutic process. These questions are designed to move families to reflect on the meaning they extract from their current perceptions and actions, stimulating them to consider alternative options. Tomm (1987b) differentiates eight groups of reflexive questions:

1. *Future-oriented questions* are designed to open up consideration of alternative behavior in the future. For example, "If the two of you got along better in the future, what would happen that is not happening now?"
2. *Observer-perspective questions* are intended to help people become self-observant. For example, "How do you feel when your wife and your teenage son get into a quarrel?"
3. *Unexpected counterchange questions* are questions that open up possibilities of choices not previously considered by altering the context in which the behavior is viewed. For example, "What does it feel like when the two of you are not fighting?"
4. *Embedded suggestion questions* allow the therapist to point clients in a useful direction. For example, "What would happen if you told her when you felt hurt or angry instead of withdrawing?"
5. *Normative-comparison questions* are questions that suggest the problem is not abnormal. For example, "Have any of your friends recently dealt with their last child leaving home, so that they would understand what you are going through now?"
6. *Distinction-clarifying questions* separate the components of a behavior pattern. For example, "Which would be more important to you—showing up your boss's ignorance or helping him so that the project can be successfully completed?"
7. *Questions introducing hypotheses* are those that use tentative therapeutic hypotheses to generalize outside behavior with others. For example, "You know how you become silent when you think your husband is angry with you? What would happen if next time you told him how you felt?"
8. *Process-interrupting questions* create a sudden shift in the therapeutic session. For example, "You seemed to get quiet and upset just now. I wonder, did you think I was siding with your partner?"

Being neutral does not imply being inactive or indifferent. Actually, the therapist might display neutrality by listening without prejudice to what is being said, but at the same time asking thought-provoking, relationship-focused, circular questions. A report that the family argues a lot might be accepted by the neutral therapist as interesting information. Without joining the family in assuming arguing is bad, the therapist might inquire, "Who enjoys fighting the most?" or "What would be missing if all the arguing suddenly stopped?" (Tomm, 1984b). (Note that a hypothesis that the family is gaining something by the fighting is subtly being explored.) Nor should the therapist become too committed to the family's changing. As Selvini Palazzoli has observed, "If you wish to be a good therapist it is dangerous to have too much of a desire to help other people" (quoted in Simon, 1987, p. 28). Rather, the therapist's goal should be to *help the family achieve change in its ability to change*. However, the therapist should also respect the family's right not to actually change. Neutrality precludes taking a position for or against any specific behavioral goals from therapy or that the therapist must somehow be the one to effect change.

An important aspect in the evolution of the Milan model is the attention given to the dimension of time. Although not directly identified, the Milan team always pays special attention to the dimension of time as a core component of the therapeutic interview. In *Paradox and Counterparadox* (Selvini Palazzoli et al., 1978), the Milan team describes the accidental way they discovered that giving families a longer time between sessions lessened resistance and provided for increased effective change. There was also a formal pause built into the five-part session itself, to give both the families and the therapist time to reflect. They also ritualized time through prescriptions, such as the **odd/even days prescription**, meant to interrupt current family interactions. Milan therapy now prefers an orientation toward the future, in the sense that futures are constructed in the "here and now" of the sessions themselves. By means of future hypothetical questions, the therapist brings the future—or rather, many possible futures—into the present and allows clients to choose the ones they prefer (Boscolo & Bertrando, 1993).

Diversity

Walsh (2012) observes that the diversity and complexity of contemporary family life have heightened recognition that no single model of family functioning should be promoted as ideal or normal. She also notes that modern families face unprecedented challenges in a highly stressful and rapidly changing society. In several aspects, the Milan model lends itself to working with increasingly diverse families. First, as outlined earlier, Milan therapists deliberately avoid definitions of normality. Therapists highlight differences among families with a conviction that each family must define what is normal or healthy for itself in its situation. Families are viewed as highly flexible and resourceful in coping

with their problems. Second, because the therapist is viewed as embedded in the family system, the Milan model assesses how the therapist's values and attitudes interface with those of the family. Third, as the model evolved over time, increasing attention was paid to the larger system context in which families reside and how families are shaped by larger system social and economic changes. Tomm (1999, 2003), in his elaboration of Milan techniques to a more collaborative dialogue, pays special attention to the institutional definitions of family problems and how families are encouraged to view themselves. The attitude of respectful curiosity combined with the interviewing techniques of circular and reflexive questioning are useful tools for exploring the holistic context of families in a way that can shift focus to a more empowering and hopeful outlook. Beyond that, Tomm (2003) proposes that therapists have an ethical responsibility to not only monitor the influence their inquiry has on families, but also promote social justice because they benefit financially from the consequences of social injustice.

Relevant Research

Friedlander, Wildman, and Heatherington (1991) compared transcripts of structural and Milan approaches to confirm that their major proponents conduct therapy in ways that are consistent with their theory. They found that structural approaches rely on more direct comments from the therapist; they "mix it up" with families. The Milan therapist, on the other hand, conveys his or her expertise through the use of questions to elicit comments from family members.

Whether the Milan model has any demonstrable superiority over other forms of family therapy remains an open question. There are few comparative family therapy studies. The evidence would suggest that, similar to the comparative studies of individual therapy, no one approach is better than the others (Wampold, 2001), particularly if only well-designed investigations are considered. However, because of methodological limitations, it is unwise to assume that different family therapy approaches do not have different success rates. Different approaches may work for different reasons, with different families, and for different family problems (Sprenkle, 2012).

Most systemic treatment approaches focus on finding techniques to change families. Moreover, these interventions are tailored to the unique characteristics of each family. This may account for why recent research has moved away from comparative outcomes to an analysis of the process of systemic practice. McGee (McGee, DelVento, & Bavelas, 2005) has outlined a model for the micro-analysis of questions as therapeutic interventions in psychotherapy. This model provides a theoretical basis and a step-by-step analysis of how questions are co-constructive in therapeutic conversations. The goal is to provide an empirical approach to the process of social construction by examining the details of the therapeutic interaction.

Given its emphasis on the interventive potential of therapeutic questions, research on the Milan model has most recently focused on a qualitative analysis of the interview questions. Using recursive discourse analysis to examine the interactive effects of two circular questions during the first therapeutic session, Diorinou and Tseliou (2014) documented how two typical circular questions shifted the conversation to a co-created relational focus. This type of research approach shows promise in linking the long-established tool of Milan/post-Milan questioning to the concerns of postmodern systemic clinical practice. In commenting on this recursive analysis, Chenail (2014) believes we may begin to consider Milan therapy from a more contemporary perspective: as a discursive therapeutic practice in which families are encouraged to be the conductors of their own therapeutic sessions.

Case Study

The following case is adapted from a conversational analysis by Strong and his colleagues (Strong et al., 2008, pp. 185–187) and illustrates a micro-analysis of Milan collaborative systemic questioning.

The session analyzed included a father (Bob), a mother (Sandy), a son (Joe, age 14), and the therapist (Karl Tomm). This was the first session following Joe's release from hospital after concerns about recent self-harming ("cutting") behaviors. Before leaving the hospital, Joe had agreed to a contract that listed things that he could do to keep himself safe. In the session, the parents began talking from a position of *certainty*. They described Joe as having created "his own" contract in which he stated that "he is going to follow through" and "he is not going to cut anymore and hurt himself." Joe, on the other hand, appeared uncertain about the contract and spoke from a discursive position of *doubt*. When asked whether he could live up to the contract, he responded, "I don't know yet, I guess." Such opposing positions show a family stuck at a discursive impasse—evident in their differing ways of talking and understanding:

Tomm: Okay, now how do you feel about this? Is this is something you feel that you can live up to?
Joe: I don't know. I don't know yet, I guess.
Tomm: Don't know. Well, that is probably an honest statement, because you don't know for sure, right?
Joe: Mm-hmm.
Tomm: But I guess your intention at the moment is to try to honor this agreement?
Joe: Uh-uh.

Strong et al. (2008) highlight some ways they perceive Tomm collaborating with Joe in this exchange. Tomm offers Joe an option to disagree with his parents' position that he will live up to the conditions of the contract. Tomm further treats Joe's response as a *legitimate* answer (instead of an avoidance strategy) and collaborates to elaborate Joe's position of doubt about following through with the safety contract. He does this by incorporating Joe's words ("don't know") into his response to Joe. In contrast to Bob's prior non-hesitant talk implying that he expects Joe's commitment to the contract, Tomm offers his ideas tentatively. Such tentativeness can show the speaker as not firmly committed to what is being said; in other words, it can show that what is said is potentially revisable. While joining Joe's position, Tomm at the same time invites a slight shift in what Joe is offering. Specifically, he encourages Joe to consider a middle ground between extreme certainty (his parents' initially articulated position) and uncertainty (Joe's current discursive position). Tomm accomplishes this by suggesting that Joe doesn't know "for sure" whether he could or could not follow through with the safety contract. Tomm also highlights (possibly for the parents) Joe's *present* ("at the moment") intention to honor the contract, a position contrasting sharply with the parents' concern for Joe's safety in the future.

Tomm goes on to validate Bob's position that the contract is "great stuff" and invites Joe to take a position rather than remain disengaged. It is noteworthy that Tomm shows non-commitment to *what* position Joe takes as long as Joe articulates a position on the safety contract. Tomm keeps "repairing" his talk *until both find a shared language* for describing Joe's experience.

Recommended Readings

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Glossary

anorexia nervosa: Self-starvation leading to a loss of 25% or more of body weight, hyperactivity, hypothermia, and amenorrhea.

boundaries: A concept used in structural family therapy to describe emotional and information barriers that protect and enhance the integrity of individuals, subsystems, and families.

circular questioning: The technique of asking questions that focus on family connections. These questions highlight differences in perception about events and relationships among family members.

circularity: The idea that actions are part of a causal chain, each one influencing and being influenced by others.

collaborative: A therapeutic attitude that minimizes the therapist's expertise. In collaborative interviews, the therapist's knowledge, experience, and values are viewed as no truer than the client's.

constructivism: A relativistic point of view that emphasizes the subjective construction of reality. Implies that what we see in families may be based as much on our preconceptions as on what is actually going on.

counterparadox: Placing the family in a therapeutic double bind in order to counter its members' paradoxical interactions.

cross-generational alliance (coalition): An inappropriate alliance between a parent and child who side together against a third family member.

curiosity: A term introduced by Cecchin to replace the idea of therapist "neutrality," which he believed had been misunderstood as aloofness and detachment.

cybernetics: The study of control processes in systems, especially the analysis of feedback of information in closed systems. This concept was introduced to family therapy by Gregory Bateson.

family games: Relates to the concept that children and parents stabilize around disturbed behaviors in an attempt to benefit from them.

family rituals: Family ceremonies and traditions, such as weddings and birthdays, that symbolize important emotional events and transitions.

five-part session: The classic Milan therapeutic interview format: the presession, the session, the intersession, the intervention, and the postsession discussion. The format has remained, but more emphasis is now placed on interview questions rather than the team's opinion at the end of the interview.

homeostasis: A dynamic state of balance or equilibrium within a system. In families, it is the tendency to remain in the same pattern of functioning and to resist change unless challenged or forced to do otherwise.

hypothesizing: The process by which a team of therapists forms suppositions regarding how and why a family's problems have developed and persisted. These suppositions are open to revision.

interventive interviewing: An orientation in which everything a therapist says and does is viewed as a potential therapeutic intervention depending on its impact on the family.

invariant prescription: A therapeutic ritual designed by Selvini Palazzoli in which parents of anorexic or psychotic children are directed to mysteriously disappear. The goal is to disrupt the dysfunctional games or family interactions that sustain symptomatic behavior.

irreverence: An attitude in which ideas and beliefs are continually challenged.

larger system: The institutions and professional helpers with whom the family interacts.

neutrality: A balanced acceptance of all family members by the therapist.

no-change prescription: A technique used in strategic therapy whereby a therapist recommends that problematic behavior remain unchanged because it is helpful to the family. It is hoped that, actually, family members will rebel against the prescription by giving up their symptoms.

nonnormative stance: When the therapist makes no assertions regarding ideal family health or functioning.

observer team: Therapists observing an interview behind a one-way mirror who share their observations about the family.

odd/even days prescription: A ritualized task in which a family is asked to alternate ideas or behaviors. For example, a father would manage a child on the even days of the week and the mother would do so on the odd days. They would then note the differences and compare the merits of each approach.

paradox: A message that contradicts itself on a metalevel (higher level); a statement or proposition that seems contradictory. For example, "I always lie" is a paradoxical statement.

positive connotation: The technique of ascribing positive motives to family behavior in order to avoid resistance to therapy. *See* NO-CHANGE PRESCRIPTION.

reflexive questions: Questions designed by the therapist to induce change.

reframing: Relabeling a family's description of its behavior to make it more amenable to therapeutic change; for example, describing a parent as "intensely caring" rather than "overinvolved."

spacing of therapeutic sessions: The technique of spacing sessions over one-month intervals. This interval is explained to the clients as the amount of time needed for change to unfold.

strategizing: The posture of the therapist when actively attempting to induce a change.

systemic epistemology: A concept that stresses the interconnectedness of family members as well as the importance of organizational change in families.

therapeutic ritual: Technique used by Selvini Palazzoli that prescribes a specific act for family members to perform, designed to change the family system's rules. *See* ODD/EVEN DAYS PRESCRIPTION.

triadic questioning: Asking one family member how two other family members relate.

universal strategic intervention: *See* INVARIANT PRESCRIPTION.

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7

THE COLLABORATIVE LANGUAGE-BASED MODELS OF FAMILY THERAPY

When Less Is More

Anne Rambo and Tommie Boyd

> All versions are neither right nor wrong. Our task is as much as possible to engage in a dialogue in order to understand how the various persons came to create their descriptions and their explanations. Thereafter, we invite them to a dialogue to discuss whether there might be other not yet seen descriptions, and maybe even other explanations not yet thought of. . . . The appropriate unusual questions are our best contributions.
>
> (Andersen, 1990, p. 52)

Introduction

In this chapter, we will discuss collaborative family therapy (Anderson & Gehart, 2007), solution-focused family therapy (including solution oriented) (Kim, 2014a; de Shazer, 1985), and narrative family therapy (Madigan, 2010; White & Epston, 1990), along with their integration in the Partners for Change Outcome Management System (Duncan, 2013). Together, these models of family therapy are considered the collaborative language-based models of family therapy. They are also sometimes called **postmodern** (Anderson, 1997) or **social constructionist** models (Hoyt, 1994a), because they posit that agreed-upon cultural realities develop through conversation and that different individuals and cultural groups may perceive reality very differently. Therapists working in these models consider all possible points of view and do not assume there is one "correct" reality.

The collaborative language-based models of family therapy are, above all, collaborative and conversational. They affect not just how family therapists work with clients, but how they work with colleagues and within the larger mental health system as well. These models have in common a philosophical stance that values respect for multiple realities and that focuses on **client-directed outcomes**.

This gentle, collaborative approach will tend to affect how therapists converse with colleagues as well as how they converse with clients.

History and Basic Assumptions

The Galveston Connection

It will be apparent that the collaborative language-based models of family therapy are indebted to the earlier school of Mental Research Institute (MRI) therapy, with its focus on **nonpathologizing** and **multiple realities**. In addition, these models share a common connection to the Galveston Family Institute, now restructured slightly and known as the Houston Galveston Institute (for more information, visit www.talkhgi.org).

The **Galveston Family Institute** was founded by Harry Goolishian and his associates, most prominently Harlene Anderson (Anderson, 1997; Anderson & Gehart, 2007; Sherman, 1992). Goolishian was present for the very beginnings of family therapy. He became interested in family therapy during the 1950s, when he was a young psychology student completing his internship at the University of Texas at Galveston Medical School clinic (Harry Goolishian, personal communication, September 15, 1989). One of his therapy clients was a man who was seeking treatment because of his wife, whom he described as nagging and domineering. Goolishian saw this man individually for some time and felt very sympathetic toward him, suffering as the client did with such a difficult family life. One of Goolishian's friends and fellow interns happened to be seeing the client's wife, also in individual therapy. In those days, it would have been a breach of confidentiality to see the husband and wife together, or even for the two therapists to compare notes. But when his friend went on vacation, and his friend's client called seeking help in a crisis, Goolishian could not resist satisfying his curiosity by meeting with his friend's client—his client's wife—just to see what she was really like. He was very surprised to find that he liked her just as much as he liked his own client, and that she had other ways of describing their marital problems that made just as much sense. Goolishian began to meet with both husband and wife. He had to do this secretly, because if his supervisor had known about it he would have been fired from his internship. Many of the founding family therapists took similar risks; it can be difficult for us today to imagine how controversial family therapy was in the beginning. At first, Goolishian wanted to find out which person was "right," the husband or the wife; he still thought there would be one correct way of understanding what was going on between them. However, after a while, he formulated the idea of multiple realities.

Goolishian participated in a research project called the **Multiple Impact Therapy Project** in 1954, also at the University of Texas Medical Branch at Galveston (UTMB at Galveston) (Anderson, 1997). This project was directed by

Albert Serrano, MD, and experimented with assigning each member of a troubled family his or her own therapist for an intensive individual session. Over a period of days, each therapist met with the other therapists, and finally all the therapists and all the family members met together. This project also came to emphasize multiple realities.

Although he continued working at UTMB at Galveston with the research project after his graduation, eventually Goolishian wanted to explore family therapy in a less constraining environment. In 1977, together with Harlene Anderson, Paul Dell, and George Pulliam, he founded the Galveston Family Institute. Dell eventually left the institute, but Pulliam and Anderson remain. After Goolishian's death in 1991, Anderson became director. It was renamed the **Houston Galveston Institute** in the late 1980s because by that time most of its office locations were in Houston rather than Galveston, and because the term *family* misled people who did not understand that the institute also consulted with individuals, couples, and even organizations (personal communication, Harlene Anderson, September 19, 1989).

The Galveston Family Institute (GFI) was in an interesting position throughout the 1970s and 1980s, because it was one of the few training centers for family therapy located between the East and West Coasts. GFI trained many people and became a stopping-off place for family therapists who were touring the United States and wanting to experience the heartland as well as the East or West Coast (Sherman, 1992). Goolishian and his colleagues were particularly influenced by (and had an influence on) Bradford Keeney (who shared his ideas about the importance of nonpathologizing while teaching at Texas Tech University), Luigi Boscolo and Gianfranco Cecchin (two of the founding members of the Milan team, who were frequent visitors to GFI during the 1980s), and Tom Andersen (a Norwegian family therapist whose work remains very closely tied with the work of the Houston Galveston Institute and will be discussed in this chapter). In addition, Goolishian corresponded with John Weakland of the Mental Research Institute. Being close to a large university as they were, the GFI staff were also influenced by developments in other fields, such as the physicist Ilya Prigogine and his groundbreaking work while at the University of Texas on the **dissipative nature of structures** (Anderson, 1997).

Out of all these influences, the GFI group evolved its own unique model of family therapy, which they call **collaborative language systems** or sometimes just **languaging**. They see the central change process in psychotherapy as a dialogical one, believing that problems naturally **dissipate through conversation** or in responsive **dialogue**. The task of the therapist, then, becomes to

- maintain a **not-knowing stance** (do not be the "expert" on the client's problem; let the client tell you what the problem is really like);
- embrace the **client's reality** (believe and trust in what the client says, even when it does not initially seem to make sense);

- ask **conversational** questions (keep the dialogue going); and
- listen responsively (provide plenty of affirmation and encouragement so that the client feels heard and understood). GFI therapists also talk about this as honoring the **client's story**.

The GFI group has gone on to play an organizing role in developing the Taos Institute (www.taosinstitute.net) and to host annual conferences on collaborative therapy (for more information, visit www.talkgfi.org).

Closely related to the GFI model of therapy is the work of Tom Andersen in Norway (1990, 1999) and Lynn Hoffman (1993) in Amherst, Massachusetts. Andersen added a formal **reflecting team** to his work with families. The reflecting team format involves having a team of therapists observing behind a one-way mirror while a therapist works with a family in the therapy room. Such teams were a feature of the Milan school of family therapy, with whom Andersen trained (notice the link with Boscolo and Cecchin, and so with GFI), and are also common in family therapy training and research facilities. Andersen's innovation was to share the team discussions with the family. In a classic, Andersen-derived reflecting team format, a therapist converses with a family in the therapy room, while a team of other therapists observes silently behind a one-way mirror. The therapist confines himself or herself primarily to conversational questions and lets the family talk, while the observing therapists hold their comments until they can be shared with the family. At a specified time, usually midway through the session, the team behind the mirror changes places with the therapist and family. Then the therapist and family watch as the team members, being careful to keep their comments affirming and nonpathologizing, comment freely on what they have noticed. The family and therapist then trade again to their original positions, and the therapist invites the family members to comment on what was useful to them about the discussion and what ideas they might like to pursue. This format is seen as less invasive and therefore more consistent with the not-knowing stance, while still allowing the therapeutic team to introduce some new ideas to the family. In this way, those ideas do not come directly from the therapist, and the family members together are free to pick and choose the ideas that appeal to them. Anderson died in 2007, but his work continues to be an influence, in Europe in particular (Anderson & Jensen, 2011).

Lynn Hoffman has adapted this format for use in a less formal way, at times turning to a co-therapist to reflect in the presence of the family during the middle of the session. Hoffman has also emphasized a broader use of self-disclosure than has been normative in family therapy, calling for increased openness on the part of the therapist. It is Hoffman who coined the term **reflexive therapy** to describe her work, the work of her colleague William Lax in Brattleboro, Andersen's reflecting team work, and the work of the GFI—Anderson and Goolishian in particular (Hoffman, 1993, 2001). "Reflexive" here means the use of the formal reflecting team, but also includes informal **in-session reflections** among

therapists and between therapist and client, the use of **self-disclosure**, and the commitment to affirming, accepting, nonpathologizing dialogue. In recent years, Hoffman has taken a leadership role in the development of the Rhizome Century conference (for more information, visit www.rhizomenetwork.com) and been the subject of a documentary by Christopher Kinman, "All Manner of Poetic Disobedience: Lynn Hoffman and the Rhizome Century" (Kinman, 2012).

Review and Summary. Drawing and expanding on the MRI tradition, the Galveston Family Institute developed a model of family therapy that emphasizes dissipating problems through dialogue. Influenced by the work of the Galveston Family Institute, Tom Andersen in Norway and Lynn Hoffman in Massachusetts added additional **reflecting** components to their practices. The work of the Galveston Family Institute—especially the work done by its two directors Harry Goolishian and Harlene Anderson—along with Andersen's and Hoffman's current work, is collectively known as the collaborative language systems model of family therapy (London & Anderson, 2013).

New Directions. The collaborative approach need not be limited to a clinical setting. Increasingly, those trained in this model, and GFI itself, are moving into the areas of organizational consulting and coaching (see, e.g., www.access-success.com).

Related Models: Solution-Focused and Narrative Therapies

Two other models of family therapy also emphasize collaboration and nonpathologizing. These are the solution-focused and narrative models of family therapy.

Solution-Focused Therapy

Solution-focused therapy (now known as Solution Focused Brief Therapy, SFBT) is quite similar to MRI therapy (see Chapter 5) but with additional influence from Milton Erickson. Erickson, a hypnotherapist, was a major influence on the early communication research of the Palo Alto Project and later on the development of MRI. In the early 1980s, two young therapists began corresponding about integrating still more of Erickson's work into their practice (for more information, visit www.billohanlon.com and www.brief.org.uk). They were Steve de Shazer, who had been trained by John Weakland at MRI, and Bill O'Hanlon, who had studied directly with Milton Erickson (de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989).

Together with Insoo Kim Berg at the **Brief Family Therapy Center** in Milwaukee, Wisconsin (his wife), de Shazer came up with the term "solution-focused therapy." While influenced by both the MRI and Ericksonian models of therapy, SFBT moved in the direction of social constructionism, particularly with de Shazer's more theoretical later books (de Shazer, 1994). De Shazer always

honored the MRI roots of the model, having John Weakland write the preface to all of his books, but SFBT is seen in the field of family therapy as social constructionist and collaborative, rather than strategic.

In this model of therapy (SFBT), the therapist begins by embracing the client's reality about the problem, but then starts to shift that reality to its hidden opposite, the absence of the problem. In other words, if a client comes in complaining that he and his wife frequently quarrel, the solution-focused therapist will draw the client's attention to the times the two do *not* quarrel and what is different about those times. (Certain specific techniques for doing this will be discussed.) In hypnotherapy, the client's attention is shifted to where the hypnotherapist wants it to go. This is why the solution-focused model borrows more from hypnotherapy than from the original MRI model. Other important solution-focused therapists are Yvonne Dolan (1994) and Eve Lipchik (1993), who expanded the model to the difficult areas of recovery from traumatic abuse and domestic violence (respectively), and Scott Miller (1994), who with Insoo Kim Berg expanded the model to the area of alcohol abuse and now concentrates on therapy outcome research across the collaborative models (Duncan, Miller, Wampold, & Hubble, 2009).

Bill O'Hanlon is another well-known therapist working in this area. O'Hanlon originally called his similar model **solution-oriented therapy** but now, to avoid confusion, calls it **possibility therapy**. Like SFBT, possibility therapy shifts the client's attention away from the problem to the absence of the problem, but in addition it widens the conversation to include a spiritual component (O'Hanlon, 2006). Michele Weiner-Davis is a well-known solution-oriented therapist who has worked with both de Shazer and O'Hanlon and whose work goes a step further in actively encouraging the client to **focus on the positives** about his or her marriage, even when the client does not want to talk about those positives at first. Her agenda is clear in the title of her bestselling book *The Divorce Remedy* (Weiner-Davis, 2002). Ben Furman and Tapani Ahola (1994), in contrast, take a less directive but still solution-oriented approach, blending solution talk and elements of reflexive family therapy in their native Finland.

Review and Summary. Solution-focused and solution-oriented, or possibility therapy, direct the client's attention away from the presenting problem and toward the absence of that problem. They do this through techniques that borrow from hypnotherapy. They share with the MRI and the reflexive models an emphasis on **collaboration**, nonpathologizing, and change through dialogue, but they are more directive in their solution focus.

Case Examples. Working from published case studies, we can see the similarities and differences between the models in practice. For example, when a mother sought treatment from Ben Furman and Tapani Ahola, mentioning that she did not always feel competent to set limits with her four-year-old, they asked her to visualize the times when she did feel competent and give that experience a name

(Furman & Ahola, 1994). In contrast, when Harlene Anderson (1997) consulted with a client who was also feeling guilty about being a bad mother, she would have found this approach too directive. She instead commiserated with the client and mused aloud about the difficulty of figuring children out. However, she limited herself to this kind of **curious stance** and reflection, avoiding giving the client any direct suggestions. She expected that the problem would eventually dissipate through dialogue.

New Directions. As noted for collaborative therapy, SFBT and solution-oriented therapy need not be limited to clinical settings. This positive, resource-focused approach may be applied in multiple settings. Solution-focused coaching and organizational consulting is a growing field (Szabó & Meier, 2009); and solution-focused approaches have been applied in school systems at both an individual/family level and a school-wide level (Kelly, Kim, & Franklin, 2008; Metcalf, 2013).

Narrative Therapy

In the late 1980s, therapists Michael White and David Epston were trying to adapt the family therapy theory they had learned from MRI and the Milan team to their practices in Australia (White & Epston, 1989). The politics of therapy in Australia and New Zealand are particularly compelling, as in the quite recent past there was oppression of the native Australian Aborigine and New Zealand Maori peoples. Therapists, especially those of European descent, in these countries must discuss these larger political issues in order to embrace their clients' reality, especially when the client is of Aborigine or Maori descent. It may be that we are naive in the United States to think that European American therapists can work with Native American or African American clients without discussing issues of historical oppression, and this has been suggested (Hardy & Laszloffy, 1995); be that as it may, it was the Australian and New Zealand schools of family therapy that first made such discussions a cornerstone of their therapy. White and Epston argued that in order to truly embrace the client's reality, the family therapist must bring into the conversation larger issues of **historical oppression**, including issues of language, culture, historical persecution, and gender and economic inequities (White, 1991; White & Epston, 1989; White & Morgan, 2006). They reiterated the early emphasis of the MRI on nonpathologizing, using **externalizing** to help meet this goal. They moved away from giving directives, preferring to concentrate on hearing the client's story.

White and Epston established **Dulwich Centre** (www.dulwichcentre.com.au) in Australia, but their model has been quite influential in the United States as well. Jeffrey Zimmerman and Victoria Dickerson (1996) saw the possibilities in this approach for more fully embracing the client's reality and have explored **narrative therapy** while on the teaching faculty of MRI. Also in California, at Berkeley,

Jennifer Freeman and Dean Lobovits combine narrative therapy with expressive play therapy, and David Epston is visiting faculty when not in Australia (Freeman, Epston, & Lobovits, 1997). Gene Combs and Jill Freedman in Chicago are also leaders in narrative family therapy (Combs & Freedman, 1996, 2012). Their center, Evanston Family Center, is in partnership with Dulwich Centre. Michael White died in 2008. His widow, Cheryl White, is now the director of Dulwich Centre.

Stephen Madigan and Heather Elliott formed the influential **Yaletown Family Therapy Centre** in Canada. Narrative therapy spoke strongly to Madigan in part because of his father's background as a labor union organizer (personal communication, Stephen Madigan, March 15, 1999). Madigan has since been instrumental in establishing the Vancouver School for Narrative Therapy (www.therapeuticconversations.com) as well. Elliott draws on her interest in feminism to encourage clients to explore less oppressive gender-related life stories for themselves (Elliott, 1998). The Narrative Therapy Centre of Toronto was co-founded by Angel Yuen, Ruth Pluznick, and Rick Eckley in 2004, and is in partnership with Dulwich Centre, along with the Evanston Family Center.

Narrative therapists use **deconstructing questions** and **unique outcomes** to broaden the **conversation** into social, political, and cultural areas. They also use externalizing to further guard against pathologizing. These specific narrative techniques will be discussed further in the Techniques section, below.

Review and Summary. Similar to reflexive therapy and solution-focused/possibility therapy, the narrative therapy model emphasizes nonpathologizing, embracing the client's reality, and change through conversation. Narrative therapists' emphasis on the importance of the **client's voice**, however, leads them to avoid explicit directives. They may shift the conversation to the absence of the problem, as do solution-focused therapists, but they do so in a particular way (through unique outcomes, which differ slightly from the solution-focused therapist's **exceptions**). They differ from reflexive therapists in that they will introduce into the conversation issues of gender, politics, and culture, even if the client does not bring up these issues or seem to want to pursue them.

Case Examples. Earlier, case examples featuring Anderson (1997) and Furman and Ahola (1994) were discussed. Both cases involved clients who were concerned that they might not be competent mothers. You may wonder why it seems many clients are mothers who feel guilty; narrative therapists would explicitly address that commonality. When Zimmerman and Dickerson (1994) saw such a client, they explicitly commented on how often mothers get blamed for their children's behavior in Western culture, cautioning the client: "A lot of parents get sucked into the notion that they're to blame for this. I don't know if you've tortured yourself with this. I hope not. I run into that a lot" (p. 310), thus broadening the conversation to consider maternal guilt as a cultural theme.

New Directions. Narrative family therapy has moved into the area of mediation and conflict resolution. As in collaborative and solution-focused models, there is no reason why narrative techniques need be limited to individuals and families in a clinical setting. Increasingly, narrative techniques are being used in the areas of social justice and conflict mediation (Denborough, 2008; Flaskas, McCarthy, & Sheehan, 2007; Winslade & Monk, 2000; Witty, 2013).

Integrations

Joseph Eron and Thomas Lund (2001) integrate elements of traditional MRI work with both solution-focused and narrative therapy. Barry Duncan, Scott Miller, Bruce Wampold, and Mark Hubble have examined the similarities among the collaborative models and have identified common factors, which include respect for the client's reality and a focus on collaboration (Duncan et al., 2009). From this, Barry Duncan developed the Partners for Change Outcome Management System (PCOM), which is now taught as an integrative model (Duncan, 2010; for more information, visit www.heartandsoulofchange.com).

Constraints and Limitations

Because there is no one correct reality, none of these models can be considered the one correct model of therapy. By and large, therapists working within the collaborative language-based models are consistent with their philosophy in that they will freely admit that their particular model can be imperfect, limited, and not a good fit for some clients. Beginning therapists trying one or more of these models of therapy tend to experience difficulties in the following areas in particular.

Social Control Issues

Although the client's reality is paramount in these models, the client's reality may be at variance with what is culturally and legally permissible. At times, therapists become agents of **social control**. For example, a parent convinced of the need to discipline his or her child by beating the child with a belt poses a difficulty for the collaborative language-based therapist. This difficulty is typically raised in one or more of three ways. First, an outside agency may be invoked. For example, if child welfare authorities are involved, the client may be reminded that such discipline techniques are not legal and be invited to consider alternatives, with the goal of ending child welfare's involvement in the client's life. (This is usually very much a goal of the client.) Second, particularly if no outside agency is presently involved, the therapist may need to make what Lynn Hoffman (1993) calls a **citizen's protest**. In other words, the client may be told that although the therapist understands how this behavior makes sense to the client, as a person and a citizen the therapist cannot approve of this

behavior and must indeed report it if legally mandated to do so. Third, particularly after the issue of outside social control is settled, or if the behavior is objectionable but not immediately dangerous or illegal, the therapist may use deconstructing questions and **curious questions** to lead the client to question the behavior on his or her own. For example, Harry Goolishian used to defuse potentially explosive child welfare–referred situations by simply asking the client, "Leaving aside for the moment whether or not it was legal, was the method of discipline you were using [before the child welfare involvement] working? Did you feel that your child was really listening to you?" Typically, physically abusive parents are also frustrated parents. In Goolishian's experience, this question was always answered with a resounding "*No,* it wasn't. My child doesn't listen," which then opened up other avenues of conversation (personal communication, Harry Goolishian, September 15, 1989).

Strongly Held Therapist Values and Beliefs

It can be difficult to listen openly to clients whose worldview differs dramatically from your own. Therapists working in these collaborative language-based models may certainly have their own cherished beliefs and convictions. It is neither necessary nor desirable to abandon these beliefs. It is necessary, however, to hold as an equally cherished conviction the idea that listening nonjudgmentally can be a healing experience for therapist and client alike. When faced with a client whose particular ideas are abhorrent, a beginning therapist should try to understand: How does it happen that this worldview makes sense to the client? Where would the client have gotten such ideas? Are there times the client thinks in other ways? This curiosity is both a fundamental value and a key technique for these models of therapy. It is also worth noting that at times the therapist may need to make a citizen's protest to ease his or her own discomfort in the room. As Tom Andersen notes, the therapist should not be the dominant voice in the room, but neither should the therapist feel silenced as a person, any more than the client should (Andersen, 1990). All voices should be valued in the therapy room. Beginning therapists, however, are usually wise to err on the side of listening, as it is easy for the therapist's voice to be overvalued and to unwittingly silence the client.

Normal Family Development

The question of normative individual and family development is an interesting one for the collaborative language-based models. It should be clear by now that a rigid set of "correct" life stages, predetermined by the therapist, would be not in keeping with the nonpathologizing stance of these models and with the focus on multiple realities. Some reflexive family therapists go so far as to discount the entire notion of development: Hoffman (1993) states that to posit a predetermined developmental path within any human group or for any human individual

dangerously downplays both individuality and the role of chaos (random chance). However, more recently narrative family therapists have offered rite-of-passage suggestions for life passages common within a particular culture, embracing the client's perceived transitions. Freeman et al. (1997) envision coming-of-age and graduation ceremonies created by the extended family and **published** with the therapist's help. However, for the collaborative language-based therapist, any concept of "norms" and "stages" must be tempered with a respect for the client's perceptions and for the possibility of multiple interpretations.

Pathology and Behavior Disorders

Diagnosis that describes the client in a way with which the client has not agreed is anathema to collaborative language-based therapists. It is on this topic that they write most passionately and are most willing to separate from their fellow family therapists. A few examples will suffice to establish the deep distrust with which diagnosis is regarded. (The first comment points out the strongest underlying bond between MRI and collaborative language-based therapies: their mutual dislike of the expert "diagnostic" role.)

- John Weakland (Hoyt, 1994b): "[MRI therapy is] a helluva lot more respectful than knowing better than the client what ails them, which I think is the most basic comparison. And that's what the whole damn other psychiatric and psychotherapeutic scheme is based on" (p. 24).
- Harlene Anderson (1997): "To my way of thinking, a problem does not have a cause that needs to be discovered; it does not need to be diagnosed, labeled, fixed, resolved, or solved . . . the traditional diagnostic processes and categories are of little use" (p. 76).
- Ben Furman and Tapani Ahola (1994): "The term *depression* can be used to refer to the condition known in psychiatry as *major depression,* but there are many alternatives, such as *down in the dumps* or *feeling blue.* It is possible to develop even more inventive names, such as *doing one's life inventory, hatching,* or *latent joy* . . . perhaps we should start by giving this problem a nice optimistic name" (pp. 42–43).
- Jeffrey Zimmerman and Victoria Dickerson (1994): "[Therapists and clients] have been subjected to normalizing judgments, and evaluated as objects . . . furthermore, anorexia (and other psychiatric diagnoses) seems to reflect many of the techniques of power that are in evidence when one group dominates another: techniques of isolation, evaluation (through surveillance and comparison), and promotion of a lack of entitlement to one's own experience" (p. 295).

A dislike and distrust of conventional psychiatric diagnosis is found across the collaborative language-based models. Yet given their emphasis on collaboration, these therapists are often also not comfortable giving up the possibility of

collaborating with physicians and other mental health professionals who do use diagnosis (Anderson, 1997). Also, as Lynn Hoffman sagely points out, even reflexive family therapists need to get paid (Gergen, Hoffman, & Anderson, 1996), and diagnosis is a requirement of insurance companies. The resulting uneasy accommodations are a frequent topic of discussion among collaborative language-based family therapists.

Techniques

The following techniques are common to all the collaborative language-based models.

1. *Maintaining a curious stance.* It may seem strange to think of curiosity as a technique, but the ability to keep an open mind and to convey genuine interest in what the client has to say is central to keeping a collaborative conversation going. A good therapist working in this model, when confronted with a comment or a behavior he or she does not understand, will continue asking questions until understanding is achieved. This is sometimes referred to as the "not knowing" position, meaning that the therapist does not act as if he or she knows more than the client; instead, the therapist acts as if what the client has to say is truly fascinating and the therapist's best source of information. This is consistent with a nonpathologizing approach, which downplays diagnosis and the therapist's evaluations of the client.
2. *Conveying respect for the* **client's own resources**. Equally central to these models is the ability to convey that the therapist and the client are a team, working together to meet the client's goals. Even in the more directive models, the client should experience therapy as a partnership, not as receiving instruction from an authority figure. The therapist conveys respect for the client's goals and for the client's ability to solve problems, using the client's language whenever possible.
3. *Asking engaging questions.* To keep the collaborative conversation going, the therapist must ask interesting questions that "invite a client into a shared inquiry" (Anderson, 1997, p. 145). These questions should come from a genuinely curious, not-knowing perspective. These questions should also utilize the client's language.
4. *Affirming and conveying hope.* A long string of questions with no comments can begin to seem like an interrogation, not at all what the collaborative therapist wants to convey. To guard against this, to build hope for change, and to create a healing, therapeutic space for conversation, the collaborative therapist is generous with what Lynn Hoffman (1993) calls her "Three A's": affirmation, affiliation, and appreciation. The therapist avoids blame and negativity, instead frequently pointing out examples of the client's progress, hard work, and/or courage in struggling with life difficulties. When it is possible to interpret a

client's action in several different ways, the collaborative therapist will choose to interpret the action in the most positive way. For example, Furman and Ahola (1994), consulting with a teenage boy whose parents disapproved of his friends, suggested that the boy was trying to help his more delinquent buddies, rather than that he was descending to their level.

In addition to these basic skills common to all the collaborative models, some techniques are specific to each of the models discussed in this chapter.

1. *Reflexive therapists reflect.* That is, they constantly wonder about their own thinking, as well as the client's, and they share their thoughts and reactions with the client on an ongoing basis (being careful to stay consistent with an affirming context).
2. *Solution-focused therapists look for exceptions.* That is, they direct their own attention and the client's attention to the times when the client is *not* experiencing the problem. Their way of being affirming includes conveying great optimism about these exceptions. To this end, *solution-focused therapists typically ask the* **miracle question**—"What if you woke up one morning and the problem was gone?"—to get the focus on the positive as quickly as possible. They may also use **scaling questions**, asking the client to rate the intensity of the problem from 1 to 10, in order to track even small progress from session to session, and so expand upon it.
3. *Narrative therapists ask deconstructing questions.* That is, they ask questions (and make comments) designed to draw the client's attention to larger social and cultural issues. In addition, *narrative therapists externalize,* meaning that they are careful to talk about the problem as a thing apart from the person of the client. For example, a client diagnosed with anorexia would be asked how the anorexia was terrorizing him or her (Zimmerman & Dickerson, 1994) to underline the point that the diagnosis represents not the client, but rather an annoying (or terrorizing) outsider. *Narrative therapists also look for exceptions, which they call "unique outcomes."* The difference is that the narrative therapist prefers unique outcomes that are exceptions to larger social and cultural patterns also, while the solution-focused therapist is content with any identified exception (Elliott, 1998). For example, a wife may notice that she and her husband fight less about housework when she calmly but firmly asserts her belief that housework should be shared, but that they also fight less when she gives up and hires outside cleaning help. Either exception will work for the solution-focused therapist, but the narrative therapist would typically prefer the first of these two exceptions (and would label it a unique outcome).

In summary, it is worth stressing that all of these auxiliary techniques rely on the central techniques of *respect for the client's own resources, affirming,* and *conveying hope,* as well as the conversational skills of *maintaining curiosity* and *asking engaging*

questions. Research suggests that these central techniques, as "low tech" as they may seem, are actually the most effective interventions of all (Duncan et al., 2009).

Diversity Issues

The issue of diversity is an interesting one for the collaborative models. As all the collaborative models consider that each client's perspective should be validated uniquely, questions of group membership and cultural allegiance may seem less relevant, given this intense honoring of each individual's reality. Yet openness to difference is also a critical element of the collaborative models, and many involved with these models have felt strongly drawn to social justice issues (Anderson & Gehart, 2007; Kim, 2014a; Madigan, 2010). Each model discussed, however, has taken a somewhat different approach to these issues.

Collaborative language-based family therapists consider that their dialogical conversations with individual clients, coupled with the not-knowing stance of the therapist, are the best way to honor cultural, gender, class, and other differences—simply as part of the individual's unique reality. This is seen as profoundly honoring of democracy: "With an . . . ever-increasing spotlight on democracy, social justice, and human rights, the importance of the people's voice, singular or plural, becomes further relevant to how we respond to the unavoidable complexities inherent in these transformations" (Anderson & Gehart, 2007, p. 1). Such an approach argues against specific training in cultural competence, preferring a focus on hearing individual voices. The therapist would not in this model raise an issue that was not raised by the client.

Solution-focused therapy historically took a similar position. Solution-focused therapists in the past have argued that training in cultural competency runs the risk of reinforcing stereotypes and reducing the therapist's focus on the individual, who after all is never just a member of a group (de Jong & Berg, 2008). But more recent voices within the field of solution-focused therapy have called for additional cultural competency training, to assist therapists in understanding their clients' history of marginalization and discrimination and sensitize therapists to particular group solutions—protective factors—developed over time by specific groups (Kim, 2014a). As solution-focused approaches grow in popularity worldwide, the cultural competency approach seems to be gaining adherents (Kim, 2014a). The therapist might assist the client in raising a culturally relevant issue, or an experience of discrimination, following the solution-focused tenet of "leading from behind" (Kim, 2014b, p. 7).

Finally, narrative therapy from the beginning has focused on issues of social justice and cultural diversity. Narrative therapists are expected to be keenly aware of historical discrimination against cultural/ethnic groups, against women, and along class lines (White, 2007). Narrative therapists are encouraged to speak up about these issues even if they are not directly raised by the client (Madigan, 2010); "thus, one uncovers the details of the techniques of power that persons are being

subjected to" (White & Epston, 1990, p. 31). Narrative therapists have taken a strong position about the importance of cultural competency (White, 2007).

Relevant Research

As recently as the first edition of this book (2003), the collaborative models rested largely on anecdotal and case study evidence. The GFI model of collaborative and reflexive therapy, and the narrative therapy approach, still do, although there have been individual studies, and there has been interest in developing empirical research into these models (Combs & Freedman, 2012). However, SFBT (solution-focused brief therapy) is now considered an evidence-based model. Large-scale research studies, especially those of Cynthia Franklin, Johnny Kim, Sara Smock, and Terry Trepper (for more information, visit www.sfbta.org) have earned SFBT a listing with the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP; for more information, visit www.nrepp.samhsa.gov) and inclusion in the Office of Juvenile Justice Model Programs Guide. Barry Duncan's research across collaborative models, using his Partners for Change Outcome Management System, has also earned evidence-based status with SAMHSA, providing indirect research support for all the collaborative models.

Case Example

Our case example parallels the history of these collaborative models, moving from a position very much outside the system to an increasing level of acceptance and finally into organizational as well as individual/family interventions. As part of our training program here at Nova Southeastern University in Fort Lauderdale, Florida, I (Anne Rambo) take master's-level family therapy interns into the public schools to work with at-risk youth. Last year, we began for the first time to see students who had been suspended and sent to an alternative school site for redirection and detention. Our interns met individually with these students, using collaborative techniques of listening and respecting each person's reality. They integrated a focus on solutions and possibilities, asking about what was working and what was going right in these young people's lives. Initially, school officials were somewhat skeptical about our approach. They wondered aloud why we were not doing more teaching of social skills or active restructuring of family patterns. It looked very much to them as if most of what we were doing was simply listening and allowing talk about positives.

For example, with one young man seen as incorrigible by the school system, our intern elicited the information that he was a very helpful

older brother to a sibling who was profoundly deaf. He was also interested in sign language. We supported that view of this young man—as a helpful person—and called his mother to congratulate her on her son's compassion. She cried, because no one from outside the family had ever told her good things about her son before. We also shared this new view of this young man with his home school, being careful to praise positives about the school as well, mentioning teachers and coaches who were seen by him as positive role models. This kind of gentle and positive conversation may not seem active and dynamic at first. But it is very effective. By school's end, the district had noticed the effect our interns had on recidivism. They also noted that SFBT was now an evidence-based model with the Office of Juvenile Justice. Starting with school year 2013–2014, our interns have been asked to see every student suspended for any one of a range of offenses, such as fighting, drug possession, vandalism, cursing a teacher, and so on, launching a major research initiative in the school district to lessen recidivism. Like the collaborative models in general, we have gone from interesting outsiders to integral change agents within the system. This sense of growing and productive partnership is perhaps the most rewarding aspect of practicing within the collaborative language-based family therapy models.

Recommended Readings

The collaborative models have inspired much writing of great interest and relevance, and the reader is advised to read everything included in the references, to gain a full knowledge of the field. However, it is recommended to begin with the following, to gain a basic understanding of each model.

For the collaborative language-based model:

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to psychotherapy.* New York, NY: Basic Books.

Anderson, H., & Gehart, D. (Eds.). (2007). *Collaborative therapy: Relationships and conversations that make a difference.* New York, NY: Routledge.

For the solution-focused model:

De Shazer, S. (1985). *Keys to solutions in brief therapy.* New York: W. W. Norton.

De Shazer, S. (1994). *Words were originally magic.* New York: W. W. Norton.

O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy.* New York: W. W. Norton.

For the narrative therapy model:

Madigan, S. (2010). *Narrative therapy (Theories of psychotherapy).* New York, NY: APA Press.

White, M. (2007). *Maps of narrative practice.* New York: W. W. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W. W. Norton.

For comparisons across models:

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Eds.). (2009). *The heart and soul of change: Delivering what works in therapy* (2nd ed.) New York, NY: APA Press. (An examination of what works across collaborative models.)

Rambo, A., West, C., Schooley, A., & Boyd, T. V. (Eds.). (2013). *Family therapy review: Contrasting contemporary models.* (Leading proponents of each model describe in five pages or less how they would approach the same case—collaborative language-based, solution-focused, and narrative are represented.)

Glossary

Brief Family Therapy Center: The clinic founded by Steve de Shazer and Insoo Kim Berg, considered a headquarters of solution-focused therapy in the United States (for more information, visit www.brief-therapy.org).

citizen's protest: Lynn Hoffman's idea about how to resolve social control issues in therapy.

client-directed outcomes: Treatment outcomes that fit with the client's goals, rather than being set by the therapist alone.

client's own resources: What collaborative language-based therapists like to focus on—the strengths and capabilities of the client, rather than any pathology or present difficulty.

client's reality: How the client understands the situation.

client's story: What the client wants the therapist to hear about the situation and about the client's life to date.

client's voice: The client's own unique perspective, which the client may be able to share only if assured the therapist will be supportive.

collaboration: Working together with one or more other people in such a way that everyone's ideas are valued and everyone puts forth the same or a similar amount of effort.

collaborative language systems: Those models of family therapy that focus on conversation and collaboration between therapist and client.

conversation: A verbal exchange in which at least two people share ideas and feelings in a mutually supportive atmosphere.

conversational: Encouraging of a verbal exchange.

curious questions: Genuine, open requests for new information, not accusations or statements disguised as questions. For example, "What did you do today?" may be a genuinely curious question; "Why didn't you mow the lawn as you promised?" is probably an accusation in disguise.

curious stance: A collaborative therapist takes a curious stance; he or she genuinely wants to find out the client's reality.

deconstructing questions: These take apart assumptions in order to understand them better. When you ask yourself why you do something the way that you have always done it, you may for the first time realize you have choices and could do it differently.

dialogue: Genuine back-and-forth conversation between two or more people. A dialogical question encourages this.

dissipate through conversation: Reflexive therapists believe that talking about problems in a supportive atmosphere helps a client deconstruct those problems. The problems then dissolve, or dissipate, upon being examined, and the client realizes he or she has more options than previously thought.

dissipative nature of structures: Structures in the natural world that tend to dissolve and reform over time, such as sand dunes on beaches.

Dulwich Centre: The clinic started by Michael White and David Epston, considered the headquarters of narrative family therapy in Australia (for more information, visit www.dulwichcentre.com.au).

exceptions: Times when there is either the absence of a problem or a time when the problem is not problematic for the client. Identifying these times is a goal of solution-focused therapists.

externalizing: Talking about a problem in such a way that it is clear the problem is outside the person, not a part of the person. For example, if we were to externalize, we would say that anger sometimes makes problems for Johnny, not that Johnny is an angry boy.

focus on the positives: Focus on what is working, rather than on what is not working; on the absence of the problem, not on the problem. This is a central tenet of solution-focused therapy.

Galveston Family Institute (GFI): The clinic started by Harry Goolishian, Harlene Anderson, Paul Dell, and George Pulliam, which has been a central influence on collaborative language systems models of family therapy (for more information, visit www.talkhgi.org).

historical oppression: Throughout the world, throughout time, certain groups of people have had unfair advantages compared to other groups. Women, people of color, the poor, members of minority religious groups, the disabled, and those who are seen as too different in any way, among others, have been disadvantaged, and narrative family therapists remind us to be sensitive to the resulting pain when we work with families.

Houston Galveston Institute: The present name of the Galveston Family Institute.

in-session reflections: When the therapist muses or wonders aloud, sharing his or her thoughts with clients openly.

languaging: The name of the model of family therapy most associated with the Galveston Family Institute.

miracle question: "What would happen if a miracle occurred and the problem disappeared?" Asking this question is a favorite technique of solution-focused therapists, to shift the client's focus away from the problem.

Multiple Impact Therapy Project (1954): An early research project investigating the multiple realities within families. This project influenced the collaborative language-based models.

multiple realities: The philosophical idea that everyone sees the world a little differently and that everyone's point of view has validity.

narrative therapy: The name of the school of therapy most associated with the work of Dulwich Centre and the Yaletown Family Therapy Center.

nonpathologizing: Avoiding labeling, demeaning, or patronizing the client, focusing on the client's strengths instead.

not-knowing stance: A position in which the therapist attempts to stay curious and not think he or she knows all the answers.

possibility therapy: Bill O'Hanlon's variation on solution-focused therapy (for more information, visit www.possibilitycenter.com).

postmodern: After the modern age; connotes no longer thinking that science and technology have all the answers or that there will ever be definitive answers to life's mysteries. This is a philosophical term often used by academics.

published (-ing): When used by narrative therapists, this means publicizing and celebrating a client's triumphs—for example, mailing a newsletter to everyone in the extended family announcing a child's improved grades.

reflecting: Wondering, thinking aloud, pondering in a curious way.

reflecting team: A technique of reflecting family therapists in which those who have been observing a therapy session from behind a one-way mirror come into the therapy room and share their thoughts in a nonjudgmental way.

reflexive therapy: The school of family therapy incorporating both languaging and reflecting family therapists.

scaling question(s): A technique of solution-focused family therapists. Clients are asked how bad the problem is, on a scale of 1 to 10 (or how much improvement there has been), and then these numbers are compared later in therapy to help the client notice improvement. For example, the therapist might say, "Well, the school problem was an eight when you first came in, but this week you say it's down to a four. That's great progress!"

self-disclosure: When the therapist reveals (in an appropriate way) something about himself or herself to the client, perhaps that the therapist has struggled with similar problems.

social constructionism: The idea that one's view of the world is largely formed by one's context. As you grow, develop, and explore the world, the reality you experience is shaped through your conversations with those around you. Similar to the term *postmodern,* the term *social constructionist* is often used by family therapists as a reminder that there is more than one way to look at the world. However, *postmodern* is primarily a term used by academics in the liberal arts; psychologists and sociologists are more likely to use *social constructionist*.

social control: The duty of the therapist to act, even against the client's wishes, if such action is judged necessary to prevent suicide, homicide, child abuse, elder abuse, or other potentially dangerous behavior.

solution-focused therapy: The name of the model of family therapy most associated with the Brief Family Therapy Center.

solution-oriented therapy: Bill O'Hanlon's variation on solution-focused therapy. *See also* POSSIBILITY THERAPY.

unique outcomes: Times when the problem is absent or the problem is not problematic for the client, and the client is not being disadvantaged by historical oppression. Identifying these times is a key technique of narrative family therapists.

Yaletown Family Therapy Centre: An important narrative family therapy center in Canada (for more information, visit www.yaletownfamilytherapy.com).

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8

EXPERIENTIAL APPROACHES TO FAMILY THERAPY

Volker Thomas and Tracie Krum

When I first begin to work with someone, I am not interested in changing them. I am interested in finding their rhythms, being able to join with them, and helping them go inside to those scary places.

Virginia Satir
Richard Simon's "Reaching Out to Life:
An Interview with Virginia Satir"

It is experience, not education that changes families.

David Keith and Carl Whitaker
In "Symbolic-Experiential Family Therapy",
Family Counseling and Therapy

Imagine family therapists such as Virginia Satir and Carl Whitaker walking into your classroom and telling you that education, knowledge, and cognitive skills do not change families, but *experience* does. What does this mean? Whose and what experience is Whitaker talking about? Is Satir really not interested in changing clients' families? Change is what family therapy is all about, right? What does Satir mean by "finding their rhythms" and going "inside to those scary places"? What scary places does she have in mind?

Experiential approaches to family therapy originated in the humanistic movement of the 1960s and combined humanism with the unique personalities of several mavericks of the early family therapy movement. Oriented on the tenets of systemic thinking and based on individual and group-based approaches such as gestalt therapy, psychodrama, Rogerian client-centered therapy, and encounter groups, the experiential approaches to family therapy almost reflect

the rebellious nature of some of their proponents (as you may have guessed from reading the quotes that begin this chapter). Thomas (1992) suggests that the experiential approaches to family therapy are characterized by

- a philosophy of growth;
- an emphasis on expression of feeling and meaning;
- the therapist sharing personal feelings and thoughts in the therapy session;
- action-oriented techniques within the therapy session;
- improvement of basic communication skills;
- an orientation toward increased physical and emotional health, leading to wholeness and balance; and
- each person taking responsibility for self. (pp. 202–229)

This chapter presents three orientations of the experiential approach to marriage and family therapy: Virginia Satir's humanistic-experiential approach, Carl Whitaker's symbolic-experiential approach, and Leslie Greenberg and Susan Johnson's emotion-focused approach to couple therapy.

Proponents of the Model

When I (Volker Thomas) participated in my first family therapy conference in the 1980s, I had a powerful and career-changing experience. I went to a plenary session in which Virginia Satir was going to present her work to a large group of professionals. Usually, speakers at these large sessions give rather boring speeches in which they present the tenets of the approaches more or less by reading from prepared notes. Satir proceeded differently. Exuding warmth and genuine charisma, she had 400 to 500 family therapists stand up, hold hands, and feel their inner love for one another. Sounds phony, right? Perhaps if I tried to lead such an effort as she did, it would seem phony, but she had the ability to connect with people and to help them connect with one another in ways that felt sincere and genuine. She not only talked about how her humanistic-experiential approach to family therapy worked; she lived it and made her audience experience it.

Many consider Satir to be the mother of family therapy in the United States. She was the only woman among the mainly White male psychiatrists of the founding generation of family therapists in the 1950s and 1960s. Having worked as a clinical social worker with families in the early 1950s, she joined Gregory Bateson and his group at the Mental Research Institute (MRI) in Palo Alto, California. She focused her early work on improving the communication patterns among family members. More interested in training than in research, she left the MRI and published the groundbreaking first description of her work in *Conjoint Family Therapy* (1964). Until her death in 1988, she continued to emphasize the importance of clear communication. She included issues of spiritual

growth and world peace in her approach (Brothers, 1991; Satir, 1988), which she identified as the human validation process model (Satir, 1986; Satir & Bitter, 1991).

During my (Volker Thomas) training as a marriage and family therapist, I had group supervision with Carl Whitaker once a month. I was in graduate school at the time at the University of Minnesota. On the first Friday of every month, Whitaker would make the five-hour car trip from Madison, Wisconsin, to Minneapolis, Minnesota, and meet with 12 family therapists for three hours. At times, we all were tired after a long week of conducting therapy and engaging in our studies. One day, when the energy in the group was extremely low, with long periods of silence, I noticed Whitaker drifting off in a nap, his head tilted to the side. When he woke up after a few minutes, I thought he would be embarrassed and apologize for his inappropriate behavior. Instead, he got up, stretched his arms a couple of times, and proceeded to walk to the door. On his way out, he said calmly, "When you guys decide that you have something meaningful to discuss during supervision, send one of you out to get me. You put me right to sleep with your boredom. Until then I'll have better things to do." We were shocked, oscillating between disgust and embarrassment. We quickly noticed the increased energy in the room. Whitaker's falling asleep and his leaving the room confronted us with our low level of energy and our unconscious desire to sit back and relax rather than work. When Whitaker came back, he thanked us for the nap, talking about his "craziness" when he gets tired. In a very different way, this experience was just as powerful to me as the one with Satir described previously. By being himself (or allowing himself to be rude and to fall asleep on us), Whitaker confronted us with our own tiredness and ambiguity about the supervision session. This was a firsthand experience (I could feel my low energy level at the beginning of the session rise after Whitaker left the room) of our process in the here and now. It was not something taught through insight.

Learning through experience—giving meaning to experiences through emotional and affective involvement in the relational process between therapist and family members—is at the core of Whitaker's approach to family therapy. Similar to Satir, Whitaker (1912–1995) had the rare ability to find and foster **connections** between and among people. With his genuine openness, he got away with sometimes outrageous violations of therapist etiquette. He was not only a maverick of family therapy; he was a maverick of life. Some of his contemporaries thought he acted highly unprofessionally, even unethically, but many appreciated his charismatic, often paradoxical ways of saying what everybody in the room was thinking.

Based on his early work with traumatized soldiers during World War II, Whitaker developed a symbolic/experiential approach to psychotherapy in the 1950s that also expressed his frustration with the limitations of classical psychoanalysis. With a group of colleagues, he (Whitaker & Malone, 1953) developed

an approach that focused on the *experiential processes* within both client and therapist as well as between the two. After his move to the University of Wisconsin Medical School in 1965, he expanded his approach to working with whole families, frequently including multiple generations, until his death in 1995 (Roberto, 1991; Whitaker & Keith, 1981).

In the late 1990s, I invited Susan Johnson to present a workshop at a regional conference on the approach she had developed with Leslie Greenberg—**emotionally focused couple therapy (EFCT)** (Greenberg & Johnson, 1988; Johnson, 1998; Johnson & Greenberg, 1995). Although I was well versed in her work, I had never met her. From my encounters with Satir and Whitaker I knew that their approaches were closely connected to their personalities and their individual idiosyncrasies. Many have tried to copy their approaches; nobody has even come close to their abilities to work with couples and families. However, Johnson is different. She is an energetic academician and researcher who is concerned about not only advocating a particular approach but also providing empirical data that prove the efficacy and effectiveness of the approach. During her workshop, Johnson presented the major tenets of her approach and reported on research findings, which showed evidence that the approach actually works with couples.

Theoretical Assumptions and Concepts

Satir's Humanistic-Experiential Approach

According to Satir and Bitter (1991), the **humanistic-experiential** approach bases its concepts on several underlying assumptions:

- Dysfunctional behavior is the result of a deficit in *growth*.
- *Growth* is a natural process occurring in all human beings.
- Human beings have within them all the resources they need to grow.
- *Subjective perceptions* rather than external/objective facts constitute a family's reality.
- Individual symptoms are viewed as the "price" paid to keep the family balanced and are usually associated with *low self-esteem* on part of the symptom bearer.
- Because relationships are highly communicational, a person's self-esteem manifests itself in *poor communication*. Low self-esteem leads to dysfunctional communication patterns.

Satir and Baldwin (1983) summarize these assumptions with a wonderful image: People are similar to *blossoms in the spring*. They are part of fully developed plants that have made it through the hard times of winter. They have slowly grown as the season has progressed. All they need in order to open up and reveal their

beauty is a little more nurturance from Mother Nature—some warm sunlight, a soft spring breeze, and a gentle soaking rain. Then the blossoms can unfold.

The humanistic-experiential approach includes the following concepts:

- *Individual growth and development.* All humans strive for growth and development and have the resources within them to grow. Three factors influence human development:

  1. the genetic makeup;
  2. things learned during the growth process; and
  3. the constant mind-body interaction.

- *Self-esteem and self-worth.* Satir (1986) believed that the core of every person or the self consists of eight different aspects that all have to be attended to and nourished in order for the human potential (i.e., flower) to unfold to its fullest (i.e., bloom). Thus, Satir worked on the following levels:

  1. physical (the body);
  2. intellectual (thoughts, cognitions);
  3. emotional (feelings, intuition);
  4. sensual (sound, sight, touch, taste, smell);
  5. interactional (I-thou, communication between oneself and others);
  6. contextual (colors, sound, light, temperature, space, time);
  7. nutritional; and
  8. spiritual (relationship to life's meaning).

  Satir (1972) believed that self-esteem is one of the most fundamental concepts of the human condition that is learned in the family from verbal and non-verbal messages. Self-worth is composed of the *feelings* **(self-esteem)** and the *ideas* **(self-concept)** people hold about themselves (Satir, 1988).

- *Communication.* The way people communicate in their family reflects the way they feel about themselves. Families whose members have high self-esteem communicate in direct, open, clear, genuine, and authentic ways. Families with low self-esteem and low self-worth tend to use dysfunctional ways of communication (e.g., indirect, covert, unclear, distorted, inappropriate). Satir (1972) developed a classification of communication styles:

Communication Style		*Role Taken Under Stress*
Placater	➔	service
Blamer	➔	power
Super reasonable	➔	intellect
Irrelevant	➔	spontaneity

A congruent communicator uses all four styles in accordance with specific relationship requirements. Under stress, most people tend toward one style that they distort and apply predominantly. A **placater** tries to please at all costs, acts weak, always agrees, and apologizes for everything. The **blamer** blames others for his or her own mistakes, dominates, and is self-righteous. The **super reasonable** remains emotionally detached and controlled, rigid in his or her thinking. Finally, the **irrelevant** becomes a distracter, totally noncommittal to the process.

Whitaker's Symbolic-Experiential Approach

Underlying Whitaker's **symbolic-experiential** approach to family therapy are several assumptions (Keith & Whitaker, 1982):

- ***Reciprocity** of therapist and family*: The therapist has to grow and get in touch with her or his own issues in order to help the family work on its problems.
- *Distrust of cognitive insight*: The therapist is active and uses physical contact.
- The affective energy of *unconsciousness* is fertile ground for growth.
- *Family roles are **flexible***. Kids may be parents temporarily and vice versa; parents/kids may be therapists temporarily and vice versa.
- ***Cotherapy*** is crucial for two reasons: (1) to protect the therapist from getting "hooked" and (2) to learn by doing.
- *The goal of therapy is to trigger anxiety* in the family, which it can use as energy to change; the therapist has to separate his or her own anxiety from the family's; the therapist cannot make the family change; change must come out of the family's own desperation and motivation.

These assumptions translate into several key concepts that are crucial if therapy is to be successful:

- ***Battle for structure.*** Assuming that the family seeks therapy because it is out of control, the therapist assumes control over the structure of therapy (Whitaker & Keith, 1981). The therapist is very firm in that he or she decides who attends the first session and when it is held. This provides a framework for the family to regain structure within its family life.
- ***Battle for initiative.*** Once the therapist has defined the structure of therapy, he or she allows the family to take the initiative for the course of therapy (Whitaker & Keith, 1981). The therapist believes the family's creative forces will unfold when he or she provides the space.
- *Nontheory.* The therapist believes that theory hinders his or her and the clients' creativity.
- *Emotional experience.* The family and the therapist should affectively engage with one another.

- ***Depathologizing of human experience.*** The therapist views families as stuck in patterns of interaction they are unable to change. Experiencing this "stuckness" is the first step to changing the pattern.
- *No preplanned techniques.* The therapist's spontaneity that develops from the spontaneous connection with clients helps families change; preplanned techniques are not necessary for this process. They may even hinder the change process.
- *Use of self by therapist.* The therapist should draw from his or her own life experiences and his or her affective reaction during the session when working with families.
- *Use of cotherapy.* Cotherapy is promoted for two reasons: (1) therapists get so deeply involved with clients in the therapy process that a cotherapist may keep some distance to observe the process and step in when necessary to support the other therapist; (2) since no theory or techniques are used to prepare for doing therapy, cotherapy is the main teaching tool of Whitaker's approach ("learning by doing").

In sessions with his clients, Whitaker would frequently do things that seemed bizarre. For example, once, during a multigenerational family interview, he sat on the floor while talking to the grandmother, who had great wisdom about what was going on in the family. When asked why he sat on the floor in front of the grandmother's chair, Whitaker replied that he was so in awe of her wisdom that he felt like a little boy who would sit in front of her, looking up to her. In another session, he gave a long monologue about his own "craziness" to a family that wanted to know whether a 16-year-old son was mentally ill. Other therapists would never do such things, but Whitaker did them in engaging and genuine ways that made the families feel supported and understood.

Johnson's Emotionally Focused Couple Therapy

Emotionally focused couple therapy (EFCT) is a newer model of experiential therapy that Greenberg and Johnson (1985, 1986, 1988) developed in the 1980s and primarily applied to their work with couples. It draws from Rogers's (1951) client-centered and Perls's (1961) gestalt therapies, integrates some of Satir's (1972) ideas, and adds aspects of family systems theory (Fisch, Weakland, & Segal, 1983). EFCT is brief and has been empirically validated through many research projects (Johnson, 1998). It helps couples change dysfunctional interactional patterns (e.g., attacking-withdrawing, pursuing-distancing) by modifying the inner experience of both partners. EFCT builds on **attachment** theory (Bowlby, 1969), which proposes that people need accessibility and responsiveness of attachment figures in order to achieve a sense of personal security, which many dysfunctional couples do not possess.

EFCT offers the central concepts of primary emotions and secondary reactive emotions:

- **Primary emotions** express our *core feelings.* They are authentic and genuine. Once a therapist has helped a couple bond and helped them alter their dysfunctional interactional pattern, the partners have access to their primary emotions and can relate in open and genuine ways.
- **Secondary reactive emotions** act as defenses of the more vulnerable primary emotions. When there is a lack of attachment bonds in the relationship, a couple rely on secondary reactive emotions because they do not feel safe to express their primary emotions. For example, a husband may get very angry with his wife to mask his fear and hurt when she comes home two hours late from work without telling him in advance.

Normal Family Development

All three approaches to experiential couple and family therapy discussed in this chapter have something in common: they focus on growth and human **development** rather than dysfunction and pathology. They look at the world from a positive perspective, viewing the glass of human life as half full rather than half empty. Satir's aforementioned metaphor of the flower that needs some nurturing to bloom summarizes how experiential therapists view family development. We all are a family of flowers ready to bloom when sufficiently nurtured.

Satir's Humanistic-Experiential Approach

Satir's human validation process model (1986) uses the analogy of the wheel to delineate human development. The hub of the wheel represents the potential health of a person's self. Attached to the hub are the spokes, which represent the components that foster personal growth. These components include physical, intellectual, emotional, sensual, interactional, nutritional, contextual, and spiritual aspects. Families that attend to all components have the greatest chance to secure healthy development for all members over time. Using a mathematical metaphor, Satir (1986) proposed a formula for healthy development:

> A (body) + B (brain) + C (emotions) + D (senses) + E (interactions) + F (nutrition) + G (context) + H (soul) = S (self)
>
> (p. 287)

Whitaker's Symbolic-Experiential Approach

Whitaker viewed health as a never-ending process of becoming (Whitaker & Bumberry, 1988). Healthy families always change and have the ability to adapt their rules and roles accordingly. Parents deal with their children in a flexible

manner as their children grow older. This allows the children to gain independence without losing their parents as dependable and reliable guides. During the course of healthy development, all family members maintain a balance between connectedness (community) and autonomy (individuality). Flexibility serves as the regulating mechanism in this process. Families develop rituals to move through the different phases of their life cycles. For example, birthday celebrations put one family member in the center of everyone's attention to mark the developmental transition from one year to the next. "Today is my birthday, so I am the leader," my youngest son used to say when he was four or five years old. The birthday ritual gave him the opportunity to temporarily assume the role of the "family leader" usually reserved for the parents.

Johnson's Emotionally Focused Couple Therapy

In EFCT, securely attached partners characterize healthy development. When both partners in the couple relationship get their primary emotional needs met, they naturally progress through the life cycle. Both are able to identify their primary emotions and accept each other's needs. The couple engage in a close relationship that includes intimacy and connectedness as well as separateness and autonomy. Both feel secure and respond to each other with caring love.

Pathology and Behavior Disorders

Although all three experiential approaches focus mainly on growth and development, they do have some notion of pathology and associated behavior disorders.

Satir's Humanistic-Experiential Approach

From Satir's point of view, **pathology** is the absence of growth. When a family system is out of balance, some family members may act out by exhibiting negative behaviors in an attempt to rebalance the system. Thus, Satir saw family members' symptoms as signaling a **blockage of growth**. Symptoms may take on one of the four communication styles mentioned previously (placater, blamer, super reasonable, irrelevant). The lack of growth and the development of symptoms are associated with low self-esteem in family members. Let's say that a pregnant stepmother of two boys (ages three and four) is afraid for her unborn baby's life because the boys have been caught severely beating a dog. She requests that her husband give up custody of the boys and transfer them to their mother, who has been known to abuse the boys. Due to the stepmother's insecurity about herself and the future of her baby, she blames the boys for their behavior. The more she worries, the more the boys act out; the more the boys act out, the more the stepmother worries. They all pay the price of unhappiness to keep the family together when the father tries to negotiate with his wife regarding how to control the boys.

Whitaker's Symbolic-Experiential Approach

Whitaker assumed that symptoms develop when dysfunctional family structures persist over a period of time and interfere with the family's ability to carry out its life tasks (Roberto, 1991). Thus, psychopathology arises from the same mechanisms that produce normal behavior. For example, many years ago, two parents in their early 30s came into my office with their nine-year-old daughter whom they could not control. When they entered, the girl sat down on a comfortable recliner, while the parents chose hard and uncomfortable chairs. The girl misbehaved throughout the session by interrupting and correcting the parents frequently, leaving the room whenever she pleased, and refusing to answer my questions. I understood the girl's behavior to be an expression of her discomfort with having too much power (symbolized by sitting on the recliner) and running the parents' lives rather than being a normal nine-year-old girl with limits.

Johnson's Emotionally Focused Couple Therapy

Pathology arises when couples are *insecurely attached* (Bowlby, 1969)—when they hide their primary emotions and instead engage in secondary reactive emotions, which are defensive or aggressive in character. Thus, *negative interactions create negative cycles.* These cycles (e.g., pursue-distance, blame-withdraw) develop because neither partner trusts in the emotional availability of the other, and both try to protect themselves from revealing their fears and other vulnerable feelings. The continuation of these negative interactions increases each partner's fear that the other is not worthy of trust and that primary emotions have to be hidden (Greenberg & Johnson, 1986, 1988). For example, consider a married heterosexual couple in their mid-20s. The wife loves to get together with her girlfriends. After a while, the husband becomes obsessed with the idea that she is cheating on him instead of spending time with her girlfriends. He accuses her of lying and her girlfriends of covering up her lies. She feels as if she is being treated unjustly and begins to dislike him. The more she withdraws because she is afraid of his anger and of him physically hurting her, the more he controls and threatens her. He does not share his fear of abandonment with her, and she withholds her feelings of fear and intimidation.

Techniques

Satir's Humanistic-Experiential Approach

Satir used the following techniques (Satir & Baldwin, 1983):

- ***Family sculpturing.*** Family members demonstrate closeness and distance as well as communication patterns by moving people into specific bodily positions. These positions represent the relationships within the family.

- ***Metaphor.*** The therapist or the client suggests an idea that represents an interactional pattern. For example, parental nurturance is symbolized by the metaphor of the sun warming a budding tree in the spring.
- ***Reframing.*** The therapist uses a positive label for a behavior or feeling that was negatively framed. For example, I reframed the nine-year-old girl's taking a seat in the recliner while the parents sat on hard chairs as the girl's attempt to tell the parents that she had too much power in the family, from which she wanted to be released.
- *Humor.* The use of humor often makes the therapist's comments easier to accept. For example, I told the nine-year-old girl how awkward she looked in the "huge chair" while Mom and Dad "squeezed their big bodies" on the little hard chairs. The family members looked at one another and began to laugh.
- *Touch.* Applied respectfully, touch is a wonderful way to connect with clients, to validate their experience, to reinforce a therapeutic intervention, and to foster the therapeutic relationship. Gentle touch (e.g., putting a hand on a client's shoulder, holding a client's hand, a brief pat on the back) nonverbally supports the client and increases his or her self-esteem. Although touch is a central technique in Satir's approach, the therapist has to use it carefully to avoid violating personal boundaries. Asking clients for permission allows them to check their boundaries.
- *Communication stances.* The therapist invites the family to sculpt the four communication styles of placater, blamer, super reasonable, and irrelevant. Then the therapist works with the family to change these stances into that of a congruent person and have family members sculpt this stance.
- *"I" statements.* The therapist encourages family members to own their feelings and communicate them clearly. Instead of using indirect language, clients learn to begin sentences with "I" and make eye contact with the other person for congruent communication.
- ***Family reconstruction.*** One family member becomes the "star" who engages in the reconstruction of his or her family. During the reconstruction, at least three scenes are role-played: (1) the family history of each of the star's parents, (2) the story of the relationship of the star's parents from their meeting to the present, and (3) the birth of the children to the star's parents, especially the star's birth.

Whitaker's Symbolic-Experiential Approach

Contrary to Satir, Whitaker did not address symptoms directly. He believed that doing so might increase the family's distress (Whitaker & Keith, 1981). Instead, a symbolic-experiential therapist uses techniques that address the family's emotional states that underlie the symptoms. Whitaker viewed the following seven

techniques as important facilitators of the therapeutic process (Whitaker & Keith, 1981):

- ***Redefining*** *symptoms as an effort at growth*. This technique is similar to Satir's reframing. In general terms, Whitaker considered family members' symptoms as attempts to get unstuck and grow. For example, Whitaker might have told the nine-year-old girl in the recliner that she wants to be a big person and sit in a big chair because she has all the adult responsibilities in the family.
- ***Modeling*** *fantasy alternatives to real-life stress.* The therapist relies on creative ideas to model alternative behaviors to the ones the family members exhibit. In the case of the nine-year-old girl, I got up from my chair, picked up my toy box, placed it in front of the recliner, and began to play with toys on the floor while talking to the parents. The girl watched me for a few minutes, then got up and joined me on the floor. I then invited the parents to join us, which they hesitantly did. Eventually, we all played with the toys on the floor, which decreased the tension among the family members considerably.
- *Separating* ***interpersonal*** *stress and* ***intrapersonal*** *stress.* Whitaker believed that many people act out the internal stress they feel in their relationships with family members. However, because they are unaware of their internal stressors, they blindly project them onto others, which increases the interpersonal stress among family members. Humor and exaggeration are ways to uncover these unconscious processes. For example, when I told the nine-year-old girl that she wanted to sit in the recliner because she felt the pressure to be a grown-up (intrapersonal stress), it reframed the parents' complaints that they could not control the girl's behavior (interpersonal stress).
- *Adding practical bits of* ***intervention***. At times, it is very important to suggest very practical behavioral changes to client families. One of those practical bits was my invitation to the parents of the nine-year-old girl to come down and play with us on the floor.
- *Augmenting the despair of a family member.* Whitaker loved to increase family members' anxiety and add to their despair with the goal of triggering the desired change process. For example, in one of the classic books on symbolic-experiential family therapy (Napier, 1978), Whitaker engages in a wrestling match with a defiant young boy, which makes the parents feel so bad that they finally take charge of their son's behavior and set clearer limits.
- ***Affective confrontation.*** This intervention is similar to the previous one. Confronting denied or invalidated affect in a paradoxically supportive environment was one of Whitaker's favorite interventions. For example, he would call a father who would not stand up to his adolescent son's provocations a "lame duck who would be too scared to show his son how a man acts" (personal communication, 1987).
- *Treating children as children and not as peers.* Whitaker considered it extremely important to keep the boundaries between the generations clear. He believed that children needed their parents' protection and permission to be children and

should not be treated as equals, because that would put too much responsibility on them. For example, the fact that the nine-year-old girl sat in the recliner and the parents sat on the hard chairs symbolized that the parents did not treat the girl as a child but wanted to avoid a confrontation with her in front of the therapist. Thus, the goal of therapy was to relieve the girl of her burden of being a peer to her parents and to allow her to be and act like a nine-year-old.

These techniques were emphasized differently in Whitaker's four stages of therapy (Whitaker, 1977):

- During the *pretreatment or engagement phase,* symbolic-experiential therapists mainly rely on redefining the symptom and modeling fantasy alternatives. The therapist establishes that he or she has control over the sessions but that the family makes its own life decisions.
- During the *middle phase,* the family members get increasingly involved in the therapeutic process. The therapist puts more emphasis on the other techniques discussed, trying especially to increase the family members' anxiety and augment their despair. The therapist aims at affective confrontation and helps family members separate interpersonal and intrapersonal stress.
- During the *late phase,* the family needs less guidance and confrontation from the therapist. Its members have learned to implement their progress both during and between sessions. Flexibility on the part of the therapist fosters the family's growth process.
- During the *separation phase,* therapist and family members work through the pending loss of the termination of therapy. The family members use their new skills to work through their own sense of loss and grief over losing the therapist.

As unstructured as Whitaker's therapy appears in his original writings, he put a great deal of thought and systematic reflection into the therapeutic process. When asked how he came up with some of his outrageous yet extraordinarily creative interventions, Whitaker replied, in essence, "I have no idea what I am doing when I am doing it. A good therapist does not need to know ahead of time what he is going to do. But he must be able to provide a sound rationale for what he did afterward" (personal communication, 1987).

Johnson's Emotionally Focused Couple Therapy

Instead of specific interventions or techniques, EFCT offers a step-by-step treatment manual, suggesting a format for the therapy process that therapists and couples can replicate:

1. *Delineate conflict issues in the core struggle.* Once the secondary emotions have been identified, the therapist focuses on the core struggle and delineates the pertinent conflict issues in detail.

For example, during the first session with the mid-20s couple mentioned previously, the therapist identified the wife's fear of violence and the husband's anger and obsession that his wife was cheating on him.

2. *Identify the negative interaction cycle.* The delineation of the core struggle leads to the identification of the couple's negative interaction cycle, such as pursue-distance or blame-withdraw.

   To continue our example, the couple learned how the husband pursued and intimidated the wife, and how the wife tried to distance herself out of fear of being hurt. The couple also identified the reciprocity of this negative cycle—that is, the more the husband pursued the wife, the more she distanced herself; the more she distanced herself, the more he pursued her.

3. *Access the unacknowledged feelings underlying interactional positions.* During this step, the therapist helps the couple access the primary feelings that they try to protect when they pursue, blame, distance, or withdraw. Once the couple has gained some understanding of the negative cycle feeding their secondary emotions, the therapist works with each partner on getting in touch with his or her primary emotions.

   In our example, the husband experienced his fear of abandonment when he got angry and controlling, as the wife got in touch with the loneliness she felt when her husband did not want to talk and cuddle up with her.

4. *Reframe the problem in terms of underlying feelings, attachment needs, and negative cycles.* In our example, the therapist told the couple that fear of abandonment expresses attachment needs and often leads to blaming or withdrawing, in an attempt to protect against another loss and emotional betrayal. This helped the couple identify the negative cycles in terms of their attachment needs. The therapist reframed the wife's fear of the husband as her strong need to feel emotionally connected with him. The husband's anger was relabeled as his need to be close to his wife, something that she longed for as well but also feared.

5. *Promote identification with disowned needs and aspects of self, and integrate these into relationship interactions.* Once our couple identified the disowned attachment needs, the therapist helped them express those needs to each other and so bring them directly into the relationship. During this stage, the therapist coached the husband to share his fears and concerns when his wife wanted to go out with her girlfriends. The wife learned to acknowledge her husband's fear and validate it rather than get defensive and push it aside. Conversely, the wife was encouraged to express her need to have relaxed conversations with her husband (which she had previously instead sought with her girlfriends) and to feel close to him. The therapist coached the husband to accept his wife's expressed needs, even if it was difficult for him to meet those needs.

6. *Promote each partner's acceptance of the other's experiences and new interaction patterns.* When one partner has the courage to bring the needs and fear into the relationship, the therapist encourages the other partner to accept him or her, which leads to new patterns of interaction in the couple's relationship.

Once our couple learned to accept each other's experience, the husband became less anxious and angry, and he let go of his unfounded fear of infidelity. The wife felt more secure and safe with her husband and stopped distancing herself.

7. *Facilitate the expression of needs and wants, and create emotional engagement.* Once both partners have made the first step to express their primary emotions, they need coaching to emotionally connect with each other. The therapist works with the couple and encourages them to express their needs and wants to each other, as well as to respond to the other's wants and needs.

   At this stage, our couple was ready to have more closeness—having dinner together, going for walks. They even talked for the first time about having a baby. The therapist role-played with the couple to help them practice staying engaged in conversation, even when they felt anxious and uncomfortable.

8. *Establish the emergence of new solutions.* At this point, most couples are ready to find new solutions to their daily problems without falling back into the negative cycles that brought them to therapy.

   The safer our couple felt and the more they engaged with each other, the less the wife wanted to go out with her girlfriends, and the less the husband felt threatened when his wife did go out.

9. *Consolidate new positions.* During this final phase of therapy, the couple can stay emotionally connected even when dealing with stress and can openly express their needs and meet each other's needs. Our couple learned to have fun with each other, and eventually they had a baby.

Diversity

Satir's Humanistic-Experiential Approach

Satir traveled the world, teaching her approach throughout Asia, Europe, and North America. While she may have thought it important to apply her model to a wide variety of cultures, in those days it was not common to write about these applications (Bermudez, 2008). In the early 1990s, Satir, Gerber, and Gomori (1991) discussed how the approach is multicultural because it reaches across language barriers. To date, there have been only a handful of studies with specific populations to test this claim. These studies have been conducted within the Hispanic population (Bermudez, 2008) and in China, with varying results (Cheung & Chan, 2002).

Whitaker's Symbolic-Experiential Approach

There is not much written regarding Whitaker's symbolic-experiential approach and cultural considerations. This is not surprising due to the era in which he was developing this approach. Whitaker, being an educated White male, was no

stranger to making blanket, stereotyped statements (Smith, 1998). While today this may seem culturally inappropriate, it has been argued that Whitaker was a victim of his generation. Some have contended that he was progressive in his thinking for his generation, but gender and culturally sensitive therapists in today's society may not see it that way and be reluctant to apply some of his techniques with diverse populations (Smith, 1998).

Johnson's Emotionally Focused Couple Therapy

EFCT has been found to be effective with couples from diverse backgrounds and differing cultures (Greenman, Young, & Johnson, 2009). The core concepts of attachment theory, which EFCT is based upon, have been found to be universal. Even when differing cultures have different ways of expressing attachment, the underlying concepts (i.e., need for safety and security) remain the same (Liu & Wittenborn, 2011; van IJzendoorn & Sagi-Schwartz, 2008). This allows EFCT to be applied to a diverse clientele.

While the core principles of EFCT can be used with diverse clients, it is important for EFCT practitioners to be culturally sensitive. Therapists need to be cognizant and respectful of clients with different points of view, and in the case of EFCT, different expressions of attachment (Liu & Wittenborn, 2011). Therapists should approach couples with an understanding that the development and healing of couples' problems can be culturally constructed. This includes but is not limited to culturally appropriate expressions of emotions, verbal and nonverbal expressions of wants and needs, and varying forms of communication. Therapists must take this into consideration when framing the problem and when restructuring the couple's patterns of interaction (Greenman et al., 2009).

Relevant Research

Little empirical research has attempted to validate the efficacy and effectiveness of Satir's humanistic-experiential and Whitaker's symbolic-experiential approaches. The only experiential approach that has yielded relevant outcome research is Johnson's emotionally focused couple therapy. For example, Greenberg and Johnson (1988) found that helping an angry and attacking (secondary emotions) partner reveal his or her softer feelings (primary emotions) was associated with positive therapy outcome. In another study, Greenberg, Ford, Alden, and Johnson (1993) concluded that when couples express primary emotions in therapy they have more productive sessions and feel more intimate with each other. In a comparison of several empirically based treatment approaches derived from several rigorous research studies, Alexander, Holtzworth-Munroe, and Jameson (1994) reported that EFCT was one of the effective approaches for treating distressed couples. In a meta-analysis that included many outcome studies within and across different treatment approaches, Dunn and Schwebel (1995) also confirmed the efficacy and effectiveness of EFCT.

Case Studies

In this section, we revisit three previously discussed case examples in more detail by applying them to the three approaches. Imagine you are Virginia Satir, Carl Whitaker, and Susan Johnson in turn as you read the following case examples.

Satir's Humanistic-Experiential Approach

Remember the family with the two little boys whose stepmother was pregnant and feared that they would hurt the baby? Following is their story from the perspective of Virginia Satir.

Jim is in his mid-30s and has two boys, four-year-old Bob and three-year-old Cody. Jim divorced two years ago after his mentally ill ex-wife severely abused the boys. Since the incident, Jim has had sole custody of Bob and Cody. Jim is remarried to Sue, who is 27 years old and pregnant with their first child. When Sue heard from the boys' babysitter that they had attempted to choke a baby also in the babysitter's care, she became afraid for her own unborn child and requested that Jim remove the boys from their home. Jim felt torn between taking care of his two sons and protecting his new wife and unborn child. Attempts to more effectively manage Bob and Cody had failed because most of the parenting was left up to Sue, who was both afraid of and angry with the boys. Jim and Sue were quite desperate, fearing that they would not be able to create a safe environment for their new family.

Satir saw all the family members who were currently living together—Jim, Sue, Bob, and Cody—and made sure to connect with all four. When talking with one of the boys, she would move her chair in front of him and establish eye contact by gently lifting his chin so that he would look at her while they were talking. This gesture was particularly important, because the parents complained that the boys did not listen. By making sure that each boy made eye contact and by gently touching him, she modeled effective communication with the boys for the parents.

When it became clear that the boys were threatening the safety of the family, Satir reframed their violent behavior as attempts to reach out and ask the parents to stop the violence they had suffered at their biological mother's house. Then she asked Jim to face each of the boys, hold their hands, establish eye contact, and tell each of them that he loved him, that he wanted him to be part of the family, and that he wanted him to mind and behave better. While Jim talked to his sons, Satir would sit next to him, put her hand on his shoulder, and help him effectively communicate with his sons. While talking to his sons, Jim began to cry softly;

Cody gave him a comforting kiss. Satir calmly praised both father and son for their emotional connection and encouraged them to continue on this route. Sue watched the exchange with great interest and tears in her eyes. During this process, Satir made sure that the parents used "I" statements when they talked to the boys and that they did not blame the boys' biological mother for abusing them.

Then Satir turned to Jim and Sue and suggested they find a way out of the dilemma, by either removing Bob and Cody from the home or having Sue and the baby leave once the baby was born. Again, Satir modeled clear communication when she asked Jim and Sue to move their chairs so that they could squarely face each other. During the ensuing emotional conversation, Satir introduced the metaphor of the "bottom line," representing the safe ground needed for this family. Sue's bottom line was that the boys' violent behavior had to stop. Jim defined his bottom line as having one family in which he could raise his three children with Sue. Satir acknowledged how far apart the two bottom lines were and asked Jim and Sue to sculpt the families they envisioned once the boys' behavior had changed in the desired direction. To the parents' surprise, their ideal families looked almost identical. Then Satir asked the couple to sit down again and face each other. Sue and Jim held hands, and Jim told Sue that he would do the best he could to "make the boys mind" (those were his words) and protect the baby. Sue openly stated her doubts whether this would ever happen and repeated her fear for the baby's safety. After a few minutes, the couple felt stuck again and turned to Satir. She put her hands on their hands, which were still connected, and repeated their bottom lines. Then she asked the two whether they would be willing to consider the possibility of putting their doubts aside for a moment and looking into each other's eyes. They agreed and began to cry. In their pain, they began to emotionally connect in a way they had not connected before. They hugged and were silent for some time. Satir placed one of her hands on each of their shoulders. The boys observed the process quietly and with great interest. After the parents had collected themselves, the boys calmly went over to them, and the whole family engaged in a big family hug with Satir.

During the ensuing conversation, Sue expressed her relief to see the boys so passionate and calm, stating: "Sometimes they seem like untamable monsters. Now I see them as sweet little boys who need as many hugs as I do and their daddy does." This is a wonderful summary of the change Sue experienced.

Unfortunately, therapy is not quite as easy as this case might indicate. It took many sessions for Jim and Sue to permanently overcome their

doubts and fears and to be firm and supportive parents in light of the additional stress of having a baby. However, they stayed together and worked through their fears with the coaching and support of Satir (or another therapist). The more secure and confident Jim and Sue felt about their parenting, the safer the boys felt, even in the presence of this new little rival for attention—their sister Melanie, who was born after the ninth session. Actually, Bob became quite affectionate and protective of his little sister whenever Cody wanted to play rough with her. He told the therapist, "When Daddy is at work and Mommy is in the other room, then I watch Melanie." Although the boys' behavior remained difficult to manage at times, they never hurt their little sister, as Sue had feared they would. This increased her self-esteem and self-confidence considerably, which made her a more effective stepmother. Jim dealt successfully with his guilt about the boys' abuse by their biological mother, which had previously kept him from setting firm limits with them. This increased his self-esteem and self-confidence, which made him a more effective father. Sue and Jim's increased self-esteem also helped them as a couple to communicate more effectively and to avoid getting stuck in irreversible positions.

Whitaker's Symbolic-Experiential Approach

Now let's find out how a therapist such as Carl Whitaker (and his cotherapist) would work with the nine-year-old girl who came into my office and sat down in the comfortable recliner while her parents took the hard chairs. Allow me to begin by filling you in on the history of that family, starting with each parent's childhood.

Jill was the middle child of five. Her parents were professionals, and both worked full-time. As a result, she was partly raised by her two older sisters and was used to having people around at home.

Jack, on the other hand, was the only child of older parents who had struggled with infertility. When they had finally conceived, Jack's mother quit her job and put all her energy into what became her most precious accomplishment in life. Jack consequently grew up well nurtured and protected.

Jack and Jill met in college. They had a rather casual courtship and started living together only a few months before Jill got pregnant during their senior year. They decided to marry shortly after graduation. In such a quickly developing relationship, they had little time to adjust to each other and to learn about their very different family backgrounds. In addition, Jack's parents were especially upset that he "had to" get married and implied to Jack that they were concerned that Jill had "tricked" him into the marriage by getting pregnant. After Anna's birth, Jill wanted to

pursue a graduate career, but Jack opposed this, wanting her to stay home as his mother had done. Meanwhile, Jack went on to graduate school for his MBA. Jill resented Jack's lack of support and felt isolated and lonely with a young child at home. During Anna's early childhood, Jill would accept odd jobs—against Jack's wishes—in order to get out of the house and have adult contact. The tension between the two grew. Jack accused Jill of being a "neglectful" mother and withdrew into his studies and his job more and more. Jill resented Jack's withdrawal, accusing him of not doing his share around the house and with Anna. Both Jack and Jill were very achievement oriented and rather competitive. Both felt shorted when it came to their marriage. Both considered getting a divorce several times. However, Jack did not want to give his parents the satisfaction of being correct that the marriage would not work out, and Jill's value system did not include divorce as a viable option.

Thus, Anna grew up amid this tension about parental roles and accomplishments. She became quite achievement oriented herself. She picked up on her parents' strong wills and their tendency to engage in open arguments. Over the years, she learned to take advantage of her parents' entrenched situation by playing them against each other. For example, she would complain to Jack that Jill would leave her alone too much, which would make him angry at Jill, and he would spoil Anna with the intent to make up for Jill's neglect. When Jill found out about Jack taking Anna places behind her back, she would get angry with Jack. Or Anna would complain to Jill that Jack had yelled at her unjustly. Jill would get angry at Jack and withdraw into her bedroom with Anna to read to her for hours, both giving Jack the "silent treatment." In turn, Jack would get angry and withdraw even more into his job and his schooling.

Over the years, this cycle became so powerful that eventually Anna ran the family by manipulating her parents as she pleased. Although she was very unhappy that her parents would get angry so frequently and be unhappy as well, she thought that was how life was supposed to be; she did not know what else to do. When Jill finally was so desperate that she threatened to divorce Jack despite her values, Jack agreed to seek family therapy.

This background helps us understand how the family ended up in my office. Before they even showed up, we went through a battle for control. Jill, who had made the initial phone call and scheduled the appointment, called back the next day reporting that Jack was so busy with school and work he could not make the appointment. According to Jill, Jack had suggested that Jill and Anna go ahead with the session, because it would be more important to them anyway. I insisted that I would see them only

if all three would come in at the time of the scheduled appointment, and I suggested that Jill talk it over with Jack and call me back. The following day, Jack called and tried to make his case with me personally. I stayed firm and insisted on seeing all three of them because I considered Jack a crucial part of the family. Finally, Jack gave in, and the family showed up at the scheduled time.

As mentioned, Jack and Jill entered my office in a depressed and discouraged mood and sat down helplessly on the hard chairs, while Anna placed herself in the recliner. This picture in my office reflected the way they had seen their family world. I engaged Anna in playing with toys on the floor (something the parents had rarely done), which Anna greatly enjoyed. When I finally succeeded in getting the parents off the chairs, they awkwardly kneeled down next to Anna on the floor; I had found a way to join with them. At the end of the first session, I gave them homework: play with Anna once a day for 15 minutes until our next session.

When they all came back the following week, I could feel the increased tension in my office. They reported that the daily playtime had been a disaster. Anna had argued with the parents about what to play, dictated and controlled their actions, and threw tantrums when they did not do what she had demanded. After two attempts, the parents discontinued playtime, which also led Anna to throw tantrums. Apparently, the negative cycle had escalated and the family felt more desperate than before. I decided to listen to the family members and let them take the initiative in this session (battle for initiative). The longer we sat there with the family not knowing what to do, the more the intensity in the room increased. Finally, Jill suggested trying the playtime again, hoping that I would help facilitate the process and keep Anna from "running the show." Jill got down on the floor and asked Jack and Anna to join her, which Jack did after a few moments. However, Anna refused to get up from the recliner, accusing her parents of being bad playmates. In response, the parents accused each other of being insensitive to Anna's needs. Imagine this grotesque picture: two adults on the floor with toys, arguing about their child, while she sits in the recliner, cursing at them.

At this point, I was so disgusted with them that I rose from my chair and announced that I would leave the room until they were ready to do therapy. I told them that I understood how they were acting at home and that they did not have to waste their time and money to do the same in my office. I said that I would take a book and read in the waiting room. When they were ready to do therapy, one of them could come and get me. As all three sat in shock, their mouths and eyes wide open, I left my office. After five minutes, Anna came out and politely asked me

to come back. She promised that they would not fight any longer and wanted to try to be a happy family. When I entered my office, I saw Jill in tears and Jack looking furious. They were sitting on the hard chairs, full of emotions they did not know how to handle. Anna went quietly to the floor and began to play with a dollhouse.

I ignored the parents and asked Anna what she wanted to show me. She took a male doll and put it in a big box in the attic. Then she placed a female doll in a bed in the basement. She then had a female child-size doll start preparing a meal in the kitchen.

"This is my family after a big fight," Anna exclaimed. I shared with Anna how impressed I was that she kept taking care of the family even after a fight, and I asked what would happen next. She showed me the child-size doll cooking for a while, then bringing a plate with food to the basement and quietly handing it to Mom (the female doll). She repeated the same with another plate and brought it to the attic and placed it quietly on top of the closed box in which Dad (the male doll) had been placed.

"How nice of you to bring Mom and Dad something to eat when they are sad," I commented, adding, "What a responsibility for a nine-year-old girl—to take care of her mom and dad!"

Anna looked at me, surprised, and teared up. She turned and looked at her mother, who was still quietly crying. Their eyes met in sadness. Jill got up and went to her daughter, who was now sobbing. While Jill was holding Anna on the floor, I went over to Jack, sat down next to him, and put my arm around his shoulder. He fought his tears as hard as he could, but they were too insistent to be held back.

"You may join them if you like," I said. "There is room for everybody in this family, even in pain and sadness." Relieved by my permission, Jack got up and joined Jill and Anna in their embrace. Without any reluctance, they welcomed him. When they got up from the floor, something astonishing happened. Anna asked to sit on Jack's lap. After some awkward tiptoeing around each other, Jack ended up in the recliner with Anna on his lap, and Jill moved one of the hard chairs next to the recliner and sat there.

When I asked what had happened, Anna responded first. "I want to be a little girl and not have so much responsibility. It's much more fun sitting on Dad's lap than bringing him food he does not eat anyway." Jack and Jill looked at each other and confirmed that they both had forgotten that Anna was just nine years old. They wanted to learn to be better parents and to be a better husband and wife.

As with the Satir family, it took several months of weekly (and later biweekly) sessions for Jack and Jill to accomplish their goals and for Anna

to fully accept being a nine-year-old girl rather than a parentified child who runs the house. She had to learn to let go of the power that came along with the parentification and to accept the limits her parents set. Jack and Jill had to learn to work through their family-of-origin issues that had led them into their negative cycles. That freed up energy so that Jack and Jill could attend to each other's needs, and most of all, to recognize and meet Anna's needs according to her developmental stage. And I learned how to deal with the intensity of three people who had greatly unmet needs and to appreciate the power of emotional connections that arise out of fear and pain.

Johnson's Emotionally Focused Couple Therapy

Joe and Cindy are the couple in their mid-20s who live together and are bound by Joe's fear of Cindy's perceived infidelity and by Cindy's fear of possible violence perpetrated by Joe.

Joe grew up as the youngest of seven children. His father was an alcoholic who died of liver problems when Joe was 10 years old. His mom, although severely depressed at times, raised the children by herself and never remarried. When Joe was 14, he went to live with his maternal aunt's family and started working; he worked all through high school. After graduating high school, he supported himself in college, before dropping out in his junior year to work for a landscaping company because he loved to be outdoors.

Cindy grew up as a big sister to two brothers in a lower-middle-class home. Both of her parents worked to make ends meet, which left Cindy with the responsibility to take care of the house and her younger brothers until her mother returned home from work. Cindy's parents instilled in the children the value of education so that they would have a better life than their parents had as high-school graduates. Cindy was a good student and also succeeded in college despite having to work her way through.

Cindy and Joe met in a class at the beginning of their junior year. Since Joe was struggling with school at that time, Cindy would help him with assignments and study with him. They dated for about six months and then moved in together.

According to Cindy, Joe was clingy and controlling from the first day they lived together. He always wanted to know where she was and did not show any interest in spending time with other people. She hoped that he would change once they had lived together for some time. When she realized that he would not change, she began to resent him and accused him of holding her hostage in her own house. At the same time,

she felt guilty for wanting to be away from him because she genuinely loved him. Because she needed somebody to talk to about her dilemma with Joe, she increasingly went out with her girlfriends. However, the more she went out, the more difficult Joe became, until he finally accused her of having an affair and of trying to get rid of him.

According to Joe, at the beginning of their relationship, he was so in love with Cindy that he wanted to spend as much time with her as possible. He was convinced that he had finally found a person who would unconditionally be there for him for the rest of his life. He pushed Cindy to move in with him so that they could be together all the time (though at the time, he said the reason was so they could save money). He quit college so that he could make more money and become a "good man" who could provide well for Cindy. That was something his father had never managed to do, because most of the money he earned went toward alcohol. From the beginning, Joe sensed Cindy's discomfort at staying home every night. He tried to tolerate her need to go out and see her girlfriends. One day, he found a pack of condoms in her car, which convinced him that she was having an affair. Her explanation—that one of her girlfriends had left the pack in her car—only increased his resentment toward her when she wanted to go out with them. He began to check up on her and would get very angry when she would come home later than agreed. The resentment and tension between the couple increased until one night—after she had stayed out late and he had gone looking for her at the place where she was supposed to be, to find she wasn't there—he hit her. She then threatened to leave him if he did not agree to engage in couple therapy.

Joe was so afraid of losing Cindy that he called an EFCT therapist (such as Susan Johnson) to set up the first appointment. He felt comfortable that the therapist was a woman, hoping that she would convince Cindy to be more open and honest and to quit the affair he was still convinced she was having. Cindy also wanted to have a female therapist, hoping that she would receive support in dealing with this clingy, insecure man. Using the step-by-step treatment manual as discussed, the therapist met with Cindy and Joe for 12 sessions over a three-month period.

During the first session, the therapist identified Cindy's fear of violence and Joe's anger and obsession that Cindy was cheating on him. Then the couple learned how Joe pursued and intimidated Cindy, while she tried to distance herself out of fear of getting hurt. The couple also identified the reciprocity of this negative cycle—that is, the more Joe pursued, the more Cindy distanced herself; the more she distanced

herself, the more he pursued her. Once the couple gained some understanding of the negative cycle feeding their secondary emotions, the therapist worked with each partner on getting in touch with his or her primary emotions. Joe experienced his fear of abandonment when he got angry and controlling, while Cindy got in touch with the loneliness she felt when Joe did not want to talk and cuddle with her. The therapist said that these feelings, which expressed attachment needs, often lead to blaming or withdrawing in an attempt to protect against another loss and emotional betrayal. This helped the couple identify the negative cycles in terms of their attachment needs. The therapist reframed Cindy's fear of Joe as her strong need to feel emotionally connected with him. Joe's anger was relabeled as his need for closeness with his wife, something that she longed for as well but also feared.

Once the couple identified their disowned attachment needs, the therapist worked with them on expressing these needs to each other to bring them directly into the relationship. During this stage, the therapist coached Joe to share his fears and concerns when Cindy wanted to go out with her girlfriends. Cindy learned to acknowledge Joe's fear and validate it rather than get defensive and push it aside. Conversely, the therapist encouraged Cindy to express her need to have relaxed conversations with Joe (which she had previously instead sought with her girlfriends) and to feel close to him. The therapist coached Joe to accept Cindy's expressed needs, even if it was difficult for him to meet the need. Once the couple learned to accept each other's experience, Joe became less anxious and angry, and he let go of his fear that Cindy was being unfaithful. Cindy felt more secure and safe with Joe and did not distance herself as much as before.

Now the couple was ready to experience more closeness—having dinner together, going for walks. They even talked for the first time about having a baby. The therapist practiced helping the couple stay engaged in conversation, even when they felt anxious and uncomfortable. After a few more sessions, Cindy and Joe were ready to find new solutions to the daily problems they faced without falling back into the negative cycles that had brought them to therapy. The safer and more engaged the couple felt, the less Cindy wanted to go out with her girlfriends and the less Joe felt threatened when she did go out. During this final phase of therapy, even when dealing with stress Cindy and Joe were able to stay emotionally connected, openly expressed their own needs, and met each other's needs. They learned to have fun with each other, and eventually they had a baby.

Conclusion

Hopefully, this chapter has given you an impression of what experiential couple and family therapy is about and how three different schools of thought conceptualize and apply experiential therapy. Like other schools of thought, the experiential approaches depend very much on the personality of their proponents. The human growth experience was so important to Virginia Satir and she felt so comfortable being with clients on so many levels that her humanistic-experiential approach to therapy replicated her approach to life. Similarly, Carl Whitaker was so strongly convinced that therapists should emotionally engage with family members and he felt so comfortable doing so that he shaped a unique approach that fit his personality. Finally, Susan Johnson, influenced by the push for empirical validation of experiential approaches to therapy, developed a step-by-step procedure that has been shown to be efficacious and effective and at the same time fits her own strengths—her ability to get clients involved emotionally and to work with those emotions.

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Glossary

affective confrontation: One of Whitaker's techniques to challenge denied or invalidated emotions.

attachment: The most basic need for emotional and physical connection.

battle for initiative: Allowing the family members the freedom and giving them the responsibility to determine the course of therapy (used by Whitaker after the battle for structure is won).

battle for structure: Therapist taking control of the structure of therapy in order to establish an effective working relationship with the family.

blamer: One of Satir's communication types that describes a person who holds others responsible for his or her own mistakes by being dominating and self-righteous.

blockage of growth: Internal and external forces that keep people from growing emotionally.

connection: A form of relating between people that has emotional, cognitive, and sensual aspects.

cotherapy: Two therapists working at the same time with an individual, couple, or family for training purposes.

depathologizing of human experience: To put human behavior and feelings in a context that is not related to problems or disease.

development: The movement from one stage to the next over time.

emotionally focused couple therapy (EFCT): An experiential approach based on humanistic, systemic, and attachment foundations, that helps couples change negative interactional cycles and to express their primary emotions.

experiential: The therapeutic approach in which therapists reveal their real person and use the self to change the family (proponents include Susan Johnson, Virginia Satir, and Carl Whitaker).

family reconstruction: Families reenact key family situations in order to gain new insights into their family and their own lives.

family sculpturing: Physical arrangement of family members in space as determined by one family member who is called "director"; the sculpted constellation represents the relationships among family members.

flexibility of roles: A person may temporarily take on the role of another person.

humanistic-experiential: Virginia Satir's approach to family therapy that has a life-affirming view and emphasizes each person's uniqueness and worth, the potential for positive human interaction, and personal growth.

interpersonal: Between or among persons.

intervention: A therapist's statement or question that has the goal to change a client's behavior and/or affective state.

intrapersonal: Within a person.

irrelevant: One of Satir's communication types that describes a person who is a distracter and remains noncommittal toward interaction processes.

metaphor: A figure of speech in which a term is transferred from the object it ordinarily designates to an object it may designate only by implicit comparison or analogy.

modeling: Exhibiting behavior and affect a therapist would like the client to adopt.

pathology: Behavior and affect that is associated with problems and disease.

placater: One of Satir's communication types that describes a person who tries to please at all costs, always agrees, and apologizes for everything.

primary emotions: Expressing one's core emotions that are related to the true genuine self.

reciprocity: A mutual condition or relationship.

redefining: Putting the meaning of a term into a different context in which its meaning changes.

reframing: Relabeling behavior by putting it into a new and positive context with the goal of eliciting a different behavior.

secondary reactive emotions: Emotions that serve as defenses to protect the vulnerable primary emotions. Couples rely on secondary emotions when they have insecure attachments to each other and do not trust their partners.

self-concept: Thoughts and ideas people hold about themselves.

self-esteem: Feelings and emotions people hold about themselves.

super reasonable: One of Satir's communication types that describes a person who remains emotionally detached, controlled, and rigid in his or her thinking.

symbolic-experiential: Carl Whitaker's approach to family therapy that focuses on the symbolic meanings of relationships.

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9

COGNITIVE-BEHAVIORAL THERAPIES FOR COUPLES AND FAMILIES

Norman B. Epstein and Mariana K. Falconier

> Couples are often adept at dealing with people outside the relationship, but few people enter an intimate relationship with the basic understandings—or the technical skills—that make a relationship blossom. They frequently lack the know-how to make joint decisions, to decipher their partners' communications. . . . Because of the strength of the feelings and expectations, the deep dependency, and the crucial, often arbitrary, symbolic meanings that they attach to each other's actions, partners are prone to misinterpret each other's actions. When conflicts occur, often as a result of miscommunication, partners are likely to blame each other rather than to think of the conflict as a *problem* that can be solved.
>
> Aaron T. Beck, MD
>
> *Love Is Never Enough: How Couples Can Overcome Misunderstandings, Resolve Conflicts, and Solve Relationship Problems Through Cognitive Therapy*

Behavioral treatments for couple and family problems are based on the assumption that dysfunctional behaviors are learned and can be reduced or replaced with more constructive behaviors through new learning processes. Behavioral approaches for a wide range of human problems had their roots in laboratory research on learning processes in animals and humans. Ivan Pavlov (1932) demonstrated how emotional and behavioral responses could be conditioned so that they would be elicited by a **neutral stimulus**, by pairing the neutral stimulus with an existing **reflexive response**. For example, a dog could be conditioned to salivate at the sound of a bell if the bell was rung a number of times as the dog was salivating to the smell and taste of food. John Watson's publicized case

of "Little Albert," in which a phobia was established in a child through such **classical conditioning** (Watson & Raynor, 1920), increased interest in applying **learning principles** to understand a variety of human clinical disorders. However, it was not until Joseph Wolpe (1958) developed **systematic desensitization** as a treatment for phobias that therapeutic interventions based on learning principles gained significant credibility as effective treatments. Based on the concept that a phobia is a classically conditioned response to a stimulus that is not dangerous, systematic desensitization involves pairing the anxiety-producing stimulus (e.g., a mouse) with relaxation, assertiveness, or some other response that is incompatible with anxiety. The exposure of the individual to the anxiety-provoking stimulus is done in steps, or a hierarchy, beginning with a mildly distressing aspect of the feared stimulus, such as looking at a caged mouse from across a room, and eventually progressing to holding a mouse. At each step, the individual practices the relaxation or other response that counteracts the anxiety response, and moves to the next higher step in the hierarchy only when he or she has **deconditioned** the anxiety at the current step. Wolpe's work advanced the field of behavior therapy and contributed to the development of effective treatments for a variety of clinical problems, such as anxiety disorders and sexual dysfunctions. Nevertheless, the focus of the **behavioral assessment** and interventions tended to be on the individual, and potential application to interpersonal problems was unclear.

B. F. Skinner's (1953) work on **operant conditioning** had a more extensive impact on the development of behavioral approaches to couple and family problems. Skinner demonstrated that one could increase or decrease an animal's specific action by controlling the **consequences** of the action. Thus, a rat could be taught to press down a bar in a box if pressing the bar dispensed a food pellet (i.e., **positive reinforcement**). In contrast, a behavior could be decreased by following it with conditions that are assumed to be aversive (**punishment**), or by discontinuing the reinforcement. Skinner (1953, 1971) argued that all human behavior could be explained in terms of such learning processes, and concepts about internal processes such as emotions and thoughts as causes of behavior are superfluous. Skinner considered all responses, including overt behaviors and internal responses, as acts that are controlled by consequences in the individual's environment, so treatment of problematic responses should involve changing the environmental conditions. Similar to Wolpe's work, Skinner's theoretical model was in opposition to psychodynamic models (e.g., psychoanalytic theory) that dominated the field of psychology in the first half of the 20th century with their focus on intra-psychic causes of behavior. Unlike psychodynamic propositions that an individual's current problems were caused by residual issues from childhood and other earlier life experiences, learning theories such as Skinner's emphasized present conditions that affect the occurrence of particular positive and negative behaviors. Equally important for clinical intervention was the idea that learned responses could be modified or eliminated through learning

procedures. Skinner's ideas about the impact of one's environment (the specific consequences received for one's responses) had a major influence on the development of behavioral therapies, including early versions of behavioral couple and family therapy. Because members of a couple or family continuously provide positive and negative consequences for each other's behavior and influence each other's actions, changing those consequences could modify members' problematic behavior.

Even though operant conditioning principles were helpful in understanding how animals and people learn a variety of responses, it became clear that they had some limitations in accounting for the rapid and varied learning that takes place in humans during childhood and beyond. Humans learn complex responses without having to wait for reinforcement of the small acts that constitute them. Social learning theorists such as Rotter (1954) and Bandura (1977; Bandura & Walters, 1963) described observational learning processes in which an individual can imitate a complex behavior demonstrated by another person, particularly if the observer sees that the model has high status or receives reinforcement for the behavior. Bandura and Walters's (1963) research showed that a child who observed an adult hitting a large toy clown was likely to imitate the behavior. Beginning early in life, a child learns many complex skills—speaking a language, playing sports, and so forth—by observing and imitating others. Social learning theorists began to focus on the interpersonal context in which behaviors are adopted and maintained, and the relevance of such learning processes for **mutual influences** between members of an intimate relationship began to be noted.

The earliest behavioral conceptualizations of couple and family relationships focused on ways in which two members of a relationship **shape** each other's behavior by providing consequences for particular responses. As two people interact, they reinforce each other for certain responses and either ignore or provide punishment for others. Over time, each person increases his or her frequency of responses that were reinforced and decreases his or her frequency of those that were ignored or punished. Goldstein (1971) and Stuart (1969) developed somewhat different treatments for marital distress, based on this concept of mutual influence. Goldstein worked with women whose husbands refused to take part in marital therapy; Goldstein instructed the wives in reinforcing their spouses for desired changes in specific behaviors without informing the husbands about this procedure. Stuart intervened jointly with both members of a couple, guiding them in devising behavioral "contracts" in which each person agreed to perform particular behaviors desired by the other person in return for receiving reinforcements from the partner. The procedures were also based on social exchange theory, developed by social psychologists (Thibaut & Kelley, 1959), in which an individual's satisfaction with a relationship is a function of the ratio of benefits to costs that he or she experiences in the relationship.

Behavioral marital therapists such as Liberman (1970), Weiss, Hops, and Patterson (1973), O'Leary and Turkewitz (1978), Jacobson and Margolin (1979),

and Stuart (1980) further developed techniques for increasing couples' mutual exchanges of positive behavior, using social learning principles to teach communication skills and set up behavioral contracts between partners. Similarly, Patterson (1971) developed behavioral interventions for families with children who exhibited aggressive and other problematic behavior, based on social learning principles such as operant conditioning. Behavioral family therapists commonly have focused on developing parents' skill at decreasing their children's problematic behaviors and increasing their desirable behaviors (Barkley & Benton, 1998; Blechman, 1985; Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Dishion & Patterson, 2005; Forgatch & Patterson, 2010; Kazdin, 2005; Webster-Stratton & Herbert, 1994). By the end of the 1970s, behavioral approaches to couple and family therapy had become established treatment modalities, with growing evidence of their efficacy.

Even though behaviorists focused on changing family members' overt acts in order to establish more satisfying relationships, they increasingly acknowledged that there is **subjectivity** in individuals' experiences of what behaviors by their family members are pleasing or displeasing. For example, marital treatments by Margolin and Weiss (1978) and Jacobson and Margolin (1979) took into account partners' attributions for each other's behavior. Thus, if an individual intends to behave positively toward a partner, but the partner makes an inference (attribution) that the individual had negative motives for the behavior, the partner will be upset by the actions, whether or not the attribution is accurate. Nevertheless, publications on behavioral marital and family therapy did not provide much information on how clinicians could assess and modify family members' negative cognitions that were contributing to relationship conflict and distress.

Beginning in the 1980s, behavioral couple and family therapists began to integrate into their model concepts and methods from the rapidly developing **cognitive therapies** of Ellis (1962), A. Beck (1976), and Meichenbaum (1977). Whereas behaviorists had largely focused on family members' overt actions, cognitive therapists emphasized how internal thought processes that can be distorted influence individuals' emotional and behavioral responses. Consideration of subjective internal experiences posed a challenge for behaviorists, who often had rejected intrapsychic explanations of behavior offered by psychodynamic theorists. However, findings from basic research on human cognition, research on the effectiveness of cognitive therapy for individual problems such as depression, and evidence that strictly behavioral interventions for couples' relationship problems had limited effectiveness all contributed to a growing acceptance of cognitive interventions among behaviorists (Baucom & Lester, 1986; Epstein & Williams, 1981; O'Leary & Turkewitz, 1978).

In turn, the tradition in cognitive therapies has been to focus on assessing and modifying individuals' cognitive distortions and other **inappropriate thought processes**. If an individual is unhappy in his or her marriage, a cognitive therapist would be most likely to help the person distinguish between

distorted and accurate views of the relationship. Cognitive restructuring procedures could be used to change distorted cognitions, but if the individual's views of the relationship are accurate, the implications for treatment are less clear. A cognitive therapist could help the individual devise alternative solutions to the problem of living in a distressing relationship, such as requesting change from one's partner or perhaps ending the relationship. However, attempting to improve the relationship by working only with one member presents significant limitations. Consequently, as cognitive therapists have increasingly considered how individuals' interactions with significant others affect their well-being, they have integrated behavioral interventions into their treatments (A. Beck, 1988; Epstein, 1982).

Thus, two converging trends led to integration of behavioral and cognitive theories and clinical techniques in the field of couple and family therapy. On the one hand, behaviorally oriented therapists have adopted concepts and methods from cognitive therapies as a means of taking into account family members' subjective responses to one another's actions. On the other hand, cognitive therapists have adopted the behaviorists' focus on interaction processes among family members, which influences each person's subjective thoughts and emotions. Resulting **cognitive-behavioral approaches** to couple and family treatment attend to both the overt interactions among family members and the internal experiences of each member.

Increasingly, cognitive-behavioral couple and family therapy models also have focused on family members' emotional responses to each other, not only as results of their cognitions and behaviors, but also as causal factors. For example, Weiss (1980) described the process of **sentiment override**, in which an individual's existing feelings about another person influence the individual's reactions to the person more than the other's current actions do. Thus, a man who left the house angry at his wife in the morning may criticize her when she attempts to express her caring for him later in the day, because his residual anger overrides any positive impact of her caring behavior. In addition, cognitive-behavioral therapists (e.g., Epstein & Baucom, 2002) have drawn on concepts from emotionally focused couple therapy (Greenberg & Goldman, 2008; Johnson, 1996) in helping couples increase awareness of their own and each other's underlying emotions that contribute to negative interaction patterns. Finally, methods from dialectical behavioral therapy (Linehan, 1993) are used to help couples regulate potentially damaging experiences and venting of negative emotions (Fruzzetti & Iverson, 2006; Kirby & Baucom, 2007).

Behavioral, cognitive, and cognitive-behavioral models of couple and family therapy have been challenged by some adherents of systems theory as being limited to linear rather than **circular concepts of causality** in family relationships. They have argued that behaviorists' learning concepts, such as operant conditioning, involve **linear causal thinking**, in that reinforcement of a person's action causes an increase in that action. Similarly, systems-oriented theorists have

argued that cognitive therapists see a linear causal relationship between a person's cognitions and his or her emotional and behavioral reactions (e.g., a parent views a child as intentionally disobeying him or her, and this inference leads to anger toward the child and a spanking). Although these critiques have been accurate to some degree, they have overlooked aspects of cognitive-behavioral theory and practice that take into account mutual, circular influences involving members of a couple or family, which are described in this chapter. For example, Bandura's (1977) social learning model takes into account how individuals who are interacting with one another mutually influence the probabilities that the other person will respond in particular ways.

During the 1970s, James Alexander and his colleagues (e.g., Barton & Alexander, 1981) developed **functional family therapy** (FFT) as an integration of systems and behavioral approaches, based on recognition that both models focus on interaction patterns among family members. Similar to other behavioral approaches, FFT identifies sequences of behavior among family members and is intended to modify problematic patterns (Alexander, Waldron, Robbins, & Neeb, 2013; Sexton & Alexander, 2003). Consistent with systems theory, it is based on a premise that understanding an individual's behavior requires identifying its interpersonal context—how the person influences and is influenced by his or her family members. Functional family therapists tend to differ from other behaviorists by assuming that a person's behavior is intentionally designed to produce particular consequences (e.g., aversive behavior that leads others to back off), even if the person is not fully aware of the intent. That premise has been debated but challenged behaviorists to identify why family members continue to engage in negative actions that seem to be at odds with their positive goals for their relationships. Over the years, FFT has become even more integrative, addressing cognitive, affective, and environmental factors that place adolescents and their family members at risk for negative interactions. FFT has strong empirical support, and it has contributed to the development of cognitive-behavioral approaches that take into account interpersonal processes and circular causality in family relationships.

This chapter describes the current state of cognitive-behavioral therapy with couples and families. Following a summary of the model's major concepts and identification of major proponents of the approach, normal and dysfunctional family processes are described. Ways of assessing and treating couple and family problems from a cognitive-behavioral perspective are described, with illustrative case examples, and the current status of research on the efficacy of these methods is summarized.

Theoretical Concepts

As described in the beginning of this chapter, cognitive-behavioral approaches to couple and family therapy focus on the behavioral interactions and family members' subjective thoughts and emotional responses that contribute to relationship

problems. The following sections describe the major behavioral, cognitive, and emotional aspects of family interactions that are relevant in a cognitive-behavioral approach to understanding and treating relationship problems.

Behavioral Factors in Couple and Family Relationships

Based on social learning principles (Bandura, 1977), it is assumed that when two adults form a relationship they each bring a personal learning history that affects how they relate to the other. In past relationships, especially family of origin, each person learned skills and styles of communicating and relating to significant others—by observing parents, siblings, and so forth and through being reinforced for certain actions and punished for others. These learned ways of interacting with others may differ across cultures. In addition, parents implicitly model and explicitly teach their children skills for solving both small and large life problems. Some parents model effective problem-solving skills, whereas others model ineffective and even destructive approaches. For example, a child may observe a parent responding to conflict with extended family members and friends by behaving aggressively, or by cutting off contact with the other people. This **observational learning** may result in the child lacking constructive skills for dealing with conflict in relationships in his or her own life. In a cognitive-behavioral framework, it is assumed that individuals develop both positive and negative behavioral responses through the same learning processes and that learning procedures can be used to modify problematic responses.

Problematic Couple and Parent-Child Interaction Patterns

Given the behavioral tendencies that they bring to their relationship, members of a couple develop patterns for interacting with each other, based on how they react to each other over time. These patterns can vary considerably in their effectiveness in meeting the partners' needs. For example, if a couple develop a pattern of mutually avoiding expression of areas of dissatisfaction, it likely will result in chronic unresolved issues. Cognitive-behavioral couple therapists (e.g., Baucom & Epstein, 1990; Epstein & Baucom, 2002; Jacobson & Christensen, 1996; Rathus & Sanderson, 1999) have noted that at least some conflict is inevitable in an intimate relationship, due to differences in partners' needs, personalities, temperaments, and so forth. One of the risk factors for relationship distress is poor skill at identifying and implementing effective solutions to problems (Gottman, 1994; Weiss & Heyman, 1990). Gottman's research has indicated that distressed couples tend to respond to conflicts with negative behaviors such as criticism, defensiveness, contempt, and stonewalling (withdrawal), which are strong predictors of dissolution of the relationship.

Couples who engage in high rates of negative behavior toward each other tend to lack adequate skills for communicating their needs and solving relationship

problems in a cooperative way. In one common pattern, partners develop an almost "automatic" response pattern in which a perceived negative behavior by one person results in **negative reciprocity** from the other person. In negative reciprocity, a person who receives a negative from a partner reciprocates with a negative action toward the partner. Sometimes the reciprocation is immediate, as an argument between partners escalates with mutual insults, but at other times an individual waits until a later time to "get even." Distressed couples are more likely than satisfied ones to engage in negative reciprocity (Baucom & Epstein, 1990; Weiss & Heyman, 1990). A second common problematic pattern involves one person pursuing the other, while the other person withdraws (Christensen, 1988). This **demand/withdraw** pattern typically becomes a repetitive cycle. Although family therapists can see the circular process in mutual attack and demand/withdraw patterns, the members of such couples typically perceive linear causality in their interactions, with the other person being at fault. For example, an individual who keeps pursuing a partner says, "I pursue only because my partner withdraws," but the other person's view is "I withdraw because my partner keeps pursuing me." The cognitive-behavioral therapist's job is to help the couple understand the circular nature of their pattern and motivate each person to modify his or her contribution to it.

Parents' marital conflict has been found to be associated with a variety of child problems, including **conduct disorders** and **depression** (e.g., Kaczynski, Lindahl, Malik, & Laurenceau, 2006; Zimet & Jacob, 2001). Research suggests that a major way in which a couple's conflict influences their children is through its effect on their own parenting behavior. Thus, a parent who is upset and distracted by couple relationship problems is less likely to guide and discipline a child in a patient, consistent, and constructive manner, as well as less likely to provide warm emotional support to the child. Furthermore, a couple may express conflict in the area of parenting by openly counteracting each other's attempts to discipline a child and by trying to form an alliance with the child against the other parent. Therefore, when presented with a family with child emotional and behavioral problems, a cognitive-behavioral therapist may intervene in parental conflict to the extent that the couple is open to doing so, but the primary interventions will likely focus on ways that the two parents interact with the child.

Research also indicates that problem-solving skill deficits and negative interaction patterns commonly exist in distressed parent-adolescent relationships (Robin & Foster, 1989). Patterson (1982) described how aggressive children commonly grow up in **coercive family systems**, in which their parents use criticism, threats, and forms of punishment to try to control the children's behavior, and in turn the children use aversive behavior to influence the parents. Thus, the parents and children engage in a pattern of negative reciprocity, in which they exchange negative acts in a retaliatory manner.

If a child receives little attention or other reinforcement for positive behavior, but receives attention from parents for negative actions, such as verbal and physical

aggression, it is likely that the attention will reinforce and thus strengthen the negative behavior. Based on operant conditioning principles, the reinforcement of negative behavior is likely to produce a stronger effect if the parents provide it to the child inconsistently. Research by learning theorists such as Skinner indicated that an individual who receives **intermittent reinforcement**—the reinforcement occurs occasionally or unpredictably rather than every time—will repeat the actions that produced the reinforcement even when there is no reinforcement for a long time. The individual has learned that sooner or later reinforcement is likely to occur, so he or she should keep trying to elicit it. The power of intermittent reinforcement is demonstrated by the persistence of individuals who gamble by playing slot machines.

Furthermore, parents can unwittingly teach a child to use verbal and physical aggression through modeling, if they use those types of behavior in disciplining the child. Although a parent may be tempted to vent frustration toward a child by using aversive words and actions, particularly if the parent lacks more effective parenting skills, that approach tends to backfire by contributing to more coercive exchanges between the child and the parents. One of the tasks facing a cognitive-behavioral family therapist is changing some parents' beliefs that verbal and physical aggression are useful in developing more positive behavior in their children.

Time-out procedures are an alternative form of consequences that cognitive-behavioral therapists advocate for negative child behavior, at least for younger children. Time-out involves removing the child physically from all available sources of reinforcement, such as having him or her sit in a chair in a corner—away from TV, games, siblings, and even the attention of parents. Its power is based on the child's tendency to seek reinforcement and the unpleasant experience of being deprived of it. Sometimes parents report that they are familiar with and use time-out procedures to punish a child, but the therapist discovers that they use the procedure inconsistently. Some parents send the child to a location where there is plenty of enjoyable activity to be found, such as the child's room, whereas other parents may effectively cut off the child from reinforcement occasionally but fail to do so consistently (perhaps yelling at the child instead).

Effective parenting also includes reinforcement of positive behavior (Forgatch & Patterson, 2010; Kazdin, 2005). Often a parent is so focused on a child's negative behavior that he or she either fails to notice instances in which the child behaves well or fails to provide reinforcement such as praise for those acts. Ignoring positive behavior follows the operant learning principle of **extinction**, in which an act that has no positive consequences will decrease. If parents want children to behave less negatively, they need to use a combination of techniques for decreasing negative acts and techniques for increasing positive acts.

As previously noted, providing reinforcement for a child's positive behavior requires that the parent notice those actions. Jacobson and Margolin (1979) labeled

the tendency to notice another's negative behavior and overlook positive behaviors as **negative tracking**. This biased perception is one form of cognition described in the next section. Once a parent notices a child's positive behavior, the parent faces a decision about how he or she should respond. Parents who believe that children should behave well "just because it is the right thing to do" and view reinforcement as "bribes" are unlikely to use praise and other rewards. These beliefs are **assumptions** and **standards**, two other forms of cognition that influence family relationships and are described in the next section. A third factor in parents' failure to reinforce positive acts is **deficits in communication skills**. Some parents are unfamiliar with ways to phrase positive feedback messages to their children. Rather than giving a vague, general message such as "You had a better day yesterday," the parent may need to learn how to give the child specific behavioral feedback, such as "I was very happy to see you putting your dirty clothes in the hamper and cleaning up the dinner table." Parent training interventions (e.g., Forgatch & Patterson, 2010; Kazdin, 2005) help develop knowledge and confidence to provide clear constructive feedback and instructions to children.

Inconsistency in parenting behavior may be due to various factors. Some involve deficits in parents' behavioral skills, and others involve ways that they think about their parenting roles. Some parents are ambivalent about setting firm limits on children's behavior, because they equate strictness with harshness. In some cases, a parent has bought into a child's complaint that the parent is unloving or unfair in setting limits. Parents who have experienced separation or divorce or who work long hours and have limited time to spend with their children may feel guilty that their children have experienced these family situations. Still others feel overwhelmed by stresses in their lives, such as trying to balance work and family roles, and do not believe that they can tolerate the effort involved in consistent parenting. These factors involve the parents' **cognitions** about parenting, and in cognitive-behavioral family therapy the clinician helps each parent identify and modify thoughts that interfere with constructive interactions with the children. A more detailed description of cognitive factors follows.

Cognitive Factors in Couple and Family Relationships

Cognitive therapies are based on the premise that a person's emotional and behavioral responses to life events depend on the person's thoughts about those events. Virtually the same event might happen to two people, but the two individuals might react differently because they interpret the event differently.

> Bonnie and Fred were eating breakfast together and talking about ideas for a family summer vacation when their 16-year-old son Mike walked into the kitchen. When Bonnie told Mike that they were thinking about the whole family spending 10 days at a beach resort, Mike responded, "I don't want to go to any resort. I want to stay home and spend time with

> my friends." Bonnie's immediate reaction was strong sadness, and she sat quietly, but Fred became quite angry and yelled at Mike, telling him he was "ungrateful for the nice things we do for you." When Bonnie and Fred discussed the incident later, Bonnie described how Mike's comment made her feel sad because it made her think that their days as a whole family were ending, as their son was moving toward independence. In contrast, Fred noted that his anger had been associated with thoughts that Mike should be grateful that his parents were willing to spend a lot of money to take him to a special place, and that Mike's comment was disrespectful. Thus, each parent interpreted Mike's behavior somewhat differently, and their subjective interpretations led to different emotions and behaviors.

Aaron Beck's cognitive therapy (A. Beck, 1976; A. Beck, Rush, Shaw, & Emery, 1979; J. Beck, 2011; Leahy, 1996) focuses on helping individuals learn to identify aspects of their thinking that contribute to negative emotions and behavior, test the validity of their thoughts, and replace distorted cognitions with more realistic ones. In Beck's model, two major types of cognitions influence individuals' responses to events in their lives: automatic thoughts and schemas.

Automatic Thoughts

Automatic thoughts are stream-of-consciousness thoughts that spontaneously run through one's mind and seem plausible at the time, even if they are distorted. People typically do not stop to question their automatic thoughts, so the thoughts can control their moods and behavior. Aaron Beck (1976) originally developed cognitive therapy based on his observation that depressed individuals had frequent overly negative thoughts about themselves, the world, and their futures. These negative thoughts are shaped by **cognitive distortions**, or errors in processing information. For example, **overgeneralization** is a cognitive distortion in which the individual observes one instance of an event and views it as representing a general characteristic. For example, when five-year-old Amanda disobeyed Tim's instruction to put her toys away, he thought, "She *never* listens to what I tell her to do," and this thought made him angry. Later, Tim was able to take a broader perspective and acknowledged that sometimes Amanda is obedient. Some other types of cognitive distortions include **personalization** (assuming that events involve you when in fact they do not), **mind reading** (making unwarranted inferences about others' thoughts and emotions), **dichotomous thinking** (placing experiences into distinct, opposite categories, such as "good child" versus "bad child"), **selective abstraction** (biased perceptions such as negative tracking), **magnification** (viewing something as more important than it is, such as seeing a minor mistake as a catastrophe), and **minimization** (viewing something as less important than it is, such as seeing one's own or another's improved behavior

as "no big deal"). Cognitive therapists help clients become aware of upsetting distortions in their thinking and teach them ways to challenge negative automatic thoughts (A. Beck et al., 1979; J. Beck, 2011).

Theorists and researchers who have studied forms of cognition affecting couple and family relationships (see reviews by Baucom & Epstein, 1990; Baucom, Epstein, Sayers, & Sher, 1989; Epstein & Baucom, 1993, 2002; Fincham, Bradbury, & Scott, 1990) have identified three types of cognition that can involve the information-processing errors involved in cognitive distortions. **Selective perception** is equivalent to the distortion of selective abstraction, in which an individual notices only some aspects of his or her interactions with a family member. Tim's selective perception of his daughter Amanda's disobedience contributed to his anger. Research has indicated that couples, especially those in distressed relationships, commonly disagree on what events occurred in their interactions within the last 24 hours (Christensen, Sullaway, & King, 1983; Jacobson & Moore, 1981).

Attributions are inferences that individuals make about causes of events they observe, and these inferences may be accurate or distorted. Some attributions concern the characteristics of a cause—that is, whether it is global versus specific, stable versus unstable, and internal to a person or relationship versus external.

> When Denise told Sam that she lost her job, he said little to her. Her attribution that his failure to express support for her was due to "his self-centered personality" was global, stable, and internal to Sam. It was global because she viewed his lack of support as due to a broad personality characteristic that is likely to influence many areas of Sam's functioning in relating to Denise and others. It was stable because it involved a personality characteristic that is likely to be present over a long period of time. Finally, as part of Sam's personality it was an internal characteristic rather than an outside cause. In contrast, Denise might have attributed Sam's behavior to his being distracted by a stressful project at his job. Such a cause is more external to Sam, is unstable to the extent that stresses at his job tend to be temporary, and is specific to the extent that it adversely affects his ability to listen to Denise when they are discussing their jobs.

Research has generally found that distressed couples are more likely than satisfied couples to attribute each other's negative behaviors to global, stable characteristics of the partner (Baucom & Epstein, 1990; Bradbury & Fincham, 1990). These attributions concerning negative traits in the partner are associated with individuals' future distress and negative communication with their partners (Bradbury & Fincham, 1992; Durtschi, Fincham, Cui, Lorenz, & Conger, 2011; Fincham & Bradbury, 1987; Fincham, Harold, & Gano-Phillips, 2000). Barton and Alexander (1981) note that when family members attribute relationship problems to others' negative traits, it reduces the chance that they will work

toward improving the ways they interact with each other. Blaming problems on another person typically leads to waiting for the other person to change and failing to recognize ways in which one can contribute to change oneself. Also, viewing problems as being caused by global, stable traits can result in the individual feeling hopeless about change.

Other attributions affect relationships because of their particular content. For example, Pretzer, Epstein, and Fleming (1991) found that individuals who attributed their couple relationship problems to a lack of love or malicious intent by their partners were more dissatisfied in their relationships. Similarly, Morton, Twentyman, and Azar's (1988) clinical observations of child-abusing parents indicated that these parents commonly believe that their children's misbehavior is caused by intentional efforts to be annoying and spiteful.

Expectancies are the third type of cognition that potentially involves distorted processing of information. An expectancy is a prediction that an individual makes about the probability that particular events will occur in the near or distant future in particular situations.

> Dave tells his son Robby that he cannot play outside before dinner, because he has an expectancy that Robby will run off with his friends. As with other types of inferences, expectancies can vary in their accuracy, and to some degree a person's expectancies about family members are shaped by past experiences with those individuals. Dave's expectancy may be due to past episodes of Robby disappearing with friends at mealtimes. However, perhaps Robby has never done that, and Dave's expectancy is based on his general belief that "young boys are impulsive and mostly pay attention to having fun with their friends."

Research studies have indicated that couples' negative expectancies about their abilities to solve relationship problems are associated with higher levels of relationship distress (Pretzer et al., 1991; Vanzetti, Notarius, & NeeSmith, 1992). Cognitive-behavioral therapists help family members identify their expectancies and test their validity.

Schemas

Whereas cognitive distortions shape the *form* of a person's thoughts, cognitive-behavioral therapists examine how the *content* of the thoughts is based on **schemas**, long-standing beliefs or "knowledge structures" that the individual has about characteristics of people, objects, relationships, and so forth. In contrast to selective perceptions, attributions, and expectancies, which tend to focus on events occurring at a particular moment or in a particular situation, schemas are relatively stable ways in which a person understands his or her world. They include basic beliefs about how human beings function and how they relate to one

another. It is thought that many of these schemas begin to develop during childhood, based on experiences that an individual has with people and other aspects of the world. Later life experiences can alter an existing schema, but research indicates that strongly established beliefs can be highly resistant to change (Fiske & Taylor, 1991). Examples of schemas relevant to couple and family relationships are beliefs about **gender roles** and characteristics of females and males, beliefs about how love "feels," beliefs about appropriate behavior of individuals in particular family roles such as "child," and beliefs about the characteristics of a "good marriage" (Dattilio, 2010; Epstein & Baucom, 2002). Two major categories of schemas that affect couple and family relationships are assumptions and standards (Baucom & Epstein, 1990; Baucom et al., 1989; Epstein & Baucom, 1993).

Assumptions are beliefs that an individual has about typical characteristics of people and objects. Assumptions are concepts about how aspects of the world are and how they work. As a child observes people over a period of time, he or she develops concepts about human thoughts, emotions, and behavior. Those concepts vary from one person to another, depending on the particular people the individual observed, the cultural patterns to which he or she has been exposed, and the idiosyncratic inferences that he or she made about what was observed. A child who is raised in a home in which parents and older siblings frequently vent anger through sudden verbal and physical outbursts may develop a basic assumption that the expression of strong emotions is automatic and uncontrollable. Such an assumption may affect the way the child deals with his or her own emotions in relationships with others, during childhood and adulthood. Eidelson and Epstein identified some assumptions associated with marital distress, including the beliefs that (1) disagreement between partners is destructive to their relationship, (2) problems in male-female relationships are due to innate differences between the sexes, and (3) once patterns have developed in a relationship, the partners cannot change them (Eidelson & Epstein, 1982; Epstein & Eidelson, 1981).

Standards are beliefs about ways that people, relationships, and events "should" be. Similar to assumptions, it is likely that individuals develop standards for themselves and relationships on the basis of life experiences and context. Those experiences can involve family-of-origin relationships, observation of other people's characteristics and relationships, mass media (e.g., the Internet, television, movies, books, popular songs), peer relationships, teachers, clergy, and more. Standards are largely influenced by the norms established by ethnic, socioeconomic, religious, and sociopolitical contexts, although members of each cultural context typically are not aware of how the norms that seem so "natural" to them differ from those held by members of different cultures.

Holding standards is not inherently problematic; in fact, people typically have standards that comprise their personal moral codes (e.g., "Parents should nurture their children and avoid abusing them"). However, standards can vary in how

realistically they represent the possibilities of real life, and unrealistic beliefs may lead to frustration and disappointment. For example, Eidelson and Epstein (1982) found that the more individuals adhered to the standards that (1) partners should be able to read each other's thoughts and emotions and (2) partners' sexual relationships should be perfect (trouble free and highly satisfying), the more they were unhappy in their relationships. The concept of extreme or **unrealistic beliefs** is similar to the **irrational beliefs** that are a focus of **rational-emotive therapy** (Ellis, 1962; Ellis, Sichel, Yeager, DiMattia, & DiGiuseppe, 1989), which was renamed "rational-emotive behavior therapy" due to its increased focus on clients' behaviors. Ellis and his colleagues emphasized that when an individual holds unrealistic beliefs about people and life experiences, he or she is likely to be upset and to behave negatively when the realities of daily life fall short of those standards.

Standards also might be problematic either when two partners' standards are in conflict or when a person's standards are realistic but are not being met to his or her satisfaction in the couple's relationship. Baucom, Epstein, Rankin, and Burnett (1996) developed a questionnaire to assess individuals' standards for couple relationships, focusing on standards about **boundaries** (how much autonomy versus togetherness partners should have), the degree of **investment** of time and energy that partners should make for their relationship, and how **power/control** should be distributed and used in the couple's relationship. Their Inventory of Specific Relationship Standards (ISRS) assesses these three types of standards concerning 12 different areas of one's relationship, such as affection, sex, household tasks, finances, and the expression of positive and negative feelings. Differences in standards for boundaries, investment, and power/control issues in each of those 12 areas may be particularly challenging for intercultural couples in which partners come from cultures that hold opposite standards in many of those areas. For example, Epstein, Chen, and Beyder-Kamjou (2005) found differences in relationship standards between U.S. couples and mainland Chinese couples, such as that Chinese couples considered it more acceptable to exercise power in their relationships. Chinese couples also tended to be less overtly expressive of affection verbally and nonverbally than U.S. couples. Increasingly, couple and family therapists are describing ways in which Western-derived therapy models that are based on particular assumptions and standards regarding appropriate relationship qualities must be applied in culturally sensitive ways that take different beliefs and traditions into account (Epstein et al., 2012).

Thus, a cognitive-behavioral model of couple and family functioning takes into account a number of types of cognitions that individuals have about themselves and their close relationships. The types of behavior patterns described in the previous section are influenced by the ways that family members interpret one another's actions. For example, in negative reciprocity, two family members are more likely to reciprocate each other's negative acts if they selectively notice

the negatives and overlook the positives, or if they attribute the negative behavior to causes such as the other person having malicious intent. Similarly, an individual may withdraw from a family member if he or she has an expectancy that any attempt to communicate with this person will be ineffective. Concerning schemas, a parent may fail to use positive reinforcement for a child's good behavior if the parent holds a standard that children should naturally behave well because "they know it's the right thing to do" and holds an assumption that rewarding children "only spoils them." The parent's beliefs result in dissatisfaction with the child's behavior and influence how the parent responds to the child's failure to live up to what the parent expects. Consequently, understanding and treating problems in couple and family relationships necessitates paying attention to both the ways that family members interact and the family members' cognitions that influence those interactions.

These emphases on behavior and cognition in the literature on cognitive-behavioral therapies sometimes create an impression that family members' emotions are neglected in these approaches. In fact, family members' emotional responses are central aspects of their satisfaction or distress in their relationships and are of major concern to cognitive-behavioral therapists. The next section describes emotional factors in couple and family relationships.

Emotional Factors in Couple and Family Relationships

Much of the literature on cognitive therapy has focused on thought processes as causes for depression, anxiety, anger, and other emotions (e.g., A. Beck, 1988; A. Beck et al., 1979; A. Beck & Emery, 1985; Dattilio & Padesky, 1990; Deffenbacher, 1996; Ellis et al., 1989) when the individual responds to life events. Similarly, behavioral couple and family therapists have emphasized how exchanges of positive and negative behavior between two people in a relationship affect satisfaction with the relationship. Thus, it is easy to get the impression that cognitive-behavioral models take a linear causal view, in which emotions are results, but not causes, of family members' cognitions and behaviors. However, considerable clinical and research evidence suggests that people's emotions about their relationships influence their thoughts and behavior as well. Weiss (1980) described a process of sentiment override, in which a person's overall feelings about a spouse determine the person's cognitions and behavior toward the spouse more than the spouse's current behavior does.

> Ken had built up strong resentment toward Sarah based on a number of incidents over the past two years in which she made personal choices that seemed selfish to him. Sarah was aware of Ken's upset about those events, and she was committed to improving their relationship. She had begun to make special efforts to ask Ken about his preferences about decisions she was considering. However, each time Sarah asked to talk to Ken about

such a decision, even when she began the discussion by emphasizing that she wanted to consider his input, Ken quickly reacted with anger and criticized her for being selfish. His strong emotion interfered with his ability to listen to her and led to his negative behavior toward her.

Similarly, Nikki had become depressed about her relationship with James, because their work shifts and child-rearing activities left them very little time as a couple. Unfortunately, whenever they did have an opportunity to do something together, her depressed mood made it difficult for her to enjoy herself. James would notice her lack of enthusiasm and comment on it. Nikki would react defensively, and they would have an argument.

Cognitive therapists also have noted how an individual's emotional states can influence his or her perceptions and behavior. They have described how an individual may engage in **emotional reasoning**, relying on cues of his or her emotions as signs of some "truth." For example, depressed individuals commonly experience symptoms of low energy, inertia, and low motivation to engage in basic daily activities such as getting out of bed and getting dressed. If a person concludes, "I don't feel that I can do anything," it is likely that he or she will become inactive, which tends to worsen the depression. A cognitive therapist would help this person understand that it is important not to trust the physical and emotional cues, and that it is possible to engage in activities even when one feels that way. Similarly, people who experience panic attacks often interpret the symptoms (e.g., rapid heart rate, sweating, shortness of breath) as signs of a serious physical problem such as a heart attack or signs of "going crazy." Cognitive-behavioral treatment of panic disorder includes teaching the individual that those symptoms are uncomfortable but not dangerous (Barlow, 2002).

Difficulty regulating one's anger commonly contributes to verbally and physically aggressive behavior toward others, so interventions to improve anger management are a key component of cognitive-behavioral couple therapy (CBCT) treatments for intimate partner violence (Heyman & Neidig, 1997; LaTaillade, Epstein, & Werlinich, 2006). In order to reduce intense anger that fuels aggression, therapists teach couples a variety of strategies, such as self-soothing methods (e.g., muscle relaxation, going for a walk, taking a warm shower), nonaggressive self-talk (e.g., "Even if he's trying to provoke me, I can stay calm"), and effective use of "time-outs" in which partners agree to physically distance themselves from each other temporarily in order to calm down. Similar techniques are taught to parents who have difficulty regulating anger toward their children (Nicholson, Anderson, Fox, & Brenner, 2002; Sanders, Cann, & Markie-Dadds, 2003).

Thus, emotion has a crucial role in cognitive-behavioral approaches to couple and family relationships, and therapists typically gather a lot of information about the emotions that each family member experiences during their interactions. It

is important to differentiate various types of emotions, rather than asking family members how happy versus unhappy they are. Individuals' negative emotions regarding their relationships can include anger, sadness, depression, and anxiety, and each type of emotion may require a different form of intervention. For example, an individual's anxiety may be associated with negative expectancies that communicating directly with his or her partner will lead to criticism by the partner and tension between them. The individual may find anxiety symptoms so unpleasant that he or she generally avoids expressing important thoughts and emotions to the partner. Intervention is likely to include exploration of how valid the negative expectancies are. To the extent that communicating with the partner appears to be tension-provoking but otherwise safe, and direct communication would help meet the person's needs in the relationship, therapy may focus on reducing the person's avoidant behavior.

In contrast, another individual may primarily experience anger, associated with sentiment override from past unpleasant experiences with the partner. Rather than avoiding the partner, this person quickly becomes upset whenever the partner discusses their relationship, and the anger leads him or her to attack the partner verbally. In this case, therapy is likely to focus on moderating the individual's strong, global anger response and helping him or her practice listening to the partner. The past events that contributed to the pervasive anger also would be explored, with a goal of seeing whether those conditions have changed or could be changed.

Proponents of the Model

As described previously, current forms of cognitive-behavioral therapy (CBT) for couples and families represent an integration of behavior therapy and cognitive therapy traditions, along with systems theory concepts. The model has grown rapidly over the past two decades, and the number of its proponents has increased markedly. Many proponents (e.g., Donald Baucom, Steven Beach, Gary Birchler, Guy Bodenmann, Thomas Bradbury, Andrew Christensen, Frank Fincham, Alan Fruzzetti, John Gottman, Kurt Hahlweg, Amy Holtzworth-Munroe, Neil Jacobson, Howard Markman, Michael Metz, Clifford Notarius, Timothy O'Farrell, K. Daniel O'Leary, Jill Rathus, Galena Rhoades, Ronald Rogge, Lorelei Simpson Rowe, William Sanderson, Keith Sanford, Steven Sayers, Tamara Sher, Scott Stanley, Gregory Stuart, Richard Stuart, Kieran Sullivan, Robert Weiss, Mark Whisman) have focused predominantly on couples, whereas others (e.g., James Alexander, Iliana Arias, Ian Falloon, Frank Floyd, Rex Forehand, Marion Forgatch, Sharon Foster, Alan Kazdin, Kristin Lindahl, David Miklowitz, Kim Mueser, Susan O'Leary, Gerald Patterson, Arthur Robin, Matthew Sanders, Stephen Schlesinger, Andrew Schwebel) have focused more on families, although a number of individuals (e.g., Frank Dattilio, Norman Epstein, Gayla Margolin) have addressed both couple and family relationships extensively, and proponents vary in the relative degrees

to which they attend to behavioral, cognitive, and emotional factors in the overall CBT model. Sometimes authors' publications describe cognitive interventions as **adjunctive interventions** to their primary focus on behavioral interactions. For example, if the members of a couple are resistant to practicing constructive communication skills because they attribute each other's past negative communication to a lack of caring about their relationship, the therapist might shift from the behavioral intervention to challenging the negative attributions. At other times, therapists whose background was primarily behavioral have shifted toward giving cognition and emotions relatively equal weight as behavior in their approaches. On the other hand, therapists whose background focused on cognitive processes have embraced concepts and clinical methods involving behavioral interactions and systems theory. Sometimes they use behavioral interventions primarily as a means of producing cognitive changes, such as when training in constructive communication is used to modify partners' lack of hope that their relationship can improve or to increase their ability to give each other feedback that can challenge other negative cognitions about each other.

As behavior and cognition have been integrated in cognitive-behavioral clinical training programs, more therapists are entering their clinical careers with a view that treatment of relationship problems necessarily involves attention to complex relations between behavior and cognition, as well as family members' emotional responses. As noted earlier, the increased attention to emotions has been stimulated by cognitive-behavioral therapists who have focused on emotion regulation problems (e.g., Fruzzetti & Iverson, 2006; Kirby & Baucom, 2007; Linehan, 1993), as well as by the empirically supported emotion-focused approaches (Greenberg & Goldman, 2008; Johnson, 1996). Publications by Alexander et al. (2013); Baucom and Epstein (1990); Dattilio (1998a, 1998b, 2010); Epstein and Baucom (2002), Epstein, Schlesinger, and Dryden (1988); Rathus and Sanderson (1999); Robin and Foster (1989); and Schwebel and Fine (1994) reflect the trend toward integrative cognitive-behavioral approaches to couple and family therapy. Throughout this chapter we have cited the work of many cognitive-behavioral couple and family therapists as we have described the history of CBT approaches, their increasing sophistication, and their applications with special populations and presenting problems (e.g., depression, child behavior problems, substance abuse, major mental disorders, family violence).

Normal Family Development

Within a cognitive-behavioral model, normal couple and family development depends on the fulfillment of each member's personal needs, as well as core functions of the relationship. Among the major needs of individual members are those involving connection with significant others (e.g., intimacy, nurturance, altruism) and those involving individual functioning (e.g., autonomy, achievement, power) (see Prager, 1995, for an excellent discussion of these **communal needs**

and **agentic or individual-oriented needs**, respectively). Major relationship functions include those that provide for the physical and economic security of the couple or family, as well as those that allow the family to interact successfully with aspects of the outside world, such as schools. Needs and relationship functions are likely to be fulfilled to the extent to which the members of a couple or family

(1) are aware of those needs and types of actions involved in meeting them,
(2) communicate in clear, constructive ways that facilitate those actions,
(3) engage in effective problem solving when their current interactions are inadequate for meeting their needs, and
(4) have cognitions that facilitate all of these processes.

In normal family development, the members are relatively free of distortions in their appraisals of the events that occur in their relationship, have realistic standards for the ways in which they interact, approach each other in a spirit of collaboration and mutual support (rather than as adversaries), and have good skill at communicating and working together to resolve problems.

Communal and individual-oriented needs may vary depending on socioeconomic circumstances, cultural background, age, and so forth. Sometimes those needs conflict with each other, either within an individual or between family members (Baucom & Epstein, 1999; Epstein & Baucom, 2002). For example, Janice, a Caucasian middle-class female, valued close relationships with her husband and children but also was highly motivated to achieve in her career. Although those needs were not incompatible in principle, Janice experienced internal conflict and stress when time demands of family and career pulled her in different directions. In addition, her husband, Pablo, who came from a low-income Latino family, experienced internal conflict about her working. He valued Janice's financial contributions to their family, but due to his more traditional view of gender roles that emphasized the male role of breadwinner, he felt uncomfortable with her time investment outside of the home and periodically pressed her to decrease her work hours. This led to conflict between the two.

Similarly, adolescents commonly experience a need for increasing autonomy from their parents, which often is expressed through preferences to make their own decisions, as well as desires to spend time with friends rather than with family. This can create some parent-adolescent conflict, because the parents may be unprepared for the change in the relationship. The adolescent may experience inner conflict between the emotional attachment that he or she still has to the parents and his or her need for autonomy. However, the adolescent may express the desire for autonomy more, leading the parents to infer that their child no longer cares about them. Such intrapersonal and interpersonal conflicts over normal human needs commonly pose challenges for couples and families.

In normal family development, the individuals realistically understand their own needs and those of their family members, and they have flexible ways of thinking about and relating to one another in order to solve problems. Their cognitive flexibility and rationality allow them to engage in creative problem solving. Thus, the parents of an adolescent who has become argumentative and less interested in family activities may be able to interpret (i.e., make attributions about) the child's behavior in nonthreatening ways and experiment with new ways of letting him or her balance increased autonomy and family connectedness. Consistent with **social exchange theory** (Thibaut & Kelley, 1959), if a relationship becomes less satisfying over time because the ratio of positives to negatives exchanged has decreased, normal family development involves identifying the shift and interpreting it in a benign way rather than as a sign that the relationship is ruined. Family members' ability to communicate clearly and collaborate in problem solving allows them to increase positive behaviors and decrease negative behaviors, restoring a more satisfying balance.

Pathology and Behavior Disorders

In contrast to normal couple and family development, dysfunction develops when the behaviors that meet the members' needs and fulfill the relationship's basic functions decrease, become less effective, or are outweighed by behaviors that interfere with fulfillment of needs. In a cognitive-behavioral model, these changes may be influenced by the family members' cognitions as well as the specific behaviors that occur. For example, a husband may exhibit fewer affectionate and caring actions toward his wife because he has become busier and distracted by his job. However, the husband may be behaving similarly as in the past, but his wife's response to his behavior may have changed, in that she now finds his "predictable" behaviors less meaningful than she did years ago. Consistent with family systems concepts, dysfunction occurs when patterns in a relationship fail to help the members adapt to changing life circumstances (Carter & McGoldrick, 1999). Thus, if parents have rigid standards about how an adolescent should relate to the family, attribute the adolescent's autonomous behavior to disrespect toward them, experience strong negative emotions (anxiety, anger), and respond in an authoritarian manner to the adolescent's violations of their rules, parent-adolescent conflict is likely to escalate. Research on distressed couples and families has indicated high levels of unrealistic assumptions and standards, negative attributions regarding one another's motives, and **aversive control** strategies such as threats and punishment. As members of a relationship rely on aversive control to try to change each other's behavior (and often each other's "bad attitude"), that approach typically backfires, contributing to escalation of negative behavior exchanges or a demand/withdraw pattern. Gottman's (1994, 1999) research identified behavior sequences or **cascades**, in which attacking, defensive, and

withdrawing behaviors increase partners' distress and increase the probability that they will end their relationship.

A combination of negative cognitions, emotions, and behaviors in a relationship results in either a relatively chronic level of dissatisfaction or a deterioration over time. Even when an individual attempts to behave positively toward his or her family members, they are unlikely to notice or appreciate it, due to their overall negative sentiment toward him or her. Thus, each individual's negative behavior tends to be reinforced in the family interactional system, and his or her positive behaviors are ignored or even punished. In the absence of good communication skills, as well as problem-solving skills and emotion regulation skills, the family is unable to disengage itself from these destructive patterns.

When a member of a family experiences personal difficulties such as psychopathology symptoms, those symptoms can place stress on family relationships and, in return, family stress and conflict can exacerbate an individual's personal adjustment problems (Halford & Bouma, 1997; Miklowitz, 1995; Monson & Fredman, 2012; Mueser & Gingrich, 2006; Whisman & Beach, 2012). This bidirectional causality necessitates that therapists assess the degree to which an individual's development of psychological disorders affects the development of relationship problems, and vice versa. A cognitive-behavioral model focuses on both processes, and decisions about combining individual therapy with couple or family therapy depend on the evidence concerning the causal processes in a particular family.

Techniques

Cognitive-behavioral techniques for couple and family therapy tend to emphasize **cognitive restructuring**, modification of problematic emotional responses, and changes in behavior. Cognitive restructuring techniques are designed to help family members increase their awareness of their cognitions that are contributing to distress and conflict and to test their validity or appropriateness (Dattilio, 2010; Epstein & Baucom, 2002). Behavior change techniques focus on increasing family members' positive actions toward one another, decreasing negative actions, and developing their skill at effective communication and problem solving. Interventions for emotion include techniques for improving family members' awareness of their emotions, their skill at expressing their emotions in clear and constructive ways, and their ability to regulate their emotional responses (Epstein & Baucom, 2002; Fruzzetti & Iverson, 2006). **Emotional regulation** involves an individual's ability to control the strength of his or her emotions—for example, using **relaxation techniques** so that the person feels moderate anger rather than rage. In clinical practice, interventions for cognitions, behaviors, and emotions commonly are combined during treatment sessions, as well as for homework assignments between sessions, but for clarity they are described separately in the following sections.

It is important to note that cognitive-behavioral therapists are not restricted to any particular interventions and can use any approach that is designed to modify problematic family interactions, is objectively measurable, and has been subjected to empirical evaluation of its effectiveness (Wetchler & Piercy, 1996). The therapist's role is one of teacher/consultant, in which he or she provides didactic information, instructions, modeling of constructive responses, and coaching as family members try new skills and responses with one another. Treatment is designed to teach families skills that they can use long after therapy has ended.

Cognitive Assessment and Interventions

Cognitive restructuring begins with assessment of family members' selective perceptions, attributions, expectancies, assumptions, and standards concerning their relationships. The major approaches are

(1) interviews with the family,
(2) observation of thoughts they spontaneously express as they speak to one another,
(3) probes for cognitions associated with family members' emotional and behavioral responses during sessions, and
(4) use of questionnaires.

Interviews Concerning Cognitions

A therapist can assess an individual's selective perceptions of his or her family members' behavior by asking what specific acts he or she observes, when they occur, in what circumstances, and how often (Dattilio, 2010; Epstein & Baucom, 2002). Sometimes it becomes clear that the individual is leaving out important information because he or she has failed to notice it. For example, a parent initially may report that a child "fails to obey directions." When asked for examples, the parent describes instances when the child was told to "clean his room" and in which he was instructed to "stop interrupting adults when they are talking." When the therapist asks the parent to describe any instances in which the child did obey a directive, the parent replies, "I can't think of any. He's a very willful child." However, the therapist then asks, "When you send him to clean his room, are there any things he does to clean up?" The parent hesitates and then replies, "He puts some toys away in his closet, but he leaves dirty clothes on his bed and books on the floor." The therapist begins to understand that the parent selectively fails to notice, or discounts, instances when the child exhibited obedient behaviors that the parent could praise in order to encourage the child. Noticing that the parent uses the **negative trait label** "willful child," the therapist asks questions to determine the degree to which

the parent assumes that "willfulness" is a broad characteristic affecting many areas of the child's life.

Often parents in distressed families attribute their children's negative behavior to such traits rather than to **situational conditions**. For example, given widespread publicity concerning attention deficit/hyperactivity disorder (ADHD), many parents attribute their children's distracted, active, or disobedient behavior to that disorder and fail to consider ways in which the child's environment may be eliciting and reinforcing the undesirable behavior. Differentiating between ADHD and a behavior problem that developed primarily through learning experiences requires careful observation of a child's behavior in a variety of situations, as well as assessment of specific cognitive deficits (Gupta & Bhoomika, 2010). A therapist can interview each family member about attributions for others' behavior by asking questions such as "When you see her behaving like that, what do you think causes that behavior?"

Similarly, the therapist can tap into individuals' expectancies about events in their relationships by asking questions such as, "When you think about [behaving in a particular way], how do you think [particular family members] will react?" It is important to identify how the person anticipates that others will respond in the short term *and* in the long term, because the expectancies may be different. For example, when Susan was asked how she believed her partner, Michele, would react if Susan said she wanted to discuss possible changes in their responsibilities for household tasks, she replied, "She would listen quietly and would agree to do some chores more often." However, when asked what Michele might do later, Susan said, "She'd probably make me pay for it later by turning me down when I want to go out to do something I enjoy."

Assessing family members' assumptions about each other and their relationships involves asking questions about the characteristics that they believe certain types of people have and questions about how they believe relationships function (Dattilio, 2010; Epstein & Baucom, 2002). For example, some parents assume that young children are incapable of depression, anxiety, and other strong emotions that adults feel, so they do not consider that their children's behavior problems or academic difficulties may be influenced by such emotional responses to life events. A therapist can ask a parent about his or her assumptions by using questions such as "Your family recently moved here, leaving relatives and friends behind. You mentioned that your son's school problems started soon after you moved. How do you think he has coped with the big changes in his life?" Perhaps the parent would reply, "He complained about moving, but within a couple days he was playing outside with the boy next door. Kids make new friends easily, and they just move on with their lives." The therapist might continue the inquiry into the parent's assumption about the son's emotional life by saying, "You described how you have felt sad about leaving your friends. How do you think your son's experience of leaving his friends might compare with yours?"

An individual's relationship standards can be assessed with questions in the form of "How do you believe [some aspect of oneself, the partner, or the relationship] should be? If things could be just the way you want them to be, what would it be like?" Alternatively, when an individual describes a characteristic of his or her self, partner, or relationship, the therapist can ask, "How does that compare with the way you want it to be?" (Dattilio, 2010; Epstein & Baucom, 2002). Inquiring about relationship standards is especially important when therapists are working with couples and families with different cultural norms, sexual and/or gender orientation, and/or spiritual beliefs from theirs, because this assessment can inform therapists about their clients' diverse standards. These questions are also crucial when assessing relationships of partners or of parents and children who differ in their cultural identity, sexual and/or gender orientation, or religiosity/spirituality.

Observation of Spontaneously Expressed Cognitions

Family members often spontaneously express some of their cognitions as they speak to the therapist and one another. For example, clues to selective perception include language such as "You *always* . . . " and "You *never* . . . ." Attributions are commonly expressed with trait labels such as "You're so *selfish*!" and descriptions of others' motives such as "You want to control my life." Concerning expectancies, an individual might spontaneously voice a prediction such as "If I count on you to pick up after yourself, in a few days I won't be able to see the floor of your bedroom." Assumptions tend to be expressed with statements about the ways that things *are* (e.g., "Men are . . . "), whereas standards tend to be expressed as conditions that *should* exist (e.g., "You should want to do your fair share of the chores"). However, a therapist must ask questions to pin down the individual's specific meaning rather than assume that he or she knows exactly what cognitions an individual's comments reflect.

Probing for Cognitions Associated with Emotional and Behavioral Responses

During a couple or family therapy session, the therapist often will notice cues that an individual is reacting to something that another person has said or done. Sometimes there are verbal or nonverbal signs of an emotional response (e.g., a pained facial expression), and sometimes the individual's actions (e.g., turning away) suggest that he or she is interpreting the other's behavior in a negative way. At such times, a therapist can gently interrupt the interaction, point out the person's response, and ask what the person was just thinking (Dattilio, 2010; Epstein & Baucom, 2002). This "here and now" probing for cognitions is valuable, in that it gives the therapist opportunities to identify specific thoughts that occur as family members interact. Catching cognitions as they occur often is

preferable to asking family members to try to recall what they were thinking during past upsetting experiences.

Meichenbaum's (1977) work with **self-statements** (similar to automatic thoughts) that influence individuals' abilities to cope with stressful situations is relevant for assessing and treating spontaneously occurring cognitions in family interaction. Meichenbaum noted that the content of some cognitions interferes with coping ability by fueling negative emotion and eliciting problematic behavior. For example, when Barbara told Luke that she wanted to discuss a problem in their relationship, Luke replied that he was too busy and began to walk out of the room. As Barbara thought, "He can't get away with ignoring me! He's not getting out of here!" she felt her anger rise and moved quickly to block Luke's path to the door. It is important to help family members identify their **internal dialogue**, to see how it contributes to negative responses and to help them practice more constructive self-statements.

Questionnaires

A number of self-report questionnaires have been developed to assess particular types of relationship cognitions; for example, Eidelson and Epstein's (1982) Relationship Belief Inventory that assesses assumptions and standards, Roehling and Robin's (1986) Family Beliefs Inventory that assesses parents' and adolescents' unrealistic beliefs about their relationships, Pretzer et al.'s (1991) Marital Attitude Survey that assesses attributions and expectancies, Fincham and Bradbury's (1992) Relationship Attribution Measure, and Baucom et al.'s (1996) Inventory of Specific Relationship Standards. These scales have been used primarily in research, but therapists can administer them to family members as a way of surveying particular types of cognitions, which can be explored further during interviews.

Cognitive Restructuring Techniques

The overall goal of cognitive restructuring is to broaden each person's ways of thinking about his or her close relationships. Particular interventions tend to be most useful for intervening with each type of cognition described previously.

Reducing selective perception. When the assessment indicates that an individual is selectively attending to particular aspects of family interaction and overlooking others, the therapist can ask the person, as a homework assignment, to keep a daily written log of specific acts. This will influence the person to pay closer attention to his or her family members' behavior.

> Brenda claimed that Carl rarely participated in child-care activities such as dressing, feeding, and reading to their two young children. When she was asked to monitor his specific child-care behavior each day for the next week, she returned with a log that indicated some days with few

such behaviors but other days in which Carl had engaged in several of them. Of course, because Carl was aware that Brenda was keeping track of his behavior, he may have increased his involvement, and Brenda told the therapist that she attributed his child-care activity to "being on the spot" and wanting to impress the therapist. Nevertheless, the therapist emphasized that Carl did engage in child-care activities, he chose to do so, and it would be helpful if Brenda could let him know that she appreciated it rather than criticizing him about his motives. Similarly, therapists can ask family members to monitor one another's behaviors during therapy sessions in order to counteract selective perceptions.

Modifying biased attributions. When it appears that an individual is making a biased attribution about the cause of another's responses, the therapist can ask him or her to think of other possible explanations for the person's actions.

When Brenda attributed Carl's child-care behavior to his wanting to impress the therapist, the therapist said that Brenda might be correct, but that it was important not to jump to conclusions and to consider other possible causes for his behavior. The therapist coached Brenda as she listed a few other explanations, including the idea that the therapy had opened Carl's eyes to how overburdened she felt and that he was trying to improve their parenting relationship. Direct feedback from the family member in question also can help challenge an individual's negative attribution. Carl told Brenda that he had increased his child-care behavior primarily because their discussions during therapy sessions made him think about how he was missing out on time with their children, who would be growing up quickly.

Modifying inaccurate expectancies. An individual who makes a negative prediction about one or more family members can be asked to think back systematically to similar past situations and whether those events unfolded as he or she now expects. A second technique is to ask the person to keep a log of events during the next week and to focus on the degree to which his or her predictions come true. Finally, the therapist can coach the person in setting up a "behavioral experiment" in which he or she intentionally tests the negative expectancy.

During a session with his wife, Lois, Ted predicted that their adolescent daughter would talk excessively on the phone with her friends if he and Lois stopped reminding her to keep her calls brief and gave her the responsibility for monitoring her phone use. The couple agreed to try it, however, and when they returned the next week, they reported that Karen had surprised them by talking only a little more than they would have preferred.

Challenging unrealistic or extreme assumptions and standards. Because core beliefs tend to be long-standing aspects of a person's worldview, it likely will take time and persistence to modify them (Dattilio, 2010). For example, an individual may hold a standard that in an intimate couple relationship the partners should spend virtually all of their free time together, and they should share all of their thoughts and emotions with each other. This person may have become involved with a partner who initially seemed to value togetherness just as much (early in their relationship they were inseparable), but in fact who holds a standard that members of a couple should have opportunities to develop some autonomous activities. When the partner's desire for some autonomy became clear, the individual responded with great disappointment, anger, and attempts to coerce the partner to spend more time together. A therapist might ask each member of this couple to describe his or her standard about togetherness versus autonomy, how well the standard was met in their relationship, and what specific behavior changes would be needed to meet the standard adequately. As described earlier, differences in two partners' standards for their relationship are not necessarily problematic as long as both people can accept some deviation from what they desire most (Baucom et al., 1996).

The potential for meeting each person's standards depends on whether the standard is realistic and flexible or whether it is extreme and inflexible. Thus, if the individual who wants a very high level of togetherness and open communication is unwilling to accept that the partner wants some degree of autonomy, the couple will likely have great difficulty finding a mutually acceptable solution. As Jacobson and Christensen (1996) have noted, resolving conflicts in a relationship depends in part on each person's **acceptance** of differences between their needs, personalities, and so forth. Cognitive-behavioral therapists explore with each person the advantages and disadvantages of clinging to a standard versus trying to live by a "softened" version of the standard (Epstein & Baucom, 2002). Thus, the individual who demands togetherness with the partner could be coached in considering a standard such as "I greatly enjoy togetherness and open communication with my partner, but I realize that we can have a close relationship even when my partner wants to have some independent activities and thoughts. The key is that we are still the most important people in each other's lives."

As with other types of cognitions, one must often have direct experience with living according to a revised standard before he or she finds it acceptable. In the case we just described, when the therapist coached the individual in trying intentional planning of independent as well as shared activities, the partner was relieved by the reduced pressure and was in a better mood whenever the couple spent time together. The pleasant times together also felt more intimate to the person with the strong togetherness standard, which made the revised standard easier to accept.

These have been examples of cognitive interventions, but no standard set of techniques is used routinely. The therapist can be creative in helping family

members consider the validity and appropriateness of their cognitions. The next section describes behavioral interventions.

Behavioral Techniques

Based on social learning and social exchange theoretical principles, as well as research findings described earlier, the major types of behavioral interventions focus on (1) increasing exchanges of positive behavior and decreasing exchanges of negative behavior among family members, (2) training in communication skills, and (3) training in problem-solving skills. Each of these major types of intervention is summarized in this section.

Therapists assess the behaviors that are in need of modification in each family by observing the family members interacting during sessions, as well as by asking the members to describe specific examples of the interactions that they find distressing. A **functional analysis** involves observing sequences of behaviors in family interaction and identifying both what behaviors of other family members precede (tend to elicit) another's problematic behavior and what behaviors of other family members follow it (tend to reinforce or punish it).

> Zhang Wei (age 30), his wife, Wang Xiu Ying (age 28), and their daughter, Zhang Li (age 5), a Chinese family, had been living in the United States for six months so that both parents could attend graduate school. They were referred to a family therapist by Li's school because her kindergarten teacher had considerable difficulty managing her behavior. Both parents were very embarrassed by the attention that Li's behavior had drawn and were frustrated about her increasing tantrums, which were occurring more often in public places such as stores, as well as in school and at home. The family therapist interviewed the parents in detail about the events that typically occurred just before Li began a tantrum and after she started one. The parents were visibly uncomfortable when describing their daughter's problematic behavior, stressing that she got a lot of positive attention from both parents and from her paternal grandparents who lived with them, but they detailed how typically a tantrum began after they told Li to stop doing something that she was enjoying (e.g., playing with a toy, taking packages of candy from store shelves). They explained that Li's teacher also described a pattern in which she became very upset and disobedient when instructed to stop play activities in class. Wei and Xiu Ying also noted that they usually tried to explain to Li why they wanted her to stop what she was doing, and that sometimes they gave in (e.g., bought her the candy) in order to end her embarrassing public display. To observe the family interaction directly, the therapist asked the parents to instruct Li to stop playing with a toy in the therapy room and to sit in a chair. After the parents looked at each other for a few moments, Xiu Ying asked her

daughter to please put the toy down and sit in the chair. Li resisted Xiu Ying's instructions and began whining. The mother tried talking to her more, looked at her husband, and then stared at the therapist helplessly. This assessment gave the therapist crucial information about the behavioral patterns that needed to be changed to improve the family's problem.

Changing frequencies of positive and negative behavior. The most widely used technique for increasing positive exchanges and decreasing negative ones involves setting up **behavioral contracts** among family members. Typically this is a formal agreement, commonly written, that each person will enact particular behaviors that another family member desires. Some contracts involve **quid pro quo agreements**, in which a person commits to behaving in particular ways that another person requests, with the understanding that in return the other person will behave in ways that the first person requests. A limitation of this approach is that one person's failure to carry out his or her side of the contract may lead the other person to void the agreement. Alternatively, couples can be coached in forming **good-faith agreements** in which each person agrees to change particular behaviors, whether or not the other person reciprocates (Baucom & Epstein, 1990; Jacobson & Margolin, 1979).

In **parenting training** (e.g., Forgatch & Patterson, 2010; Kazdin, 2005; Webster-Stratton & Herbert, 1994), parents are coached in setting up contracts with their children, in which the child is expected to behave in particular ways the parents desire, and to avoid behaving in particular negative ways, in return for specified types of reinforcement. However, contracts of this type may not be welcome in more collectivist cultures, in which it is expected that children and other family members should be motivated to act in the best interest of the family, rather than their own (Epstein et al., 2012). These parents initially may be opposed to the suggestion that they provide a child rewards for behavior that they view as the child's obligation to the family. In such cases, therapists must be culturally sensitive, discussing the parents' beliefs with them and perhaps reframing the contract as an initial means of establishing more cooperative behavior in children who are not yet mature enough to understand the importance of contributing to the well-being of the family group.

A contract in which the parents have the authority to decide on the types of behavior to be changed, as well as the types of reinforcement to be earned, differs from an agreement between two adults, who may have equal power in their relationship. Therapists generally encourage parents to use reinforcements such as praise, time playing with the child, and other rewards that do not involve spending money, although reinforcements involving small expenses (e.g., renting a movie the child wants to see) can be effective. A contract can be formalized by creating a **behavior chart** that lists the specific behaviors to be monitored by the parents and includes spaces in which the parents indicate the frequency with which the child exhibited each behavior during each day of the week.

Parents can use a system in which occurrences of positive behaviors and days without particular negative behaviors earn points toward a large reward. Punishment for negative behavior can consist of temporary removal of particular privileges or a time-out for younger children.

Communication skill training. Couples and families are coached in clear, constructive communication, involving both **expressive skills** and **listening skills**, based on an assumption that good communication requires effective sending as well as receiving of messages (Epstein & Baucom, 2002; Mueser & Gingrich, 2006). Guerney's (1977) guidelines are among the most widely used for communication training. In Guerney's approach, two individuals practice taking turns as the person expressing his or her thoughts and emotions and the person listening empathically in order to understand the expresser's experience. The person in each role is coached in following guidelines for good communication. For example, the expresser is supposed to describe his or her thoughts briefly, using specific descriptive language. The expresser is to describe his or her thoughts and emotions as subjective rather than as "the truth," conveying that the listener has the right to have other views. When describing dissatisfaction with the listener's behavior, the expresser should convey empathy for the listener's personal experiences. In turn, the listener's job is to try to understand the thoughts and emotions of the expresser (i.e., imagine how it feels to be in his or her position). The listener is to avoid interrupting the expresser, criticizing him or her, offering advice, and so forth. After the expresser has briefly described his or her personal experience, the listener's task is to "reflect" back what he or she has heard. The expresser gives the listener feedback about the accuracy of the reflecting, and they repeat the process until the communication has been effective.

In addition to providing coaching in expressive and listening skills, therapists observe each family and identify other specific verbal and nonverbal behaviors to target for change. For example, if members of a family make little eye contact with one another as they talk, the therapist will coach them in increasing it. Therapists teach families these communication skills by describing them briefly, demonstrating the skills, and coaching family members as they practice them during therapy sessions. Family members continue to practice the skills as homework between sessions. Communication training is widely used in cognitive-behavioral couple and family therapy (Epstein et al., 1988; Markman, Stanley, & Blumberg, 2010; Mueser & Gingrich, 2006; Robin & Foster, 1989).

Problem-solving training. Whereas communication training focuses on messages about each family member's thoughts and emotions, problem-solving training deals with steps that family members need to take in order to find mutually acceptable solutions to problems they face together. Some problems involve people or circumstances outside the family (e.g., a member's job demands), whereas others involve issues within the family (e.g., partners' different approaches to handling family finances). Cognitive-behavioral therapists (e.g., Epstein & Baucom,

2002; Jacobson & Christensen, 1996; Mueser & Gingrich, 2006; Robin & Foster, 1989) teach couples and families a series of steps, including

(1) defining the nature of the problem clearly and specifically, in behavioral terms (the "who, what, when, and where"),
(2) brainstorming a variety of possible solutions to the problem (without evaluating them at this point),
(3) discussing advantages and disadvantages of each potential solution, in terms of costs and benefits to all parties involved,
(4) choosing a solution (or combination of two or more solutions) acceptable to all, based on the cost-benefit analysis (step 3),
(5) implementing the solution between sessions, and
(6) evaluating its effectiveness. Solutions that turn out to be inadequate are reconsidered and revised as needed.

In addition, increasing attention has been paid to helping couples develop more effective dyadic coping strategies for dealing with stressors in their life together (Bodenmann, 2005). In contrast to problem-focused coping styles (e.g., looking for a new job when one has lost a job) and emotion-focused coping styles (e.g., exercising to reduce emotional distress) that each individual may use, forms of dyadic coping include the partners assisting each other or working cooperatively to reduce or overcome a stressor (Bodenmann, 2005). The forms of dyadic coping that are acceptable and used by couples can be influenced by cultural beliefs regarding gender roles in intimate relationships (e.g., whether it is considered acceptable for a wife to give her husband suggestions for coping with his job stresses) (Falconier, 2013).

Techniques Focused on Emotions

When a therapist determines that an individual is failing to monitor his or her emotional states, and thus cannot communicate about them to family members, the therapist coaches the person in paying attention to cues that he or she is having emotional experiences. For example, the therapist noticed that Alan sometimes showed nonverbal signs of sadness when his teenage children criticized his life philosophy and personal habits. When the therapist asked him how he was feeling, Alan replied that he was disappointed in them but did not feel any emotions about it. The therapist gave him feedback about his facial expressions and his slumped posture at such times, asking him to pay attention to how his body felt. Alan began to notice a "heavy feeling" in his body and a tightness in his throat. The therapist continued to coach him in noticing his bodily cues and thinking about the thoughts and emotions associated with them.

As described earlier, some people have difficulty with emotion regulation, or the ability to keep emotional arousal from reaching a level so high that it

interferes with constructive thinking and behavior. For some individuals, deficits in emotion regulation constitute a lifelong trait that probably calls for individual therapy, whereas for others it may result from faulty learning of skills that can be practiced in family therapy. For example, some family members who engage in angry outbursts characterized by verbal aggression but who pose no danger of physical violence to one another may be treated jointly with interventions focused on anger management (e.g., relaxation training, anger control self-statements, use of "time-outs" in which partners temporarily go to separate locations and "cool off," and communication training) (e.g., Heyman & Neidig, 1997; LaTaillade et al., 2006). Meichenbaum (1977) and Deffenbacher (1996) use a **stress inoculation** approach in which individuals rehearse self-statements that calm them (e.g., "Stay calm. You don't have to react to his provocative behavior") and that direct their behavior (e.g., "Speak slowly and don't raise your voice"), and those techniques can be used in conjoint couple and family therapy sessions as well.

Cognitive-Behavioral Couple and Family Therapy for a Diverse Population

Couple and family therapists are likely to treat clients who are diverse in terms of race, ethnicity, income, education, age, sexual orientation, gender identification, and level of physical/intellectual functioning. This cultural diversity requires that therapists be culturally competent (Sue, 2006) by (a) being aware of their own cultural values, beliefs, and biases that are based on their own and their clients' cultural backgrounds, (b) understanding the worldviews of the cultures that clients identify with, and (c) applying interventions that are consistent and respectful of the cultural beliefs and traditions that clients want to uphold.

Awareness of One's Own Cultural Values, Beliefs, and Biases

Identifying their own cultural values and beliefs as well as their biases about other cultural groups is the first step for therapists in preventing those cognitions from affecting the therapeutic process. For example, a therapist may inadvertently treat clients differently who are affiliated with a religion toward which he or she is negatively biased. Similarly, a middle-class therapist who grew up in a social context that portrayed individuals from lower socioeconomic groups as dangerous or unreliable may maintain distance from clients belonging to that group, which may be expressed even in the way he or she greets these clients. When therapists raise their awareness about their own biases and beliefs, they can challenge them and prevent them from affecting the therapeutic process. CBT with couples and families provides a theoretical framework for understanding therapists' schemas, as well as tools with which therapists may challenge their own cognitive distortions. Our biases about other cultural groups, both positive

and negative, stem from distorted cognitions such as selective perceptions, overgeneralizations, inaccurate attributions, and unfounded assumptions. Cognitive restructuring procedures may help therapists challenge their own schemas about other cultural groups, which is likely to modify their habitual responses to individuals in those groups. A therapist who becomes aware of his or her learned responses and the cognitive schemas accompanying them might be in a better position to assist clients.

Understanding Clients' Worldviews

As noted earlier, therapists can learn about their clients' values, beliefs, and traditions by asking about them. Therapists also can learn by observing clients' behaviors. For example, in some cultures physical contact in public is avoided, and clients would not be comfortable shaking hands with a therapist, whereas in other cultures physical expressions of affection are favored, and clients may try to hug or kiss the therapist good-bye. It is also important that couple and family therapists try to learn about the particular cultural groups their clients belong to by educating themselves through reading, watching videos, or immersing themselves in a cultural activity (e.g., attending a ritual ceremony, a school, a family meeting, or a community fair). These experiences will increase the therapist's knowledge about norms and traditions in the clients' culture, which must be taken into account in assessing whether family patterns that may be considered abnormal in the therapist's culture are normative within the clients' worldviews. For example, in the case of the Chinese family described previously, it was important for the therapist to be aware that Chinese families typically are reluctant to expose family problems to outsiders, try to avoid loss of face, and focus considerable positive attention on children (Epstein et al., 2012).

Applying Culturally Sensitive Intervention

Cognitive-behavioral therapy interventions have been applied to diverse populations, including Latino (Aguilera, Garza, & Muñoz, 2010; Duarte-Vélez, Bernal, & Bonilla, 2010; Gelman, López, & Foster, 2005), African American (Gore & Carter, 2003; LaTaillade, 2006), and Asian clients (Dattilio & Bahadur, 2005; Epstein et al., 2012) (for a review of CBT applied across all ethnic minorities, see Voss Horrell, 2008), LGBT clients (e.g., Martell, Safren, & Prince, 2004; Safren & Rogers, 2001), and clients with intellectual disabilities (for a review, see Nicoll, Beail, & Saxon, 2013). Cognitive-behavioral couple therapists who work with minority populations focus on the cultural sensitivity of their interventions by evaluating whether they are consistent with their clients' values, beliefs, traditions, and worldviews. For example, when working with clients from societies with more traditional gender roles and more hierarchical family structures, therapists might discuss with parents (and often a father) the possibility of using

behavioral contracts or engaging the whole family in joint problem solving before assuming that the family will welcome a democratic approach that involves negotiations. Similarly, interventions that prioritize an individual's needs and desires might not be welcomed by clients from more collectivistic groups, for whom communal goals may be prioritized.

Research on Cognitive-Behavioral Couple and Family Therapy

Because behavioral therapies had their roots in laboratory research on animal and human learning, with a focus on objectively measurable changes in specific behaviors, behaviorists have a tradition of emphasizing that therapy procedures should be based on sound evidence showing that they are effective. A similar strong record of research on the role of cognition in individual and relationship problems has strengthened the foundations of cognitive therapies. Consequently, there has been more empirical research on the effectiveness of behavioral and cognitive-behavioral couple and family treatments than on any other approach, with the notable exception of the well-researched emotion-focused therapy (EFT) approach (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dunn & Schwebel, 1995; Gurman, 2013; Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003, 2005). In addition to studies of treatments clearly labeled as "behavioral" or "cognitive-behavioral," Alexander and his colleagues have compiled research support for their functional family therapy approach, which in practice is to a great extent a cognitive-behavioral approach involving communication training and behavioral contracting (Alexander et al., 2013).

Research on Cognitive-Behavioral Couple Therapy for Relationship Distress

The vast majority of the studies demonstrating that CBCT is more effective in improving self-reported relationship satisfaction than a no-treatment "waiting list" control condition and placebo or "nonspecific" treatments (e.g., having couples discuss their issues without intervening actively) have included primarily behavioral interventions including some form of behavioral contracting, communication training, and problem-solving training (Baucom et al., 1998; Dunn & Schwebel, 1995; Lebow et al., 2012; Shadish & Baldwin, 2003, 2005). When studies have compared the effectiveness of the major components of behavioral marital therapy (communication training, problem-solving training, behavioral contracts), they have been found to be equally effective, although small sample sizes in these studies may have limited their ability to detect treatment differences (Baucom et al., 1998; Hahlweg & Markman, 1988; Shadish et al., 1993). The positive effects of behavioral interventions tend to last through one-year follow-up assessments, but approximately one-third of the improved couples relapse over

the next few years. When researchers have assessed not only statistically significant change but also how many treated individuals score in the non-distressed range on marital adjustment questionnaires, studies have shown that between approximately one-third and one-half met the latter criterion. It is important to note that the studies involved an average of 11 therapy sessions (based on research design considerations), which may not be adequate treatment for many distressed couples.

Those couple therapy protocols included little or no cognitive restructuring or interventions intended to address inhibited or unregulated emotional responses that are important foci in the more recent Enhanced Cognitive-Behavioral Couple Therapy (ECBCT; Baucom, Epstein, LaTaillade, & Kirby, 2008; Epstein & Baucom, 2002). However, a few studies examined outcomes for cognitive restructuring interventions. Huber and Milstein's (1985) study compared a cognitive intervention focused on reducing partners' unrealistic relationship beliefs (assumptions and standards) with a wait-list control condition, and the findings indicated that the cognitive intervention produced more realistic beliefs and higher relationship satisfaction than the control condition did. Halford, Sanders, and Behrens (1993) compared twelve to fifteen 90-minute sessions of traditional behavioral marital therapy with an enhanced behavioral intervention that included cognitive restructuring, exploration of partners' emotional responses associated with negative couple interactions, and treatment generalization enhancement. The cognitive restructuring involved identifying each partner's maladaptive relationship beliefs and attributions and then using cognitive therapy Socratic questioning to challenging those negative cognitions, as well as some self-instructional training. The amount of each type of intervention in the integrative treatment varied according to the therapists' assessment of each couple's needs. Both the traditional behavioral marital therapy and the integrative treatment condition decreased couples' negative behavior and cognitions, but those changes were not significantly correlated with increases in their relationship satisfaction. The amount of cognitive restructuring was not specified, and the study's design does not allow conclusions about the degree to which cognitive restructuring contributed to improvement in the couples' relationships.

Two studies by Baucom and colleagues (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990) have been cited frequently as demonstrations of the degree to which cognitive restructuring can contribute to effectiveness of couple therapy. Baucom and colleagues investigated whether adding cognitive restructuring modules to the behavioral components of contracting, communication training, and problem-solving training would increase positive effects of behavioral marital therapy. The cognitive restructuring that they used involved sessions meant to educate partners about attributions and guide them in identifying negative attributions they made about causes of problems in their own relationships, plus sessions meant to teach couples about unrealistic relationship beliefs that might be affecting their relationship and guide them in identifying their own unrealistic

beliefs. The study design involved comparison of different combinations of behavioral and cognitive interventions, to determine whether a combination treatment would be more effective than solely behavioral couple sessions. In order to keep the total number of sessions constant across treatment conditions, the researchers replaced some sessions of behavioral interventions with sessions of cognitive restructuring. Baucom et al. (1990) provided couples in all treatment conditions with 12 weekly sessions. The *behavioral marital therapy alone* condition included 12 sessions of communication skills training, problem-solving, and quid pro quo contracts, whereas the *cognitive restructuring plus behavioral marital therapy* condition included six sessions of cognitive restructuring (three on attributions, two on unrealistic relationship standards, and a final session integrating cognitive restructuring concepts) followed by six sessions of the behavioral interventions. Finally, the *cognitive restructuring plus behavioral marital therapy plus emotional expressiveness training* (skills for expressing emotions and listening empathically) condition included three sessions of each of the three components.

Overall, findings from the studies by Baucom and colleagues indicated that cognitive interventions tended to produce more cognitive change, whereas behavioral interventions produced more behavioral change, but all of the active treatment conditions increased relationship satisfaction more than the wait-list control condition, and all the active treatment conditions were equally effective. Some writers concluded that such findings indicate that cognitive restructuring does not enhance the effects of behavioral interventions (Baucom et al., 1998; Halford et al., 1993), but it is important to note that substituting cognitive restructuring sessions for behavioral intervention sessions produced *equal overall effectiveness.* Furthermore, the very small number of sessions of each type of intervention that were allowed in the combination treatment conditions may have weakened the effectiveness of each component. Epstein (2001) noted that research is needed on a truly integrated CBCT that provides adequate intervention for each couple's particular cognitive, behavioral, and affective problems. Furthermore, Whisman and Snyder (1997) pointed out that tests of cognitive interventions have been limited by a failure to assess the variety of problematic cognitions (selective attention, expectancies, attributions, assumptions, and standards) that Baucom et al. (1989) identified as influencing relationship quality. The few existing studies examining effects of cognitive interventions also have been limited to samples of predominantly White middle-class couples, so their effectiveness with other racial and socioeconomic groups is unknown, an issue of concern for examining cultural sensitivity of the treatment.

A survey of the practice characteristics of clinical members of the American Association for Marriage and Family Therapy (Northey, 2002) indicated that cognitive-behavioral interventions were the treatments most commonly used. Nevertheless, in spite of the widespread enthusiasm for cognitive-behavioral therapy, the strong body of empirical support for behavioral interventions, and the encouraging findings from the existing outcome studies examining cognitive interventions,

there is a need for more outcome research, especially investigating the effects of integrative approaches that address behavior, cognition, and emotion.

Research on Cognitive-Behavioral Couple Therapy for Specific Clinical Problems

CBCT also has been evaluated as either a sole treatment or an adjunctive treatment component for a number of clinical problems, involving both relational issues and disorders of individual functioning. The following is a brief overview of that research.

As noted previously, CBCT has been used to treat couples who exhibit psychological and mild to moderate physical aggression (Heyman & Neidig, 1997; LaTaillade et al., 2006). Partners are provided psychoeducation about partner aggression and its negative consequences, taught strategies for anger management (e.g., self-soothing practices, nonaggressive self-talk, and use of "time-outs" to de-escalate aggressive interactions), and coached in skills for constructive communication, problem solving, and modifying aggression-eliciting cognitions. The Couples Abuse Prevention Program interventions conducted by Epstein and colleagues (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011; LaTaillade et al., 2006) in a racially and socioeconomically diverse community clinic sample produced improvements in relationship satisfaction, negative attributions, trust, self-reported partner aggression, and observed negative communication behavior. Change in negative attributions was associated with decreases in aggression, but the study did not identify the relative contributions of the treatment components to those outcomes, and further research is needed to identify the degree to which modification of cognitions helps.

Another application of CBCT for relational problems has been Baucom, Snyder, and Gordon's (2009) empirically supported, largely CBT-based program for couples experiencing infidelity. The interventions help partners cope with traumatic aspects of the experiences, gain insight into factors that led to the affair, make good decisions regarding the future of the relationship, and develop strategies and skills for reducing risk factors if they choose to continue the relationship.

CBCT also has been used to address forms of individual psychopathology. For example, studies by Beach and O'Leary (1992) and Jacobson, Fruzzetti, Dobson, Whisman, and Hops (1993) indicated that behavioral marital therapy improved both the depression symptoms and marital distress of women who presented with both problems and whose marital problems appeared to be a major factor in their depression. The CBCT interventions are designed to decrease negative couple interactions and enhance mutual emotional support (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008; Whisman & Beach, 2012). Similarly, CBCT approaches have been used as an adjunctive intervention with standard individual or group CBT treatments for anxiety disorders. For example, Chambless (2012) uses couple

therapy that includes psychoeducation about the partner's anxiety disorder and how anxiety symptoms affect and are commonly affected by couple interactions. The couple therapy also includes communication skills training, problem-solving training, preparation for coping with symptoms, and reduction of patterns in which the couple have accommodated their daily interactions to the individual's anxiety symptoms. Monson and Fredman's (2012) empirically supported cognitive-behavioral conjoint therapy for post-traumatic stress disorder (PTSD) also includes psychoeducation regarding mutual influences between an individual's symptoms and the couple's interactions, building positives in the relationship, improving emotion regulation, using communication skills to reduce the individual's emotional numbing and avoidance, improving the couple's problem-solving skills, and cognitive restructuring to reduce beliefs that maintain PTSD symptoms and relationship problems. Another application of CBCT with individual psychopathology is Bulik, Baucom, Kirby, and Pisetsky's (2011) program for anorexia nervosa that combines interventions specific to the eating disorder (e.g., the partner provides emotional support to the individual specifically to reinforce appropriate eating and other healthy behaviors) with traditional CBCT procedures of problem-solving and communication skill training. Finally, Birchler, Fals-Stewart, and O'Farrell (2008) developed an empirically supported program that integrates behavioral couple therapy (increasing exchanges of pleasing and caring behavior, increasing sharing of activities that are rewarding to both partners, improving communication and problem-solving skills, avoiding threats of separation, focusing on the present, avoiding physical aggression) with interventions focused on a partner's substance use (e.g., self-help meetings, medication, behavioral contracts between partners to promote the individual's abstinence).

Another important application of CBCT to stressors in couples' lives is its use in assisting couples who are dealing with severe physical illness. For example, Baucom, Porter, et al. (2009) developed a CBT-based relationship-enhancement program for women who are being treated for breast cancer and their male partners. Couples are taught expressive and listening communication skills that are applied to cancer-related topics (e.g., fear of mortality, medical decisions). They also are taught problem-solving skills relevant to making medical treatment decisions. Furthermore, they are given psychoeducation regarding the psychological and physical effects of cancer treatments on sexual functioning and are helped to find meaning and growth in their experiences with cancer. Thus, CBCT is an adaptive, integrative approach to treating a wide variety of stressors that couples experience both within and outside their relationships.

Research on Cognitive-Behavioral Family Therapy

In contrast to couple therapy, which often is motivated by partners' overall unhappiness and conflict within their relationship due to differences in their needs, preferences, and communication styles, cognitive-behavioral family therapy

(CBFT) approaches more commonly have focused on the treatment of particular problems or disorders in individual family members—in particular, children and adolescents. There has been strong empirical support for the efficacy of training parents in behavioral interventions for children's conduct disorders (Forgatch & Patterson, 2010; Kazdin, 2005), based on the social learning principles described earlier in this chapter, including Patterson and colleagues' concept of the "coercive family system." Functional family therapy also has been demonstrated to be effective in reducing adolescents' aggression and substance abuse (Alexander et al., 2013; Henggeler & Sheidow, 2012). Because Estrada and Pinsof (1995) noted a high attrition rate among families in studies of this approach, it appears that clinicians need to be careful to establish positive therapeutic connections with parents who enter therapy feeling inadequate and who may easily feel threatened if they perceive their parenting skills are being criticized.

Research also has provided evidence for positive effects of behavioral family therapy for childhood attention deficit/hyperactivity disorder (ADHD) (Kaslow, Broth, Smith, & Collins, 2012). Typically the family-oriented interventions of training parents in dealing with the child's symptoms of inattention, impulsivity, hyperactivity and noncompliance are used in combination with interventions that focus on those symptoms (e.g., medication and self-control training) (Barkley, 1998). CBFT also has been found to be effective in treating childhood anxiety disorders (Kaslow et al., 2012). Finally, the behavioral couple therapy approach that O'Farrell and his colleagues use to treat alcohol abuse also has been applied to family treatment of substance abuse (O'Farrell, Murphy, Alter, & Fals-Stewart, 2010).

Behavioral family therapy has been empirically supported for major mental disorders in adolescents and adults, including schizophrenia and bipolar disorder (Miklowitz & Goldstein, 1997; Mueser & Gingrich, 2006). It typically includes CBFT-derived

(a) psychoeducation concerning etiology, symptoms, risk factors for symptom exacerbation (e.g., life stresses, including family conflict), and evidence regarding effective treatments;
(b) communication skill training;
(c) problem-solving skill training; and
(d) management of relapses and crises.

Studies in several countries with racially and socioeconomically diverse families have demonstrated that this approach is effective in reducing family stress and patient relapse (Baucom et al., 1998; Lucksted, McFarlane, Downing, Dixon, & Adams, 2012).

CBFT has been applied to the treatment of a variety of problems, and research has demonstrated its effectiveness. More research is needed to examine the effects of CBFT on families' difficulties in adapting to developmental life-stage changes

(e.g., children reaching adolescence; formation of stepfamily relationships) and in coping with external stressors such as parental unemployment. Furthermore, more attention is needed to developing methods for assessing family members' cognitions about each other and to testing the effectiveness of interventions for modifying cognitions that contribute to family conflict.

Case Study

Earlier, the case of Wei, Xiu Ying, and their five-year-old daughter Li was described briefly as an example of how a therapist uses a functional analysis to identify how an individual's problematic behavior may be influenced by both the behaviors of family members that precede it and those that are *consequences* of it. Li's tantrums in school, public places, and at home tended to occur after her teacher or parents instructed her to stop doing something that she was enjoying, such as playing with a toy or handling packages of candy in a store. When the therapist asked Wei and Xiu Ying how they typically responded to Li's initial refusal to follow their directions, Wei sat quietly and Xiu Ying reported that she tried to explain to Li why she wanted her to stop her behavior (for example, "Li, put the candy back. We already have a lot of candy at home, so you don't need any more"). Xiu Ying noted that both she and Wei spent many hours at the university working, and Wei's parents provided a lot of the child care during the day. She looked at Wei and uneasily stated that Li's grandparents often spoiled Li (their only grandchild), letting her do what she pleased. In addition, when Li continued her misbehavior in public, Xiu Ying and Wei were embarrassed and could not think of anything more effective to stop her, so they sometimes bought Li what she wanted. The therapist took note of the associations between the parents' responses and the child's negative behavior and formed a hypothesis that among the factors operating in this family's problem were (1) the grandparents had developed Li's expectancy that she would receive things that she desired (with minimal limits set on rewards), (2) the parents had no effective means of punishing Li for tantrum behavior, and (3) the parents were unwittingly reinforcing Li's tantrums by giving her things that she wanted whenever she behaved sufficiently aversively. In fact, it appeared that the parents were providing intermittent reinforcement for Li's whining and tantrum behavior by trying to ignore it for a while and then providing the rewards.

As noted earlier, the therapist also conducted a functional analysis by observing the family interaction after instructing Wei and Xiu Ying to get Li to stop playing with a toy in the therapy room and sit still. Consistent

with the parents' reports of what occurred at home, at school, and in public, Xiu Ying began by saying, "Li, please put the toy down and come sit in this chair next to me. It's very important for us to all talk together." When Li ignored her, Xiu Ying repeated herself twice, each time looking over at the therapist and Wei and showing more discomfort. "Li, listen to me now! Will you please put the toy down and come over here?" As Li continued to ignore Xiu Ying, the therapist turned to Wei, asking him how Li tends to respond to his directions, and Wei responded that he usually leaves it to Xiu Ying as the child's mother to manage her behavior. At this point, both parents looked embarrassed as they glanced in the therapist's direction. The therapist also asked the parents whether they had suggested to Wei's parents that they establish firmer limits with Li. Wei was silent, and Xiu Ying stated, "My husband's parents do so much for us. They take care of our home and child while we are at the university. We appreciate that very much."

Thus, in this *behavioral assessment*, the therapist gathered detailed information about the family interaction patterns associated with Li's problematic behavior, using both self-reports from the parents and direct observation of parent-child interactions. The data suggested that the child had learned that she could do much as she pleased, because on the one hand her grandparents were overly giving and implemented no consequences for negative behavior, and on the other hand Xiu Ying was for the most part the only parent trying to set limits and was also using ineffective techniques. When the adults gave in to the child's tantrum behavior, they experienced relief when the tantrum stopped (*negative reinforcement* for them), and Li received *positive reinforcement* (e.g., more time to play with a toy) for her negative behavior. In other words, there was a circular causal pattern in which the parents and the child were influencing each other's behavior. Xiu Ying and Wei might have benefited from some parenting training in the use of time-outs and other forms of nonaggressive *punishment* for Li's negative behavior, as well as the use of *positive reinforcement* whenever she behaved in desirable ways. However, as long as Wei remained uninvolved in setting limits for Li and left that responsibility to Xiu Ying, Xiu Ying's effectiveness could be compromised. Furthermore, as long as the grandparents continued to set no limits on Li, that would limit the overall effectiveness of changes in Wei and Xiu Ying's parenting behavior.

Although the therapist might have intervened directly with a couple from a Western cultural background to coach Wei in becoming a parenting partner with Xiu Ying and might have encouraged the couple to put pressure on Wei's parents to cooperate with the new child management

plans, the therapist was aware of traditional Chinese family roles and patterns that still often are male-dominated and in which grandparents have significant status in helping couples raise young children. Rather than risk an uncomfortable confrontation with the couple and possibly damage the therapeutic alliance, the therapist decided to use a more indirect approach by appealing to the couple's cultural values.

The therapist inquired about the parents' assumptions and standards concerning appropriate child behavior and how they wanted Li to behave in school and as a member of society. Both parents noted how important education is for success in life, adding that they wanted Li to grow up to be a cooperative member of society and a very successful student. The therapist commented that an individual's contribution to harmony in relationships is important, reflecting a core Chinese value (Epstein et al., 2012), and the parents agreed. The therapist also noted that being a successful student involves paying good attention to teachers and doing one's work, and children begin to learn those skills in kindergarten. Parents can help young children prepare for good classroom performance and eventual good performance in adult life roles by shaping their ability to respond to authority figures' requests. Wei and Xiu Ying seemed to be "on board" with this line of thinking, so the therapist continued by presenting psychoeducation about parenting strategies that have been found to be appropriate for children at Li's developmental stage. The therapist focused on scientific knowledge about parenting, in order to appeal to the couple's respect for education and professional expertise. This discussion also touched on both parents' assumption that children of Li's age are able to understand and appreciate logical explanations for behavioral rules, which had resulted in their repeated ineffective attempts to reason with her about proper behavior. They also held a standard that "loving parents try to protect their children from experiencing frustration and emotional distress," so they easily felt guilty or ashamed about disciplining Li if it appeared that it made her very upset.

Because the therapist had noticed that Wei was minimally active in parenting during the family session, she had a goal of increasing his involvement without challenging the roles in the family. She described to the couple how children learn best when they have consistent feedback regarding their behavior from the adults in their environment. The therapist pointed out that she had noticed that when Xiu Ying gave Li instructions, Li looked at Wei to see his reaction. The therapist said, "Wei, it is easy to see that you are a very important person in Li's life, and she looks for your reactions. It seems to me that if you show her that you and Xiu Ying are a close team, and that when Xiu Ying tells her something, she

is speaking for both of you, Li will get a strong message about the expectations that both of you have for her. One way that you can give Li that message is to give her similar instructions and to tell her that she must obey her mother. Wei and Xiu Ying, you are both smart and successful people, and Li is lucky that she can learn a lot from both of you." The therapist then followed up this cognitive intervention with systematic coaching of the parents in using effective parenting behavior in sessions and planning "homework" for extending it to daily life.

The therapist addressed the boundary issue regarding the grandparents' influence on Li's behavior in a similar manner. She affirmed to Wei and Xiu Ying that Wei's parents were very helpful to the couple and conveyed that she was familiar with the importance of grandparents in Chinese families. At the same time, however, the therapist suggested that Wei could encourage his parents to help Xiu Ying and him prepare Li to be a better student by giving her practice in following directions and cooperating with authority figures. This way of construing the guidance to be given to his parents was probably more palatable for Wei than any suggestion that he reduce their place in the family hierarchy would have been.

The therapist then guided Wei and Xiu Ying in devising a simple behavior chart with a list of two types of behavior that they wanted Li to *increase* (make eye contact with parents when they address her, obey requests such as "put the toy back on the shelf") and three types of behavior that they wanted her to *decrease* (whining, stomping her feet, and screaming). With coaching, the couple drew the chart on a sheet of paper, explained it to Li, and took it home to be posted on their refrigerator. The therapist also guided the parents in thinking of specific consequences, involving punishment for instances of negative behavior and reinforcement of positive behavior, that they would use at home. The therapist described the use of time-out procedures, and the parents also agreed to try taking away for brief periods some of Li's privileges for instances of negative behavior. The therapist and the couple identified privileges (e.g., TV watching) that the couple felt comfortable withdrawing temporarily, as well as small but meaningful rewards (e.g., praise and hugs) that they could give Li when she exhibited desired behavior. The parents also agreed to draw a star on Li's behavior chart each time she exhibited a desired behavior, and she earned rewards (e.g., renting a movie, playing a game with a parent) for reaching particular point totals.

The therapist stressed the importance of gradually shaping Li's positive behaviors rather than expecting her to make major changes suddenly.

Xiu Ying and Wei agreed that initially they would immediately praise Li if she complied at least partly with a request (e.g., putting *some* toys away). The therapist emphasized the importance of being consistent in providing negative consequences for *any* instances of noncompliance and tantrum behavior. She encouraged the parents to communicate more at home regarding their work with Li, using expressive and listening skills, and they decided to schedule a 15-minute "check in" with each other each evening after Li was asleep.

Recommended Readings

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Glossary

acceptance: An individual's attitude that a family member's personal characteristic or behavior falls within the range of his or her personal standards of how that person should be; in contrast to an attitude that that person should change.

adjunctive intervention: A therapeutic technique that is added to enhance an existing treatment by addressing an aspect of clients' needs that is not adequately addressed by the primary treatment.

agentic or individual-oriented needs: A person's basic needs that involve functioning and growth as an individual; for example, a need for autonomy.

assumption: An individual's basic belief or schema about typical characteristics of people and objects; for example, an assumption that men are generally unaware of their feelings.

attribution: An individual's inference, that can vary in validity, about an unobserved cause of an observed event, such as the cause of a spouse's or a child's sarcastic remark.

automatic thoughts: Stream-of-consciousness thoughts that run through a person's mind and seem plausible to the person, whether or not they are accurate or valid.

aversive control: An individual's use of threats, criticism, and punishment to control another person's behavior.

behavior chart: A chart to log instances of specific behavior enacted by a family member each day; most often used to log a child's behaviors that parents want to increase or decrease.

behavioral assessment: Monitoring frequencies of family members' specific acts and circumstances that precede and follow them, through family members' observations and logs of their interactions at home, or therapist observation of family interactions during sessions.

behavioral contract: A formal or informal written or oral agreement among family members for each person to enact particular behaviors that are desired by the others.

boundary: A degree of psychological or physical separation between people in a relationship, such as the degree to which family members share personal thoughts and feelings with each other.

cascade: A sequence in which one type of behavior by a member of a couple or family leads to another type of behavior by another member, and over time there is a positive or negative trend to the pattern; for example, when criticism by one person leads to defensiveness by the recipient, which produces more criticism, more defensiveness, and so on.

circular causality: The idea that people in a relationship have mutual effects on each other, in a circular manner; for example, person A withdraws because person B nags, and person B nags because person A withdraws.

classical conditioning: A learning process in which a stimulus that has been relatively neutral for an individual (e.g., the sound of squealing car tires) elicits an automatic reflexive response (e.g., anxiety symptoms) after the neutral stimulus has been associated with another stimulus that produces the reflexive response (e.g., a severe car accident).

coercive family system: A pattern of family interaction in which parents and children each use aversive behavior such as yelling and threats in attempts to control each other's actions.

cognitions: Forms and processes of thinking (e.g., attributions, expectancies, assumptions, standards, selective perception) with which individuals process information about themselves and the world.

cognitive distortions: Automatic, distorted processing of information (e.g., dichotomous thinking, emotional reasoning, maximization, minimization, mind reading, overgeneralization, personalization).

cognitive restructuring: Therapeutic interventions intended to modify an individual's distorted or inappropriate thoughts, by challenging the logic of those thoughts, presenting information concerning their validity, or examining their impact on the individual's life and relationships.

cognitive therapies: Forms of psychotherapy focusing on identifying an individual's distorted, invalid, or inappropriate forms of thinking that are contributing to his or her psychological and/or interpersonal problems.

cognitive-behavioral approaches: Concepts and methods for understanding and treating individual and relationship problems in terms of behavior patterns, cognitions about oneself and others, and emotional responses associated with those behaviors and cognitions.

communal needs: A person's basic human needs that involve connections with other people (e.g., a need for intimacy or deep sharing of personal experiences with another person).

conduct disorder: A child's or adolescent's pattern of problematic behavior that includes threats or harm to people or animals, damage to property, deceitfulness, theft, or serious violations of rules set by parents, schools, and so forth.

consequences: The results that occur following an individual's particular action, either consistently or intermittently, and that reinforce or punish the person for the action.

deconditioning: The weakening or eliminating of a previously classically or operantly conditioned response by reversing the conditions that initially established it; for example, reducing a child's tantrum behavior by eliminating a parent's attention that reinforced it.

deficits in communication skills: A person's lack of ability to express himself or herself verbally and nonverbally in a clear, direct, but nonaggressive manner, or a lack of ability to pay close attention to another's messages, understand his or her perspective, and reflect back that understanding.

demand/withdraw: An interaction pattern between two people in which one person tends to approach the other and press for attention and communication, while the other person tends to withdraw, and each person's type of behavior elicits more of the other's type of response.

depression: Psychological distress that may be chronic or occur in episodes and that typically includes a variety of emotional symptoms (e.g., low mood), cognitive symptoms (e.g., hopelessness, self-criticism), physiological symptoms (e.g., fatigue, poor appetite), and behavioral symptoms (e.g., withdrawal from other people).

dichotomous thinking: A cognitive distortion in which an individual categorizes people and events in all-or-nothing terms rather than considering degrees of characteristics; for example, a parent who dichotomizes a child's school grades as "either A's or failure."

emotional reasoning: A cognitive distortion in which an individual interprets his or her subjective emotions as objective facts; for example, when members of a couple who have recently had little time together notice a lack of intimate feelings and conclude that they no longer love each other.

emotional regulation: An individual's ability to control the strength of the emotions that he or she experiences and expresses.

expectancy: An individual's inference involving a prediction about the probability that an event will occur in the future under particular circumstances.

expressive skills: The abilities to be aware of one's thoughts and feelings and to express them to another person clearly, succinctly, and in a nonjudgmental way that encourages the listener to consider them without becoming defensive.

extinction: The decreasing and possibly elimination, by removal of the reinforcement, of an individual's behavior that previously was given reinforcement.

functional analysis: Identification of the antecedent situational conditions that tend to elicit an individual's behavioral, cognitive, or emotional response, as well as the consequences that follow the response and serve to reinforce, punish, or extinguish it.

functional family therapy: A behaviorally oriented therapy that focuses on ways in which family members' responses toward each other are due to the functions that the responses serve in producing outcomes consciously or unconsciously desired by the individuals.

gender role: The set of behavioral, cognitive, and emotional responses commonly accepted in society as appropriate and desirable, as well as those considered inappropriate, for males or females.

good-faith agreement: A behavior contract in which each person agrees to enact some of the behaviors desired by the other person without an agreement about which behaviors he or she will choose. The individual's compliance with the other's requests is not contingent on whether the other person carries out his or her part of the agreement.

inappropriate thought processes: Cognitions that are irrelevant or extreme such that they do not realistically fit circumstances in an individual's personal life; for example, holding a standard that one's spouse or children should always share one's personal values and preferences.

intermittent reinforcement: When an individual receives reinforcing consequences for his or her specific action occasionally or unpredictably rather than after every instance of that action.

internal dialogue: An individual's thoughts concerning a current experience; for example, an internal debate about the pros and cons of behaving a particular way toward family members.

investment: The degree to which an individual puts time and energy into a relationship.

irrational belief: An individual's unrealistic belief about characteristics that an individual or relationship should or must have, which leads the individual to respond with emotional upset and negative behavior when actual events fail to meet the standard.

learning principles: Concepts about processes by which individuals acquire new knowledge and behavioral and emotional responses, as well as processes by which responses are weakened.

linear causal thinking: An individual's concept that the causal relationship between two people's responses exists in only one direction (i.e., person A's behavior produces person B's behavior); in contrast to circular causal thinking, which focuses on mutual influences.

listening skills: Communication skills for accurately receiving information from another person who is expressing thoughts and emotions; for example, abilities to take another's perspective, avoid thinking about one's own thoughts and feelings instead of focusing on those expressed by the other person, and reflect back what was heard.

magnification: A cognitive distortion in which an individual exaggerates the effects of an event beyond what the evidence suggests is accurate; for example, catastrophic thinking such as "My daughter was disciplined at school for talking in class. Her reputation is ruined."

mind reading: A cognitive distortion in which an individual observes an aspect of another person's behavior and makes an arbitrary inference or attribution that he or she knows the other's unstated thoughts and emotions; for example, "She stayed at work later than she told me she would, so she obviously decided the work was more important than spending time with me."

minimization: A cognitive distortion in which an individual underestimates qualities or effects of a person or event beyond what the evidence suggests is accurate; for example, an individual whose spouse turned down a job opportunity so the couple would not have to face moving might conclude, "It was no big sacrifice for her."

mutual influences: A process in couple or family interactions in which each person's behavior simultaneously affects and is affected by others' behavior; as when a child's tantrums elicit stress, frustration, and harsh punishment from parents, and in turn the parents' yelling and harsh punishment elicit frustration, anger, and tantrum behavior from the child.

negative reciprocity: The tendency for members of a relationship, especially a distressed one, to reciprocate negative actions toward each other, either immediately or at a later time.

negative tracking: A form of selective perception, particularly common in distressed couples and families, in which an individual notices a family member's negative behavior but overlooks the person's neutral or positive acts.

negative trait label: Using a broad personal trait label to describe and explain a person's behavior; for example, describing a child as being a "selfish" *person* rather than exhibiting particular selfish *acts.*

neutral stimulus: A condition or event that has no natural automatic effect on increasing or decreasing an individual's behavioral, cognitive, or emotional responses.

observational learning: A process through which an individual learns how to perform particular responses merely by observing another person's performance of them; as when a child imitates a parent's way of expressing anger.

operant conditioning: A process through which an individual learns to enact particular behaviors more or less frequently, based on the reinforcing or punishing consequences that occur when he or she exhibits those behaviors.

overgeneralization: A cognitive distortion in which a person concludes that an event that actually occurs only occasionally either *never* or *always* occurs; for example, a man whose wife sometimes complains about his failing to clean up after himself may overgeneralize, "You *always* criticize me."

parenting training: Developing parents' knowledge of normal child development and teaching them effective, nonaggressive methods for increasing their children's positive behavior and decreasing their children's negative behavior.

personalization: A cognitive distortion in which an individual interprets an event as related to his or her own actions, when in fact the event may have been caused by other factors; for example, a man notices his wife seems upset and automatically concludes, "She's angry at me."

positive reinforcement: Consequences provided for an individual's behavior that result in the person exhibiting that behavior more frequently in the future, presumably because the individual experiences the consequences as pleasant.

power/control: The degree to which a member of a family has input and impact on decisions that the family makes about its priorities and activities.

punishment: Consequences provided for an individual's behavior that result in the person exhibiting that behavior less frequently in the future, presumably because the individual experiences the consequences as aversive.

quid pro quo agreement: A behavior contract in which each person agrees to enact particular behaviors desired by the other person, and each person's adherence to the agreement is contingent on the other's adherence to it.

rational-emotive therapy: A psychotherapy approach, developed by psychologist Albert Ellis, focusing on modifying irrational beliefs that elicit an individual's dysfunctional emotional and behavioral reactions to events in his or her life.

reflexive response: A behavioral or emotional response that occurs naturally and automatically, such as fear a person instantaneously feels at the moment when a truck is about to hit his or her car.

relaxation techniques: Procedures, such as tensing and relaxing muscles in each part of one's body, or practicing slow deep breathing, that an individual can use to increase overall physical relaxation and to reduce tension.

schema: An individual's generally long-standing basic concept or belief about characteristics of people, a particular object, a type of interpersonal relationship, or a type of event.

selective abstraction / selective perception: A cognitive distortion in which an individual notices certain aspects of information available in a situation and overlooks other information.

self-statement: A form of cognition in which an individual gives himself or herself an instruction to guide his or her thoughts (e.g., "Listen to my parents' instructions"), behavior (e.g., "Tell her how I am feeling, but don't blame her"), or emotions (e.g., "Stay cool, just relax").

sentiment override: When an individual's emotional and behavioral responses to another person are determined more by preexisting feelings toward the person than by the person's present behavior.

shape: To gradually develop an individual's new response by rewarding him or her for small approximations of the end goal; for example, reinforcing a child for cleaning part of his or her room.

situational conditions: Characteristics of the physical or interpersonal setting in which a behavioral, cognitive, or emotional response occurs; for example, the amount of structure in home and classroom settings associated with a child's controlled versus hyperactive behavior.

social exchange theory: A theory that members of any relationship exchange actions that each person experiences as costs and benefits, and each person feels satisfied in the relationship to the degree to which he or she perceives receiving a favorable ratio of benefits to costs.

standard: A belief or schema an individual holds about characteristics that individuals and relationships "should" have. Standards can vary in flexibility, extremeness, and the degree to which they are realistic.

stress inoculation: Methods to prepare an individual to cope with stressful situations; for example, training to use self-statements about relaxing and speaking calmly to family members who are upset.

subjectivity: The degree to which a person's experiences of events involve idiosyncratic interpretations rather than objective perception of external reality.

systematic desensitization: Gradually decreasing an individual's negative cognitive, emotional, and behavioral responses to a situation that the person finds stressful, by exposing the person to increasingly stressful aspects of the situation while having him or her practice relaxation techniques during the exposure.

time-out: A discipline technique that removes a child from sources of reinforcement by placing him or her in a place of isolation (for example, a chair in a corner, with no access to entertainment or attention from others) for a fixed amount of time.

unrealistic belief: *See* IRRATIONAL BELIEF.

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10

TRANSGENERATIONAL FAMILY THERAPIES

Julie Ramisch and Thorana S. Nelson

That which is created in a relationship can be fixed in a relationship.

—Murray Bowen

Major Figures

Transgenerational or **intergenerational** family therapies typically attend to dynamics across more than two generations. Although other family therapies, such as structural or strategic, may attend to dynamics across two generations (e.g., parent-child) in the present, transgenerational therapies are more interested in how the past affects the present. These therapies are not interested in learning about individual pathology. Rather, they are interested in how families, across generations, develop patterns of behaving and responding to stress in ways that prevent healthy development in their members and lead to predictable problems. Individuals and families can develop new ways of interacting that do not include symptoms by understanding how certain patterns develop and changing the way they resolve past issues and interact in their families.

Several key figures are identified with transgenerational family therapies. Murray Bowen (Bowen family systems theory) and Ivan Boszormenyi-Nagy (contextual family therapy)—or Nagy (pronounced "najh"), as he is often referred to—are probably the most noted theoretical writers. James Framo also is included in this category and will be discussed briefly. Depending upon how transgenerational is defined, Carl Whitaker is sometimes considered a transgenerational therapist because of his insistence on focusing on multiple generations. He is included in Chapter 8 on experiential therapy in this book because of his focus on the ways people interact based on symbolic experiences and psychodynamic motives.

Bowen Family Systems Therapy

Murray Bowen became interested in psychiatry as a physician in World War II. After the war, he trained and worked at the famous Menninger Clinic in Topeka, Kansas. The Menninger Clinic was founded by two brothers who used classic **psychoanalytic techniques** in psychiatry. Bowen discovered that he often felt confused and trapped in the dynamics at Menninger, and he was particularly distressed at the way the brothers and staff involved patients and other staff in "crazy-making" interactions. Bowen also discovered that he could think more clearly about what was going on at the clinic when he was traveling, but was quickly pulled back into the dysfunctional processes as soon as he returned to work.

Bowen also noticed that he could think more clearly about his own family-of-origin dynamics when he was not with his family of origin. He recognized that his family members often complained to him about another family member rather than talking directly to that person about the problem. Based on these observations, Bowen deliberately changed his own ways of interacting in his family. He gave a speech at a professional meeting; however, instead of giving his intended speech, Bowen told the audience about these deliberate actions he had made in his family and their consequences. At that time (1967), therapists *never* disclosed personal family information. Thus, Bowen broke tradition and published his now-famous paper on his family of origin anonymously (Framo, 1972).

As a theorist, Bowen hypothesized that mentally ill individuals were caught up in patterns of family fusion or **undifferentiated ego mass** such that they were symptom bearers for the family rather than characterologically flawed or ill. He therefore hospitalized whole families in order to treat the emotional system rather than the individual.

Key Concepts

Differentiation of Self

The hallmark concept of Bowen theory, **differentiation of self**, refers to an individual's ability to maintain a strong sense of self while maintaining a connection with a strong emotional system. By being able to distinguish what one thinks and feels as separate from the system dynamics, an individual is able to have his or her own opinion and act on personal judgment without the undue influence of family members. A person with a differentiated self is able to use the opinions and advice of others, but makes independent decisions. Differentiation of self is a process and a part of family dynamics rather than a personality characteristic. This process can be observed in many kinds of systems including family, friendships, and work.

Closely tied to differentiation of self from the family is the concept of **differentiation of thinking from emotion**. Bowen believed that this is a biological, physiological, and mental process. To the degree that a person is able to distinguish

emotions from thinking, he or she is able to make decisions about behavior rather than reacting to the intensity of the emotional system.

The opposite of differentiation is **fusion**. Bowen believed that individuals are constantly balancing needs for intimacy and autonomy. Without autonomy, individuals are fused with others and unable to think for themselves. Individuals are easily swayed by other people's opinions and wishes. There is a natural tendency to want intimacy with others, to feel connected, understood, and important. At the same time, there is a natural aversion to too much fusion, such that individuals get anxious when they begin to lose autonomy. **Fusion anxiety** is a motivator to separate and try to develop a separate self, to differentiate. Bowen believed that anyone, even the most differentiated person, can become symptomatic under sufficient stress. More differentiated persons are less likely to develop severe symptoms from stress and are able to recover more quickly when they do develop symptoms. The ability to be **responsive** rather than **reactive** allows a person to more easily make thoughtful decisions about what to do. It is not that emotions are not present in that person, but that those emotions are less likely to paralyze or inhibit his or her thinking and thereby lead to impulsive behaviors. For example, a differentiated person will still become angry under certain circumstances, but is more likely to decide what to do (e.g., walk away, say something calmly, yell, or even act out physically) after thinking about it.

Bowen talked about differentiation of self as a continuum and even wrote about a scale that went from 0 (no differentiation) to 100 (total differentiation). He later regretted this, because it led people to attempt to quantify the concept in individuals. Bowen was more interested in the qualities that distinguished more and less differentiated persons and systems. In addition, he wrote about the scale as though the low end of the scale was characterized by a lack of **autonomy**. Although this is a reasonable understanding of what he wrote, Bowen's idea was much more complex. He believed that most of life's difficulties arise because individuals are ruled by emotion and depend on others' goodwill. Over time, individuals become more autonomous and **interdependent** rather than **dependent**. Therefore, individuals are more likely to be able to act on their own. However, individuals are always more or less susceptible to the opinions of others, which affects the ability to think clearly. To the extent that individuals have unresolved differentiation issues, individuals are ruled in reactive ways by emotions and by what they believe others want them to do. Individuals need to exercise their ability to think while under emotional strain, not focus on what they are feeling.

However, Bowen also believed that it is necessary for people to be in well-established intimate relationships, able to draw upon these relationships under stress, and able to appreciate and enjoy them as part of basic human needs and interactions. It is clear from his writings that he believed **intimacy** is an important part of differentiation and that differentiation and autonomy are not the same thing. Bowen also talked about **basic self** and **pseudoself**. The basic self is stable and is less likely to be affected by day-to-day situations. The basic self is

established through the **nuclear family projection process** and does not change much after childhood. The pseudoself, on the other hand, is one's ability to distinguish a sense of self depending upon particular situations. The concept of the pseudoself accounts for apparent changes in maturity or personality. The pseudoself relates to the way an individual can be overconfident in some situations without being considered an arrogant person or can act silly with children or certain friends without being considered a childish person.

Finally, Bowen believed that people tend to marry those with similar levels of differentiation of self. A newly engaged couple are at their most undifferentiated, or fused. That is, newly engaged people are immensely affected by their oneness and by each other's wishes and desires, and they are quite vulnerable to each other's systemic needs. One member of the couple may *appear* more differentiated than the other, perhaps by acting more emotionally stable, but this is due to the effects of pseudo rather than basic differentiation.

To summarize, differentiation of self is the center of Bowen's theory. The concept describes both the psychological ability to distinguish thinking from feeling and the relational ability to distinguish self from others. It also describes the ability to maintain both a sense of autonomy and a sense of intimacy. This ability is dependent upon three things: level of basic self, amount of stress and **anxiety**, and the emotional nature of the situation.

Triangles

Bowen believed that in nature, all things are affected by other things, including human relationships over multiple generations, and that this is a holistic or systemic rather than linear process. Using an analogy from physics, he described two-person systems as unstable depending upon the amount of stress and conflict in the system. His emphasis was on the system as a whole, not the individuals in the system. He believed that any system, given enough stress and anxiety, will attempt to stabilize by forming triangles. These **triangles**, the smallest stable unit of a system, may be formed by one or both of the individuals drawing a third person into the relationship. The third part of the triangle also can be work, a hobby, or an issue. All systems form triangles, and this is sometimes good. For example, an arguing couple may become temporarily distracted by an interesting story that one of their children tells them and become very involved in talking about the story rather than their disagreement. It may even appear that they are *using* the story to avoid their disagreement. However, after a time, when they are both more calm and able to think clearly, they may be able to resolve their difference quite easily.

If the third part of the triangle is a person, this person can be favored and may enjoy special privileges or position when stress is high. When stress lessens, this person becomes the "odd one out" and may triangle another person to reduce his or her anxiety. In this way, systems are made up of multiple interlocking

triangles with stress, anxiety, and tension dynamically moving around the system. The problem comes when there is a **rigid triangle**—one that always involves the same person, issue, or problem—or when a triangle is severe and prevents the system from dealing with the difference directly. For example, triangles may be as mild as the one described in the previous paragraph, or they may be as destructive as an affair, or drug or alcohol abuse, or involving a child or other person to such an extent that he or she becomes symptomatic.

Nuclear Family Emotional Process

Individuals and families develop typical patterns of dealing with stress in order to reduce anxiety, often referred to as the **nuclear family emotional process**. Each of these patterns can be useful, if it is moderate and flexible. If used severely or exclusively, on the other hand, it can be harmful. In mild form, each pattern allows emotions to cool down so that thinking processes are more available. When people are emotionally heated, they have difficulty thinking of alternatives and are easily reactive. "I just couldn't think clearly" is an example of this. When people are able to think clearly, they can more easily control their emotions (not ignore or bury them) and choose actions that are likely to lead to desirable outcomes rather than more trouble. Reactivity is seldom if ever helpful.

The first pattern to reduce anxiety that Bowen described is **conflict**. When there is a difference of opinion, people can talk about it reasonably, heatedly, or—in its extreme—violently. A couple may disagree about where to go for dinner. They can decide to go with one person's choice because the other got to choose last time, a process that leads to resolution and is healthy. Another way they can handle conflicts is to let the discussion deteriorate with name-calling and hurt feelings. In this case, one person may give in to avoid further conflict at the expense of his or her own autonomy. The conflict may lead to a heated argument that includes past hurts and issues and further deteriorate into mental, emotional, or physical violence. It is often puzzling to hear about the seemingly irrational "causes" of violent arguments.

The second pattern is the appearance of a **symptom** in one person. Symptoms can be physical, emotional or mental, or social. For example, one person could develop a headache or become depressed. Another person could become anxious or turn to alcohol. In extreme cases of chronic unresolved anxiety, one person could develop "stress headaches," chronic back pain, or even a serious or fatal condition such as heart disease or cancer. According to Bowen, rigid family patterns over the generations can make an individual susceptible both physiologically and emotionally to some kinds of symptoms. That is how therapists may see patterns of illness in families: heart problems, "nervous" conditions such as depression, or alcoholism and drug abuse. Social symptoms include such events as alcohol or drug abuse and related activities, problems with the law, or

poor school or work performance. Many individuals are not used to thinking of physical, mental, or social problems in this way.

The third pattern Bowen describes is **distancing**. In its mildest and most helpful form, distancing may mean something as simple as a time-out agreed upon by the people involved. It can be a way of temporarily reducing anxiety to prevent escalation of conflict that is not helpful. In moderate forms, distancing not only keeps people from becoming more anxious, it also keeps them from developing more intimate relationships that otherwise would lead to increased differentiation and intimacy as well as autonomy. In its most extreme form, distancing can mean divorce or cutting oneself off from important others.

The fourth pattern in of the nuclear family emotional process is **triangling**, which happens when tensions or anxiety rise in a two-person system or dyad. One person, or both people, attempt to reduce their anxiety by involving a third party to which the anxiety can be spread. Bowen originally limited this idea to the involvement of a child; however, therapists have come to recognize that this process can involve other people, activities, and issues. In its mildest form, triangling may serve as a temporary distraction from the anxiety-producing stress. In more moderate forms, it can actually increase anxiety because issues do not get resolved or because the relationship with the triangled person becomes problematic itself. For example, a woman may complain to her mother about her husband. The mother, in turn, tries to give helpful advice and feels closer to her daughter. After the woman and her husband calm down and resolve their difference, the mother is no longer in such a favored position. She may complain to another daughter that the woman does not listen to her advice, thereby creating another triangle. Triangling can involve more than one party or person when the first attempt is not successful or is inadequate for reducing anxiety. Similarly, triangled persons may, in turn, triangle others to reduce *their* anxiety. In these ways, anxiety spreads throughout a system and appears "contagious."

In its most extreme form, triangles include such problems as affairs, preoccupation with work, or zealousness about some topic or issue—a "cause." Notice that these things are a way of reducing anxiety in the original dyad but also may spiral back into the dyad in the form of more stress and anxiety. When the same child is always used in the triangle, that child may become symptomatic in a physical, emotional, or social manner. In therapy, it is not uncommon to see parents arguing heatedly over differences while their child waits for their support and appropriate discipline. The child's behavior may serve to distract the parents from their couple issues, but it is at the expense of the child's growth, development, and personal differentiation.

All four of these mechanisms for reducing anxiety are available to everyone. However, families sometimes "choose" one pattern or another as the family's "way," or they may elect certain individuals to carry certain patterns. These patterns may then become described as fixed characteristics of a person's personality. Each person seems to have a "typical" way of dealing with problems in general or with certain

kinds of problems or relationships. One person may tend to engage in conflict with his or her children but distance from his or her partner. Another person may become depressed whenever he or she disagrees with his or her mother. Difficulties arise when individuals or families use the same mechanism over and over or in extreme forms. Less differentiated people and systems are more likely to develop rigid or extreme patterns and to use them more often.

Nuclear Family Projection Process

The family projection process helps explain how children from the same family can be so different. Parents tend to project their unresolved differentiation issues onto one or more of their children. The children who are "elected" for this honor tend to be special to one or both parents for various reasons. The child may remind a parent of an important family member. The child may have been born at an important time in the family—when a grandparent died, for example, or after a period of infertility. The child may share a birth-order position with the parent or other family member or have a physical vulnerability. These children then tend to be the recipients of parents' attention—negative or overtly positive—which may compromise their ability to develop and differentiate. Children in the family who are not treated in such a way may suffer from lack of attention—compromising their differentiation process—or may be freed from negative attention in a way that allows them to mature beyond their parents and siblings.

Sibling Birth Order

Using the ideas of German psychologist Walter Toman (1961), Bowen hypothesized that people's sex and **sibling birth order** affected the attention they received and their roles in their family of origin. This often led to certain and particular characteristics and vulnerability to triangling by parents. For example, oldest children often tend to follow the family rules, to be more responsible, and to develop leadership skills. Conversely, younger siblings tend to be more carefree, to be irresponsible, and to march to their own drummers.

Multigenerational Transmission Process

The **multigenerational transmission process** reflects variance in levels of differentiation across generations. Over several generations, different branches of family trees exhibit more and less differentiation. The cousins on one branch seem to do very well—graduate school, high-powered professions, philanthropists, and generous helpers. Cousins on another branch, however, have problems with drugs, the law, and the in-laws. To the extent that one or more children are the recipients of the parents' negative attention or triangling, these children are stunted in their own differentiation processes and develop with possibly less differentiation than their parents. They then tend to marry people with similar levels of differentiation, and

their triangled children develop with even lower levels of differentiation. Over many generations, according to Bowen, this process leads to individuals who are so unable to think for themselves that they develop symptoms of schizophrenia, a thought disorder. Conversely, children who are spared the negative attention or triangling by their parents may develop higher levels of differentiation, marry, and produce some children who are even more differentiated. This branch of the family tree, over time, may produce a Gandhi or an Einstein.

Emotional Cutoff

Emotional cutoff describes the process by which some people attempt to distance themselves in their families so much that they believe that their families have no influence on them. People who are cut off are not able to access the intimacy and other benefits of their families and believe that they are mature, autonomous, and unaffected by their family influences. These people may move to another part of the country or world, or they may live across the street from their family members. They pretend, however, that they have no emotional involvement with their families. These people may take the opposite view on an issue, but they do not realize that this position is dictated by what the other person thinks, not their own independent perspective.

Normal Family Development

Bowen believed that the same processes are found in all families. Differences in quantity rather than quality of the dynamic determine how well a family manages stress without symptoms. That is, *all* families use processes of triangling and conflict. All families struggle with unresolved issues and problems that are exacerbated by poor differentiation. Typical families, in Bowen's view, are more or less *functional,* not "healthy" or "unhealthy." That said, for purposes of this chapter, we will examine **typical** (and relatively healthy) **family development**.

Healthier families are those that can balance the needs for autonomy and intimacy for each individual over time and across situations. Some stressful situations require that families give up "self" for a time—during grieving, for example. Healthier families are those that can pull together, assisting one another in the emotional morass of crisis, and then gradually redifferentiate, sometimes resulting in higher levels of differentiation for their members.

Fusion, or what Minuchin (1974) calls **enmeshment**, is normal in two situations: when a couple are first engaged to be married (or first make a commitment to each other—Bowen did not discuss possibilities of unmarried commitment), and when children are first born. It is normal for newly committed persons and new parents to be totally consumed by the other and quite susceptible to the emotional flooding that naturally occurs. In healthier families, this state of fusion develops into a process of differentiation. The differentiation

process is not a steady upward line. Rather, it is more like the waves of an incoming tide: some forward movement, some backward movement, but overall, forward.

Healthier families can move through the typical stages of the individual and family life cycles without undue difficulty. People are able to be flexible in their ability to tolerate conflict and difference and are able to adjust to the comings and goings of family members through birth, leaving home, marriage or commitment, death, and divorce. Children are involved in parental triangles, but not excessively, and they are able to get on with their own lives when released or when they free themselves. Parents do not inappropriately involve children in their couple life, nor do they overfocus on their children or each other, unduly giving up self for the sake of the other. There is a good balance of family, couple, and individual time. People are relatively symptom free and, when symptoms of systemic stress are evident, they are easily overcome and the family moves on in its evolution. Members of the extended families are neither overfocused upon nor cut off.

Pathology and Behavior Disorders

The corollary of functional family processes is dysfunctional processes. This is where Bowen's view—that dysfunction is a matter of quantity rather than quality—differs so significantly from other theories' views. For example, Bowen believed that the processes that are evident in individuals diagnosed with schizophrenia or other problems are operating in everyone. Everyone can "hear voices"; it is just that some people hear them to a greater degree and with greater discomfort (or greater discomfort to others).

Whether a particular behavior is problematic is decided more by the individuals or situation than by some gold standard of health. For example, whether someone is given treatment for schizophrenia may depend on how well the symptom is succeeding at reducing anxiety in the triadic system in which it is embedded. If no one in the system is troubled and the system is otherwise stable, it may be that no treatment is necessary. However, if someone is troubled by the difficulty or if it does not decrease anxiety (indeed, it may *increase* anxiety), someone may decide that professional treatment is needed. It is at this point, when someone labels something as problematic, that it *becomes* problematic. A behavior in and of itself would not be considered problematic, in Bowen's view.

Any of the four anxiety-reducing mechanisms described (conflict, distancing, triangling, and symptoms) can be problematic. This is more likely to happen when a family is caught in a generations-old pattern that uses one or two of the mechanisms excessively. Any system, however, even the healthiest, may appear or become dysfunctional given enough stress. The key factor, in Bowen's view, would be how differentiated the individuals are and therefore how able they are to rebound from the stress with fewer, less severe, and shorter-lived symptoms.

Another situation in which symptoms may appear involves a parental dyad that is so unstable and fraught with stress that the anxiety spills over onto more

than one child. In these situations, each child develops his or her own way of absorbing or managing the anxiety. One may develop physical symptoms; another, school problems. One may become antisocial and another may work so hard to be "good" and overfunction that she or he slips into depression or another emotional illness. Rarely, such a child may be able to detriangle and redirect the anxiety back onto the parents.

In couples who do not triangle their children, one partner may act as an "overfunctioner." Such a position requires a complementary "underfunctioner" in order to exist. That is, there can be no overfunctioner if no one is in need of such care. The overfunctioner often appears healthier and is sometimes held up as a martyr. Examples are long-suffering husbands of depressed women and long-suffering wives of alcoholics. However, recall that Bowen believed that people married others with similar levels of differentiation. One partner simply *appears* healthier. The overfunctioner is just that: *over* functioning. To be functional, a person is neither overfunctioning nor underfunctioning. This does not mean that people should not take care of each other. The process described refers to a habitual pattern in which one person must play his or her role to the exclusion of other roles and at the expense of self-differentiation. The difference between health and not-health in such situations is evident when the caretaker becomes overburdened and either obtains help from outside (healthier) or becomes dysfunctional (less healthy) himself or herself.

Clinical Goals

The chief goal of Bowen family therapy is differentiation of self. Bowen believed that problematic behaviors ought not to be the focus of therapy except as they point to habitual and unhelpful family processes or issues. Simply talking about problems will not make them go away, because the underlying difficulty is the system's inability to handle stress without symptoms. Increasing differentiation helps people increase their ability to think rather than act and therefore to choose responses rather than using habitual, impulsive behaviors and to handle stress without overusing any of the four mechanisms.

A goal of therapy is to have individuals detriangulate from within a complex network of relationships, particularly in his or her family of origin. Difficulties with partners and children often are directly tied to, or heightened because of, rigid and harmful triangles in families. Pragmatically, it often is easier to calm emotions in the family of origin and to pull oneself out of those dysfunctional triangles first. This often calms the family anxiety sufficiently so that progress can continue in therapy.

Mere symptom removal is not a goal of Bowen family therapy. Symptoms can be removed, but without changes in triangles or differentiation of self, symptoms of one sort will be replaced by symptoms of another sort. Triangles in one situation may abate, but the need to reduce anxiety will not, and other triangles will

appear. Some of these triangles may be less unfortunate than others. For example, a couple may stop triangling a child into their relationship and may use a therapist for a time to reduce their anxiety. If the therapist can maintain his or her own self and not become anxious—can remain a calm third and temporary point in the triangle—the system may become stable enough to allow the couple to resolve their difficulties directly and increase their differentiation. This allows healthier functioning in terms of separating emotion from thinking, self from other, and self from family of origin.

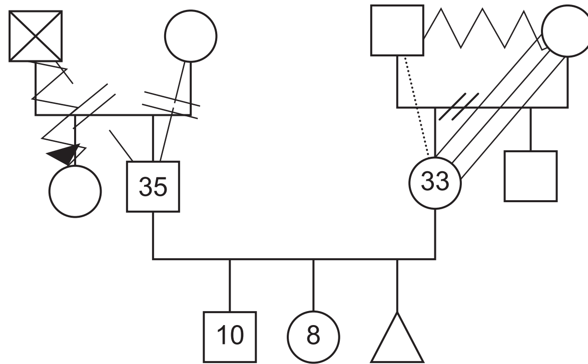
Techniques

The chief technique of Bowen therapy is the therapist herself or himself. People come to therapy because their usual ways of managing stress and anxiety are not working and often involve high emotionality. From this perspective, therapy becomes the third point in a triangle, one way to reduce anxiety and stabilize the system. To the extent that a triangled person can remain calm and not get pulled into the anxiety of the dyadic system, the dyadic system can resolve its difficulty, which may increase differentiation for both persons. However, in most intense emotional systems such as families, it is very difficult for the third person to remain calm. In therapy, the differentiated therapist has the opportunity to help clients by remaining calm, not becoming activated by the clients' stress and anxiety, not getting caught up in the family's issues, and helping the clients think about what is going on. Therefore, the chief technique is the calm presence of a differentiated therapist.

Recall that Bowen believed that very few people, including therapists, are very well differentiated. Therapists can become reactive and feel compelled to search for answers, give advice, and *do* something. This is not helpful if it does not help the client increase his or her ability to think under stress. Therefore, therapists must increase their own differentiation of self through Bowen therapy. By learning about their own "toxic" issues and detriangling in their own families of origin, therapists are able to increase their ability to think and remain calm when they are invited to take on others' anxiety.

Genograms

Beyond the presence of a calm therapist as technique, a few practices are hallmarks of Bowen therapy. The first step is helping the clients understand the family system in which they are embedded. Rather than protecting hypotheses and insights, the therapist explains the principles of the model to the clients so that they have a clearer picture of what is happening and a map to use for guidance. This map is sometimes called a **genogram** or **family map** (see Figure 10.1). It is like a family tree, but includes information about mental health and relationships in addition to demographic information.



□ = male; ○ = female; ✕ = death; △ = child in utero; // = cutoff; ^^^ = conflicted relationship

FIGURE 10.1 Basic Genogram Showing Parents with Two Children and a Pregnancy. (Father is cut off from his mother and his father, who is dead. The mother has a fused relationship with her mother and a distant relationship with her father. Her parents are divorced and their relationship is conflictual.)

The genogram gives a quick picture of what the family looks like: men and women, marriages and divorces, children, dates, and significant events. The genogram may also contain information about emotional functioning including overinvolved relationships, cutoffs, distance, and conflict. By drawing these relationships on the genogram, clients and therapists are able to see triangles and patterns of reacting to stress. This information may give clues to how and where clients can detriangle and change their own functioning in the family. According to systems thinking and Bowen theory, when a person changes his or her own position in the family, others *must* change in order to adapt to the first person's changes. The genogram also holds clues to probable reactions. The more rigid the family pattern, the more likely it is that family members will react to change with messages that suggest the client should "change back" to predictable ways. Knowing the typical family patterns and helping clients choose wisely in their strategies can reduce the likelihood of discouraging results.

The therapist also helps the client identify particularly loaded or toxic family issues. These issues are the ones that tend to get people stuck, and people are often less likely to be able to think independently about them. These issues may include money, childbearing or child rearing, religion, alcohol, or affairs.

Detriangling

The therapist helps clients detriangle in sticky emotional systems by having them think about their positions in these systems when they are less emotional and

therefore more able to think clearly about them. This increases intellectual functioning, but not at the expense of intimacy. By planning detriangling moves and anticipating family members' countermoves, the client is able to prepare for new family interactions, ones in which she or he is an actor and a responder rather than a reactor.

Therapeutic Mode

Bowen preferred to work with couples. He believed that child difficulties were symptomatic of the way the parents involved the child in their marriage. By replacing the child in the triangle, Bowen was able to free the child so that he or she could continue his or her normal development and, at the same time, to assist the couple by being a calm rather than reactive part of their triangle. According to these ideas, the child's symptoms would disappear because the child was detriangled and because the parents would become more able to care for the child appropriately—better than any therapist could.

During the couple sessions, the therapist helps the clients maintain their self-positions using two important techniques. First, the clients are seldom instructed to talk with each other unless the therapist is sure that they can do so without being reactive to each other. Rather, the clients are instructed to talk to and through the therapist. One partner is able to listen less reactively to the other than when the partners are talking directly to each other, which tends to activate more emotions than rational thinking.

Second, the therapist asks each partner what he or she thinks about what is being discussed. By encouraging thinking and talking in the form of **"I" statements**, the therapist helps the clients differentiate their emotional and thinking systems, bringing thinking to the forefront. Emotions are important, but because of the tendency to get caught up in them and to not think clearly, therapists encourage clients to talk about them rather than reexperience them. Experience alone, without thoughtful examination, does not help people change their lives, according to Bowen.

As couples become more able to talk calmly without resorting to their usual patterns of reacting, the therapist steps back and intervenes only when the system needs calming again. As the two increase their differentiation from each other (which is accompanied by both increased autonomy *and* increased intimacy), they are more able to help each other in differentiating in their families of origin. The genogram helps them understand how they came to be the way they are and to plan new ways of interacting with each other. The genogram then becomes a tool for planning changes in the couple's respective families of origin. At this point, therapy often becomes less frequent. It takes time for changes in families of origin to be accomplished. Also, at this time, many couples discontinue therapy. Their anxiety has been reduced and they sometimes do not see the need or the value of continuing. Sometimes, the idea of making changes

in the family of origin produces enough anxiety to make therapy seem unnecessary, unduly difficult, and even dangerous for the individuals.

Bowen therapists also work with individuals, but in very systemic ways. Examining the genogram over multiple generations helps people understand past patterns and plan changes so that rigid patterns are not carried forth into future generations.

Contextual Family Therapy

Contextual family therapy was developed by Ivan Boszormenyi-Nagy, a psychiatrist who was a contemporary of Murray Bowen, Carl Whitaker, Lyman Wynne, and other psychiatrists who also were developing ideas regarding the multigenerational nature of relationships and, particularly, problems. Nagy believed that individuals and families are governed not only by patterns of behavior that are developed over multiple generations but also by principles of relational fairness. The core concept of contextual therapy relates to the **trustworthiness of relationships** in terms of an oscillating balance of credits and debits, or give and take. A context of **fairness**, **mutuality**, and trustworthiness leads to individuation, **balanced relationships**, and personal fulfillment. This theory takes into consideration **ethical dimensions** of relationships and the way loyalties, legacies, entitlements, and obligations are balanced over time and over multiple generations.

Key Concepts

According to Nagy's ideas, there are four dimensions to an understanding of relationships and the parts played by the individuals in them. The first of these dimensions is **facts**, the undisputed things that have happened or that exist. These include birth, death, physical differences, marriages, divorces, and natural and human-made events such as hurricanes and war.

Unlike in other models of family therapy, **individual psychology** is an important dimension in contextual theory. Contextual therapy considers the dynamics of individuals' inner lives, including thoughts, dreams and aspirations, intellectual ability, and emotions. Elements of individuals' psyches interact with others' in ways that encourage patterns in relationships—good and bad, helpful and harmful. This is especially important when dynamics from one person's family are similar to a partner's and evoke certain expectations, emotions, and reactions.

Transactional patterns are the ways that people interact with one another. These processes are both simple and complicated, involving just two people and involving many people over multiple generations, even those who do not know each other. Interactional patterns are not a primary target here, as they are in other family therapy models. Rather, they give clues as to the legacies, entitlements, and **indebtedness** that constitute fair and just relatedness over time.

The final dimension that Nagy discussed is the ethics of due consideration, or **relational ethics**. This concept does not refer to ethics or morality as they typically are understood. Rather, it refers to what Nagy believed was the natural and fundamental basis for interactions: a balance of ethical consideration for others' interests as well as one's own. According to this idea, people both deserve and owe fairness in their relationships. This dynamic is called "trustworthiness" and is considered over time and across generations. Something that does not seem fair in the present interaction must be and can be balanced at a later time. Failure to consider others' interests can lead to symptomatic behavior and relational problems. This concept does not refer simply to a *felt* sense of injustice, unfairness, or entitlement. Rather, it is in the **existential**, natural order of humanity that people are treated fairly and that they treat others fairly in relationships. Therefore, people who have not been treated fairly cannot simply "get over it," but must, in some way, be involved in **exoneration** through exonerating and/or being exonerated. In order for this to happen in therapy, (1) the therapist must demonstrate consideration of all people and relationships involved, including past and future generations, and (2) the clients must understand the need for consideration on all sides and to make efforts to balance the ledgers in the family.

To the extent that relationships are trustworthy, the individuals within them are involved in balanced give-and-take. Each person deserves and receives consideration of his or her interests by others. People are neither exploited nor scapegoated. No one must balance a ledger with negative behavior; relationships should serve as resources of trust for the people involved in them, so that they can navigate other relationships without undue strain.

An important concept of contextual therapy is **loyalty**. Loyalty is not simply blind faithfulness, commitment, and dedication to another person. Rather, loyalty to parents, for example, is what is owed to parents by virtue of what they have given their children through birth and care. Loyalty is fundamental and factual in parent-child relationships. Parents maintain a balance of fairness with their children, which reinforces the loyalty commitment of the children.

Overt or healthy loyalty is demonstrated when people are able to keep the lines of communication open with their parents, even when the parents are difficult or require great amounts of care. Covert or **invisible loyalty**—when people are not consciously aware of the dynamic, but are nonetheless driven by it—is destructive. Because they are not aware of the nature of the loyalty, they are unable to make choices about repayment. Repayment and demonstration of invisible loyalty are made through automatic, driven, and often destructive actions. An invisible loyalty to a legacy of failed marriages—where a person feels as if to do better might demonstrate a lack of loyalty—may doom a person to failure in his or her relationships.

Legacy refers to expectations within a family that may be spoken or unspoken, conscious or unconscious. These expectations are derived from being born to particular people and the belief that we owe family some measure of loyalty.

Failure to meet legacy expectations can lead to loss of trustworthiness in the relationship and can violate fairness to previous generations, even when the legacy is negative in nature. If one has a legacy obligation to a family, he or she may "pay it off" in kind to the next generation. For example, an abused child learns to abuse. He or she may pay the debt by continuing abuse into the next generation. A person may be dealt a legacy of failure and evidence his or her loyalty to family by continuing to fail. Therapy involves conscious efforts to give up nonproductive legacies without blaming or cutting oneself off from the prior generation. Instead, the client consciously develops constructive ways of balancing ledgers and paying debts instead of unconstructive or damaging methods of paying that debt.

Entitlement is what is due to people by virtue of the fact that they are born or give birth, plus any merit that they earn. Children are entitled to trustworthy parenting, for example. If they don't receive it, they will provide for it themselves through **parentification**, thereby participating in an untrustworthy relationship. As children grow, they also are entitled to make efforts to fulfill their obligations. Parents who do not allow children to do this contribute to unbalanced ledgers of entitlements and obligations. Parents are entitled to consideration by their children, depending upon the child's age and ability to pay the debt.

People earn **merit** by being trustworthy and considering the interests of others. Merit is specific to particular relationships and can be repaid only in those relationships, not in any others. This creates difficulty, for example, between parents and children when children can never fully repay their parents for giving them life as well as the love and care (or lack thereof) they received when they were growing up. Merit is earned by crediting others with their contributions to relationships even when they are, at the same time, behaving in difficult ways. This can be seen when parents are able to love their children at the same time that they are angry with them. In this way, children "owe" their parents for their ethical fairness in the relationship. Children earn merit by exonerating their parents for failures and credit their parents by understanding them in a multigenerational perspective.

The family **ledger** is a balance sheet of entitlements and **obligations** and indebtedness. The ledger may appear unbalanced at any one point in time due to life cycle stages, particular circumstances, and the nature of human interaction. However, over time, it is expected that people will maintain their trustworthiness by paying back their debts through actions and exoneration. Relationships in which people are not allowed to pay their debts are not trustworthy and do not contribute to healthy growth and development. That is, parents do their children no favors by refusing to accept a child's efforts to acknowledge and pay debts. Over time, imbalances in ledgers may lead to **stagnation**, or lack of development toward autonomy and trustworthiness in the relationship. A person may never give up the search for ways to restore balance in the parental relationship.

As you can see, the idea of a ledger, borrowed from economics, speaks to an economy of what is owed and what is due in relationships. Some of these debts or obligations and entitlements arise simply from the act of being born. Even adopted children who never know their biological parents still have a loyalty obligation to them. When attempts to forestall the oscillating balance of entitlement and obligation are successful, relationships stagnate and people may develop symptomatic ways of fulfilling the legacy. For example, an adopted daughter may give birth as a teenager. She may decide to keep the baby as a way of making up for what was missing in her own parent-child relationship, or she may decide to give the baby up for adoption as a way of continuing the legacy her birth mother paid her, a way of demonstrating loyalty.

Nagy believed that problems in living are embedded in the numerous and complex relationships of multiple generations. To the extent that relationships are trustworthy—that is, balanced in terms of credits and debits—they serve as resources as people develop other relationships, even troubled ones. A reserve of trust can carry a person through an unbalanced period, but a multigenerational deficit of trust—of negative loyalties and unfulfilled entitlements—can prevent someone from being trustworthy in other relationships. This reserve or lack thereof then affects future generations.

The **revolving slate** is the process by which entitlement is "paid back" through destructive actions, either to oneself or to others. Sometimes a child has not been treated fairly and has not had basic needs met by his or her parents, usually because the parents also were treated unfairly and had no merit or trust to give their child. In these circumstances, the child may enact his or her legacy by getting into trouble, treating others badly, using drugs, or doing poorly in school. This revolving slate of **destructive entitlement** will continue until something happens to balance the ledger and restore the family relationships to fairness and health. As you can see, this may mean examining ledgers over many generations.

Nagy believed that revolving slates of destructive entitlement are the chief factor in couple and family dysfunction. An imbalance in the ledger over time leads to discouragement and stagnation in relationships, a depletion of trust resources, and a lack of consideration for the interests of others. This lack of consideration leads to revolving slates of destructive entitlement. Therapy helps by drawing attention not to the particular issue or dysfunctional behavior, but to the lack of fairness in important relationships. Attempts to make up for this lack of fairness, driven by invisible loyalties and the particular nature of one's legacy, appear in couple and family relationships as problems or acting out. Conflict or lack of intimacy in a marriage is more a reflection of a need to demonstrate loyalty to parents than lack of communication skills or poor problem-solving methods, according to Nagy. **Exploitation** (taking advantage of someone's dependency position in a relationship) and **scapegoating** (placing a negative legacy on a child instead of accepting it) are two ways that the revolving slate and stagnation can develop into symptoms or complaints.

Normal Family Development

Imbalances in relationship ledgers are inevitable. Life is not always fair, and people do not always treat one another fairly. However, in the well-functioning family, there is a balance over time, an oscillation of give-and-take that keeps the entitlements and obligations in balance. Children become more accountable for their debts as they mature and are allowed to make payments, although they may never be able to completely repay their parents. People are able to consider the interests of others in their actions and decisions. Trustworthy relationships are strong and encourage autonomy in children, which increases everyone's entitlement to take responsibility for their decisions and actions. Yes, people are *entitled* to accountability. This accountability and acknowledgment increases the trustworthiness of relationships, adding to the well of trust upon which people must draw from time to time.

The well-functioning family has no hidden ledgers or undue amounts of unpaid debts. Life cycle transitions offer opportunities for further growth as changes are negotiated among family members. There is mutual reciprocity of care, consideration, and interdependence. No one is unduly exploited or scapegoated, and no one is held in unhealthy dependencies as a recipient of unhealthy attempts to pay old debts. Resources of trust help people as they develop and navigate the stresses and strains of life. Symptoms are not necessary, because relationships are trustworthy and everyone is overtly aware of and able to consider everyone else.

Pathology and Behavior Disorders

The chief reason for **disjunction** is a breakdown in trustworthiness. This break leads to stagnation and a lack of flexibility in relationships over time. Nagy used the word *disjunction* rather than *dysfunction*. He believed that systems malfunction not because they are pathological or dysfunctional but because the ethical considerations that are necessary for healthy functioning are broken. This may seem to be quibbling over words, but it is important to understand how Nagy saw the existential character and being of a family over time. The balance necessary for healthy functioning is not something that can easily be assessed, pinpointed for its brokenness, and "fixed." Rather, the very nature of the family interaction is amiss. People need to understand the ethical nature of relatedness and address it as a fundamental property of making relationships something that hold people in justice and fairness, increasing both individuals' autonomy and their sense of connectedness to the family goodness.

When relationships are not balanced, people become disengaged from caring for others and being accountable to them (as well as to themselves). This leads to destructive entitlement—vengeful or spiteful behaviors by the entitled person. This stunts personal growth and further destroys trustworthiness in relationships.

Sometimes, parents exploit their children's vulnerability and needs, parentifying them or engaging them in split loyalties. Parentifying is a process whereby

children are inappropriately brought into the marriage or expected to take on responsibilities beyond their abilities. **Split loyalties** occur when a child can be loyal to one parent only by being disloyal to the other parent. This is similar to triangling (discussed previously in the section on Bowen therapy) and is destructive, binding children in processes for which they cannot balance their ledgers. Paying back one parent (loyalty) is accomplished at the expense of trustworthiness in the other relationship (disloyalty). Asking a partner not to give consideration to a parent results in a **loyalty conflict** and breaks trustworthiness in the couple relationship, leading to dissatisfaction and conflict.

When loyalties to past generations are unspoken, they may interfere with a person's loyalty to a partner or to children. These invisible loyalties are often very insidious and difficult to examine. They are very powerful, however, and sometimes seemingly paradoxical. For example, if a parent or grandparent did poorly in school, there may be an unspoken, invisible loyalty that keeps a child from doing better than his or her elder or succeeding in some other way. This is not "fear of success" but "fear of violating an invisible loyalty." These destructive legacies can lead to all sorts of problems and symptoms, from indifference to depression or even homicide.

Clinical Goals

The change that needs to occur, according to Nagy's contextual theory, is not merely behavioral or interactional. Behaviors and relationships can change, and it can appear that the family has been restored to balance and fairness. However, this change may be very temporary and very much on the surface. According to Nagy, the change that needs to occur is in the consideration of obligations in relationships, in the balance of entitlements and debts, and in the ways that people enact their loyalties and legacies.

The goal of therapy is to enable people to make efforts at **rejunction**. Rejunction is a healing of the breach or disengagement in important relationships. It is a reconnecting so that ledgers may be balanced and autonomy and trustworthiness established. Rejunction is the refusal to allow stagnation to prevent connection and fulfillment. The therapist works as a guide to the process by assisting people in examining all interests and developing action plans that will be rejunctive or healing in relationships, rather than continuing legacies of problems and unhappiness.

Rejunction is accomplished in therapy by first opening up a perspective of fairness in terms of considering others' views as well as one's own. Learning about and understanding (although not necessarily agreeing with) other people's perspectives and one's own behaviors, thoughts, and feelings can be placed in the larger relational context that includes multiple generations. Grievances are examined in their original contexts of loyalties, legacies, entitlements, and revolving slates and not just in terms of their present-day consequences. For example, an adolescent's behavior is understood in a context of how the youth is acting out

a legacy that is bigger than even the parent-child relationship. People are held accountable; this is not a therapy that lets people off the hook for their behavior. Rather, the behavior is understood in a context bigger than the problem so that people can develop new, less destructive ways of balancing ledgers.

Rejunction begins with an understanding of the dynamics in multiple generations of relationships, but it must include actions or efforts to heal the breach. The therapist begins by demonstrating **multidirected partiality**. The therapist does not side with any one person, but takes in and even demands each person's position and views of the unfairness in the family, their own as well as others'. This is not *impartiality*; the therapist is very invested in holding all perspectives as important and valid. By sequentially listening with curiosity and genuine interest to family members, the therapist demonstrates that everyone's interests and opinions are important and necessary to the process.

In marital therapy, the therapist demonstrates the principles of fairness to **posterity** (future generations) by pointing out how parenting is a part of marriage. When couples have no children, they are still accountable to their parents or to others who may have investments of trust in them. Thus, children's positions are important in marital therapy. For example, when spouses complain to and about each other, the therapist may ask the children how this affects them, whether they feel tugged and pulled, and what their obligations are in the family in order for the parents to understand the effects of their legacies and behaviors on their children.

The therapist considers the interests of everyone involved, not just those present in therapy. This includes those who are absent, dead, or not yet born. To the extent that the therapist can hold this context as important, family members develop new understandings of their own and others' actions and the need to find other ways to balance ledgers and pay debts.

Assessment includes an examination of relationships for their trustworthiness and resources of trust. All four dimensions of relationships are explored, although the relational ethics of balanced reciprocity transcend those of facts, individual psychology, and transactional patterns. Each client is held accountable for assessing his or her own position and situation and for explaining it to others. In this way, each person holds all others accountable for considering his or her interests. The therapist is flexible and sequential in understanding and being curious about each person's views of entitlements and obligations.

After assessing each person's ability to engage in trustworthy interactions, the therapist helps each person understand where and how imbalances may be occurring. Discussion then centers on how rejunctive efforts are going to be made—that is, how old debts and obligations are going to be paid. Therapy is very much action oriented, but the therapist does not assign tasks. Rather, the therapist helps the clients decide what actions to take by being curious about reserves of trust and about possible consequences of certain actions. The therapist prods, encourages, confronts, and supports clients in their efforts to rebalance relationships so that symptoms are not necessary, always considering the interests of everyone involved.

It is not necessary for rejunctive efforts to be successful in the sense that family members open their arms and harmony is restored. Payment may come from rejunctive efforts in themselves. That is, attempting to reconnect is rejunctive in and of itself. The therapist, by holding the therapeutic relationship trustworthy, helps the client develop ways of attempting rejunction and supports the client in both successes and failures.

The therapist **sides** with each and every client, holding each accountable for exposing injustices as well as for making efforts to pay debts. Through this process, the therapist demonstrates and models fairness in relationships, allowing clients to (1) explain their own perspectives and positions, (2) understand how their and others' actions fit into the multigenerational patterns, and (3) develop plans for reconnecting with parents and others and exonerating them for past hurts. Clients must always be held accountable for their behavior, regardless of its multigenerational context of loyalties and legacies. However, by understanding this context, clients can allow themselves to accept these and other actions as attempts to balance ledgers, not because a parent wanted to hurt a child, but because all were bound up in revolving slates.

The therapist helps clients place seemingly negative behavior in a relational context partly through **loyalty framing**. Although Nagy did not claim to use positive connotation, reframing, or relabeling, loyalty framing certainly resembles these therapeutic techniques. For example, the therapist may explore an acting-out teen's behavior as a loyal attempt to fulfill a father's legacy, thereby drawing attention to the destructive nature of the family relationships, forcing the family members to find other ways to deal with one another and past generations. This frees the teen from the hot seat and places him or her in a different role among all relationships, not just as the focus of the current family concern or anger.

Exoneration and rejunctive efforts are not always met with pleasant results. Sometimes clients are so aware of possible negative reactions that they choose not to try. However, through engaging in a trustworthy relationship, the therapist can help them free themselves from negative legacies so that they and future generations do not repeat the same hurtful actions. Therapy may end without joyful reunions; it ends, however, when people are able to reestablish their own positions as trustworthy in relationships, building reserves of trust that can be used to repair and enhance current and future relationships. They are then able to make a commitment toward rejunctive action and behaving ethically in all relationships. This may take as little as a few sessions or as long as a few years.

James Framo

James Framo started seeing couples and families in the late 1950s. Through his interactions with Nagy (Boszormenyi-Nagy & Framo, 1965) and others, Framo developed a therapy that integrated ideas from **object relations theory** and techniques of conjoint marital and family therapy. The chief idea from object

relations theory that intrigued Framo was that of **projective identification**. During infancy, we are dependent upon caretakers to meet all our needs. The primary caretaker has both good and bad characteristics. For example, the caretaker feeds the child when he or she is hungry (good), but may not always do so as soon as the infant would like (bad). Because there is no way for the infant to change the bad parts of the caretaker, these parts are incorporated into the psyche as **introjects** or representatives of the external object (caretaker). These introjects become part of the personality as unconscious objects, or "splits." People tend to view the world as though it were made up of the same kinds of objects with which one was familiar as a child, although this usually is an unconscious process. Mates select each other by "discovering" lost aspects of themselves in their partners, aspects that are familiar but not primary parts of the self. People project the introjected bad parts of themselves onto their spouses and children and then battle them. This is an attempt to resolve old issues in current relationships rather than in the parental generation, where they belong.

Therapy consists of first helping people understand these concepts, freeing them to interact with their partners in more constructive ways. They are not totally free, however, until they have understood their parents in the fullness of their persons, not just the introjected and bad remembered aspects. To accomplish this, Framo first prepared individuals and couples through conjoint marital and group marital therapy. He then invited whole families into therapy, usually in a marathon weekend of two 2-hour sessions. In the family-of-origin session, Framo helped clients talk about things the way each of them remembered them, enlarging their perspective so that it included parents and siblings as whole people, not just introjects. By understanding their parents differently and the role that past interactions play in current relationships, clients are further freed to interact with their spouses and children as real people, not battle split-off projections of themselves. After the family-of-origin sessions, the couple could be free to explore their interactional dynamics in a larger context, reducing blame and opening opportunities for more intimate connections.

Framo believed that children's problems are reflections of their parents' unresolved marital and family-of-origin issues. He believed that the best way to help children is to help their families. Therefore, he did not typically see children in therapy. Framo also believed that cotherapy is useful to the extent that the cotherapists can assist each other in not becoming entangled in their own unresolved object relations issues. Similar to Bowen and Nagy, Framo believed that good therapists examine their own family-of-origin dynamics.

Diversity Issues

It is difficult to separate an individual's beliefs and behaviors from a family's culture, or shared background. For this reason, it is important to thoroughly explore a client's family history. Genograms are an essential tool for transgenerational therapists,

and many researchers have focused on the adaptability of the genogram to culturally diverse families. The genogram is versatile and can be used to explore different facets of a family's multigenerational history. In order to assess diverse components of a client's life, Thomas (1998) described the multicultural genogram: "As the multicultural genogram can improve cultural socialization, determine the impact of culture on family roles and functioning, and highlight family differences, it is an important assessment tool for family counselors" (p. 25). Thomas (1998) provides examples of questions to address cultural factors such as race, ethnicity, immigration, gender, socioeconomic status, and spirituality.

More specific genograms addressing varying cultural facets have also been addressed in research. Variations of the genogram include the spiritual genogram (Frame, 2000), the sexual genogram (Belous, Timm, Chee, & Whitehead, 2012; Hof & Berman, 1986), the gendergram (White & Tyson-Rawson, 1995), and the African American genogram (Watts-Jones, 1997).

Research Evaluations

Many of the concepts and assertions in Bowen's theory have been supported through empirical research, specifically the relationships between differentiation, chronic anxiety, marital satisfaction, and psychological distress (Miller, Anderson, & Keala, 2004). Researchers in this field have been aided by the development of several differentiation scales. The most used is the Family of Origin Scale (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). This scale purports to measure the balance of intimacy and autonomy as a measure of family health. The scale has been used recently to show differences in family health in a number of clinical and nonclinical samples (see Chung & Gale, 2009; Gardner, Busby, Burr, & Lyon, 2011; Smith & Ng, 2009).

The Differentiation of Self Inventory (DSI; Skowron & Friedlander, 1998) is used to measure Bowen's theoretical construct of differentiation of self (see Sandage & Jankowski, 2010; Schwartz, Thigpen, & Montgomery, 2006; Skowron, 2004; Skowron, Stanley, & Shapiro, 2009). Kim-Appel, Appel, Newman, and Parr (2007) studied individuals aged 62 years or older, and using the DSI found that there are significant relationships between level of differentiation and level of psychological adjustment for older adults. This study adds support for Bowen's concept of a stable level of differentiation across the life span.

Bray, Williamson, and Malone (1984) developed the Personal Authority in the Family System Questionnaire (PAFS-Q) to measure the extent of personal authority in an individual. Williamson (1981) hypothesized a life cycle stage called "personal authority," typically found during a person's mid-30s. This life cycle stage is marked by the ability of an adult to see her or his parents as real and distinct people similar to other people. Personal authority allows people to have adult rather than parent-child relationships with their parents.

Using the Family of Origin Scale and the PAFS-Q, Nelson (1989) attempted to investigate Bowen's notions that (1) people tend to marry those with similar levels of differentiation and (2) the partner who exhibits symptoms is not necessarily less differentiated than the more functioning partner. She found that married people in her sample were similar in terms of personal authority and that people in therapy were more similar to their partners than to subjects in a nonclinical sample.

Fewer studies have been conducted on the concepts of contextual family therapy. Grames, Miller, Robinson, Higgins, and Hinton (2008) found that the total score of the Relational Ethics Scale (Hargrave, Jennings, & Anderson, 1991) was a significant predictor of marital satisfaction in a national sample of married individuals. Additionally, Gangamma, Bartle-Haring, and Glebova (2012) used the Relational Ethics Scale to study the concept of fairness with couples in therapy, reporting support for the association between perception of unfairness and relationship dissatisfaction.

Case Study

The following case study incorporates aspects of Bowen's, Nagy's, and Framo's theories and therapies. Remember that there often are differences between *theory*, or explanations of phenomena, and *therapy*, or the ways that therapists behave. In many instances, the therapeutic technique may be more in the mind and intent of the therapist—the way the therapist thinks—than in any particular action or technique. Therapists often use techniques and interventions from many models, keeping in mind the goals that they develop from their own ways of thinking. This is as true for these transgenerational therapies as for other kinds of therapy. Similarly, explanations of what goes on in therapy or why it works may also be in the mind of the reader, the therapist, or clients.

Christine (age 29) and Rob (age 30) met as juniors in college. After they dated for a few months, Christine became pregnant, and they married shortly after they graduated. They had three children in all: Christopher (age seven), Samuel (age five), and Mackenzie (age three). Christine stayed at home with the children, while Rob worked as a fitness instructor.

Rob did not make enough money to support his family as a fitness instructor, and therefore the family lived with Christine's parents, Steve and Sharon. Rob contributed toward the mortgage payment and groceries, leaving a little money to pay for gas, as well as clothing and other supplies for the children. To help out with the monthly expenses, Christine gathered newspapers and scoured websites for coupons to help reduce the grocery bills. Rob and Christine slept in the finished basement of the house, while the children slept in bedrooms on the main level.

Christine and Rob sought therapy due to issues in their marriage. The couple reported that there was a lack of communication between them. At the initial session, the therapist first assessed the couple for potential violence. During individual sessions, Rob and Christine both said that there had never been any threats or violence. The therapist also assessed for alcohol or other drug use to determine that chemicals were not a part of the system in such a way as to interfere with therapy. Had there been alcohol or drug abuse or addiction, or if there was violence in the relationship, the therapist would have recommended other therapies before using transgenerational therapy. To do otherwise would be contraindicated because (1) the chemical itself or physiological addiction would interfere with progress, and/or (2) one or both partners would not be safe in an atmosphere of threatened or actual violence that has the potential for escalating when couples deal with difficult issues.

Next, the therapist explained the concepts of both Bowen's theory and contextual theory and completed a detailed genogram with Rob and Christine (see Figure 10.2). Rob was the middle son of three boys, while Christine was an only child. Both sets of parents were still alive, except for Rob's mother, who died due to complications during a hysterectomy when Rob's youngest brother was a baby. Rob's father ran a furniture store in his town, about an hour from where Rob and Christine lived with Christine's parents. Christine's father worked as an electrician, while her mother was a nurse at a hospital. Rob's father had a younger sister who lived with her family in a neighboring state. The two families often got together around the holidays. Rob's mother had a younger brother, but

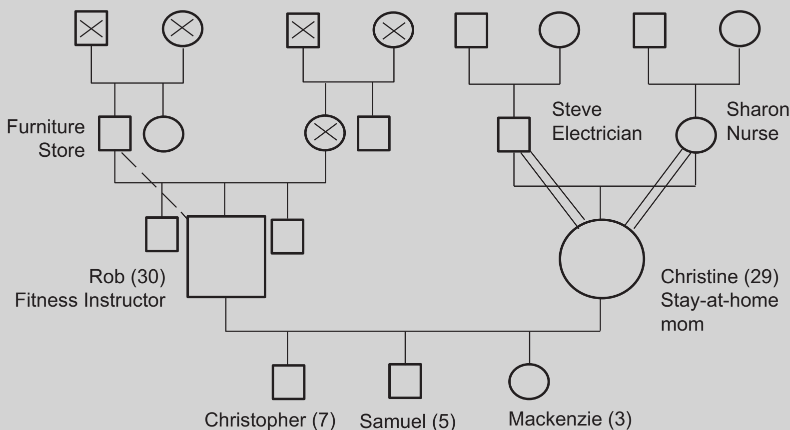


FIGURE 10.2 Rob and Christine's Family Genogram

he no longer kept in contact with Rob and his brothers since Rob's mother passed away. All four of Rob's grandparents passed away when he was young, and he did not remember them very well. Both of Christine's parents were only children, and Christine and her parents often spent time with all four of Christine's grandparents on the holidays. She reported that even though her family was quite small, everyone was very close.

Rob described his relationship with his father as strained. After Rob's mother had passed away, his father had had the responsibility of caring for Rob and his two brothers. Rob felt that he had not gotten enough attention as a child. His older brother had been successful in school and had a lucrative career in the insurance business. Rob's father often publicly praised his older brother for his successes. Rob was not praised as often, which made Rob feel as though he could never live up to his father's standards. Rob's younger brother was mischievous and had gotten in trouble at school. He demanded a lot of attention from Rob's father. After high school he had gone into the army. Rob had attempted to gain his father's praise by getting a college scholarship, which seemed to improve his relationship with his father for a couple of years, but their relationship quickly reverted when Christine became pregnant. Rob's father expressed disappointment in Rob's failure to practice protected sexual intercourse.

Christine reported fond memories of being an only child. She had enjoyed lots of attention from her parents, whom she reported as being nurturing and energetic. She also had fond memories of family functions, in which the family would often play games together or share memories about past events. When Christine had become pregnant with Christopher, she had been nervous about telling her parents, but they turned out to be supportive and offered Christine and Rob a place to stay until they could get on their feet. Both of Christine's parents, Steve and Sharon, were very actively involved with all three grandchildren (Christopher, Samuel, and Mackenzie). Christine would often go to her parents for advice about the children. Steve and Sharon attempted to stay out of Christine and Rob's relationship, but would sometimes ask Christine about it. Rob was bothered by this, but Christine did not see anything wrong with this, as she had always shared intimate details of her life with her parents.

Christine and Rob reported that Christopher, Samuel, and Mackenzie were well-behaved children who minded well and respected their parents, grandparents, and great-grandparents. Christopher was in second grade and was doing well academically. He enjoyed playing soccer with his friends and was frequently invited to birthday parties and play dates. Samuel was in kindergarten and was experiencing a bit of a transitional period adjusting to the school structure. Christine loved being home with her children so much that they had not attended day care or preschool. Her parents would

watch the children if both Christine and Rob were away from the home. Therefore, both Christopher and Samuel experienced a transition as they started kindergarten. Since Christopher had adapted to school after a few weeks, Christine assumed that Samuel would also settle down after a few weeks. Mackenzie stayed home with Christine all day and was "Mommy's helper." They cleaned the house together, went grocery shopping, cut out coupons, and played with Mackenzie's toys as much as they could.

In regard to their couple relationship, Christine and Rob reported that they had had a lot of fun as a new couple while in college. They had had many shared friends whom they would hang out with as a group. Christine had worked at the campus childcare center, while Rob worked at the university fitness center, and they would see each other as much as possible. They were both confused and scared when Christine had become pregnant with Christopher. They decided to move in together, and Rob had proposed to Christine within a few months. However, knowing a baby would soon come, they had rushed to plan their wedding. Christopher had been born during their senior year of college, and both Christine and Rob described their senior year as very difficult. They had lacked sleep, felt pressured to pass all of their classes, and worried about the future. Once they graduated they moved into Christine's parents' home, because there was not any more student loan money to use and Rob was the only one to find a job. Once she graduated, Christine loved being at home with Christopher so much that she begged Rob for more children. Rob had known that to have more children would postpone moving into their own home, but he had wanted to make Christine happy. Rob and Christine reported that they seemed to have drifted apart. Rob was so busy with work that he did not spend much time at home with Christine and the kids. They no longer had any shared activities, and they did not have much money to go out together.

Christine and Rob discussed that their nuclear family emotional process patterns seemed to be distancing and triangulating. Christine first noticed her involvement in a triangle with her parents and Rob. She said that she triangulated her parents into her relationship with Rob by sharing intimate details with them about her relationship with him. Additionally, she would go to her parents whenever she was upset with Rob or had a parenting concern. Christine realized that she tended to go to her parents because of her closeness with them. She thought that going to them might be contributing to the lack of communication between her and Rob. She decided that she would work in therapy to learn how to take her concerns to Rob and have discussions with him about her feelings and parenting concerns. She realized that this would help her and Rob become closer.

Christine also realized that she was not differentiated from her parents. Instead of achieving autonomy from her parents, Christine had become

fused with them. Primarily this had to do with Christine's small family size and high dependence on her parents financially. Christine spoke with her mother and father about this, and she realized that fusion with parents was something many people in her family experienced. Christine realized, though, that this level of fusion was preventing her from becoming differentiated from her parents and thus from forming a healthy relationship with Rob. Christine also realized that she did not want her children to experience the same fusion. With the help of the therapist, Christine found ways to become more autonomous from her parents even though they lived in the same home. She also worked with the therapist and Rob on helping her children become autonomous in developmentally appropriate ways.

In therapy, Rob discussed his relationship with his father. After his mother passed, Rob had tried to not burden his father out of loyalty, yet he could never seem to make him proud. After attempting to receive his father's approval for so many years, and then losing it when Christine became pregnant, Rob had convinced himself that he did not need his father's approval regarding his life decisions. Instead of achieving autonomy and a healthy level of differentiation, Rob had cut himself off his father. Rob decided that in this therapy he would work on his relationship with his father. He explored his needs as a child and why it was appropriate for him to desire his father's praise. He talked with his father about his father's relationship with his own parents (Rob's grandparents). Rob found out that his grandparents had treated Rob's father and his sister (Rob's aunt) in much the same way as Rob's father treated him and his brothers. His grandparents had praised the child who was the most successful while more or less ignoring the successes of the other. They had felt that it was the best parenting strategy, as it encouraged the other children to work harder to earn praise. Rob made a decision that he did not want to carry on this pattern of destructive entitlement with his children. He decided that he would make more of an effort to praise each of his children for good behaviors, especially when they seemed to be experiencing trouble with developmental transitions.

Instead of having Christine and Rob talk to each other in session to enhance their communication, the therapist had Christine and Rob talk to her. While one was talking, the other was encouraged to listen carefully. Occasionally, the therapist asked the one who had been listening to comment on what the other had just said. When she noticed that Christine and Rob started to withdraw from each other to manage their anxiety, she would turn to the genogram as a way of reducing emotionality and to help the couple manage their anxiety by getting more ideas about how their actions fit into their original families. In this way, Christine

and Rob each learned about the typical patterns of conflict, symptoms, and triangulation that their families had used to reduce marital tension. They also learned that turning to slightly different topics could help them stay connected when things became stressful between them.

Rob and Christine worked hard in therapy to change their roles within their families. They explored their legacies of work and family and their loyalties, including invisible ones tied to their legacies. They noticed patterns that they did not like and made efforts to change their own behaviors in ways that still honored their parents and grandparents. They worked together to establish new ways of parenting and communicating with each other. Rob also made an effort to establish a communicative relationship with his father in which Rob could go to his father for support when needed. Christine attempted to establish a new relationship with her parents, but in a way that also supported her relationship with Rob. Christine's parents were alarmed when Christine stopped sharing details about her relationship with Rob, but once Christine explained what she was doing they seemed to understand.

Recommended Readings

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Glossary

anxiety: In Bowen theory, the natural state that arises when two people are in human relationship with each other. As people attempt to balance AUTONOMY and INTIMACY in relationships, natural differences and attempts to resolve those differences arise, leading to mild to moderate to severe anxiety. Difficulties arise in the ways that people attempt to manage anxiety, not from anxiety per se.

autonomy: In Bowen theory, a dimension of differentiation of self that allows a person to have a self that is separate from others.

balanced relationships: In contextual theory, balanced relationships are trustworthy, fair, and each person, over time, both receives and gives as situations require.

basic self: In Bowen theory, the maximal level of differentiation of self that one achieves. The basic self remains fairly constant over time, with minor fluctuations. *Contrast with* PSEUDOSELF.

conflict: In Bowen theory, one process that a system uses to manage ANXIETY. Conflict can range from moderate, reasoned discussions of differences, to yelling and arguing, to homicide. Conflict, as a concept, is not dysfunctional or symptomatic; it is part of the condition of being in human relationships.

dependent: Having a need to have others take care of one; may indicate normal, healthy functioning (when very young or ill, for example) or chronic underfunctioning.

destructive entitlement: In contextual theory, entitlements that are "paid back" in destructive ways to self and others. Attempts to get what one is due in negative and destructive ways; often related to INVISIBLE LOYALTIES and LEGACIES.

differentiation of self: In Bowen theory, the ability to maintain a separate self while remaining emotionally connected to one's family of origin. Differentiation of self includes two dimensions: INTIMACY and AUTONOMY.

differentiation of thinking from emotion: In Bowen theory, the ability to separate thinking and feeling, but stay connected to emotions or feelings. Lack of balance in this area of differentiation leads to reactivity (too much influence of emotions) or excessive rationality (too little influence of emotions).

disjunction: In contextual theory, moving away from trustworthy relatedness. Unbalanced ledger of debts and entitlements in a family.

distancing: In Bowen theory, one process by which a system manages anxiety. Distancing can be mild or severe, rare or frequent, short lived or long-lasting. It can include methods such as taking a time-out or a more severe form of EMOTIONAL CUTOFF.

emotional cutoff: In Bowen theory, an excessive form of distancing that attempts to resolve emotional attachments by removing oneself from the emotional system.

However, the person involved in the cutoff is not differentiated, which requires an ability to remain intimate in an emotional system. Rather, such a person is still REACTIVE and tends to make decisions that are overly influenced by emotions and anxiety.

enmeshment: In structural family therapy, Minuchin's term for loss of autonomy due to a blurring or lack of psychological and family boundaries.

entitlement: In contextual theory, this term refers to merit that accumulates as a result of behaving in an ethical manner with due consideration toward others. It is different from an arrogant attitude. Rather, it is what one is actually due either from acts of credit or from being part of a fair and trustworthy relationship.

ethical dimensions (of relationships): ethical dimensions in relationships include facts, individual psychology, systems transactional patterns, and merited trust. In contextual theory, the belief that relationships which are balanced in terms of facts, individual psychological factors, transactional patterns, and merited trust are healthy and lead to satisfied family members.

existential: In philosophy, the idea that humans experience life and a sense of existing as humans. In contextual theory, this also refers to the experience of existing in relationship with others and in relation to others.

exoneration: In contextual theory, a process of seeing the positive intent and intergenerational legacies and loyalties behind the behavior of members of previous generations. When exoneration occurs, negative holds from the past are loosened, releasing the client from INVISIBLE LOYALTIES and relational debts of others.

exploitation: Taking advantage of someone's dependency position in a relationship.

fact: In contextual theory, one of the four dimensions of ethical relatedness. Facts are things handed to a person by destiny that cannot be changed: gender, particular parents, adoption, genetic predispositions and anomalies, and so on.

fairness: In contextual theory, the notion that over time, people are given their due and are given chances to reciprocate in relationships. This leads to TRUSTWORTHINESS OF RELATIONSHIPS and a sense that the relationship is healthy and will serve the needs of its members.

family map: *See* GENOGRAM.

fusion: In Bowen theory, the tendency of one person to be so emotionally attached to another that his or her own sense of self and boundaries becomes dependent on the other. It is marked by a blurring of the intellectual and emotional systems within an individual and is the opposite of DIFFERENTIATION OF SELF.

fusion anxiety: In Bowen theory, the physiological anxiety that one feels when in danger of losing a sense of self within a relationship. Often leads to symptoms.

genogram: Developed by Bowen and now used in many therapies. A schematic drawing of a family, similar to a family tree, with information about the family, including the nature of emotional relationships and dynamics.

"I" statements: A technique in systems therapy in which the therapist encourages family members to speak for themselves in the form of "I think . . .," "I believe . . .," or "I feel . . .," rather than mind reading and speaking for another person (e.g., "She thinks . . ." or "He feels . . .").

indebtedness: In contextual theory, the fact of "owing" another either because the other has earned consideration in the relationship or because the other, a parent, is simply due consideration by virtue of having given birth to the person.

individual psychology: In contextual theory, one of the four dimensions of ethical relatedness. Individual psychology refers to the way that one processes information within oneself. This may include such things as intelligence, personality, and predispositions.

interdependent: Having the ability to care for others and be taken care of by others as needs require.

intergenerational: Having to do with patterns of behavior or family dynamics between generations. Often used interchangeably with TRANSGENERATIONAL.

intimacy: In Bowen theory, the dimension of differentiation of self that includes the ability to be emotionally connected to others.

introjects: In object relations theory, taking on aspects of other people which then become unconscious parts of the self-image.

invisible loyalty: In contextual theory, Boszormenyi-Nagy's term for unconscious commitments that children take on to help their families, to the detriment of their own well-being.

ledger: A "balance sheet" of entitlements, obligations, and indebtedness for each individual in the family.

legacy: In contextual theory, expectations that originate not from the earnings of the parents but simply by being born of those parents. Legacies sometimes come in the form of INVISIBLE LOYALTIES, in that they are not in conscious awareness but are significant factors in relational dynamics and the ways that people live in the world.

loyalty: In contextual theory, the notion that internalized expectations, injunctions, and obligations in one's family of origin have powerful interpersonal influences. What to an outsider may seem an irrational or pathological behavior may, in fact, conform to a basic family loyalty. For example, a scapegoated, irresponsible child may be unconsciously acting out this loyalty message: "I will be the bad one to help you look good, because you have done so much for me."

loyalty conflict: In contextual theory, LOYALTIES can be helpful or unhelpful, healthy or dysfunctional. A loyalty conflict arises when loyalty to one's spouse is in conflict with loyalty to one's family of origin.

loyalty framing: In contextual theory, a therapeutic technique of describing a behavior in a new way that places it in a positive light, as being a way that the client attempts to live out a LEGACY or LOYALTY.

merit: In contextual theory, contributions to the balance of a relationship by considering and supporting the interests of the other.

multidirected partiality: The clinical stance whereby therapists are accountable to everyone whose well-being is potentially affected by their interventions. Everyone in therapy should feel as if the therapist understands and "sides" with them. Therapists also take into account others who are affected by the therapy, especially children and future generations.

multigenerational transmission process: In Bowen theory, similar to family transmission process. Over time, as one branch of a family tree produces more and more differentiated individuals, other branches produce less and less differentiated individuals. This accounts for different branches of families that appear very different in maturity or differentiation. According to Bowen, it takes many generations (four to ten) to produce someone with symptoms of schizophrenia.

mutuality: In contextual theory, a sense that people in relationships can count on one another to be trustworthy in reciprocal fashion. That is, there is a

sense of balance in relational credits and debits, with each receiving his or her due.

nuclear family emotional process: In Bowen theory, the dynamics that nuclear families use to manage stress. These processes include a physical or emotional SYMPTOM in one partner, CONFLICT, DISTANCING, or TRIANGLING. None of these, used in moderation, is by itself problematic. Using one to the exclusion of others or using one or more excessively can lead to individual or system dysfunction.

nuclear family projection process: In Bowen theory, the process by which unresolved lack of differentiation of parents is passed on to the children. Typically, one child is spared the triangling process and becomes more differentiated than the parents; and one child, who is triangled, becomes less differentiated and more likely to develop symptoms.

object relations theory: A theory based on notions of internalized images of self and others that occurred in early parent-child interactions. These affect a person's way of perceiving and relating to other people.

obligations: Acts and attitudes based on loyalty and on merit earned by another person in a relationship. Obligations are owed to the other in a balanced relationship.

parentification: A process in which a child is pulled into a caretaking role for one or both parents as well as siblings. A child assumes excessive responsibility in a pseudoadult role by emotionally and/or physically caring for parents or siblings.

posterity: Future generations; descendants.

projective identification: In object relations theory, a defense whereby unwanted aspects of the self are attributed to another person, which elicits these behaviors from the other person.

pseudoself: In Bowen theory, the self that fluctuates according to levels of stress in intimate and emotional situations. Pseudoself can look like basic or solid self: "This is who I am and what I believe." However, the pseudoself is more likely to be less differentiated in highly emotional or stressful situations.

psychoanalytic techniques: Techniques developed and used by early-twentieth-century psychoanalysts. The chief technique was for the analyst to allow the patient to free-associate so that unconscious material could be brought to consciousness and interpreted by the analyst.

reactive: In Bowen theory, excessive influence from emotions that leads to impulsive or reactive behaviors that have not been thought out. Opposite of RESPONSIVE.

rejunction: In contextual theory, the process of balancing an unbalanced ledger in a system of relationships. This often involves EXONERATING one or more parents or grandparents and giving up DESTRUCTIVE ENTITLEMENTS so that other relationships may also move toward balance.

relational ethics: In contextual theory, life is a chain of interlocking consequences in relationships between the generations. One's behavior is rooted in the past and, at the same time, will affect future generations. Because of this, individuals are ethically responsible for the consequences of their behaviors.

responsive: In Bowen theory, the ability to think clearly and choose behaviors or actions based on information and self-differentiation rather than purely on emotions. A responsive, angry person may *choose* to act violently or to say something that others might find objectionable. The difference is that the responsive person has chosen these behaviors after carefully considering the consequences. Opposite of REACTIVE.

revolving slate: In contextual theory, the process by which entitlement is "paid back" through destructive actions, either to self or to others.

rigid triangle: In Bowen theory, a human-system triangle that is inflexible and endures over time. At times of great stress, the primary dyad favors the third party as a way of spreading anxiety. Over time, when a system uses triangling or a particular triangle excessively, the triangle becomes rigid and can lead to symptoms in one person.

scapegoating: In contextual theory, placing a negative legacy on one's child instead of accepting responsibility for one's own legacy or debts.

sibling birth order: A concept borrowed by Bowen from Walter Toman suggesting that children in different birth-order positions tend to take on typical characteristics of that position.

sides: Side taking. A clinical technique in contextual therapy in which the therapist deliberately takes one position over another. This is a temporary stance of MULTIDIRECTED PARTIALITY so that each person feels understood and supported.

split loyalties: In contextual theory, a situation in which two parents set up conflicting claims so that their child can offer loyalty to one parent only at the cost of his or her loyalty to the other.

stagnation: In contextual theory, ethically invalid attempts at solving life's problems that prevent the development of autonomy and trustworthy relationships.

symptom: In Bowen theory, a state or behavior that signals an unbalanced and dysfunctional system. Symptoms can be physical (e.g., headaches), emotional (e.g., depression), or social (e.g., stealing). They can include excessive conflict or fighting, excessive or chronic distancing, or triangling of a child or other third party. Symptoms can be mild or acute, short-lived or long-lived. Under stress, any person or system can become symptomatic. Systems that are more differentiated tend to suffer less severe and shorter-lived symptoms.

transactional patterns: In contextual theory, one of the four dimensions of ethical relatedness. This term refers to the patterns and dynamics that develop over time for individuals in relationships.

transgenerational: Between generations of families; often having to do with transmission of patterns, values, and myths from one generation to another. Often interchangeable with INTERGENERATIONAL. In Bowen theory and others, often meaning more than two generations of patterns.

triangle: In Bowen theory, a three-person system; the smallest stable unit of human interaction. A two-person system is an unstable system that forms a triangle under stress. More than three people in a system form themselves into a series of interlocking triangles. *See* RIGID TRIANGLE.

triangling: In Bowen theory, the process of introducing a third person into a dyadic relationship to provide stability in the system.

trustworthiness of relationships: In contextual theory, the balance of debits and credits in a relationship that contributes to members' sense that the relationship is fair and will lead to fair dealings. The balance oscillates; however, over time, all parties receive their due.

typical family development: Developmental patterns that most families go through as members differentiate and form new attachments.

undifferentiated ego mass: In Bowen theory, a situation in which the family members are not able to distinguish their own feelings and thoughts from those of other family members. Often leads to dysfunctional behavior or symptoms.

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PART III

Special Issues and Topics in Marriage and Family Therapy

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11

COUPLE THERAPY

Karen B. Helmeke, Anne M. Prouty, and Gary H. Bischof

> Typically couples come in and one partner wants one thing to happen; the other partner wants something else. So satisfying both of them becomes very, very tricky. . . . Couple therapy is a very complicated form of therapy. . . . It's always been the thing that has most fascinated me and kept me captivated. . . . And even though I do workshops and am presented as an expert on couple therapy, I still find it very difficult to do.
>
> Neil S. Jacobson, PhD (1949–1999)
> Leading researcher and expert on couple therapy

In this chapter, we focus on therapy with one of the most intense and important family relationships: the intimate couple. In earlier times, this area was known as "marriage counseling" or "marital therapy." The focus was on improving relationships between married spouses. As family forms have become increasingly diversified, many have found the term "marital therapy" limiting. It does not include, for example, cohabiting couples or in some states same-sex couples who may be in committed long-term relationships. We consider a couple to be two partners who are in a serious, intimate, committed relationship, including gay, lesbian, or bisexual couples, cohabiting couples, and married couples. Thus couple therapy addresses these serious, committed relationships.

Several areas related to couple therapy will be addressed in this chapter. After a brief historical perspective, we consider recent trends in couple therapy. Next we describe some of the key clinical issues in doing therapy with couples, including how to address multicultural and diversity issues when working with couples, such as working with same-sex couples. Then we examine three well-established

approaches to couple therapy as well as discuss three emerging models. Finally, common problems in couples seen by couple therapists are considered.

Historical Background

The profession of marriage counseling began about 1930, nearly 20 years before the formal beginnings of the family therapy movement. Around that time, three professional centers for marriage counseling were established. Paul Popenoe opened a center in Los Angeles, California, and Abraham and Hannah Stone opened a similar clinic in New York City. A third center was opened by Emily Mudd in Philadelphia, Pennsylvania, in 1932 (Broderick & Schrader, 1981; McGeorge, Carlson, & Wetchler, Chapter 1, this volume). Popenoe claimed to be the first to introduce the term *marriage counseling,* and in 1930 he began seeing couples for three dollars per hour (no small sum during the Great Depression). He promoted public recognition of the marriage counseling profession through a monthly feature in *Ladies' Home Journal* called "Can This Marriage Be Saved?" which began in 1945 and continues today. He also provided case material for an early television series, *Divorce Court,* which aired in the United States in the 1940s and 1950s.

Members of this new profession of marriage counseling began meeting in 1942 and formed the American Association of Marriage Counselors (AAMC) in 1945. This group developed outside the mainstream of the mental health establishment of psychiatry. Early marriage counselors included clergy, physicians, social workers, and family guidance professionals (Broderick & Schrader, 1981). The AAMC, along with the National Council on Family Relations, published standards for marriage counseling in 1949 and identified marriage counseling as a specialized field of family counseling. This diverse group continued to assist marriages using a variety of approaches without a unifying theory. In 1970, the AAMC changed its name to the American Association of Marriage and Family Counselors, to reflect its members' interest in systems theory and the growing family therapy movement (Broderick & Schrader, 1981). This group became the current American Association for Marriage and Family Therapy (AAMFT) in 1978, as was discussed in the section on the history of the field of marriage and family therapy in Chapter 1. Unlike family therapy, which developed specific theories and models, couple therapy continued using techniques and concepts from models of individual or family therapy, such as general systems theory, cybernetics, and family development theory. The late 1980s and 1990s saw the development of couple therapy models designed specifically for couple therapy. Simultaneously, John Gottman was researching the science of intimate relationships, studying what factors made marriage succeed and fail. Although not directly related to couple therapy, his findings contributed a great deal to understanding what occurs in marriages that are happy and unhappy.

Four leaders in couple therapy have identified several significant developments and key trends for therapy with couples in the last decade (Lebow, Chambers,

Christensen, & Johnson, 2012). They found that about 70% of most forms of couple therapy showed positive change, a level comparable to individual therapy. However, an iconic study conducted in 1995 (Seligman) seemed to cast a shadow on these findings. A *Consumer Reports* study in 1995 on consumers' views of various types of psychotherapies reported that clients were least satisfied with couple therapy. Lebow et al. (2012) suggested that perhaps this gap between the efficacy of couple therapy and the lower level of consumers' satisfaction with couple therapy was due to researchers' lack of controlling for therapist training, or even including it as a variable. This is emblematic of a larger issue facing the field of marriage and family therapy. There is little regulation as to who can claim that they know how to conduct couple therapy. In one study of psychotherapists (Orlinsky & Ronnestad, 2005), 70% of psychotherapists in private practice reported they treated couples. It is likely, however, that only a small minority of those psychotherapists had received any specialized training in working with couples. As Doherty (2002) said, "Where they got their training is a mystery, because most therapists practicing today never took a course in couples therapy and never did their internships under supervision from someone who'd mastered the art. From a consumer's point of view, going in for couples therapy is like having your broken leg set by a doctor who skipped orthopedics in medical school" (p. 28). Doherty asserted that the specialty of marriage and family therapy, which makes up about 12% of the mental health practitioners in the United States, is the only one to require coursework in couple therapy. What we do know then, despite the Seligman (1995) report, is that when therapists trained in couple therapy are the ones who conduct couple therapy, about 70% of the couples show positive change. One of the responsibilities of the field of marriage and family therapy is to educate consumers that effective couple therapy is available to them, but they need to know what to look for in a therapist. A starting place is to look for a therapist who is a licensed marriage and family therapist, who has graduated from a couple/marriage and family therapy training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or who is a Clinical Fellow of the AAMFT. Doherty (2001) also argued that it is important to look for a therapist who will not remain neutral about the outcome of the relationship, but will actively work on behalf of the marriage or relationship.

Lebow et al. (2012) also found that research on couple therapy for particular relationship difficulties, such as infidelity, forgiveness, and **intimate partner violence** (IPV), had increased. Recent research also confirms that couple therapy is an effective form of treating individual psychological or psychiatric problems. Another trend in the last decade, according to Lebow et al. (2012), is the continuing attention placed on process and outcome studies that examine *how* therapy works, and on the underlying mechanisms of change, although far more studies are needed.

Along these lines, another new development has been the identification of processes characteristic of good couple therapy regardless of the model used. Christensen (2010) identified principles that transcend therapeutic approach. Similarly, Davis, Lebow, and Sprenkle (2012) discuss common factors unique to couple therapy models that have been associated with positive therapy outcomes. These include conceptualizing the problem in family therapy terms, disrupting dysfunctional relational patterns, expanding the direct treatment system, and fostering an alliance with both partners and between the partners. They asserted that effective couple therapy models are effective not just because of factors unique to a particular model, but also because of the way the models incorporate these common factors.

Another important development in the last decade is the surge in qualitative research that has examined clients' perceptions of couple and family therapy. Chenail et al. (2012) conducted a meta-analysis of 49 qualitative research studies conducted between 1990 and 2010 in order to derive a theory of clients' experiences in couple therapy and family therapy. Prior to 2000, almost no research had been conducted that asked couples directly about their understandings of what changes occurred and why in couple therapy—a crucial part of understanding the processes of change in couple therapy that seems obvious now, but was long neglected (Helmeke & Sprenkle, 2000). Practicing clinicians can easily relate to and apply the clinical implications found in qualitative research, and can even implement similar methods in their own work, such as receiving client feedback each week on the progress of couple therapy and the therapeutic relationship or employing measures that can track individual and relationship progress. See Box 11.1 for an example of comments from clients about their experience of couple therapy.

BOX 11.1. A Client's View of the Advantages of Couple Therapy

As part of a research study on clients' perceptions of pivotal moments in couple therapy (Helmeke & Sprenkle, 2000), one of the couples discussed the importance of attending therapy sessions as a couple:

Beth: "I think I could work on me as much as I wanted, but if he wasn't here, we wouldn't be nearly where we are now."

Joe: "No, Beth would have found the self-confidence and the happiness, and would have left me, and that would have been the end of it. I'd have been the one left behind. If she would have gone on by herself, she probably would have found answers for herself. But I wouldn't have been a part of it, if I had sat out of the process."

General Clinical Issues in Couple Therapy

Couple therapy is unique and presents particular challenges. In this section, we examine some of the clinical issues faced by couple therapists. Approximately 50% of marriages end in divorce, with half of the divorces occurring in the first seven years (Lebow et al., 2012). When couples do seek therapy, they are often experiencing significant conflict and each partner often blames the other for their problems. For instance, a husband may focus on the fact that his wife does not show affection or respond to his attempts to initiate sexual intimacy, and she may attribute their problems to his failure to listen and to the fact that he does not communicate his feelings to her. Each holds that if only the other would change, things would be better. Positions on the issues in the relationship become very rigid and polarized, and by the time the couple seeks therapy, each may attempt to win the therapist over to his or her viewpoint or look for the therapist to play "judge" to settle disputes. It is crucial for the couple therapist to *join with both partners without taking sides with either.* The therapist validates the view of each partner, stressing not only how each contributes to their difficulties but also how both can make changes to solve their problems. At times the therapist may challenge one partner or the other, and at any one point in therapy it may appear that the therapist is taking one person's side, yet this will shift at a later point, ideally yielding a balance overall in the process of therapy.

Couple therapy calls for an **active**, **directive approach**, especially early in treatment. The therapist tracks the couple's negative interactions, rephrases harsh statements, and blocks hurtful patterns. Unlike in individual therapy, where taking a reflective listening stance is very helpful, the couple therapist needs to be able to interrupt and redirect the flow of the discussion. Failure to play an active role can allow a couple's minor quibbles to escalate into major fights, and the couple will leave the therapist's office feeling discouraged.

Therapists also need to be careful that they are attending to the couple's typical *process* and identifying patterns of negative interactions rather than focusing solely on the content of individual arguments. It can be very easy to be drawn into problem solving various fights one by one and neglecting to see the general pattern that occurs for a couple, no matter what the fight is about. It is the *way* that couples are fighting and interacting with each other that needs to be the focus of change in couple therapy.

Dealing with secrets is another key clinical issue when working with couples. The secret may be about an affair, steps one partner has taken to end the relationship, or other behavior or information that is unknown to the other. Many couple therapists conduct some individual sessions with each partner, during which a secret may be revealed. Therapists differ as to how to handle secrets. Some prefer to have all the important information and may be willing to maintain a secret to this end. Others believe that sharing a secret with one partner compromises the therapy and prohibits the therapist from maintaining neutrality.

Still others inform the couple early in treatment about their stand on secrets, perhaps stating that they see secrets as destructive to therapy and to the relationship, and that secrets will need to be shared if they become known during therapy. The couple, then, can decide what they wish to reveal. Each of these positions has some unique advantages and disadvantages. Couple therapists must think through their stand on the issue of secrets, as it will inevitably arise in work with couples.

The role of *sessions with individual partners in couple therapy* is another important clinical consideration. Many approaches begin with an initial interview with the couple together. This may be followed by an individual session with each partner to assess in more detail individual concerns and commitment to the relationship. Other couple therapists see couples only conjointly. The main point is that the decision to see partners separately should be made *not* based on the therapist's discomfort with partners' expression of strong emotions, but out of a theoretical consideration for what is most productive for a particular couple. If partners are especially volatile, and cannot be seen together without intense arguing, individual sessions may be appropriate to de-escalate the conflict, and the therapist can work with each separately to improve the relationship. (See the section on IPV for comments on conjoint sessions if violence is an issue in the relationship.) Individual sessions may also be utilized when there is a question about commitment to the relationship or when things are simply not adding up and the therapist senses that something else is going on that one or both partners are reluctant to reveal in conjoint sessions.

In some cases, *one partner may refuse to come* to therapy. Ideally, starting with the initial phone call, especially if the presenting problem is related to the relationship, the therapist will emphasize the importance of both partners attending therapy together. Therapy may proceed even if only one partner attends; however, in this case, the therapist seeks to understand the reasons for the reluctance of the absent partner to attend and may offer to contact him or her. A family systems approach posits that it is possible to change relationships through work with one member of the couple, but this is not the preferred route in couple therapy.

Another relatively common situation occurs when therapy *begins as individual therapy* and, as therapy progresses, the need for couple therapy becomes evident. Two options are available, depending upon (a) the nature of the relationship between the partner attending therapy and the therapist and (b) the comfort of the other partner in coming to see a therapist already well known to the first partner. One option would be for the couple to be referred to a new therapist for couple therapy. Alternatively, the therapist could shift from individual to couple therapy if all parties are agreeable. In this case, the therapist needs to spend some time joining with the new partner and finding out his or her perspective on the relationship, which can be accomplished either conjointly or by meeting individually with the partner who has not been attending.

Multicultural and Diversity Issues in Couple Therapy

To work effectively with couples, couple therapists need to be sensitive to issues of diversity and to develop a multicultural perspective when working with couples, a perspective "by which one becomes empowered to effectively challenge society's many legacies of oppression. These include the social inequities and injustices that organize our lives" (Bobes & Bobes, 2005, p. 4). Therapists from the dominant culture especially need to be open to the ways that discrimination and a history of oppression are experienced by their clients.

Gender

A current trend in couple therapy is to look at how a person's gender intersects with other aspects of a person's identity, such as age, culture, religion, education, physical ability, socioeconomic resources, and country of citizenship (Almeida, 2009; Prouty, Bermúdez, Helmeke, & Ko, 2012; Prouty & Lyness, 2011). Looking at these intersections enables the therapist to see overlapping similarities and differences both within the couple and between the therapist and each member of the couple.

Issues of gender can surface under many guises in couple therapy, although it is rarely the presenting problem. Williams (2011) states that "current research suggests that gendered power processes continue to organize how heterosexual partners relate to each other" (p. 517), but it is difficult for couples to recognize on their own how power imbalances affect their interaction (Knudson-Martin & Mahoney, 2009). Similarly, it can be difficult for therapists to recognize power imbalances, and they may unwittingly perpetuate these power imbalances in therapy (Ward & Knudson-Martin, 2012), by privileging the voice of the dominant partner, for instance. Thus, presenting problems about communication issues, disputes related to work, child care, household division of labor, and dissatisfaction with a partner's lack of expression of emotion can all signal that the therapist needs to explore issues of power and gender with the couple.

Culture

All therapists will encounter couples whose cultural, ethnic, religious, political, or racial backgrounds are different from their own. Typically, in their training and supervision, therapists examine biases and assumptions that stem from their own cultural backgrounds and experiences, so that they do not "operate under the influence" of these biases in their work with clients.

For instance, Sandy is a Caucasian therapist who grew up in a small Catholic community and had little contact with minorities. A Latino couple from Puerto Rico with a strong Pentecostal religious background comes to see her. In addition to becoming aware of assumptions she is making regarding communication

styles, gender roles, and racial stereotypes, Sandy might also need to do some research on themes affecting clinical work with Puerto Ricans and Pentecostals. She might even ask the couple to help educate her about particular cultural values that will be important for her to be aware of in her work with them. Another popular technique, called the "tourist approach," aims at helping partners mutually explore each other's culture (Papp, 2000). In this approach, each person takes the lead in giving the other a tour of his or her culture's values, timing, and assumptions using commonly negotiated couple topics like holidays, boundaries, and power dynamics. These issues are covered in greater detail in Chapter 3 and can also be investigated in the work edited by Karis and Killian (2009), Falicov (2014), Helm and Carlson (2013), Rastogi and Thomas (2009), and Wetchler (2011).

Presenting Problems Unique to Same-Sex Couples in Couple Therapy

Although couples share much in common regardless of sexual orientation, there are a few significant differences that therapists need to understand to work effectively with gay and lesbian couples. Green and Mitchell (2008) report three challenges facing same-sex couples: (1) coping with lesbian and gay minority stress, the vulnerability to antigay prejudice, discrimination, and marginalization; (2) resolving relational ambiguity, or a lack of clarity in how they define their couplehood, in the areas of commitment, boundaries, and gender-linked behavior; and (3) developing a "family of choice," a close, supportive social network that may or may not include their families of origin. Same-sex couples may have faced issues such as hate crimes, the inability of same-sex partners to legally marry, adopt children, and the inability of a partner to have access to health care and inheritance rights that are assumed for heterosexual couples in many places. Same-sex parents may experience barriers to both parents having access to their children (e.g., hospital visitation or school consents). Some people in same-sex couples have internalized society's negative attitudes and view the relationship as less viable or stable than a heterosexual relationship.

Unlike heterosexual relationships, which are presumably influenced by different gender-role socialization, same-sex partners are more likely to share common influences, strengths, and deficits. On the other hand, both partners may feel freer to explore roles and work typically reserved for the opposite gender. Jonathan (2009) found that most same-sex partners consciously strove to maintain evenly distributed family work, decision making, and initiation of emotional connection.

Couples may face issues related to the coming-out process: the process of acknowledging to oneself and revealing to others one's sexual orientation. Heterosexual partners sometimes face the coming-out process when their partner becomes aware that he or she is gay, lesbian, or bisexual. When a couple presents with the coming-out process as an issue for couple therapy, Grever (2012) offers several suggestions for helping them deal with this shift within their relationship

and common emotional process. When both partners are either gay or lesbian, each may also be at different places in their coming out to co-workers or family members. This may result in tensions and issues related to public recognition as a couple. For example, if Howard has not shared with his family that he is gay, he might describe his partner Craig as a "roommate," possibly leading Craig to question Howard's commitment to the relationship. One final issue related to outness is connected with partner violence. Threatening to out a partner as a means of control or retaliation is considered psychological abuse, and if carried through on can result in discrimination (e.g., at work, in the medical community, in courts, in the religious community) and a loss of family ties, including parenting rights.

Well-Established Approaches to Couple Therapy

In this section, we will zero in on six approaches to therapy that have been designed for use particularly with couples. The first two, integrative behavioral couple therapy (IBCT) and emotionally focused therapy (EFT), are well-established, heavily researched models. The third model, **Imago Relational Therapy** (IRT), has been widely practiced across the United States since 1988 and will soon begin conducting research in order to establish IRT as an evidence-based practice (Imago Center, 2011). The final three are models that have emerged in the last decade.

Case Study

The following case study is presented to help you in understanding how therapists, using each of these six approaches, would conceptualize therapy for this couple. Amy and Ron have been married for eight years. They have two children: a daughter, age five, and a son, age three. Ron works full-time in sales for a software company, and Amy also works full-time managing accounts in an advertising agency. When Amy calls to arrange couple therapy, she reports that they have been arguing increasingly, and a recent especially volatile argument culminated in Ron moving out for a couple days. At the first session, Amy complains of Ron not sharing fairly in household duties and child care, not listening to her concerns, often coming home late without warning, and leaving when she attempted to address problems in the marriage. Ron states that Amy does not appreciate the demands placed upon him at work, has failed to notice the things he does around the house—constantly criticizing him instead—and is seldom responsive to his attempts to initiate physical intimacy. Amy's parents have remained married. Her father had problems with alcohol when she was growing up, but is sober now. Ron's parents divorced

when he was 10 years old, and he was shuffled between his parents' homes through most of his teen years. Both Ron and Amy express a desire to improve their marriage, and though divorce is mentioned at times in their arguments, neither has taken any steps to pursue a divorce.

Integrative Behavioral Couple Therapy

Integrative Behavioral Couple Therapy (IBCT), and its original form, **Behavioral Couples Therapy** (BCT), are two of the most widely utilized and researched types of couple therapy. Behavioral couple therapists generally assume that each partner's interactions are maintained and changed by environmental events following each partner's behavior (Jacobson & Margolin, 1979). Of particular interest are negative or "coercive" cycles in which partners attempt to control the behavior of the other with negative behaviors. In our case study, Amy's repeated complaints and Ron's tuning her out and leaving are examples of these types of negative interactions.

Intervention in BCT involves two primary components. These are behavior exchange and communication and problem solving (Jacobson & Holtzworth-Munroe, 1986). Behavior exchange strategies are direct efforts to identify and change the frequency with which behaviors are reinforced or punished. Behavior exchange is often used early in the treatment process; its goal is to increase positive interactions and decrease negative, coercive cycles. The therapist helps the couple identify behaviors that may be mutually positively reinforcing and encourages them to do more of these behaviors. Each partner is encouraged to ask directly for what he or she wants, perhaps providing a range of options that would be acceptable, rather than assuming the other can read his or her mind. Partners are also trained to recognize and acknowledge the positive behaviors their partner has done for them (Jacobson & Holtzworth-Munroe, 1986). Increasing positive interactions and decreasing negative ones helps establish goodwill and hope, setting the stage for the other primary type of intervention in BCT: communication skills and problem-solving skills training (Jacobson & Holtzworth-Munroe, 1986; Jacobson & Margolin, 1979).

Through systematic training, the therapist assists the partners to resolve current problems and equips them with skills they can apply to problems in the future. Ron and Amy would work to increase positive interaction between them; Amy might acknowledge the ways Ron helps out at home, and Ron might become more attentive, listening to Amy's concerns. The therapist would help them address problems, such as Ron not calling when he is going to be late, and how they might manage work, home, and parenting demands in a way that feels better to them both.

BCT has been modified in recent years to promote **emotional acceptance**, resulting in IBCT (Dimidjian, Martell, & Christensen, 2008; Jacobson & Christensen,

1996). With IBCT, in addition to focusing on the change interventions (behavior exchange and communication and problem solving), partners are also taught to experience the problematic behavior or a facet of their partner in a new way. Though framed as emotional acceptance, this newer development in fact is a change in perception or meaning related to the once-problematic behavior (Dimidjian et al., 2008). Behavior once viewed as intolerable may instead be seen as simply part of the imperfect package of qualities that makes up one's mate. Attention is also paid to "softer" emotions, such as fear, hurt, and disappointment, in which vulnerability is expressed; these expressed emotions are more likely to promote closeness between the partners. This addition was made to enhance treatment in response to BCT research that showed that although two-thirds showed improvement in the short term, only half the couples treated with traditional BCT were achieving long-lasting benefit (Jacobson & Christensen, 1996). In a more recent study comparing the two approaches, Christensen et al. (2004) found that 71% of distressed couples improved and stayed improved when the couples received IBCT, while only 59% of the couples who received BCT improved and stayed that way.

Emotionally Focused Couple Therapy

Emotionally Focused Couple Therapy (EFT) integrates aspects of family systems and experiential therapies (Greenberg & Johnson, 1988; S. Johnson, 2004, 2008). EFT has nine clear steps that occur over three stages of therapy and typically lasts from 12 to 20 sessions (S. Johnson, 2004). The model, based on 25 years of process and outcome research, proposes that due to problems with attachment (Bowlby, 1969), couples will hide their **primary emotions**, such as fear and insecurity, and instead exhibit secondary reactive emotions, such as defensiveness and anger. Partners assume rigid interactional positions that lead to repetitive negative cycles. Patterns such as pursue-distance (one partner continually pursues the other, while the other distances; as the pursuer presses harder for contact, the partner becomes even more distant) and blame-withdraw serve as a defense against expressing vulnerable emotions. Ongoing negative interactions reinforce that it is unsafe to be vulnerable, thus further burying primary emotions (Greenberg & Johnson, 1988). Ron and Amy are in a blame-withdraw cycle, with Ron withdrawing and not being attentive, Amy then criticizing and blaming, and Ron in turn withdrawing further and leaving at times, leaving Amy feeling even more frustrated and blaming and criticizing Ron further.

The first goal of therapy is to access and reprocess each partner's primary emotions, thus facilitating a shift in the couple's rigid negative interactional positions with each other toward greater accessibility and responsiveness (S. Johnson, 2004). The second goal of therapy is to create new interactional events in which both partners can access and process their own emotions and to respond to their partners' newly expressed emotions, enhancing and securing the emotional bond between them. The experience of primary affect serves as a means for couples to reframe their relationship and to see negative interactions as stemming from

deeper unexpressed emotions. For example, Ron might begin to see Amy's criticism as an expression of her overwhelming fear that he is abandoning her, perhaps reminiscent of her feelings that her alcoholic father was not available to her. Amy might understand Ron's withdrawal as fear of being emotionally hurt and feeling as if he has never quite measured up, common feelings from his childhood. As they experience each other differently, their interactions will change and they will develop a more stable bond.

EFT therapists create a safe environment for the exploration of these vulnerable feelings and at times work intensely with one partner as the other observes. The therapist attends to nonverbal cues and emotional tones that indicate deeper emotions and heightens the experience of these emotions. In our case, the therapist might notice and gently point out Ron's slightly down-turned lip and moist eyes as he discusses what it is like for him to know he has disappointed Amy. The therapist might then repeat a key phrase, "It's sad for you—it feels as if you just don't measure up," thus deepening Ron's expression of sadness in the session. The therapist might then turn to Amy to check in with her about how it has been for her to see her husband's pain and to experience him in a novel way. Later, the therapist might focus on Amy's primary emotions in the same manner.

Process research indicates that several factors may account for the high effectiveness of this model: the depth of emotional experiencing in key sessions, the development of new interactions that replace the negative destructive patterns (Lebow et al., 2012), and the softening of emotional expressiveness (S. Johnson & Greenberg, 1985). EFT has been applied to a wide variety of couples, including couples in numerous countries, gay and lesbian couples, and remarried couples, and to a wide variety of presenting problems, including couples in which one or both of the partners experienced depression, sexual difficulties, trauma, infidelity, or other **attachment injuries** or physical illnesses (Furrow, Johnson, & Bradley, 2011).

Imago Relationship Therapy

Imago Relationship Therapy (IRT) was developed in 1988 by Harville Hendrix and Helen LaKelly Hunt specifically for working with couples (Hendrix, 1988), and it is based on depth psychology, Western spiritual traditions, Transactional Analysis, gestalt psychology, systems theory, and cognitive theory. IRT was one of the early models to integrate understandings about how the brain functions (Luquet, 1996). Selection of a partner is believed to be the result of an unconscious match between a mental image of one's parents or caretakers created in childhood (called the *imago,* Greek for "image") and certain character traits of the attractive partner (Hendrix, 2008). It is no coincidence that partners get together, and each unconsciously chooses the other in an effort to heal childhood wounds. As romantic love inevitably wanes, and since the selected partner shares some of the same limitations as the other's parents, each reexperiences frustrations

from his or her childhood. Creating a healing dialogue between the partners helps create a "conscious marriage/committed relationship" in which they intentionally meet each other's unmet childhood needs (Hendrix & Hunt, 1999). Because of this, in IRT the therapist almost never meets individually with a partner, because each partner, rather than the therapist, is seen as the vehicle of healing for the other (Hendrix & Hunt, 1999).

The three-step **couples dialogue** is the cornerstone of IRT (Hendrix, 2008; Hendrix & Hunt, 1999). The therapist uses psychoeducation and presents the steps of the dialogue to the couple. They are coached to follow the steps rigidly, especially initially. The three steps are **mirroring**, **validation**, and **empathy**. Partners take turns being the sender (speaker) and receiver (listener) during the dialogue. The sender uses "I" messages and speaks about his or her own experience, not blaming or attacking the other person. Information on one issue at a time is communicated in small bits, particularly when the couple are first learning these skills. For example, Amy might say, "When you come home late without calling, I worry about what might have happened to you, and the kids get antsy about when you are coming home." The receiver then uses *mirroring,* essentially active listening, to reflect back the content of the sender's message. Thus, Ron would mirror back: "Let me see if I've got that. What I heard you say was that when I come home late without calling, you worry about [. . .]. Did I get that? Is there more?" In this way, the receiver invites further information from the sender and conveys to the sender that he or she has been heard and understood. This does not mean the receiver has to agree with what the sender has said, but it does give the sender a chance to know what he or she has said has "registered" with the receiver, something that rarely happens in a typical heated discussion, in which both partners are speaking over each other.

Validation, the second step, acknowledges that the sender's reality makes sense, given his or her perspective. Validating statements begin with an affirming phrase: "It makes sense that you would feel . . ." Using validation, Ron might say, "I can see how you would feel worried and upset when I don't call." This is often an important step for couples in conflict who talk past each other and are made to feel that their reactions are unreasonable or unjustified. Mirroring and validation help the sender feel heard and understood. Again, at this step, efforts often have to be made by the therapist to clarify that the partners are not being asked to agree with what their partner is saying, only to make sure they have really heard and understood it.

Empathy, the third and final step, involves the receiver not only recognizing how the partner could feel the way he or she does, but also attempting to experience the sending partner's feelings. This step adds an emotional element and creates connection between the partners. As the receiver, Ron might say (and communicate nonverbally with a compassionate tone of voice), "I can imagine that you might feel disrespected, ignored, and worried when I don't call when I'm late." Although remaining a separate self, the receiver is still able to empathize

with the sender. Through empathic attunement, couples make a deep emotional connection, which is healing in itself (Hendrix, 2008).

Three variations of the couples dialogue are the *parent-child dialogue,* in which one partner assumes the role of the other's parent, and the sender assumes the role of herself or himself as a child and speaks to the partner-as-parent; *behavior change requests,* in which each partner asks for what he or she needs from the other using a structured format; and *reromanticizing,* in which couples answer prompts about their partners' caring behaviors, such as "I feel loved and cared about when you. . ." (Hendrix, 2008).

Although there are few scholarly articles related to IRT, it has been a very popular model, with its own certification program, membership, publications, conference, and workshops for clients. The Institute for Imago Relationship Therapy (IIRT), founded in 1984, certified over 1,400 therapists worldwide (Hendrix & Hunt, 1999); in 2001, it was transformed into a nonprofit organization called Imago Relationships International, Inc. (IRI), which continues to support Imago therapists worldwide. Hendrix has published numerous books on this model of couple therapy, including *Making Marriage Simple: Ten Truths for Changing the Relationship You Have into the One You Want* (Hendrix & Hunt, 2013). A professional journal dedicated to the approach, *The Journal of Imago Relationship Therapy,* has also been established.

Emerging Approaches to Couple Therapy

In addition to these three well-established models, two fields of study have been very important to the generation of new models for couple therapy in the last two decades; one is the science of intimate relationships featuring John Gottman who has pioneered this research for almost 40 years, and the second is a more recent development, that of neuroscience or neurobiology, which examines how different functions of the brain impact emotional relationships. We will focus on three models that have emerged in the last decade, all of which draw on findings from Gottman's research (see Box 11.2) and from neuroscience: Gottman Method Couple Therapy, Mona Fishbane's model of Relational Empowerment, and Brent Atkinson's Pragmatic/Experiential Therapy for Couples.

BOX 11.2. The Science of Committed Relationships

John Gottman, a psychologist at the University of Washington in Seattle, has spent over 35 years studying the intricacies of committed relationships. His sophisticated labs at the Relationship Research Institute included a mock apartment so couples could be observed and videotaped in a simulated home setting; participants were hooked up to equipment to measure physiological changes, such as changes in heart rate and sweating, during

discussions with their partner. Gottman can predict with over 94% accuracy which marriages will succeed and which will fail (Buehlman, Gottman, & Katz, 1992; Gottman, 1994; Gottman, Coan, Carrere, & Swanson, 1998). Gottman's early research focused on predicting which couples were likely to remain married (the "masters,") or likely either to remain married but be unhappy or to divorce (the "disasters"). He identified three types of successful, long-term marriages (Gottman, 1994). *Validating couples* are good friends, listen well to each other, validate their partner's experience, and compromise easily. *Volatile couples* argue and bicker over lots of issues; try to persuade each other rather than understand or validate; show high levels of engagement; show anger, laughter, and affection easily; are passionate; and are good at making up. *Conflict-minimizing couples* seldom argue, preferring to see the overall relationship as more important than some issue over which they might differ. They lead calm, pleasant lives, often exhibit lower levels of companionship and sharing, and value separateness and personal space or interests. Gottman found that successful relationships across all three types were characterized by a *5:1 ratio of positive to negative* feelings and actions toward their partner; it was not that expression of anger that was predictive of divorce, but that daily, mundane patterns of interaction were highly predictive of which couples would be happy and which ones would not. By 1999, Gottman was able to predict marital outcome from the first 15 minutes of a marital conflict discussion (actually, he could accurately predict marital outcome from data from the wives' interactions in the first three minutes; Carrere & Gottman, 1999). He concluded that the way an argument starts is crucial to how it will play out, as the "masters" showed less negative and more positive affect in the beginning of a fight (a softer start-up), and only then did husbands become more negative. However, the "disasters" had more negative affect in the beginning of a fight, which quickly cascaded into the **Four Horsemen of the Apocalypse** (see below). Another important finding that distinguished the happy from the unhappy couples was the willingness of the men to accept influence from their partners, a finding that emerged from research on types of male batterers, males who perpetrate interpersonal violence (Coan, Gottman, Babcock, & Jacobson, 1997; Jacobson & Gottman, 1998).

Gottman identified four especially corrosive behaviors that lead to the downfall of a marriage, termed the Four Horsemen of the Apocalypse (Gottman, 1994):

1. **Criticism:** attacking or blaming a partner's personality or character, rather than a specific behavior
2. **Contempt:** insults or put-downs, such as name-calling, hostile humor, sarcasm, and body language such as eye-rolling and grimacing

3. **Defensiveness:** warding off a perceived attack by denying responsibility, making excuses, engaging in one-upmanship, or pointing out a partner's faults when even legitimate concerns are raised
4. **Stonewalling:** one partner (in heterosexual couples, usually the man) removes himself or herself, withdrawing, becoming as a "stone wall," unresponsive and unmoved by his or her partner's complaints. Occasional withdrawal is not uncommon, but habitual use of stonewalling signals serious trouble for the relationship.

Subsequent research led Gottman to add a fifth corrosive behavior, belligerence, which is defined as behavior that is provocative and challenges the partner's authority and power (Gottman et al., 1998). Gottman gives the example of a husband saying to his wife, "What can you do if I go drinking with Dave? What are you gonna do about it?" (Gottman et al., 1998, p. 6). Noting gender differences, Gottman found that men tended to become more physiologically aroused or "flooded" (evidenced by increases in heart rate, muscle tension, and blood pressure) when confronted with marital tension, perhaps explaining their tendency to withdraw in order to protect themselves and prevent blowing up (Gottman & Levenson, 1988; Levenson & Gottman, 1985). Gottman suggests that a key is for partners to be aware when they are getting overwhelmed (e.g., to notice when their heart rate increases or their muscles tense) and take a break to calm down before attempting further conversation.

Gottman's work is presented in several useful and readable books, complete with self-tests and exercises designed to evaluate and improve relationships: *Why Marriages Succeed or Fail* (Gottman, 1994), *Seven Principles for Making Marriage Work* (Gottman & Silver, 1999), *The Relationship Cure* (Gottman & DeClaire, 2001), *And Baby Makes Three* (Gottman & Gottman, 2007), and *What Makes Love Last?* (Gottman & Silver, 2012).

Gottman Method Couple Therapy

John and Julie Gottman have developed a model called Gottman Method Couple Therapy, which is based on their Sound Relational House theory of how marriages work, rather than focusing on solving the conflicts and problems in a relationship (Gottman & Gottman, 2008). The Sound Relational House theory has seven "levels" or concepts:

1. Build love maps of each partner.
2. Strengthen fondness and admiration in the relationship by showing affection and respect.

3. Turn toward a partner rather than turn away or against by noticing a partner's bids for communication.
4. Work to have positive sentiment override, so that each partner responds either positively or neutrally to a partner's negativity.
5. Manage conflict by (a) bringing up issues with a soft start-up, by accepting influence from a partner, by physiologically soothing self and partner, and by compromising and (b) keeping dialogues open on perpetual issues in order to see the dreams that lie beneath the conflict.
6. Honor each other's dreams.
7. Build the couple's shared meaning system.

In their model, Gottman and Gottman (2008) help couples decrease negative affect during conflict, and increase positive affect during conflict and nonconflict.

In the assessment phase of therapy with Ron and Amy, the therapist might utilize a videorecorded conflict discussion between them to provide feedback about their relationship. The therapist might notice that their discussions quickly escalate from the mild negativity of a typical complaint to the more extreme negativity of the Four Horsemen. For instance, when Amy complains about Ron being late, Ron quickly becomes defensive and starts accusing Amy of not supporting his work, mocking her inability to parent their son without a lot of handholding. Amy in turn becomes defensive and blames Ron for being selfish, after which Ron yells back at her, but then quickly shuts down, refusing to speak anymore. The therapist also might report that based on the physiological responses monitored during their taped conflict, both had diffuse physiological arousal (higher heart rate, skin conductance, and blood velocity, and lower oxygen blood concentration) and begin to teach them deep breathing and relaxation techniques. The therapist might then process a recent fight the couple had, coaching Amy to have softer start-ups (bringing up her concerns in a non-attacking, non-blaming type of way) and coaching Ron to accept influence from Amy (taking in Amy's concerns, accepting responsibility for even a small part of the problem, and adapting his responses based on her concerns). The therapist also might work to block any signs of contempt, including whenever Ron or Amy starts being sarcastic or insulting toward the other, explaining that contempt is one of the best predictors of relationship dissolution. In future sessions, the therapist might continue to show videorecordings of their discussions in therapy, helping them process their fights and their emotions, and use the in-session feedback of heart rates and blood oxygen levels to teach them to soothe themselves physiologically when they become agitated. In addition to reducing this cycle of negativity, the therapist might help the couple develop a culture of appreciation and admiration for each other, pointing out that two-thirds of parents experience a significant drop in relationship satisfaction after the birth of their first baby (Gottman & Gottman, 2007).

Fishbane's Relational Empowerment Model

Mona Fishbane (2010, 2011, 2013) believes the blame, reactivity, and power struggles that many couples bring to therapy result from a desire to be understood and validated by each other and can be viewed as signs of relational disempowerment. Her goal is to strengthen relational empowerment for both partners. Fishbane's integrative relational couple therapy approach draws on neuroscience, attachment, intergenerational family systems theory, narrative family therapy, and feminist therapy (Fishbane, 2010). She utilizes the findings of neuroscience to teach couples how the brain works when people feel threatened, suggesting tools for couples to activate their prefrontal cortexes when they are highly activated. For instance, when her clients feel stuck and discouraged that they have not been able to change, Fishbane introduces the concept of neuroplasticity, that new neurons and new neural circuits can still be established in the brain all throughout adulthood (Fishbane, 2007, 2013). One of her key techniques is to use the vulnerability cycle diagram (Scheinkman & Fishbane, 2004) when couples reach an impasse. First, the therapist helps each partner identify his or her "self-protective survival strategies" (Fishbane, 2010, p. 211) and the underlying "vulnerabilities" that the survival strategies are designed to protect. Survival strategies or positions are the set of beliefs and approaches that individuals adopt in order to protect themselves or to maintain control over their vulnerabilities (Scheinkman & Fishbane, 2004), such as "If I show any weakness, someone is going to take advantage of me, so I have to be strong." Vulnerabilities are sensitive areas that partners carry with them from their pasts, but are triggered by current intimate interactions and, once activated, produce pain and reactivity (Scheinkman & Fishbane, 2004). Vulnerabilities may stem from traumatic incidents or patterns from five contexts in the past:

1. family of origin
2. past relationships
3. sociocultural issues (e.g., gender, racial, or other power inequities, discrimination, poverty, violence, war, natural disasters)
4. the current relationship
5. current major stresses or crises (Scheinkman & Fishbane, 2004).

When vulnerability is triggered in the present, automatic survival strategies that have been used in the past kick in.

Furthermore, what often occurs during impasses is that one partner's strategies to protect himself or herself stimulate in the other partner a need to protect and defend his or her own vulnerabilities, which sets off what Scheinkman and Fishbane (2004) call a "mutual activation process": "In a core impasse, both partners are guarding their vulnerabilities, and acting and reacting from their survival positions" (p. 284). Fishbane (2010) uses neuroeducation to teach partners

how to self-regulate their emotional reactivity. Once couples learn not to react automatically as they feel threatened, Fishbane works with them to choose to respond instead by hearing the vulnerability and pain in their partners and to respond with empathy. Studies from the neurobiology of empathy show that the expression of vulnerability can elicit empathy, which in turn begets a softer response from the partner (Fishbane, 2013).

One of the strengths of Fishbane's model is that issues of gender and power do not remain invisible, as she recognizes some of the subtle ways that both men and women are disempowered by gender roles. She integrates research that finds that even heterosexual couples who begin their relationships with the intention of having gender equality can unwittingly structure their relationship to favor the man's needs and interests (Knudson-Martin & Mahoney, 2009). Fishbane attends closely to the balance of power in the relationship, looking at both sociocultural factors and the ongoing power arrangement of the couple, especially when one partner is in a subordinate position relative to gender, race, social class, cultural and educational background, or earning capacity (Scheinkman & Fishbane, 2004). Fishbane works to transform the "power-over" dynamic of power struggles into a process of "power to" and a "power with," where the couple can work together so that both can be the kind of people they want to be and nurture their relationship together (Fishbane, 2010).

Considering our case study, a therapist using this approach might explore the social underpinnings of Ron and Amy's impasse in terms of how men and women balance work and family, pointing out how some of these sociocultural assumptions seem to be constraining their relationship, such as the unstated expectation that Amy will automatically pick up any extra work related to the home and family, even though she, too, works full-time. They might discuss how they both assume it will be Amy who will be up during the nights when the kids are sick, and how she has to take time off work to be home when the plumber comes to the house for repairs. The therapist might point out how for men, work and earning capacity become the definers of their identity, and with the added pressure of the poor economy and a lack of available jobs, how impossible it feels for Ron to miss any of his work, even though he knows that Amy will be upset with him. The therapist might also track Ron and Amy's interactional dance, highlighting each one's vulnerabilities and challenging their survival strategies. She might discuss with Ron how demeaned he feels when Amy complains that he is not meeting her needs, as it triggers his feelings of inadequacy that go back to his childhood when his parents divorced and he felt incapable of meeting either of his parent's increased needs. His typical response was to become aggressive and point out how his needs were not being met either, until he felt worn out, at which point he withdrew. She might discuss with Amy how overwhelmed she felt when she was placed in charge of her siblings when her father was drunk and her mother was at work, how unequipped she was to handle all the demands placed on her, and how lonely she felt trying to figure it all out by

herself. Her survival strategy was to try to do everything herself, and not let anyone know she needed help, until she became so overwhelmed that she would become irritable and angry. Gradually Ron and Amy might begin to change their vulnerability cycle so that they can start to nurture their relationship.

Pragmatic/Experiential Therapy for Couples

Brent Atkinson's model of Pragmatic/Experiential Therapy for Couples (PET-C) is another example of an approach that utilizes findings from neuroscience. In his book, *Emotional Intelligence in Couples Therapy: Advances from Neurobiology and the Science of Intimate Relationships* (Atkinson, 2005), he describes ways the functions of the brain affect couples in conflict and distress, and he challenges the long-held assumption that cognition is the primary organizer of experience, arguing instead that our brains are wired to respond to emotions, as well as to cognitions and perceptions.

In the first, or pragmatic, phase, of PET-C, couples learn alternatives for responding effectively when their partners upset them (Atkinson, 2005). Knowing what to do and being able to do it under stress are not the same, however. Atkinson (2005) says that "distressed intimate partners are frequently unable to do what is needed because they are caught in automatic, conditioned internal states that perpetuate unhelpful thinking and action, and block needed thinking and actions" (p. 91). Thus, in Phase I, Atkinson helps partners shift from defensive or aggressive internal states that in turn allow them to make changes in their thoughts and actions. This often involves asking one partner to show vulnerability at the very time he or she feels most threatened, and listening at the very time he or she feels like arguing. Atkinson and his colleagues (Atkinson et al., 2005) argue that the intractable, persistent nature of couples' problems is due to the way emotional habits become wired into neural internal states. What is needed in therapy, they claim, is for therapists to help clients learn, experience, and practice new emotional reactions until these new emotional habits become programmed in the brain. Thus, in Phase II, each partner works individually to be able to shift internal states without the help of the therapist, and at that point, couples can enter into Phase III, in which they can develop more positive interactions with each other.

Ron and Amy's therapist, using the PET-C model, would know that he needs to help them establish new emotional habits, but that this will take time and practice, and new neural processes will need to be established. One of the techniques he might use with this couple is to record a CD designed to help them shift to a different internal state, for them to listen to at home when they become upset with each other. Here is an example of how this might play out:

Amy, agitated with Ron for getting home late and feeling herself getting upset, remembers to listen to her CD. She hears the therapist's voice reminding her that if she allows herself to react automatically, she will chase Ron away again and not

get her needs met. But the therapist's voice also validates her frustration and loneliness when Ron comes home late, while reminding her that the two of them have different pressures and perspectives and that Ron is not purposely trying to hurt her. By the time Ron gets home, Amy might still not be happy, but she will be able to bring up her concern in a softer manner. Meanwhile, Ron realizes on his drive home that he forgot to call Amy to tell her he will be late. He feels the dread build up in him as he pictures how upset she will be. He plays the CD that the therapist and Amy made for him, in which Amy complains sarcastically about how he doesn't care about his family. He has practiced listening to this CD before, and as he listens, he works on not getting triggered and instead finds to his surprise that he gets a flash of understanding how she might be upset, since their kids have been sick, and she was up with them the night before. "She was probably hoping for a breather when I got home, he thinks, and instead, here I am late again."

Summary of Six Approaches to Couple Therapy

Hopefully you have noticed some commonalities among the six approaches summarized above. Although we are still struggling to figure out what makes couple therapy effective, there are a number of ingredients that appear across successful couple therapy approaches:

1. the therapist attending to, understanding, and validating both partners' perspectives in a more or less balanced way;
2. the overt identification of the couple's process, their circular, repetitive negative interactional patterns, which makes neither partner to blame for the whole pattern but both partners accountable for their reactions at each step;
3. overt identification of possible ways that each partner can change his or her own thoughts, emotions, and behaviors that constitute the negative cycle;
4. the therapist facilitating a shift in partners' expressions of feelings from "harsher" feelings (e.g., anger, blame, accusations) to "softer" feelings (e.g., sad, lonely, vulnerable, painful);
5. the therapist facilitating a shift in clients' responsiveness to their partners so that they can listen, take in, and respond more empathically to each other;
6. the therapist coaching partners as they adapt to the changes in their couple processes;
7. therapist sensitivity and attention to gender and power in the relationship and to contextual issues such as family life cycle stage, and the partners' families of origin and previous relationship histories; and
8. the therapist encouraging the couple to reestablish elements of positive regard, playfulness, responsiveness, fondness, and respect.

Again, only two of these models have been the focus of much research, but it is important to keep in mind that whenever couple therapy models are

researched, they have generally been found to be more effective than no treatment, and at least as effective as individual therapy. This does not necessarily mean, however, that these are more effective than other approaches that have not yet been researched (it may mean, for instance, that an approach is more amenable to being researched). It behooves all of us to find a variety of ways to show the effectiveness of a variety of couple therapy models, so that we continue to have a number of approaches from which to choose.

Common Problems in Couple Therapy

What are the most common types of problems that lead a couple to seek out a marriage and family therapist? Whisman, Dixon, and Johnson (1997) surveyed 122 couple therapists on the problems and therapeutic issues encountered in couple therapy. The top three problems identified were communication, power struggles, and unrealistic expectations of marriage or spouse. Several problems on the list, such as physical abuse, infidelity, alcohol and substance abuse, and serious individual problems, require specialized approaches or attention to specific issues within the overall couple therapy.

Intimate Partner Violence

Domestic or intimate partner violence (IPV) is a pervasive social problem that has devastating effects on all family members. Increased attention to this problem has been identified in recent decades as a significant trend in couple therapy. It is estimated that 85% of the victims of IPV are women. One in every four women will experience domestic violence in her lifetime, and an estimated 1.3 million women are victims of physical assault by an intimate partner each year (National Coalition against Domestic Violence [NCADV], 2007). In 70% to 80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder (NCADV, 2007). Female victims of IPV were twice as likely as male victims to report being fearful of bodily injury or death (Tjaden, 2000). Married and cohabiting women who are battered are more likely to suffer severe physical injuries and serious psychological and emotional consequences than are married and cohabiting men who are battered.

While most IPV is perpetrated by men, women are also perpetrators of violence, and many instances of violence are reciprocally perpetrated. Whitaker, Haileyesus, Swahn, and Saltzman (2007), in their study of 11,370 adults aged 18 to 28, found that 24% of relationships had some violence, and half of these relationships were reciprocally violent (both partners assaulted each other). However, when women use violence in their relationships, it is with a different frequency and degree than when men use violence. Women are more apt to use violence as a means of self-defense, and men are more likely to use aggression as a means of controlling their partners (Stets, 1988). There is general agreement

about two types of perpetrators: *characterological perpetrators,* whose violence is part of an overall effort to control and dominate a partner and whose violence is not limited to the family, and *situational perpetrators,* in which the violence is a means to exert control over specific interactions (Babcock, Canady, Graham, & Schart, 2007). Similarly, M. Johnson (2006) identified four types of violent couples:

1. intimate terrorism, in which only one of the partners is violent and controlling,
2. violent resistance, in which one partner is violent (but not controlling) as a means of protecting oneself from intimate terrorism or as an expression of anger to a controlling partner,
3. situational couple violence, in which one or both partners are violent in response to a particular situation, and
4. mutual violent control, in which both partners are violent and controlling and are struggling for control of the relationship.

Couple treatment for IPV has been controversial. Some experts strongly advocate for separate group or individual treatment for batterers and victims, and indeed Maiuro and Eberle (2008) found that 45 states have standards for using couple therapy for IPV, with 68% of state standards prohibiting conjoint couples' treatment during the primary phase of therapy, despite research that shows the effectiveness of systemic interventions and the limited effectiveness of traditional approaches (McCollum & Stith, 2008; Stith, McCollum, Amanor-Boadu, & Smith, 2012). Frequently, treatment is mandated after an assault has come to the attention of the legal system, and the man (in a heterosexual couple) first has to complete a group program that covers topics such as anger management, problem solving, communication skills, gender roles, the need for control, and other issues related to IPV. Two primary reasons are given for opposition to couple therapy. One is that including the victim of the violence in treatment sessions may suggest that he or she is in part responsible for the violence; for this reason, the structure of treatment should reinforce that the batterer is responsible for his or her violent behavior. The other objection raised about couple therapy for IPV is that sessions with both partners might increase the risk of further abuse, as the perpetrator might retaliate later for issues that were raised in session. These are legitimate concerns that need to be taken into account and addressed if couple therapy is utilized.

Some believe that IPV-focused couple therapy for carefully screened couples can offer a safe environment in which they can resolve problems and improve their conflict-resolution skills together while the therapist keeps the level of anxiety and emotional intensity under control, which may be crucial skills to learn as a couple, given that at least 50% of battered wives remain with their abusive partners or return to them after leaving a women's shelter (Stith, 2000). Two key indicators supporting the use of couple therapy for IPV are that both partners are committed to ending the violence and finding alternatives, and their

reports of the history of the violence in their relationship, obtained individually, are compatible (Stith, McCollum & Rosen, 2011). Smith, Whiting, Karakurt, Oka, and Servino (2013) have developed a new measure, called the Self Assessment of Future Events (SAFE) Scale, to assess clients' perceptions that their partners will engage in future physical, verbal, or psychological violence. When deciding whether conjoint treatment is appropriate, clinicians can use the SAFE Scale, as well as assessing the severity and frequency of violence both within and outside the home, the type of perpetrator, and the type of IPV.

Stith et al. (2012) developed domestic violence-focused couple treatment in 1997. In one of their safeguards, the partners commit to a no-violence contract that is reiterated throughout treatment and may specify what the consequences of further violence would be (e.g., batterer moving out). Another useful intervention is for the victim of violence to develop a safety plan, in which he or she thinks through the details of what he or she would do, where he or she would go, and what important documents he or she might need, in the case of the threat or occurrence of additional violence. Couples also work on anger-management skills and learn the use of negotiated time-outs, in which the partners agree on a prearranged cue to signal a time-out, which can be called by either partner. During the time-out, generally suggested to be about an hour, the partners leave the scene of conflict, take time to cool off, perhaps taking a walk, and think about what transpired, their own feelings, and their own part in the argument. After cooling down, the couple attempts to resolve the issue calmly, if both are agreeable to doing so, or to arrange a later time to discuss their concerns. Even with safeguards, couple therapy with couples experiencing IPV should proceed with caution and be conducted using approaches specific to working with IPV.

Infidelity

Therapists estimate that 50% to 65% of couples coming for therapy have experienced infidelity, which is one of the main problems couples identify that lead them to therapy (Hertlein, Weeks, & Gambescia, 2009). Yet infidelity has been identified by therapists as one of the most difficult problems to treat (Whisman et al., 1997). Emotions are intense, ambivalence about continuing the marriage is common, and recurrent crises are the norm (Glass, 2000). Given the secrecy and stigma surrounding affairs, it is very difficult to get an accurate idea of the frequency of affairs, with studies indicating that anywhere from 15% to 70% of adults engage in infidelity (Hertlein, Wetchler, & Piercy, 2005), including singles, people in committed relationships, and married people. Affairs exact a steep emotional toll on couples and their families, and the skyrocketing number of books and articles written on this subject indicates that clients and therapists alike are searching for ways to deal with infidelity. Three recent developments in the field are the appearance of edited books on infidelity (e.g., Carlson &

Sperry, 2010; Piercy, Hertlein, & Wetchler, 2011); the appearance of new approaches to infidelity, including ones that are research-based; and a focus on Internet infidelity.

There are a number of clinical dilemmas that the couple therapist must be aware of when working with infidelity. One important consideration to address early in treatment is the nature of the continuing contact between the betraying spouse or partner and the person with whom the partner is having an affair. If the affair is over and both partners are willing to work on the relationship, then couple therapy is preferred. On the other hand, if the betraying spouse is ambivalent or is continuing contact with the lover, couple therapy is not indicated; instead, individual sessions would be more appropriate, with a focus upon decision making and clarifying commitment to the marriage or relationship.

Another dilemma occurs for the therapist when the affair is revealed in an individual session with the therapist and that partner does not want the affair to be known to the other partner. In cases like these, some therapists refuse to see the couple for couple therapy, believing that keeping a secret will compromise therapy for the couple. Others are willing to provide both individual and couple sessions to deal with ambivalent feelings while attempting to improve the relationship.

Couple therapists have to decide the degree and the extent of disclosure of the details of the affair. Most injured partners will have many questions about the affair, and new questions will emerge throughout therapy. However, this process can be fraught with peril, because disclosing too little or too much can be problematic for any given couple. For instance, sometimes too much information can leave the injured partner haunted with images of graphic details related to the affair, causing further trauma. It is important to make a separate evaluation of each couple in order to determine to what degree complete and specific details need to be shared, and part of this assessment needs to consider what benefits will come from revealing the details as well as *who* will benefit. Simple facts such as who, what, when, and where can be answered during the early stage to relieve the pressure for information. Explicit details about sexual intimacy and questions about motivations should be delayed until some healing has occurred, or perhaps not shared at all.

Weeks, Gambescia, and Jenkins (2003) suggest that therapists consider additional dimensions of affairs. These dimensions include:

- the duration of the affair (e.g., a one-night stand compared to an affair of many years);
- the frequency and extent of communication and sexual contact (including sexual contact between the partners and the total number of contacts);
- the location of encounters (a random hotel room compared to the betrayed partner's own bed, for instance);
- the level of deception/secrecy involved;
- the history of past infidelity (including sexual addictions);

- gender and age of the affair partner;
- the type of infidelity (sexual, physical but not sexual, emotional, both emotional and sexual, Internet);
- the relationship of the affair partner to the betrayed partner (e.g., a close friend or relative of one of the partners); and
- the perceived attractiveness of the affair partner.

It is also important for the couple therapist to understand how gender and power issues are intertwined with relationships in general and with affairs in particular (Williams & Knudson-Martin, 2013). Some research, for instance, suggests that men and women can have different motivations for having affairs; for women, infidelity tends to be related to relationship dissatisfaction and emotional connection, whereas men often describe infidelity as related to sexual experience or their desire for sexual excitement (Blow & Hartnett, 2005; Glass, 2003); only 30% of men who have had affairs reported marital distress prior to the affair (Pittman & Wagers, 2005). Power imbalances in relationships interfere with becoming vulnerable with each other and establishing and maintaining intimacy in relationships, which in turn can leave those relationships susceptible to affairs (Knudson-Martin & Mahoney, 2009). However, it is difficult for couples themselves to "recognize how power inequalities structure their interaction" (Williams, 2011, p. 517). In response to the need to be sensitive to issues of gender, culture, and power in relationships, Williams (2011) has developed an approach to treating infidelity called the Relational Justice Approach.

Because the feelings of the betrayed partner can be so strong and so negative, other models treat infidelity similarly to post-traumatic stress disorder (PTSD) (Glass, 2002; Lusterman, 2005) or to attachment injuries (Halchuck, Makinen, & Johnson, 2010). Because of the wounding and trauma that come from an attachment injury, typical couple therapy is not enough, and the breach of trust and subsequent erosion of the secure base must be addressed. Betrayed partners may exhibit symptoms that include obsessive thinking, flashbacks, hypervigilance, obsessive rumination, depression, and anxiety.

Another approach specifically designed for the treatment of infidelity is a practice-based evidence model that reviews the best practices in treating infidelity and looks for themes common across a number of approaches (Dupree, White, Olsen, & Lafleur, 2007), an approach that values not only empirically validated approaches, but also standards that have emerged from years of clinical experience across clinicians and models. Gordon, Baucom, and Snyder (2005), in their empirically validated model, describe three critical tasks that therapists facilitate for couples recovering from an affair. In the first stage—addressing the impact of an affair—they help clients find ways to manage all the difficult emotions and disruptions in individual functioning that arise following the disclosure of an affair. In the second stage—examining context—therapists help clients examine the individual, relationship, and outside contextual factors that might have

contributed to the affair. In the third stage—moving on—therapists help couples reach a healthy, informed decision about how to move forward (Snyder, Baucom, & Gordon, 2007, 2008). Weeks et al. (2003), in their approach, redefine infidelity so that it is no longer just a sexual infraction, such as extramarital sex, but can include any form of betrayal to a married or committed couple's own understanding of exclusivity, which also incorporates Internet infidelity. Another important component of their model is that it emphasizes the role of forgiveness, a theme that has increasingly been featured in couple therapy literature in the last decade.

One concern about the direction these models of infidelity have taken is the tendency to label the complicated process of restoration of trust after an affair as "forgiveness" and the possible misunderstanding that can come from using this term. "Forgiveness" implies that the burden of action rests on the injured partner. Without a sincere effort on the part of the betraying partner to take responsibility for the breach, and to recognize and repair the hurt and havoc that have been inflicted on the betrayed partner, it is very difficult and perhaps unwise for the betrayed partner to forgive. Pittman and Wagers (2005) recognize this need for accountability, pointing out: "When someone has made the decision to have an affair, the decision making needs to be a focus of the treatment. The question is not 'How did your husband or wife make you have the affair?' but 'How did infidelity . . . get into your repertoire of responses to stressful situations?'" (p. 138). There is research that supports the need for apology or remorse to be expressed *before* forgiveness can occur. In a study of eight heterosexual couples in which the woman had been betrayed by her partner, a task analysis indicated five steps that *preceded* forgiveness in couple therapy, four of which are actions of the betraying partner:

1. the injurer or betraying partner's expression of non-defensive acceptance of responsibility for the emotional injury;
2. the injurer's expression of shame or distress;
3. the injurer's heartfelt apology;
4. the injured partner's shift in his or her view of the injurer; and
5. the injurer's expression of relief, contrition, or acceptance of forgiveness (Woldarsky Meneses & Greenberg, 2011).

Interestingly, two steps common to the couples who did *not* reach forgiveness were the betraying partner's repeated pressure for the injured partner to forgive and the betraying partner's engagement in a competition of hurts experienced. While clinicians need to be fair, empathic, and nonjudgmental to both partners and keep the whole picture in mind, it is important that they not be misled by the term "forgiveness" into glossing over the sensitive work of holding the betraying partner accountable for his or her actions and pressuring the injured partner to forgive prematurely.

Finally, one new critical area for therapists working with couples is dealing with Internet infidelity. The Internet, with its ease of access, in relative secrecy,

has provided fertile grounds for people in a committed relationship to become involved with other people. Hertlein and Piercy (2006), in their review of recent publications on Internet infidelity, discuss how difficult it is to find agreement among researchers, therapists, and couples on what precisely Internet infidelity is. It is important for couple therapists to be able to distinguish between three related but separate online behaviors: Internet infidelity, sex addictions facilitated by the Internet, and Internet addiction (Jones & Hertlein, 2012). While approaches for dealing with infidelity can be used with Internet infidelity, extra measures are called for, such as reducing Internet access and the ability to use the Internet in secret (Hertlein & Piercy, 2008). Another dilemma is that the criteria for what constitutes an Internet-related intimacy problem can vary a great deal from couple to couple. The same online behavior that sets off a crisis for one couple may be a non-issue for another couple, so therapists need to help each couple work out their own agreement as to future online behaviors that are acceptable (Hertlein, 2011).

Alcohol and Substance Abuse

Addiction to alcohol or other drugs constitutes another significant problem that can have a large impact upon couple therapy. Results from a 2012 national survey show that 23% (59.7 million) of Americans aged 12 or older were binge alcohol users, and heavy drinking was reported by 6.5% (17 million). Over 9% (an estimated 23.9 million) of Americans were current (past month) illicit drug users, including those who misused prescription medications (Substance Abuse and Mental Health Services Administration, 2013). A third of American families report family problems due to alcohol abuse (Stanton, 1999). Similar to IPV, abuse of or dependence upon substances is often underreported by couples seeking counseling, and clients often minimize or deny the existence of problems in this area.

Couple therapy approaches for alcohol and other drug abuse are supported by a growing body of research. A recent review of research concludes that couple and family therapy are both successful and cost-effective in the treatment of drug abuse (Rowe, 2012). Other reviewers concur that couple-based treatment for alcohol and drug abuse is consistently more effective than individual treatment (Powers, Vedel, & Emmelkamp, 2008; Ruff, McComb, Coker, & Sprenkle, 2010). What is unique and beneficial about couple and family therapy approaches to the treatment of alcohol and substance abuse is the way these approaches address the social situation and relationships of the abuser. For instance, family members may be among the most powerful sources of leverage in bringing alcohol and drug abusers into treatment and in maintaining positive changes, and family support is an important factor in maintaining abstinence and improving relationship functioning (Landau, Stanton, Brinkman-Sull, & Ikle, 2004; O'Farrell & Clements, 2012; Rowe, 2012). It is important to keep in mind that

relational distress often precedes relapse (Fals-Stewart, O'Farrell, Birchler, & Lam, 2009), and in turn, substance abuse itself increases the stress in a relationship. The therapist helps the couple understand the role that substances play in the relationship and the role that relational dynamics and power issues play in the problematic use of substances.

One of the most commonly used couple therapy approaches to treat alcohol and substance abuse is BCT. Ruff et al. (2010) reviewed over 23 studies conducted by O'Farrell, Fals-Stewart, and colleagues (leaders in researching couple therapy regarding substance use and abuse) on the use of BCT for the treatment of drug and alcohol use, which has two main components: drug- or alcohol-focused interventions to build support for abstinence, and relationship-focused interventions to increase positive feelings, shared activities, and constructive communication (O'Farrell & Clements, 2012). Among the assignments given as part of BCT are:

- developing an individualized sobriety contract;
- "catching" your partner doing something nice;
- caring days;
- planning and doing shared rewarding activities; and
- teaching effective communication skills.

Relapse prevention is also addressed, and the couple completes a continuing recovery plan that is reviewed at quarterly follow-up visits for an additional two years.

Another model is an integrative family systems approach for use specifically with *female* alcoholics and drug abusers (Wetchler & DelVecchio, 1995; Wetchler, McCollum, Nelson, Trepper, & Lewis, 1993). This 12-session systemic couple therapy incorporates aspects of structural, strategic, and transgenerational family therapies and was designed to be used in conjunction with an individual substance abuse treatment program for the abuser. This approach addresses present-centered issues such as interactional sequences involving the substance use and the structural makeup of the relationship, such as power differentials and gender issues. For example, the therapist may have the couple describe what happens prior to and after use of substances and examine how the couple makes decisions, exploring how substance use is related to power in the relationship. Family-of-origin information is gathered through the use of genograms. Couples are assisted in negotiating and resolving conflicts more effectively, altering dysfunctional sequences, neutralizing negative family-of-origin influences, examining ways in which substance abuse was a part of family rituals, and changing current relationships with their family members. These family issues have long been found to be tied to substance abuse (Stanton, 1999). Another approach, recently developed by Peter Steinglass (2009)—a key researcher on couple and family dynamics related to substance abuse—combines family therapy and motivational

interviewing in a systemic-motivational model for the treatment of alcohol and drug problems. Like the treatment of other individual problems, the treatment of drug and alcohol use no longer remains solely in the domain of either individual or group therapy.

Serious Individual Problems

What role does couple therapy play in the treatment of disorders that are generally considered individual in nature? Ironically, although couple therapy itself is not reimbursed by many insurance companies, an increasing number of effectiveness research studies have shown that couple therapy is as effective as, if not more effective than, many individual therapy models in treating a variety of emotional, behavioral, and physical health problems of individuals, such as depression, chronic illness, and substance abuse (Sprenkle, 2002). Family systems theory posits the circular nature of influence in relationships, so it stands to reason that symptoms influence a couple's interactions and a couple's interactions influence the symptoms. Marital distress is associated with a number of individual problems, such as phobias, generalized anxiety disorder, PTSD, depression, bipolar disorder, and substance abuse disorders (Whisman, 2007), and relationship distress contributes to the onset or worsening of individual problems (Whisman & Uebelacker, 2006).

Along with these findings, and other research that marital distress impacts physical health, such as cardiovascular and immunological functioning (Kiecolt-Glaser & Newton, 2001), couple therapy has begun to be viewed as a viable part of an overall plan of treatment for individual problems and even as an equally and sometimes more effective alternative to individual treatment.

Indeed, couple therapy has been shown to be effective in treating a range of emotional and behavioral dysfunctions, including mood and anxiety disorders, chronic pain, and related health problems (Lebow et al., 2012; Snyder, Castellani, & Whisman, 2006). This includes trauma related to childhood abuse (Johnson & Wittenborn, 2012); obsessive-compulsive disorder, agoraphobia, female sexual dysfunction, and alcohol abuse (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998); panic disorder (Byrne, Carr, & Clark, 2004); PTSD (Monson et al., 2012); borderline personality disorder (Kirby & Baucom, 2007); bipolar disorder (Peven & Shulman, 1998); eating disorders (Root, 1995); and personality disorders (Slipp, 1995). Recently, the impact of physical illness on couples' relationships has begun to be defined, and couple and family therapy interventions for conditions such as chronic illness, cancer, neurological diseases, cardiovascular diseases, and diabetes are beginning to be developed (Baucom et al., 2009; Johnson & Wittenborn, 2012; Shields, Finley, Chawla, & Meadors, 2012). In some cases, couple therapy may be the only form of treatment, but typically it is used in conjunction with individual therapy, group therapy, or medication.

Let us briefly examine further some of the issues related to *couple therapy with depression,* since it is one of the most common mental health problems, and the

research pointing to the effectiveness of couple therapy in treating individual depression is especially strong (Barbato & D'avanzo, 2008; Whisman & Beach, 2012). A large body of research has established the bidirectional association between relationship distress and the presence of depression (Whisman, 2001). Whisman and Beach (2012) found that baseline marital discord predicted later appearance of depressive symptoms, and likewise, baseline depression in either spouse predicted later marital discord. Kung (2000) found that all but one of the seven couple therapy approaches she evaluated were at least as effective as a control group or individual treatment of depression in reducing symptoms of depression in an individual partner. In addition, couple therapy for depression has been shown to be effective not only in reducing depression but also in reducing relationship distress and improving relationship functioning (Dessaulles, Johnson, & Denton, 2003). While most of these studies have utilized a behavioral or a cognitive-behavioral model of couple therapy, Dessaulles et al. (2003) have demonstrated that EFT for couples is also an effective treatment for women with depression. Their study showed that EFT was more effective than medication. Another study showed that EFT with antidepressant medication was as effective as treatment for depression with medication alone, but that those who were treated with both EFT and medication also improved their relationship quality (Denton, Wittenborn, & Golden, 2012).

Working with Military Couples

Nearly half of military veterans report experiencing strains in family life after leaving the military. With over two million current service members and their families (Blaisure, Saathoff-Wells, Pereira, Wadsworth, & Dombro, 2012), and since more than half of U.S. troops are married (Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011), the need has been more acute than ever for therapists who are trained to work with returning service members and their partners. The high rates of PTSD, substance abuse, depression, stress, and IPV associated with returning service members can have a destructive impact on couple and family relationships (Sautter, Armelie, Glynn, & Wielt, 2011). Until recently, few studies existed that measured the effectiveness of working with these couples. Doss et al. (2012), for example, reported that 43% of military couples showed statistically reliable change after couple therapy was administered at two VA medical centers (the models of couple therapy used were not described in detail). One new model of couple therapy that has been developed that specifically addresses PTSD is called Structured Approach Therapy, which uses empathic communication training and dyadic coping skills (Sautter et al., 2011). Schumm, Fredman, Monson, and Chard (2013) also address PTSD symptoms in conjoint therapy using cognitive-behavioral conjoint therapy for PTSD. Erbes, Polusny, MacDermid, and Compton (2008) use an adaptation of IBCT to reduce conflict and increase intimacy. More research is needed to determine which approaches are effective, but one necessary factor specific to working with military couples that has emerged

is the need for therapists to educate themselves about and become familiar with military culture—such as military language, abbreviations, ranks, and chains of command—and the challenges military families face (Blaisure et al., 2012).

Sex Therapy

A discussion about couple therapy would be lacking without some attention to a specialized form of therapy for couples—sex therapy, which is discussed in more depth in Chapter 13. The field of sex therapy followed a different path than the field of marriage and family therapy, with the two converging only in the 1980s. William Masters and Virginia Johnson (1970) conducted their work on the human sexual response cycle in the late 1960s and 1970s, focusing on the physiological changes that accompany sexual experience. Another pioneer in sex therapy, Helen Singer Kaplan (1979), extended their model by including desire as another important factor in human sexuality.

Early methods in sex therapy included education, as well as reducing anxiety about sexual performance through the use of behavioral assignments. These assignments gradually increased the emotional and physical intimacy for the couple, so that successful, functional sexual intercourse could be achieved. A typical assignment, still employed by many sex therapists, is the sensate focus exercise (Masters & Johnson, 1970). The intent of the exercise is to decrease anxiety and introduce a sense of exploration and focus on self and partner pleasure without initial expectations of intercourse.

Beginning in the 1980s, family systems–oriented sex therapists emphasized the relational and systemic aspects of sexuality, expanding the previous emphasis on the physiological components of sexual response (Binik & Hall, 2014; Leiblum, 2007). David Schnarch (1991, 1998, 2002) stands out as a family systems sex therapist. His "sexual crucible" approach provides an excellent example of a systemic framework for human sexuality and sex therapy that moves beyond earlier behavioral and biological models. This model focuses on intimacy, passion, and meaning, issues that had been neglected in traditional sex therapy. Unlike many couple therapists who address sexual problems indirectly, believing that improving intimacy and communication often improves sexual interaction, Schnarch sees the couple's sexuality as a window into the dynamics of their relationship and directly addresses sexual matters early in treatment. The therapeutic process is designed to resolve past personal or relational issues by increasing the *individual's* level of self-differentiation, thus paradoxically leading to increased potency and intimacy in the *relationship*.

Others who have written more recently about systemic sex therapy include Hertlein, Weeks, and Sendak, who published *A Clinician's Guide to Systemic Sex Therapy* (2009). They offer a step-by-step approach using an "intersystems" model that takes into consideration several layers of systems including biological,

individual psychological, couple, family-of-origin, and the wider social and cultural contexts in a comprehensive treatment of sexual difficulties.

Conclusion

This chapter has covered some of the main issues and trends in couple therapy. We have considered some of the challenges in doing therapy with intimate partners and examined well-established and emerging approaches to help couples with their problems. Common problems for couples presenting for therapy have been identified, and treatments of some especially difficult problems were discussed in detail.

Approaches to assist couples in conflict are becoming increasingly sophisticated and are supported by sound research. Couple therapy has indeed come of age. As partners continue to have expectations of their committed relationships that are unparalleled compared with previous generations, this specialized area of marriage and family therapy will likely continue to thrive.

Recommended Readings

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Glossary

active, directive approach: The couple therapist plays an active role, structuring the session, setting an agenda, directing the clients, interrupting negative sequences, suggesting homework assignments, and so forth.

attachment injury: A violation of trust resulting from a betrayal or abandonment.

Behavioral Couples Therapy (BCT): A focused and structured form of couple therapy based upon social learning theory that attempts to improve effective

communication skills and problem-solving skills and to enhance positive interactions between the partners.

contempt: Displayed by insults or put-downs, such as name-calling, hostile humor, sarcasm, or body language such as eye-rolling and grimacing. The second of four behaviors Gottman identifies as the Four Horsemen of the Apocalypse.

couples dialogue: A structured communication exercise used in IRT that involves partners taking turns assuming the roles of sender and receiver and includes three parts: MIRRORING, VALIDATION, and EMPATHY.

criticism: Attacking or blaming one's partner's personality or character, rather than a specific behavior. The first of four behaviors Gottman identifies as the Four Horsemen of the Apocalypse.

defensiveness: Warding off a perceived attack by denying responsibility, making excuses, engaging in one-upmanship, or pointing out one's partner's faults when even legitimate concerns are raised. The third of four behaviors Gottman identifies as the Four Horsemen of the Apocalypse.

emotional acceptance: One of the key components of IBCT; focuses on each partner accepting some of the human limitations of the partner and attends to "softer" emotions, such as fear, hurt, and disappointment, which express vulnerability and are more likely to promote closeness between the partners.

Emotionally Focused Therapy (EFT): An approach to couple therapy that emphasizes emotions and attachment between the partners, the goal of which is to access primary emotions, enhance the emotional bond, and alter negative interaction patterns.

empathy: Generally, empathy is the ability to experience something from another's perspective. Specifically in IRT, it is the third and final step of the couples dialogue, involving the receiver experiencing and understanding the sending partner's feelings, helping create an emotional connection between the partners.

Four Horsemen of the Apocalypse: A biblical allusion to signs of the "end times"; refers to four especially corrosive escalating behaviors identified by researcher John Gottman that lead to the downfall of a marriage. *See* CRITICISM, CONTEMPT, DEFENSIVENESS, and STONEWALLING.

Imago Relationship Therapy (IRT): A form of couple therapy developed by Harville Hendrix and colleagues that stresses that partners choose a mate based

upon an image of an ideal mate (*imago* is Greek for "image") that results from childhood experiences with primary caregivers. This approach utilizes structured communication exercises that empower partners to become a source of healing for each other.

Integrative Behavioral Couple Therapy (IBCT): Developed by Neil Jacobson and Andrew Christensen, a modification of BCT's emphasis on change-oriented interventions to include acceptance-oriented interventions designed to promote acceptance of one's partner and to elicit softer emotions regarding one's partner and the relationship.

intimate partner violence (IPV): Formerly referred to as domestic violence, IPV is physical or psychological abuse of one's intimate partner.

mirroring: A form of active listening used in IRT that involves the receiver reflecting back the content of the sender's message. For example, a mirroring statement might begin: "What I heard you say was [. . .]. Is that about right?"

primary emotions: Emotions that are deeper and more core to one's experience, such as fear and insecurity, but instead are sometimes manifested as secondary reactive emotions, such as defensiveness and anger. Susan Johnson in EFT creates an environment that allows clients to experience their primary emotions.

stonewalling: An especially corrosive behavior for couples; one partner (in a heterosexual couple, usually the man) removes himself or herself, withdraws, becoming a "stone wall," unresponsive and unmoved by his or her partner's complaints. The fourth of four behaviors Gottman identifies as the Four Horsemen of the Apocalypse.

validation: The second step of IRT's technique of couples dialogue, in which the receiver acknowledges that the sender's reality makes sense, given his or her own perspective. Validating statements may begin, "It makes sense that you would feel. . . ."

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12

COMMUNICATION TRAINING, MARRIAGE ENRICHMENT, AND PREMARITAL COUNSELING

Lee Williams

An ounce of prevention is worth a pound of cure.

Benjamin Franklin

Beginning in the 1960s, the divorce rate in the United States dramatically climbed to unprecedented levels. Although the divorce rate stopped rising in 1980, current estimates are that roughly 45% of first marriages will end in divorce within 20 years (Copen, Daniels, Vespa, & Mosher, 2012). The high divorce rate has focused attention on the need for programs designed to help couples develop happy and lasting marriages.

Unfortunately, messages from society often reinforce the notion that couples simply fall in and out of love, or that "love conquers all." Often overlooked, however, is the importance of couples learning skills to help them sustain their relationship. Indeed, it can be far more difficult to get a driver's license than a marriage license, even though sustaining a successful marriage would appear to be a much more difficult endeavor.

Given these messages from society about marriage, perhaps it is not surprising that few follow Benjamin Franklin's advice. Most couples, for example, do not seek out marriage preparation. Research suggests that less than a third of couples have received premarital counseling (Halford, O'Donnell, Lizzio, & Wilson, 2006; Silliman & Schumm, 1999; Stanley, Amato, Johnson, & Markman, 2006), although there is evidence that the percentage of couples receiving marriage preparation in the United States may be increasing. Many couples do not seek help for their marriages until they are highly distressed, if they seek help at all. By the time couples do seek help, it is not uncommon for one partner to be seriously considering divorce.

This chapter describes **preventative approaches** that are intended to help couples develop healthy and lasting marriages. Many of these approaches focus on providing skills and education about relationships; thus the term **relationship education** is sometimes used to collectively label these programs. Preventative approaches differ from traditional couple therapy in their focus on enhancing couple relationships before significant problems arise. In contrast, couple therapy is aimed at helping couples who are already experiencing distress. In reality, couples frequently seek out the programs described in this chapter because they are already experiencing problems in their relationship. Fortunately, most of these programs are suitable for both distressed and nondistressed couples. Indeed, many of the programs have elements such as **communication training** that could be easily incorporated into traditional couple therapy.

The chapter focuses on five preventative approaches that have been used in **premarital counseling** and **marriage enrichment**. Premarital counseling is distinguished from marriage enrichment in that premarital counseling seeks to prepare engaged couples for marriage, and marriage enrichment helps couples who are already married strengthen or enhance their relationship. The programs described here are suitable for couples preparing for marriage or for those who are already married:

1. Relationship Enhancement (RE)
2. COUPLE COMMUNICATION
3. The Prevention and Relationship Enhancement Program (PREP)
4. Practical Application of Intimate Relationship Skills (PAIRS)
5. PREPARE/ENRICH

Although other programs exist (e.g., see Berger & Hannah, 1999), these five programs were selected because they are among the best known in the marriage and family therapy field. As the title of this chapter suggests, communication training is an element in these programs. In addition to describing these programs, I will also present case studies of premarital counseling, as traditionally offered in church settings.

Theoretical Concepts

No one theoretical approach encompasses or embodies the premarital counseling or marriage enrichment programs described in this chapter. Most of the programs are eclectic in nature; that is, they draw upon more than one theory. Relationship Enhancement, for example, is based upon psychodynamic, behavioral, humanistic, and interpersonal theories. The PAIRS program also draws from a wide range of theories, including experiential, object relations, communication, behavioral, and family systems approaches (e.g., Satir, Bowen, Boszormenyi-Nagy). As shown by their strong emphasis on teaching communication and conflict

resolution skills, many of the programs have been influenced by **behavioral couple therapy**. In addition to theory, empirical research has heavily informed the development of some programs, such as PREP and PREPARE/ENRICH.

Despite the eclectic nature of these programs, they do share some common features. All share a preventive philosophy. They work from the assumption that it is better to prevent problems than to fix them once they develop. All the preventive approaches described in this chapter emphasize the importance of couples learning effective communication and conflict resolution skills. Upon mastery, these skills can be applied to a variety of issues the couple may need to address in their relationship. More comprehensive programs such as PREP and PAIRS share other commonalities, such as emphasizing the importance of nurturing the couple's intimate bond and exploring expectations in the relationship.

Major Proponents of Marriage Enrichment and Premarital Counseling

Major proponents of premarital counseling and marriage enrichment include both individuals and organizations. Individuals who have developed the programs highlighted in this chapter are recognized as key figures in the field. Bernard Guerney Jr., for example, is widely recognized as the primary developer of Relationship Enhancement. The idea for Relationship Enhancement came out of Guerney's effort to enlist parents as helpers by training them to behave in a therapeutic manner when interacting with their children (Cavedo & Guerney, 1999). Sherod Miller is the name most closely associated with COUPLE COMMUNICATION, which was born out of research by Miller and his colleagues Elam Nunnally and Daniel Wackman that explored couples' transition from engagement to early marriage (Miller & Sherrard, 1999).

PREP's beginnings are also rooted in research. Howard Markman conducted a longitudinal study that showed communication to be a key predictor of whether couples would later become distressed (Stanley, Blumberg, & Markman, 1999). Based on this research, Markman developed PREP with the contributions of Scott Stanley, Susan Blumberg, and others. Lori Gordon is founder of PAIRS, a comprehensive workshop for couples. PAIRS originated as a graduate school course that Gordon taught to marriage and family therapy students (Gordon & Durana, 1999).

David Mace would probably be considered the most prominent early proponent of marriage enrichment. He, along with his wife Vera, cofounded the Association of Couples for Marriage Enrichment (ACME), an international organization for supporting and training couples to lead marriage enrichment groups. ACME is now known as Better Marriages (for more information, visit www.bettermarriages.org).

Other organizations have also supported marriage education for couples. Michael and Harriet McManus (2003) created Marriage Savers (www.marriagesavers.org), an organization that works with clergy in cities and towns to develop "Community

Marriage Policies." With the assistance of trained mentor couples, churches in a community agree to offer couples resources before and after marriage to reduce the divorce rate. Diane Sollee founded the Coalition for Marriage, Family and Couples Education (CMFCE). CMFCE sponsors Smart Marriages (www.smartmarriages.com), a website that provides numerous resources on marriage education, including articles and a directory of programs. More recently, the National Association for Relationship and Marriage Education (NARME; narme.org) has emerged as a promoter of marriage education, holding an annual conference.

Churches should also be recognized as one of the strongest proponents of premarital counseling. Individuals who are married within the Catholic Church, for example, are generally required to go through some form of marriage preparation. Clergy from other faiths also provide premarital counseling to couples. In fact, clergy perform the majority of premarital counseling (Glenn, 2005; Stahmann & Hiebert, 1997).

Pathology: Development of Relationship Distress

A picture is emerging through marital research as to why some couples become distressed and eventually divorce and others do not. Stanley, Blumberg, and Markman (1999), developers of PREP, have described one common pathway through which relationships become distressed. As a couple spend time together, their attachment or bond to each other grows. A commitment to the relationship develops between the two, which eventually leads to marriage for many couples. Satisfaction tends to be high for couples at this stage, because they have not encountered many significant issues. Therefore, they have had little chance to test their abilities to handle conflict.

As time passes, couples must deal with an increasing number of life problems. Couples who do not have good conflict management skills often fall into patterns that damage the relationship. These negative patterns can include escalation, invalidation, withdrawal/avoidance, and negative interpretations (Markman, Stanley, & Blumberg, 2010). Through **escalation**, partners respond to each other with increasingly negative comments, creating a spiral of anger and frustration. **Invalidation** occurs when one partner denigrates the thoughts, feelings, or character of the other. **Withdrawal/avoidance** is a reluctance or unwillingness to talk about important issues. Men are more likely than women to be withdrawers or avoiders. **Negative interpretations** occur when an individual consistently believes the motives of his or her partner are more negative than they are in reality.

Over time, mismanaged conflict erodes the quality of the relationship. Eventually, "the presence of the partner becomes increasingly associated with pain and frustration, not pleasure and support" (Stanley et al., 1999, p. 282). Negative interpretations about the partner become commonplace and further erode the commitment and bond in the relationship. At this point, individuals are faced with a decision to stay in or leave the relationship. With fewer constraints to

divorce in American society today, couples are now more likely to consider divorce rather than remain in a stable but unhappy marriage.

John Gottman is also noted for his research on examining why couples become distressed. Much of what he and his colleagues have learned about marriages has come from studying couples longitudinally over time. Through this research, it has been possible to predict with over 90% accuracy the couples who will later divorce (Gottman & Gottman, 1999). One of the key findings from this research is that couples who stayed married maintained a ratio of five positive comments to one negative comment during conflicts (Gottman, 1994). In contrast, couples who divorced showed nearly an equal amount of positive to negative comments (ratio of 0.8 to 1) during conflicts. The presence of **criticism**, **contempt**, **defensiveness**, and **stonewalling**, which Gottman labels as the **Four Horsemen of the Apocalypse**, in couples' interactions has also been found to be predictive of couples who will divorce. Criticism frames the problem as a deficit in the partner's character (e.g., you are lazy) rather than simply complaining about a specific behavior (e.g., you did not do the dishes). Contempt reflects a position of superiority and is often expressed through sarcasm, put-downs, insults, or name-calling. Contempt conveys a lack of respect for the other person and can be quite damaging to relationships. Criticism and contempt often lead to the third horseman: defensiveness. Defensiveness is evident when an individual avoids taking responsibility when his or her partner raises a concern—for example, by making excuses or counter-blaming his or her partner. Defensiveness is destructive because it tends to escalate rather than resolve conflict. The same is true for stonewalling, the fourth horseman. Stonewalling occurs when an individual, often a man, withdraws or stops participating in a discussion or argument. Trying to engage the individual further is like speaking to a stone wall. Men are more likely than women to stonewall because men are more likely to become **flooded** during marital conflict, a state of physical arousal accompanied by negative thoughts and feelings. The inability to effectively handle conflict can lead to chronic flooding, which can eventually lead the individual to adopt a negative view of his or her partner and the marriage (Gottman, 1994). With repeated flooding, an individual can develop a negative response to his or her partner through **conditioning**, even when the partner makes a neutral or benevolent comment or exhibits a harmless behavior.

Chronic flooding can set in motion a **distance and isolation cascade** (Gottman, 1994; Gottman & Gottman, 1999), in which a partner views the problems in the marriage as severe but believes there is no point in trying to work out the issues. The couple begin to do less and less together, thereby developing parallel lives. This, in turn, leads to each individual feeling lonely in the marriage. Gottman and his wife have developed an approach for treating couples based on this research (Gottman & Gottman, 2008), which has also been adapted for premarital education (Barnacle & Abbott, 2009).

The research on how marriages become distressed points to the need for couples to learn how to effectively manage conflict. Not surprisingly, most premarital

counseling and marital enrichment programs incorporate teaching couples communication and conflict management skills to avoid the destructive patterns that can erode and destroy the relationship. Programs such as PREP and PAIRS also examine the dysfunctional attitudes and beliefs that can affect the relationship; they also encourage couples to nurture their emotional and sexual bond.

Programs and Techniques

The five key programs highlighted in this chapter are described below. This section discusses the goals and formats of each program, as well as provides examples of interventions or techniques that are used to accomplish the program's goals.

Relationship Enhancement (RE)

Relationship Enhancement (RE) is a skills-based program that can be used with either married or engaged couples. Couples are taught a set of 10 skills to help them develop and maintain a healthy relationship (Cavedo & Guerney, 1999; Scuka, 2005).

Some of the skills teach couples how to effectively communicate. **Expressive skill** helps speakers better understand their own needs, desires, and feelings and express them in a way that will minimize the listener's defensiveness. For example, individuals are instructed to include a positive underlying feeling if they state an implied criticism and, if appropriate, the behavior they would like to see the other person display. **Empathic skill** helps listeners compassionately understand the emotional and psychological needs of the speaker and how to effectively respond to the speaker's message. In RE, the emphasis is not on having the listener simply repeat or paraphrase what the speaker has said, but on getting the listener to try to comprehend the speaker's experience by asking himself or herself how similar circumstances would make the listener think and feel. An effective empathic response can help build compassion, trust, openness, and respect in the relationship. **Discussion and negotiation skill** facilitates maintaining a positive atmosphere when discussing difficult issues, in addition to uncovering the deep feelings and root issues behind the difficult issues. Couples are also taught **facilitation** (or coaching) **skill** to help them exit negative communication cycles and resume using the RE skills.

Couples also learn skills for managing and resolving conflict. **Conflict management skill** helps individuals regulate their emotions and manage difficult conflict situations. Couples are also taught **problem/conflict resolution skill**, which facilitates their discovery of creative, mutually satisfying solutions to their problems. Two additional skills, **changing-self skill** and **helping-others-change skill**, are taught to help individuals bring about the desired changes. Changing-self skill helps individuals alter their own behaviors for the purposes of self-improvement or to honor agreements to change they have made with their partner.

Helping-others-change skill helps individuals change the attitudes, behaviors, or feelings of others.

Finally, individuals are taught **transfer and generalization skill** and **maintenance skill**. Transfer and generalization skill aids individuals in using RE skills in their everyday lives with people besides their partner; maintenance skill helps individuals maintain their high level of skills over time. Continued use of these skills, in both the couple's and in all other relationships, can reduce stress and improve self-esteem, interpersonal effectiveness, and personal satisfaction.

RE can be flexibly adapted for use in therapy with a distressed couple, or it can be taught in a group format using a preventative approach. In the latter format, RE participants are given the rationale for the skills and then learn the skills through readings and demonstrations. Participants are given the opportunity to practice the skills through role-playing and discussing issues in the relationship. Couples practice the skills with less intense issues in the beginning and then work on more difficult issues as their skill level builds. An essential ingredient to RE is the use of coaches, who provide participants with feedback on how well they are using the skills.

COUPLE COMMUNICATION

The **COUPLE COMMUNICATION** program is designed to promote healthier and more satisfying relationships by teaching couples how to more effectively communicate and resolve conflicts (Miller & Sherrard, 1999). COUPLE COMMUNICATION has been used with both distressed and nondistressed couples, and it can be used either as a component of therapy or as a program for premarital couples or couples seeking enrichment.

COUPLE COMMUNICATION helps individuals better understand themselves and their partner, educating them on effective versus ineffective means of communication. Couples are taught 11 specific communication skills for talking and listening and are given guidelines for resolving issues. A key part of the COUPLE COMMUNICATION program is practicing the skills and getting feedback from coaches, who observe the couples as they apply the skills.

When offered in a group format, COUPLE COMMUNICATION is typically divided into four 2-hour sessions (Miller & Sherrard, 1999). The first session focuses on caring for oneself, emphasizing themes of self-esteem and how each individual is unique. Couples are taught, for example, that individual differences are potential resources for the couple, and not just potential sources of conflict. Couples are taught how to use the **Awareness Wheel**—a tool used to help individuals increase their self-awareness—to better understand issues or situations, and use this information to communicate more effectively with others. The Awareness Wheel encourages individuals to explore and articulate different aspects of an issue, including their experiences, feelings, thoughts, wants for themselves or others, and current or future actions.

The focus of the second session is on caring for one's partner. The participants are told that expanding their awareness of their partner is necessary for a healthy relationship. Individuals develop this awareness by learning five listening skills and using the **Listening Cycle**. Couples are taught, for example, how to allow whichever of them is speaking to direct the conversation, rather than having the listener try to lead the conversation. The importance of seeking understanding before trying to reach an agreement is also emphasized. In addition, couples are encouraged to communicate concern and validate each other's experience through listening.

In the third session, couples learn about effective and ineffective strategies for resolving conflict. Couples are taught a process for resolving conflicts called **mapping an issue**, which includes the following eight steps (Miller & Sherrard, 1999, p. 142):

Step 1: Identify and define the issue.
Step 2: Contract to work through the issue.
Step 3: Understand the issue completely.
Step 4: Identify wants.
Step 5: Generate options.
Step 6: Choose actions.
Step 7: Test the action plan.
Step 8: Evaluate the outcome.

In the fourth session, the focus is on teaching couples about different negative and positive styles of communication. Couples are then encouraged to identify which styles they typically use. Finally, couples are given the opportunity to practice the positive communication styles while discussing an issue.

A unique aspect of the COUPLE COMMUNICATION program is the use of **skill mats**, which are 30-inch square floor maps printed with either the Awareness Wheel or Listening Cycle framework. The skill mat with the Awareness Wheel is divided into different sections to help individuals explore or process their experiences. Individuals first step onto the skill mat and state the issue they want to talk about, then step on other parts of the Awareness Wheel to explore and articulate different aspects of the issue, such as their experiences, feelings, thoughts, wants for themselves or others, and actions. The skill mats are intended to accelerate learning by engaging both the right brain (learning through words, concepts) and the left brain (learning through associated experience).

The Prevention and Relationship Enhancement Program (PREP)

The **Prevention and Relationship Enhancement Program** (**PREP**), which has a strong research or empirical base, emphasizes a skills-oriented approach to

addressing factors that can lead to marital breakdown. The traditional version of PREP is a 13-hour program that is typically delivered to couples in a group format, although elements of PREP can easily be incorporated into couple therapy. PREP is suitable for couples who are engaged to be married as well as those who are already married.

PREP was developed with four goals in mind (Stanley et al., 1999). The first goal is to teach couples better communication and conflict resolution skills. The second goal is to help couples explore their expectations in the relationship. Couples can be at risk if one or both partners have expectations that are unreasonable or unexpressed. Unmet expectations often lead to disappointment and frustration in the relationship. The third goal of PREP is to have couples explore their attitudes and choices regarding commitment. The fourth goal enhances the couple's relationship bond through fun, friendship, and sensuality.

Various techniques or strategies are used throughout the program to achieve these goals (Markman, Stanley, & Blumberg, 2010). To improve a couple's ability to handle conflict in a more positive manner, PREP teaches couples the **speaker-listener technique**. Using this technique, one individual is the speaker, and the other individual assumes the listener role. The speaker follows certain guidelines, such as speaking only about his or her own experiences, not his or her partner's, and keeping statements brief so the listener can paraphrase what is being said. The listener must paraphrase what the speaker says and avoid interjecting rebuttals while in the listener role. Couples are also instructed on how to take **time-outs** when their discussions escalate to the point that they are damaging or unproductive. They are also taught other **ground rules** to help them avoid negative or harmful strategies for handling conflict.

To help couples explore their expectations within the relationship, partners are given a set of questions to answer individually and are then encouraged to share their responses with each other. PREP asks couples to explore their expectations in a number of different areas, such as sexuality, children, spending time together, communication, and decision making. Another exercise encourages couples to identify and share with each other their core belief system. Individuals explore a number of aspects of their core belief system, including religious and spiritual values, core relationship values, and moral views.

Couples are taught a number of strategies for building and nurturing commitment in their relationship. For example, couples are cautioned that thinking too much about alternatives to the relationship can ultimately lead to disappointment and even breakup. Instead, individuals are encouraged to focus their thoughts and energy on improving the current relationship. Couples are also encouraged to take a long-term view of their relationship—which tends to be less reactive to current events in the relationship—rather than a short-term view. PREP also invites individuals to explore whether their choices reflect their life priorities. The partners may discover, for example, that they need to devote more time to nurturing their relationship.

PREP helps couples enhance their relationship through fun, friendship, and sensuality using a number of techniques. Couples are asked to brainstorm fun activities they can do together, for example, and are then encouraged to set aside time for these activities. To nurture the friendship aspect of the relationship, they are asked to find time to spend with each other in order to share and talk together. Discussing issues or problem solving should be avoided during these times in order to protect the relationship from conflict. Couples are taught how to separate sexuality from sensuality, and they are encouraged to do exercises that promote physical affection (e.g., hugging, massage) outside of sexual intercourse.

Halford and his colleagues have also developed a promising program called Couple CARE, which is based on a variant of PREP called Self-PREP (Halford, Moore, Wilson, Farrugia, & Dyer, 2004). Couple CARE and Self-PREP are similar to PREP in content, but they include an additional focus on **self-regulation**, which is where individuals learn how to appraise their relationship and change their own behavior for its enhancement. Couple CARE uses DVDs and guidebooks so that couples can learn the material on their own. A therapist also periodically contacts the couples by phone to review their progress and troubleshoot problems that may arise.

Practical Application of Intimate Relationship Skills (PAIRS)

The **Practical Application of Intimate Relationship Skills (PAIRS)** program is a comprehensive course designed to help couples maintain intimacy in their relationship (Gordon, Temple, & Adams, 2005). PAIRS accomplishes this by helping couples realign their beliefs and attitudes about love and relationships, develop competence in dealing with emotions, and learn skills for building intimate relationships. The complete PAIRS program is offered in a group format and consists of 120 hours of training over four months. Shorter versions of the program (e.g., 9-hour PAIRS Essentials) have also been developed. Participants range from well-functioning couples to distressed couples.

PAIRS is divided into six main sections (Gordon et al., 2005). In the first section, participants learn communication and problem-solving skills. Skills are taught that focus on both listening (e.g., empathic listening) and speaking to enhance the couple's ability to confide in each other. Participants, for example, are taught how to use the **Dialogue Guide** to express a range of thoughts, feelings, and assumptions by completing sentences that begin with phrases such as "I notice," "I assume," "I am hurt by," and "I appreciate." This section of the course also addresses negative communication styles and teaches skills for effectively handling conflict.

Participants uncover their hidden expectations or beliefs about love and relationships in the second section of the course. For example, couples are taught to check out assumptions with their partner to get out of the habit of mind reading. Couples are also taught how to identify unexamined beliefs that commonly sabotage relationships.

The third section focuses on each partner learning about his or her history and how it may impact the couple's relationship. The creation of a **genogram**, a multigenerational family map, is used to facilitate this exploration. The genogram is used to uncover the early messages individuals learned about love and relationships and to explore how family-of-origin rules, myths, or loyalties have shaped each individual. This knowledge can help the couple understand sensitivities that can be triggered through the couple's conflict. The impact that each person's personality style can have on intimacy is also explored in this section of the course.

The fourth section focuses on helping couples learn to deal with intense emotions to facilitate bonding. For example, PAIRS teaches couples how to comfort each other when experiencing painful and intense emotions from the past, which opens the possibility of healing. Couples learn that expressing intense emotions can strengthen their bond and restore lost passion.

Enhancing the couple's physical intimacy is the focus of the fifth section. Couples explore the pleasures of physical bonding and touch, as well as their sensuality and sexuality. Early sexual decisions, sexual myths, and jealousy are other topics addressed in this section of the course.

The sixth and final section is devoted to clarifying expectations and goals. Using the skills and insights developed throughout the program, couples negotiate a contract or set of expectations for their relationship.

PREPARE/ENRICH

Premarital inventories have become a widely used tool for preparing couples for marriage. Premarital inventories are not intended to evaluate whether or not a couple should marry. Rather, they are intended to be a springboard for the couple to explore and discuss their relationship. The inventories can help couples identify strengths and areas of growth within their relationship.

In a review of premarital inventories, Larson, Newell, Topham, and Nichols (2002) noted that **PREPARE/ENRICH**, **FOCCUS**, and **RELATE** could be confidently used in premarital counseling, although each had its own strengths and limitations. Both PREPARE/ENRICH and FOCCUS use a facilitator to administer the inventory and provide the couple with feedback. Couples can take RELATE by themselves and receive the feedback directly. PREPARE/ENRICH is perhaps the most widely recognized premarital inventory in the family therapy field; it is described in more detail below.

PREPARE/ENRICH is an online inventory that is customized to each couple's situation (Olson, Larson, & Olson, 2009). PREPARE is tailored for couples preparing for marriage, while ENRICH is a version of the instrument designed for married couples. After couples complete the inventory online, the facilitator receives a detailed feedback report on the couple. The facilitator can use the report to guide the couple in exploring their relationship, such as by identifying strengths and areas for growth. The facilitator also receives a briefer report that

can be given to the couples to keep. In addition, couples receive the *Building a Strong Marriage Workbook,* which contains over 20 exercises for developing skills and strengthening their relationship. Facilitators typically meet for three to six sessions to go over the feedback and exercises with the couple.

The PREPARE/ENRICH inventories assess all couples on 10 core scales: Communication, Conflict Resolution, Partner Style and Habits, Financial Management, Leisure Activities, Affection and Sexuality, Family and Friends, Relationship Roles, Spiritual Beliefs, and Idealistic Distortion (the extent to which the individual has unrealistic or idealist views of marriage). For each of these areas, couples receive feedback on whether it is a potential strength or potential growth area.

The couple also receives customized feedback in other areas based on their characteristics or situation. For example, questions and scales are tailored to each couple based upon marital status (e.g., dating, engaged, married), whether they were previously married, and whether they live together. It is also customized based on their parental status (e.g., have no children; have young children, stepchildren, grown children), whether they are from different cultural/ethnic backgrounds, their religious affiliation (e.g., Catholic, Protestant, Jewish, interfaith), and whether they are older than 55.

PREPARE/ENRICH also contains other scales that provide supplemental information for couples. For example, the Relationship Dynamic scales measure Assertiveness, Self-Confidence, Avoidance, and Partner Dominance for each partner. Assertiveness and self-confidence mutually reinforce each other in a positive cycle, whereas avoidance and partner dominance mutually reinforce each other in a negative or undesirable cycle. PREPARE/ENRICH also measures the level of **cohesion** and **flexibility** in each partner's family of origin and in the current couple relationship. The results for both partners are plotted on the Couple and Family Map to help examine the relationship between the family of origin and the couple's relationship. A couple might explore, for example, how different levels of closeness or cohesion in each's family of origin may influence his or her expectations about closeness in the current relationship. Lastly, PREPARE/ENRICH assesses each individual's personality using the SCOPE scales. SCOPE is an acronym for the five personality dimensions that are assessed: Social (introverted or extroverted), Change (open to change or closed and conventional), Organized (orderly or flexible), Pleasing (agreeable or assertive), and Emotionally steady (calm or reactive).

Case Studies of Premarital Counseling in Church Settings

The five programs discussed above represent some of the most established programs for communication training, marriage enrichment, and premarital counseling. However, the majority of premarital counseling today continues to be offered through churches. Many churches require some form of marriage preparation or premarital counseling for couples who are to be married. The following brief case studies illustrate the variety of approaches couples may encounter in church settings.

Case Study 1

Janna and Bill are both 27 and preparing for their first marriage. Both are Lutheran, and they plan to have their wedding at the church Janna currently attends. Pastor Dan agrees to meet with the couple for three sessions. He begins by asking the couple questions about their expectations regarding the marriage. Over time, Pastor Dan has developed a list of eight questions he asks all couples. He begins by asking Janna and Bill to each identify 12 reasons why they want to marry the other person. After listening to their answers, Pastor Dan tells them that most couples will feel good about their marriage a year later if 10 out of the 12 items still hold true, but adds that individuals are generally unhappy if the marriage is fulfilling six or fewer of the items. Next, he asks them to state their personal and collective goals for the next 5, 10, and 15 years. He informs them that their goals should be specific, measurable, compatible, and time bound. Janna and Bill both state they want to buy a home within the next five years. Pastor Dan encourages them to be more specific by asking them what size house they want. What size of down payment will they need? How much will they need to save each year to realize their goal? In the second session, the couple and Pastor Dan go over other questions, such as the couple's definition of love and marriage. Pastor Dan emphasizes that marriage equals commitment, and he explores their reaction to this comment. In the third and final session, the couple and Pastor Dan go over the couple's wedding plans.

Case Study 2

Thomas and Virginia, 33 and 29 years old respectively, are also preparing for their first marriage. Virginia is a practicing Catholic; Thomas identifies as Methodist, but does not regularly attend church. Virginia notifies her priest of the couple's intention to get married at least six months in advance of the wedding, as required by her church. Father Jerry meets initially with the couple and explains that all couples preparing for marriage must take the FOCCUS premarital inventory. After they complete FOCCUS, Father Jerry spends two sessions with the couple going over the results of the inventory and asking them to discuss their responses with each other. The couple scores strongly in communication, problem solving, friends and interests, lifestyle expectations, and sexuality. The inventory shows the couple to have uncertainty or lack of agreement in four key areas: finances, family of origin, religion and values, and interfaith marriage. The couple spends considerable time discussing their thoughts, feelings, and expectations in these areas. Father Jerry meets with the couple one additional time to discuss the plans for the wedding ceremony.

Father Jerry also tells the couple they need to either attend an Engaged Encounter weekend retreat or participate in a mentor program. Father Jerry tells the couple that **Engaged Encounter** is similar to Marriage Encounter (Elin, 1999), but designed specifically for engaged couples. During an Engaged Encounter weekend, a team of married couples and a priest would give several presentations on marriage. After each presentation, Thomas and Virginia would be given the opportunity to privately reflect on the presentation and discuss with each other the meaning the topic had for their relationship.

Thomas and Virginia elect to do the mentor program and are assigned to Linda and Craig, a couple who have been married for 10 years and had two children. Linda and Craig invite Thomas and Virginia to their home for an initial meeting. After getting to know one another through conversation, Linda and Craig introduce Thomas and Virginia to a workbook that the two couples will complete together. Linda and Craig explain that the workbook will help Thomas and Virginia explore important areas in their relationship through reflection and discussion. Linda and Craig say that they will also complete the exercises and share their answers with Thomas and Virginia so they can benefit from their experiences. Thomas and Virginia are also encouraged to ask the couple questions as they go through the process. During the next month, the two couples meet weekly to share and discuss their responses to the reflective questions in the workbook.

Case Study 3

Dennis and Diane are in their early 40s and both previously married. When the couple notify the church of their plans to marry, they are referred to a local agency that the church has contracted to do premarital counseling. The couple's therapist, Dr. Ramirez, contracts with Dennis and Diane to do a **Dynamic Relationship History** (Stahmann & Hiebert, 1997), a detailed history of the couple's relationship intended to uncover relational dynamics, issues, and patterns. Dr. Ramirez asks Dennis and Diane each to describe how they first met, their initial impressions of each other, and how their first dating experiences were. Questions of this nature help uncover what attracted Dennis and Diane to each other. Dr. Ramirez also explores how the partners decided to date seriously and how they became engaged, revealing how the couple developed a bond and commitment to each other. The couple's first fights and decisions are also explored, giving insight into the couple's conflict resolution skills and the distribution of power or influence within the relationship. Since both Dennis and Diane were previously married, a brief history of those marriages is explored.

They also agree to briefly explore their families of origin to see what potential influence those have on their relationship. One session each is devoted to constructing a three-generation genogram for Dennis and Diane.

At the end of the relationship history and family-of-origin exploration, Dr. Ramirez gives the couple a summary of what he has learned about their relationship. He shares with the couple how they seem to possess several strengths, such as their similar interests and shared religious and moral values. He also compliments them on their realistic expectations regarding finances and their sexual relationship. He notes, however, that Dennis and Diane seem to have difficulty with issues of conflict, describing how they seem to follow a distance-pursuing pattern. When Diane would raise an issue in the relationship, Dennis would often be a reluctant participant in the conversation. This would upset Diane, leading her to complain that Dennis did not seem to care about her or her concerns. Dennis would offer little in reply, trying to avoid escalating the fight. This would only make Diane more upset. After pointing out the pattern to Dennis and Diane, Dr. Ramirez helps the couple see how each person experiences the other's behavior and why each responds in a certain way. Dr. Ramirez talks about how men sometimes withdraw in order to avoid conflict, never recognizing how their action actually escalates the conflict. He also suggests that the couple's family-of-origin experiences might be contributing to the pattern. He notes how Dennis's withdrawing could trigger Diane's fear of being abandoned, a fear she developed as a child with emotionally unavailable parents. Likewise, he observes that Dennis grew up with an alcoholic father who was abusive when drunk. Dennis had learned to stay away from his father when he showed any signs of being upset, which likely contributed to him being fearful of conflict. The couple finds the summary session very informative and agrees to continue seeing Dr. Ramirez for an additional three sessions to address better ways of handling conflict in the relationship.

These case studies reflect the diverse ways in which premarital counseling is being conducted in church settings. Consistent with the first two, a common format for premarital counseling is for the couple to meet privately with a clergy member. The number and nature of these meetings can vary widely depending upon the clergy member. Some clergy have only one session with the couple and focus primarily on wedding plans, with little attention given to preparing the couple for marriage. On the other end of the spectrum, some clergy devote several sessions to marriage preparation, exploring a variety of areas in the relationship. Wilmoth and Smyser (2012) found that the most common areas addressed by clergy were the wedding ceremony, relationship to God, communication,

spiritual dimensions of marriage, realistic expectations, conflict resolution, roles, personality, problem solving, and finances. The quality of the counseling that is provided is another important factor that can affect how helpful the premarital counseling experience is (Schumm et al., 2010).

The case studies illustrate a variety of techniques that can be used in premarital counseling, such as premarital inventories, conducting a relationship history, and exploring each person's family of origin. In some cases, couples may participate in daylong or weekend programs with other engaged couples, such as Engaged Encounter. These programs often include presentations or lectures in combination with opportunities for couples to discuss their relationship privately or with other couples. Premarital counseling in church settings may also include training in communication and conflict resolution skills through instruction or participation in a skills-based program. One such program is Christian PREP, which is a variation of PREP that incorporates scriptural guidelines (Stanley & Trathen, 1994).

Premarital counseling within a church setting is not the exclusive domain of clergy, as evidenced by case studies 2 and 3. Married couples may lead weekend retreats such as Engaged Encounter or act as a mentor couple. In some churches, married couples, rather than clergy, administer the premarital inventory and discuss the results. Some churches also turn to counseling professionals to perform the premarital counseling. These counselors may be part of the church staff, or they may be professionals within the community who are contracted to provide the services on an as-needed basis.

Relationship Education with Diverse Populations

In the past decade, the field has seen significant growth in work being done to examine how relationship education can be made more widely applicable. Rather than the view that one size fits all, there is a recognition that different groups of people may have distinct needs that require the program be tailored for that population. This section will briefly summarize some of the work being done with diverse populations.

Many programs have been adapted to help accommodate racially and ethnically diverse populations. For example, the PREPARE-ENRICH and FOCCUS premarital inventories can be taken in Spanish and other languages. Some of the programs like COUPLE COMMUNICATION, PAIRS, and PREP also have Spanish versions. There is a version of PREP specifically for African American Christian couples, called ProSAAM.

The state and federal government has also recently provided funding for relationship education to see whether it can strengthen the relationships of low-income couples and improve the well-being of children within these relationships (Hawkins & Fackrell, 2010). PAIRS, a version of RE called Mastering Mysteries of Love, and various versions of PREP have been evaluated in studies that targeted

low-income couples. Initial findings suggest that marriage education can provide a benefit to low-income couples (Hawkins & Fackrell, 2010).

Same-sex couples are another population that has recently begun to receive attention. Shurts (2008) was one of the first to advocate that same-sex couples may benefit from premarital counseling. However, Shurts used the term pre-union counseling to reflect the fact that only one state (Massachusetts) allowed same-sex couples to get married at the time the article was written. Shurts argues that same-sex couples can benefit from many of the same topics addressed with heterosexual couples in premarital counseling, but the approach should be adapted to their special needs. Premarital counseling for same-sex couples should address heterosexist discrimination, the lack of normative or legal blueprints for same-sex couples, challenges in developing a support network, and potential gender role issues. Shurts also notes that gay male couples and lesbian couples may each have their own unique needs. For example, gay male couples frequently need to negotiate whether or not the relationship will be open sexually.

Others have also suggested that same-sex couples may benefit from relationship education tailored to their needs (Casquarelli & Fallon, 2011; Kerewsky, 2012; Whitton & Buzzella, 2012). In addition, Casquarelli and Fallon (2011) argue that premarital education also requires sensitivity to the unique concerns of bisexual individuals. Similarly, Kerewsky (2012) believes that couples with bisexual and transgender partners would also benefit from couple enrichment. The next step is to develop and evaluate programs for these couples. Buzzella, Whitton, and Tompson (2012) found promising results when they evaluated a relationship education program tailored for male same-sex couples.

The field is also exploring how relationship education can be tailored to other special populations. For example, Adler-Baeder and Higginbotham (2004) reviewed marriage education programs for couples who are remarrying and creating stepfamilies. Special versions of PREP have been developed for military couples (Strong Bonds) and individuals in prison seeking to improve their relationships (Walking the Line). Rhoades, Stanley, and Markman (2009) also believe relationship education should be tailored to those who have cohabitated before marriage. For example, they recommend that couples make conscious decisions regarding their commitment to the relationship rather than "sliding" into marriage. As it evolves, the field will likely continue to expand its ability to address various types of couples' unique needs and the challenges those couples may face.

Relevant Research

Two areas of research related to premarital counseling and marriage enrichment are discussed in this section. The first part discusses the research that examines the general effectiveness of marriage enrichment and premarital counseling programs

based on meta-analyses and survey research. The second part briefly highlights the available research on each of the five programs highlighted in this chapter.

The Effectiveness of Marriage Enrichment and Premarital Counseling

Meta-analysis is a powerful tool for evaluating the effectiveness of treatments because it enables researchers to combine results across different experimental studies. To conduct a meta-analysis, the results from the different studies must be standardized to a common unit of measure. This is accomplished by converting the original statistics (e.g., *r, t,* or *F* statistics) in the studies into a common statistic called the **effect size**. The effect size allows researchers to quantify how powerful the treatment effect is in comparison to a control (no treatment) or alternative treatment. Researchers can also study various factors that may influence the strength of the effect size.

In the first meta-analysis to evaluate the effectiveness of preventative programs, Giblin, Sprenkle, and Sheehan (1985) found an average effect size of .44 for all types of premarital, marital, and family enrichment programs combined. An effect size of .44 means that the average person participating in a treatment program was better off than 67% of those who received no treatment. Further analyses revealed an effect size of .53 for premarital programs, an effect size of .42 for marital enrichment programs, and an effect size of .54 for family enrichment programs. Giblin, Sprenkle, and Sheehan (1985) noted that the effect size for the preventive approaches is smaller than the effect size of .85 for psychotherapy in general (see Smith, Glass, & Miller, 1980).

Hahlweg and Markman (1988) also did a meta-analysis of behavioral premarital intervention programs and found comparable results to the earlier study. Behavioral premarital intervention programs had an effect size of .55 when compared to no-treatment controls. In another meta-analysis, also focusing on premarital prevention programs, Carroll and Doherty (2003) discovered a mean effect size of .80, which means the average person who participated in a premarital prevention program was better off than 79% of those who did not.

However, a more recent meta-analysis on premarital education by Fawcett, Hawkins, Blanchard, and Carroll (2010) found less compelling results. The authors found that the effect size when measuring communication skills was .454 when both published and unpublished experimental studies were combined. However, the effect size based on relationship quality or satisfaction was not significant when both published and unpublished studies were combined, although it was significant (.578) if one looked only at published studies. In both cases, the effect size was significantly larger when comparing published to unpublished studies.

A meta-analysis that included both marriage and premarital education programs found a similar pattern of results to the above study (Hawkins, Blanchard, Baldwin, & Fawcett, 2008). The effect sizes for experimental studies were larger

for communication skills (.44–.45) than for relationship quality measures (.30–.36). The effect size for communication skills was also significantly different when comparing published studies to unpublished studies.

The meta-analytical research to date provides some support for the effectiveness of premarital and marital education. However, meta-analyses that include only published studies may reflect inflated effect sizes because there is evidence that inclusion of unpublished studies may lower the effect sizes (Fawcett et al., 2010; Hawkins et al., 2008). There is also evidence to suggest that marital and premarital education is more effective in improving communication skills than it is relationship quality or satisfaction (Fawcett et al., 2010; Hawkins et al., 2008). This may not be surprising, given that couples who participate in premarital and marital education programs may already view their relationship in a positive light, so there is not as much room for change on these measures (Fawcett et al., 2010). Thus, an important question is whether equipping couples with communication skills will help them maintain positive relationship quality in the long term. We cannot fully answer this question, given that most programs have not been evaluated beyond a year. One notable exception is PREP, which is discussed in more detail below.

In addition to meta-analyses, survey research also suggests that premarital counseling may be of value to couples. A survey of over 3,000 randomly selected individuals in four states (Oklahoma, Kansas, Arkansas, and Texas) discovered that those who had received premarital education were 31% less likely to divorce compared to those who had not (Stanley et al., 2006). Another study surveyed married Army soldiers and their spouses to see whether premarital counseling was related to higher marital satisfaction and greater utilization of marital and family therapy (Schumm, Silliman, & Bell, 2000). Although the results did not show a difference in marital satisfaction between individuals who received marriage preparation and those who did not, they did reveal that those who had premarital counseling were significantly more likely to seek out marital and family therapy services during their marriage. These findings suggest that another potential benefit of premarital counseling is that it may make couples more open to seeking out help if problems do arise.

Other research found that individuals who had marriage preparation within the Catholic Church perceived the experience to be valuable (Williams, Riley, Risch, & van Dyke, 1999), but the perceived value declined the longer the individual had been married. Among those who had been married for 12 months or less, 87.5% agreed marriage preparation had been a valuable experience. By the seventh and eighth year of marriage, approximately half of the respondents agreed marriage preparation had been a valuable experience. This decline over time could be due to three factors. First, it is possible that individuals may have simply forgotten the value of marriage preparation with the passage of time. Or, like some immunizations, the benefits may wear off with time. Couples may need periodic booster sessions throughout the marriage (Markman & Rhoades,

2012). Finally, it is possible that marriage preparation, as currently practiced, is most helpful to couples during their initial adjustment to marriage. Couples may benefit from marriage or relationship education at other important transitions, such as the birth of their first child (Petch, Halford, Creedy, & Gamble, 2012).

Empirical Support for Specific Programs: Relationship Enhancement (RE)

RE is one of the more extensively studied preventive programs. In Skuca's (2005) review of the research for RE applied to couples, he notes, "The collective weight of this body of research on the RE model, especially given the superior results of its head-to-head comparisons with other interventions, provides significant empirical validation of RE" (p. 30). For example, multiple studies show RE to be superior to problem-solving or relationship discussion programs for premarital couples. In a meta-analysis by Giblin, Sprenkle, and Sheehan (1985), RE demonstrated the largest effect size (.96) among marriage enrichment programs.

COUPLE COMMUNICATION

COUPLE COMMUNICATION has been extensively studied, with Miller and Sherrard (1999) reporting that over 40 independent outcome studies have been conducted on the program. These studies support that COUPLE COMMUNICATION leads to the following changes:

- improved communication behavior within couples;
- improved perception by the couple of their ability to communicate;
- improved perception of relationship quality;
- increased self-disclosure; and
- improved self-esteem.

A meta-analysis comparing COUPLE COMMUNICATION to no treatment controls found an effect size of .52 using relationship satisfaction as the outcome measure (Wampler & Serovich, 1996).

PREP

PREP has been evaluated in a number of studies. In a key study conducted in the United States, couples who completed PREP were compared to matched control couples who received no treatment; they were then followed longitudinally over several years (Markman, Floyd, Stanley, & Storaasli, 1988; Markman, Renick, Floyd, Stanley, & Clements, 1993; Stanley, Markman, St. Peters, & Leber, 1995). Couples who received PREP performed better than control couples on a number of communication measures. They also reported fewer instances of

physical violence and were less likely to divorce. At the five-year follow-up, for example, the incidence of divorce and separation was 8% for PREP couples versus 19% for the control group. After 12 years, 19% of PREP couples were divorced or separated, compared to 28% of the control couples, although the difference was no longer statistically significant.

Another outcome study in Germany compared a version of PREP to a mixed control group of couples, in which half received no treatment and half received treatment from alternative premarital programs (Stanley et al., 1999). After five years, PREP couples continued to report a lower incidence of divorce (4% versus 24%) compared to control couples. A third study, in the Netherlands (van Widenfelt, Hosman, Shaap, & van der Staak, 1996), did not show the same promising results as the studies in the United States and Germany, possibly due to some methodological problems (Stanley, 2001). However, a recent study (Stanley, Allen, Markman, Rhoades, & Prentice, 2010) found that Army couples who received a version of PREP called Strong Bonds had a lower divorce rate (2.03%) after one year compared to those who did not (6.20%).

One of the most impressive aspects of the PREP research is the length of time that couples are followed. Following couples longitudinally over a significant period of time is important for two reasons (Stanley et al., 1999). First, differences between treatment and no-treatment groups are difficult to tease out initially, because most engaged couples are highly satisfied with their relationship in the beginning, leaving little room for improvement. Second, one of the outcomes of most interest is whether a couple stays married or divorces. Couples need to be followed over a sufficient length of time to see whether the interventions affect the long-term stability of the relationship.

PAIRS

In their summary of the research, Gordon and Durana (1999) discuss several studies that suggest PAIRS can lead to improvements in several areas, such as marital satisfaction, cohesion, and emotional well-being. A key limitation of the research, however, is that PAIRS participants have not been compared to control groups, giving us less confidence in the results. Gordon and Durana (1999) cite only one unpublished study, by Turner, that compared PAIR participants to control participants, which found that the PAIRS intervention had a positive impact on interaction style, social support, and marital discord.

Research on PAIRS Essentials, a 9-hour version of the program, has also demonstrated positive results. Individuals had significantly higher scores on a measure of relationship quality after completing the program (Eisenberg, Peluso, & Schindler, 2011). These positive gains were also evident at 6-month and 12-month follow-up. However, there was no control group for comparison. More empirical research using controlled, randomized experiments is clearly needed to confirm the initial, promising results for the PAIRS programs.

PREPARE/ENRICH

The customized version of PREPARE/ENRICH generally has good reliability, with **internal reliability** coefficients for the 10 core scales ranging from .64 to .89, with the majority being .80 and above (Olson et al., 2009). Studies have assessed the **predictive validity** of an earlier version of PREPARE (Fowers & Olson, 1986; Larsen & Olson, 1989), demonstrating that the PREPARE topics have some ability to predict later marital success after two to three years. Another study (Fowers & Olson, 1989) showed that ENRICH scores could successfully distinguish between happily and unhappily married individuals, giving evidence to its **discriminant validity**. However, there are no studies on the validity of the customized version of PREPARE/ENRICH.

A study by Knutson and Olson (2003) demonstrated the value of couples receiving feedback from an earlier version of PREPARE. Couples in this study were divided into three groups: (1) those who took PREPARE and received feedback, (2) those who took PREPARE but received no feedback, and (3) a waitlist control group. Only couples who took PREPARE and received feedback saw a significant improvement in relationship satisfaction. This group also saw an increase in the percentage of couples categorized as Vitalized and a reduction of couples classified as Conflicted.

Conclusion

This chapter reviewed five well-known programs within the family therapy field that are used in premarital counseling and marital enrichment. This chapter also presented a variety of approaches and techniques used in premarital counseling within a church setting, because premarital counseling is offered predominantly in this setting. Teaching couples skills for effectively communicating and for managing conflict is an important feature in the programs presented in this chapter. The emphasis on these skills is supported by marital research, which shows that couples' ability to communicate and handle conflict is predictive of later marital success. Although the aim or goals of these programs are preventive in nature, distressed couples often seek out and participate in these programs as well. Elements of these programs can also be incorporated into couple therapy. To varying degrees, there is empirical support for the efficacy of these programs. However, further research is clearly needed, particularly in establishing the long-term benefits of these programs.

Recommended Resources: Programs and Organizations

Better Marriages—www.bettermarriages.org
Couple CARE—www.couplecare.info
COUPLE COMMUNICATION—www.couplecommunication.com

FOCCUS—www.foccusinc.com
National Association for Relationship and Marriage Education (NARME)—www.narme.org
Practical Application of Intimate Relationship Skills (PAIRS)—www.pairs.com
PREPARE/ENRICH—www.prepare-enrich.com
Prevention and Relationship Enhancement Program (PREP)—www.prepinc.com
RELATE—www.relate-institute.org
Relationship Enhancement—www.nire.org
Smart Marriages—www.smartmarriages.com

Glossary

Awareness Wheel: A tool used in COUPLE COMMUNICATION to help individuals explore and articulate different aspects of an issue, such as their feelings, thoughts, desires, and actions.

behavioral couple therapy: An approach that primarily focuses upon teaching couples effective communication and problem-solving skills, as well as increasing positive or caring behaviors between partners.

changing-self skill: A skill taught in Relationship Enhancement that helps individuals alter their own behavior.

cohesion: The amount of emotional closeness or distance within a couple or family.

communication training: Any approach that emphasizes learning skills to effectively communicate and resolve conflict with other individuals.

conditioning: A process in which two stimuli are paired together and eventually become associated with each other.

conflict management skill: A skill taught in Relationship Enhancement that helps individuals regulate their emotions and manage difficult conflict situations.

contempt: Disgust or lack of respect for an individual.

COUPLE COMMUNICATION: A preventative program designed to enhance couple relationships through the teaching of effective communication and conflict resolution skills.

criticism: An attack on an individual's personality or character rather than a complaint about a specific behavior.

defensiveness: An individual's response, to a complaint or criticism, that implies he or she did nothing wrong. Defensiveness can take many forms, such as making excuses or blaming another for the problem.

Dialogue Guide: A sentence completion exercise used in PAIRS to help individuals uncover and express their thoughts, feelings, and assumptions.

discriminant validity: Evidence as to whether an instrument is measuring what it is supposed to be measuring, based on its ability to differentiate between two groups.

discussion and negotiation skill: A communication skill taught in Relationship Enhancement that helps individuals uncover root issues and maintain a positive atmosphere when discussing difficult topics.

distance and isolation cascade: A process in which individuals in a couple begin to view their problems as severe, with the additional belief that there is no point in trying to work out problems with their partner. This can result in couples doing less and less together, creating feelings of loneliness in the relationship.

Dynamic Relationship History: An assessment technique in which a couple's relational dynamics, issues, and patterns are uncovered through collecting a detailed relationship history.

effect size: A statistic that measures the strength of the treatment effects in comparison to a control (no treatment) or alternative treatment. Effect sizes can be used to standardize results across studies, allowing researchers to compile or compare results across different studies using a technique called meta-analysis.

empathic skill: A communication skill taught in Relationship Enhancement that helps individuals understand the needs of a speaker.

Engaged Encounter: A weekend retreat for engaged couples that includes presentations and opportunities for individuals to reflect and participate in dialogue with their partner.

escalation: A negative sequence of interaction in which partners respond to each other with increasingly negative comments or actions.

expressive skill: A communication skill taught in Relationship Enhancement that helps individuals communicate about themselves in a way that minimizes listener defensiveness.

facilitative skill: A communication skill taught in Relationship Enhancement that helps individuals exit negative communication cycles and resume using the RE skills.

flexibility: The degree of adaptability within a couple or family. At the two extremes, couples can be either too rigid or too chaotic when responding to the need to change.

flooded: Describes a state of physical arousal accompanied by negative thoughts and feelings that can occur during conflict.

FOCCUS: A widely used premarital inventory that encourages couples to explore and discuss their relationship in a variety of topic areas. FOCCUS stands for Facilitate Open, Caring Communication, Understanding, and Study.

Four Horsemen of the Apocalypse: Four behaviors (criticism, contempt, defensiveness, and stonewalling) in couple interactions that have been found through research to be predictive of divorce.

genogram: A multigenerational family map or family tree that is used to explore important events and psychological processes in a person's family of origin.

ground rules: Strategies in PREP that couples can use to protect a relationship from poorly handled conflict.

helping-others-change skill: A skill taught in Relationship Enhancement that helps individuals change the attitudes, behaviors, or feelings of others.

internal reliability: An indication of whether all the items in an instrument measure the same concept. Higher scores (closer to 1.0) indicate greater reliability.

invalidation: Putting down the thoughts, feelings, or character of another person.

Listening Cycle: A conceptual map and tool used in COUPLE COMMUNICATION to help individuals develop better listening skills.

maintenance skill: A skill taught in Relationship Enhancement that helps individuals sustain using the other RE skills over time.

mapping an issue: An eight-step problem-solving approach to resolving conflict that is used in the COUPLE COMMUNICATION program.

marriage enrichment: Programs designed to enhance the quality of marital relationships. They frequently focus on teaching couples effective communication and conflict resolution skills.

meta-analysis: A statistical analysis that allows researchers to compile and compare the results across several experimental studies. Meta-analyses generate an effect size, which is a measure of how effective a treatment is relative to a no-treatment control or alternative treatment.

negative interpretations: When an individual consistently believes the motives of his or her partner are more negative than they are in reality.

Practical Application of Intimate Relationship Skills (PAIRS): A comprehensive program designed to enhance participants' knowledge of self and how to build a satisfying intimate relationship.

predictive validity: A way of demonstrating that an instrument is measuring what it is supposed to be measuring by showing that the scores are able to predict some phenomenon.

premarital counseling: Counseling or programs designed to help couples who are preparing for marriage have stable and satisfying marriages.

PREPARE/ENRICH program: An inventory that assesses premarital couples (PREPARE) and married couples (ENRICH) in a variety of topic areas important to marital success. The inventory encourages couples to explore and discuss their relationship and includes a workbook with exercises for strengthening the relationship.

preventative approaches: Programs that generally attempt to teach couples skills and enhance relationships before the onset of major problems.

Prevention and Relationship Enhancement Program (PREP): A preventive program designed to teach couples effective communication and conflict resolution skills, as well as enhance commitment and bonding.

problem/conflict resolution skill: A skill taught in Relationship Enhancement that helps couples discover creative solutions to their problems.

RELATE: An inventory that encourages couples to explore and discuss their relationship in a variety of topic areas. RELATE does not require a facilitator.

relationship education: Programs that provide couples education and skills to prevent distress and enhance marital quality.

Relationship Enhancement (RE): A skills-based program that primarily focuses on teaching couples effective communication and conflict resolution skills.

self-regulation: A skill in which partners appraise and set clear goals for what they want in the relationship and then change their own behavior to achieve positive change.

skill mats: Thirty-inch-square floor mats with either the Awareness Wheel or Listening Cycle printed on them, used in COUPLE COMMUNICATIONS.

speaker-listener technique: A technique in which one person is designated as the speaker and the other person the listener. The speaker must follow certain guidelines, such as speaking only about his or her own experience, while the listener paraphrases what the speaker is saying without interjecting his or her own thoughts or feelings.

stonewalling: When an individual withdraws from or stops participating in discussion of an issue, often as a result of becoming FLOODED due to the conflict.

time-out: A technique in which either partner requests that the couple temporarily suspend discussing an issue if the conflict reaches a point at which it is destructive or unproductive.

transfer and generalization skill: A skill taught in Relationship Enhancement that helps individuals utilize the other RE skills in everyday life with people other than their partner.

withdrawal/avoidance: A reluctance to talk about important issues.

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13

SEXUAL DISORDERS AND SEX THERAPY

Joan D. Atwood

> The only unnatural sex act is that which you cannot perform.
>
> —Alfred Kinsey

> Sex is a natural function. You can't make it happen, but you can teach people to let it happen.
>
> —William Masters

The demand for treatment for sexual problems has increased in the past three decades. This is in large part due to increased public knowledge that effective treatments are available and the growing recognition that these problems are comparable to other behavioral difficulties and therefore often respond to behavioral treatment (Hawton, 1983). There is also increased awareness within the fields of couple and family therapy, social work, and clinical psychology that sex therapy should be a primary part of training in these areas. Thus, professionals in these disciplines are now more likely to ask couples about the sexual aspects of their relationship. As De Silva (1992) points out, training in sex therapy need not be an elective specialization; rather, it should be an essential component of the training of every practitioner.

Sexual Problems

Sexual disorders, or sexual problems, are impairments or disturbances in sexual desire, arousal, or orgasm. (For women, the *DSM-V* has combined problems with sexual desire and arousal into one disorder: Female Sexual Interest/Arousal Disorder.) Sexual disorders are usually considered to be a group of problems within

"normal" sexuality, different from **sexual deviations** or **paraphilias**, which are treated as a separate clinical category (although overlap can occur—e.g., a man presenting with erectile disorder with his wife may, upon close inquiry, show a history of paraphiliac sexual activity). It is also important to keep in mind that sexual disorders cannot be considered mutually exclusive from the non-disorders. Functional and disordered presentations are considered to be on the same continuum. In other words, there are degrees of disorder, and there are areas of satisfactory sexual activity alongside areas of difficulty. Also consider the social aspect: what is considered a disorder may vary from person to person, from couple to couple, and from society to society. In addition, many couples would consider their sexuality normal and therefore would not be part of a clinical population; yet a certain proportion of them would report their sexual behavior as less than satisfactory. Frank, Anderson, and Rubinstein (1978) reported that 80% of their happily married couples reported that their sexual relations were happy and satisfactory, even though 40% of the men reported erectile or ejaculatory problems and over 60% of the women reported problems of arousal or orgasm.

Several factors appear to be associated with sexual disorders, including sexual ignorance, attitude, anxiety level, fear of performance, and the quality of the couple's relationship. Sexual ignorance, or lack of proper information about the various aspects of sex, is sometimes a major factor in these disorders (Bancroft, 1989; Zilbergeld, 1978). Another important factor is the person's attitude toward sex and sexual activity (Spence, 1991; Zilbergeld, 1978, 1992). Anxiety is associated with sexual disorders in that some difficulties can be caused by anxiety and others can be maintained by it (Bancroft, 1989; Lief, 1977; Masters & Johnson, 1970; McCabe et al., 2010). For example, a young man may fear getting caught by his parents when he is having sex, and this may keep him from achieving erection. In another situation, he may become anxious about getting an erection in the first place.

Fear of performance (aka **performance anxiety**) occurs when **spectatoring** (in which one or both partners assume a spectator role, often judging personal sexual performance) (Masters & Johnson, 1970) reduces a person's sense of engagement in the sexual activity and eventually creates a loss of arousal and/or erection. Generally speaking, when a "spectator" rates his or her own sexual performance, a **self-fulfilling prophecy** occurs, in which a reduction in natural, spontaneous sexuality often leads to a decreased state of arousal, causing the spectator to believe his or her sexual performance is less than adequate, causing more performance fear, and so on. Fear of performance may affect men or women, although it is most obvious in men. It may lead to an avoidance of sex, loss of self-esteem, or loss of spontaneity in the relationship, or it may negatively affect the relationship in general. In addition, a loss of intimacy in the relationship could result, as couples often report that it feels as if a third person is in the room rating their sexual performance.

In couples with sexual problems, there is a clear link between the quality of the couple's relationship and their sexual problems (Crowe & Ridley, 1990; McCabe

et al., 2010; Woody, 1992). That is to say, sexual difficulties can emerge in a poor relationship. Jealousy fears and worries about infidelity or constant conflicts in areas other than sex may contribute to, or be reflected by, a sexual problem. Sex sometimes may become a battleground of dominance, jealousy, and punitiveness (Harbin & Gamble, 1977; Metz & Epstein, 2002). Equally, a sexual problem can cause wider relationship difficulties, and when couples present with other problems it is not unusual for a specific sexual problem to be present as well.

Some sexual problems are caused by or associated with physical factors. The relevance of such factors as alcoholism, diabetes, aging, neurological damage, and prescription drug and street drug use to sexual activity is well established (Bancroft, 1989; Kolodny, Masters, & Johnson, 1979; Lewis et al., 2010). The presenting sexual problem may be a manifestation of the underlying physical problem.

Sexual problems can produce just as much anguish and sorrow as any psychological disorder. Many people cannot help but feel that their masculinity or femininity is affected if a sexual problem is present. Failing to achieve sexual gratification in a relationship often affects the couple's experience of the whole relationship as well.

Many useful classifications of sexual disorders exist (see American Psychiatric Association, 2013; Bancroft, 1989; De Silva, 1994; Hawton, 1985; Kaplan, 1974; Masters & Johnson, 1970). See Table 13.1 for a simple list of sexual disorders that may occur for each gender.

Sexual disorders may be categorized as a **primary sexual problem** (present since the person became sexually active) or a **secondary sexual problem** (occurring after a normal period of sexual activity), generalized (not limited to certain situations) or situational (present in some circumstances), and mild, moderate, or severe. A man with a lifelong erectile disorder has never had the ability to maintain a successful erection or ejaculation. The **anorgasmic** woman has never had an orgasm. An example of an acquired problem is when premature (early) ejaculation happens during sexual intercourse but not during masturbation.

The two major areas of male disorder include disorders of potency and ejaculation.

TABLE 13.1 Sexual Disorders

Males	*Females*
Hypoactive Sexual Desire Disorder	Female Sexual Interest /Desire Disorder (Formerly Low Sexual Interest and Arousal Disorder)
Erectile Disorder	Orgasmic Disorder
Premature (Early) Ejaculation	
Delayed Ejaculation	Genito-Pelvic Pain/Penetration Disorder (Formerly Vaginismus and Dyspareunia)

Erectile Disorder (DSM-V 302.72)

Erectile disorder is defined as the inability to achieve or maintain an erection. Lifelong erectile disorder tends to be rare, occurring in only 1% of men under age 35 (Masters & Johnson, 1970). Acquired erectile disorder is said to occur if erection is insufficient to engage in sexual intercourse. This occurs approximately 25% of the time. The basic premise of the therapy for this disorder is that anxiety disrupts erectile response. Thus, the object of therapy is to diminish the anxiety sufficiently.

Although psychological treatment for erectile disorder has changed very little since its inception (Zilbergeld, 1992), medical treatment options have increased dramatically. The use of sensate focus is supplemented with cognitive techniques used to promote relaxation, positive self-statements, sexual fantasy, and the restoration of self-confidence. For men with lifelong erectile problems, individual psychodynamic treatment has been suggested along with sex therapy (Althof, 1989). Beck and Barlow (1984) have found that men with erectile disorder pay more attention to how much of an erection they have and less attention to their feelings of arousal.

The treatment of erectile disorder has become increasingly medical in the past 10 to 15 years. Drugs, devices, and surgery dominate the field. An adrenergic antagonist drug has been reported as a successful treatment (Assalian, 1988). Sildenafil citrate (Viagra), a Type-V phosphodiesterase inhibitor, also has been demonstrated to be an effective medication for the treatment of erectile disorder via arteriolar smooth muscle relaxation in the **corpus cavernosum**, which increases blood flow to promote penile **tumescence** (Goldstein et al., 1998; Moreland, Goldstein, & Traish, 1998; Sivalingam, Hashim, & Schwaibold, 2006; Wise, 1999). Although this drug may be successful as a medical treatment for erectile disorder, it is important to explore with the couple the psychological changes that have occurred in their relationship as a result of the problem. For example, unrealistic expectations, inadequate information regarding sexuality, and couple difficulties could be problems associated with poor outcomes. In some cases, couples may dissolve following successful medical or psychotherapeutic intervention for erectile disorder. It is possible that the couples were stable with the sexual disorder and once the disorder was removed, instability ensued. Research is greatly needed in this area.

Although most urologists believe that the vast majority of erectile problems have an organic basis (LoPiccolo, 1992), there are several problems with this view. For example, it is often quoted that 50% to 90% of erectile problems have an organic basis, but this definition is usually made without examination of age. If one looks at men under the age of 50 with erectile disorder, the percentage drops drastically (Seagraves & Seagraves, 1992). The other problem is inattention to normal changes in erectile response that occur with age (Schiavi, Schreiner-Engel, Mandeli, Schanzer, & Cohen, 1990). Healthy men over age 50 who report good sexual function have tumescence test results (tests that measure how much blood

is in the penis or how erect the penis is) that look just as abnormal as men reporting erectile disorder (Schiavi et al., 1990). This means that there is variety in the male erectile response.

It is important to note that even when urologists see a man with a purely psychological basis to his sexual problem, they often prescribe nonsurgical treatment such as **intracavernous injection therapy** or **vacuum erection devices**. They may contend that their patients will not go to a mental health professional, or that there are no sex therapists in their community, or that sex therapy is too expensive and the patient's insurance will not cover it. Some evidence suggests that a combination of sex therapy with injection therapy might be helpful in alleviating anxiety, which would help the man later achieve firmer erections without the medication (Bahren, Scherb, Gall, Beckert, & Holzki, 1989; Kaplan, 1990; Turner et al., 1989). It is important to keep in mind, however, that these studies tend to downplay an important side effect of injection therapy, which is the incidence of **fibrosis** (scarring of the soft tissue of the penis) (Lakin, Montague, VanderBrug Medendorp, Tesar, & Schover, 1990). Severe cases of fibrosis, which occurs in about a third of men using injection therapy, can cause pain during erection and curvature of the penis. Support for men with erectile disorder can be obtained from Impotence Anonymous, a national organization located at 119 South Rush Street, Maryville, Tennessee 37801 that offers therapy for men and their partners. Call 1-800-669-1603 for information on local support groups or 1-800-867-7042 for names of physicians in your area who have a special interest in treating **impotence**.

Premature (Early) Ejaculation (DSM-V 302.75)

Masters, Johnson, and Kolodny (1985) believe that **premature (early) ejaculation** affects 15% to 20% of all men. It is difficult to define premature (early) ejaculation. A common definition is—given a normal, healthy, functioning partner—the inability to delay ejaculation long enough to bring the partner to orgasm.

The treatment of premature (early) ejaculation is based on the assumption that it is possible to exert conscious control over ejaculation—that men can learn to prolong erection when sexually aroused. The main components of this treatment program involve couple communication and increasing the ability of the premature ejaculator to perceive impending orgasm.

The **squeeze technique** is a common approach used to treat this disorder. The couple is encouraged to engage in foreplay until the premature ejaculator achieves erection. He is asked to let his partner know when he is approaching the feeling of inevitability of orgasm. The partner then can use the squeeze technique or stop activity until the sensation subsides. The squeeze technique involves squeezing the penis just below the glans, with the thumb on one side and the forefinger on the opposite side, gently but with sufficient force to diminish the impending sensation of orgasm. The exercise can be repeated several times. Next, for heterosexual couples,

intercourse in the female superior position is suggested so that the squeeze technique may be more easily applied and/or intercourse can be interrupted. In addition, several self-help techniques have been proposed. For example, the use of a condom seems to help because it reduces sensation in the penis. Some men drink an alcoholic beverage before sex to decrease the rapidity of their response; others masturbate before intercourse, knowing that a second orgasm will take longer. Kaplan (1974) suggests using the **stop-start technique** (in which intercourse proceeds until the feeling of impending orgasm and then stops until the feeling has subsided) first developed by Semans (1956).

Delayed Ejaculation (DSM-V 302.74)

Delayed ejaculation is a marked delay in ejaculation or a marked infrequency or absence of ejaculation. **Masters and Johnson** (1970) say that it occurs in less than 5% of men, usually those who are younger and sexually inexperienced. It is the least common disorder reported by men. If a man has never ejaculated during intercourse, he is said to have lifelong delayed ejaculation. If he has been able to ejaculate during intercourse previously but currently cannot, then he has acquired ejaculatory disorder. These men may be able to ejaculate via masturbation or oral sex.

An unintended side effect that could occur with this disorder is that the man is able to maintain sexual intercourse for long periods of time without ejaculating. This may be considered a positive effect. On the other hand, in some cases he may begin to question his partner's sexual abilities, or his partner may feel as if he is not physically attracted to her.

Sensate focus exercises are used to treat delayed ejaculation. Sensate focus is basically sensual touching. The partners touch each other first in non-erogenous zone areas, focusing on the pleasurable sensations. This enables the delayed ejaculator to focus on his sexual and sensual feelings. In a stepwise fashion, he learns to ejaculate via masturbation alone, then by masturbating with his partner present, and then having his partner masturbate him to the point of **ejaculatory inevitability**, eventually inserting his penis in his partner to actually ejaculate.

Female Low Sexual Interest/Arousal Disorder (DSM-V 302.72) and Male Hypoactive Sexual Desire Disorder (DSM-V 302.71)

Lief (1977) and Kaplan (1979) are responsible for the labeling of low sexual desire as a sexual disorder. They observed that the lack of motivation to have sex was a crucial factor in unsuccessful sex therapy cases.

In the case of men, no erection occurs and no urges to engage in sexual behavior are felt. In the case of women, there is a lack of sexual arousal, the vagina does not lubricate, and no change in vaginal size occurs (to ease intercourse). The causes of **low sexual interest** may include organic as well as **psychogenic** factors.

Approximately 10% to 20% of men with low sexual interest have pituitary tumors that cause too much of the hormone **prolactin** to be produced. This hormone reduces the amount of testosterone and can lead to low sexual interest or erectile disorder (Buvat, 2003; Schwartz, Bauman, & Masters, 1983). Sexual unresponsiveness can also be psychogenic, caused by factors such as shame, poor self-esteem, a bad relationship, guilt, embarrassment about sexual activity or one's body, or a history of sexual abuse. Before any treatment can begin, the etiological factors must be identified.

The goal in cases of low sexual desire is to create a non-demanding, relaxed, and sensuous environment in which mutually gratifying sexual activity can take place. The sensate focus exercise is critical in assisting a woman with low sexual desire to relax and in some cases to help her learn about her own sexuality. For heterosexual couples in which the woman has low sexual desire, the female superior position is often helpful because it increases female sensitivity. However, a review of the current treatment programs for sexual desire disorders reveals that current approaches are more eclectic than the original behavioral techniques (see Leiblum & Rosen, 1988).

Orgasmic Disorder (DSM-V 302.73)

Female inability to orgasm is known as **orgasmic disorder**. Orgasmic disorder occurs in a woman who is sexually responsive but does not reach orgasm when aroused. Many women report that they enjoy sexual intercourse even though they do not orgasm (Hite, 1976). Lifelong orgasmic disorder occurs in women who have never had an orgasm by any means. If a woman has experienced an orgasm at one time in her life, the current problem is said to be acquired orgasmic disorder. Situational orgasmic disorder occurs situationally. For example, a woman may have an orgasm during masturbation but not during sexual intercourse, or with one partner and not another.

Kaplan (1974) reports that approximately 8% of women are anorgasmic by any means for unknown reasons. Approximately 10% of women are coitally anorgasmic (Kinsey, Pomeroy, & Martin, 1953; Levin & Levin, 1975). Only 30% to 40% of women report that they regularly experience orgasm through sexual intercourse without having the clitoris manually stimulated at the same time (Ellison, 1980; Hite, 1976). Only about 5% of cases of orgasmic disorder are the result of organic factors (Masters et al., 1985). Organic causes include diabetes, alcoholism, hormone deficiencies, and pelvic infections. The other 95% are psychogenic, with causes such as guilt or shame associated with sexual activity. These states of mind tend to interfere with a woman's ability to relax and let go.

In general, the therapist's basic task is to help the woman let go of an over-controlled response. This involves maximizing clitoral stimulation and at the same time diminishing those forces that inhibit orgasm. The major objective is for the woman to have an orgasm. Masturbation is encouraged. Vibrators may

be used. The woman is encouraged to fantasize and to try thrusting movements. She is encouraged to use **Kegeling exercises** (starting and stopping the flow of urine in order to strengthen the vaginal muscles) to strengthen the muscle used in orgasm. Next, once the woman has achieved an orgasm, she may work with her partner to achieve orgasm through intercourse. First, she should be manually stimulated. Next, the bridge technique can be used, in which the partner continues to stimulate the clitoris during intercourse. For heterosexual couples, female superior position is used, since this maximizes female stimulation and allows the woman freedom of movement. These techniques were all set forth in the 1970s. The only alternatives have been the incorporation of systemic and psychodynamic couple therapy into the sex therapy sessions. The outcome studies report that more success occurs with women who have never had an orgasm than with women who enter therapy because they want to increase their ability to have orgasms with their partner (DeAmicis, Goldenberg, LoPiccolo, Friedman, & Davies, 1985; Hawton, Catalin, Martin, & Fagg, 1986).

Genito-Pelvic Pain/Penetration Disorder (DSM-V 302.76)

According to the *DSM-V,* there is a merging of the categories vaginismus and dyspareunia. Sexual aversion disorder has been eliminated. This has occurred mainly in terms of difficulty of diagnostic processes.

Genito-pelvic penetration disorder (formerly **vaginismus**) is defined as the involuntary spastic contraction of the outer one-third of the vagina. Genito-pelvic penetration disorder (vaginismus) may cause severe pain (genito-pelvic pain disorder—formerly **dyspareunia**) and as a result the woman may avoid sexual activity. Masters, Johnson, and Kolodny (1985) estimate that 2% to 3% of all women experience vaginismus. Generally, those with vaginismus do not have a problem with sexual arousal. The causes of vaginismus are usually psychological and generally related to shame, fear, and embarrassment. Dyspareunia can sometimes lead to vaginismus. Masters and Johnson (1970) found that vaginismus is associated with erectile disorder in male partners, strong religious teachings against sexuality, homosexual feelings, a history of sexual assault, and negative or hostile feelings for one's partner.

The successful treatment of vaginismus most often utilizes behavioral techniques focused on modifying a conditioned response. Often **vaginal dilators** of progressive size are used, combined with Kegel exercises to teach control of the vaginal muscles, cognitive restructuring to alleviate guilt about sexuality or to resolve past sexual trauma, and attention to systemic couple issues or intrapsychic problems. The dilators are generally used in the doctor's office with or without the partner present. The woman must learn to allow for the presence of the dilator without the conditioned fear response. The goal is to decrease the woman's fear and anxiety sufficiently so that penetration can occur. Encouragement and support by the partner is crucial (Lazarus, 1989; Leiblum, Pervin, & Cambell, 1989).

Genito-Pelvic Pain Disorder (Formerly Dyspareunia)

Genito-pelvic pain disorder is painful intercourse, and it may occur in men as well as women. In men, dyspareunia may be caused by infection in the foreskin, testes, urethra, or **prostate**, as well as by an allergic reaction to spermicidal creams or foams. Some men complain of sensitivity to the string of their female partner's contraceptive intrauterine device (IUD). They experience dyspareunia as pain in the penis, the testes, or the glans area. In women, pelvic inflammatory disease, endometriosis, tumors, rigid **hymen**, yeast infections, creams, and many other factors may cause dyspareunia. Although many women sometimes experience pain during sexual intercourse, dyspareunia is chronic. The pain could manifest as a burning sensation or a cramping. It could occur externally in the vaginal area or internally in the pelvic area. Masters and Johnson estimate that approximately 1% to 2% of women experience dyspareunia on a regular basis.

Assessment Considerations

Couple therapists dealing with sexual issues are involved in four areas of assessment that are not adequately described in the literature: possible medical or organic causes; individual vulnerability issues; interpersonal and/or partner factors; and **systemic** issues. The impact of one's cultural, religious, and socio-historical-political background on his or her sexual behavior is explored in a subsequent section.

Medical Factors

Organic factors can affect sexual functioning. They may be the direct cause, the primary cause, or a contributing factor. Even in sexually disordered clients who are seemingly organically intact, usually some bio-physiological processes can be implicated (for a detailed description of these factors, see Kolodny et al., 1979). For this reason, the couple and family therapist should have a basic knowledge of the potential organic factors that can cause sexual symptoms.

- Biochemical/physiological disorders may serve to decrease sexual interest or energy. This includes **cardiopulmonary**, **hepatic**, **renal**, **endocrine**, and **degenerative diseases** as well as **malignancies**.
- Diseases such as mumps, tuberculosis, and tumors may affect **libido** or arousal. In addition, tumors, infections, and invasive surgeries can negatively impact libido.
- Anatomic or mechanical interference includes **endometriosis**, **prostatitis**, **urethritis**, and **pelvic inflammatory disease (PID)**, and conditions such as **priapism**, **phimosis**, and **clitoral adhesion** can make intercourse painful.

- Postsurgery neurological or vascular damage can affect sexual drive. Causes may include problems in abdominal aortic surgery, complications from a hysterectomy, and problems related to a prostatectomy.
- Neurological disorders that damage the higher nerve centers, such as **spina bifida** and **multiple sclerosis**, damage to the temporal or frontal lobe of the brain (e.g., caused by lack of oxygen), or surgery on or trauma to the sacral or lumbar cord may generally increase or decrease sexual drive. When there is spinal damage, sexual drive may not be affected, but erectile response, ejaculation, or orgasm might be.
- **Vascular disorders** may cause erectile problems in men by interfering with vascular flow to the penis.
- Endocrine disorders can depress sexual drive by decreasing androgen levels in both men and women.
- Genetic or congenital disorders such as **Klinefelter's syndrome** may result in impotence in men. Undescended testes in men may affect sexual response.
- Drugs and medication may have a direct or indirect effect on sexual functioning. Although many drugs are said to be **aphrodisiacs**, this is mostly myth. Currently, no drug can be considered a specific aphrodisiac.

Assessment and diagnosis should include some of these relevant questions:

- Is there a physical disease or disability (e.g., renal failure, circulatory problems, diabetes)?
- Does the partner of the person who is presenting the sexual disorder have a disease? The person may be responding to the partner's post-cardiac vulnerability, cancer, **prostatectomy**, or **mastectomy**. If illness or injury permanently affects sexual function of the partner, body image and sexual role behavior may be ignored.
- Is the client taking any drugs that could affect sexual function (e.g., hypertensive medicine, alcohol, methadone, even over-the-counter medications)? I once had a client who had seen a psychologist for painful intercourse for two years. As it turned out, the client was addicted to Dristan, an over-the-counter medication that dries up mucous membranes. The problem was that it dries up *all* mucous membranes, including in the vagina! This client could have gone to psychotherapy for 20 years and the true problem still might have remained uncovered.
- Has the person had any surgery, such as prostate gland removal or a **vulvectomy?**
- Is there an escalation in the aging process that is impairing sexual functioning?

Individual Vulnerability Factors

Briefly, individual vulnerability factors refer to the complex and unique elements in each individual that can shape his or her sexual attitudes and behavior (e.g., adequate or inadequate sex information and education). The psychological sequences that mediate most disorders are an unwillingness to make love, an inability to relax,

and an inability to concentrate on sensation. A major assessment issue here is to identify the inhibitions that serve to block sexual desire. The most common inhibitions are anxiety, guilt, and reaction to sexual trauma. Once they are identified, they need to be conveyed to the couple in a non-blaming, nonjudgmental manner.

Generally speaking, the following individual vulnerability issues may be involved in sexual disorder:

- *Early sexual attitudes and experiences.* Early rape, incest, or other sexual trauma; thoughts that sex is bad or dirty; and confusion about one's sexual preference may affect sexual functioning.
- *Lack of information about sexuality.* Lack of information may result in ignorance of technique, fear of pregnancy, or unrealistic expectations concerning sexuality and/or orgasm.
- *Situational factors.* These may include unemployment, family stresses, and relationship problems (see below).
- *Communication problems.* General communication problems sometimes extend to the sexual arena.
- *Intrapsychic issues such as* ***performance anxiety*** *and depression.* With depression, it is important to understand whether the individual is depressed because of the sexual disorder, whether the depression caused the sexual disorder, or whether both problems are influencing each other. Low self-esteem or poor body image can also play a role in sexual disorder.

The therapist should assess the following in a sex history interview:

- The client's history of sexual behavior, including a psychosexual/developmental overview/exploration of the client's childhood personal history and religious upbringing.
- The client's current sexual behavior.
- Attitudinal and cognitive factors.
- How the client thinks about his or her sexual disorder and whether the client has negative attitudes about sex in general. (For a more detailed sex information instrument, see Masters & Johnson, 1970.)

Relationship and/or Partner Factors

Relationship and partner issues can affect sexual functioning through ineffective sexual communication styles (e.g., not openly discussing sexual needs.) In other words, the couple may have negative communication patterns with respect to sexual issues. Some relevant assessment areas follow:

1. *Conflict resolution*—the ease with which differences of opinion are resolved.
2. *Affection*—the degree to which feelings of emotional closeness are expressed by the couple.

3. *Sexuality*—the degree to which sexual needs are communicated and fulfilled by the couple.
4. *Identity*—the couple's level of self-confidence and self-esteem.
5. *Compatibility*—the degree to which the couple are able to work and play together comfortably, along with commitment to the relationship and similar attitudes, belief systems, and preferred activities.
6. *Intellectual and affectual expressiveness*—the degree to which thoughts, beliefs, attitudes, and feelings are shared within the couple, as well as self-disclosure.
7. *Autonomy*—the degree to which the couple have independence from their families of origin and their offspring, both as individuals and as a couple.
8. *Relational structure*—the degree to which the couple have explicit rules and roles that provide structure and definition.
9. *Sexual boundary rigidity*—the degree of enmeshment or disengagement of the couple. (Disengagement in a relationship could lead to stimulus and touch deprivation, sexual isolation, and/or body image anxiety.)
10. *Disruptions of established power hierarchies*—a possible disruption within the couple or family subsystem occurring at about the time when the sexual disorder began—for example, a challenge to the husband's decision-making authority that resulted in inhibited sexual desire or erectile disorder.
11. *Life cycle crisis*—the capacity of the family structure to transform in response to predictable major life crises.

Systemic Issues

Zimmer (1987) believes that clinicians should carefully evaluate the couple's general relationship at the beginning of therapy. Couples in distress usually exhibit some sexual disorder. These disorders, however, could play various important roles in the maintenance of the couple system. For example, they may divert the couple from other family interactions. They may help the couple maintain emotional distance. They may provide the couple with outlets for power positions or hostility. They may sustain role-specific behavior. In these cases, treating the sexual disorder in a sex therapeutic modality alone is likely to meet with failure, as the sexual disorder must be sustained in order to maintain the stability of the couple.

This type of conceptualization enables the therapist to accomplish the following:

- Assess and understand the place of influences within the couple in the etiology and maintenance of the sexual disorder.
- Assess the relative strength of relationship-enhancing forces that could potentially facilitate and support the process of sex therapy.
- Assess the relative strength of relationship-diminishing forces that would potentially inhibit and perhaps even undermine the process of sex therapy.

Therefore, a comprehensive and multidimensional approach to the treatment of sexual disorders must include a thorough evaluation of the couple's relationship. Focusing on relationship problems will facilitate rapid changes in both couple and sexual functioning.

Approaches to Sex Therapy

Presently, three widely accepted theoretical orientations are used to treat sexual problems: psychoanalytic; cognitive-behavioral, including the "new sex therapies," based on and including Kaplan, and systemic. It is important to note that there also needs to be a consideration of "normal" sexuality or at least the physiological aspects of the normal human sexual response. Before the publication of *Human Sexual Response* by Masters and Johnson in 1966, no data or information existed on what was considered "normal" physiological functioning.

The Psychoanalytic Perspective

Prior to 1970, the treatment of sexual problems was based on anecdotal observations and was considered the domain of psychiatry. The typical therapies for sexual problems that have evolved from this tradition are dyadic. Their aim is not to focus on the sexual symptom but rather to achieve a more complete understanding of the person's mental life.

The first implication of the psychoanalytic view of sexual disorder is that the disorder itself is not the problem. It is a symptom of a deeper pathology. The second implication is that sexual problems are symptomatic of an underlying personality conflict that requires intense psychiatric therapeutic intervention and resolution. For example, a psychoanalytic interpretation of premature ejaculation might be intense, unconscious feelings of hatred toward women. In this view, a man supposedly has orgasm rapidly because it satisfies his sadistic impulses and ensures that his female partner will receive little or no pleasure from the act. Vaginismus is seen as one way a woman may deal with her **penis envy**—which is thought to occur in all girls during the **phallic stage of development**. The problem is an expression of their unconscious desire to castrate their partner.

The therapeutic goal is not just to relieve the symptom, but also to resolve its infrastructure—the underlying conflict. Insight, understanding, mastery, and psychological growth are highly valued therapeutic goals. The means of symptom removal used by the other therapeutic approaches are considered "transference cures" or "suggestion," likely to be followed by symptom substitution. This psychodynamic or psychoanalytically based treatment approach requires a lengthy treatment, often with questionable outcomes. After the evaluation phase, a patient with a sexual problem is usually seen alone, because interpersonal problems tend to be viewed as the acting out of the patient's internal conflicts.

A Cognitive-Behavioral Model: Masters and Johnson

The major treatment approach presented in this chapter is that of Masters and Johnson (1966, 1970), which forms the basis for all sexual therapy programs available today. With Masters and Johnson's (1966) publication of *Human Sexual Response* and their 1970 publication of *Human Sexual Inadequacy,* a new approach emerged, one that appeared to be an effective treatment approach of much shorter therapeutic duration than psychoanalysis. This new approach, known as the Masters and Johnson's approach, radically challenged psychoanalytic attitudes. The first book was based on a study that examined the physiological changes that took place during sexual activity. The second book was based on data that explored a new treatment model for sexual disorders.

The Human Sexual Response Cycle

One of Masters and Johnson's major contributions to the field was the first-ever description of the physiological responses that occurred during the **human sexual response cycle**. To understand sexual disorders, it is important to first grasp the nature of sexual functioning.

There are four phases of the human sexual response cycle. Individuals generally progress sequentially through the four phases. For a complete description of the changes that occur during these phases, I refer you to Masters and Johnson's *Human Sexual Response* (1966). Following is a brief description of each of the four phases.

1. *The excitement phase* is characterized by increased penile and vaginal vasocongestion. (There are two generalized responses to sexual stimulation in both men and women: **vasocongestion** and **myotonia**. Vasocongestion refers to increased blood flow to the penile or vaginal area, and myotonia refers to increased muscle tension.)
2. *The plateau phase* occurs when maximal enlargement and congestion of pelvic organs has been reached. In women, the orgasmic platform occurs as the uterus elevates. In men, secretions from the **Cowper's gland** occur. This secretion contains semen and may cause impregnation even though it is released prior to ejaculation. Immediately prior to ejaculation, a period of ejaculatory inevitability occurs, at which point the man is no longer able to voluntarily inhibit ejaculation.
3. *Orgasm* consists of involuntary contractions occurring at 0.8-second intervals in both the penis and vagina. The frequency of contractions is related to the subjective report of intensity of orgasm (see Atwood & Gagnon, 1987). Respondents reported subjectively more intense orgasms the more contractions they had.
4. *The resolution phase* consists of a return to a resting state. For men, there is a refractory period during which the excitement phase cannot recur. This refractory period increases with age. For women, no such refractory period is evident, suggesting a physiological basis for multiple orgasms.

In addition, both genders experience **tachycardia**, whereby heart rate increases from about 70 beats per minute to about 180 beats per minute. Both men and women experience a **sex flush** during sexual stimulation and orgasm. This refers to a blushing of the face, neck, chest, and arms. Keep in mind that although there is much overlap, there is also variation in the human sexual response among individuals and between the genders. Women tend to be more varied in their response than men. Some proceed to orgasm similar to the male response; others proceed to the plateau phase and move into the resolution phase without orgasm, and others are multi-orgasmic. Women tend to spend more time in the excitement phase, and their resolution phase is not as long as men's. Vaginal and penile **plethysmographs** are devices used in the laboratory to measure vasocongestion (Geer & Atwood, 1976). Basically, a plethysmograph is a sensor that indirectly measures blood volume.

In *Human Sexual Inadequacy,* Masters and Johnson (1970) presented a comprehensive treatment approach, which is still the main basis for most sex therapy programs today. In this view, sexual disorders are learned disorders rather than symptoms of underlying personality disorders. The disordered man or the woman with an orgasmic disorder is thought to have been exposed to an environment that taught him or her to be anxious in a particular situation. In addition, the psychoanalytic view would see the person's sexual problems, interpersonal relationships, and attitudes toward his or her parents as understandable in terms of one single underlying conflict, while the cognitive-behavioral view would suggest that each aspect of the person's functioning might be caused by separate variables. The rapid acceptance of this new form of therapy by both the lay and the professional public testified to the inadequacy of the psychoanalytic tradition in dealing with the common presence of sexual problems.

The general program most widely used in sex therapy is the conjoint (i.e., couple) therapy of Masters and Johnson (1970), modified in its detail by Bancroft (1989); Gillan (1987); Hawton (1985); Spence (1991); and Wincze and Carey (1991). The knowledge gained from Masters and Johnson's original research formed the basis of their treatment model and, since that time, their work has been reviewed, evaluated, and followed up. For the most part, the model has been upheld, with the changes representing refinements of the original approach rather than departures from its basic concepts. In any form of sexual therapy, the goal is to help people enjoy sexuality with natural abandonment, to free themselves from self-control. Sexual problems are often multifaceted; therefore, to deal with them effectively, therapists need several methods.

Annon (1976) suggested that some sexual disorders respond relatively well to short brief therapy and others require a more long-term approach. Based on this belief, he developed the **PLISSIT model**, which is an acronym for Permission, Limited Information, Specific Suggestions, and Intensive Therapy. This therapeutic approach advances from the simple to the more in depth.

During the **permission stage**, the therapist helps individuals accept their sexual feelings, fantasies, and desires. The therapist, depending on the situation, encourages the clients not to have sexual intercourse if they do not want to. The therapist suggests that the couple not compare themselves to any other couple, nor compare their sexual behavior with any statistics they might have read. During the **limited information stage**, the therapist provides information about sexuality in general, giving clients more realistic information for their knowledge base. In the third phase, **specific suggestions**, the therapist may suggest limited tasks to the couple, such as self-stimulation, sensate focus, or the squeeze technique. A more **intensive therapy** may be necessary if the sexual disorder is still not resolved after the individuals have progressed through the previous steps. This therapy is more long term and aims at identifying deep-seated issues that might interfere with sexual functioning.

The Masters and Johnson treatment procedure consists of three phases. The first phase, which lasts three days, involves *history taking*—both medical and psychological. The goal is to learn as much as possible about the clients' lives and personalities. The second phase consists of a *roundtable discussion* with both partners and both co-therapists (see below) present. The therapists offer their hypotheses about possible causes of the disorder and correct any misconceptions the clients may have. Here too, the therapists promote communication between the partners. The third phase consists *of training the couple* in sensate focus exercises and other techniques specific to their disorder. Sensate focus involves the couple providing each other with sensual pleasure that is not explicitly sexual. They basically explore each other's bodies with their hands. Some couples become sexually aroused for the first time in years. They are told not to have intercourse because so often it has become their preoccupation and indicator of failure. This approach may be termed "conjoint behavioral therapy." The program is behavioral in that there is no attempt to interpret the presenting symptoms in terms of psychodynamic constructs, and behavioral tasks are a major part of the package. The degree to which an approach geared toward unraveling conflicts and relationship problems is incorporated into this varies from therapist to therapist and from case to case (Woody, 1992). Anxiety reduction is key to this therapy. The therapist's prohibition against intercourse helps in this regard, because it immediately removes any performance fears or fears of painful intercourse. Some basic assumptions of this approach follow.

The problem is a joint *problem.* Behaviors, attitudes, values, judgments, and anxieties often impact both members of a couple. A person's problem is never only his or her own if that person is in a relationship. This does not necessarily imply causality or fault, but rather reinforces that when in a relationship, what one person does affects the other. In terms of a sexual problem, it is possible that the problem may have preceded the relationship, but it could also have an impact on the relationship and an effect on the other partner. In these cases, conjoint therapy is often helpful. Both partners, regardless of the specific etiology of the disorder, share the

responsibility for treatment. Thus, a husband cannot blame his wife for his premature ejaculation and vice versa. One partner is not seen as the "at fault" one or the "sick" one. The couple are encouraged to view the disorder as a common problem and to view the solution as needing a team effort. With conjoint therapy, the emphasis is always on the relationship; it is the relationship that is in therapy. This reduces the risk that the partner with the apparent sexual difficulty will be labeled as the one with the problem while the other partner sees himself or herself as having no problem. This type of attitude can create therapeutic difficulties.

Sex is a natural function. Sexual behavior is enormously affected by social learning, family definitions and values, individual personality dynamics, and biology, but it is also considered a natural function. Sex as a natural function means that the reflexes of sexual behavior are present from birth. Erections happen; vaginal lubrication happens. These reflexes are not taught; they occur automatically. However, this does not mean that they cannot be disrupted. Many obstacles to healthy sexual expression can be learned through chronic stress, health-related problems, or psychological factors. The therapist provides an atmosphere of acceptance of sexuality as a natural function and gives permission for sexual enjoyment. The partners are encouraged to view sexuality as a means of giving each other pleasure and relaxing with each other, not as a performance that is supposed to occur at specific times and in specific ways.

The couple need education and sexual knowledge. Information about clients' anatomy and physiology is gathered by conducting a thorough medical history, physical examination, and laboratory evaluation of both partners. Couples are given information about anatomy, physiology, and different coital positions. Here it is important to work hand in hand with medical personnel in order to flush out accurate information regarding any organically based etiology of the sexual disorder.

Anxiety must be reduced. This is usually achieved by restricting any attempt at intercourse. The couple are told not to engage in intercourse at this time. As mentioned, this removes the immediate pressure to perform and thus tends to reduce anxiety. Relaxation skill training may be used. The emphasis is on enjoyment and pleasure and not necessarily on orgasm or intercourse.

The couple must be helped to develop sexual communication skills. Generally, sexual difficulties are concomitant with communication difficulties. Effective communication skills can be taught and often lead to a more pleasurable and satisfying sexual relationship. In addition, because both partners are included in the therapy, both partners' feelings and expectations can be addressed. For example, a man with erectile disorder may believe that he does not experience firm erections during intercourse. His partner may feel otherwise and is therefore an additional source of information. Sometimes a partner may raise a question that the other has been reluctant to ask. In other situations, a partner, during the sexual history taking, may provide information that the other knew nothing about. Verbal and physical communication, and acceptance of each other's desires, values, and differences are

emphasized. In addition, partners are taught to describe their own motivations rather than attributing their motivations to the other. For example, one should say, "I feel unattractive" rather than "You do not find me attractive."

The Basic Concepts

A bio-psycho-social approach. The Masters and Johnson model employs a **bio-psycho-social approach**, which is a basic recognition of the importance of the underlying physiological and anatomical bases of human sexual behavior. This knowledge is integrated into their treatment program and is considered a crucial component primarily because it will discover those clients whose sexual disorder has an organic etiology, which would render psychotherapy unwarranted. In addition, it takes into account the health status and physical functioning of the clients, as well as providing a basis for answering clients' questions related to sexual anatomy and physiology.

Dual-sex therapy teams. Masters and Johnson believe that a **dual-sex therapy team** of a male and a female therapist is important because only a woman can understand female sexuality and only a man can understand male sexuality. In this way, each partner's sexual expression, attitudes, problems, and feelings can be understood in the broader social context. A woman who is trying to explain to her husband that she likes to be romanced outside of the bedroom can be helped immeasurably by a female therapist. The therapists do not take sides, so to speak, or advocate for one partner over the other. Rather, they share the responsibility for assisting the partners with their relationship. The function of the dual-sex therapy team is to educate, model, and provide both overt and covert permission for the couple to be sexual.

A rapid treatment approach. The Masters and Johnson treatment program consists of intensive daily treatment over a period of two weeks. This type of therapy format helps couples stay focused and gives them an intense, effective, educational, and therapeutic experience without outside distractions. A common criticism of such a format is that the couple is "on vacation," so to speak. They have been removed from the day-to-day stresses of life.

History Taking and Initial Assessments

History taking occurs the first day, with each therapist interviewing the partner of the same sex. This session typically lasts from one to two hours. In this session, a detailed social history is taken as well as a detailed sexual history. Some of the questions considered are:

- What are the specific sexual disorders?
- What are the etiologies of these disorders?
- Does the couple have nonsexual problems?

- Do they have any other sexual problems?
- Are there any underlying psychopathologies in either partner?
- Are there any physical problems?
- How motivated are they to participate in and follow through with the course of therapy?
- Are there any secrets?
- Are there any major discrepancies in the histories taken?
- What objectives do the partners have for therapy? Are these objectives realistic?
- Is this treatment modality appropriate for this couple?

After a lunch break, each therapist interviews the other partner. Additional information is taken. Next, a thorough medical examination is given.

Beginning Treatment

The basic therapy program of Masters and Johnson involves two weeks away from home and work, devoted completely to therapy. Although this approach has good success rates, it is not practical and too expensive for most couples. However, some aspects of it are common of most sex therapy programs:

- Usually there is a period of coital abstinence to reduce performance anxiety and facilitate communication.
- There is a focus on giving and receiving pleasure rather than on orgasm per se.
- Sensate focus exercises involving tactile stimulation are used. These exercises are the cornerstone of any sex therapy program. They begin with an emphasis on nonverbal communication.
- The couple are encouraged to find a time and place to focus on sexual interaction without distractions. They are encouraged to spend time together engaging in communication and non-genital touching.
- They are asked to verbalize to their partner how the touching feels and what aspects they like. They are asked to fondle and touch each other for the specific purposes of giving and receiving pleasure. Again, the emphasis is neither on sexual intercourse nor on orgasm.
- **Hand-riding techniques** are used to assist the partners in showing each other what feels pleasurable. Each partner takes turns placing his or her hand on the hand of his or her partner and gently moving the partner's hand over the body, showing what is pleasurable.

As therapy progresses, the therapist encourages additional exercises. Genital stimulation is suggested, and the partners are encouraged to discuss how they feel. The exercises progress in a non-demand manner, and the clients progress eventually to sexual intercourse. The couple are asked to explore alternative positions and

discuss which ones are preferable. Rest periods are suggested, in order to prolong sexual pleasure as sexual tension mounts.

There is a sequencing of sexual activities and techniques that facilitate success. Specific techniques are suggested that will meet the specific needs of the couple—for example, the squeeze technique for delaying premature ejaculation.

In sum, at the time that Masters and Johnson first published their results, there were very little data on human sexuality practices utilizing good methodology with generalizable samples. Even less exploration into effective treatment approaches had occurred. Masters and Johnson's (1966, 1970) data represented the first study examining sexual functioning and disordering. Their work suggested a number of interesting possibilities for dealing with disorders. Both members of a couple were included in the treatment, and the concerns of each partner were considered without placing blame for the disorder. The symptoms belonged to the marital pair, not to the **symptom bearer**. Masters and Johnson believed that the psychological mechanisms of disorder are largely related to current rather than past influences—for example, performance anxiety, spectatoring, anger at the disordered spouse. A new emphasis was placed on social forces rather than on past intrapsychic causes—for example, cultural expectations that prevent the normal development of female or male sexual expression, or religious orthodoxy. Masters and Johnson believed that male and female **co-therapy teams** are uniquely suited to foster communication and mutual understanding between the spouses. They felt a therapy team is also more effective in identifying and dealing with the high frequency of serious interpersonal problems, because two therapists working together are better able to correct misinformation and impart knowledge.

Criticism of Masters and Johnson's model came primarily from Zilbergeld and Evans (1980), in their article "The Inadequacy of Masters and Johnson." Zilbergeld and Evans challenged Masters and Johnson's outcome statistics and their research methodology as well. They claimed that Masters and Johnson worked primarily with highly motivated and educated middle-class couples, many of whom were health professionals in their community. Thus, they believed Masters and Johnson were dealing with a highly select population with an unusually high prognosis. Second, they asserted that the Masters and Johnson model did not really measure success rates; instead, it measured failure rates, and these were vaguely defined. According to Zilbergeld and Evans, a more operationalized definition of the human sexual response and sexual problems was needed.

Masters and Johnson reported very low failure rates (see Masters & Johnson, 1966). However, as Zilbergeld and Evans pointed out, their sample was preselected so the couples' motivation for change was probably higher than that of the general population. Yet their results were so outstanding that few researchers bothered to conduct controlled evaluative studies or attempt to replicate their findings. There was some attention paid to comparing sex therapy to other forms of therapies, but the designs were often inferior; couples with different disorders were lumped

together, with little attention paid to prognostic factors. The question as to whether sex therapy was more effective than no therapy at all was not addressed until 1983. At this time, Heiman and LoPiccolo (1988) demonstrated that the sexual and general adjustment of couples with a variety of sexual disorders was much improved after sex therapy in comparison to changes that occurred to them while on a waiting list. Two additional studies compared sex therapy with treatment by self-help instructions and limited therapist contact (Dow, 1981; Mathews, Whitehead, & Kellett, 1983) and demonstrated that sex therapy was more effective. The Mathews, Whitehead, and Kellett study also compared **systematic desensitization** plus counseling and found that sex therapy was more effective.

Studies have shown that the Masters and Johnson format of daily treatment sessions conducted by co-therapists can be modified. On the basis of several treatment studies, it appears that weekly or biweekly treatment sessions are actually preferable to daily sessions (Clement & Schmidt, 1983; Heiman & LoPiccolo, 1988; Mathews et al., 1983). Four studies have shown no differences in outcome between treatment conducted by co-therapists or therapists working alone (Clement & Schmidt, 1983; Crowe, Gillian, & Golombok, 1981; LoPiccolo, Hieman, Hogan, & Roberts, 1985; Mathews et al., 1983). In two of these studies (Clement & Schmidt, 1983; LoPiccolo et al., 1985), there was no evidence of an intervening therapeutic effect between the gender of the therapist and that of the presenting partner. Currently in most clinical settings, individual therapists provide sex therapy in weekly treatment sessions.

The New Sex Therapy

The New Sex Therapy, written by Helen Singer Kaplan (1974), represented a blending of two approaches. Kaplan's approach involved a synthesis of the theory and procedures of psychodynamic theory with the more behavioral perspectives. It was an attempt to modify the antecedents to a couple's sexual difficulty, with recognition that sexual difficulty could have deeper roots. In this theory, Masters and Johnson's (1970) learning theory principles were brought into the process of identifying the mechanisms by which transactions are maintained and reinforced in order to provide appropriate behavioral modifications. Following this model, a therapist is treating the symptoms rather than the underlying cause of the symptoms. This view is systemic in that for the most part the relationship, not the individuals, is seen as the problem. This approach involves the couple, so if one of the partners cannot tolerate the anxiety or change, then this treatment based on behavioral principles will not work. The goal here is more limited than traditional psychodynamic therapies in that the focus is on alleviating symptom distress rather than on personality overhaul.

Originally, Kaplan (1974) proposed a **biphasic model** of human sexuality. The first phase involved vasocongestion of the genitals, and the second phase consisted of the reflective muscular contractions of orgasm. Later, Kaplan's biphasic

model evolved into a **triphasic model** consisting of a **desire phase**, an **excitement phase**, and a **resolution phase** (Kaplan, 1979). She also believed that sexual disorders could fall into one of these categories and that these categories are separate and distinct—that is, one phase can function well even if the individual is having problems with another. Adding the desire phase to the human sexual response cycle was an important contribution because, in many cases, sexual desire is not always present. This phase basically expanded Masters and Johnson's model and has been incorporated into their basic paradigm.

Zilbergeld and Ellison (1980) contended that both Masters and Johnson's and Kaplan's models ignored the cognitive and subjective aspects of the sexual response, which they thought should be considered. Zilbergeld and Ellison's five components of the sexual response cycle are:

1. interest or desire, defined as how frequently a person wants to engage in sexual activity;
2. arousal, defined as how excited one gets during sexual activity;
3. physiological readiness (erection or vaginal lubrication);
4. orgasm; and
5. satisfaction (one's evaluation of how one feels).

Thus they were interested in the cognitive elements of sexual experiences.

Systems Theory

A major problem in the field is that sex therapy for the most part has not been grounded or related to **systems theory**, meaning that sex continues to be treated as a special area both theoretically and clinically within the couple therapy field. In other words, little effort has been made to elaborate the conceptual connections between the family theories and theories of sexual behavior. Systems theorists generally see sexuality only as a symptom or a metaphor for the relationship in order that the couple might avoid dealing with the more essential issues in their relationship. Similarly, there are a variety of ways in which systems theorists, depending on the context of the relationship, may view sexual issues. The systems-theoretical viewpoint stresses that sexual disorders do not exist in a vacuum but are often related to problems in the couple's emotional relationship, such as poor communication, hostility and competitiveness, and sex role problems. Even in cases in which the sexual disorder is not related to relationship problems, the couple's emotional relationship is often damaged by the sexual problem and feelings of guilt, inadequacy, and frustration that usually accompany sexual disorder.

In this view, sexual problems hold a cyclical position in the couple's interaction. One partner's demands may be the result of his or her own sexual frustration and feelings of rejection. Anxiety may be a combination of sexual conflict, self-doubt about sexuality, and fear of failure to please one's partner. Thus, the important

features of therapy include interrupting whatever cycle has been developed, separating the sexual problem from the relationship as a whole, exploring the roots of the sexual problem, and then integrating it with feelings of love. Therapy from this viewpoint tends to focus on the couple's interactions and the system dynamics that are maintaining the problematic sexual patterns.

In essence, the major approaches to sex therapy can be separated into two camps. On one hand, using the Masters and Johnson and the newer sex therapies' models, sexual disorder is treated seriously and the sexual issue presented is the problem to be worked on. On the other hand, using the psychoanalytic and the more systemically based therapies, sexual disorder is seen as a manifestation of some underlying conflict or as a metaphor or a symptom of a problem in the relationship. These two major divisions represent the division between the fields of sex therapy and couple therapy. However, it is one purpose of this chapter to suggest that it does not make sense to train people to practice couple and family therapy without giving them adequate training in human sexuality. Neither is it fruitful to train people to practice sex therapy without giving them the context in which to apply it. Atwood and Weinstein (1989) suggest that it is time for the two fields to be brought together. Sager (1976) also believed that couple and family therapists need to be versed in sex therapy and ready to shift focus when necessary, rather than refer clients to a "sex therapist." Lief (1977) also believes it is impossible to undertake sex therapy without exploring the quality of the couple's relationship.

Recently, **postmodern** approaches to therapy with couples have begun. For a description of one such postmodern approach, see Atwood (1993). Current research (Althof, 2010; Binik & Meana, 2009; McCarthy & Thestrup, 2008; Metz & McCarthy, 2004) overwhelmingly supports an integrative approach and belief that one need not specialize in sex therapy to effectively work with the many permutations of sexual issues couples and individuals present. Regardless of one's sexual orientation, preferences, sexual identity, race, ethnicity, and culture, the assessment techniques remain constant. A thorough analysis of the clients' sexual history, current sexual practices, relationship quality and history, emotional well-being and satisfaction, and contextual factors combine with all relevant biological and medical elements necessary to understand the genesis and maintenance of the current relational conditions (Althof, 2010). Through mindful listening to each client's narrative, the thoughtful practitioner can ascertain whether and how the dominant paradigms have been incorporated (Atwood, 2002).

Research Outcomes

There has been considerable variation in outcome among different types of sexual problems and some other important prognostic factors. This information has been enhanced by evidence from long-term follow-up studies of couples who have received sex therapy (DeAmicis et al., 1985; Hawton et al., 1986). In terms of male problems, sex therapy for erectile disorders appears to produce

satisfactory results in both the short term and the long term, but sex therapy for premature (early) ejaculation has less sustained results. Men with low sexual desire, or hyposexuality, appear to have a very poor prognosis. With regard to female problems, the results of sex therapy for vaginismus (now known as genito-pelvic penetration disorder) are excellent and sustained, whereas the results of treatment for desire disorders are often disappointing, especially in the long term.

There thus needs to be a considerable rethinking of the problem of low sexual desire, or hyposexuality, in order to develop a better understanding of its nature and causes and to establish alternative treatment approaches. A text directed solely at this problem (Leiblum & Rosen, 1988) represents an excellent first step. Zimmer's (1987) demonstration that for distressed couples with female sexual disorders, sex therapy combined with marital therapy was more effective than sex therapy plus placebo treatment might serve as a basis for more broad-based approaches to this problem.

Other factors shown to be of prognostic significance in sex therapy are the quality of the couple's general relationship; pre-treatment motivation, especially of a male partner; the degree of attraction between partners; and early progress in terms of carrying out homework assignments (Hawton & Catalin, 1990; Whitehead & Mathews, 1977, 1986).

Of relevance to the psychological treatment of sexual disorders is the explosion that has occurred in physical treatments, especially the use of intracavernosal injections and vacuum devices for men with erectile disorders. Although these undoubtedly represent important advances in treatment, especially for men with organic disorders, it is worrying that some clinicians are readily using them to treat apparent psychogenic cases. In the future, more collaboration should occur between those specialists experienced in psychologically based treatment approaches and those, such as urologists, who largely provide only physical treatment.

The most pressing need in the field is for the development of an understanding of low sexual desire. It appears that there is no physiological factor present in healthy premenopausal women that could be responsible for the disorder, leading to the idea that social affective and cognitive factors may be present in this disorder. Bringing in couple therapy might result in an approach likely to help couples experiencing this and other difficulties. In addition, the fields of couple therapy and sexual therapy need to see more of an overlap with respective courses present to a larger degree in therapist training programs.

Socio-Historical and Multicultural Influences

It is also important to keep in mind that these approaches assume that sex is a primary way of exchanging pleasure, that it is a natural activity, that both partners are equally involved, that people should be educated about sexuality, and that communication is a necessary factor in sexual relationships. However, culture also has a great influence on sexual attitudes, **sexual scripts**, and behavior. In

egalitarian relationships, the major goals are sexual pleasure and psychological disclosure and intimacy. However, for example, in Hispanic cultures men are permitted to engage in sexually pleasurable activities, but the norm for women is purity. In these cultures, women view sex as an obligation to satisfy the husband's needs. For the men, sexuality is an expression of their masculinity (Eaton & Rose, 2012).

In addition, it is important to understand the socio-historical, political, and cultural context that is embedded in the discussions surrounding sexual diversity (Foucault, 1976; Mulholland, 2007; Tiefer, 2006). In the not so distant past, deviations from the "sexual norm" were categorized at best as deviant and at worst, diseases. The ensuing labels and subsequent "treatment" permitted the therapeutic community full access to the sexual narratives of many (Atwood, 2002). It was Freud (1962) who recognized the polymorphic nature of human sexuality and acknowledged the complications involved with agreeing upon exactly where the boundaries of normalcy are drawn. According to Atwood (2002), as attitudes regarding sexual diversity evolve, so do the platforms for expression, understanding, and discourse. Greater social awareness and mainstream acceptance of those with minority sexual identities (including but not limited to gay, lesbian, bisexual, transgender, BDSM, celibate, and polyamorous) have made certain narratives that were less expected in the past now a normal part of the therapeutic setting (Atwood, 2002).

All of us have ideas about sexuality that are infused with our own value system based on the sociocultural milieu. Therapists carry with them their own sexual scripts and, because the therapy itself is grounded in the socio-historical-political-cultural context, it is crucial for the therapist to keep in mind that clients have their own ideas about the meaning of their sexuality, what role gender plays, and what a good sexual relationship is for them. They also have ideas about what constitutes a sexual disorder, what causes sexual disorders, what the role of a good therapist is, and what the goals of the therapy should be. The therapist needs to be respectful of what clients bring to therapy in terms of their own definitions and meanings.

In therapy, the premier factors that encourage empathy, mindfulness, and nonjudgmental communication are the therapist's comfort with sexualities and understanding of his or her own sexuality (Atwood, 2002). According to Bettinger (2002), when this awareness is absent, negative or positive countertransference may result. Often rooted in one's personal or familial experiences, *countertransference* is a conscious and unconscious process resulting in the therapist experiencing positive, negative and/or neutral feelings in response to clients (Slakter, 1987). Areas with great potential for a negative countertransference are anal and oral sex, non-monogamous relationships, group sex, "kinky" sexual practices, "safer" sex issues, and drug use during sex (Bettinger, 2004). Bettinger (2004) states that it is also essential for the clinician to recognize if he

or she personally identifies with choices of the couple, because this can also impede the therapeutic relationship. Although it is impossible to eliminate the potential for countertransference, the expectation is to recognize and contain countertransference to minimize its impact on the work (Bettinger, 2004).

When to Refer

Under any circumstances, it is important for couple and family therapists to have a basic understanding of sexual disorder etiology. The following may be used as a guide for when to refer for the therapist who does not have specific training in sexual therapy. Refer when the following conditions are present:

1. Clinical depression underlying the sexual complaint.
2. Significant past psychiatric history.
3. Problems complicated by sexual preference conflict or gender confusion, overt or latent.
4. Patients who present with marked personality or characterological disorders.
5. Primary sexual disorder.
6. Lack of commitment to the relationship or to the partner.
7. Significant secrets, such as ongoing infidelity.
8. Major reality concerns, such as major family or work problems that would detract from the therapy.
9. Major difficulties in the relationship.
10. Lack of commitment to the therapy by one or both partners.

Summary

This chapter presented and explored the major sexual disorders, impairments in one of the phases of the human sexual response cycle. These include erectile disorder, premature (early) ejaculation, delayed ejaculation, orgasmic disorder, female sexual interest/arousal disorder, male hypoactive sexual desire disorder, and genito-pelvic pain/penetration disorder. Assessment issues were discussed. Medical factors contributing to sexual disorders were discussed, along with individual vulnerability factors and relationship/partner issues. Several sex therapy approaches are available, and these were presented and explored. Some of the programs deal specifically with the sexual problem, while others focus on the relationship and psychological issues. Masters and Johnson's program is basically a cognitive-behavioral approach, with the main treatment being temporary coital abstinence and the sensate focus technique. Their model forms the basis for most sexual therapy programs today. Kaplan's approach combines features of traditional insight therapy with Masters and Johnson's approach. One of her most important contributions is in the area of inhibited sexual desire. Systems theory was presented, along with an examination of the way sexual issues may

be a metaphor for couple or relationship issues. Cultural, religious, and the socio-historical-political contexts were also emphasized, and their influence on sexual behavior were presented, along with a discussion of when sex therapy is contraindicated.

Recommended Readings

Binik, Y. M., & Hall, K. (Eds.). (2014). *Principles and practice of sex therapy (5th ed.).* New York, NY: Guilford Press.

Hertlein, K., Weeks, G., & Sendak, S. (2009). *A clinician's guide to systemic sex therapy.* New York, NY: Routledge.

Levine, Stephen (Ed.). (2003). *Handbook of clinical sexuality for mental health professionals.* New York, NY: Routledge.

Glossary

anorgasmia: A condition marked by the absence of or inability to experience orgasm.

aphrodisiacs: Agents that arouse or increase sexual response or desire.

bio-psycho-social approach: Viewing the necessary relationship between a person's health and his or her mental and social conditions (mind and body connection).

biphasic model: The concept of the biphasic nature of the sexual response provides a theoretical framework that will further the understanding of sexual physiology and anatomy. The sexual response is not a single entity. Rather, it consists of two distinct independent components: a genital vasocongestive reaction and the muscular contractions that constitute orgasm.

cardiopulmonary: Relating to the heart and lungs.

clitoral adhesion: When the clitoral hood adheres to the glans, making orgasm difficult or impossible.

corpus cavernosum: The paired, cylindrical, sponge-like bodies of the penis or clitoris that transverse the length of the shaft, one on either side.

co-therapy team: Two therapists simultaneously involved in working with an individual, couple, or family.

Cowper's gland: Two pea-sized glands at the base of the penis, under the prostate, that secrete a clear fluid into the urethra during sexual intercourse.

degenerative disease: A retrogressive pathological change in cells and tissues that may cause their functions to be impaired or destroyed.

desire phase: The first of three general divisions of the sexual response cycle in which the desire for sexual activity increases, leading to the physiological changes of sexual arousal in the excitement phase.

dual-sex therapy team: A male co-therapist and a female co-therapist in the treatment of sexual inadequacy and disorder.

dyspareunia: A term for a sexual disorder characterized by difficult or painful intercourse or by an inability to enjoy sexual intercourse; recurrent or persistent genital pain in a man or woman before, during, or after sexual intercourse.

ejaculatory incompetence (or retarded ejaculation): The inability of a man to reach an orgasm and ejaculate during intercourse and/or during masturbation.

ejaculatory inevitability: The feeling, occurring in the emission phase of ejaculation, when a man becomes aware his arousal has passed the point where he can control ejaculation and where it is now a reflexive process.

endocrine: Pertaining to internal secreting; hormonal; producing secretions that are distributed in the body by way of the bloodstream.

endometriosis: A painful condition caused by the growth of endometrial tissue outside the uterus, such as over the ovaries and fallopian tubes.

erectile disorder: The inability of a man to have or maintain an erection sufficient to intercourse or sufficient masturbation.

excitement phase: The first phase in the sexual response cycle. This phase can last for just a few minutes or extend for several hours. Characteristics of this phase include an increasing level of muscle tension, a quickened heart rate, flushed skin (or, for some people, blotches of redness may occur on the chest and back), hardened or erect nipples, and the onset of vasocongestion. Vasocongestion results in swelling of the clitoris and labia minora or erection of the penis.

fibrosis: The formation of excessive fibrous tissue.

flashback: A recurring, intensely vivid mental image of a past traumatic experience.

hand-riding technique: A nonverbal technique used to improve sexual interactions.

hepatic: Relating to the liver.

human sexual response cycle: The four stages that humans go through from the beginning of arousal to the time after orgasm. These phases are excitement, plateau, orgasm, and resolution.

hymen: A thin membrane partially covering the entrance to the human vagina.

impotence: The inability of a male partner to have or maintain an erection sufficient for complete intercourse. This condition is now called ERECTILE DISORDER.

intensive therapy: Therapy that occurs with a skilled professional sex therapist, aimed at resolving the sexual concerns a client brings to therapy. Therapy sessions continue until complaints are resolved.

intracavernous injection therapy: A method used to treat erectile disorder, administered through injection.

Kegeling exercises: A regimen of isometric exercises in which a woman executes a series of voluntary contractions of the muscles in her pelvic diaphragm in an effort to increase the muscle contractibility of the vaginal muscles.

Klinefelter's syndrome: The most common numerical sex chromosome anomaly in males; involves at least one extra X chromosome.

libido: The sexual drive, urge, or desire for pleasure or satisfaction; also a term used to denote sexual motivation.

limited information stage: The stage in which the therapeutic effects of permission giving are usually reinforced and enhanced by providing limited information related to the patient's specific problem.

low sexual interest: A lack of desire to have sexual intercourse.

malignancy: Tendency to a fatal issue; a cancer.

mastectomy: Surgical removal of the glandular tissue of the breasts, often as a treatment for cancer.

Masters and Johnson: William Masters and Virginia Johnson, pioneers of observational sexual research who developed new methods of sex therapy.

multiple sclerosis: A disease of the central nervous system.

myotonia: The buildup of muscle tone or tension, especially during sexual arousal.

orgasmic disorder: The inability of a man or woman to reach orgasm following normal sexual stimulation, either alone or with a partner.

paraphilias: Sexual actions that are pleasurable and gratifying, yet whose object (with whom or what one has intercourse) and/or aim (a goal other than seeking sexual intercourse) deviates from the norm.

pelvic inflammatory disease (PID): An inflammatory condition of the female pelvic organs, especially due to bacterial or other sexually transmitted infection.

penis envy: In psychoanalytic theory, an alleged unconscious sense of sexual inadequacy and inferiority in a female because she lacks a penis and as a result envies the male.

performance anxiety: The fear that one will not be able to perform adequately in a sexual relationship—by failing to achieve an erection or have an orgasm, by not being able to be aroused and lubricated, or by not being able to satisfy one's partner.

permission stage: On the simplest level of sexual therapy, this is the stage in which the disordered person is given permission to be sexual and to discuss any sexual issue of concern.

phallic stage of development: In psychoanalytic theory, the third of five stages in psychosexual development; the period when a boy becomes aware of the pleasure-giving possibilities of his penis and girls become aware of its symbolic equivalent.

phimosis: The narrowing of an opening; tightness of the prepuce or foreskin of the penis, which prevents its retraction over the glans.

phobia: An anxiety disorder characterized by an obsessive, irrational, intense, and morbid dread or fear of something. An irrational or persistent fear.

plethysmograph: A photosensitive instrument for measuring and recording changes in the sizes and/or volumes of organs by measuring changes in their blood volume.

PLISSIT model: A model for the use of different levels of sex therapy, PLISSIT stands for four levels of therapy, starting with Permission giving and often Limited Information, moving to Specific Suggestions, and—for problems that are not resolved by the efforts of the first three levels—culminating in Intensive Therapy.

postmodern: A philosophical outlook that rejects the notion that there exists an objectively known universe discoverable by impartial science and instead argues that there are multiple views of reality.

premature ejaculation: A sexual disorder in which a man is unable to sustain the pre-orgasmic period of arousal so that ejaculation occurs too soon relative to his own expectation or that of his partner.

priapism: A rare, pathological condition involving prolonged and painful erection of the penis, usually without sexual desire.

primary sexual problem: Any sexual disorder that has always been experienced by an individual.

prolactin: The hormone that stimulates milk production, produced and secreted by the posterior pituitary gland.

prostate gland: A golf ball-sized muscular and glandular structure in the urogenital system of males.

prostatectomy: A partial excision of the prostate to enlarge the prostatic urethra when it is closed.

prostatitis: An acute or chronic infection or inflammation of the prostate, treatable with antibiotics, bed rest, and fluids.

psychogenic: Originating in the mind.

renal: Relating to the kidney.

resolution phase: In this phase in the sexual response cycle, after orgasm the heart rate, blood pressure, breathing, and muscle contraction return to normal levels. Swelled and erect body parts return to normal, and skin flushing disappears. Women may return from the resolution phase to the orgasm phase with minimal stimulation. Mean experience for the refractory period is from a few minutes to several days; there is great variance in the length of the refractory period among men.

secondary sexual problem: Any sexual disorder that follows a period of satisfactory sexual functioning.

self-fulfilling prophecy: Predictions about a future event that in turn increase the probability of the occurrence of that event.

sensate-focus exercises: Non-coital, non-demand, graduated pleasuring exercises for use in behavioral therapy of various sexual disorders.

sex flush: A temporary reddish rash or a change in color of the skin that sometimes develops in both men and women as a result of vasocongestion during the plateau stage of sexual arousal.

sexual deviation: Any sexual behavior regarded as abnormal by society.

sexual disorder: The inability to react emotionally and/or physically to sexual stimulation in a way expected of the average healthy person according to one's own standards.

sexual script: A cultural script whose goal is to enhance, reduce, or permit sexual arousal under acceptable conditions; an individual's unique set of attitudes, expectations, and values regarding sexual behavior, emotions, and relationships.

specific suggestions: If the sexual disorder is not resolved with application of permission giving and limited information, the sex therapist may make specific suggestions, such as the use of sensate-focus, stop-start, and squeeze behavioral exercises.

spectatoring: A psychological response whereby a person acts as an observer, monitor, or judge of his or her own sexual performance and/or that of his or her partner. It is a common outcome as well as cause of sexual disorder.

spina bifida: An abnormal development of the embryonic neural tube characterized by defective closure of the bony encasement of the spinal cord.

squeeze technique: Used to subside orgasmic sensation in men by squeezing the penis just below the glans with the thumb on one side and the forefingers on the opposite side until sensation diminishes.

stop-start technique: A therapeutic behavioral exercise to teach male control of orgasm and premature ejaculation.

symptom bearer: An individual in a structured group who manifests symptoms of a disorder.

systematic desensitization: A behavioral therapy in which deep relaxation is used to reduce anxiety associated with certain situations; a therapeutic technique in which a person is gradually exposed to increasing amounts of anxiety-producing stimuli.

systemic: Relating to systems or a system.

systems theory: Refers to the view of interacting units or elements making up an organized whole.

tachycardia: A rapid pulse.

triphasic model: Classifies a sexual disorder as a disturbance of sexual desire, sexual excitement, or the orgasmic response. It recognizes that orgasm, excitement, and desire phase impairment are separate diseases, and each responds to different and specific therapeutic interventions.

tumescence: A swelling; the erection and enlargement of the sexual organs, particularly the clitoris or the penis, resulting from the vasocongestion accompanying sexual stimulation.

urethritis: An infection of the urethra.

vacuum erection device: A method used to treat erectile disorder whereby the penis is placed into a cylinder and a vacuum is created, which causes blood to flow into the penis, thereby creating an erection.

vaginal dilators: A treatment used in a medical setting to help resolve vaginismus by helping a woman gain voluntary control over the pelvic muscles and gently widen the vagina.

vaginismus: Involuntary spasms of the muscles surrounding the lower third of the vagina when penetration is attempted.

vascular disorder: Disorder of the blood vessel system.

vasocongestion: A normal increase in the amount of blood concentrated in certain body tissues, especially in the genitals and female breasts, during sexual arousal.

vulvectomy: Surgical removal of part or all of the vulvar tissue.

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14

SPECIAL TOPICS IN FAMILY THERAPY

Mental Illness, Physical Illness, Substance Abuse, Family Violence, and Divorce

Jacob B. Priest, Connie Salts, and Thomas Smith

Family therapy approaches were first conceived and implemented in response to specific types of mental health issues that challenged the practitioners of the time. The first "special problems" addressed by the pioneering family therapists were those of the seriously mentally ill (Nichols & Schwartz, 2001). This chapter follows in this longest of family therapy traditions: the application of family therapy perspectives to health and relational problems. In particular, five specific problem areas are addressed: mental illness, physical illness, substance abuse, family violence, and divorce. In this chapter, the societal impact of each problem area is discussed, along with the contribution that marriage and family therapy approaches have made to the conceptualization and treatment of these problems.

Mental Illness

Mental illness is one of the largest economic and social burdens. The World Health Organization estimates that the global cost of mental illness is nearly $2.5 trillion (WHO, 2011). Moreover, individuals with mental illness report diminished quality of life for themselves and for their families (WHO, 2011). Mental illness is associated with distressed marital and family relationships (Priest, 2013; Whisman, 2007) and an increased likelihood of divorce (Breslau, et al., 2011). Anxiety and mood disorders are some of the most common mental disorders in the United States (Kessler, Chiu, Demler, & Walters, 2005).

Anxiety and Mood Disorders

> Individual symptoms, such as phobias or depression which have repercussions in intimate relationships, may be viewed as a function of the

> individual's position in a relationship system and as being maintained by the interactional patterns of that relationship. Symptoms are viewed then as being both system maintained and system maintaining. Individual symptoms can function in such a way as to balance power or regulate closeness and distance in a relationship.
>
> (Greenberg & Johnson, 1988, pp. 189–190)

Each year in the United States, approximately 22.3% of adults will meet diagnostic criteria for an **anxiety disorder**, as will 31.9% of those aged 13 to 18 (Kessler et al., 2005; Merikangas et al., 2010). Additionally, 18.1% of adults and 14.3% of those aged 13 to 18 in the United States will meet diagnostic criteria for a **mood disorder** (Kessler et al., 2005; Merikangas et al., 2010). Many of these disorders are chronic conditions that cause significant social and emotional distress. The most common types of treatment for these disorders are individual psychotherapy and **pharmacotherapy**. For many, these treatments are successful; however, others do not experience symptom remission following these types of treatments. For example, less than 50% of people with depression who are treated with individual psychotherapy or pharmacotherapy recover (Keller et al., 2000; Trivedi et al., 2006). Similar rates of recovery are found for those with some anxiety disorders (Siev & Chambless, 2007).

Given the poor treatment outcomes for many with these disorders, researchers have examined factors that may be associated with these disorders and that may affect response to treatment. A growing body of research suggests that distressed romantic and family relationships have connections with anxiety and depression. For example, researchers have found that distressed romantic relationships were linked to a greater risk of major depressive (MDD), bipolar disorder, generalized anxiety disorder (GAD), posttraumatic stress disorder (PTSD), and social phobia (Whisman, 2007). Other research has found that distressed family relationships were linked to an increased risk of many anxiety disorders. Specifically, for those who were divorced, widowed, or separated, distressed family relationships were linked to agoraphobia, GAD, PTSD, and social phobia. For those who were single, distressed family relationships were linked to an increased risk of GAD, and for those who were married or cohabiting, distressed family relationships were linked to an increased risk of GAD, PTSD, and social phobia (Priest, 2013). In one of the few studies examining longitudinal links between romantic relationships and mental illness, Overbeek and colleagues (2006) found that a person's reported marital discord was associated with the onset of new mental health problems two years later. Specifically, more marital discord was linked to a greater risk of having a new incidence of MDD and social phobia two years later.

Not only are distressed relationships linked to mental illness, but having a distressed relationship reduces the effectiveness of the treatment for many with these disorders. For example, Denton et al. (2010) studied 171 outpatients with chronic depression who were randomized to either pharmacotherapy, individual therapy,

or a combination of both treatments. Specifically, they tested whether the presence of a discordant romantic relationship predicted worse response to depression treatment. In the pharmacotherapy group, only 25% of those with discordant romantic relationships had their depression symptoms remit, compared to 53.3% of those without discordant relationships. In the individual therapy group, only 25.9% of those with discordant relationships remitted, while 56.6% without remitted. In the combination group, 47.2% of those with discordant romantic relationships remitted, while 74.1% without remitted. Overall, 34.1% of those with dyadic discord remitted, compared to 61.2% without dyadic discord. Similar patterns have been found for anxiety disorders. Chambless and Steketee (1999) found that poor relationship quality with relatives reduced the effectiveness for treatment of obsessive-compulsive disorder. Zinbarg, Lee, and Yoon (2007) found that those receiving treatment for GAD were more likely to drop out of treatment and had poorer treatment outcomes if they reported distressed romantic relationships.

Anxiety, Depression, and Family Therapy

Given the strong connection between family and couple relationships and mental illness, family-based treatments have been developed to target both childhood/adolescent and adult mental illness. In the last decade, family-based interventions for these disorders have been gaining in popularity (Kaslow, Broth, Smith, & Collins, 2012), and a growing body of research is showing support for these interventions (Beach & Whisman, 2012; Kaslow et al., 2012); however, family-based interventions do not always outperform individual interventions.

Research into the treatment of children's depression has found including the family in treatment did not always result in better outcomes. For example, Birmaher, et al. (2000) found that children who received individual therapy experienced greater depression symptom remission than children who received family therapy. However, more recent developments in family-based treatment for children's depression are showing promise. Attachment-Based Family Therapy is one example (ABFT; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Diamond, Siqueland, & Diamond, 2003). ABFT is designed to improve the attachment between parents or caregivers and the child in order to relieve symptoms of depression. Specifically, it targets the family processes of criticism and disengagement to improve parental skills, while at the same time focusing on the child's ability to regulate emotions. In a randomized clinical trial comparing ABFT to a wait-list control group, those in the ABFT group had greater reduction in symptoms of depression, anxiety, and suicidal ideation than those in the control group. Additionally, those in the ABFT group also showed an improved attachment relationship with their mothers.

Research into family-based treatments for children's anxiety has shown more consistent positive results than family-based interventions for children's depression. For example, Wood, Piacentini, Southam-Gerow, Chu, and Sigman (2006) compared family-based and individual treatment for children with GAD, social anxiety disorder, and social phobia. They found that, even though both groups

showed improvement, those in the family-based treatment reported greater reductions in symptoms. Moreover, family-based treatments may be especially useful when the anxious child also has an anxious parent. In a review of treatments of child anxiety, Creswell and Cartwright (2007) highlighted the effects of parental anxiety on response to treatment. They noted that if an anxious child has an anxious parent, the child is less likely to respond to individual psychotherapy treatment. However, if a family component is added to individual psychotherapy treatment, children's outcomes tend to improve.

Research addressing family-based treatments for adult mental illness has focused mainly on depression. Bodenmann et al. (2008) wanted to test whether couple therapy could be more effective at reducing symptoms of depression than individual therapy. Specifically, they compared Coping-Oriented Couples Therapy to two individual treatments: cognitive behavioral therapy and interpersonal psychotherapy. Using a sample of 60 couples (20 couples in each treatment condition), no differences were found between the groups following the conclusion of treatment with regard to depression symptoms; however, those in couple therapy reported positive changes in relationship functioning. Denton, Wittenborn, and Golden (2012) studied the effects of Emotionally Focused Therapy (EFT) for couples on women's major depression. They tested whether women who received EFT and medication would report lower levels of depression than women who received only medication. Similar to Bodenmann et al. (2008), Denton et al. (2012) found no difference between the groups on reported depressive symptoms, but those who received EFT reported greater increases in relationship satisfaction.

The results of the findings of couple and family treatments for child and adult mental illness highlights the need for future research. In a 2012 review of couple treatments for depression and other mood disorders, Beach and Whisman emphasized the importance of future research using larger sample sizes, examining the longer-term effects of relational interventions, and using observational measures to examine change. They suggest that doing so may help uncover "potential mechanisms of change" (2012, p. 213) that may help improve couple therapy treatment of depression. Bodenmann and Randall (2013) have further suggested that couple-based interventions for mental illness might benefit from taking a "we-disease" approach. In other words, they suggest that partners of those with mental illness should be viewed as integral to the process of recovery. Moreover, since couple therapy interventions are often as effective at reducing depression symptoms as individual psychotherapy, but since couple interventions also improve relationship functioning (e.g., Bodenmann et al., 2008; Denton et al., 2012), including both partners in treatment may prove to be more effective at sustaining reductions in symptoms of mental illness.

Diversity, Mental Illness, and Family Therapy

When considering issues of mental illness, family therapists need to acknowledge and understand the social and cultural context of symptoms of mental illness.

In a 2006 study, Halbreich et al. examined cultural aspects of depression and anxiety symptoms. Specifically, they asked psychiatrists from India, Brazil, Peru, Chile, Venezuela, Tunisia, Morocco, and Serbia to prepare descriptions of the main symptoms that women in their cultures described when seeking treatment for depression or anxiety. Though there were many similarities between the reports of psychiatrists from these countries and the diagnostic criteria of anxiety and depression used in many Western industrialized countries, Halbreich et al. (2006) found that in some instances some criteria were not even mentioned. The authors wrote:

> Although current biomedical diagnostic systems and the instruments derived from them are presumably designed to reflect the presentation of mental disorders across cultures, in reality they are more heavily biased toward descriptions of psychiatric disorders in European and North-American cultural contexts.
>
> (p. 160)

If family therapists desire to accurately assess and provide culturally sensitive treatment for those with depression and anxiety, it is important that they understand that the presentation of these symptoms may be culturally dependent.

Physical Illness

> We now know that human life is a seamless cloth spun from biological, psychological, social and cultural threads; that patients and families come with bodies as well as minds, feelings, interaction patterns, and belief systems; that there are no biological problems without psychosocial implication, and no psychosocial problems without biological implications. Like it or not, therapists are dealing with biological problems, and physicians are dealing with psychosocial problems. The only choice is whether to do integrated treatment well or do it poorly.
>
> (McDaniel, Hepworth, & Doherty, 1992, pp. 1–2)

Chronic diseases, including diabetes, heart disease, and obesity, are the leading cause of disability and death in the United States (Kung, Hoyert, Xu, & Murphy, 2008). It was estimated that in 2005, nearly one out of every two adults in the United States would have at least one chronic illness (Wu & Green, 2000). It has been well documented that many behaviors, including lack of physical activity, alcohol and tobacco use, and poor nutrition, contribute to physical health problems (CDC, 2008). However, recent research has shown that people with physical illness often have distressed romantic and family relationships. For example, in a recent study of low-income adults in a primary care clinic, 53.7% reported distressed family relationships, and 39.5% reported distressed romantic relationships (Woods, Priest, Fish, Rodriguez, & Denton, 2014).

Research is beginning to highlight how distressed family and couple relationships are linked to physical illness (Carr & Springer, 2010). In this section, we will examine the conceptualization and research regarding family process and physical illness using the Biobehavioral Family Model (Wood, 1993). Then we will discuss medical family therapy (McDaniels et al., 1992). Medical family therapy is the use of family-systems-based principles to provide integrative care for families and individuals with physical illness.

The Biobehavioral Family Model

The Biobehavioral Family Model (BBFM) was developed to explain the role of family functioning in physical illness (Wood, 1993; Wood; Klebba, & Miller, 2000). This model draws upon principles of general systems theory and structural family therapy to describe the influence of psychosocial factors on biological processes and disease activity. Specifically, the BBFM has three concepts—family emotional climate, biobehavioral reactivity, and disease activity.

In the BBFM, the family emotional climate is conceptualized as the intensity of the family emotional process. This emotional intensity can either be positive or negative. This construct includes emotional processes such as interpersonal responsiveness, connection, relationship quality, criticism, and hostility. Biobehavioral reactivity is the way an individual reacts to the family emotional climate; it is often conceptualized as a person's ability to regulate emotions. Emotions are seen as a reflection of a person's ability to adapt to changes in his or her environment and are considered self-regulatory responses that help coordinate these adaptations (Thayer & Lane, 2000). In the model, people with poor emotion regulation have difficulty adapting to changes in the environment, and these difficulties may manifest as symptoms of anxiety or depression (Wood et al., 2008; Woods & Denton, 2014). Disease activity is the presence or absence of physical health problems.

In the BBFM, if the family emotional climate is marked by high negativity, this stress will activate several biological systems (e.g., the autonomic nervous system and the hypothalamic-pituitary-adrenal axis). If these systems are constantly being activated by negativity, a person experiences not only emotional dysregulation, but also physiological dysregulation (Wood et al., 2008). In other words, the stress of the family emotional climate is not only contributing to the manifestation of symptoms of poor emotion regulation (e.g., depression or anxiety), but also taxing the biological systems, leaving a person more susceptible to physical illness or exacerbating symptoms that are already present (Kiecolt-Glaser, Gouin, & Hantsoo, 2010). Specifically, the BBFM suggests that a person's emotional interpretation of his or her family functioning will affect the neuroendocrine activity of the body, which will result in behavioral and emotional responses. The person's heightened emotional state may lead to greater disease activity.

Research testing the constructs of the BBFM has demonstrated support for the process by which family emotional climate can affect mental and physical health

in both children and adults. For example, Wood et al. (2008) tested the model for children with asthma. They found that if a child's family emotional climate was marked by negativity, this contributed to worsening symptoms of depression; as symptoms of depression worsened, so did the children's asthma symptoms. Similarly, Woods and Denton (2014) tested the BBFM with adults in primary care. They found that patients who reported distressed romantic and family relationships had higher rates of depression and anxiety symptoms, which in turn resulted in poorer health.

Medical Family Therapy

Medical family therapy arose as a response to the fragmented health care system and the research linking health problems to family and emotional functioning. The term "medical family therapy" refers to the biopsychosocial treatment of people dealing with health problems. A biopsychosocial approach to the treatment of illness suggests that all problems are conjointly biological, psychological, and social (McDaniel et al., 1992). One of the main purposes of medical family therapy is to encourage therapists and other health professionals to collaborate and so provide integrative care. "Medical family therapy interweaves the biomedical, and the psychosocial by utilizing a biopsychosocial/systems theory, with collaboration between medical providers and family therapists as a centerpiece of the approach" (McDaniel et al., 1992, p. 101).

The use of medical family therapists in health care settings has demonstrated the importance of a biopsychosocial approach and integrative care. For example, Harrington, Kimball, and Bean (2009) interviewed health care providers at a pediatric oncology clinic regarding their experiences working with medical family therapists. The interviews with the practitioners revealed that having a medical family therapist as a part of the treatment team allowed for a more holistic treatment approach and that the practitioners felt that they were able to provide better care to the cancer patients because they felt that the families' emotional needs were being managed.

As the importance of biopsychosocial treatment has grown, so has the issue of training family therapists to work effectively in health care settings. Research conducted by Tyndall, Hodgson, Lamson, White, and Knight (2012) explored the skills and training medical family therapists need to have in order to effectively work in health care settings. Based on their the findings, they suggested that medical family therapists should be able to:

- effectively collaborate with other health care providers;
- know the current health-related research and have an understanding of human physiology and pharmacology;
- be aware of cultural and contextual variables related to health and illness;
- understand ethical issues of delivering therapeutic services within a health care system;

- recognize the many disciplines involved in medical care; and
- understand the role of medical family therapists in the health care environment (Tyndall et al., 2012).

Diversity and Medical Family Therapy

One of the main challenges facing medical family therapists and other health care providers is the large differences in access to health care and health insurance among racial and ethnic groups. In the United States, minority families (especially Latino and African American families) are less likely than White families to have health insurance (Nelson, 2002; Smedley, Stith, & Nelson, 2009). Moreover, even when minority families have the same type of health insurance as non-minorities, they tend to receive lower quality care (Nelson, 2002; Smedley et al., 2009).

Medical family therapy may be a way to help improve care for minority families. For example, in a 2008 article, Willerton, Dankoski, and Martir suggested that medical family therapy may provide a way to address health disparities among Latino families. They noted that for many Latinos, emotional problems may often by expressed through somatization (Kouyoumdjian, Zamboanga, & Hansen, 2003), and that Latinos disproportionately use general medical providers when seeking treatment for mental health problems (Vega, Kolody, & Aguilar-Gaxiola, 2001). Willerton et al. (2008) suggested that medical family therapists may be uniquely equipped to work with and improve care for Latino families. Specifically, they suggested that given the emphasis on family in many Latino cultures, medical family therapists may provide a culturally congruent approach for working with Latinos. Additionally, the ability of medical family therapists to collaborate with health care providers may remove barriers and integrate treatment, thereby improving the quality of care Latinos receive. Finally, Willerton et al. (2008) noted that, "if well trained and culturally competent, [medical family therapists] could potentially train physicians and other health professionals how to best serve Latino clients . . . through understanding some of the systemic and contextual issues that impact Latino clients" (pp. 203–204). Though not the complete answer to remedying health disparities, medical family therapy may provide a framework to improve health care access and treatment for many minority families.

Substance Abuse

> It is widely accepted that addiction generally develops within a family context, frequently reflects and promotes other family difficulties, and is usually maintained and exacerbated by family interactive processes.
>
> (Stanton & Heath, 1995, p. 530)

Substance abuse is a substantial problem in the United States. In 2011, an estimated 58.3 million Americans aged 12 and older reported current (within

the past 30 days) **binge drinking**, and 15.9 million reported current **heavy drinking** (SAMHSA, 2012). Approximately 22.5 million Americans reported current illicit drug use, with marijuana being the most commonly used illicit drug (18.1 million users), followed by prescription drug abuse (6.1 million users) and cocaine (1.4 million users; SAMHSA, 2012).

Research suggests that there is a **family predisposition** toward substance abuse (Andrews et al., 2011) and that family functioning plays a significant role in substance abuse (Fals-Stewart, Lam, & Kelley, 2009). It is important to note, however, that most clinicians and researchers operating from a family-system perspective do not believe that the family *causes* the substance abuse or that family members are responsible for the abuser's use. Often families may feel blamed by a poorly skilled therapist's efforts to highlight family involvement. Family members' involvement should be presented as critical to their loved one's recovery (Walitzer, 1998).

Substance Abuse and Family Therapy

In 1974, the National Institute of Alcohol Abuse and Alcoholism issued a report in which couple and family therapy was identified as "one of the most outstanding current advances in the psychotherapy of alcoholism" (Keller, 1974, p. 161). Before that time, substance use disorders were viewed as an individual disease and thus treated with individual therapy (O'Farrell & Fals-Stewart, 2006). However, in the last few years, research has documented the effectiveness of couple and family therapies as interventions for substance use disorders (Baldwin, Christian, Berkeljon, & Shadish, 2012; Ruff, McComb, Coker, & Sprenkle, 2010). Today, couple- and family-based interventions are considered some of the most effective treatments for both adults and adolescents with substance abuse problems (Rowe, 2012). Though there are many family-based treatments that have proved to be effective at reducing substance use problems for adolescents and adults (Baldwin et al., 2012; O'Farrell & Clements, 2012; Rowe, 2012), we will focus on behavioral couples therapy and multidimensional family therapy.

Behavioral couples therapy (BCT) was developed to build support for **abstinence** and to improve relationship quality for individuals in romantic relationships with substance abuse problems (O'Farrell & Fals-Stewart, 2006). It is based on the assumption that a romantic partner can help reward abstinence and thereby decrease the likelihood of **relapse** of the substance-abusing partner. BCT is often offered after completion of an inpatient or outpatient substance abuse treatment program, although it may also be offered in conjunction with an outpatient treatment program.

BCT includes both substance-focused interventions and relationship-focused interventions. One of the main substance-focused interventions in BCT is the daily sobriety contract. When couples make this contract, each day they have a "sobriety trust discussion" (O'Farrell & Fals-Stewart, 2006). In this discussion, the substance-abusing partner states his or her intention to remain abstinent that day, thanks his

or her partner for listening, and may ask the partner not to mention past drinking or fears about future drinking. The other partner records the substance-abusing partner's intention to remain abstinent on a calendar and thanks the substance-abusing partner for stating his or her intention (O'Farrell & Fals-Stewart, 2006).

Once sobriety contracts are being consistently made and kept, BCT then shifts to relationship-focused interventions. The purposes of these interventions are to increase positive activities, goodwill, and commitment to the relationship and to improve communication. For example, the "Catch Your Partner Doing Something Nice" homework assignment is used to help couples recognize each other's positive behaviors (O'Farrell & Fals-Stewart, 2006). Each partner is instructed to record one caring act that he or she noticed the other partner doing each day. The couple read these acts to each other during the subsequent therapy session. BCT also teaches couples communication skills and has couples schedule "communication sessions" in which times to talk face-to-face are scheduled. In these sessions, the partners take turns expressing their emotions and opinions and listening to the other's emotions and opinions. These sessions are at first scheduled daily for 2 to 5 minutes, and as treatment continues, they are often changed to occur three or four times a week for 10 to 15 minutes (O'Farrell & Fals-Stewart, 2006).

BCT has proved to be effective at reducing substance abuse problems. For example, women who abused alcohol who received BCT with their romantic partner reported more days of abstinence and fewer heavier drinking days than women who received individual therapy (McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009). Research also suggests that BCT is effective at reducing substance use problems for gay and lesbian couples (Fals-Stewart, O'Farrell, & Lam, 2009) and male veterans with PTSD (Rotunda, O'Farrell, Murphy, & Babey, 2008).

Multidimensional family therapy (MDFT) was developed and tested to address substance use problems with adolescents. MDFT is based on the idea that substance abuse is a multidimensional problem that includes individual, interpersonal, and familial factors. These factors all contribute to the development, course, and maintenance of substance abuse problems. In MDFT, family functioning is seen as key to creating opportunities to re-track developmental functioning in order to reduce substance use (Liddle, 2013). Drawing on these ideas, MDFT has four target areas: (1) the adolescent, (2) the parent or parents, (3) the family's interaction, and (4) the community social systems.

In MDFT, the therapist builds a strong therapeutic foundation with the adolescent and works with him or her to establish therapeutic goals that are personally meaningful. The therapist and the adolescent engage in problem solving, trying to create practical alternatives to substance use. This is often done through individual sessions with the adolescent. When working with the parent(s) or caregivers in MDFT, the focus is on increasing parental love and emotional connection between the adolescent and the parent(s). The therapist works with the parent(s) to acknowledge past efforts and difficult circumstances that having a substance-abusing teen may have created. Further, the therapist focuses on

improving parenting practices through teaching and through behavioral coaching around areas such as age-appropriate limit setting, parental monitoring, communication, and overt emotional support (Liddle, 2013).

MDFT also targets the family's interaction. The goal is to assess and change family interactions directly. Drawing on techniques from structural family therapy (Minuchin & Fishman, 1981), MDFT shapes family interaction by engaging the family in frank discussions about important relationship topics and themes. These discussions are used to help the therapist assess the problems that are occurring in the family interaction. Using **enactments**, the therapist helps the family expand perceptions and experiences and come up with emotional and behavioral alternatives so that they can find new ways to solve problems (Liddle, 2013).

In addition to targeting the family system, MDFT also targets community social systems. Often, multiple community agencies are involved with families of substance-abusing adolescents. Parents or caregivers can become overwhelmed by the complexity of the various community and social agencies. In MDFT, therapists team up with parents to organize and coordinate with school administrators and probation officers. Though not all multisystem problems are solvable, the goal of targeting community social systems is to help the family navigate these systems in order to reduce stress and prevent the relapse of the adolescent (Liddle, 2013).

Many research studies have documented the effectiveness of MDFT in reducing substance use for adolescents. For example, MDFT has proved to be successful for low-income, minority teens, and the changes seen in those teens who participated in MDFT were still present 12 months after treatment concluded (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). Additionally, MDFT has been shown to be more effective than individual therapy at reducing adolescent substance use. Specially, adolescents with more severe substance use problems reported they had better outcomes when they received MDFT than when they received individual psychotherapy (Henderson, Dakof, Greenbaum, & Liddle, 2010). In 2005, Austin, Macgowan, and Wagner published a review of the research of family-based interventions for adolescent substance abuse. They concluded, "Overall, MDFT emerges as the only family-based intervention with empirical support for changes in substance use behaviors that are both statistically significant and clinically significant immediately following treatment and at 1 year post treatment" (Austin et al., 2005, p. 80).

Diversity and Substance Abuse Treatment

Though substance abuse treatment is effective for many who seek it, ethnic and racial minorities often respond more poorly to treatment and are at greater risk for relapse (Amaro, Arévalo, Gonzalez, Szapocznik, & Iguchi, 2006; Walton, Blow, Bingham, Chermack, 2003). One reason for this poor treatment response among minorities may be the lack of attention paid to cultural variables associated with

treatment outcomes. As Castro and Alarcón (2002) noted, most substance abuse treatment models do not take into account how cultural variables affect outcomes for ethnic and racial minorities. They suggested that in order to improve treatment outcomes, researchers and practitioners should address two questions: (1) How does the experience of being a racial/ethnic minority person influence the etiology and onset of substance abuse and dependence? and (2) How is this ethnic experience related to specific health service needs? (Castro & Alarcón, 2002, p. 790). As researchers and practitioners ask themselves these questions, substance abuse treatment may begin to incorporate cultural variables that capture issues and themes that are relevant to the lives of minorities seeking substance abuse treatment, thereby creating "culturally-rich" (p. 801) models for substance abuse treatment. The development of culturally-rich substance abuse models may serve to improve treatment outcomes and prevent relapse among minorities (Castro & Alarcón, 2002).

Family Violence

The application of marriage and family therapy theory and practice to the issue of **relationship/family violence** has been at times interesting, promising, and frustrating. For the purpose of this chapter, our discussion about relationship/family violence is specifically limited to intimate partner violence, intrafamilial violence, and abuse perpetrated upon children. We recognize that other important types of relational/family violence, such as dating/premarital and elder violence, also occur at staggering rates.

Intimate Partner Violence

The incidence of intimate partner violence in the United States is epidemic. For example, Whitaker, Haileyesus, Swahn, and Saltzman (2007) found that in their sample of adults aged 18 to 28, 24% of the respondents reported some violence in their relationship. Tjaden and Thoennes (2000) found that approximately 25% of women and 8% of men in the United States will be victimized by an intimate partner during their lifetime. Part of the challenge in trying to understand and subsequently intervene in relationally violent or abusive situations begins at the simplest level: determining what we mean by "violence" and "abuse." The terms **abuse** and **violence** are often used interchangeably or exclusively by various groups of professionals (Walker, 1999). For example, in the professional literature, intimate partner violence is referred to as "spouse abuse," "wife abuse," "battering," "domestic violence," and "wife beating," among other terms. In order to improve screening and treatment of intimate partner violence, Kelly and Johnson (2008) differentiated between four patterns of violence: coercive controlling violence, violent resistance, situational couple violence, and separation-instigated violence.

Coercive Controlling Violence

Coercive controlling violence is a pattern of behavior used to control a partner. In this pattern of violence, intimidation and coercion are used along with physical violence. Methods of intimidation and coercion may include blaming, isolation, intimidation, emotional abuse, use of children, asserting male privilege, and threatening. These tactics alone may be effective at controlling a partner, therefore, coercive controlling violence does not always manifest in high levels of violence; however, on average this type of violence is more severe and frequent than other types of couple violence (Kelly & Johnson, 2008). Victims of coercive controlling violence have a high likelihood of injury (Leone, Johnson, Cohan, & Lloyd, 2004). Research has found that in heterosexual couples, coercive controlling violence is mostly perpetrated by men. For example, M. Johnson (2006) found that in his sample, 97% of the coercive controlling violence was perpetrated by men, and similar high percentages have been found with other samples (e.g., Graham-Kevan & Archer, 2003).

Violent Resistance

Violent resistance is defined as "violence that takes place as an immediate reaction to an assault and that is intended primarily to protect oneself from or others from injury" (Kelly & Johnson, 2008, p. 484). Women who are the victims of coercive controlling violence often resist with their own violence (Miller, 2005; Pagelow, 1981). Many violence resisters may resort to violence to protect themselves or their children; however, this violent resistance may lead to an escalation of violence, which often results in injury for the violent resisters. Data from the National Crime Victimization Survey suggest that women who defend themselves from their partners are more than twice as likely to be injured as those who do not defend themselves (Bachman & Carmody, 1994).

Situational Couple Violence

Situational couple violence is defined as couple violence that results from the escalation of a situation or argument (Kelly & Johnson, 2008). Situational couple violence is distinct from coercive controlling in that it is not marked by a pattern of controlling or intimidating behaviors. Those who report situational couple violence do not often report fear of their partner, and men involved in situational couple violence do not report high levels of **misogyny** (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Leone et al., 2004). When compared to coercive controlling violence, situational couple violence more often includes minor forms of violence such as pushing, shoving, and grabbing. However, some patterns of behavior found in coercive controlling violence are also found in situational couple violence. For example, cursing, yelling, jealousy,

and name calling are often found in both types of violence. Situational couple violence is initiated by both men and women and is less likely to escalate than coercive controlling violence (Babcock, Green, & Robie, 2004).

Separation-Instigated Violence

Separation-instigated violence is violence that occurs between partners who are separating or divorcing (Kelly & Johnson, 2008). This type of violence is perpetrated by both men and women, and it often occurs in couples who have no previous history of violence. It usually occurs when one partner is shocked by the separation action and may suddenly lash out at the other partner by destroying property, throwing possessions into the street, brandishing a weapon, or ramming the partner's car (Kelly & Johnson, 2008).

Couple Therapy and Intimate Partner Violence

It seems clear that the most important guide for the clinician in deciding whether couple therapy is indicated must revolve first around the issue of physical and psychological safety for the victim. Bograd and Mederos (1999) sensibly argue that to reach the "minimize risk, maximize safety" goal, a focused, even structured interview process is necessary. They further suggest that because violence is often not presented as a problem, a **universal screening** should occur. The standard procedure for initiating couple therapy should include an initial couple session, followed by an individual session with each partner, before any agreement to begin conjoint couple therapy is made. These authors believe that a detailed **lethality assessment** should occur. Finally, they suggest that all seven of the following conditions should be met before a clinician considers undertaking conjoint couple therapy:

1. Both partners/spouses freely agree to couple therapy.
2. The violence is limited to a few episodes of minor (e.g., slapping, shoving, grabbing, restraining) violence.
3. Psychological abuse has been used infrequently or only mildly.
4. No risk factors for lethality are present, and the victim does not fear retaliation.
5. The perpetrator admits and takes responsibility for the abuse.
6. The victim does not feel that he or she is responsible for the abuse.
7. The perpetrator must demonstrate an ongoing commitment to effectively deal with his or her explosive feelings without blaming others or acting out.

If one or more of these criteria are not met, then the authors suggest that couples work should not occur and the more traditional separate individual and/or group modalities should be employed (Bograd & Mederos, 1999).

Domestic Violence–Focused Couples Treatment

For those couples who meet the above criteria, couple-based interventions for violence have proved to be effective. In particular, Domestic Violence–Focused Couples Treatment (DVFCT), which was developed in the late 1990s, has been shown to reduce violence between couples (Stith, McCollum, Amanor-Boadu, & Smith, 2012). Based on principles of solution-focused brief therapy, DVFCT's goals are to eliminate all violence (i.e., physical, sexual, psychological), to promote individuals' responsibility for their actions, and, if couples decide to stay together, to improve the relationship (Stith & McCollum, 2009).

DVFCT begins with gender-specific pretreatment groups. Participants are required to meet weekly with the group for six weeks prior to beginning conjoint couple treatment. In the group sessions, which are co-facilitated by a male and a female therapist, topics such as types of abuse, safety plans, alcohol and drug use, and conflict resolution are discussed. Within each of the sessions, there is a focus on accountability and taking responsibility for one's own behavior. Additionally, in each session, participants are led through exercises that are designed to promote awareness of the escalation process, behaviors that trigger anger, and appropriate ways to display anger (Stith, McCollum, Rosen, Locke, & Goldberg, 2005).

After the completion of the six week gender-specific pretreatment groups, partners begin to meet conjointly. In DVFCT, this can occur in an individual or multicouple format, and these meetings normally last 12 weeks. In the conjoint couple treatment phase of DVFCT, the co-facilitators and the couple focus on establishing a healthy, violence-free vision of their relationship, learning and practicing communication skills, and addressing the couple's pain and anger. Therapists facilitate this by taking an appreciative stance that assumes that the couple have competency and strengths that can help them overcome their problems, by changing static descriptions into fluid descriptions, and by emphasizing the many paths that can lead to solutions.

In 2004, Stith, Rosen, McCollum, and Thomsen tested the effectiveness of DVFCT. Specifically, they explored which version of DVFCT—the individual couple format or the multicouple format—was more effective at reducing violence. Couples were randomized to either the individual couple group, the multicouple group, or a wait-list control group. The results favored the multicouple group. Men in the multicouple group were less likely to be violent than those in the control group, whereas those in the individual couple group were just as likely to be violent as those in the control group. Additionally, couples in the multi-couple group reported less marital aggression and increased relationship satisfaction, but those in the individual and control group did not.

Diversity, Domestic Violence, and Family Therapy

It is impossible to discuss domestic violence without considering issues of **gender**, **patriarchy**, and **feminism**. Researchers have reported that men and

women are violent toward each other in roughly equal numbers (Steinmetz, 1977a, 1977b; Straus & Gelles, 1986; Whitaker et al., 2007). Feminists counter that gross numbers from national surveys do not reflect the true situation. They cite research that reports that men are more likely to be more violent, less likely to be intimidated by their partner's violence, and less likely to be injured (Cantos, Neidig, & O'Leary, 1994; Cascardi & Vivian, 1995) and that women are more likely to use violence in self-defense, escape, and retaliation (Miller, 2005; Stets & Straus, 1990).

Flynn (1990) recounts the political uproar that began when Steinmetz (1977a) described what she called "The Battered Husband Syndrome." Flynn describes the feminist response that denounced the data, the researcher, and her conclusions as drawing attention away from what feminists considered to be the more important issue of patriarchy, maintaining that serious male-to-female violence occurs. In fact, Anderson (1997) states that the heart of the debate between feminists and family violence professionals revolves around the relative importance of patriarchy as the cause of domestic violence. Patriarchy, in application to family relationships, refers to a structure in which males are the dominant gender. It is generally agreed that the predominant family structure in the United States is patriarchal. A feminist explanation for intimate partner violence states that men perpetrate violence against women to maintain power and control of the heterosexual relationships they are in. This theory is the support for what Flynn (1990) calls "selective inattention" to the issue of female-to-male violence.

Child Abuse

Child abuse is a significant problem in the United States. In 2011, approximately 3.7 million referrals were made to child protective services regarding children being abused or neglected (U.S. Department of Health and Human Services, 2012). It has been estimated that one in seven children in the United States experiences some form of childhood abuse in his or her lifetime (Finkelhor, Turner, Ormrod, & Hamby, 2009), and in 2011 approximately 1,175 children died from abuse (U.S. Department of Health and Human Services, 2012). The vast majority of victims are abused by parents (U.S. Department of Health and Human Services, 2012).

Child abuse and neglect are defined in many ways. The specifics are important especially in relation to the generalizability of research findings and to the comparison of incidence and prevalence statistics. For the purpose of this chapter, **child abuse** is defined as intentional harm or threat of harm to a child by someone acting in the role of caretaker, for even a short period of time (Wissow, 1995), and may be **physical**, **emotional**, **psychological**, or **sexual**. **Neglect** is defined as the lack of provision for the basic needs of a child.

Family Therapy for Child Abuse

One of the most important and consistent findings by child abuse researchers is that family—in particular, nonoffending parent support—is a consistent predictor of better recovery outcomes for child victims (Mullen & Fleming, 1998). Cohen and Mannarino (1997) reported that parental emotional support was the variable that most strongly predicted a positive treatment outcome. For example, Deblinger (1994) reported that providing parents and children with treatment was associated with parents perceiving more symptom reduction in their children than in cases involving child therapy only. Conversely, in the same study, children who received treatment either alone or with parents perceived their own symptoms to improve more than those children who received no therapy while their parents were treated (Deblinger, 1994, as cited in Finkelhor & Berliner, 1995). Given that family therapy has proved to be effective at improving outcomes for victims of child abuse, the remainder of this section will describe one family-based intervention that is frequently used to help victims of child abuse: filial therapy.

Filial Therapy

Louise Guerney and Bernard Guerney (1987) coined the term **filial therapy** to describe a type of child-centered play therapy administered by the child's parents. "Filial" comes from the Latin root for "son" *(filius)* and "daughter" *(filia)*. Though currently conceptualized as a treatment with individual families, originally filial therapy was practiced as a family group therapy in which parents were trained as play therapists during 10 two-hour sessions. Between the 1960s and 1990s, very little literature addressed filial therapy. During the 1990s, the idea of integrating play therapy and family therapy had a resurgence (Gil, 1991, 1994; L. Johnson, Bruhn, Winek, Krepps, & Wiley, 1999; VanFleet, 1994b).

To fully explicate the therapeutic effect of filial therapy, let us offer a brief background addressing the play therapy component. Play therapy has a history dating to Sigmund Freud's work with the famous case of "Little Hans" in 1909. **Play therapy** can be conceptualized as child therapy using play as the medium through which the child will primarily express his or her feelings as well as seek mastery of conflicts. Axline (1947) offered a play therapy model that seems to include the core beliefs of most modern play therapy practitioners. At the heart of these methods is the relationship that develops over time between the child and the practitioner. Axline's method involves nondirective, unconditional acceptance of the child and the child's actions in the play setting. Play therapy traditionally is considered to be an approach that encourages the child to deal with his or her intrapsychic conflicts through the accepting therapeutic relationship, which includes the opportunity for the child to symbolically work through the conflict using play. Play therapy requires that the therapist have a variety of materials available for the

child's use. These materials may include dolls, dollhouses, toy soldiers, stuffed toys, toy animals, household types of toys such as furniture and kitchenware, puppets, and objects that may be smashed or hit. Art supplies, including crayons, paint, finger paints, and sand art, are particularly useful. Gil finds that in addition to these materials, telephones, sunglasses, feelings cards (i.e., illustrations of faces expressing feelings), therapeutic stories, mutual storytelling technique, puppet play, sand play, nursing bottles, dishes and utensils, and video therapy are particularly effective in working with abused children.

The idea of integrating play therapy and family therapy is supported by the previously noted research, which emphasizes the critical role that family, particularly nonoffending parents, can have in positive outcomes for abused children. Directly involving the child's nonoffending parent(s) may greatly facilitate their support for the child.

The following are the core beliefs of a filial therapist, according to VanFleet (1994b):

1. Play is an essential element of child development and is therapeutically beneficial.
2. Nonoffending parent involvement is associated with more positive and longer-lasting results.
3. Most child problems are environmentally induced (e.g., abuse); therefore, education and skill development are usually associated with positive outcomes for children and their families.
4. Child-centered play therapy is associated with positive child outcomes.

As previously mentioned, originally filial therapy was conceptualized and practiced as a group therapy method. An example of a comprehensive program for child abuse treatment that includes group filial therapy as a primary component is the Cedar House program (Kendig & Lowry, 1998). The following briefly outlines how VanFleet (1994a) proposes a filial therapy should proceed:

1. Initial assessment of the child and family using interviews, family play observations, and measures of parent-child behaviors, attitudes, and skills.
2. As appropriate, recommendation of filial therapy to parents, including full discussion of its rationale, content, and process.
3. Therapist demonstrations of child-centered play sessions with the children as parents observe.
4. A training period for parents to learn play session skills, which includes skills-training exercises and mock play sessions with therapist feedback.
5. Office-based parent play sessions with their own children, followed by supervisory feedback from the filial therapist.
6. Ongoing home-based play sessions, followed by regular therapist-parent meetings to discuss play themes, parents' concerns, additional parenting skills, and generalization of skills.

7. As needed, and prior to discharge, follow-up office-based play sessions with **live supervision** by the therapist for maintenance.
8. At discharge, evaluation of filial therapy by parents and therapist; post-therapy assessment of parent-child behaviors, attitudes, and skills.

The results of a review by Bratton, Ray, Rhine, and Jones (2005) strongly support the use of play therapy for children. After reviewing 93 studies that examined the outcomes of children participating in play therapy, these authors found that play therapy has an effect on children's behavioral problems, social adjustment, and personality and that these results held across age and gender, in both clinical and non-clinical populations. Moreover, they noted that parental involvement plays a key role in the outcome of play therapy. Specifically, in order to have the most effective outcomes, it is important not only to involve the parent in play therapy, but also provide structured supervision experiences so that parents can practice the skills learned in play therapy.

Diversity, Child Abuse, and Family Therapy

Child abuse is widespread and affects millions of children all over the world (Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn, & Alink, 2013). Research has identified contextual factors that put children at increased risk. Child abuse occurs more frequently to children with socioeconomic disadvantage (Mesman, van IJzendoorn, & Bakermans-Kranenburg, 2012). Specifically, parents with more economic hardships are more likely to have high stress levels, and increased stress is associated with lower parental sensitivity, leading to an increased risk of abuse. Other factors, such as minority status, acculturation, and discrimination are also linked to greater stress, less sensitivity, and greater risk of abuse (Alink, Euser, van IJzendoorn, & Bakermans-Kranenburg, 2013; Mesman et al., 2012). The presence of a stepparent, poor parent-child attachment, and physical separation of the child from the home are also more highly associated with abuse (Mullen & Fleming, 1998).

Divorce

> To change our thinking about divorced families—to remove from them the label of deviance or pathology . . . we must unambiguously acknowledge and support them as normal, prevalent family types that have resulted from major societal trends and changes.
>
> (Ahrons & Rodgers, 1987, pp. 201–202)

Divorce is one solution to an unsatisfactory marriage. Couples most likely to divorce are those in which both partners are 20 years of age or younger. Individuals with lower incomes and education tend to divorce more than those with higher education and incomes. One exception to this general rule is that women with five or

more years of college with good incomes have higher rates of divorce than do poorer and less educated women. Approximately, half of all marriages in the United States end in divorce or **separation** (Amato, 2010).

Although divorce is a common event in families, it is an unscheduled transition that alters the traditional family life cycle and interrupts developmental tasks (Carter & McGoldrick, 1999). It is a multidimensional process involving many decisions, changes, and adjustments. How the divorce is handled emotionally is the key to whether the process becomes a transitional crisis or has a crippling effect on the adults and children of the nuclear family as well as the extended family. Although an individual's experience and adjustment needs vary considerably from case to case, most divorcing families must address common issues, and each spouse must face challenges. In addition to the **emotional divorce**, the couple will be faced with the implications of the **legal divorce**, **economic divorce**, **co-parental divorce**, **community divorce**, and **psychic divorce** (Bohannan, 1970; Kaslow, 1991).

Because divorce is not a single event, it usually takes a minimum of one and a half to three years after the initial separation for a person to successfully adjust to the changes, stabilize one's feelings, and move through the divorce process. When families cannot adequately resolve the issues of the emotional divorce, they can struggle for years with various family and individual developmental issues. Models of divorce therapy have divided the process into sequential stages (Kaslow, 1991; Salts, 1985; Sprenkle, 1989) and transitions (Ahrons, 1999; Ahrons & Rodgers, 1987) that, when presented as a normative process rather than one of pathology or dysfunction, can be used by clinicians to help families cope more effectively during this painful and complex process. These stages consist of the predivorce (decision-making) stage, the divorce (restructuring) stage, and the postdivorce (recovery) stage.

The Predivorce (Decision-Making) Stage

During the **predivorce stage**, at least one partner has become disenchanted with the marriage or his or her marital partner, thus beginning the emotional divorce. Unfulfilled emotional needs, financial and job-related problems, third-party involvement, different values and goals, communication difficulties, bad personal habits, parenting differences, substance abuse, and violence are examples of the multitude of reasons the nagging feelings of dissatisfaction begin (Textor, 1989). As these feelings grow, the disenchanted spouse may exhibit flares of anger toward his or her partner or, alternatively, may privately simmer in unhappiness and depression. In many cases, the marital relationship is unsatisfactory and/or unstable for a long time; in others, the marriage deteriorates suddenly. In some families, open conflict occurs between the spouses; in others, a distancing and withdrawal of **emotional investment** in the marriage and/or family life takes place. As the disenchanted spouse struggles with the loss of love for his or her partner, it is not unusual for him or her to have an **affair** and/or consult a therapist. Whether the spousal

relationship is highly conflictual or cold and distant, children living in the home frequently develop emotional or behavioral problems (Ahrons, 1999).

Few couples actually enter therapy at this stage with a mutual desire to work toward an amicable divorce. Often one partner will seek individual therapy for the purpose of dealing with an unhappy marriage. In such cases, most therapists warn the client that excluding the spouse from therapy may be an intervention in favor of divorce. A marriage and family therapist will see many couples in which one or both partners have contemplated divorce and are attending therapy for the purpose of "giving it one last try" before moving to end the marriage. In other cases, the disengaged partner may seek a therapist who can become the caretaker of the soon-to-be-left spouse.

Although a divorce often ends up being a mutual decision, one person usually takes the first step to begin the process. The decision to separate is a difficult and complex one, often fraught with trepidation, confusion, feelings of inadequacy, rejection, and anger. For some, it may take two or more years to make the final decision, especially for those who have been married for a long time. Who leaves whom, the vehemence of the couple's conflict, the interaction style of the couple at the time the decision to divorce is made, the process used to make the final decision, and the individuals' personal explanation for the failure of the marriage will all affect the emotional aspects of divorce for each individual.

During the predivorce stage, most parents are not likely to seek a therapist to find help for a child in coping with the effects of **marital discord** and/or a dissolving marriage, unless the child has displayed severe behavior problems. Many adults are too caught up in their own emotional divorce to recognize the negative impact their actions have on the children. Parents may deny this possibility by rationalizing that the children are either too young to understand what is going on or too involved with their own friends and activities to be bothered. Although the first major task of the therapist during the predivorce stage is to help the couple assess and work toward a resolution of the marital conflict, the second major task is to help the parents begin addressing their children's needs during the process (Nichols, 1985).

Conjoint marital therapy is the most likely treatment in this stage of divorce, and couples who are able to identify and resolve their conflicts do not move to the next stage. In some cases, marital therapy provides the opportunity for a couple to come to a mutual realization that ending the marriage may be the best decision. For many couples who may or may not have sought therapy, the conflict becomes too intense and a decision to separate is made by at least one partner. It is estimated that in the United States and most European countries, between two-thirds and three-quarters of all divorces are initiated by women. The recent increase in women's economic independence is one of the biggest factors in this statistic (Ahrons, 1999).

Once the decision to separate is made, announcing the end of the marriage is not an easy task. Rarely are the two spouses at the same point in the emotional divorce process. Therefore, while the process is legally **no-fault divorce** in all

U.S. states, blame often plays a big role. Anger, unresolved grief (e.g., over the loss of one's present lifestyle and the loss of future plans and dreams), and depression are major obstacles to a healthy adjustment to divorce. Family therapy during this time may help de-escalate the anger. It can help both children and adults handle their fears about the major changes that divorce will bring, and it can provide an opportunity to plan how the separation will occur.

The Divorce (Restructuring) Stage

The predivorce stage ends when the decision to divorce is made and the separation begins. Separation day is a major life transition and has the potential for severe stress and crisis. If there has been time for some preparation and planning before the actual physical separation occurs, the adults and especially the children will have the opportunity for a more orderly experience and will have time to process some of the emotional trauma. Abrupt departures frequently result in severe crises for those left behind. It is shocking; the feelings of abandonment often leave adults and children feeling totally helpless (Ahrons, 1999).

In the short term, some negative emotions can have beneficial value. Anger may help provide the energy one needs to get through the crisis of separation. Appropriate grief and sadness are healthy ways to mourn the many losses experienced in divorce. Unfortunately, far too many couples enter this stage with high negative emotional intensity and with both parties taking an adversarial stance over property and/or children. In other situations, one partner may still be in denial of the end of the marriage due to continued attachment to his or her spouse. Although constructive caring or friendship between former intimates can facilitate the adjustment process, one person attempting to win back a partner who does not wish to be in the relationship can constrain the individual's long-term adjustment and interfere with cooperative co-parenting.

Healthy separations have two common factors: **good management** and **firm relationship rules** about how the spouses will interact and will not interact. Good management requires knowing about and preparing for the transitions of divorce, defusing tension at high stress points, and giving everyone enough time to begin adjustment. For relationship rules or boundaries to remain firm, spouses need to recognize how their roles have changed, which means coping with **role losses** and establishing new roles (Ahrons, 1999).

When couples begin the actual physical separation, the legal, economic, and co-parental issues of divorce come to the forefront, contributing to a high degree of stress among family members. When both spouses have accepted the end of the marriage, **divorce mediation** may aid them with their decisions about custody, visitation, and distribution of property and financial assets. Mediation is a process that involves consideration of the best interests of all involved and is based on cooperative problem solving. Although therapists trained in divorce mediation can help couples make decisions regarding these issues, financial and

tax professionals may need to be consulted regarding the financial implications of custody and the distribution of assets. Divorce mediation is estimated to be beneficial for about 80% of divorcing couples, but it will not be successful if the couple maintain high emotional intensity or if one partner has not accepted the end of the marriage (James, 1997).

The legal divorce involves the parties, jointly or separately, taking action to legally end their marriage. If couples can effectively use divorce mediation, the legal divorce becomes a formality. When couples use the court system to continue their marital battle, a long "cold war" may result, in which children, extended family, and friends are forced to take sides. When couples use the adversarial system to make decisions regarding their lives, it then becomes difficult to separate the emotional divorce from the legal, economic, and co-parental aspects.

The economic divorce interfaces with the legal divorce when decisions are made on how to divide the accumulated property and financial assets, as well as how to settle issues of alimony and child support. Couples who have accumulated property and other financial resources frequently battle over an equitable division of these assets. Other couples, however, must contend with assigning responsibility for their debts. The economic divorce also entails individual decisions about where one can now afford to live and the lifestyle that he or she can financially sustain. Some individuals will also be faced with the task of learning how to handle their own finances.

When the divorcing couple have children still living at home, the complexity of the legal and economic divorce increases. Even when there is no dispute regarding which parent the children will live with, issues of financial and parental responsibility will greatly affect the adjustment of the parents and the children. As part of the co-parental divorce, parents should focus on how to deal with the children's perceptions and responses, helping the children interpret what is happening to them and express their fears, feelings, and hopes. Involving children in family therapy and/or mediation can facilitate this. Frequently, however, parents are so invested in the decisions of who will be financially responsible for the children's current and future expenses, as well as which parent gets to have them for which holidays, that the children's emotional needs are overlooked.

Healthy adjustment for children of divorce requires that their basic economic and psychological needs be met. It is important for children to be able to maintain the familial relationships in their lives that were significant and meaningful prior to the divorce, including not only parents, but also extended family members, such as grandparents. Children will benefit when the relationship between their parents is supportive and cooperative. When divorcing couples can reorganize their family into a **binuclear family**, the opportunity for these elements of child adjustment can be met. In most binuclear families, children divide their time between the households. Although the division of time spent in each household varies greatly from one binuclear family to another, the important factor is that the family remains a family—it just has a very different structure than before the divorce (Ahrons, 1999).

When the families move to separate households, there is an undertaking of new activities and the establishment of new daily routines to which individuals must adjust. Separation also often marks the time when friends and extended family members are first informed of the impending divorce, thus moving the process beyond the couple and into the community. Included in the community divorce is the social support of formal and informal contacts with individuals and groups that provide emotional and material resources. Social support and participation are related to low stress and better adjustment for the divorcing individual. Unfortunately for some, this may be a time when their support network is reduced as family and friends take sides (Kaslow, 1991).

Due to the multidimensionality of the **divorce (restructuring) stage**, individuals may come to therapy in a state of high stress and crisis. It is important for clinicians to help clients become aware of the many transitions in the divorce process and to help clients cope more effectively during this difficult time. In addition to helping the clients deal with their emotional pain, clinicians can teach problem-solving approaches, conflict reduction techniques, and stress management skills to help individuals and families manage the emotional divorce so that they are better able to make decisions about the legal, economic, co-parental, and community divorce.

The physical separation is generally the most stressful time for children of all ages. "The needs of children in divorce situations can be stated very simply: They need whatever will provide them with continuing assistance to develop as normally as possible" (Nichols, 1989, p. 73). Children need a clear explanation of what is happening and what it means for them. They need parents to adequately handle the adult developmental tasks so that they are free to continue their own development in relation to the divorce and their normal life cycle tasks. Children need adequate parenting so that age-appropriate dependency-independency needs are maintained, and they need attention and support to minimize the expected abandonment anxiety issues (Nichols, 1989). Research supports the importance of a healthy parent-child relationship to child adjustment to marital disruption (Simons, Lin, Gordon, Conger, & Lorenz, 1999).

The Postdivorce (Recovery) Stage

As decisions are made and changes continue, the divorce (restructuring) stage moves toward the **postdivorce (recovery) period** and what has been termed by some as the psychic divorce (Bohannon, 1970; Kaslow, 1991). This can be a stage of devastation or of exciting new challenges. Some of the personal challenges at this time include coping with loneliness, regaining self-confidence, and rebuilding social relationships. If the former spouses can reduce their negativism, **emotional closure** regarding the divorce can be gained. Separate divorce adjustment groups (Salts, 1989) or individual therapy may help them adjust to the status and roles of singlehood and their continuing responsibilities as parents.

The measure of how successfully a partner traverses the tasks and stages of divorce has been termed **divorce adjustment**. It involves the development of an identity that is not tied to the status of being married or to the ex-spouse; an ability to function adequately in the role responsibilities of daily life; being relatively free of symptoms of psychological disturbance; and having a positive sense of self-esteem. As indicated previously, successful divorce adjustment takes time, and the more complex the process, the longer individuals and families need to move forward in meeting the developmental tasks of their particular life stage.

For 35% of divorced American women, the end of the divorce process occurs when they settle into their lives as single individuals and, for those with children, as single parents or co-parents in a binuclear family structure. For 65% of divorced American women and 75% of American men, an additional transitional crisis occurs when either or both spouses **remarry**. Unfortunately, the re-divorce rate is about 14% higher than the first-marriage rate, with about half of remarriages terminating in less than five years.

Diversity and Divorce

When talking about the stages and types of divorce, it is important to acknowledge how gender and socioeconomic status affect the former spouses' well-being after the divorce. For many decades, women experienced great economic losses following divorce (Holden & Smock, 1991). However, recent research shows that since women have greater access to education, and because the income gap between men and women is narrowing, the difference between men's and women's economic decline following divorce is closing. Specifically, in the 1970s, 63% of women who divorced or separated from a partner experienced income decline of at least 25%, whereas only 30% of divorced men experienced a similar decline. In the early 2000s, 49% of women experienced a decline in income of at least 25% following divorce or separation, and the same was true for 47% of men (Economic Mobility Project, 2012).

It is important to note that though the gender gap between men's and women's income following divorce may be narrowing, many other factors can contribute to women having more economic disadvantages following divorce. For example, following divorce, women are more likely than men to be custodial parents, and only 41% of custodial parents receive full child support payments (Grall, 2011). These payments are especially important to low-income custodial parents, because child support accounts for more than 60% of their annual income.

Conclusion

Families face many challenges, of which mental illness, physical illness, substance abuse, family violence, and divorce are some of the most common. Marriage and family therapy has been integral to increasing the understanding and

awareness of these issues by examining them from a family systems perspective and highlighting how the family affects and is affected by these challenges. With this unique perspective, marriage and family therapy has been able to advance and enhance treatments to help families that are dealing with these issues. Family therapy approaches were originally designed to address major challenges confronting families. Marriage and family therapists continue to be at the forefront of designing and testing treatments to help families understand, overcome, and adapt to these challenges.

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Glossary

abstinence: Continued success by a client in completely avoiding the targeted symptom. For example, in the case of alcoholics, the client attempts to completely avoid ingesting alcohol in any form.

abuse: Physical, sexual, and/or psychological maltreatment used by one person against another.

affair: When a marital partner either has a sexual relationship or makes an emotional investment with someone other than his or her spouse.

anxiety disorder: Psychological disorder marked by difficulty controlling anxiety that may negatively affect daily living.

binge drinking: A pattern of consuming alcohol that results in bringing the blood alcohol concentration to more than .08 percent.

binuclear family: A co-parental divorce arrangement in which the family remains a family, and children divide their living time between the two separate households.

child abuse: The intentional harm or threat of harm to a child by someone acting in the role of caretaker, for even a short time.

community divorce: The dimension of the divorce process involving the social support of formal and informal contacts with individuals and groups that provide emotional and material resources for the person experiencing divorce.

co-parental divorce: The dimension of the divorce process in which divorcing parents must address the continuing developmental needs of their children, including their perceptions of and responses to the divorce.

divorce: The ending of a marriage by an act of law, and the multidimensional process through which the marital couple transition as a result of their changed marital relationship.

divorce adjustment: A measure of how successful a party to divorce is in completing the tasks of and moving through the divorce process.

divorce mediation: A process in which a divorcing couple work with a mediator to make decisions regarding custody, visitation, and distribution of property and financial assets, based on the best interests of all involved and on cooperative problem solving.

divorce (restructuring) stage: The stage in the divorce process when the decision to divorce is made and the separation begins.

economic divorce: The dimension of the divorce process involving division of accumulated property and financial assets, issues of alimony and child support, and decisions by the individuals resulting from no longer having a shared financial base.

emotional abuse: Child abuse that includes actions that traumatize the child yet do not include physical harm, such as berating and cursing.

emotional closure: When the various different emotions a party to divorce has experienced as a result of the divorce process no longer play a significant role in his or her life.

emotional divorce: The dimension of the divorce process in which one is faced with various different emotions regarding his or her marriage and the life changes resulting from the divorce.

emotional investment: A commitment of one's emotions to a relationship with the expectation that one's partner will reciprocate.

enactments: An interaction that occurs in therapy that allows a therapist to observe and change transactions that create the family structure.

family predisposition: The probability that membership in a particular family increases the possibility of a particular characteristic, such as alcoholism, manifesting in any member.

feminism: A doctrine that advocates equal rights for men and women.

filial therapy: A type of child-centered play therapy administered by the child's parents.

firm relationship rules: Having expectations that are not subject to change about what is and what is not suitable behavior between ex-spouses.

gender: Sets of behaviors that are associated with the two biological sexes—masculine or feminine.

good management: Learning about and preparing for the transitions resulting from divorce, using effective life skills to make decisions and to control one's life.

heavy drinking: For men, consuming more than two alcoholic drinks per day or more than 14 per week; for women, consuming more than one drink per day or more than seven per week.

legal divorce: The dimension of the divorce process in which the parties jointly or separately take action to legally end their marriage.

lethality assessment: An assessment that is intended to determine the potential for death associated with actions on the part of an individual.

live supervision: Oversight by a more experienced therapist through direct observation of the session as it occurs. Usually this is accomplished by using one-way mirrors or a video camera.

marital discord: When a marital couple fail to get along well together, have conflict, or have lack of agreement.

misogyny: Hostility or hatred toward women.

mood disorder: A psychological disorder marked by the raising or lowering of a person's affect, mood, or emotional state.

neglect: The lack of provision for the basic needs of a child.

no-fault divorce: A legal divorce option in which neither party is required to show that the other is responsible or to blame; irreconcilable differences.

patriarchy: A social structure that places the male or father as the ultimate authority.

pharmacotherapy: Medical treatment through the use of medication.

physical abuse: Child abuse that includes acts of violence against the child's person.

play therapy: A type of therapy that can be conceptualized as child therapy using play as the medium through which the child will primarily express his or her feelings as well as seek mastery of conflicts.

postdivorce (recovery) period: The stage in the divorce process following the restructuring stage, when the parties to the divorce are continuing to make decisions and changes in their lives as a result of the divorce.

predivorce stage: The time period that falls between the beginning of the deterioration of the marriage and the decision by the couple to divorce.

psychic divorce: The dimension of the divorce process in which a party to the divorce addresses issues such as coping with loneliness, regaining self-confidence, and rebuilding social relationships.

psychological abuse: Maltreatment by one person against another that does not include any physical elements but is nonetheless damaging to the internal makeup of the victim.

relapse: The return of symptoms after treatment goals to lessen or eradicate those same symptoms appear to have been met; to regress after partial recovery from an illness.

relationship/family violence: Physical, sexual, and/or psychological maltreatment by one person against another in an intimate relationship.

remarry: To enter into marriage with a new partner following the dissolution of a previous marriage.

role loss: When an individual no longer functions in a certain role—for example, as a spouse following a divorce.

separation: A time during which the marital couple are not living together. When this occurs as part of the divorce process, a legal separation agreement may be implemented.

sexual abuse: Child abuse that includes actions that are sexual with or toward the child, such as the performance of any sexual act with a child.

substance abuse: A maladaptive pattern of substance use leading to clinically significant impairment or distress.

universal screening: The idea that all potential therapy cases should be assessed for the presence of a particular symptom pattern.

violence: Physical, sexual, and/or psychological maltreatment used by one person against another.

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15

ETHICAL, LEGAL, AND PROFESSIONAL ISSUES IN MARRIAGE AND FAMILY THERAPY

Lorna L. Hecker

> To understand the whole, it is necessary to understand the parts. To understand the parts, it is necessary to understand to the whole. Such is the circle of understanding. We move from part to whole and back again, and in that dance of comprehension, in that amazing circle of understanding, we come alive to meaning, to value, and to vision.
>
> Ken Wilber, in *The Eye of Spirit: An Integral Vision for a World Gone Slightly Mad* (2001, p. 1)

In order to study ethics in marriage and family therapy, we do not stray from family systems theory (see Chapter 2). Our understanding of therapeutic situations must look at the whole situation, as well as the parts and stakeholders in each situation. Meanings and values are part and parcel of ethical clinical practice and lead us toward our vision of what healing should look like in family therapy. In this chapter, we will focus on how ethics and legal issues affect the practice and profession of marriage and family therapy. As you learn about ethics, you will begin to understand about the pieces of ethical decision making, but also the whole of how these decisions can affect clinical work.

Take the following example: Mrs. Chapman has called for therapy because her 16-year-old son, Randy, has been failing school. You, the family therapist, ask to see the entire family at the initial intake session. Everyone attests to Randy's problems, except Randy, who remains silent. You decide to see Randy alone, to get to know him. During your session with Randy, he opens up and tells you that he regularly drinks vodka as a way to "chill out." He reports carrying vodka to school in his backpack.

What do you do with this new information regarding Randy?

Your treatment of the Chapman family, like all family therapy, now involves ethical and potentially legal issues. Many ethical and legal questions are posed by the dilemma described, including the following:

- *Who is the client?* Is it the Chapman family, the parents, or Randy?
- What are Randy's rights to *confidentiality* or *privilege?* Are there any legal statutes governing treatment of a minor? What are the parents' rights to know of Randy's drinking behavior?
- Is Randy's behavior dangerous? Would his behavior fall under a *duty to protect*?
- How do you handle this situation clinically so that Randy and his family are most likely to get the help they need, while balancing the rights of the individuals involved?
- What might happen to your relationship with the parents if you do not tell them about Randy's behavior? What might happen to your relationship with Randy if you do tell them?

Each time a family therapist sees a client, there is the potential for ethical, legal, and professional issues to arise. Therapists must be educated on these issues, or they may inadvertently hurt individuals or families, make poor clinical judgments, or violate laws.

In this chapter, first, we will define and discuss ethics and ethical decision making in family therapy. Entrenched in this decision making is the need for the therapist to be aware of legal issues, including state statutes (which will not be specifically discussed, because they vary from state to state), and any applicable federal statutes. The importance of therapists and therapists-in-training receiving therapy themselves will also be discussed. Last, an overview of the field of marriage and family therapy will include information on how one becomes a family therapist.

Ethics in Marriage and Family Therapy

Ethics is "the study of what constitutes good and bad human conduct, including related actions and values" (Barry, 1982, p. 4). When clients enter therapy, they place their lives (sometimes literally) in the hands of the therapist. Without ethical standards, clients would have no reason to trust a therapist with their most private information. Thus, without ethical practices there would be no marriage and family therapy profession.

To guide ethical practice, all mental health professions have **professional codes of ethics** if the therapist is a member of a professional organization such as the American Association for Marriage and Family Therapy (AAMFT), the American Psychological Association (APA), the American Counseling Association (ACA), or the National Association of Social Workers (NASW). A code of ethics is a written statement established and distributed by a discipline or profession that expresses how a profession should and should not conduct itself. (See Appendix

A to this chapter to view the AAMFT Code of Ethics [2012].) Ethical codes perform the following functions (Schlossberger & Hecker, 1996):

1. *Ethical codes define the role of the profession.*
   - The codes express the dominant morality of the field.
   - They define values and goals of the profession.
   - They define the standards that both the professionals and users of the professionals' services can expect in any professional interaction.
2. *Ethical codes guide the conduct of professions and can provide specific guidance about conduct in the form of advice or mandates.*
3. *Ethical codes serve as a basis for sanctions.* Sanctions may vary from censure to fines, revocation of **licensure** or **certification**, denial of privileges, or supervision of future work. Legal ramifications may occur if laws were broken.

If an AAMFT clinical member violates the AAMFT Code of Ethics, for example, a consumer may file a complaint with the AAMFT. The AAMFT has a specific decision tree that is followed for every ethical complaint filed. In addition, a consumer may also file a complaint with the therapist's state licensing board.

Ethical codes are important guides for clinicians practicing marriage and family therapy, but ethical practice constitutes much more than just following ethical codes. Each day a therapist practices, he or she is faced with ethical issues, many of which are not discussed in the Code of Ethics. In addition, a therapist must weigh three factors when making ethical decisions: the *ethical* implications of the decision, any *legal* implications of the decision, and any *clinical* implications of the decision.

In this chapter we focus on what constitutes ethical practice by marriage and family therapists (MFTs), and we also discuss how ethical decisions are made.

Ethical Clinical Practice

What constitutes ethical clinical practice? Ethical practice by a therapist generally occurs when the therapist has good moral compass (knows, understands, and behaves in accordance to values [Hecker, 2010]), follows his or her professional code of ethics, is knowledgeable about existing laws impacting his or her clients, and has good clinical expertise (or for one still learning the profession, has adequate supervision of his or her work).

Most states now legislate that therapists provide written professional disclosure statements to their clients. A **professional disclosure statement** typically includes information such as what formal education and training the therapist has, the therapist's state license number, information regarding clients' rights, fees, the complaint process, and/or the therapeutic process. The content of the disclosure statement is governed by state statute and promotes ethical practice.

If allowed, some therapists may integrate disclosure statement requirements into their **informed consent**. An informed consent is a document about the specifics of therapy treatment; it provides information to the client prior to treatment regarding the client's rights and helps him or her make informed treatment decisions (Hudgins, Rose, Fifield, & Arnault, 2013). After reading and understanding the document, the client consents to treatment by signing it. Besides specific information required by law, therapists should generally provide the following information to the client via informed consent (Beamish, Navin, & Davidson, 1994; Hare-Mustin, 1980; Hecker, 2010; Huber, 1994; Margolin, 1982). The risks and benefits of therapy are always included, and limitations to confidentiality are outlined. Office procedures are typically included. Informed consent can foster a positive therapeutic relationship, enhancing client autonomy and responsibility, and limiting therapist liability (Beahrs & Gutheil, 2001).

See Appendix B to this chapter for an example of an informed consent document.

Lastly, if the therapist is a Covered Entity under HIPAA (the Health Insurance Portability and Accountability Act), the therapist must provide a HIPAA-compliant Notice of Privacy Practices.

Confidentiality and Privilege

One of the largest concerns that clients have when educated about therapy is concern for their privacy. Clients expect that their exchanges with MFTs will be kept confidential. In our society, to some extent, we think people should be entitled to privacy: freedom from intrusions from the state or third parties (Smith-Bell & Winslade, 1994). In marriage and family therapy, professional therapists grant their clients **confidentiality**. Confidentiality is the ethical obligation of therapists to keep communications between themselves and their clients strictly private, not privy to any outside parties. However, although MFTs are duty-bound to keep therapy confidential, a therapist may be charged with contempt of court if he or she refuses to testify about a client (Smith-Bell & Winslade, 1994). In addition, legal exceptions to confidentiality, which are discussed next, exist in all 50 U.S. states. Consider the following case study of an issue surrounding client confidentiality.

Case Study and Analysis

Mrs. Johnson calls the Marriage and Family Therapy Center where Ms. Moore works to inquire about her son, Terry, who is a client of Ms. Moore's. Terry, age 43, is struggling with issues of independence from his family of origin, with whom he still lives. Mrs. Johnson tells Ms. Moore that Terry has been progressively getting worse since attending

therapy, and that he has been fighting continuously with both Mr. Johnson and herself. Ms. Moore defends her treatment of Terry and discusses the possibility of Mr. and Mrs. Johnson joining Terry for family therapy sessions.

Ethical implications: Ethically, Ms. Moore has violated the AAMFT Code of Ethics, section 2.2, which states, "Marriage and Family Therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law."

Ms. Moore violated Terry's right to confidentiality not only by telling his mother about his treatment, but *by even acknowledging that Terry was in treatment at the Marriage and Family Therapy Center at all.* The simple fact that a client is in therapy must be kept confidential.

Legal implications: Ms. Moore has violated Terry's right to confidentiality; typically she will also have violated the law. (This would not necessarily be the case if Terry were incapacitated in some way and his mother was named his legal guardian.)

Clinical implications: The profession of marriage and family therapy rests on the trust that clients place in their therapists to keep confidential information they divulge. The therapist, Ms. Moore, violated that trust. This could affect Terry's feelings about the therapeutic relationship. Most clients would feel very betrayed by Ms. Moore's actions. In addition, if Terry is struggling with issues of independence from his family of origin, Ms. Moore inadvertently created "more of the same" by discussing Terry's treatment with his mother.

In many states, in addition to the ethical obligation to maintain client confidentiality, the therapist is expected to uphold a legal obligation of client privilege. **Privilege** is a legal right, *typically owned by the client,* that is governed by state statute. Legal privilege allows clients to block admittance of information into court or administrative proceedings. All states have passed some form of privilege statutes for psychotherapy clients (Youngren & Harris, 2008).

If a client is entitled by state law to privilege, information revealed in therapy sessions is not privy to the courts.

There are notable legal exceptions to confidentiality or privilege. All states have some form of **child abuse reporting laws** that mandate therapists to report suspected child abuse or neglect. (In some states, *all* citizens, not just counselors and psychologists, are required to report suspected child abuse or neglect.) Thus, if an MFT suspects child abuse or neglect, he or she is legally mandated to violate client confidentiality and report the information to the proper authorities. In addition, since the now famous *Tarasoff v. Regents of University of California* case

(1976), ethics codes for the mental health professions all issue a duty to protect if the professional believes a client has intent to hurt someone else; 28 states have codified duty to protect into law (Harvard Mental Health Letter, 2006).

The details of the *Tarasoff* case are as follows: While in psychotherapy, Prosenjit Poddar threatened to kill Tatiana Tarasoff. Tarasoff was a fellow student in Poddar's square-dancing class. Although Tarasoff was not mentioned by name, the therapist knew her identity. Tarasoff was not informed of this threat against her life. Two months later, Poddar murdered Tarasoff. The Tarasoff family filed suit, and the court ruled that "When a therapist determines or pursuant to the standards of the profession determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger" (*Tarasoff v. Regents of University of California,* 1976, p. 346). Either by law and/or ethical duty, therapists also have **duty to protect** when the following three criteria are met:

1. The therapist has established there is likelihood that the client will cause harm to himself or herself or to someone else.
2. A "special" (i.e., therapeutic) relationship exists between the therapist and client.
3. There is a foreseeable victim (Lamb, Clark, Drumheller, Frizzell, & Surrey, 1990). (Courts have at times ruled that a victim can also be a group or class of people.)

Last, confidentiality or privilege may be violated if a courtroom judge so orders, or if the therapist is a defendant in legal action arising from the therapy itself. In all cases, if the therapist attains a written waiver of confidentiality from the client, the therapist may discuss issues with those persons the client specifically designates in writing.

HIPAA: The Health Insurance Portability and Accountability Act of 1996

Most everyone is familiar with receiving Notice of Privacy Practices at their doctor, dentist, or other health care provider's offices. If an MFT's practice falls under HIPAA as a "Covered Entity" (if they meet the criteria for HIPAA), the MFT must also give clients a Notice of Privacy Practices and document that the client received it. Covered entities are businesses that transmit any transactions electronically, such as for insurance reimbursement; they have a responsibility to keep clients' Protected Health Information (PHI) confidential. The Notice of Privacy Practices informs clients that their protected health information may be released for treatment, payment, or health care operations. However, when state law is more stringent than HIPAA regulations, as is the case with most laws regarding mental health practitioners' clients, then state

law is followed (Hecker & Edwards, 2014). In addition to privacy regulations, HIPAA regulations also address security of electronic Protected Health Information (ePHI) with important safeguards.

Depending upon the practice setting of the therapist, he or she may also need to be aware of legal requirements of the Family Education Rights and Privacy Act (FERPA) or the Federal Confidentiality of Alcohol and Drug Abuse law (42 CFR Part 2).

All therapists have the responsibility to be well trained and to follow what the courts deem an **appropriate standard of care**. An appropriate standard of care is how most therapists would treat a case under similar circumstances. Although this may vary widely, depending upon the training and theoretical orientation of the therapist, there are standards of practice that therapists must follow. Therapists who do not provide an appropriate standard of care leave themselves at risk for **malpractice**. Malpractice claims are legal actions taken against a therapist for actions that are believed to fall below the appropriate standard of care and cause injury to a client or clients. Therapists can be sued for malpractice if they do not provide sufficient care for clients and if the following circumstances are met (termed the "4 D's" [Ash, 2009]):

1. The therapist had a *duty of care* (meaning a client-therapist relationship was established),
2. there was a *dereliction of duty* (meaning the client care fell below the standard of care), which led directly to
3. *damages* (Ash, 2009), meaning an injury actually occurred (Schultz, 1982).

When Boland-Prom (2009) researched state sanctions for social workers, she found that the most common sanctions were for multiple relationships and boundary violations (both sexual and non-romantic), license-related problems (such as working with a lapsed license), crimes (e.g., fraudulent billing, theft, DUIs, sex crimes), practicing below the standard of care (e.g., not maintaining case records, informed consent, or confidentiality; problems with forensic reports; failure to get supervision; client abandonment). Most of these claims include areas that have to do with therapist competence and knowing one's field of expertise, as well as the limits of that expertise. We discuss later in this chapter the options for obtaining competent training. The primary area of sanctions, Boland-Prom discovered, was **multiple relationships**, which trigger both ethical complaints and legal malpractice claims. Multiple relationships occur when a professional does not keep appropriate boundaries and blends a personal or business relationship with the professional therapeutic relationship (Borys, 1992; Borys & Pope, 1989; Gottlieb, 1993; Kagle & Giebelhausen, 1994; Kitchener, 1988; Pope, 1991; Ramsdell & Ramsdell, 1993). Consider the following case study.

Case Study and Analysis

Rhonda is distraught over a breakup with her abusive boyfriend. Although she knows that she made the right decision, she misses her boyfriend and seeks the help of an MFT to deal with her grief over the loss of her relationship, as well as to explore her history of getting into bad relationships. Rhonda feels very vulnerable and lonely as she begins therapy with Mr. Mason, a master's-level MFT. Mr. Mason compliments Rhonda on her ability to leave her relationship and begins to explore the vulnerabilities that tend to lead Rhonda into abusive relationship patterns. Mr. Mason is extremely complimentary to Rhonda, often commenting about her hairstyle or clothing. He even states he enjoys her perfume. Rhonda is struck by his sincerity and begins to trust Mr. Mason. Throughout the course of treatment, Mr. Mason continues to be complimentary to Rhonda, holds her hand during sessions as she cries about her past relationships with men, and he always sits next to her on the couch. He massages her shoulders as she talks, and he even asks her for a kiss on his birthday.

Ethical implications: Mr. Mason has clearly violated section 1.3 of the AAMFT Code of Ethics (2012). Although he has not (yet) engaged in sexual relations with the client, he has engaged in a multiple relationship with Rhonda. He is fostering a close personal relationship with Rhonda that is inappropriate in the context of the professional relationship of therapy.

Legal implications: Legally, Mr. Mason has broken no laws as of yet. He has acted unprofessionally and unethically, and if he moves the relationship into one clearly defined by law as a sexual relationship, he will, in some states, have committed a crime. Some state statutes make sexual intimacies between client and therapist a felony, and the prohibition is clearly stated in the state licensing statutes.

Clinical implications: The clinical implications of Mr. Mason's actions are numerous. Rhonda came to therapy in a vulnerable position, and Mr. Mason exploited that vulnerability and the trust of the therapist-client relationship. Since Rhonda wanted to learn how to avoid abusive relationships, which invariably involve a misuse of power, Mr. Mason has recreated her problem in the context of the therapeutic relationship. Haas and Malouf (1995, p. 80) write, "The therapist's elevated power position, combined with the fact that the client expects the therapist to act in a fiduciary capacity, make it virtually impossible for a client to make an autonomous decision regarding sexual involvement."

Because a therapist always holds more power than a client in their relationship, the risk of a multiple relationship becoming exploitative always exists. Although all therapy is indeed personal, it is the therapist's responsibility to maintain appropriate, professional boundaries and protect the client's best interests.

In addition to following a professional code of ethics, the therapist needs to know how to make ethical decisions for the many gray areas not covered in codes. Ethical decision making can be a frustrating process because often there is no "one right answer." One must choose from many possible answers to a problem and weigh the costs and benefits of each possible decision carefully.

Ethical Decision Making

MFTs face ethical issues on a daily basis. Often, ethical issues are entwined with legal issues. Generally, a model for making ethical decisions can be discussed in simple terms, but the process of weighing ethical, legal, and clinical considerations can be complex. Generally, the following steps are part of the ethical decision-making process:

Step 1: Awareness of Potential Ethical Issues

In addition to being knowledgeable of the ethical codes of the professional organizations to which they belong, therapists should know the literature regarding additional potential ethical issues. For example, when seeing a family, one potential pitfall for the therapist occurs when a family member independently shares a secret with the therapist. This puts the therapist in a sticky position of either (a) unwillingly aligning with one family member because the therapist is a "knower" of the secret and others are not or (b) asking the family member to share the secret. In any scenario such as this, the therapist's **maneuverability** (ability to intervene effectively) is compromised.

Over time, wise therapists learn to identify potentially problematic clinical issues that may give rise to ethical dilemmas, and they work to preempt ethical problems. For example, many therapists develop policies regarding secrets (Karpel, 1980) to avoid conflicts of interest that may occur when one family member shares a secret about himself or herself or about another family member. Such **secret policies** are usually written statements about how information shared privately with the therapist shall be handled by the therapist, signed by the involved parties. Some mental health professions require release forms be signed in order for couple or family therapists to share information between parties.

Imagine if you will that a therapist sees a spouse separately, only to be told by the client that he or she is having an extramarital affair. At this point, the therapist is immediately put in a situation of having a secret. What should the therapist do? If the therapist shares the secret, he or she violates the revealing client's trust. In addition, some ethical codes deem that information shared by an individual in couple, family, or group therapy should be held confidential unless there is a written contract to the contrary (see AAMFT Code of Ethics [2012], section 2.2); and others leave it to therapist/family verbal agreement (see section 3.05, APA Code of Ethics, 2010) or a verbal agreement followed by a written contract (see section B.4.b, ACA Code of Ethics, 2005). If the therapist

does not take action, the therapist has put himself or herself in alignment with the revealing client at the expense of the unknowing spouse. These types of situations can be thwarted by the therapist coming to agreement with the couple about how information should be handled at the onset of therapy. Some therapists avoid this problem by never seeing partners individually. However, with the high prevalence of domestic violence in couples (38%–58% of couples presenting for therapy; Jose & O'Leary, 2009), this may preclude a therapist from ever learning about abusive situations occurring within the family. Heightened awareness of potential ethical conflicts will decrease therapy pitfalls.

Case Analysis

Recall the Chapman family mentioned at the beginning of the chapter. A wise therapist would be aware of the potential for a conflict of interest if he or she promises Randy confidentiality, yet find himself or herself faced with an adolescent who may confess to being in danger. The therapist instead should have agreed on a secrets policy with the family. Most parents will agree to adolescent confidentiality with the exception that if the therapist learns the child is doing something that may jeopardize his or her health, the therapist should share that information with the parents. This would have given the therapist the ability to share Randy's behavior with Mr. and Mrs. Chapman. The downside of this agreement is that Randy may not have shared the information of his alcohol abuse if this type of agreement had been established.

Step 2: Define the Ethical Problem

What is the ethical issue or dilemma? What immediate facts have the most bearing on the decision you must make? Are there any economic, social, or political pressures to take into consideration? What do you think each of the clients or people involved would want you to do regarding this issue?

Case Analysis

The ethical dilemma for the therapist is that Randy is behaving in a way that could hurt or kill him. The therapist now knows the information, but if he tells the parents about Randy's drinking he risks alienating Randy from therapy or perhaps any future therapy or therapists. On the other

hand, the therapist is fearful Randy may hurt himself. The therapist may also consider whether Randy is driving after he drinks. Surely the parents would want to know if their child is at risk, but will the therapist be clinically effective if he tells the parents at this point in therapy? What risks are there if the therapist does not tell the parents?

Step 3: Gather Information from All Relevant Sources

What sources may be of help in solving the problem? Sources to consult may be your professional code of ethics, other professionals, and state or federal laws.

Case Analysis

The AAMFT Code of Ethics (2012) addresses confidentiality between family members. Section 2.2 states: "In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written consent of the individual." The code of ethics clearly errs on the side of protecting client confidentiality, yet in most states parents could legally get access to the information.

The therapist must consider what might happen if the parents are not alerted to Randy's behavior. Might he drink and drive? Might he drink to the point of poisoning himself? Yet again, the therapist has to consider whether Randy is telling the truth. Some teens might make up bravado stories to impress a therapist. On the other hand, if Randy is drinking, underage drinking is against the law. What do you suppose would happen if Randy does hurt himself through his drinking behaviors and the parents find out the therapist knew but did not inform them?

Step 4: Define the Ethical Principles or Values That Influence Your Thinking About the Problem

Ethical guidelines are guided by moral principles. Several authors have discussed the need for ethics to be guided by the following moral principles (Forester-Miller & Davis, 1996; Kitchener, 1984; Rosenbaum, 1982; Stadler, 1986):

Autonomy: This is the belief that people should be allowed freedom of choice and action.

Nonmaleficence: This is an important maxim for all therapists. This principle means that above all else, the therapist should do no harm.
Justice: This principle states that humans should be treated fairly and that goodness and badness be distributed justly among them. This can be done by

1. distributing good and bad to people based on their merits,
2. equal distribution of good and bad, or
3. distributing good and bad according to people's needs and abilities or both (Thiroux, 1980, p. 125).

Fidelity: Refers to the value of honoring commitments and promoting trust.
Veracity: Refers to the importance of truth-telling.
Beneficence: Refers to promoting good.

Case Analysis

Let's explore the Chapman case using moral principles to guide us.

Autonomy: Should the therapist violate Randy's autonomy as an individual by telling the parents about his drinking behavior? Would the therapist be violating the autonomy of others (those who might be driving when an intoxicated Randy is driving) if he or she does not tell? Does the therapist violate the parent's right to know about a child's dangerous behaviors so that the parents can keep the child safe?

Nonmaleficence: What action do you think will do the least amount of harm in this situation? Telling the parents may cause the therapeutic relationship with Randy great harm. Not telling the parents may cause Randy or others harm and/or injure the therapeutic relationship between the therapist and Randy.

Fidelity: If you promised Randy confidentiality, then you should honor that commitment. If you told the family you were there to help them, yet do not reveal the information, are you being deceptive to the parents?

Beneficence: Which course of action—telling the parents or keeping Randy's confidence—would do the most good for the greatest amount of people?

Step 5: Formulate and Weigh All Possible Alternatives

The therapist must consider all courses of action and the possible ramifications of each decision.

Case Analysis

If the therapist tells Randy's parents, will he increase the chances of keeping Randy safe? Will the damage done with Randy be irreparable? Might the therapist consider asking Randy to tell his parents about his behavior? The therapist could work with Randy individually to curb his behavior in the hopes that the drinking problem resolves. The therapist could tell the parents and then work closely with the family to regain trust and communication so that Randy could talk about his problems and not engage in drinking behavior to mask them. The therapist could work with Randy and his parents to increase family structure so that the parents were more aware of Randy's behaviors and decrease the chances that Randy would be allowed in environments where alcohol would be available. A sensitive therapist can find many solutions to difficult problems.

Step 6: Choose the Best Ethical Alternative and Implement the Decision

After a therapist has gathered all the information and weighed possible outcomes of various courses of action, he or she chooses what is considered to be the best course and acts on his or her decision.

Case Analysis

The therapist decides to wait and assess the situation for a little longer before deciding what to do about Randy's drinking behavior. Indeed, he is not even sure at this point that Randy is telling the truth, because he knows little about Randy. The therapist decides to work on the structure of the family by putting the parents in charge of the family again, so that Randy has fewer chances for illegal drinking. He also decides to work on improving family communication so that Randy has an outlet to discuss his feelings, and he works with Randy individually as well to identify sources of coping, such as positive peers and other social circles from which Randy could obtain support. (However, this action would depend upon the therapeutic context; not everyone would respond the same way.)

Step 7: Monitor Your Decision and the Outcome of Your Decision; Reevaluate If Necessary

Ethical decisions are evaluated and reevaluated repeatedly.

Case Analysis

If the therapist senses Randy's situation is declining, or finds that the situation is even worse than Randy originally described it, he or she may choose to reconsider telling the parents about the behavior. The therapist, meanwhile, may learn more about the legal implications of telling, by consulting an attorney to obtain advice about the validity of breaking confidentiality and to see whether there are any state laws governing the situation.

In summary, making ethical decisions is a complex task. The therapist strives to do the right thing, but ethical decision making, clinical expertise, and legal knowledge must guide him or her.

Common Ethical Dilemmas Faced by Marriage and Family Therapists

The list of ethical issues faced by MFTs is endless. Family therapists must have a good working knowledge of law, their code of ethics, and an ethical decision-making model in order to traverse the daily entanglements of performing marriage and family therapy. Drawing on the work of Margolin (1982), Zygmond and Borhem (1989), Beamish, Navin, and Davidson (1994), Green and Hansen (1989), and Hecker (2010), and clinical experience, some ethical dilemmas faced by marriage and family therapists are outlined next.

Balancing the Interests of More Than One Client

Therapists generally have a responsibility to promote the best interests of their clients. But if therapists have multiple clients, such as in marriage or family therapy, these interests may diverge. Consider the marital couple that comes to therapy. The wife has agreed to come to therapy because she wants a divorce but also wants the best possible outcome for her children, so she agrees to meet with the therapist to discuss the children. The husband, however, wishes the marriage to be saved—he does not want a divorce. Whose agenda does the therapist follow? If the therapist follows the wife's agenda, the husband will feel that the therapist is supporting divorce. If the therapist follows the husband's agenda, the wife may leave treatment, and the issues concerning the children's welfare will remain untended. Promoting the welfare of one or more family members may not support the welfare of others (Fenell & Weinhold, 1989; Jensen, Josephson, & Frey, 1989).

Maintaining Multiple Client Confidences

Therapists must maintain client confidences, but in the face of multiple clients this can get convoluted. For example, if a family member shares a secret with the

therapist about another member during a call to reschedule a missed session, does the therapist honor that confidence? If the therapist does honor the confidence, he or she is now in the unique position of being a secret holder—an involuntary ally to the person who told the secret. This type of confidence keeping can severely limit the therapist's effectiveness. Therapists typically address this issue in their informed consent or a first-session discussion (with documentation following).

Conflicting Values Between Therapist and Client

What happens when a client has values opposing those of the therapist? For example, a client wants counseling regarding her decision to have an abortion, but the therapist is a staunch antiabortion advocate. Another example might be a child who is brought to counseling because her parent caught her masturbating. The therapist sees masturbation as a normal part of sexual development, but the parents, based on religious convictions, consider it a sin.

Theoretical Purity vs. Real-World Demands

The goal of systems theory is to see health and dysfunction as a function of the entire system, not just one individual. Many couples or families present one person in therapy as the **identified patient** (such as Randy in the Chapman example at the beginning of the chapter), the person bearing the symptomatology of the family system. The therapist's job is to "spread the symptoms around" in the family and decrease the pathologizing of this individual family member by further understanding and clarifying the family context of the problem.

If the therapist is to be paid by an insurance company, however, he or she usually must identify one family member and give this person a diagnosis in order to make the services reimbursable by insurance. The therapist may risk the family not receiving reimbursement and being denied services if he or she does not assign a diagnosis to the identified patient or another family member. This clash between systems theory and the medical model in which therapists operate can leave the practitioner with continuing ethical issues (Denton, 1989).

Choice and Implementation of Therapeutic Theory

The theory or model from which one chooses to practice marriage and family therapy also may pose ethical dilemmas. For example, some systems therapists refuse to treat family members unless all family members participate directly (O'Shea & Jessee, 1982). Thus, if one or more family members refuse to participate in treatment, the others are denied needed treatment. Some systems therapists believe their work will not be effective if all family members do not participate in therapy (Haley, 1980). Refusing to treat motivated family members when others will not participate poses an ethical problem (Tiesmann, 1980).

Feminists (Avis, 1985; Bograd, 1984; Goldner, 1985a, 1985b; Hare-Mustin, 1978, 1979, 1980; Jacobson, 1983) have criticized that the notion of *circularity* (see Chapter 2 for discussion of this concept) as well as other systems concepts do not take into account the power dynamics in relationships and the very real inequities women face on a daily basis in relationships. Feminists charge that women do not hold equal power in relationships and, for example, in the case of domestic violence, certainly do not hold "equal influence" on the present system.

Another example of how theory poses ethical dilemmas is evident in a popular newer postmodern movement called **social constructivism**. Social constructionist family therapies grew out of a philosophy that maintains that there is no objective reality—we create and perpetuate our realities through the stories that we tell and live by (Friedman, 1993). Social constructivism argues that facts do not exist; only our stories exist. When two people's stories of the same event are vastly different, whose narrative do therapists listen to? For example, if the story of a child is that her stepfather sexually abused her, but the stepfather's story denies this, whose story or narrative does the therapist follow? Theories do not always answer these difficult questions posed daily in clinical work (see Chapter 6 for further information on social constructionist family therapies).

Often criticized on ethical grounds has been strategic therapy (Schwartz, 1989; Slipp, 1989). Strategic therapy typically employs therapeutic paradox, including prescribing the symptom and restraining change. For example, a strategic family therapist might order a client to be depressed, in an attempt to ameliorate the depression. Strategic therapists might also indicate that they have concerns about clients becoming cheerful too quickly, telling them that they feel clients should be depressed for a little while longer. Again, the goal is to paradoxically cure or lessen the depression. Although some would conclude that integrity and authenticity are needed when guiding clients (Wendorf & Wendorf, 1985), others would argue that family change is a more important goal. Some authors have provided guidelines for how to utilize this type of therapy while maintaining ethical integrity (Fisher, Anderson, & Jones, 1981; O'Shea & Jessee, 1982; Rohrbaugh, Tennen, Press, & White, 1981).

In summary, marriage and family therapists face thorny ethical issues on a daily basis. Knowledge of the law, one's professional ethical codes, and ethical decision making is important to the profession of marriage and family therapy. The importance of good training cannot be overemphasized. Following is a discussion regarding the profession of marriage and family therapy and how a prospective student can gain information on the field and apply to graduate school.

What Is Marriage and Family Therapy?

Marriage and family therapy has been recognized as a distinct mental health discipline since 1978. At that time, the U.S. Department of Health, Education, and Welfare designated the AAMFT Commission on Accreditation for Marriage

and Family Therapy Education as the sole accrediting agency for both graduate and postgraduate educational and training programs in marriage and family therapy. In addition, the National Institute of Mental Health lists marriage and family therapy as a core mental health profession.

The American Association for Marriage and Family Therapy (AAMFT), as mentioned in Chapter 1, is charged with ensuring that the public receives quality care in marriage and family therapy. The AAMFT promotes understanding, research, and education within marriage and family therapy. Practitioners who become clinical fellows of the AAMFT have masters' degrees, doctoral degrees, or postgraduate training in marriage and family therapy, as well as 1,000 hours of supervised clinical experience with individuals, couples, or families. Clinical fellows of the AAMFT have met stringent requirements set by the organization that tell the public that the professional is qualified for independent practice. The AAMFT has approximately 24,000 members in the United States, Canada, and other countries. Currently, all 50 states and the District of Columbia recognize and license MFTs as independent mental health providers (for more information, visit www.aamft.org).

An estimated 48,000 marriage and family therapists are in practice throughout the United States and Canada, meaning that the remaining family therapists do not identify with AAMFT, but likely identify with related fields of psychology, social work, counseling, and so on. Some see marriage and family therapy as a separate profession; others see it as part of other mental health disciplines. Although the AAMFT as well as the International Family Therapy Association (IFTA; www.ifta-familytherapy.org) and the International Association of Marriage and Family Counselors (IAMFC; www.iamfconline.org) would see family therapy as a separate profession, other mental health disciplines (such as psychology and social work) may see family therapy as a professional specialty or an area of elective study within another mental health profession.

One can become an MFT in one of two ways. One is to obtain a master's or doctoral degree specifically in marriage and family therapy. The other is to earn a graduate degree in another mental health field and do postgraduate clinical training that provides clinical education in MFT. By whatever method a therapist becomes trained in family therapy, he or she must meet the training requirements to practice marriage and family therapy (or a related profession) established by his or her particular state. Generally, states require a minimum of a master's degree in a related field (marriage and family therapy, psychology, social work, counseling) and supervised experience practicing marriage and family therapy. A written exam is also required. See Appendix C to this chapter for advice on pursuing graduate education.

Therapists Receiving Therapy

For persons entering a helping profession, it is often helpful if not mandatory that they receive counseling for themselves. Some programs actually expect students to

receive therapy; others strongly recommend it. There are many benefits to counselor trainees receiving therapy:

- Increasing self-esteem.
- Understanding therapy from the client's perspective.
- In vivo learning of therapy techniques.
- Recognizing blind spots that may interfere with providing effective therapy for clients.
- Increased self-awareness, which enhances ability to intervene as a therapist.
- Becoming comfortable with the degree of interpersonal intensity required in therapy.
- Gaining an understanding of one's own needs so that they do not interfere with providing therapy to others.
- Understanding how and why one may react to certain clients or situations based on personal beliefs and values or certain issues that may cause reactivity in the trainee.

Finding a therapist is not always an easy task. The following strategies are recommended to find a therapist who fits your needs as a developing MFT:

- Discuss with other students and faculty whom they would recommend for personal growth counseling.
- Check to see whether your insurance covers psychotherapy; if it does, there may be requirements as to the type of therapist allowed. If you do not have insurance and cannot afford a private practice clinician, try community agencies with sliding fee scales. In addition, university campuses have counseling or psychological centers where therapy is provided free or at low cost to students.
- Upon contacting a therapist, ask the following questions:

    1. What are the therapist's training and qualifications? Ask specifically what type of degree and what type of license he or she holds. Ask whether he or she belongs to any professional organizations (APA, AAMFT, NASW, ACA). You may also ask whether he or she has ever been accused of any ethics code violations.
    2. What theoretical orientation does the therapist utilize? The therapist should be able to articulate the models or schools of therapy he or she utilizes.
    3. Ask about fees and payment policies.
    4. Discuss concerns about confidentiality. As a therapist in training, you will want to be especially careful to whom you divulge information.
    5. *Do not* use people with whom you may have future contact in the role of faculty or employer, if at all possible. You want to avoid any future multiple relationships that may make you feel uncomfortable. It would be difficult to be evaluated down the road by someone who knows your personal history.

6. Ask whether the therapist has seen other therapists before in his or her practice. Some therapists become "the therapist's therapist" and are the best sources to seek out. These practitioners have experience with providing therapy to therapists, and they understand the unique concerns that go with seeking therapy within your own profession.

In summary, some graduate programs require therapists in training to receive therapy; others do not. If a therapist in training is reluctant to obtain therapy, his or her reasons for the reluctance should be examined in the context of the supervisory relationship.

Professional Resources

Associations for Professional Therapists

The following associations oversee the practice of counseling and psychology–related professions. Each one has codes of ethics that members agree to abide by and that set standards for the profession.

American Association for Marriage and Family Therapy (AAMFT)
112 S. Alfred Street
Alexandria, VA 22314-3061
(703) 838-9808
www.aamft.org

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304-3300
(800) 347-6647
www.counseling.org

American Psychological Association
750 First Street NE
Washington, DC 20002-4242
(800) 374-2721; (202) 336-5500
www.apa.org

National Association of Social Workers
750 First Street, NE, Suite 700
Washington, DC 20002-4241
(202) 408-8600; (800) 638-8799
www.naswdc.org

Journals

The following is a list of journals that publish research, theory, or clinical practice information related to the field of marriage and family therapy.

The Journal of Marital and Family Therapy (the journal of AAMFT)
Family Process
Journal of Marriage and Family Counseling
Family Journal: Counseling and Therapy for Couples and Families
The American Journal of Family Therapy
Journal of Couples Therapy
Journal of Couple and Relationship Therapy
Journal of Divorce and Remarriage
The Journal of Family Psychotherapy (the journal of the International Family Therapy Association)
Journal of GLBT Family Studies
The Journal of Family Psychology
Journal of Family Violence
Contemporary Family Therapy
Journal of Marriage and the Family
Family Therapy
Journal of Systemic Therapies
Journal of Sex and Marital Therapy
Child and Family Behavior Therapy
Family Relations
Family, Systems, and Health
Family Systems Medicine
Family Therapy Case Studies
Journal of Feminist Family Therapy
Journal of Couples Therapy
Journal of Divorce and Remarriage
Journal of Family Issues
The Australian and New Zealand Journal of Family Therapy

Appendix A

AAMFT CODE OF ETHICS (EFFECTIVE JULY 1, 2012)

Code of Ethics
Effective July 1, 2012

Preamble

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 2012.

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories, all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

Principle I
Responsibility to Clients

Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1 Non-Discrimination. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

1.2 Informed Consent. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

1.3 Multiple Relationships. Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships

include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

1.4 Sexual Intimacy with Current Clients and Others. Sexual intimacy with current clients, or their spouses or partners is prohibited. Engaging in sexual intimacy with individuals who are known to be close relatives, guardians or significant others of current clients is prohibited.

1.5 Sexual Intimacy with Former Clients and Others. Sexual intimacy with former clients, their spouses or partners, or individuals who are known to be close relatives, guardians or significant others of clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. After the two years following the last professional contact or termination, in an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients, or their spouses or partners. If therapists engage in sexual intimacy with former clients, or their spouses or partners, more than two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client, or their spouse or partner.

1.6 Reports of Unethical Conduct. Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 No Furthering of Own Interests. Marriage and family therapists do not use their professional relationships with clients to further their own interests.

1.8 Client Autonomy in Decision Making. Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Relationship Beneficial to Client. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Referrals. Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

1.11 Non-Abandonment. Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.

1.12 Written Consent to Record. Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.

1.13 Relationships with Third Parties. Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third

party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

1.14 Electronic Therapy. Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronic therapy is appropriate for clients, taking into account the clients' intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with electronic therapy; (c) ensure the security of their communication medium; and (d) only commence electronic therapy after appropriate education, training, or supervised experience using the relevant technology.

Principle II Confidentiality

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Disclosing Limits of Confidentiality. Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Written Authorization to Release Client Information. Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

2.3 Confidentiality in Non-Clinical Activities. Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Subprinciple 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.4 Protection of Records. Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.5 Preparation for Practice Changes. In preparation for moving from the area, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

2.6 Confidentiality in Consultations. Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

2.7 Protection of Electronic Information. When using electronic methods for communication, billing, recordkeeping, or other elements of client care, marriage and family therapists ensure that their electronic data storage and communications are privacy protected consistent with all applicable law.

Principle III
Professional Competence and Integrity

Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, or supervised experience.

3.2 Knowledge of Regulatory Standards. Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

3.4 Conflicts of Interest. Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Veracity of Scholarship. Marriage and family therapists, as presenters, teachers, supervisors, consultants and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

3.6 Maintenance of Records. Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

3.7 Development of New Skills. While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their

work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.8 Harassment. Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Exploitation. Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.10 Gifts. Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

3.11 Scope of Competence. Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.12 Accurate Presentation of Findings. Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.

3.13 Public Statements. Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.14 Separation of Custody Evaluation from Therapy. To avoid a conflict of interest, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.

3.15 Professional Misconduct. Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

Principle IV
Responsibility to Students and Supervisees

Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Exploitation. Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Therapy with Students or Supervisees. Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Sexual Intimacy with Students or Supervisees. Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. If a supervisor engages in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.

4.4 Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Oversight of Supervisee Professionalism. Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Existing Relationship with Students or Supervisees. Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

4.7 Confidentiality with Supervisees. Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

Principle V
Responsibility to Research Participants

Investigators respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.

5.1 Protection of Research Participants. Investigators are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5.2 Informed Consent. Investigators requesting participant involvement in research inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate. Investigators are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children.

5.3 Right to Decline or Withdraw Participation. Investigators respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

5.4 Confidentiality of Research Data. Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

Principle VI
Responsibility to the Profession

Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

6.1 Conflicts Between Code and Organizational Policies. Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics,

marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

6.2 Publication Authorship. Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

6.3 Authorship of Student Work. Marriage and family therapists do not accept or require authorship credit for a publication based on research from a student's program, unless the therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on a student thesis, dissertation, or project should be determined in accordance with principles of fairness and justice.

6.4 Plagiarism. Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

6.5 Accuracy in Publication and Advertising. Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

6.6 Pro Bono. Marriage and family therapists participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

6.7 Advocacy. Marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest.

6.8 Public Participation. Marriage and family therapists encourage public participation in the design and delivery of professional services and in the regulation of practitioners.

Principle VII
Financial Arrangements

Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Financial Integrity. Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Disclosure of Financial Policies. Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related

to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

7.3 Notice of Payment Recovery Procedures. Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Truthful Representation of Services. Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

7.5 Bartering. Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.

7.6 Withholding Records for Non-Payment. Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

Principle VIII
Advertising

Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

8.1 Accurate Professional Representation. Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy.

8.2 Promotional Materials. Marriage and family therapists ensure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television, Internet, and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services and consistent with applicable law.

8.3 Professional Affiliations. Marriage and family therapists do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

8.4 Professional Identification. Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead,

Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

8.5 Educational Credentials. In representing their educational qualifications, marriage and family therapists list and claim as evidence only those earned degrees: (a) from institutions accredited by regional accreditation sources; (b) from institutions recognized by states or provinces that license or certify marriage and family therapists; or (c) from equivalent foreign institutions.

8.6 Correction of Misinformation. Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

8.7 Employee or Supervisee Qualifications. Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

8.8 Specialization. Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

Violations of this Code should be submitted in writing to the attention of:

AAMFT Ethics Committee
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808
Fax: (703) 838-9805
email: ethics@aamft.org

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Appendix B

EXAMPLE INFORMED CONSENT DOCUMENT

Ima Goodhelper, PhD

Licensed Marriage and Family Therapist (Indiana License #25802312A)
Center for Family Change
2415 Golden Street
Regionville, IN 55511
Telephone 888-442-1234, Fax 888-442-1235

Informed Consent for Treatment

I am very pleased that you have selected the Center for Family Change to meet your behavioral health care needs. This consent is designed to assist you in understanding your therapeutic experience with me.

Please read the following information carefully; if you have questions regarding the content, please ask your therapist for an explanation to your questions prior to signing the consent.

What Can I Expect from the Center for Family Change?

The therapy process is a partnership between us to work on areas of concern or dissatisfaction in your life and help you achieve your goals and improve your overall well-being. We will work together to identify goals you would like to accomplish in therapy. My goal is to help you define the choices, behaviors, and directions in life you wish to pursue, and then help you explore the steps to help you achieve them. My therapeutic approach will be discussed with you individually.

Is What I Say Going to Be Kept Confidential?

All information about clients is kept strictly confidential. In most cases, you must give written consent for the release of any information. There are, however, a few legal exceptions to my keeping therapy information confidential:

1. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members who can provide protection.

2. If you threaten physical violence against another party, and have both the means and intent to commit violence, I must disclose information in order to take protective action.
3. If I have reasonable cause to suspect child abuse or neglect or elder abuse or neglect, I am required to report this information to the proper authorities.
4. If a communication by you reveals the contemplation or commission of a crime or a serious harmful act, I must disclose this information if subpoenaed or as required by law.
5. If you file a lawsuit against me, I have the right to disclose relevant information in my defense.
6. If a judge orders release of therapy information, I am required to provide it, though I will attempt as best as I can to protect your confidentiality and legal right to privilege.
7. I may at times speak with professional colleagues about our work for supervision, consultation, or education; your identity will be disguised in these limited situations.
8. In the event of my death or incapacitation, Dr. Jason Britt, LMFT (phone 888-432-1234) is designated to review my files to contact my clients about my condition.

Individual confidences between family members are protected. I will discuss with you how these confidences will be handled to best benefit your situation. Any release of information to other family members will need to be approved by you, in writing.

What Is the Cost of Therapy, and What Does That Include?

The standard fee for your initial intake is $120; subsequent sessions are $100 per 50-minute hour. You are responsible for paying for your sessions at time of service unless prior arrangements have been made. In the event of non-payment, I reserve the right to use an attorney or collection agency to secure payment. If you do not cancel an appointment before 8:00 p.m. the day prior to your session, you will be charged half of your normal fee. In addition, on your first visit you will be charged an assessment fee of half of your normal fee. There is a $35 fee for any checks returned for non-sufficient funds.

What Are My Rights as a Client?

In addition to the right to confidentiality as outlined above, you have the right to ask questions about any therapeutic plan or procedure. You have the right to terminate therapy at any time. You have the right to have input into your treatment goals and treatment plan. As your therapist, I am expected to comply with the ethical code set by the American Association for Marriage and Family

Therapy. If you would like a copy of this code, you may ask me for a copy or access it at www.aamft.org. You have the right to ask about alternative or supplemental treatments to therapy. You have the right to fair treatment no matter what your race, religion, gender, ethnicity, age, disability, or sexual orientation.

What Are the Risks and Benefits of Attending Therapy?

Risks of therapy include that talking about unpleasant events, feelings, or thoughts can at times result in feelings such as anger, fear, sadness, and worry. As your therapist, I may challenge some of your assumptions or perceptions that may be causing you difficulty. Sometimes a decision that is viewed as positive for one family member is viewed quite negatively by another family member or may have other unintended consequences.

Therapy has been shown to provide benefits including relief of feelings of distress, symptomatic relief, increased life and/or relationship satisfaction, improved mood, improved communication, and increased personal awareness and insight. You may also learn stress management skills and problem solving. There are no guarantees that therapy will work for you. Therapy requires active effort from you. There are no guarantees that therapy will be effective.

Change will sometimes be easy and swift, but often it can be slow and frustrating. There is no guarantee that therapy will yield positive or intended results.

How Long Will I Be in Therapy?

Length of treatment varies, depending upon the nature of your problems, what your goals are, and the needs that may arise as therapy progresses. Therapy is normally scheduled once a week. If you are experiencing a crisis, more frequent visits may be arranged. Sessions typically last 50 minutes.

What Are My Responsibilities as a Client?

- You have the responsibility to keep your appointment or to provide at least 24 hours' notice in the event of a cancellation.
- You have the responsibility to pay your fees regularly.
- You have the responsibility to inform us if your personal information changes, such as address, phone number, insurance, medications.
- Openly question your therapist about your care, and discuss any concerns you have.
- You have the responsibility to be invested in your own change and to complete any "homework" agreed to in therapy.

Where Can I File an Official Complaint Against My Therapist?

While I hope that you discuss any differences with me so that we can work together toward a solution, you can file a complaint with the state of Indiana at the following address:

Behavioral Health and Human Services Licensing Board
402 West Washington Street, Room W-072
Indianapolis, IN 46204

If I'm Considered a Minor, or I Want Someone to Participate in Therapy Who Is a Minor, What Do I Need to Do?

Clients who are under 18 years of age and are not emancipated in Indiana must have written parental consent for treatment. Parents have the right to be involved in their minor child's treatment and to have access to his or her treatment file, session notes, and treatment plan.

How Do I Contact My Therapist?

Due to differing schedules, I may not be immediately available by phone. I will make every effort to return your call within 24 hours, excluding weekends, holidays, and closures.

In Case of Emergency

If you are experiencing a psychological emergency, you may use my emergency paging system by calling (888) 432-1248 and leaving your name and phone number and indicating that it is an emergency. If I am not available immediately and you need assistance, you may call the emergency crisis line at (888) 723–8123, or go to your nearest emergency room.

Agreement

I have read the above information fully and completely, I have discussed any questions I had about the information, and I understand the information. My signature below indicates that I freely give my informed consent for treatment at the Center for Family Change.

_______________________________ _______________

Client Signature Date

Appendix C

FIRST STEPS IN PURSUING GRADUATE EDUCATION—ADVICE TO STUDENTS

Those considering an occupation as a helping professional should start preparing for graduate school relatively early in their undergraduate career. Here are several things you should do if you haven't done them already.

1. *Explore the various areas of mental health that interest you.* Counseling, psychology, marriage and family therapy, social work—compare and contrast the professions while considering your career goals. Take an introductory overview class in the field or fields that interest you.

2. *Gain experience in working with people.* You may be able to understand more thoroughly how to guide your career if you discover your likes and dislikes, as well as your strengths and weaknesses, in working with people. Try to find jobs in which you are exposed to people, preferably jobs in mental health settings. If you cannot find a job, volunteer. Volunteer experience is invaluable and can be added to your developing professional résumé.

3. *Talk to professors and other professionals in the field you are considering entering.* Ask about their training, their job market, and their opinions on the various types of training available. Solicit any general advice they might have for someone wanting to pursue an education in a mental health field.

4. *Take courses in both statistics and research methods.* As a mental health professional, you will be expected to keep apprised of research. In order to provide the appropriate standard of care, you need to be familiar with the latest research findings regarding the problem you are treating. For example, if you are treating a child for enuresis, there may be a new, proven technique that works well for children with bed-wetting problems. If you are unable to grasp the details of journal-published research, you will be an ineffective practitioner. For your immediate career future, almost all graduate schools in the helping professions require these courses. Faculty in graduate programs look for students who understand and value research.

5. *Gain experience in research.* Volunteer to be a research assistant to your professors. This experience (a) provides valuable experience in the research process; (b) gives you a competitive edge for your application to graduate school; and (c) allows the professor to get to know you and your skills much more closely than he or she would be able to do in the classroom alone. A professor for whom you have served as a research assistant is a good person to ask to write a letter to support your application to graduate school.

6. *Begin to put a professional résumé together.* Tailor your volunteering, work, and collegiate experiences toward your career goal.

7. *Call or write for application packets from the graduate programs that interest you.* Look over the materials and apply to several. Do not choose just one graduate school to apply to; entrance to graduate schools can be quite competitive.

8. *Study for and take the Graduate Record Exam (GRE) early.* Most graduate programs have application deadlines long in advance of the start of classes, and you must have taken your GRE and sent your scores in to the graduate program to which you are applying before the application deadline. Waiting too long to take the GRE is a common mistake that may disqualify you from the application process. Your college counseling or career center should have applications for the GRE. Find out whether the graduate programs you are applying to require a subject test (e.g., psychology subject test). You will need to have your GRE scores sent directly from the testing organization to your colleges of interest.

9. *Get good grades.* Your grade point average is an important consideration in entrance into graduate school. If there was a period of time during which your grade point average wavered due to a personal crisis, but then you pulled your grades back up, explain your situation briefly in your application packet.

10. *Get to know your present professors and other professionals in the mental health field.* You will need letters of recommendation to get into graduate school. Three letters of recommendation are typically required (some colleges have required forms that must be filled out by the recommending source). Do not bother with recommendation letters from family, friends, or family friends, because letters from personal sources will be assumed to be biased. Stick to letters from professionals. Take the time to get to know your professors and let them know you, so that they will be able to write a detailed letter about you. When asking a professor to write a letter for you, give him or her plenty of lead time, then check to be sure he or she completed the letter prior to the application deadline. If the graduate school you are applying to requires three letters of recommendation and receives only two, your application will likely not be considered. Remember to thank your professor for the letter; it takes time to compose a good letter.

11. *If possible, visit the program prior to the application deadline.* This action shows an interest and investment in the program. Ask to meet with the program director. Tell him or her you are interested in applying and would like to come and learn more about the program. Bring along a list of questions you have regarding the training.

12. *If finances are in question, ask the graduate program about scholarships and graduate assistantships.* Many graduate programs offer graduate assistantships, in which you become a teaching assistant or research assistant. In exchange for your work, you receive a small monthly stipend and a tuition waiver. Some students choose to take out student loans during their graduate program.

Glossary

appropriate standard of care: How most professionals would treat a case under similar circumstances.

certification: State legislation that prohibits the use of a particular professional title without a certificate.

child abuse reporting laws: All states have some form of child abuse reporting laws requiring professional therapists (and sometimes laypersons as well) to report child abuse or neglect.

confidentiality: The ethical obligation of therapists to keep communications with clients strictly private, not privy to any outside parties.

duty to protect: The responsibility of the therapist to inform the intended victim(s) if a client threatens to harm a person or group of persons.

ethics: The study of what constitutes good and bad human conduct, including related actions and values.

identified patient: The person bearing the symptoms of a dysfunctional family (or couple) system.

informed consent: A document that informs clients about their rights and what to expect during therapeutic treatment.

licensure: This term refers to a state statute that prohibits the practice of a profession without a license from the state.

malpractice: Practicing in a way that causes injury to a client.

maneuverability: Ability to intervene effectively.

multiple relationship: Having a professional relationship with a client and also a personal, business, or intimate type of relationship with him or her.

privilege: Legal right to privacy owned by the client, typically regulated by state statute.

professional codes of ethics: Written codes of conduct set by professional organizations stating acceptable and unacceptable behaviors and standards for the discipline.

professional disclosure statement: A written statement introducing clients to the therapist's qualifications, the nature of the therapeutic process, and other important issues entailed in marital and family therapy.

secret policies: A written or verbal agreement with marital or family therapy clients on how information will be handled in therapy with respect to information shared individually with the therapist (separate from the other member of the couple or the other members of the family).

social constructivism: A philosophy that maintains that there is no objective reality.

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16

RESEARCH IN MARRIAGE AND FAMILY THERAPY

Richard J. Bischoff

> Couple and family therapy began with a belief . . . that "relationships matter." . . . We can now assert with considerable confidence that many CFT interventions frequently add value and that relationships do indeed matter when it comes to many interventions.
>
> —Douglas Sprenkle (2012)

In my undergraduate program in family studies, I had an instructor who during a class asked students to raise their hands if they disliked research, statistics, and math. Nearly every hand shot up amid chuckles of recognition. He then commented that this was just as he had expected, and that in his opinion this is one of the primary reasons students gravitate toward the social sciences, including marriage and family therapy. He explained that students of the social sciences succeed without analytical and research skills and without interest in either (a point with which I absolutely disagree!). I don't remember the specific reasons he gave for his comment, but the crux of it was that family studies and family therapy are driven more by informal theory than by formal theory and the results of research—the whole art of practice trumps the science of practice argument. As a faculty member in a family science/family therapy program now more than 25 years later, I have observed that not much has changed. Few of my students have a particular interest in research, and most profess a lack of analytic skill. This is true for both undergraduate and graduate students. Research methods and statistics courses are often dreaded and, in many cases, put off until they cannot be avoided any longer. It is as if students are secretly hoping that the program requirements will change so that these courses will be removed before they have to take them! I suspect that most of you reading this chapter are doing so begrudgingly.

In teaching graduate-level research courses, I have been struck by the level of anxiety that my family therapy students bring to the first few class sessions. Students' anxiety is almost palpable. I have actually structured my class to address this anxiety directly during the first few sessions, which seems to help—temporarily. The anxiety typically subsides, only to skyrocket again when we begin discussing statistics six to eight weeks into the semester.

Now, I would not say that aversion to math, statistics, and research is the reason that people choose family science and family therapy as major areas of study, but I do believe it is a factor. If we are doing it correctly, all of us gravitate toward areas of study and professions that capitalize on our natural strengths and skills, that are of most interest to us, and that do not excessively emphasize our weaknesses. Frankly, not everyone has the inclination to become a researcher or statistician. It may be that many people who do not have inclinations to become researchers or statisticians have natural skills for helping others with problems. This may be due to their ability to see people in context and to appreciate each person's uniqueness. It may be due to the value they place on natural intuition to help both themselves and others. It may be due to a host of other variables. Whatever the reason, quantifying behavior or conducting **observations** in ways that follow rules of **disciplined inquiry** often flies in the face of appreciating uniqueness and valuing intuition. Frankly, the characteristics of successful mental health treatment have perpetually been difficult to **operationalize** and **quantify**. Even when researchers are able to operationalize and quantify them, understanding them through the aggregation of data and the comparison of **means** and **standard deviations** can easily result in loss of meaning.

Consequently, many clinicians (and students) complain that research provides little to inform their clinical work. Many clinicians say that the laboratory nature of research—with its tight **controls** on **extraneous variables**—often does not reflect the real world of working with clients. Even empirically supported treatments are criticized because it is unrealistic to apply them to "real" clients in real-world settings. Even though the number of these treatments is growing, most therapists aren't even aware of their existence. The criticism is that treatments that are conducted as part of a study often are so tightly controlled that they cannot—and, in fact, should not—be duplicated in the real world of clinical practice (Hagemoser, 2009; Pinsof & Wynne, 2000). Client **inclusion criteria** are often so exclusive that they act to eliminate clients representing those typically seen by most clinicians.

To give a specific example, in an excellently designed (tightly controlled) study, Jose Szapocznik and his colleagues (Szapocznik et al., 1988) looked at the degree to which a structural-strategic-systems engagement (SSSE) strategy was an improvement over the engagement-as-usual (EAU) strategies when attempting to engage adolescent substance abusers and their families in treatment. The problem is an important one for study because adolescent substance abusers and their families are notorious for being difficult to engage in treatment.

The SSSE strategy the investigators developed is essentially one in which the therapist attempts to overcome each family member's resistance to participating in treatment prior to the first session. Using SSSE, joining, assessment, and restructuring begin at the first contact, which is typically the point at which the first request for treatment is made. For the purposes of the study, these investigators operationalized engagement as existing on six levels. At the lowest level, at the point of first contact (the first telephone call) an inquiry about the problem situation and an expression of polite concern is made by the therapist, and an appointment to meet with the family is set. This type of interaction represented EAU because it represented what would typically occur when a potential client calls to set up an appointment. Four higher levels of engagement were attempted, which grouped together were considered SSSE. SSSE interactions were ones in which the therapist assertively attempted to address or restructure the resistance of family members in order to engage them in treatment. For example, although rarely used, at the highest level, the therapist would visit the family home before the first session in the therapist's office to restructure the family members' resistance and thereby engage them in treatment.

Szapocznik and his colleagues found the SSSE condition to produce an impressive 93% engagement rate, while the EAU condition produced a dismal 42%. Also, of those engaged in treatment, those in the SSSE condition were much more likely to complete treatment than those in the EAU condition. These findings appear to have immediate clinical application. It would seem that any responsible therapist would immediately abandon the EAU practices and adopt engagement practices that have been shown to be more effective, not only in engaging clients in treatment but also in producing treatment outcomes! However, it isn't that simple. The application of these findings to clinical work is impractical for many clinicians. In order to implement an SSSE engagement strategy, a clinician would need to spend a significant amount of unreimbursable time in engaging client families. This is something that most clinicians and agencies are unwilling to do. The financial models for reimbursement don't support it. So, although the tight controls that eliminated error were important to finding the differences between the two types of engagement strategies, these same controls make the application of the findings impractical for many clinicians.

The Role of Research in the Practice of Marriage and Family Therapy

Despite the fact that very few clinicians report an interest in research, there is probably no more important time than now for marriage and family therapists to be active consumers and producers of both **quantitative** and **qualitative research**. Mental health care has unwittingly become caught up in the rapidly changing health care marketplace. Third-party payers, other professionals, governmental entities, and clients are increasingly demanding evidence to support claims of the

effectiveness of couple and family therapy. Although it has always been the ethical responsibility of those within the field to legitimate treatments through rigorous research methods (see Cavell & Snyder, 1991; Gurman, 1983; Liddle, 1991; Pinsof & Wynne, 1995b; Sprenkle & Bischoff, 1995), we now have additional motivation to conduct and use this research—our livelihoods depend on it.

It is the ethical responsibility of members of a profession to substantiate the effectiveness of the services being provided. This is especially important in the continually elusive mental health care field, in which standards for diagnosis and standard of care practices are difficult to determine. It is difficult to justify as ethical the provision of services for something as important as a person's mental and relationship health without **substantive evidence** as to its effectiveness. Yet the number of new, untested approaches to therapy continues to grow. Way back in 1987, Rollo May estimated that there were over 300 distinct models of therapy. There is every reason to believe that that number has continued to increase. This is an incredible number of approaches to psychotherapy, the majority of which have no **empirical** support to justify their use.

Research in marriage and family therapy is important to the field for a number of reasons (see Sprenkle & Bischoff, 1995). First, and probably most important, *research can improve the practice of couple and family therapy.* Research that targets the outcomes of couple and family therapy as it is used to treat specific problems in specific contexts will lead to better treatment planning and treatment decision making when it comes to finding the most effective treatment approach for specific situations and contexts. In 1967, Gordon Paul explained that psychotherapy research should be most concerned with attempting to determine which treatment works best for which clients under which treatment circumstances. As a field, we are getting closer to an answer to this question. In 2012, the *Journal of Marital and Family Therapy* published a special issue containing 12 articles summarizing what we know from the research about the outcomes of couple and family therapy. Doug Sprenkle (2012), the editor of the special issue, concluded that we now have a critical mass of research suggesting that we know many problem areas and populations for which couple and family therapy works, and even for which it is the treatment of choice. Of course, outcome research, especially that which attempts to determine the **efficacy** of a treatment, is fraught with problems that limit **generalizability**. Yet we can learn much from this research to inform our decision making in treatment.

For example, in a well-designed outcome study of the use of family therapy in the treatment of eating disorders, the investigators (Dare, Eisler, Russell, & Szmukler, 1990) found that their modified structural family therapy approach was superior to individual therapy when the age of onset of the eating disorder (anorexia nervosa) was younger than 18 years. However, they also found that individual therapy was superior to family therapy when the age of onset was older than 18 years. These findings have important implications for treatment planning when working with eating-disordered clients and their families, regardless of the theoretical model being used to guide treatment.

Research that investigates the **process of therapy** (what happens during therapy that produces change and that leads to an outcome) can help clinicians understand how change takes place given certain conditions or problems and the role of the therapist in facilitating those changes. As we better understand the process by which therapeutic change takes place, therapy can become more efficient, thus improving both the delivery of therapeutic services and client outcomes. Also, as we learn more about the various factors that account for variation in treatment outcomes, we can attempt to use these factors in a way that improves treatment outcomes.

Second, *research can add legitimacy to the field of family therapy with other mental health clinicians.* Marriage and family therapy is the new kid on the mental health care scene. Psychiatry, social work, and psychology have been around for 50 to 70 years longer than family therapy as a profession. Many professionals in other mental health fields consider couple and family therapy as a subspecialty of their own professions, and definitely not one that warrants the status of legitimate profession. Cleveland Shields and his colleagues (Shields, Wynne, McDaniel, & Gawinski, 1994) have identified marriage and family therapy as a marginalized mental health profession. Although there are advantages to being on the margins (e.g., flexibility to creatively develop treatments), there are also disadvantages—the primary one being the lack of legitimacy afforded by our peers in other mental health disciplines. These authors have cautioned that until the clinical effectiveness of the approach is legitimated through scientific means, the field will continue to be marginalized in the professional community.

Third, *research can provide evidence to the larger mental health community that family therapy is a treatment of choice for many mental health problems.* Third-party payer and managed care companies are increasingly reluctant to pay for treatments that do not have "proven effectiveness," and the evidence these entities are looking for comes from research.

Fourth, *research can legitimate family therapy with the public at large.* Because of the newness of the field of marriage and family therapy, consumers of mental health care generally do not know about the role of marriage and family therapy in the treatment of mental health problems. In general, when average consumers of mental health care consider finding a therapist, they think of either a psychologist or a psychiatrist. This is true even for those with relationship problems such as marital conflict or family problems. The term *psychologist* has become synonymous with the term *therapist* for many people, including many mental health professionals.

Although as a marriage and family therapist I have known this for some time, it became even more clear to me when I examined the results of a study that I coauthored. In this study, conducted to determine how therapists are presented in the movies (Bischoff & Reiter, 1999), we examined over a 10-year period of time 66 movies that presented therapists and therapy. Of the 99 therapists presented in these movies, only four had a professional identification as a marriage

therapist, couple therapist, family therapist, marriage and family therapist, or marriage, family, and child counselor. Yet, there were many more instances of therapists providing marital or couple therapy or working with families.

Marriage and family therapy research will increase the visibility of the field and profession with consumers of marriage and family therapy. Research into the utility of marriage and family therapy for treating relationship problems and mental health concerns, and into the impact of relationship function on mental and physical health and well-being, will improve the legitimacy of the field and profession for the treatment of serious mental health problems.

The Evolution of Research Within the Field of Marriage and Family Therapy

That research is an enigma for marriage and family therapists is especially interesting given that the practice of couple and family therapy actually originated from the research efforts of its founders (e.g., Broderick & Schrader, 1981; Nichols & Schwartz, 1998; Sprenkle & Bischoff, 1995; Wynne, 1983). Murray Bowen, Lyman Wynne, Theodore Lidz, the members of the Mental Research Institute (MRI) group, and other founders of family therapy developed their models of family therapy as a result of their attempts to understand problem families through research. Through their research on schizophrenia and other serious adult pathologies, these early researchers began to recognize the influence of family communication and other family interactions on the exacerbation of symptoms. As these researchers began to understand the influence of the family on individual functioning, they began to experiment with family intervention in an attempt to alleviate pathology. It worked! They found that as they mobilized the family differently, the symptoms of pathology lessened. So, through basic research efforts they developed models of intervention that could later be tested for effectiveness (through applied research).

Miklowitz and Hooley (1998) have identified this as the ideal process for conducting modern clinical research: The results of basic research lead to the development of interventions and/or treatment manuals that are then tested. However, the research efforts of today do not really resemble the research efforts of the founders of family therapy (Wynne, 1983). According to Lyman Wynne (1983), in the early days of family therapy there was little distinction between the researcher and the clinician. In fact, both the research interview and the clinical interview were designed to intervene in the family pathology, and both were designed to provide data for the development and refinement of clinical theory. Researchers/clinicians would meet with subjects or patients and their families, interviewing them as others observed through one-way mirrors, or the session would be audio- or videotaped and listened to or watched afterward. Researchers/clinicians would then get together to discuss "each session, formulating **hypotheses** and criticizing the hypotheses for many, many hours" (Wynne,

1983, p. 114; emphasis added). This sounds more like an intensive clinical training experience than it does the research of today. Current research, including qualitative research, is truly a disciplined inquiry: Observations are carefully planned and recorded and follow strict guidelines that ensure confidence in the results of these observations. While different from the early research effort of the founders of family therapy, this blending of research and clinical work in the early days of family therapy provided a foundation for the growth of the field.

Fortunately, the research of today has become much more sophisticated and rigorous. Elusive **constructs** have been operationalized in ways that allow them to actually be measured. Measures have been developed and tested to determine their **psychometric qualities**. We now have measures of very complex constructs that show **reliability** (showing consistent results across time and situation) and **validity** (i.e., we are actually measuring what we think we are measuring). Studies are now designed to eliminate **competing explanations** to the results. **Programmatic research** has been conducted that allows for the results from sequential studies to build upon one another. This increased sophistication has allowed researchers to place greater confidence in their results. We know more now about what makes therapy work and the effectiveness of therapy than we would have ever known with the research methods of the past. In fact, many of the claims forwarded by these early researchers have been discounted or at least tempered as a result of later research efforts.

The Research-Practice Gap

Unfortunately, however, the increased sophistication of research methods today have distanced research efforts from clinical work to the point that many clinicians now avoid research findings, saying that they have little bearing on their clinical work (Cohen, Sargent, & Sechrest, 1986; Stewart & Chambless, 2007). One study of clinicians' attitudes toward research found that less than 14% said they use research findings to inform their clinical work[1] (Morrow-Bradley & Elliott, 1986). While this study was published in 1986, there is nothing to suggest that this attitude is changing, even though there is greater attention being given to research and empirically supported treatments and practices. Clinicians often say that research is too reductionistic to be helpful clinically (Hagemoser, 2009) and that the presentation of **clinical case studies** (Cohen et al., 1986; Jacobson, 1985a; Kaye, 1990) and their own experience as clinicians is more helpful than is research (Atkinson, Heath, & Chenail, 1991; Morrow-Bradley & Elliott, 1986; Stewart & Chambless, 2007). This is supported by Mahrer's (1988) observation that the charisma of the proponents of the approach to therapy, its fit with the personality of the therapist, and the therapist's intuition and life experience are more important in determining which approach to treatment will be used than research is (see also Stewart & Chambless, 2007). Given that this unscientific approach to treatment selection is normative, it is surprising that

therapy is as successful as it is. Or, should we be surprised at all? It may be that the specific approach to treatment is not nearly as important as other factors in determining treatment success (Sprenkle, Davis, & Lebow, 2009).

In fact, attempts to compare models of therapy have been fraught with difficulty, and many prominent researchers have encouraged the field to move away from such efforts (e.g., Jacobson, 1985b). Studies comparing one model of therapy against another typically do little more than polarize those working within the field. Like it or not, therapists are not going to adopt a new approach to therapy just because research says their favored one is not the best (Stewart & Chambless, 2007). No study of this type is ever so rigorously designed that reasonable competing explanations do not exist. You can be assured that therapists who have adopted the therapy that "lost" or that does not have research support will be quick to point out the deficiencies in that research. This type of research has done nothing to improve the services provided to clients.

Take for example the study by Douglas Snyder and Robert Wills (1989) comparing insight-oriented marital therapy with behavioral marital therapy. Snyder and Wills found fairly convincingly that insight-oriented marital therapy produced better outcomes than did behavioral marital therapy. Neil Jacobson (1991b) published a paper critiquing the Snyder and Wills study and defending behavioral marital therapy. His contention was that Snyder and Wills misrepresented behavioral marital therapy by eliminating essential aspects of this approach from their treatment manual. In addition, he contended that Snyder and Wills, as insight-oriented therapists, could not adequately train the insight-oriented therapists used in the study to fully or correctly implement behavioral therapies. This article was followed by a lively debate on behavioral marital therapy and on the value of comparing approaches to marital therapy by researchers throughout the field (Baucom & Epstein, 1991; Gurman, 1991; Jacobson, 1991a; Johnson & Greenberg, 1991; Markman, 1991; Snyder & Wills, 1991).

This debate was beneficial in several ways. First, it identified as futile the efforts of researchers to compare models of therapy with the intention of proving one therapy superior to another. These attempts are counterproductive to improving treatment outcomes. Therapists are not going to abandon their beloved approaches to treatment just because research suggests that another approach produces better results than the one they are accustomed to using. This debate also reinforced the idea that psychotherapy research cannot be free of confounding variables. Although Snyder and Wills designed a fairly well-controlled study, it did not sufficiently control for error to protect the integrity of both approaches to treatment. That is to say, behavioral therapists should research behavioral therapies, and insight-oriented therapists should research insight-oriented therapies. Intraschool studies of therapeutic approaches are the best-known way of assuring that the therapies are being represented fairly.

Comparative research studies are especially counterproductive now that **cooperative research** efforts to enhance the general delivery of services are

most needed. Cooperative research may be more appropriate anyway, given the burgeoning evidence that there are more similarities across therapies with successful outcomes than there are differences.

Attempts to Address the Research-Practice Gap

The practice gap between research and clinical work is of such serious concern for those within the field that numerous articles have been written in an attempt to address it. Meetings, conferences, and special caucuses as well have been sponsored by the National Institute of Mental Health, the American Association for Marriage and Family Therapy, the American Psychological Association, and other professional organizations in an attempt to overcome this gap. However, it still exists.

This is not to say that research is not occurring. It is, and researchers are generating research results at a very rapid pace. The number of excellently designed studies is growing exponentially, spurred on by advances in **research design** and **analytic methodology** that have expanded the types of questions that can be asked through research. The expected result of these advances is that research will become increasingly more applicable to clinical practice.

In general, researchers who are also clinicians acknowledge the gap. The cynical part of me believes that this acknowledgment comes from their frustration in seeing that their great research efforts are not being used in clinical practice. So, as is true for most problems, those most interested in seeing the problem resolved are the first to offer solutions to its resolution (and yet by virtue of being the ones most interested, they are precisely those with the least relational power to effect the change). It is not surprising that suggestions from these researcher-clinicians have included socializing clinicians in graduate training programs to research, redesigning graduate curricula to emphasize research, modeling the use of research to inform clinical work, and standing on the proverbial soapbox to call for clinicians to use research more.

Complicating this problem within the profession of marriage and family therapy is the fact that most of the most prominent researchers within the field identify primarily with psychiatry, psychology, or social work rather than marriage and family therapy (Hawley, Bailey, & Pennick, 2000; Sprenkle, 2012). In fact, the most prominent researchers in the field are psychologists who publish in psychology journals as much as or more than in family therapy journals. It is also important to note that although the research literature on couple and family therapy is becoming quite large, most of this research is separated into research about couple therapy and research about family therapy or family-based interventions (Alexander, Holtzworth-Munroe, & Jameson, 1994). Research studying the effectiveness of marriage and family therapy (as an integrated treatment approach) is rare. This is probably because most researchers consider couple therapy to be significantly different from family therapy and a subspecialization to one of the other mental health disciplines.

This has several implications (only two of which will be mentioned). First, couple and family therapy research is not research on the profession of marriage and family therapy; it is research on the practice of couple and family therapy. Second, marriage and family therapists who want to be up to date on the research must keep up with the research published in psychology and social work journals as well as in family therapy journals if they hope to not become marginalized (Liddle, 1991; Shields et al., 1994). This is a daunting task, and one that is filled with a large number of barriers to its accomplishment. I believe this maintains the gap between research and practice—not because of clinicians' disinterest in research, but because of the inaccessibility of this information to those whose primary affiliation is marriage and family therapy.[2]

Three advances hold the most promise for bridging the practice-research gap. First, there has been a call to move away from the tightly controlled studies of the efficacy of psychotherapy to the study of the *effectiveness* of psychotherapy (Pinsof & Wynne, 2000). Second, there has been a trend toward the more frequent use of qualitative methodologies in studies of marriage and family therapy (Moon, Dillon, & Sprenkle, 1990). Third, there is a growing emphasis on generating empirical support for the role of the factors common to all treatment approaches that contribute to treatment outcomes (Sprenkle et al., 2009).

Movement Toward Effectiveness Studies

Efficacy studies are those that have tight controls on extraneous variables that might influence the results. These studies typically have a carefully designed **treatment manual** and a **no-treatment control group**. These studies are designed to determine whether a particular type of psychotherapy is more effective than no treatment or another type of treatment. Efficacy studies are as close to a laboratory setting as we can get in the study of mental health treatment.

The problem with efficacy studies is that by virtue of their exceedingly tight designs, the results are often of little relevance to the real-life practice of psychotherapy. This is not to say that efficacy studies are not important; they are. It is through efficacy studies that we know that treatment is better than no treatment for most mental health and relationship problems.

Effectiveness studies are those that evaluate the real world of clinical practice. Instead of having tight controls that limit participation in the study to certain clients meeting certain criteria, and restrictions on how the model of therapy can be implemented, these studies investigate the real world of clinical practice, as messy as it is. The result of wider use of this type of studies will be that the results will be more applicable to the practitioner.

The Increased Use of Qualitative Methodology

In 1990, Sidney Moon and her colleagues published an article in the *Journal of Marital and Family Therapy* (*JMFT*) advocating for the increased use of qualitative

methods in family therapy research. Each of the mental health disciplines had seen a growing interest in the use of qualitative research prior to 1990, but this article seemed to punctuate and legitimize the trend in the field of marriage and family therapy. Through this paper, Moon, Dillon, and Sprenkle (1990) argued that the increased use of qualitative methods could in fact facilitate the use of research findings in clinical work. They explained that qualitative methods are similar to clinical interviewing and discovery as it occurs in the context of therapy. In both clinical interviewing and most qualitative research, the richness of individual experience is preserved in context and is valued over gross generalizations and group averages. This, they reasoned, would appeal to clinicians and facilitate the use of research findings to inform clinical work. Although it is unclear whether the increased use of qualitative research has resulted in a lessening of the research-practice gap, I can speak from my own experience—as the director of a marriage and family therapy training program—that most master's-level students appear to be more attracted to qualitative methods in completing their thesis requirements than they are to quantitative methods. This is true even when students are given the option of conducting less time-consuming quantitative investigations within the same area of interest. My students generally explain that they want to produce a thesis that has practical applicability, and they find it difficult to see how quantitative investigations could have the same practical applicability as qualitative investigations.

What Is Research?

After discussing the contemporary context of marriage and family therapy research, and before progressing any further in this discussion, it is important to clarify what is considered research in the field of marriage and family therapy. Despite all the talk about statistics, experiments, surveys, sampling, and scientific methods, research is really no more than disciplined inquiry—or, in other words, the use of systematic, **replicable procedures** for obtaining and evaluating information. Although I admit that "research" (and even more so the synonymous term "science") can be intimidating, when you realize that research really is nothing more than using **systematic procedures** in trying to understand the world, it becomes less scary. To a certain extent, most everyone reading this book is a researcher, because nearly everyone, at one time or another, has used systematic procedures for obtaining information. More important, nearly everyone can become a researcher, whether the results of their findings are published or not.

In order to understand research, however, you must realize that it is not the only way of knowing about the world. In his introductory research text, Earl Babbie (2013) explained that a number of commonly used ways of knowing about the world cannot be classified as research. He calls these ways of knowing **natural human inquiry (NHI)** and notes that each of them is prone to producing errors in knowing, primarily because the pursuit of knowledge through each of them is not disciplined. The purpose of research is to arrive at knowledge by overcoming the errors associated with undisciplined inquiry.

Because NHI is such a popular way of learning about the world—and of learning how to do therapy—I will review some of the most popular forms of NHI (see Babbie [2013] for an expanded discussion). My personal favorite form of natural human inquiry—and, I think, a favorite of many of my colleagues—is **personal experience**. Through personal experience, one learns about the world firsthand, through trial and error. There is no mistaking the power of this kind of knowledge! Everyone has had experience with this type of learning and, if you are like me, some of these experiences are very good, while others are so bad that you hope to never repeat them. The problem with this type of learning is that you often *do* repeat experiences, or you come to a mistaken conclusion about what you have learned. So you end up learning the same thing over and over again, with slight variations in experience each time. Another problem with this type of learning is that you never know how transferable it is to other people in other situations. Knowledge obtained in this way is yours and yours only, no matter how much in error your conclusions are. Learning through personal experience is a popular method of knowing used by mental health clinicians. Much of what clinicians know about how to conduct therapy comes from their experience of conducting therapy (Cohen et al., 1986; Morrow-Bradley & Elliott, 1986). Therapists even gravitate toward therapies or approaches to therapy that fit with their personal experience in relationships and with the world—more so than through research findings (Mahrer, 1988).

Tradition is another popular way of knowing about the world, both in and outside of the world of therapy. Tradition is often knowledge that is assumed to be known by everyone because it has been passed down for generations. The problem is that it is *not* known by everyone, even by those who should be in the know. It is through tradition that I conduct therapy as I was taught in my graduate program, whether that approach to treatment is based on evidence of helpfulness or not. It is through tradition (and convenience) that I conduct therapy in 50-minute increments. However, the problem with tradition is that it often prevents us from exploring new possibilities and from seeing the obvious.

To obtain knowledge through **authority** is possibly a variation on obtaining knowledge through tradition, but can be distinguished in two important ways. First, knowledge obtained through authority is obtained through people who we believe have special knowledge (whether this is true or not) because of their positions of power. Because we see them as authorities, the information they give us carries more weight and we tend to believe it more. Second, knowledge obtained from authorities is typically overt and available to us in the conscious mind. However, information gained through tradition is typically passed to us through covert means and is often not readily available in the conscious mind (many have had the experience of someone questioning why they do something the way they are currently doing it and have become stupefied and can respond only with a "because that's how it's always been done"). This isn't necessarily a bad way of knowing (researchers are often seen as authority figures!), but errors

in knowing occur when authority figures speak outside their area of expertise or provide information that has little factual support. Politicians, doctors, lawyers, teachers, clergy, parents, and even therapists are examples of authority figures who have great power to influence people in Western societies.

Research, or science, attempts to overcome the deficits of obtaining knowledge through natural human inquiry by subjecting the search for knowledge to principles of disciplined inquiry. Procedures are followed in asking questions and in obtaining data in such a way that error and bias are eliminated. This is really not too different from what happens in good clinical interviewing (Atkinson et al., 1991). The clinician obtains information through a variety of well-designed questions, tasks, or instruments—from a variety of sources that have been planned in advance to elicit certain information.

Types of Marriage and Family Therapy Research

Research in marriage and family therapy is not homogeneous. It takes many different forms, has a variety of purposes, and uses a large number of strategies. To understand marriage and family therapy research, you must understand the different varieties.

Basic and Applied Research

Basic research is carried out when a researcher wants to generate knowledge about something, whereas **applied research** is carried out when a researcher wants to find solutions to problems or wants to intervene (Ellis, 1994). For example, a researcher who is interested in understanding marital affairs might engage in basic research to attempt to identify the degree to which various factors are associated with the occurrence of affairs. The researcher may attempt to determine whether factors such as gender, years married, number of children, type of employment, religiosity, permissiveness, and marital satisfaction are associated with the occurrence of affairs. To use a clinical example of basic research, a researcher may be interested in the degree to which a particular population, such as Mexican Americans, has access to mental health care. Although both of these research areas may have clinical applicability, they are not applied research.

Using applied research, the researcher would attempt to determine the best way of intervening to help couples whose relationships are distressed by an affair, or would attempt to determine how access to mental health care can be improved. Applied research typically follows basic research. As researchers gain a greater understanding for the phenomenon they are studying, they are able to develop interventions designed to address the problems being studied (Miklowitz & Hooley, 1998). However, basic and applied research efforts are not necessarily mutually exclusive endeavors. In fact, a single study may have both basic and applied aspects.

Although it has been generally presumed that the sine qua non of applied research has been the **clinical trial** (developing an intervention or treatment program, implementing it under strict controls, and then evaluating its success), there is significant criticism about this approach to research. In fact, prominent researchers within the field have even criticized this type of research as not clinically applicable (Pinsof & Wynne, 2000; see also Sprenkle, 2012). Pinsof and Wynne explain that we should be concerned about two types of applied research. The first, efficacy research, follows strict experimental design principles. The basic question being asked through efficacy research is whether the treatment in question is better than no treatment at all. In general, the answer is a resounding "yes" for nearly every type of therapy studied and for every type of problem studied. Although this information is important, it falls short of being clinically helpful and it really confirms only what is already presumed by nearly every mental health clinician, regardless of discipline or treatment approach. The primary problem with efficacy research is that to ensure that alternative explanations for findings are ruled out, the therapy being evaluated becomes sterile and does not look like the therapy as it would be applied in the real world.

This is where the second type of applied research, effectiveness research, can step in. Through effectiveness research, researchers evaluate the effectiveness of therapy as it is actually conducted in the messy, real world of clinical practice. The drawback to this type of research is that confounding variables abound. It can be unclear whether it was actually the treatment that made the difference or some other variable, such as the exceptional skill of the therapist implementing the treatment or the good advice the client got from his or her hairdresser. The advantage to effectiveness research is that it is actually a test of therapy as it is conducted in the nonlaboratory world of clinical practice and so has immediate relevancy to clinical work.

Qualitative, Quantitative, and Mixed Methods Research

If the strategies used to develop the first systematic approaches to couple and family therapy could be characterized as research, they would be best characterized as applied qualitative research. While many say that these first approaches to couple and family therapy were developed through research, the qualitative research strategies used did not really meet the standards that characterize rigorous research methods (Wynne, 1983). These early researchers used loosely defined qualitative research strategies with very little concern for controlling for **investigator bias**. This resulted in findings that can best be considered impressionistic, but that nonetheless resulted in the development of the early models of couple and family therapy.

Probably in reaction to the mildly disciplined research of the founders of family therapy and the resulting claims of universal success of their approaches to treatment, researchers attempted to adopt more "scientific" principles in the evaluation of therapies and the study of clinically related material. So, as the

mental health field developed and the profession of marriage and family therapy emerged, research became more experimental and, consequently, almost exclusively quantitative in nature. During this period, a large number of outcome studies were conducted. Most of these compared one couple or family treatment to another or compared a couple or family treatment to an individual psychotherapy or no treatment. As this transformation in research emphasis became more pronounced, clinicians began to lament that research was no longer applicable to their clinical work. They began to turn away from the exclusive reliance on quantitative methods and to re-explore the value of qualitative methodologies.

Beginning in the mid-1980s, qualitative methods increased in sophistication, resulting in greater acceptability of these methods among couple and family therapy researchers (Sprenkle & Moon, 1996). Until the early 1990s, it was difficult if not impossible to find an article based on qualitative research in the leading marriage and family therapy journals. The publication of these studies stimulated a very public debate of the role of both qualitative and quantitative methods (Atkinson et al., 1991; Cavell & Snyder, 1991; Moon, Dillon, & Sprenkle, 1991), which appeared to open the minds of journal editors to accept these papers describing the results of qualitative investigations and to stimulate researchers to adopt more rigorous qualitative methodologies in conducting these studies.

Because qualitative research has the potential of preserving the richness of lived experience, many welcomed this valuing of qualitative research as a bridge between research findings and clinical work. But, this usually meant that researchers would specialize in either qualitative or quantitative methods, resulting in a gap among researchers as wide as the researcher-clinician gap! Fortunately, the current trend is toward an appreciation of the unique contributions of both quantitative and qualitative research and a blending of both quantitative and qualitative methods within the same study (Gambrel & Butler, 2013). This is referred to as "mixed methods research."

To appreciate the debate and the significance of the trend toward mixed methods research, you must understand that qualitative and quantitative research are led by different types of research questions, methods, and purposes, resulting in different knowledge.

Quantitative investigations are deductive in nature (the theory or hypothesis drives the collection of data and how the data are interpreted) (Sprenkle & Bischoff, 1995); in essence, "quantitative research aims for rigorous scientific empiricism by counting, comparing, measuring, and subjecting data to statistical analysis" (p. 543). Prior to conducting a quantitative investigation, the researcher articulates questions and hypotheses, and then designs the study to specifically answer the question being asked. Strict controls are built into the study to limit the effect of the investigator and to limit the degree to which alternative explanations for the results are possible. To control for bias and alternative explanations, variables are well defined beforehand and are reduced to their simplest forms so as to eliminate complexity. Because generalizability of results to a broader

population is often the goal, **sampling theory** is often used to guide the identification and recruitment of subjects from whom data will be collected.

Qualitative investigations are inductive (the theory or explanation emerges from the data itself). Using qualitative methods, researchers try not to limit or place restrictive controls on the data or data collection, with the hope that this openness will lead to previously undiscovered knowledge. Qualitative investigations tend to be exploratory in nature and recognize the influence of the investigator on the data being collected. Investigator bias is addressed through the identification and articulation of the sources of bias and through the use of multiple data collection methods and data sources (a quality control measure called **triangulation)** and **time in the field** (the amount of time the investigator spends with the **participants** [subjects] or with the data). Data are analyzed using narrative analytic strategies that facilitate theory development and that preserve the richness of the data in the results.

To make a gross generalization (meaning that there are exceptions), quantitative investigations focus on the verification of knowledge, whereas qualitative investigations focus on the discovery of knowledge. Quantitative investigations focus on the elimination of alternative explanations, whereas qualitative investigations attempt to facilitate the discovery of alternative explanations, if they exist. Quantitative investigations focus on reducing data to something that can be counted and numerically compared, whereas qualitative investigations focus on the narrative nature of the data and the context from which the data come. Quantitative investigations are designed so that results will be generalizable to the larger population, whereas qualitative investigations are designed so that the uniqueness of this set of subjects is emphasized.

Outcome and Process Research

Clinical research can be described in terms of outcome and process. **Outcome research** is designed to determine the results of a course of therapy generally or of an intervention or set of interventions specifically. For example, a researcher may attempt to determine the long-term or short-term outcomes as a result of a particular treatment. Those engaged in outcome research are often interested in the degree to which change has taken place, the degree to which change is sustained over time, the degree to which the intervention impacts other aspects of functioning, and the degree to which the treatment produced better results than another treatment (or no treatment).

Process research is designed to determine what happens during therapy. For example, determining changes in client resistance throughout the course of therapy would be an example of process research. Those engaged in process research are often interested in moment-by-moment changes in clients' experience of treatment, the interaction between therapist and client or among family members, or the processes involved in change.

Although the earliest family therapy research was concerned with the process dimensions of therapy, including how families interacted with one another and the way in which intervention into the family took place, as family therapy developed, researchers quickly began concentrating more on the outcomes of treatment. The most prominent research of the 1970s and early 1980s tended to be outcome-oriented research. However, beginning in the 1980s—probably due to the increased sophistication of research and the realization that significant differences among therapies were hard to find—researchers began to return to the study of the process of therapy. At this time, publications of studies on moment-by-moment in-session changes, clients' experience of therapy, and the nature of intervention began to appear. This resurgence in interest in the process of therapy within the context of the proliferation of outcome studies led to what Alan Gurman and his colleagues called "the new process perspective" (Gurman, Kniskern, & Pinsof, 1986). Through this perspective, researchers will often not conduct an exclusively process or outcome study, but will integrate both process and outcome indices within the same study. To do this, researchers focus on **incremental outcomes** within the context of therapy that lead up to the overall outcome of treatment. In this way, researchers are able to understand the incremental processes of change that occur within the course of treatment as well as the incremental outcomes associated with specific interventions. Two examples of this new process perspective will help you understand the value of integrating process and outcome research.

Gerald Patterson and his colleagues at the Oregon Social Learning Center (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Patterson & Chamberlain, 1988; Patterson & Forgatch, 1985) examined the relationship between therapist interventions and client resistance. These investigators developed a measure for evaluating client resistance on an incident-by-incident basis at the beginning, middle, and end phases of treatment. They also developed a measure of moment-by-moment therapist techniques that could be grouped into categories of support, confront, and teach. They measured both therapist use of technique at the various stages of therapy and the associated client expression of resistance. They found client resistance to be at its lowest at the beginning and ending phases of treatment and highest in the middle phase. The middle phase of treatment was also the time when therapists were more likely to engage in teach and confront interventions. Poorer outcomes (e.g., dropping out of treatment) were associated with a higher proportion of teach and confront techniques in the beginning phase of treatment (and consequently with more resistance at the beginning phase as well). This research has immediate treatment implications.

Leslie Greenberg and Susan Johnson refined their approach to couple therapy, called emotionally focused couple therapy (EFCT), through the implementation of an integrated process and outcome research approach (Greenberg, Ford, Alden, & Johnson, 1993; Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988). These researchers studied specific events and occurrences in therapy in which,

according to theory, they expected change to occur. They found that EFCT promotes more **affiliative behaviors** in couples during the later stages of treatment, that experiencing underlying emotions is positively associated with conflict resolution, and that one partner's **intimate self-disclosure** is positively associated with affiliative responsiveness in the other. They also found that clients identified the **critical incidents** of successful therapy to be expressing underlying emotions, understanding one's own experience of the relationship, taking responsibility for one's own experience, and having experience and emotion validated by one's partner. The result of this research is a refined approach to couple therapy that emphasizes empirically validated treatment processes for successful outcomes.

What Does the Research Literature Say?

The state of the art of couple and family therapy intervention research concerns the outcomes of couple or family therapy in the treatment of specific problem areas (Gurman et al., 1986; Piercy & Sprenkle, 1990; Sprenkle, 2012; Sprenkle & Bischoff, 1995). However, most of the studies conducted to determine the effectiveness of couple and family therapy have used a very small number of the hundreds of therapies that exist. The reason for this is quite practical. To study the effectiveness of a therapy on a specific problem area, the outcomes of the therapy must be able to be operationalized. In other words, to conduct an outcome study, it must be possible to measure change in some way. Pragmatically, this means that therapies that are primarily focused on behavioral change are more amenable to empirical study. Probably more important, therapists who espouse such therapies are more likely to ask questions about the effectiveness of their therapies that are more likely to be able to be operationalized.

Therefore, in the field of marriage and family therapy, behavioral, structural, and strategic therapies or therapies that have ties to these models of treatment are more likely to be those used in studies of the effectiveness of marriage and family therapy. Therapies that are focused on producing growth or change, which is difficult to operationalize, have only rarely been subjected to empirical investigation. For example, therapies that are narrative, experiential, or transgenerational in nature have rarely been used when evaluating family therapy outcomes. I suspect there are two primary reasons that these therapies are underrepresented in the research literature: first, their desired outcomes are difficult to operationalize and measure. For example, how do you measure the authoring of a new story or detriangulation? Second, advocates of these therapies often criticize traditional research methods (Gurman et al., 1986) as reductionistic, arbitrary, and not useful to the real world of clinical practice (e.g., Griffith & Griffith, 1990; Kaye, 1990; Tomm, 1983). When studies of these more **aesthetic therapies** (Keeney & Sprenkle, 1983) are conducted, they tend not to be published in refereed journals. When they are published, they are often found in more obscure journals with a limited readership or in books that are not held to the standards of objective peer review.

It would be a mistake to assume that this means aesthetic therapies are less effective than **pragmatic therapies** just because they do not lend themselves to study using traditional research methodology, especially in light of the common factors research that is currently being conducted (see Blow, Sprenkle, & Davis, 2007; Hagemoser, 2009; Sprenkle et al., 2009). It may be that there are unique factors that are common to all couple and family therapies that are more important to determining outcomes than model-specific factors (see Sprenkle et al., 2009). For example, could it be that a common factor in couple and family therapy is the marshaling of couple or family resources through the involvement in therapy of multiple members of the family (see Sprenkle et al., 2009, for common factors unique to couple and family therapy)? This would certainly be consistent with the commonly used definition of family therapy found in the research literature: family therapy is psychotherapy that is conducted with more than one family member involved in the session for greater than 50% of the time (Shadish, Ragsdale, Glaser, & Montgomery, 1995).

In 2012, Douglas Sprenkle guest-edited a special issue of *JMFT* focused on what we know from the extant research literature about couple and family therapy. The contributors to this special issue were leading researchers in the field who summarized the research findings within the mental health field as they pertained to the practice of couple and family therapy. I recommend this issue of *JMFT* to any student seriously interested in learning more about what we know about the effectiveness of marriage and family therapy. This is the third such special issue to appear in *JMFT* (1995 and a series of articles spanning 2000–2003). In an article introducing the 2000 series, William Pinsof and Lyman Wynne concluded the following:

1. Couple therapy (CT) or family therapy (FT) is better than treatment that does not involve family members for treating adult schizophrenia (FT), depression in women in distressed marriages (CT), marital distress (CT), adult alcoholism and drug abuse (FT), adolescent conduct disorders (FT), adolescent drug abuse (FT), anorexia in young adolescent females (FT), childhood autism (FT), aggression and noncompliance in attention deficit-hyperactivity disorder (FT), dementia (FT), and cardiovascular risk factors (FT).
2. CT or FT is better than no treatment for all of the above clients and disorders as well as for adult obesity (CT), adult hypertension (CT), adolescent obesity (FT), anorexia in younger adolescents (FT), childhood conduct disorders (FT), childhood obesity (FT), and almost all childhood chronic illnesses (FT).
3. There are no studies that show that CFT has negative or destructive effects. [Note: CFT refers to couple and family therapy.]
4. There are insufficient data to support the superiority of any particular form of CFT over any other (meta-analytic findings).
5. CFT appears to be more cost-effective than standard hospital treatment for adult schizophrenia and unipolar depression as well as residential treatment for adolescent conduct disorders.

6. CFT is not sufficient unto itself to treat a number of severe and chronic mental disorders such as schizophrenia, major unipolar and bipolar affective disorders, addictions, autism, and severe conduct disorders. However, CFT significantly enhances the treatment packages for these disorders. (Pinsof & Wynne, 2000, p. 2)

In introducing the 2012 special issue of *JMFT,* Douglas Sprenkle wrote that research conducted in the past decade or so has only strengthened these conclusions. Below is a brief review of the most important areas of research in the field.

The General Effectiveness of Couple Therapy

Couple therapy has consistently been found effective for reducing marital conflict and increasing marital satisfaction (Alexander et al., 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Bray & Jouriles, 1995; Johnson & Lebow, 2000; Lebow, Chambers, Christensen, & Johnson, 2012; Pinsof, Wynne, & Hambright, 1996). This is true regardless of the therapeutic approach being studied (Dunn & Schwebel, 1995). However, the degree of effectiveness is debatable. Couple therapy has been found to produce superior outcomes to no treatment and wait-list/placebo controls in efficacy studies. Some evidence even suggests that couple interventions reduce the likelihood of divorce within two years after the completion of treatment (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). However, other studies have found that although the short-term benefits of couple therapy are evident, it is difficult to maintain these benefits over time.

The primary outcome measures used for studying the success of couple therapy are the continued presence of relationship conflict and the occurrence of dissolution or divorce. It is reasonable to assume that a desirable outcome of couple therapy would be greater relationship satisfaction and stability, but this may not be a reasonable expectation for all couple therapy. Jacobson and Addis (1993) explain that couples who have better outcomes are those whose partners at the beginning of treatment are less distressed and more emotionally engaged with each other. These couples also tend to be younger, with less relationship history, and with less individual psychopathology. This may mean that couples whose relationships are healthier and who have undertaken fewer attempts to solve relationship difficulties are more likely to benefit from couple therapy. It also may mean that for some couples seeking couple therapy, their problems may be insurmountable. For these couples, relationship dissolution may in fact be a *successful* outcome of a course of treatment.

A large number of studies have been conducted to determine both the process and the outcome of couple therapy; however, nearly all of these studies have examined just three models of therapy: behavioral marital therapy (or cognitive-behavioral marital therapy), EFCT, and insight-oriented marital therapy. So, although it can be said that couple therapy is generally effective, it must be said

with reservation because of the limited number of clinical models that have been subjected to inquiry. However, the three models that have been subjected to the most rigorous investigation each represent very different underlying assumptions about the nature of change and the role of the therapist in producing change. For example, the behavioral marital therapy model emphasizes the role of overt behavioral and interactional change, with the therapist intervening actively in the couple's interactional sequence. However, EFCT and insight-oriented couple therapy, while also addressing the overt interactional experience between intimate adults, have as underlying assumptions the role of internal emotional experience and internal subconscious experience, respectively. So, emotional experience and subconscious experience become the targets of therapeutic intervention. Although the investigated models are few, in their fundamental differentness they do account for a broad range of ways in which problem development and change can be conceptualized, making it easy to justify a statement of therapeutic effectiveness.

Couple and Family Therapy in the Treatment of Specific Problem Areas

Major Mental Disorders

It is fitting that our discussion of the effectiveness of family interventions on specific problem areas begin with major mental disorders. Many of the prominent early family therapy models were derived from the study of individuals showing schizophrenic symptoms and their families (Broderick & Schrader, 1981; Goldstein & Miklowitz, 1995). These early models have provided the foundation for many of the family therapy approaches currently being practiced. This area of study also exemplifies the differences in family therapy research since the 1950s, demonstrating change in focus toward multimodal treatments, the acknowledgement of the role biology plays in the development of psychopathology, and the limitations of family intervention. It is also fitting because some of the best-designed studies in the field have addressed the impact of family intervention on the management of schizophrenia.

That family therapy has its roots in the study of one of the most severe forms of psychopathology is interesting and perplexing for many students. However, when you consider that family dynamics are more obvious under conditions of chronic distress than under conditions of the waxing and waning of normal life stress, the birth of family therapy from the study of families in which one member has schizophrenic symptoms makes sense. If interventions designed to change the family dynamic in this extreme situation were found to be effective (and they were found to be effective using the impressionist methodology of the 1950s), then it makes sense that they would also apply to less extreme situations.

As early family therapy researchers began studying individuals with schizophrenia, their attentions were quickly directed toward the families of their

subjects and patients. It was the obviousness of the family dynamics associated with severe psychopathology that attracted the early researchers to this area of study and that resulted in their experimentation with interventions designed to create changes in the family dynamic with the hope of alleviating schizophrenic functioning. However, unlike the research on schizophrenia today, the research of the late 1950s and early 1960s considered family pathology to be the root cause of schizophrenia. The assumption was that an individual essentially developed schizophrenia in reaction to, as a defense against, or as a result of severe family pathology. The belief was that under the most severely pathological of family interactions, psychotic symptomatology in one member would be a logical result. This also led to the belief that symptoms point to underlying systemic pathology. Therefore, symptoms carry a function within the family—either to point toward underlying systemic pathology (e.g., as is the belief in strategic approaches) or to scapegoat one member so the rest of the family can be free to be more functional (e.g., as is the belief in transgenerational approaches).

As family interventions gained popularity and began to be used more generally, family research in the area of schizophrenia essentially stopped. In fact, nearly 20 years passed before renewed research and treatment interest in this area emerged. In the 1970s, clinicians began again to see the influence of the family on schizophrenic symptoms and to take notice of the family dynamics associated with schizophrenic symptomatology. As clinicians more frequently used aftercare treatment programs that would place patients in greater proximity to their families sooner after stabilization, they began to notice the resurgence of symptomatic behavior once the patients were placed in prolonged contact with their families (Goldstein & Miklowitz, 1995). However, this time around, a new set of assumptions about the **etiology** of schizophrenia and improved research methodologies informed both the studies and the treatments.

Underlying both the research and family treatments being studied at this time was the use of a **stress-vulnerability model** to explain etiology. Unlike the assumption informing the early research efforts, this model states that environmental stress alone is probably not sufficient to result in the development of schizophrenia. Instead, it is assumed that there are biological predispositions to schizophrenia, and under sustained environmental stress a person with such biological vulnerabilities may develop the condition (Anderson, Reiss, & Hogarty, 1986). Thus, it is believed that schizophrenia occurs as the result of an interaction between biological vulnerability and environmental stress.

In my opinion, two very important developments have come out of the modern family research on schizophrenia in particular and major mental disorders in general. These developments have since been successfully applied to other psychopathological conditions. First is the development of the construct of **expressed emotion**, and second is the emphasis on **psychoeducational family treatments** within the context of a multimodal treatment package.

Expressed emotion (EE) refers to the degree to which a person is subjected to behaviors such as criticism or harsh tones of voice from family members, spouse, or partner (Anderson et al., 1986). When criticism of the person characterizes his or her most intimate interactions, that individual is said to be subjected to high EE. Low EE is present when these close family relationships are free of criticism and other belittling and degrading behaviors. High EE families tend to be very emotionally reactive to the patient and his or her expression of symptoms. EE has been the primary measure of environmental stress in family studies of schizophrenia, and both observational (e.g., Falloon et al., 1985) and self-report (Shields et al., 1994) measures have been developed to assess the level of EE.

Research has found that individuals with schizophrenia who are subjected to high EE after discharge from hospitalization are more likely to relapse than those for whom treatment was able to produce decreases in EE (Falloon et al., 1985; Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982). The Leff et al. (1982) study was specifically designed to determine the curative characteristics of the treatment they provided. They found that it was the aspects of the treatment designed to produce decreases in EE that accounted for the greatest variation in treatment outcome. In other words, individuals who have schizophrenia who also have family members who are critical, demanding, and judgmental in words and actions are more likely to relapse and to have more severe symptomatology than those who do not have critical family members. It is difficult to say whether high EE creates schizophrenia, or the stress of living with someone who has schizophrenia creates critical responses by family members, but it is instructive to note that treatment focused on reducing EE is associated with fewer relapses and greater compliance with medication regimens.

The second major advancement produced by this line of research concerns the development of psychoeducational family treatment models that are provided in the context of a multimodal treatment program (Lucksted, McFarlane, Downing, & Dixon, 2012). First, psychotic symptomatology is controlled through the use of neuroleptic medication. Environmental stress is primarily addressed through a behaviorally based psychoeducational treatment package that includes the family in treatment. Research has found that neither the therapeutic nor the educational component alone (with medication) is as effective as the integrated psychoeducational family treatment, and that medication alone has the highest relapse rates of any treatment (Hogarty et al., 1986).

The psychoeducational family treatments studied are founded in behavioral therapy treatment principles. These treatments emphasize:

1. the early engagement of the family;
2. family education about schizophrenia, including its etiology, course, and symptoms;
3. recommendations for coping with the disorder;
4. communication skills training;

5. problem-solving training; and
6. crisis intervention. (Goldstein & Miklowitz, 1995)

The family is taught that schizophrenia is a disorder that resides in the individual and is biologically determined and that it can be exacerbated or calmed by the family's influence.

Goldstein and Miklowitz (1995) have summarized the findings regarding family treatment of schizophrenia. They conclude that convincing evidence suggests that medication management coupled with behaviorally based psychoeducational family therapy is more effective than either medical management alone or medical management with individual therapy.

Affective Disorders

Most of the research on the effectiveness of psychotherapies in the treatment of depression and other mood disorders has been conducted using individual-based therapies (Prince & Jacobson, 1995). In general, these studies have found that individual therapies (typically cognitive or interpersonal therapy) are successful in treating depression. Some studies have even found that psychotherapy-only treatments are as effective as medication-only treatments (Krupnick et al., 1996). Treatments combining both medication management and individual psychotherapy tend to produce the most successful outcomes, with close to 60% of patients recovering from unipolar depression in clinical trials (Elkin et al., 1989).

However, do not forget the 40% of patients who do not show improvement. Although there is a statistically significant difference in **recidivism** (the recurrence of symptoms) between depressives who are treated and those who are not, the recurrence rate of symptoms (Maxmen & Ward, 1995) in the treated population is about 50%! Therefore, although psychotherapy may be important in reducing the severity of acute symptomatology, it is far from overwhelmingly successful in producing longitudinal absence of symptoms.

Depression and other mood disorders are especially resistant to intervention. This is made evident not only by the high rate of recidivism in the treated population but also by the surprisingly high rate of patients not completing treatment (Prince & Jacobson, 1995). Some prominent couple and family researchers (e.g., Prince & Jacobson, 1995) have speculated that one of the reasons for this resistance might be the recursive influence of depression and couple and family relationships. Because of this contextual influence, couple and family therapy has been seen as a preferred treatment for depression by many within the field.

Research on depression has shown that a strong association exists between depression and couple and family dysfunction (Prince & Jacobson, 1995). Studies have shown that the presence of intrafamily conflict is common for people who are depressed and that individuals from families in which conflict is common are at higher risk for developing depression. Research has also shown that the

presence of couple and family conflict is predictive of relapse in treated populations and that depressive episodes are more likely to occur after episodes of couple conflict, intimate relationship disruption, or interpersonal loss.

Of course, not all people with depression are in conflictual relationships, so we cannot say that couple or family conflict causes depression—but it certainly appears to make it worse. Additional support for the importance of the relationship between depression and couple and family relating is found in research addressing the protective and curative features of these relationships on the development and recurrence of depressive symptomatology (e.g., Jacobson et al., 1993). Studies have shown that depression is less common among people who are married than those who are single. Although the quality of the marital relationship has been found to be more of a protective factor than just the fact of being married, the protective function of the couple relationship has not been found to be compensated for in its absence through relationships with family and friends. When someone who is prone to develop depression or who is depressed has a supportive spouse and family, he or she is less likely to have severe symptoms and is less likely to relapse.

As mentioned before, it would be impossible—based on the existing research—to conclude that couple and family relationship dysfunction causes depression. Frankly, it is difficult to live with (and provide therapy for) someone who is chronically depressed. Their hopelessness and unhappiness is frustrating, discouraging, and just plain not very fun for partners and family members. Depression wreaks havoc not only on the individual sufferers, but also on those with whom they are in intimate relationships (e.g., Beach & O'Leary, 1993; Billings & Moos, 1983).

The research previously cited, which found that interactions between spouses in which one is depressed are more conflictual and less caring than in relationships where depression is not present, could also be explained in terms of the influence of depression on these relationships. Parenting and relationships with children have also been found to be affected by depression. Some researchers have found that depressed women are likely to experience greater hostility and resentment toward their children than women who are not depressed. The children of depressed women are more likely to experience emotional and behavioral problems. The effects of depression on the family do not stop when the depressive episode is over or when it has been successfully treated. Coryell and colleagues (1993) found in their five-year posttreatment follow-up of successfully treated patients that relationship conflict and other relationship impairment continued in 40% to 50% of the patients studied.

Because of the reciprocal influence of environmental stress and depression, researchers and clinicians have hypothesized that couple and family therapy would produce superior outcomes to individual therapy in the treatment of depression. However, disappointingly, this has not been found to be the case. Probably the safest statement we can make is that couple therapy is no less or no more effective than individual therapy in the treatment of depression when evaluating

success based on the amelioration of symptoms and relapse rates. Both treatments are more effective than no treatment.

Whereas couple therapies (behavioral marital therapies [BMT]) have been subjected to careful empirical investigation, family therapies have been investigated only rarely and, although promising, we do not have sufficient information to comment on their effectiveness.

Results produced by the research programs of Beach and O'Leary (1993; O'Leary & Beach, 1990; O'Leary, Risso, & Beach, 1990) and Jacobson (Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; Jacobson, Fruzzetti, Dobson, Whisman, & Hops, 1993) serve as examples of the type of research being done in this area. In both of these research programs, BMT was compared with individual cognitive therapy and a wait-list control condition. Both sets of researchers used women with depression as subjects. Women in both studies were randomly assigned to treatment conditions and were evaluated for severity of depression and relationship satisfaction using the **Dyadic Adjustment Scale (DAS)** (Spanier, 1976) both before and after receiving the assigned treatment. Neither group of researchers found significant differences between those clients receiving BMT and those receiving individual cognitive therapy. However, both found that those receiving BMT were likely to score higher on their measure of couple satisfaction. Long-term follow-up with these couples also indicated that they were able to maintain these improvements in relationship satisfaction. Jacobson's studies examined treatment outcomes more carefully and found that in the BMT condition, increased DAS scores were evident only when at least one spouse indicated relationship distress. If the relationship was not determined to be in distress, then BMT and individual cognitive therapy were equally effective at reducing depressive symptoms and in producing improvements in relationship satisfaction. Interestingly, neither Beach and O'Leary nor Jacobson found significant differences in relapse rates at one-year follow-up, further indicating no significant differences between individual and couple therapy in the treatment of depression.

Why devote so much attention to the discussion of the treatment of depression when no significant differences between treatments are found? There are two reasons: First, depression is one of the most prominent and frequently occurring forms of psychopathology (especially among women) (Maxmen & Ward, 1995). Therapists working with couples and families will need to be competent in working with depression.

Second, this area of research is a perfect example of the difficulty in making inferences to inform treatment from the results of basic research. In this case, research evidence linking couple and family relationship distress with depression leads logically to the hypothesis that addressing relationship distress in the context of therapy will result in improved treatment outcomes for depression. Yet this very reasonable hypothesis has not been supported through clinical trials; no significant differences among therapies have been found. This is not to say that couple and family therapy is not preferable in the treatment of depression over individual psychotherapy—especially when treating women in distressed relationships. In fact,

we can extrapolate from the research literature that increased support from the nondistressed partner—regardless of the pretreatment level of relationship distress—assists in recovery and in the prevention of relapse (Prince & Jacobson, 1995). At least a few conjoint sessions should be conducted during the course of treatment, even in cases of nondistressed relationship and individual treatment.

Eating Disorders

Eating disorders is an area of special historical interest in the field of family therapy. When they think about structural family therapy, most serious students will recall Salvador Minuchin's studies on the role of environmental stress (or family dysfunctional interactions) regarding the exacerbation of psychosomatic symptoms, first in individuals with diabetes and second in individuals with anorexia nervosa (Minuchin, 1978; Minuchin et al., 1975; Minuchin, Rosman, & Baker, 1978). As with the early studies of schizophrenia, the family dynamics associated with eating disorders were so striking and obvious that they became a source of interest for Minuchin. He found that through family intervention, exacerbation of symptoms was decreased.

A well-designed and highly acclaimed research program (Dare et al., 1990; Russell, Szmukler, Dare, & Eisler, 1987; Szmukler, Eisler, Russell, & Dare, 1985) evaluated the effectiveness of family therapy in the treatment of eating disorders. These researchers developed a treatment program based on structural and strategic family therapies and compared this family-based treatment to an individual supportive treatment that appears to be similar to a treatment-as-usual condition. Through random assignment of patients to the various conditions and the comparison of differential effectiveness based on age of the patient at the time of onset of the eating disorder, the researchers found some interesting results. First, the findings suggest that family therapy is generally more effective than individual therapy when the age of onset of the eating disorder is younger than 18 years old. However, evidence suggests that individual supportive psychotherapy is more effective when the age of onset is 18 years or older.

In addition to providing evidence for the effectiveness of family therapy in the treatment of eating disorders, the primary significance of this line of research is underscoring the importance of contextual issues, such as the age of the patient, when designing treatment plans. Although it would be inappropriate to conclude that family therapy should not be used in cases of later-onset anorexia, it did call into question the universal application of family therapy to all eating-disordered cases. Clinicians should carefully consider the needs of the individual client before rushing to a judgment regarding which treatment modality is best.

Substance Abuse

Research in the area of substance abuse has essentially followed three lines of inquiry. The first two concern the family treatment of drug abuse in adolescents

and adults; the third is the family's treatment of alcoholism. Not surprisingly, the study of the family treatment of adolescent drug abuse has far outpaced the study of the other two lines of research (Liddle & Dakof, 1995; Sprenkle & Bischoff, 1995; Stanton & Shadish, 1997). I say "not surprisingly" because the well-established and well-organized treatment provider milieu has a long tradition of providing substance abuse treatment using individual and group treatment formats. This tradition is especially prominent in the treatment of adult substance abuse disorders. Therefore, it is probably more acceptable within the treatment provider community to accept the prospect of the effectiveness of family therapy in the treatment of adolescent substance abuse than in the area of adult substance abuse. However, as Liddle and Dakof (1995) point out, the U.S. federal government has a long history of encouraging studies of the effectiveness of family therapy in the treatment of substance abuse disorders across the life span. Yet family therapy studies of adult substance abuse disorders have not been forthcoming, and those that were started have ended prematurely. This is an example of how the current mental health treatment environment influences which studies are conducted and even the implementation of research findings to practice. There are several fine studies of the effectiveness of family therapy in the treatment of substance abuse problems in both adolescents and adults, yet clinicians are still reluctant to change their practice to reflect these research findings.

Although several excellently designed research programs have investigated the effectiveness of family therapy in the treatment of adolescent drug abuse (e.g., Azrin, Donohue, Besalel, Kogan, & Acierno, 1994; Joanning, Quinn, Thomas, & Mullen, 1992; Lewis, Piercy, Sprenkle, & Trepper, 1990; Stanton, Todd, & Associates, 1982), Jose Szapocznik and his colleagues in Miami, Florida, were the first to verify the effectiveness of family therapy in this area (Liddle & Dakof, 1995).

Szapocznik and his colleagues conducted a series of studies, published throughout the 1980s and 1990s, in which they evaluated the effectiveness of an integrated structural-strategic family therapy treatment model. They found that the application of their family therapy treatment model was profoundly effective—reducing drug abstinence rates from 7% to 80% (Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, 1986; Szapocznik et al., 1989; Szapocznik, Kurtines, Santisteban, & Rio, 1990). These changes were maintained by adolescents for up to one year after the completion of treatment. Not only did adolescents stop using substances as a result of therapy, but also the researchers were able to document improved family functioning and overall target adolescent behavior. Interestingly, these treatment benefits were found regardless of whether the therapist was working with the whole family or with just the adolescent from the structural-strategic family therapy model. This is significant because this is one of the first (and only) attempts to demonstrate that family therapy works regardless of the number of participants in the therapy room.

Szapocznik et al.'s (1988) research has also validated the effectiveness of engagement strategies. It is a well-known fact that dropout rates in the treatment

of substance abusers in general and adolescent substance abusers in particular is incredibly high (Liddle & Dakof, 1995). Szapocznik tested the effectiveness of an intensive family therapy–based model of engagement. He found that the intensive family therapy engagement strategy that included phone calls to and visits with family members in their homes prior to the first session of therapy significantly improved the therapist's ability to engage adolescents and their families in therapy. Those that were engaged using the intensive engagement strategy were also more likely to complete treatment than those engaged using a less intensive engagement-as-usual procedure. Szapocznik and colleagues found that use of the intensive engagement procedure was successful in 93% of the cases, compared with 42% in the engagement-as-usual group.

M. Duncan Stanton and Thomas Todd (Stanton et al., 1982) began a research program in the late 1970s that serves as the best example of research on the efficacy of family therapy in the treatment of adult substance abuse disorder. Stanton and Todd randomly assigned male heroin addicts, who were all veterans in their early to mid-20s, to a paid family therapy condition, an unpaid family therapy condition, an anthropological/educational movie condition, and a standard nonfamily therapy treatment condition. Family therapy treatment was conducted using an integrated structural-strategic family therapy treatment approach. These researchers found that family therapy produced significantly better outcomes than did the educational treatment and the nonfamily therapy treatment. In fact, the differences between the family therapy and nonfamily therapy treatments were quite striking, with more than double the rate of improvement in the family therapy conditions. Unfortunately, the Stanton and Todd research program was not continued by the investigators, and subsequent nonprogrammatic studies by other investigators have not found the dramatic results of effectiveness that Stanton and Todd achieved. However, these other studies have at least found family interventions to be as effective as individual-based or group-based interventions.

Behavior Disorders in Children

Most therapists, regardless of their approach to treatment, would not think twice about using a family-based treatment for child behavior problems. This may be a reason why there are literally hundreds of studies on the treatment of child behavior problems. In the field of marriage and family therapy, the systemic family therapies (e.g., structural, strategic) could be considered logical choices to guide treatment plans addressing childhood behavior problems. However, studies of the efficacy and effectiveness of these models of therapy are surprisingly absent. Despite this absence of traditional family therapies, there appears to be consensus among writers within the field that family-based treatments are the treatments of choice when it comes to treating childhood behavior problems (Estrada & Pinsof, 1995; Hazelrigg, Cooper, & Borduin, 1987; Henggeler, Borduin, & Mann, 1992; Henggeler & Sheidow, 2012; Kazdin, 1987, 1991, 1994; Tolan, Cromwell, & Brasswell, 1986).

The most well-researched approach to treatment in this area is a behaviorally based set of approaches to treatment called "parent management training" (Estrada & Pinsof, 1995). Parent management training is conducted by working primarily with parents. Parents are instructed in how to observe their child's behavior and how to design interventions based on behavioral principles to change the behavior of their child. All the primary interventions take place at home and are implemented by the parents themselves. Work with the therapist is typically time limited, and sessions are highly structured and consistent across therapists.

This approach to treating conduct problems in children has been found to be very successful, with treatment outcomes being maintained years after work with the therapist has stopped. It has also been found that the gains resulting from parent management training are generalized to other behaviors in the child and the siblings. Improvements in marital quality and other areas of family functioning that have not been the focus of treatment have also been documented. Research in this area is so far advanced that investigators have even attempted to determine those client and therapist variables that mediate successful outcome (no other area of family therapy research is this far advanced). Researchers have found that socially and economically disadvantaged families and families that are isolated fare worse in treatment than those who do not possess these risk factors. Treatments based on the parent management training principles have been developed specifically to address these risk factors. These modified treatments have also been found to be effective.

Delinquency in Adolescents

"Delinquency" refers specifically to adolescents who are in legal trouble. Although many delinquent adolescents are still treated individually and in isolation from their families, research has generally shown family therapy to be a treatment with better and more sustainable outcomes than individual therapy, probation, and work programs (Tolan et al., 1986). These findings have led reviewers of the literature to generally conclude that family therapy is the treatment of choice, based upon outcome research, in the treatment of adolescent delinquency (Chamberlain & Rosicky, 1995; Gurman & Kniskern, 1978; Henggeler et al., 1992; Henggeler & Sheidow, 2012; Kazdin, 1994; Tolan et al., 1986).

One of the most original and noteworthy programs of research in the area of adolescent delinquency was begun by James Alexander and his colleagues in the early 1970s. Alexander developed what he calls "functional family therapy" (FFT), which is an integrated behavioral, structural, and strategic approach to treatment. The goal of FFT is to develop and implement a treatment plan to address the family and individual needs for proximity and distance. The idea behind this therapy is that all behavior is an attempt to meet needs for proximity or distance. Successful treatment must respect the family members' attempts to meet these needs. Functional family therapists do not attempt to challenge the

validity of the needs; rather, they offer alternative meanings to behaviors used to meet these needs or suggest alternative behaviors that can be used to accomplish the same goals of proximity or distance (Alexander & Parsons, 1982).

Alexander began his program of research by studying adolescents referred by the courts to therapy because of "soft delinquency" behavior (e.g., minor theft, truancy, running away) (Alexander & Parsons, 1982; Parsons & Alexander, 1973). He randomly assigned adolescents to an FFT condition, a family group therapy condition, a psychodynamic family therapy condition, and a no-treatment condition. The FFT condition was found to produce results superior to each of the other conditions, and these results were sustained up to two and a half years later. They also found that siblings of adolescents treated with FFT also had lower rates of delinquent behavior at the two-and-a-half-year follow-up than did siblings of those adolescents receiving the alternative treatments (Klein, Alexander, & Parsons, 1977). This research has been successfully replicated throughout the United States by many different research teams (Alexander et al., 1994).

FFT has grown in popularity, especially among psychologists, to become one of the most well-researched approaches to therapy in existence today. It is unfortunate that the approach is not as well recognized in the profession of marriage and family therapy, especially given the strong research support for the approach, which is based on systemic principles. This may be due to the fact that James Alexander himself, as a psychologist, has done most of his publishing in psychology journals.

Process Research and Common Factors

Couple and family therapy is successful. What accounts for this success? What are those factors or characteristics of the therapy, the therapist, the client, or the context in which treatment is conducted that lead to success? Although there are some exceptions, researchers generally rely on process research to answer these questions.

In general, process research is not as well developed as is outcome research. This is especially true in the study of couple and family therapies (Alexander et al., 1994). In fact, most of what is known about the process of change has come from the study of psychotherapy in general (typically individual-focused treatments) and not from the study of couple and family therapy.

One of the most notable exceptions to this has been the study of EFCT (Greenberg & Johnson, 1988; Johnson & Greenberg, 1988). In fact, Johnson and Greenberg claim that the refinement of their model of therapy is the direct result of process research. For example, they conducted a study of the most successful EFCT sessions. Sessions were chosen based on both therapists' and clients' ratings of success. Transcripts were made of the identified sessions, which were intensively analyzed using a coding system. The results of this research demonstrated that the most productive sessions were ones in which the couple

showed higher levels of experiencing (explorations of new feelings and experiences) and greater frequency of self-disclosure and understanding of what the spouse was saying.

Of course, findings such as these have direct implications for treatment. In this case, the investigators used these findings to refine their treatment approach to emphasize the importance of designing interventions that specifically target these indicators of success. However, the degree to which therapy- or model-related factors contribute, in and of themselves, to therapy outcomes is unclear. I mention this because a growing body of research suggests that client variables—and, to a lesser extent, therapist variables—account for the greatest amount of variation in treatment outcome, regardless of treatment approach used. These factors have come to be known as **common factors**, meaning that they are present in and affect all therapeutic approaches.

The Most Important Determinant of Treatment Success

Research has found that client factors account for the largest portion of variation in treatment outcome (Garfield, 1994). Client perception of the presenting problem and motivation to change, chronicity of the problem and pretreatment relationship conflict (Bray & Jouriles, 1995), socioeconomic status and ethnicity (Sue, Zane, & Young, 1994), and years married and number of children (Allgood & Crane, 1991) are all examples of variables clients bring to bear that exert great impact on treatment outcomes. However, it is interesting that the variable exerting the greatest impact on outcomes is the client's perception of the client-therapist relationship.

Janice Krupnick and her colleagues (Krupnick et al., 1996) published the results of a large multisite study comparing the effectiveness of interpersonal psychotherapy, cognitive-behavioral therapy, medication management, and a medication placebo treatment in the treatment of depression. Surprisingly, they found little difference in outcomes among treatment approaches. However, when they investigated client and therapist contributions to the therapist-client relationship (therapeutic alliance) and outcomes, they found that the therapist contributions (and type of therapy) were not significant. In other words, it did not matter to treatment outcomes how the therapist rated the therapeutic alliance (strong or weak) or how the therapist's contribution was evaluated by the researchers. What mattered and what accounted for the greatest variation in client outcome was the *client's* perception of the therapeutic alliance. If the client believed that the therapist or psychiatrist was being helpful—that he or she had a good working relationship with the mental health care provider—then a positive outcome was more likely than if the client did not believe he or she had a good working relationship with the mental health care provider.

Now, lest you throw up your hands and say, "Well, why do I need to go to school for years to learn how to do therapy if all that really matters is the

client's perception of our relationship?" you must first realize that therapeutic skill accounts for a portion of the variation in treatment outcomes as well (Beutler, Machado, & Neufeldt, 1994; Crits-Christoph et al., 1991; Green & Herget, 1991). This portion, although smaller than that accounted for by the degree to which clients feel they have a helpful relationship with the therapist, is significant. Studies have been conducted in which technique-based therapies (typically behavioral or structural and strategic) have been compared against supportive therapies (those that emphasize the relationship between therapist and client but are devoid of identifiable, programmatic techniques). These studies have repeatedly found that technique-based therapies produce better treatment outcomes than do supportive therapies. However, the supportive therapies still produce change! It's just that a strong therapeutic alliance coupled with the skillful administration of technique produces more success.

Some Final Thoughts About MFTs and Research

Although there is room for many more talented researchers within the field of marriage and family therapy, I am not naive enough to think that the majority of those who read this textbook have ambitions to become researchers. However, I do believe that it is imperative for all marriage and family therapists to have a working knowledge of research principles and to be actively involved in research. At a minimum, I think every responsible clinician should be involved in research in the following two ways.

As Consumers of Research

Everyone is a consumer of research. Practically everything sold is the result of research—from soap to cars to treatment for depression. Everything in life is informed, at least in part, by research. We live in a world in which the results of disciplined inquiry are generally given high priority. Yet despite the importance of research in our lives, most people do not understand it. Most are not informed consumers of research.

Therapists are no exception. If the degree to which therapists say they use research to inform their clinical work is any indication of their consumerism of research (and I think it is), therapists are not informed consumers of the excellent burgeoning research that exists. Yet there is probably no more important time in the history of the profession for therapists to be consumers of research. The practice of mental health is at a crossroads. Gone are the days in which unsubstantiated claims could be made, as well as the days in which claims based on undisciplined inquiry, anecdotal account, and intuition would be accepted without question by employers, third-party payers, and clients. Clients and third-party payers are increasing their demands for substantiated treatment plans and interventions with proven results. To compete in the mental health marketplace,

therapists in the 21st century need to become informed and active consumers of research. In order to do this, they need to understand research principles, be able to read research reports and evaluate the quality of the research that was conducted, and know how to integrate research into their practice.

The field of marriage and family therapy can learn from the field of medicine, which is increasingly turning to what is referred to as "evidence-based practice" (Guyatt, 1993). This is essentially the practice of medicine driven by research evidence. Although evidence-based medical practice is supported by a more developed and advanced research literature than exists in the mental health field, it would behoove mental health practice to be informed by the research literature. Clinicians working in this way would understand how to read and interpret research articles and how to apply research findings to their clinical work.

As Researchers

As I mentioned before, I'm not suggesting that every clinician be a researcher in the traditional sense of the word. However, all clinicians can and should use research principles and methods in conducting therapy and in evaluating the services they provide. From the discipline of education comes the term **action research**, a practitioner-led research activity that is as appropriate for mental health care providers as it is for educators.

Action research is essentially the application of research principles to real-life situations by practitioners. The goal of action research is not the generalization of findings to a larger population, as is the goal of traditional research endeavors. Rather, the goal of action research is the application of research findings to specific situations. For example, a particular clinician may want to evaluate the services he or she is providing to a specific population or in working with a particular client problem. This clinician would then develop a question that would allow him or her to evaluate what he or she is doing with clients and implement a "study" of that question using those clients. The results of this clinician's investigation would then result in changes to his or her own practice.

Suggested Readings

Journal of Marital and Family Therapy. (2012). Volume 38(1). This is a special issue of the journal devoted to reviewing the research on marriage and family therapy intervention studies. There is no better compilation of the most up-to-date reviews of couple and family therapy research than this.

Miller, R. B., & Johnson, L. N. (Eds.). (2014). *Advanced methods in family therapy research: A focus on validity and change.* New York, NY: Routledge.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* New York, NY: Guilford Press.

Sprenkle, D. H., & Piercy, F. P. (2005). *Research methods in family therapy* (2nd ed.). New York, NY: Guilford Press.

Glossary

action research: The application of research principles to real-life situations by practitioners, not for the purposes of the general dissemination of findings but for the purpose of informing and evaluating one's own clinical work.

aesthetic therapies: A term used by Bradford Keeney and Douglas Sprenkle (1983) to refer to treatments that are focused more on emotion, sensation, or intrapsychic processes that are difficult to operationalize than on more easily operationalized behaviors or outward, observable characteristics of a person or relationship. These therapies often focus on producing growth or change in perception of the person or relationship rather than behavioral change.

affiliative behaviors: A description used by emotionally focused therapists to refer to a set of behaviors that promotes or encourages togetherness in couple interactions.

analytic methodology: The methods, techniques, and strategies used for guiding the analysis and analyzing data.

applied research: Studies designed to find solutions to problems (e.g., the best therapy for helping couples struggling with the chronic illness of one of the partners).

authority: This form of normal human inquiry refers to knowledge obtained through people who are believed to have special knowledge because of their status or position.

basic research: Studies designed to better understand something (e.g., a condition, a situation, an interaction, a phenomenon, a construct) and to generate knowledge about that thing.

clinical case studies: Narrative descriptions of the course of treatment with one or more client systems. They are typically designed to describe how treatment should be conducted, to identify important treatment considerations, or to discuss a client population or problem area. Rather than promoting knowledge through research, they promote knowledge through experience.

clinical trial: Research evaluating the efficacy of a particular intervention or treatment program. For a clinical trial, an intervention is operationalized with the use of a treatment manual, implemented under strict controls and the experimental method, and evaluated for its success.

common factors: Those factors that account for variations in treatment outcomes regardless of the treatment being provided. For example, therapist warmth and empathy are important regardless of the treatment approach used. Client motivation and the degree to which the client believes therapy will be helpful and a strong therapeutic alliance exists are also important common factors. Common factors have often been found to account for more of the variation in treatment outcome than factors unique to the treatment approach.

comparative research study: A study comparing one model of therapy against another. The results of this kind of study usually polarize individuals within the field and result in few improvements to the services provided to clients.

competing explanation: A plausible alternative explanation of the results of a study that occurs due to insufficient controls.

construct: A theoretical creation based on observations; something that cannot be observed directly or indirectly.

controls: Research designs and procedures used by the investigator to lessen the effects of any variable other than the independent variable on the dependent variable. In general, the assumption is that the more tightly controlled the study, the more confidence can be placed in the results.

cooperative research: Research efforts that bring together researchers working from differing theoretical clinical perspectives or differing mental health care professions to solve clinical problems or generate knowledge through joint research.

critical incident: An event or point in time in treatment when change takes place or to which change is attributed. This term was used in the study of change events in emotionally focused couple therapy.

disciplined inquiry: The use of systematic, replicable procedures for obtaining and evaluating information. Observations (data collection) are carefully planned and recorded and follow strict guidelines that ensure confidence in the results of these observations.

Dyadic Adjustment Scale (DAS): A paper-and-pencil measure developed by Graham Spanier, designed to measure an adult's satisfaction with his or her relationship with an intimate partner or spouse.

effectiveness: Positive outcomes attributable to a course of therapy that suggest the value of that therapy. The research design used to study the value of the therapy reflects the real world of clinical practice.

efficacy: Positive outcomes attributable to a course of therapy that suggest the value of that therapy. The research design used to study the value of the therapy is experimental, with tight controls that limit the influence of extraneous variables on treatment outcome. Treatment manuals are followed, which standardize the treatment across providers and clients.

empirical: Based on or verifiable through disciplined inquiry and observation. Although this definition also includes qualitative investigations, many argue that empirical studies are quantitative in nature or, more specifically, experimental in nature.

etiology: The cause or causes of a condition.

expressed emotion (EE): A construct referring to the degree to which a person is subjected to behaviors such as criticism or harsh tone of voice from family members, spouse, or partner.

extraneous variable: A variable that makes possible an alternative explanation of the results.

generalizability: The extent to which the results obtained from a sample reflect the characteristics of the population from which the sample was drawn.

hypothesis: A tentative, testable assertion about something. This assertion typically involves the prediction of outcomes or the occurrence of certain behaviors, events, or phenomena—in other words, a prediction of the effect of the independent variable on the dependent variable. Although this is nothing more than a scientific (educated) guess, it is a guess that is informed by previous research and scientific knowledge and that is stated in a way that makes it testable or subject to scientific study.

inclusion criteria: Predetermined rules or guidelines designed to accomplish the goals of the research that define the characteristics of those who will be invited to participate in the study. The researcher determines the criteria to be used for inclusion, so criteria will vary from study to study depending on the goals of the research. Although the term suggests inclusion in the study, these rules and guidelines also exclude potential subjects from participation.

incremental outcomes: Short-term outcomes that contribute to the final outcome of the treatment. These outcomes may be the result of specific interventions, individual sessions, or a series of sessions.

intimate self-disclosure: A term used by emotionally focused therapists to refer to self-disclosure driven by the most basic of human emotions, the disclosure of which would normally result in feelings of vulnerability.

investigator bias: The influence the investigator has on observations and results. A researcher's training, culture, gender, past experience, political agenda, and hypotheses may be among those characteristics or attributes that bias a study and consequently influence what is seen and how it is interpreted. Although it is impossible to eliminate all investigator bias, there are methods of disciplined inquiry designed to reduce the impact of this bias on the outcomes of a study.

mean: The true statistical average, derived by adding a group of scores and dividing this sum by the number of scores in the group.

natural human inquiry (NHI): Refers to the common, undisciplined way of learning about the world. These ways of learning about the world are typically not systematic or reproducible. Knowledge obtained in these ways is subject to the effects of bias. Common methods of natural human inquiry are personal experience, tradition, and authority.

no-treatment control group: A treatment condition used in experimental research in which no treatment is administered. This treatment condition is used to control for the effects of natural maturation and other sources of internal validity on the outcomes of the experiment.

observation: (1) An act of carefully watching something for a scientific purpose. The act of watching is directed by rules or guidelines that either restrict or expand what might be otherwise seen or noted. (2) A term used to refer to what is noted, seen, or concluded as a result of an instance of careful watching for scientific purposes.

operationalize: To define the variable in such a way that it becomes observable. This entails an explicit description of those behaviors or processes that point to the variable in question. These behaviors or processes are then presented in such a way that reliable observations can be made regardless of who is doing the observing, when the observations are being made, and the context in which the observations are made.

outcome research: Research designed to determine the results of a course of therapy or of an intervention or set of interventions.

participant: A qualitative research term referring to a subject in a study. The term *participant* is preferred over the term *subject* because *subject* does not reflect the participatory and collaborative nature of qualitative research.

personal experience: A form of natural human inquiry that refers to learning about the world firsthand, through trial and error.

pragmatic therapies: Treatments whose processes, interventions, and outcomes can be easily operationalized and measured.

process of therapy: That which happens during the course of treatment that produces change and leads to an outcome.

process research: Research designed to determine what happens throughout the course of a treatment.

programmatic research: A research agenda followed by the same researcher or team of researchers that allows the results of one study to inform the development of the next study. The research agenda is thematic and directional, with researchers designing sequential studies that build upon one another with the goal of better understanding the phenomenon under study over time.

psychoeducational family treatment: A treatment of major mental illness that includes pharmacological treatments, psychotherapy, and educational components. At a minimum, family members are involved in the educational component of treatment, which typically includes information about the mental health condition being treated (including the typical course of the illness and what can be expected of the person with the condition) and the application of behavioral principles to modify the environment and intrafamilial interactions. Typically, professionals representing various areas of expertise are involved in the treatment provision.

psychometric qualities: The degree to which a measure of a construct or observable behavior is reliable and valid. Statistics are used to determine the reliability and validity of a measure or instrument. Generally, instruments that have reliability and validity coefficients of over .80 are considered psychometrically solid.

qualitative research: Disciplined inquiry focused on collecting narrative accounts, text, or observations that are analyzed without the benefit of predetermined categories or assumptions. In qualitative research, the investigator becomes the primary data analytic tool, and the generation of research questions, data collection, and data analysis are often recursive processes. Although data can be quantified and statistics can be used as analysis strategies, more narrative analytic strategies designed to preserve the richness of the data are typically preferred. Qualitative research is typically inductive in nature.

quantify: To assign numerical value to variables or characteristics of variables to aid in scientific observation or to facilitate the analysis of data obtained from scientific observations.

quantitative research: Disciplined inquiry focused on collecting data that can be summarized numerically (with numbers). The hallmark of quantitative research is the scientific experiment designed to determine the causal relationship of the independent and dependent variables. However, quantitative research also relies on survey and other methodologies that result in correlation findings (in which it is inappropriate to conclude causality). Inferential statistics are used to analyze quantitative research. Although there are exceptions, quantitative research is typically deductive in nature.

recidivism: The recurrence of symptoms after they have previously abated.

reliability: The degree to which the results of a measure of something are consistent across time, across situations, and across observers.

replicable procedures: Procedures that can be repeated or reproduced in other contexts or even within the same research study.

research design: The overall plan guiding all aspects of disciplined inquiry, including subject recruitment and sampling, treatment administration, data collection and analysis, and results dissemination. Often the term is used to refer exclusively to the structure of the administration of treatment and control groups (e.g., pretest/posttest design) or to the genre of the study (e.g., survey design, qualitative design, experimental design).

sampling theory: A theory that suggests an entire population does not need to be observed to know the characteristics of that population. By randomly or systematically selecting a sufficiently large subgroup of that population (when every member of the population has an equal chance of being selected), one can know the population's characteristics.

standard deviation: A standard unit of measurement that describes variation from the mean when scores cluster about the mean according to a normal (bell-shaped) curve. According to this measure of variability, 68% of the scores fall within one standard deviation (SD) of the mean, 95% fall within two SD, and 99% fall within three SD.

stress-vulnerability model: A model to explain the etiology of serious mental health conditions that says although some individuals have a predisposition (whether determined by genetics or sociobiology) to a class of mental health conditions, pathology will not develop in the absence of environmental stress. In other words, it is not sufficient to have a predisposition to the condition for it to develop. Other environmental factors producing stress on the system must also be present. Likewise, environmental stress alone is not sufficient to produce the condition in the absence of a genetic or sociobiological predisposition to the condition.

substantive evidence: Verifiable proof as to the reality of an observation, conclusion, or claim.

systematic procedures: Procedures that follow a method or plan.

time in the field: One of the most important determinants of the quality of a qualitative research study. This refers to the amount of time an investigator spends with subjects and is often accomplished by observing and interviewing the subjects in their natural environment.

tradition: A way of knowing about the world that is not guided by disciplined inquiry (*see* NATURAL HUMAN INQUIRY). Knowledge obtained in this way is assumed to be known by everyone because it has been passed down throughout the generations.

treatment manual: A detailed description of the treatment to be provided. These are typically step-by-step descriptions and are designed to eliminate or reduce the amount of variability in treatment administration across clients and treatment providers.

triangulation: A qualitative research strategy designed to improve the confidence one can have in the results of the study. Using triangulation, the investigators collect data from multiple sources (each of whom brings a unique perspective) using multiple methods.

validity: The degree to which a measure of something is actually measuring what it is purported to measure.

Notes

1. Cohen, Sargent, and Sechrest (1986) found that a full 27% of the respondents in their study claimed that they could identify no trace of the influence of research on their clinical practice.
2. The research-practice gap is not exclusively a marriage and family therapy problem, however. Numerous articles identifying and addressing this problem are found in psychology journals. Studies consistently find that clinicians who use research to inform their clinical work are in the minority, with less than 20% of psychologists reporting that research is useful in their clinical practice.

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