The Practice of Family Therapy

Now in its fifth edition, The Practice of Family Therapy comes at a time when traditional approaches to psychotherapy have given way to multidimensional strategies that best serve the needs of diverse groups who are grappling with the many challenges unique to family therapy practice. With expanded coverage of different models, along with new developments in evidence-based and postmodern practices, this integrative textbook bridges the gap between science and systemic/relational approaches, as it guides the reader through each stage of family therapy.

Part I lays the groundwork by introducing the first-, second-, and third-generation models of family therapy, teaching the reader to integrate different elements from these models into a systemic structure of practice. Part II explores the practical application of these models, including scripts for specific interventions and rich case examples that highlight how to effectively work with diverse client populations. Students will learn how to make connections between individual symptoms and cutting-edge family practices to respond successfully to cases of substance abuse, trauma, grief, depression, suicide risk, violence, LGBTQ families, and severely mentally ill clients and their families. Also included are study guides for each model and a glossary to review main concepts.

Aligned with the Association of Marital and Family Therapy Regulatory Boards’ (AMFTRB) knowledge and content statements, this textbook will be key reading for graduate students who are preparing for the national licensing exam in marriage and family therapy.

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To Masako, Joyce, Nori, Lisa, Todd, Mark, Clinton, Teruko, Junko, and Hiroki: In the midst of our generational detours, you helped me find my way back home. For your inspiration and love, domo arigato!
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Preface

The world of family therapists has changed dramatically in the past ten years. If you had told me then that my students today, in their first semester of practicum, would have clients who needed help with gender reassignment, or perhaps, their clients were hearing voices as they entered the therapy room, I would wonder, “How is this possible at such an early point in their career?” If you had told me then that they would work with those recovering from the murder-suicide of a loved one, or with four sexually reactive foster siblings who were doing everything they could to stay together, I would have welcomed the chance to share similar experiences from my caseload. The truth is, my students are seeing very complex cases, and so am I.

Every week, I think about how I can help them provide cutting-edge service to those who have the greatest needs. I approached this book thinking about my excellent students who do some amazing work with amazing clients, even before they are licensed! So, welcome to the “real world” of family therapy practice. Those who have a passion for systemic practice find some inspiring ways to make a difference. With that as the main goal of this fifth edition, I hope you’ll come with me behind the one-way mirror of home-based therapy, couple therapy for trauma survivors, and family therapy with families who have an undocumented member. Some are war-torn as they return from Iraq. Others will make you laugh. All want better relationships, and they bring their hopes and dreams with them when they walk in the door. Even mandated clients inspire us.

So, this edition continues to teach the basics and to visit each model of family therapy like it was an old friend, reminiscing about the past and catching up on the latest developments. In addition, you are invited to have a bird’s-eye view of how our clinical work can take key elements of our theory and practice and weave them into a tapestry of hope and creativity for each family. There are 23 case studies and over 20 dialogs to help you feel like you’re behind a one-way mirror.

When first-generation family therapists stepped in front of that one-way mirror, they had all the hope and creativity in the world. So, in Chapters 1 and 2, we’ll follow their footsteps from first- to second- and third-generation family therapists. Then, in Chapters 3 and 4, we’ll see how key elements from these models turn into common themes and common factors that help beginning practitioners find their way amid the smorgasbord of ideas that exists. These four chapters help practitioners to think systemically and to use an interpersonal lens to make sense of each case.

Then, Chapters 5 to 9 provide numerous applications of systemic thinking in the real world. As readers walk through family therapy practice from referrals, intakes, treatment planning, and
intervention, they will meet many of the clients I have just described. In addition, they will see how systemic/relational practice ultimately brings out the humanity of clients and therapists alike.

**WHAT’S NEW?**

There is an expanded coverage of our models with an eye toward some of their latest applications. For example, narrative family therapy has always focused on oppression, and many people want to know more about “just therapy,” the therapy of social justice from New Zealand. In addition, structural, strategic family therapists have some novel ways of approaching oppositional defiant disorder. There are expanded sections on how to approach substance abuse, suicide risk, violence, family secrets, and LGBTQ families. All practitioners can benefit from a roadmap that prepares them for life-threatening risks. In addition, our military deserve practitioners who can think systemically, including how the nervous system fits into the family without stigmatizing the service member, and there are somatic exercises in three chapters that are good for all members of the family.

There is a special section on work with seriously mentally ill clients and their families. Applying a systemic/relational perspective to the tragic school shooting at Sandy Hook illustrates how family therapists can play a larger role in the prevention of violence in our communities. There are relevant risk assessments that compensate for the inability of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) to adequately screen those who are at risk. Chapter 6 spends more time on Bertram’s (2001) suggestion that we must “talk the DSM talk,” and “walk the MFT walk.” Paired with motivational interviewing skills and a desire to look for the context behind the diagnosis, family therapists will find some ways to bridge these cultures.

Chapter 9 highlights new material on narrative approaches to unresolved grief, art therapy approaches to trauma, and a section on children’s issues and behavior problems. My students seem to need the practical skills that come from this chapter when specific models fall short. In addition, there are expanded case examples that help to organize couple therapy by taking a case step by step through tracking sequences and changing behaviors.

Last but not least, it’s time to help our students orient to the national licensing exam. The Association of Marital and Family Therapy Regulatory Boards (AMFTRB) has knowledge and content statements that help our beginning practitioners study for the exam. These items begin each chapter as a way of helping readers connect the dots between their study and practice while in school, and the world of licensing that takes a wide view of the field. For this purpose, there are updated tables that summarize the distinguishing features of all models, even one that pairs our models with the language of managed care to help with treatment plans.

**WHAT STAYS THE SAME?**

I make the assumption that beginning students often want suggestions as to what to say or where to start, so each chapter contains many sample questions a therapist can ask, dialogs between the therapist and client, and corresponding commentaries. The result is a mosaic of basic skills that form the core of many current mainstream approaches with families. As
students proceed through each chapter, they are given rationales for how the strengths from these varied approaches can be most useful during different stages in therapy, for different cases, and in different settings.

The approach in this book views problems as embedded in multiple relationships that evolve through many transitions. The importance of interpersonal and intrapersonal dynamics is illustrated in presenting problems, and strategies for tracking historical and day-to-day sequences of interaction with genograms and timelines are woven throughout the chapters. The theory of change in this work is strength-based and client-centered, drawing from those approaches that maximize the therapeutic alliance and realistically address the nature and history of a problem by using the resources that every family brings into the room.
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Abbreviations

AAMFT American Association for Marriage and Family Therapy
AATA American Art Therapy Association
ABFT Attachment-Based Family Therapy
ACE adverse childhood experience
ACOA adult children of alcoholics
ACT assertive community treatment
AMFTRB Association of Marital and Family Therapy Regulatory Boards
APA American Psychiatric Association
APRN Advanced Practice Registered Nurse
ARISE a relational intervention sequence for engagement
ATR-BC a registered art therapist who is board certified
BPD borderline personality disorder
CACREP Council for Accreditation of Counseling and Related Programs
CAGE cut down, annoyed you, guilty, eye opener
CATTI Chapman Art Therapy Treatment Intervention
CBCT cognitive-behavioral couple therapy
CBT cognitive-behavioral therapy
CO concerned others
COAMFTE Commission on Accreditation for Marriage and Family Therapy Education
CPS Child Protective Services
DSM Diagnostic and Statistical Manual of Mental Disorders
DUDIT-E Drug Use Disorders Identification Test – Extended
DUI driving under the influence (traffic violation)
EE expressed emotion
EFT emotionally focused couple therapy
ESSFT evolving structural strategic family therapy
ETC expressive therapies continuum
FACT family-assisted assertive community treatment
FAP Family Acceptance Project™
FBI Federal Bureau of Investigation
FIT feedback informed therapy
GARF Global Assessment of Relationship Functioning
ICD International Statistical Classification of Diseases and Related Health Problems
KFD kinetic family drawing (a common art intervention)
LGBTQ lesbian, gay, bisexual, transgender, and questioning (community)
LMFT licensed marriage and family therapist
MDFT multidimensional family therapy
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>MFG</td>
<td>multifamily groups (for schizophrenia)</td>
</tr>
<tr>
<td>MFT</td>
<td>marriage and family therapy</td>
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<td>MI</td>
<td>motivational interviewing</td>
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<tr>
<td>MRI</td>
<td>Mental Research Institute</td>
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<td>MST</td>
<td>multisystemic therapy</td>
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<tr>
<td>NIMH</td>
<td>National Institute of Mental Health</td>
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<tr>
<td>ODD</td>
<td>oppositional defiant disorder</td>
</tr>
<tr>
<td>ODD-JI</td>
<td>oppositional defiant disorder–justice injury</td>
</tr>
<tr>
<td>PCL-C</td>
<td>Post-Traumatic Stress Disorder Checklist – Civilian</td>
</tr>
<tr>
<td>PCL-M&amp;C</td>
<td>Post-Traumatic Stress Disorder Checklists – Military and Civilian</td>
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<tr>
<td>PHQ-9</td>
<td>patient health questionnaire</td>
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<tr>
<td>PTSD</td>
<td>post-traumatic stress disorder</td>
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<tr>
<td>TBI</td>
<td>traumatic brain injury</td>
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<tr>
<td>TFT</td>
<td>transitional family therapy</td>
</tr>
<tr>
<td>YCSC</td>
<td>Yale Child Study Center</td>
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As a revolution of thinking and practice in mental health treatment, family therapy is known for its historic emphasis on family relationships, systems theory, and social context. At the time, mental health treatment was emerging as a societal phenomenon in post-war America with newfound services cloaked in psychoanalytic thought and medical practice. One person at a time, psychological problems were laid bare on the couch. Meanwhile, there were those embedded in this landscape who thought about how families provided a context for understanding these problems. Families might be part of the problem and part of the solution. One family at a time, people sat up on the couch! When those pioneers finally burst onto a national stage and found each other, marital and family therapy was here to stay.

Part I is a three-generational family reunion beginning with first-generation contributions from 1940 to 1970, reviewing the transitions made in the second generation from 1970 to 2000 and celebrating new developments in the third generation from 2000 up to the present. This reunion appears in Chapters 1 and 2. They tell the story and introduce the ideas that make this family an enduring tribe of professionals who believe in the capacity of family and intimate relationships to improve the human condition.

This tribe has its identity and customs. In a family reunion, everyone may come with their dyed hair and tattoos of individuality. But, as Chapter 3 will show, once we embrace those differences, everyone comes together around common themes that reveal our systemic thinking and our values. After all, family is family. Learning to think systemically is the work of generations, handing down thoughts of communication and intimacy, human growth and development, equity, justice, and belonging. We even have dirty words, and all are instructed to avoid them. Terms like resistance, manipulation, and pathology give way to uniqueness, creativity, and wound healing.

Then, when the going gets rough, we all pitch in. This reunion will have a barn-raising. We put our traditions to work. Chapter 4 illustrates those common practices that happen, regardless of the setting, client, or type of problem. No problem is too big for this tribe, and all understand that what binds us together is our ability to deliver strength-based, relationship-centered services to a wide range of people who need flexibility, validation, and hope in a deficit-prone mental health system. We all speak the language of potential and develop healing relationships with our clients that empower them to think more highly of themselves.

In the end, we have our language, rituals, and traditions. On the street, we recognize our brothers and sisters when they talk of joining, empowering, and celebrating our clients’ talents. We wink at each other when the discussion is about how family members can be recruited as part of our team. We party together when one more family launches their children after overcoming trauma, war, and poverty. Welcome to this tribe of systemic thinkers! Because relationships are a matter of life and death, we hope you will also find this revolution contagious.
CHAPTER 1
Family Therapy: The Interpersonal View

CHAPTER OUTLINE

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Organization
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Emotional Climate
First Steps
Summary

**AMFTRB Knowledge**

01. Foundations of marital, couple, and family therapy
02. Models of marital, couple, and family therapy
03. Development and evolution of the field of marital and family therapy
06. General Systems Theory
11. Impact of couple dynamics on the system
13. Family homeostasis as it relates to problem formation and maintenance

**AMFTRB Content**

02.02 Assess client’s verbal and nonverbal communication to develop hypotheses about relationship patterns.
02.03 Identify boundaries, roles, rules, alliances, coalitions, and hierarchies by observing interactional patterns within the system.
02.04 Assess the dynamics/processes/interactional patterns to determine client system functionality.
02.09 Identify client’s attempts to resolve the presenting issue(s).
03.10 Determine sequence of treatment and identify which member(s) of the client system will be involved in specific tasks and stages.

**PROLOGUE**

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**Case 1.1: Lee**

I first meet Lee on a hot August afternoon, when he walks into a community agency, breathless, wide-eyed, dripping with sweat. Holding a brown paper bag, he is a tall man in a tank top with tattoos that show through the freckles on his muscular arms.

LEE: The man at the Dollar store said I should come over here for some help.
SECRETARY: Would you like an appointment, sir?
LEE: (Impatient and angry) No! I’m here to get some help!

The secretary summons myself (SMH), an Asian middle-aged female, and a colleague (BG), a white male with a ponytail and Levi jeans from an adjoining conference room. We usher him in.
SMH: (Motions into the doorway) Hi. Why don’t you come in here? It’s hot out there, isn’t it? We can talk in here . . .

Agitated, he enters and stands at the head of a table while we sit.

SMH: Can we help you?
LEE: (Sarcastically) No. You can’t help me. You can entertain me, but you can’t help me!
SMH: OK. So . . . we can go with that (glances at my colleague).
BG: Yeah. Are you thinking a little tap dance? I can do that for you (taps his foot).
SMH: We’re used to entertaining people. Sometimes, that’s the place to start. Sounds like you’ve got a lot on your mind.
LEE: (Grumbling) Yeah, you guys don’t know shit about what’s on my mind!
SMH: You’re right. We don’t. A lot of times, therapists just shoot in the dark, don’t they?
LEE: (Scoffs) You got that right! M____F____s act so smart . . .
SMH: So true. We don’t know your shit. What kind of shit you got goin’ on?
LEE: My baby died! Her mama killed her! They throw’d me in jail when I was up there before. She got to pay for what she did!
SMH: (Sincerely, shaking her head) I’m so sorry . . . so sorry . . . Damn! That sounds like a tough spot!
LEE: You got that right! (He reaches in his sack, pulls out a hamburger, and sits down.)

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**What Is Family Therapy?**

Was this initial encounter with Lee family therapy? Perhaps all is in the eye of the beholder. The therapists were family therapists. We would draw upon our family therapy training in interaction analysis as we worked with Lee. We would also draw upon our humanity and life experience. As this book tells the entire story of Lee and his encounters with family therapists and decades of other mental health professionals, a picture emerges that shows the unique, unconventional traditions of family therapy practice and why these are a good fit for him. Currently, family therapy is a mainstream, empowering approach to the problems of mental health for individual, couple and family functioning. However, at the beginning, the pioneers appeared to be rogue professionals or outsiders who were challenging sacred traditions. How did they do this?

First, there was a decision to “think outside the box.” What began as thoughtful observations outside tradition became a rebellion against psychoanalysis, an individual view of problems, and medicalized language. In many ways, Lee was also rebelling against conventional mental health services as he had known them.

Next, family therapy pioneers focused on the politics of language and communication. With Lee, therapists attended to the political and relational aspects of his language and theirs. A dance began as we adopted and explored his language. We resonated with his nonverbal distress and validated the unspoken messages he sent (“Professionals don’t understand me. Why should I have respect for them?”). We embraced and explored the meaning behind “entertain me.” We also sympathized with his tragedy and validated his distrust of an institutionalized society.

Lee poses unique challenges because he is homeless and has suffered multiple traumas. Many clinicians overlook the traumas of people in poverty (Mani, Mullainathan, Shafir, & Zhao, 2013; Merling, 2013; Mullainathan & Shafir, 2013). How does family therapy address...
these issues? Most survivors of trauma have needs for safety that appear to others as extreme measures of control. Nonverbally, Lee was speaking volumes (“Professionals are hopeless. How can I trust you? Show me what you’ve got. I’m in crisis!”). By exploring the meanings of “entertain me,” a nonverbal message was sent to Lee. “We can work with you on your terms. We see you have gotten a bad rap.” These messages came through a calm, inquisitive, and sympathetic demeanor.

Those careful, minute-by-minute responses are rooted in the history of family therapy practice (Ruesch & Bateson, 1951). Important communication is often implied and more powerful than words. The verbal level (report) is the content of a message. The nonverbal level (command) is the implied expectation for that relationship. Lee was telling them what happened to him (report) and how he wanted to be treated (command). As a first step in the therapist–client relationship, each party exchanged information and expectations. As this family therapy dance continued, the relationship expanded to include additional aspects of an interpersonal approach.

The Interpersonal View: Family Process, Cybernetics, and Social Ecology

In family therapy, context is everything. What is the context of a certain behavior or problem? Initially, pioneers turned to family process as the context and used the field of cybernetics as a lens for exploration. These ideas were about communication and control in human systems. All behavior is communication (Watzlawick, Beavin, & Jackson, 1967). This interpersonal view explores these questions:

1. What interaction patterns surround the problem?
2. Are there repeating cycles of communication?
3. How do people talk about it?
4. How do we treat each other when the problem is occurring (behavior)?
5. Are there politics in a family that involve different opinions about the problem (meaning)?
6. How do these opinions affect those who are needing help (outcome)?
7. How long have people held these opinions? When did they begin (development)?

At first, Lee communicated his distress nonverbally with voice tone and labored breathing. Reading those signals was an important step. When the receptionist responded with a routine, business-like question, Lee showed more distress. The communication didn’t fit his developmental level. The receptionist may have read his nonverbal messages, but she did not respond to them. It would have been helpful if this had been the sequence:

SECRETARY: Hi, how are you today? It’s hot out there, isn’t it? What brings you here?
LEE: The man at the Dollar Store said I should come over here for some help.
SECRETARY: Did he say what type of help he thought you should have?
LEE: No. I was tellin’ him about my problems and he said to come over here and talk with somebody right away.
SECRETARY: OK. It looks like you’re having a tough time – let me see who is free right now.

These details may seem small, but for family therapists, success begins with attention to small bits of communication and the action that follows. What type of help did he need? One client
sent her therapist a postcard that read, “If you could only hear what I cannot say.” Family therapists decipher and look for ways to respond to unspoken messages until clients feel settled enough for verbal communication. One pioneer might say to clients, “Don’t trust me, yet” (Watzlawick, Weakland, & Fisch, 1974). Trust is a process that happens over time. Rather than expecting clients to trust them at the outset of therapy, clinicians can acknowledge the lack of safety inherent in a new relationship. This is especially important for trauma survivors. The content of the statement is relational (trust), and the implied expectation for the relationship respects the uncertainty of it (not “yet”). Such realistic messages provide safety for survivors.

As therapist–client interaction begins to fit, there are signs of relaxation. Lee sits down and eats. His emotional crises provide a good opportunity for therapists to express their sympathy and humanity. This is not the time to conduct business. Problem-solving should come after a bond is established. Lee feels hopeless, but he sees some people who seem to care. He watches them closely. So far, they can handle his “shit” without anxiety. They provide him with emotional first aid. They do not act like other practitioners. Cybernetics explores feedback loops or cycles of interaction that form a pattern. So far, these loops seem satisfactory to Lee. They do not result in shame, criticism, or distance.

LEE: (eating his burger) I called the district attorney, and they said they can’t press charges. Son of a bitch’s been bought off by her mama. Oh yes! I know it! She’s got her connections to the system, and she’s gonna get her little girl off. It ain’t right. They tested her breath. Don’t tell me she wasn’t drunk when she rolled over on my baby. She had all kinds of DUI’s (shakes his head) . . . shit . . .

BG: That sucks, man. Is this someone you’re with now?

LEE: Hell no! I had to get outta there before the cops locked me up again. I shoulda never gotten with her. She came on to me, and I believed her. I shoulda listened to my friends. They told me she was no good.

SMH: Was this here?

LEE: Nah, nah. Over in _______.

BG: That’s a long way from here. How’d you get over there?

LEE: My friend from jail said I should come visit. I couldn’t stand my mother’s house and Granny’s got Alzheimer’s. I went over there and stayed a few years, then things went bad, you know? I had to do somethin’ . . .

SMH: You said your Granny has Alzheimer’s?

LEE: Yeah. It sucks, ya know? She’s OK sometimes . . . but she got poop all over, and she won’t let go of her cats and dogs. Man, it’s bad in there. She won’t let us do nothin’ . . .

SMH: Do you live with her?

LEE: I’m not s’pose to be with her. They say I ain’t allowed ‘cause of my felony, but she lets me be there.

SMH: I’ve worked with people who have Alzheimer’s. It’s tough on family members. I bet it’s tough on you. You got any help? There’s people who can help, you know?

LEE: I don’t know . . . nothin’ much gets through to her . . .

SMH: Here’s my card, in case you want to check your options . . . I wish I could help her in some way . . .

LEE: (abruptly stands up) I got to go. I can’t handle all this stuff. I need some beer. Man, nothin’s gonna help . . . My baby’s gone. Shit!

SMH: Oh, uh . . . what about talking a little more about your baby?

LEE: (shaking his head) Nah, nah. I’m outta here. I just need to find me some beer . . .

SMH: OK. Let us know if you want to talk again. We’ll be here.
Three days later, Lee leaves a voicemail: “Can you help my Granny?”

What may have seemed like a side issue became an entry point for helping Lee with his grief and injustices. This encounter raises many questions. Why ask about Granny instead of staying with Lee’s grief? How did he end up in jail? Is he telling the truth? Why not make a follow-up appointment?

Granny seemed to be a relational resource. One way to help Lee with his grief is to explore the people who may be resources in his healing and offer them support. These relationships are at the center of family therapy practice. Answers to the other questions would emerge in other sessions but were not relevant to developing an alliance. The focus on his language and relationships was of primary importance to understand his world view.

In the meantime, his opening message still hangs in the air. “You can’t help me. You can entertain me, but you can’t help me.” This is a message about his hopelessness for the relationship, but he provides many nonverbal clues to his real longings and motivations. At this stage in the process, therapists work on trust-earning and engagement. We follow his lead. As the dance continues, verbal messages focus on Lee’s relationships, such as his ex-girlfriend and Granny.

As the conversation continues, his angry demeanor and heartfelt narrative raise other questions. Can we help him? Is he mentally ill? Is he dangerous? Do we have the skills to provide appropriate treatment? Some of these questions are based on stereotype and bias. Managing the self of the therapist is an important part of practice (see Chapter 4). By taking a personal inventory and laying aside these biases, practitioners can form important alliances with people outside their immediate culture. As this happens and we take Lee at face value, answers to these questions emerge. His humanity shines brightly as he describes his relationship with Granny. Taking an interest in this side of his life proves to be beneficial.

Regarding Lee’s cultural context, pioneers in family therapy do not report on work with homeless, mentally ill men. Now, practitioners see a larger context outside the family. Social ecology refers to the quality and health of the human environment as a web of relationships inside and around the family (Bronfenbrenner, 1979). This framework examines the health of the family and community on behalf of each child. It examines the resources that parents and spouses need for their well-being. What are Lee’s resources? How can we use them?

Ecosystemic family therapy approaches address social justice issues, community resources, and extended-family dynamics alongside the intimate cybernetic dynamics that create secure attachments (Liddle & Schwartz, 2002). Lee will benefit from this broad focus, because he has an extensive social network and he has been the target of cultural and gender discrimination (low income, rural, white male). However, the first step involves engagement skills in cybernetics, communication analysis, and systems thinking about his relationships. Chapter 2 continues with additional information about his therapy.

An ecosystemic map helps therapists to individualize treatment and grasp the severity of Lee’s situation. It contains a three-generational family diagram, a list of his friends, and a timeline depicting his life story (Chapter 7). These visual maps help his prefrontal cortex to stay focused on the immediate process in sessions. Born into a devoutly religious family, he was once a “good church boy” who taught himself how to read the “big words that rich people use.” They told him he was smart. For a while, he got good grades in school. Now, at age 39, he had tumbled down a road that involved moving from the country to the city, his parents’ divorce, mother’s mental illness, victimization from neighborhood bullies, prostitution, drug dealing, domestic violence, incarceration, and brain injury. During the 18 months of his treatment, the voices of family therapy approaches in this book emerge as consultants. They join the voices of family
members who participate in the work with Lee. This flexibility keeps the process on his terms and not bound by a narrow model. Not all of Lee’s goals are achieved, but he never misses a session. And, as he meets some milestones and makes some transitions, it is clear there is much more to this man than meets the eye.

Thus, cybernetics, family process, and social ecology give family therapy approaches a range of motion that brings forth an understanding of all clients on their terms. How does this behavior make sense? The answer is embedded in an interactional, developmental, and ecosystemic context. These three elements comprise a framework called “systemic thinking.” This is a shorthand phrase for general systems theory, the umbrella that brings these ideas out of psychoanalytic traditions and into an interpersonal world view (von Bertalanffy, 1949). It takes a bird’s-eye view of all important relationships and suggests that connections between “parts,” such as biology, family members, neighbors, therapists, police, etc., provide a map of relationships relevant to any given symptom or problem. In working with Lee, it is important to keep the big picture in mind, because his pain comes from many directions. His behavior and language make perfect sense, once we understand his life story as a system of relationships. When the view expands beyond the individual to a system, solutions and resources also expand. Although systemic thinking is not new, a brief history of how family therapy emerged will illustrate the radical shift in mental health and social services that emerged from a rebellion of visionaries who wanted to lessen the suffering of others.

**How Did It Begin? From Freud to Minuchin**

There are some interesting parallels between the development of psychoanalysis by Sigmund Freud and that of family therapy. In his day, Freud rebelled against mainstream medical practice, too. Ironically, once psychoanalysis became part of medical practice, family therapists rebelled against mainstream psychoanalytic practice. Progress, it seems, often comes from rebellion. To place these developments in context, when Freud was born in 1856, there were no automobiles or telephones. For the treatment of “hysteria,” doctors performed hysterectomies. He made just one visit to America in 1909 and abandoned the hope of psychoanalysis as a cure by the time of his death in 1939 at age 83. Instead, Freud preferred psychoanalytic theory as an explanation of human behavior and personality (McCall, 1954). However, the American public fell in love with his mode of treatment, much to the early chagrin of the psychological establishment, who were behaviorists (Benjamin, 2009). Something resonated beyond the expertise of these scientific experts. For his time and place, Freud’s suggestion that the inner world of a person related to medical and emotional symptoms was revolutionary.

There were also those who expanded on Freud’s fundamental belief in the importance of childhood experiences. As he was breaking away from the traditions of European medicine, his inner circle was breaking away from him. They began to study family relationships from many developmental perspectives. With Alfred Adler in 1911, the point of departure was a focus on how social environment influenced personality (Adler, 1938). For Adler, a basic human motivation was the desire to belong and make a contribution. Around the world, he would go on to inspire generations of child-care workers, educators, and therapists. His theory was outside Freud’s “box,” and the practice of seeing parents in a session soon followed.

In 1933, Sándor Ferenczi, a Hungarian psychiatrist, departed. He has often been an unsung hero in the history of psychoanalysis. First, he substantiated with family members that many patients were not fantasizing but were victims of childhood molestation (Ferenczi, 1949). As a leading psychoanalyst at the University of Hungary, he would mentor Melanie Klein, a developer of object relations theory and who would mentor John Bowlby, whose sweeping work in
attachment, separation, and loss would become a foundational theory in social neuroscience, emotion-focused couple therapy, and a host of family therapy approaches. Next, Ferenczi and Otto Rank saw the importance of a therapist’s active role, providing empathy and compassion in the therapist–client relationship (Hoffer, 1994). They would go on to inspire Carl Rogers in America with his person-centered approach (Rogers, 1961). From here, psychiatrists would branch out with a focus on treating children, addressing parenting roles, and examining interpersonal dynamics for all ages. The American psychiatrist, Harry Stack Sullivan, learned about Ferenczi’s work and would become a pioneer in social psychiatry.

The influence of Harry Stack Sullivan had a profound effect on many pioneers in family therapy. As an early example of social psychiatry, he promoted the importance of focusing on the close relationships of patients and establishing a strong therapist–client relationship. Instead of the psyche and biological drives in isolation, he focused on how the self emerged from interactions in family relationships. This idea is now supported by neuroscientists (Hood, 2012; Siegel, 2012). In the 1950s, Salvador Minuchin, Don Jackson, Virginia Satir, and Murray Bowen took his ideas to heart. Later, Ivan Boszormenyi-Nagy (the last syllable is pronounced Nahsh) would receive his psychiatric training at the University of Hungary and learn about Sullivan’s work. The innovations of these pioneers used the immediacy of the session to explore the nature of relationships and plant the seeds of change through challenging roles, analyzing relationships, and reframing a family’s sticking points with systemic interpretations. Their conversations were thought-provoking and hopeful. Eventually, they traded the language of psychoanalysis for systems and emphasized changes in relationships as the path to new ways of thinking and feeling. They are highlighted as the first generation of family therapy practice with each highlighting a different dimension of relationships.

As the psychiatric establishment developed, American psychologists reluctantly embraced psychoanalysis as an alternate world alongside behaviorism (Benjamin, 2009). Then, the innovations just kept coming. Beyond object relations theory, psychotherapy would explode into hundreds of labeled “brands” or approaches over the next century (Miller, Duncan, & Hubble, 1997). The practice of family therapy also expanded into dozens of approaches. These can divide into first-, second-, and third-generation approaches. Thus, family therapy practice has always been diverse. In addition to the transitions of psychiatry, the early interests of clergy, social workers, and educators came together around issues of child welfare, family relationships, and marital enrichment. Researchers across the United States began to study communication and behavior related to schizophrenia and the family. During the 1950s, collaboration among these research groups led to an exchange of publications and joint presentations at conferences.

A number of first-generation family therapists were among the major researchers in the area of families and schizophrenia. In California, Gregory Bateson, an anthropologist, worked with Jackson, Satir, and Jay Haley. On the east coast, Nathan Ackerman, Bowen, and Boszormenyi-Nagy built on their psychiatric experiences and began to study and treat families. These parallel efforts evolved in different regions of the United States (Haley, 1971). The practice of these groups gained momentum to produce a dramatic shift in thinking: Rather than viewing a person’s problems as originating solely within the individual, therapists saw these problems from a relational perspective. If a person was depressed, the clinician explored his or her relationships in depth. If a child displayed unusual behavior, the psychiatrist involved the parents in problem-solving discussions rather than merely addressing the issues by medicating the child. As family therapists understood more about human development, they invited traditional psychotherapists to view individual symptoms within an interpersonal context. This interpersonal focus ranged from analyzing subtle verbal and nonverbal
exchanges (cybernetics) to assessing the expression of emotions across three generations of a family (family emotional process).

Outside the world of research, there were also a number of important innovators. As part of their research, Bateson sent Haley and John Weakland to study the clinical work of Milton Erickson, an Arizona psychiatrist who was known for his novel practices with hypnosis. Considered as the father of modern-day hypnotherapy, Erickson through his teachings has had a profound influence on family therapy and psychotherapy practices. His theories were more about how to help people change. What helps them make transitions? How can they bypass “learned limitations?” Aside from his teaching in formal hypnosis, Erickson taught his followers how to use patterns of change from everyday conversations. These were immediately applied in first- and second-generation family therapies. Mental Research Institute (MRI), structural, strategic, and solution-focused approaches are examples of these.

In addition, many pioneers in America established their own training institutes in which research and clinical work went hand in hand. Among them were two immigrants who became advocates of child welfare. Ackerman from Russia and Minuchin from Argentina were psychiatrists who saw children’s symptoms as the tip of a relational iceberg. Ackerman focused on parenting practices and made house calls. Minuchin began his work attending to displaced children in Israel, then came to the US and studied with Ackerman. He also became aware of Harry Stack Sullivan during his training in New York City and devoted his efforts to helping inner-city families.

Outside of psychiatrists, Gerald R. Patterson was a psychologist in Oregon who extended his practice of psychology by applying social learning theory to the world of children and their parents. In 1971, Patterson published the first edition of Families: Applications of Social Learning to Family Life, which showed the effective and positive contributions of parent training and behavior modification on family relationships. In 1975, he published A Social Learning Approach to Family Intervention. Both of these works showed the effective and positive contributions of parent training and behavior modification on family relationships. Patterson’s legacy will always be his founding of the Oregon Social Learning Center and the ongoing contributions of the center to the treatment of aggressive children. Models of parent training and intervention developed at the center have been at the forefront of violence prevention in America. The influence of social learning theory spawned a number of prominent family therapists who brought research training from their degrees in psychology and studied minute details of interactional sequences in family life. These family therapists used their findings to develop intervention strategies for child problems and marital distress.

There were many others who paved the way for the beginning of family therapy. This collection of luminaries and ideas provides a slice of the rich history that altered the course of mental health services. This pioneering community contributed a multi-theoretical collection of ideas that would gel into modern-day family therapy around the world. These theories now appear in accreditation standards for the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). They refer to a “systems/relational” view that applies general systems, cybernetics, structural, and developmental theories to relationships involved in a presenting problem. In addition, the Council for Accreditation of Counseling and Related Programs (CACREP) contains standards that refer to a systems perspective on family and major models of family interventions (CACREP, II.5.d). And finally, each state defines marriage and family therapy (MFT) according to state law. Since 2009, all 50 states now have license laws for MFTs. Typically, among the elements of these state regulations is one common thread that includes applications of family theories in the diagnosis and treatment of individuals, couples, and families. Table 1.1 summarizes the historical contributions of some early theorists who began looking at family and social systems.
<table>
<thead>
<tr>
<th>Year</th>
<th>Theorists</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Alfred Adler, MD</td>
<td>Departs from Freud. <em>Social interest</em> is the desire individuals have to belong and to make a contribution to their relational world.</td>
</tr>
<tr>
<td>1920</td>
<td>Sándor Ferenczi, MD</td>
<td>Debates with Freud. Discovers many patients are victims of <em>childhood molestation</em>. Sees the influence of traumatic relationships. Believes clinical empathy is central to psychotherapy.</td>
</tr>
<tr>
<td>1930</td>
<td>Milton Erickson, MD</td>
<td>Begins a career using <em>hypnosis</em> in psychiatry, creates a new theory for each patient that can bypass a person’s learned limitations. Suggests <em>resistance</em> is an expression of uniqueness and mind/body connections.</td>
</tr>
<tr>
<td>1948</td>
<td>Norbert Wiener</td>
<td>Coins the term <em>cybernetics</em>, the science of communication and control (action) in biological or mechanical systems.</td>
</tr>
<tr>
<td>1949</td>
<td>Ludwig von Bertalanffy</td>
<td>Applies biological concepts of <em>systems</em> as organisms of interrelated parts, in which each part is distinguished by its <em>boundaries</em> and all systems have higher and lower levels (<em>suprasystems</em> and <em>subsystems</em>).</td>
</tr>
<tr>
<td>1949</td>
<td>John Bowlby, MD</td>
<td>Develops <em>attachment theory</em>, the notion that attachment quality, separation, and loss are significant influences on the emotional development of children and adults.</td>
</tr>
<tr>
<td>1951</td>
<td>John Ruesch and Gregory Bateson</td>
<td>Study feedback loops and information. All communication has <em>report</em> (content) and <em>command</em> (process) levels.</td>
</tr>
<tr>
<td>1967</td>
<td>Paul Watzlawick, Janet Beavin, and Don Jackson, MD</td>
<td>Study interactions and paradoxes. All behavior is a type of communication. Interactions can be <em>symmetrical</em> (egalitarian) or <em>complementary</em> (opposite).</td>
</tr>
<tr>
<td>1979</td>
<td>Uri Bronfenbrenner</td>
<td>Conceptualizes the ecology of human development as person–environment interaction.</td>
</tr>
</tbody>
</table>
Why Are There So Many Models?

In comparing the history of psychoanalysis to that of family therapy, one major difference is that Freud worked hard to control the narrative. Although he has been criticized for his rigid territoriality, leading to the exits of his inner circle, an advantage in theory development is that a common language developed over time. In fact, a number of his terms have endured across centuries and beyond psychoanalysis, such as transference, countertransference, denial, objects, and ego, to name a few. These are part of object relations family therapy. In addition, the practice world of Freud was narrow, and his patients were primarily white, middle-class Viennese.

In contrast, from 1900 to 1970, the ancestors of present-day family therapy ranged from professionals in social work, psychology, anthropology, communications, psychiatry, and hypnosis. They extrapolated the knowledge of their original discipline and integrated it with other knowledge bases. Regarding clinical practice, the developing field of family therapy proudly represented a wide range of professional training and mental health settings. The passion of these mavericks fueled their propensity for being different. Amid the fervor and camaraderie of these new ideas, there was pride in being different. Just as in the general field of psychotherapy, pioneers turned into “brands” with followers that developed a distinct identity. What these early practitioners had in common was the courage to critique prevailing practices of their day and a willingness to experiment with new theories. However, as charismatic innovators, they maintained separate languages for their ideas.

No one stepped forward to develop a common language until the 1980s. This effort came from the work of family therapy pioneer, Lyman Wynne, a distinguished family psychiatrist who lobbied the psychiatric community to include family categories in the Diagnostic and Statistical Manual (DSM-IV). From this effort, the **Global Assessment of Relationship Functioning (GARF)** appeared in Appendix B of that edition. Focusing on the elements of organization, problem-solving, and emotional climate, clinicians had criteria to assess family health. However, by then, a generation of practitioners, educators, and supervisors had developed their favorite language and approach. We will apply GARF categories to some hypotheses later in this chapter; however, the field of family therapy continues as an umbrella of many approaches, each with its own vocabulary.

Thus, the need for **integration** continues to be important as a way of capitalizing on the strengths of many approaches so that the practitioner can tailor treatment to the needs and developmental realities of each family. In this book, **integration is the coordination of key elements across these models that lead to a coherent whole**. It considers whether an approach uses a **theory of human development** to explain how problems develop across the lifespan or whether it relies more heavily on a **theory of change** to explain how the therapeutic process leads to certain outcomes. Different models of family therapy weigh these ingredients differently, and both are valuable.

However, before beginning that integrative process, this chapter and Chapter 2 review first-, second-, and third-generation models, applying their theoretical concepts to case studies. Then, Chapter 3 integrates these approaches into **common themes** that provide a framework for the application of systemic thinking across family types and presenting problems. As we move from how to think systemically to actually practicing systemic thinking, Chapter 4 reviews basic clinical processes that are the hallmark of systemic practice. These attitudes and skills are the interpersonal foundation for success in using the applications, techniques, and interventions that appear later in Chapters 5, 6, 7, 8, and 9. These chapters take clinicians from the referral
process through treatment planning and beyond, with strategies for violence, substance abuse, trauma, behavior problems, and chronic illness. As readers consider each area of intervention, different case examples represent the challenges of 21st-century families.

**Overview of First-Generation Family Therapy**

The ABCs of family therapy are those pioneering approaches that began to look at social and mental health problems through the lens of relationships. In this introduction, each model explores a case problem and hypothesizes about the best place to begin work with a client. With respect to these first models, the innovators put their unique interpersonal style into technique. Sometimes, the setting and population also brought out a unique style of practice. However, these personal differences are difficult to imitate and can be overwhelming to students. Thus, this review removes such idiosyncrasies and looks only at the basics. After understanding the basic components of each model, the beginning practitioner can find simple ways to implement them.

So, take a step back in time and imagine the various contexts and populations that stimulated this new thinking. By 1970, first-generation family therapists were organized into counseling centers, training institutes, and research groups. Table 1.2 at the end of this chapter summarizes these major approaches. Is there overlap across all these models? Absolutely! They are all systemic/relational in nature and provide depth and breadth in understanding families and their ecosystems. Keep in mind how revolutionary these approaches were, given the world at that time. What did the first family therapists begin to see through the lens of general systems,
communication, cybernetics, and human development theories? The following case discussions provide different windows into the lives of the Nelson family. Each model addresses the key concepts and hypotheses that practitioners need as the first step toward effective practice. What does each window reveal about a family? What hypotheses come about from looking through each of these? Each hypothesis will help to answer the question, Where do I start? Then, in Chapters 5 to 9, clinicians will learn more about specific interventions that are compatible with each model.

Case 1.2: The Nelsons

Paul Nelson, age 14, was admitted to a residential group home for adolescent males when his truancy and behavior problems became so pronounced that his parents could no longer keep him at home. A caseworker was assigned through juvenile court, and Paul was placed in a local facility where parents were involved in parent education and family therapy. The adolescents had a structured school experience and could earn weekend visits home through good behavior.

Paul's parents, Roy, 45, and Lilly, 42, were a white, working-class couple who had three children: Ed, Janet, and Paul. Ed, 18, dropped out of high school two years prior and was working at a local gas station. His girlfriend, Roxanne, 18, was pregnant. Ed was living at home, trying to save enough money to support this forthcoming child. At the time of treatment, Ed was uncertain whether he would marry Roxanne, although they were currently seeing each other on a regular basis. Janet, 17, was in her senior year of high school. She was an A student and enjoyed school activities, such as cheerleading and chorus. She hoped to finish high school and go on to college. Paul had been held back in the seventh grade because of absences and was in the eighth grade at the time of his placement. (Figure 1.1 shows a genogram of the Nelson family. For more information about genograms, see Chapter 7.)

Structural Family Therapy

In 1960, Minuchin began a project at the Wiltwyck School in New York to study the inner-city families of delinquent boys. He and his colleagues developed a structural approach to family therapy that relates patterns of delinquency to the degree of disorganization in the family (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). Minuchin took concepts from general systems theory and applied them to family organization. Therapists using this approach observe the interactions and activities of family members to determine the organization or structure of the family. Organization can be assessed by the quality of leadership, balance, and harmony that exist within the family (Breunlin, Schwartz, & Mac Kune-Karrer, 1992). Symptoms are regarded as a consequence of organizational difficulties. According to Minuchin, this organization must evolve to meet family members’ needs as they address the developmental tasks for each family life stage.

Organization

Within families, hierarchy is the type of leadership, often expressed by the pecking order, by shared perceptions of who “the boss” is, and by interactional patterns that indicate who gets the last word. The parental subsystem is supposed to provide leadership for growth and development of the child or sibling subsystem. In turn, children are influenced by leadership style and interpersonal patterns of parents. Boundaries are imaginary lines that describe who is
included in an interpersonal event (i.e., who interacts with whom, for what purpose, and how often). They also denote the closeness of relationship on a continuum (i.e., too close, balanced, or too disengaged). The corresponding type of interpersonal boundary in a given relationship would be labeled as diffuse, rigid, or permeable. Sometimes parents develop complementary roles with their children (that is, one close, one distant). When this happens, the parental hierarchy is thought to lack balance.

**POWER**

Power is the “relative influence of each family member on the outcome of an activity” (Aponte, 1976b, p. 434). Alignment is the level of agreement or disagreement between members or subsystems in the family. A cross-generational coalition can occur when one parent joins in a coalition with one or more children against the other parent. Such a coalition is often indicated when the therapist notes critical discussions about a parent who is absent, when one parent confides in a child about marital discord, or when one parent openly sides with a child against the other parent. In structural terms, parent–child coalitions are thought of as a violation of the boundary between the parental and sibling subsystems because they change the role of the child from one of dependent to one of confidant or emotional peer.

**INTERACTIONAL SEQUENCES**

The therapist discovers that when Mrs. Nelson is called by the school, she responds by leaving work and confronting Paul. When Paul refuses to interact with her and withdraws to his room, she reports to Mr. Nelson about the situation. Mr. Nelson confronts Paul about his behavior and threatens him with punishment if his behavior does not improve. When Janet becomes aware of the problem, she spends time with Paul, encouraging him to behave better. She has also become Lilly’s sounding board, providing a listening ear as her mother worries out loud. The therapist asks Paul about his relationship with each member of the family. Of his parents, he spends the most time with Lilly and is uncomfortable with Roy. Of his siblings, he is closest to Janet and feels some disgust that Ed has gotten himself into “trouble.” Roy and Lilly are asked about the time they spend together. Because they work different shifts, they have very little time together until the weekend. Recently, Roy was asked to work overtime at the meatpacking plant as a result of layoffs and employee reductions.

**HYPOTHESES**

The structural family therapist hypothesizes from this information that the marital subsystem has become distant as a result of the family’s economic situation. In addition, Lilly seems to be overinvolved with Janet and Paul in contrasting ways. By confiding in Janet, she has elevated Janet from the status of child to that of peer. By engaging in repetitive interactions with Paul, she is equally enmeshed with him, but in a way that produces opposition rather than peer status. Because Paul has been persistent in his misbehavior, he has rendered the parental subsystem ineffective at this time, obtaining a level of influence that is inappropriate.

**Strategic Family Therapy**

In 1967, Jay Haley completed his research assistantship with Gregory Bateson and took a position at the Philadelphia Child Guidance Clinic, led by Salvador Minuchin. He joined Minuchin and Braulio Montalvo in developing a family counseling and training institute.
For ten years, the three men drove in a car pool back and forth from work, developing their shared ideas about families and family therapy (Simon, 1992).

Many new students of family therapy are unaware that Haley took the unconventional ideas from MRI and Milton Erickson and influenced Minuchin’s evolving model on the east coast. Likewise, Minuchin influenced Haley with his applications of structure and function. With each refinement came different perspectives about the role and responsibility of the therapist. Haley’s unique integration of these influences resulted in a model that conceptualized the family in terms of organization but emphasized an unwavering focus on the presenting problem. For Haley, all therapeutic interactions should relate directly to the presenting problem. Otherwise, they are irrelevant (Simon, 1992). Like Erickson, strategic family therapists emphasize a unique approach or strategy for each presenting problem.

**SYSTEMIC MEANING OF SYMPTOMS**

The strategic family therapist assumes that Paul’s behavior is a metaphor or nonverbal message about something else going on in the family. It might be related to the distance between his parents, challenges with Ed in entering the launching stage, or some other aspect of the family’s well-being that has not yet come to light. As strategic therapists explore opinions and interactions within the family, they will search for possible clues to clarify the message of the symptom.

In this way, the symptom is often an attempted solution to another problem that goes unacknowledged or unnoticed by others in the system. Such *metaphorical messages* help the therapist to conceptualize the relationship between symptoms and interactional patterns within the family. By targeting *specific interactions* that occur during the session, the therapist works on the premise that small initial changes will lead to greater changes over time (Weakland, Fisch, Watzlawick, & Bodin, 1974).

**HIERARCHY**

In a session with the family, the therapist learns about hierarchy by exploring the sequence of interactions surrounding the presenting problem. Lilly is the first to speak. Roy remains silent. Roy and Paul wait for the therapist to speak. The therapist asks Roy to describe what happens when Paul gets stubborn. Roy outlines the usual sequence of interactions: his arrival from work, Lilly’s complaints about Paul’s truancy, Roy’s questions to Paul about why he is behaving this way, and Paul’s silence. At that point, in exasperation, Roy tells Paul that if he keeps up with his behavior, he will never amount to much of anything. Finally, Paul retreats to his room and begins to listen to his collection of heavy metal music. These *patterns of leadership* become the target of *directives* to change negative cycles of interaction and address the meaning of the symptom. Sometimes, these directives might be homework. Other times, they may indirectly address the symptom by coaching different communication. Chapter 8 describes these interventions in detail.

**HYPOTHESES**

Symptoms often occur when a family is stuck at a particular *family life stage*; whereas Paul Nelson’s behavior might be a *metaphor* for conflictual interactions between his parents, his behavior might also be saying something about the family’s adaptation to a new family life stage (the launching stage).
Mental Research Institute (MRI) Model

In 1959, Jackson dropped out of the psychoanalytic training required of psychiatrists at the time and organized the MRI as a research and family therapy training organization to take the ideas of Harry Stack Sullivan into scientific projects. The approaches at MRI are sometimes called communication models or brief therapy models. Jackson began to see the psyche as influences by relational systems and applied the physiological concept of homeostasis to the family. As used in family therapy, homeostasis is the family’s tendency toward stability through maintaining consistent patterns of thought, emotion, and interaction over time. Although the concept was originally thought of as a social force that resisted change within the family, later applications suggest that any family or social system has two balancing dimensions, one of maintaining stability during the threat of change and one of flexibility (adaptability) in the wake of change, whether it is normal, developmental, or a time of crisis.

COMMUNICATION AND BEHAVIOR

Jackson is remembered as having an uncanny ability to blindly assess a child’s symptoms from merely listening to a tape of parents describing how they met and married. Without being told of the presenting problem, he would listen to a segment of tape and then say, “All right, if they have a son, he is probably delinquent” or “If they have a girl, she probably has some psychosomatic problem” (Weakland, Watzlawick, & Riskin, 1995, pp. 13–14). When asked how he did it, Jackson replied, “Well, because of the way they laugh here.” Careful observation of interactional nuances became the hallmark of MRI approaches.

Another important concept addressed at MRI was that of circular causality, which refers to the way in which any symptom or behavior is understood by seeing it as part of a cycle of interaction rather than as an isolated entity. The MRI incorporated the work of Jackson, Bateson, Erickson, Haley, Weakland, and others into a creative theory and practice projects that continue to have a compelling influence on the practice of family therapy and psychotherapy (Ray, 1995).

As Bateson added his insights to this research group, he coined the term “metacommunication” and defined it as communication about communication (Ruesch & Bateson, 1951). Practically speaking, anytime people discuss how they communicate or what their interactional process involves, this is metacommunication. Moving to a higher level of observation, couples and families develop a greater awareness of their cycles when therapists explicitly explore their process. This activity is a common occurrence for most family therapists. These are standard questions:

1. How does the problem start?
2. What is happening, and who is doing what at the time?
3. What happens next?
4. What have you done to try to solve the problem?
5. Who does what?
6. What is the response from the other person when you try this?

Like strategic family therapists, brief family therapists believe that symptoms in the family are messages about some aspect of the family system. This concept comes directly from communication theory. These therapists are also influenced by the work of Milton Erickson, who was pioneering hypnotic and paradoxical techniques that emphasized the uniqueness
of the symptom and the importance of behavioral directives. This blend of communication, cybernetics, and Ericksonian influences results in a pragmatic approach to therapy that avoids any personal conflict with the client. The biggest difference between MRI approaches and strategic therapists is the latter’s emphasis on family structure. After Haley left MRI, his work with Minuchin influenced his focus on parent roles and responsibilities. In contrast, brief therapists will focus on the formation of the problem as stemming from communication patterns.

Because behaviors often communicate meaning on more than one level, the symptom can contain an explicit message (“I have a stomachache”) as well as an implicit message (“I want more affection”). This is another example of the report and command levels of communication. Because these therapists view all behavior as communication, a symptom is a communicative act between two or more members that symbolizes some problem within the interpersonal network (Watzlawick et al., 1974). Thus, any behavior can potentially be an attempted solution to some unidentified problem (“I want my divorced parents to reconcile”). In addition, family members’ attempts to address problem behavior might become a vicious cycle in which the solution becomes the problem.

ANXIETY

Jackson took to heart a major tenet of Sullivan’s as he developed an interview style that looked for manifestations of anxiety that would disrupt communication (Ray, Stivers, & Brasher, 2011). Anxiety in this approach is behavior generated by fear of rejection that shifts a conversation away from a risky exchange that threatens a person’s safety in a relationship. In sessions, Jackson would explore these subtle shifts and the minute-by-minute progression of anxiety that leads to the shift.

HYPOTHESES

Therapists at MRI explored which solutions had been tried to resolve the problem (Weakland et al., 1974). Often the attempt to solve the problem would worsen the original situation. In exploring the Nelsons’ attempts at solving the problem of Paul’s behavior, the therapist discovers that their primary solutions have been verbal (nagging, criticizing, and threatening), and Paul’s responses have been nonverbal; furthermore, none of these attempted solutions have been successful. These would be considered first-order attempts at change, rather than second-order solutions that change the nature of the relationship. In first-order change, the method changes slightly, but the category of the method stays the same (negative interaction). Second-order change would require Lilly and Roy to identify options they could implement in order to be more action-oriented and less verbal and negative (the change in category leading to a more constructive relationship). This type of change would also address parents’ anxiety and empower them to be firm, regardless of Paul’s complaints.

Behavioral Family Therapy

Because Patterson began to consider the cost-effectiveness of the treatment of children, he paid increased attention to employing the child’s parents as agents of change. As he began to help parents with the behavior of their children, he also observed and noted the interactional patterns of other family members (Patterson, 1971). Research began to shift from investigating the child’s inappropriate behavior to studying patterns of interaction between family members (i.e., how two family members influence each other in ways that maintain the behavior).
SEQUENCES AND REINFORCEMENTS

This approach focused on the behavior of individuals and the events in the social environment that trigger their behavior (antecedents) and that shape and maintain their behavior. Clinicians using this approach conduct a functional analysis that explores the consequences of behaviors (what follows) that are considered goals and reinforcements to them (see Box 9.1 for an example of a functional analysis). The social learning approach views family dysfunction as the result of infrequent positive reinforcement between family members (i.e., not enough rewards for positive behavior). Thus, positive behavior is consistent when it is rewarded accordingly. Often an aversive stimulus, or punishment, is used by one family member to control the behavior of another. Social learning theory views family conflict as the use of aversive control rather than the use of positive reinforcement. The eventual outcome is a low rate of positive reinforcers exchanged over an extended period of time.

COERCION THEORY

Patterson also developed coercion theory, the result of intensive home observations over extended periods (Smith et al., 2014). He found that aggressive behaviors often occurred after a pattern that alternated between withdrawal and giving in. This inadvertently reinforced antisocial behavior and would lead to deadlocks filled with negativity and parental control with little positive reinforcers. One important research finding is that coercive parenting at age 2 was positively related to antisocial behavior at age 6. This evidence encourages early interventions for parenting styles.

HYPOTHESES

Before skipping school, Paul reports getting up in the morning and wishing that he didn’t have to face his teacher, Mr. Rawls. He is self-conscious about being held back a year in school, and he’s jealous that Ed doesn’t have to get up as early. When he goes in the school door, he feels a heaviness in his chest. Out of his mother’s view, he walks down the hall and out the other door. He walks through the neighborhood and sometimes goes to the gas station where Ed works.

The remaining sequence of these events appears in the earlier section on structural family therapy. Although the questions are similar, note the antecedent information that comes from a functional assessment. The therapist can hypothesize that Paul’s interactions with his teachers serve as an aversive stimulus, signaled by the heaviness in his chest. This might be a phobic reaction (fear). His visits to the gas station may serve as positive reinforcement. After school, his mother’s reaction might be a negative reinforcement and his sister’s attention might be a positive reinforcement.

Psychodynamic Family Therapy

Several pioneers share an attention to family dynamics across several generations and a history in psychodynamic theory. They conceptualize families and their problems in terms of psychological dynamics passed from generation to generation. The rise of Freudian thinking resulted in a proliferation of approaches that used similar names. Each brand of psychotherapy developed distinctions that led to names, such as psychoanalysis, psychotherapy, logotherapy, reality therapy, etc. The umbrella of psychodynamic therapy often referred to those who no longer adhered to Freud’s psychosexual focus but maintained a focus on the importance of childhood emotional experience. Psychodynamic family therapies are those that consider the
influence of the developmental past in the present, whether working with individuals, couples, or families in the room. Their theories helped them chart a therapeutic course across time.

During the 1930s, Nathan Ackerman, MD, sometimes referred to as the grandfather of family therapy, considered psychiatry to be the study of family relationships. An early practice site exposed him to depression-era coal miners who were dejected and unemployed. He saw the effects of these social processes on their children and concluded that personal well-being was clearly influenced by environment, not only internal process. In the 1940s, Ackerman worked as chief psychiatrist for the Menninger Clinic in Topeka, Kansas. Bowen was also there (1946–54). During this time, the Menninger Clinic became renowned for pioneering a biopsychosocial approach to psychiatry that integrated medical, psychodynamic, developmental, and family systems approaches to treatment.

PAST IS IN THE PRESENT

In 1958, Ackerman published The Dynamics of Family Life. This was the first book describing the diagnosis and treatment of family relationships and bridging the gap between intrapsychic and interpersonal theories. Ackerman was a child psychiatrist, and his interest in the welfare of children took him into homes and stirred his interest in seeing the entire family. He noticed a “live type of history” emerging as families reviewed the history of a problem. Because these historical disclosures related to present emotional experience, he considered this “the ‘live past,’ not the ‘dead past’ of family life” (Ackerman, 1981, p. 319). For him, the main tasks of the therapist became reeducation of the family, reorganization of family communication, and facilitation of growth through an exploration of the emotional experience of the family.

Ackerman founded the Family Institute of New York in 1965 and became known for other concepts such as body talk, and circular interchange of emotion. He wrote about interlocking pathologies and the purpose of the family therapeutic interview. He promoted therapeutic interactions that would enable family members to “feel in touch with the therapist” through the therapist’s use of self. At the time, these were novel and groundbreaking ideas. The old-fashioned language of pathology did not prevent Ackerman and others from respectful, compassionate relationships with their patients. His work reflected the relevance of past experience on the present, the importance of reading nonverbal communication, and the centrality of emotions in family process. However, as a result of Ackerman’s untimely death, the work of Bowen, Boszormenyi-Nagy, and object relations family therapists became more widely known and carried forth.

SUBJECTIVE EXPERIENCE

While these early leaders were evolving in America, there were also European analysts who continued a focus on childhood influences but refined other theories related to personality development. Some of these were Alfred Adler, Melanie Klein, Ronald Fairbairn, and John Bowlby. Adler developed his individual psychology to explore the social world of children and how that impacted their motivations. Adler developed a keen sense of children’s desire to belong and fit in. He emphasized the importance of subjective experience, as he asked his patients to describe their early recollections. From these, he would interpret themes, such as competition, inferiority, and social interest. For Adler, all behavior had a purpose based on a person’s goal of belonging. Today, neuroscientists with no knowledge of Adler report research findings that suggest “we are all hard-wired to belong” (Izuma, Saito, & Sadato, 2008). They provide an interesting validation for Adler’s central interest in connection and belonging.
Adler also focused on fostering cooperation and prosocial behavior rather than competition. His follower, Rudolf Dreikurs, popularized the concept of having the **courage to be imperfect** (Dreikurs & Grey, 1968). This principle is now found in numerous parenting and wellness programs that encourage family members to avoid perfectionism and overcontrolling. These interfere with positive relationships and attachment bonds. Parents are encouraged to accept imperfection in themselves and their children. They are encouraged to make peace with themselves and model a type of optimistic, prosocial, strength-focused approach to encourage children’s development. In doing so, they can help children avoid the **four goals of misbehavior**, which are attention, power (control), revenge, and avoidance. When children have a strong sense of belonging and a desire to contribute, misbehaviors diminish. Adlerian models of parenting provide guidance on positive strategies that address these four goals. They are relevant for all ages and help families overcome marital difficulties, antisocial behavior, and mental health challenges.

**OBJECT RELATIONS**

Klein and Fairbairn are credited with developing **object relations theory**, an offshoot of Freud’s original concepts that left drive psychology behind but continued an interest in the subjective world of children. Trying to have scientific credibility, Freud used the word **object** to mean a target for libidinal drives, whether in an infant or adult. Klein worked with children and developed techniques to access their objects or **fantasies**. Fairbairn believed that objects were not fueled by biological drives but were really about the **desire for relationships**.

Now, object relations theory refers to **internalized images of people, ideas, experiences, relationships**, and anything that is part of one’s subjective experience of self and the world (Scharff & Scharff, 2014; Slipp, 2014). A person’s inner world is no longer divided into Freud’s drive psychology but has become phenomenological and interactional. Conscious experience of judgments, perceptions, and emotions become a world of its own (object). These subjective images interact with each other in a person’s life. Images of emotional childhood experiences become objects. Internal perceptions of people who were central to a child’s well-being are objects.

A relevant aspect of neuroscience is the study of **memory**. Hood (2012) maintained that the subjectivity of memories renders the human memory bank more “compost heap” than “filing cabinet.” Subjectivity has an organic domino effect that defies order. Thus, the exploration of these subjective memories (or objects) can unlock explanations for behavior that are useful in addressing couple conflict, parent–child detachment, aggression, depression, borderline personality disorder, obesity, and many stress-related health problems. Chapter 7 will outline the process of constructing genograms and timelines in a way that shifts these subjective-interactional images over time.

**ATTACHMENT**

Although object relations theory became very popular among the British, Bowlby split from Klein when she would not allow him to interview parents of his young patients under her supervision (Bowlby, 1987 as cited by Bretherton, 1992). He believed that the lived experience of children was more relevant than their fantasies and wanted to understand the developmental context of a child’s subjective experience. First, he spoke to parents about their children. Later, he met with the entire family. For him, **attachment** behaviors are evolutionary tools of survival for infants and children. As his work evolved, he saw the importance of examining
separation and loss as important points in the course of human development. Bowlby’s work has now made its mark on other family therapists for decades to come. In this book, some third-generation approaches directly address attachment at various life stages, and all family therapy models consider positive emotional climate to be synonymous with secure attachment in families.

James Framo was a psychologist who adopted an object relations approach to family therapy and worked with Boszormenyi-Nagy at the Eastern Pennsylvania Psychiatric Institute (1958–68). His work was informed by Fairbairn (1954) and Dicks (1967), as he convened family groups with adult children to explore and heal intergenerational wounds. Usually, symptoms were reported in the children. Unlike Bowen (1978), who often worked with individuals alone, Framo used whole family sessions to identify issues, increase empathy, and work toward resolution. This dynamic process shifted the images (objects) that each family member carried as their reality of others.

HYPOTHESES

Phenomenologically, Paul may be trying to find his place in the family and his sense of belonging. His brother has a girlfriend and his sister has friends and school activities that create connection. Paul’s misbehavior would be a sign that he is discouraged and needs encouragement to see his strengths and use them to connect with others. Lilly may get caught in circular interchanges of emotion with Paul due to painful childhood experiences. She may step out of a parent role and over-identify with Paul’s discouragement. Roy, as an only child, may have had attention from both parents in a way that kept him from developing more leadership skills. Parents may benefit from exploring what childhood memories emerge when they are in conflict with Paul. There may be assumptions about his behavior that are based on previous experience rather than his unique circumstances.

The unmet needs of Roy and Lilly from childhood may also be factors. They may have painful experiences or traumas that have led to various coping strategies with their children. Memories of formative events may shed light on how they have responded to Paul’s behaviors. The therapist discovers that Roy’s mother lives in their neighborhood and has been widowed for five years. As family members begin discussing the loss of Grandpa, Paul becomes animated and talkative for the first time. He relates his memories of Grandpa, giving particular emphasis to the sadness that he can still vividly remember feeling on the day of the funeral. Other family members also describe family vacations that Grandpa organized and the great void his death left in the family. Since his death, there have been no family vacations. The year after his death, Lilly went to work outside the home for the first time. Paul was ten at the time.

The Nelsons can be seen as having not recovered fully from Grandpa’s death. The void in the family was not filled by anyone else taking on the planning of family vacations. For Paul, the void might have widened when Lilly went to work and Janet graduated from elementary school, leaving him to attend his school alone for the first time.

Bowenian Family Therapy

In 1954, Murray Bowen left the Menninger Clinic and began a project for the National Institute of Mental Health (NIMH) with Lyman Wynne. In the project, families and their children with schizophrenia lived in a research inpatient unit. Bowen developed a set of concepts taken from biological systems and his family systems theory contributed to decades of therapists exploring their own families of origin. From these trainings, Bowenian therapists found their own creative
ways of addressing these dynamics in their clients. Similar to Ackerman, many use a form of exploration and education. Like Freud, Bowen placed more emphasis on his work as a theory of human development, rather than a specific model of practice.

**NATURAL SYSTEMS**

Bowen drew parallels between the behavior of cells, organs, and family groups. In their own way, each plays out the balancing forces of nature that lead to survival. He used principles of biology to explain concepts of family health, such as individuality and togetherness. All biological systems survive through coordinated processes that lead to balance and equilibrium. Similar to Jackson’s interest in homeostasis, Bowen’s thinking was that social systems need balance in the same ways as biological systems. Based on these ideas of balance, he developed hypotheses about how individuals, like cells, have capacities for submitting to the greater whole (togetherness) or specializing to provide other resources for survival (individuality). In addition, he used concepts of brain development to explain how the human emotional system develops before the thinking system, highlighting the importance of strengthening the balance between the two. This balance enables a greater range of logical reactions to anxiety and stress (Kerr, 1981).

**EIGHT INTERLOCKING CONCEPTS**

From this view of natural systems, Bowenians use eight concepts as a lens for assessment. **Differentiation of self** is the process by which adult children develop a balance of independence (autonomy) and connection with their families of origin and with other important social-emotional systems. **Triangles** are the smallest relational systems that have enough resources to stabilize anxiety. **Family projection process** is the transfer of parents’ anxieties onto a triangled child. This can continue across one or more generations as a multigenerational transmission process. **Emotional cut-off** occurs in the wake of overwhelming emotion in a relationship. **Sibling position** may uniquely influence how a child comes to have a certain role in the family. **Nuclear family emotional process** is the balance of emotional reactivity (anxiety) and rationality that each family exhibits during times of change or stability, based on beliefs, attitudes, and behaviors at the time. **Societal emotional process** is a community’s response to current events that impact families and may fall prey to imbalances in emotion vs. rationality.

Through Bowen’s work, therapists today often explore beliefs, values, and interactions that influence the emotional growth and maturity of family members. Unlike structural, MRI, and strategic therapists, these practitioners consider information about past relationships to be a meaningful springboard from which to design interventions in the present (live past). Bowenian therapists assume that parenting and marital patterns are influenced by experiences in each parent’s family of origin. As parents pass on their level of differentiation to children, relationships are often fused (too close and too emotionally reactive). Bowen introduced the widespread use of the genogram, such as that in Figure 1.1, used by many approaches to family therapy, regardless of their theory. This became his vehicle for exploring family dynamics and educating family members on basic principles of healthy relationships.

This model suggests that each member of the family acts impulsively out of emotion or tradition and is unaware of how the power of reason can generate improved relational patterns. This imbalance of emotionality over rationality is also referred to as a lack of differentiation, even if issues of independence are not obvious. The fact that family members engage in
repetitive interactions that bring about the same unsatisfactory results is an indication of the intense anxiety that motivates their behavior. In addition, this anxiety leads to a process of triangulation, in which one person enlists the support of another person against a third party in the family. This model suggests that when family members can discern the difference between the anxiety of their current behavior and the logic of alternative solutions, they can develop more healthy relationships in the future.

**HYPOTHESES**

Bowenians would assert that both Roy and Lilly respond out of emotion rather than rationality when addressing Paul’s behavior. They would reason that Paul and his siblings are mirrors of a transmitted family process (family projection process) rooted in the historical evolution of previous generations. Paul’s behavior would be thought of as coming from some gut-level instinct that manifests the same level of differentiation as his parents.

The historical development of the Nelsons illustrates how a lack of differentiation can be passed down through the generations and also how it can be exacerbated through traumatic life events. It emerges that Paul’s behavior did not become problematic until the sixth grade, approximately one year after Grandpa’s death. This was also the year that Lilly went to work. During the interview, Roy and Lilly describe the first years of their marriage as very happy. Lilly’s parents died when she was young, and she was happy to be adopted into Roy’s family. Thus, their level of differentiation from Roy’s family may have been interrupted. For example, the fact that Grandpa planned all the family vacations suggests a lack of involvement and leadership from Roy. Lilly may have felt nurtured by her in-laws but not have the necessary independence to be a proactive parent. She reported feeling helpless when Paul would demand that she pay attention to him, listen to him, and buy things for him.

**Contextual Family Therapy**

Boszormenyi-Nagy was a psychiatric resident in Budapest, Hungary during 1944–48. There he studied under Kalman Gyarfás, a relationally oriented psychiatrist and friend who eventually moved to Chicago and became a mentor to Satir before she migrated to MRI. Boszormenyi-Nagy also came to Chicago at that time, becoming influenced by the ideas of Hegel and Buber. Hegel (2015) was a philosopher who sought to reconcile polarities and acknowledged social connections as the source of meaning through families, cultures, groups, and institutions. In his view, societies evolve in the same way arguments do. A thesis or idea is met with an antithesis or argument, and this eventually leads to a synthesis or integration of positions. He explored hierarchical relationships, such as master-slave, looking for ways to reconcile the power differential that prevented personal relationships. He suggests that self-consciousness evolves through the eyes of another. This orientation is evident in Boszormenyi-Nagy’s work with family members as he takes opposing views and facilitates dialog and discussion to bring the two perspectives together.

In addition, Martin Buber (2010), a Jewish philosopher, became known for his thinking about relationships as either I-thou or I-it. He acknowledged the reality that people have many relationships with objects and things, but it is important to maintain a priority on I-thou, relationships between people, and the importance of those bonds. Life is interpersonal in nature, and recognizing the basic humanity of all people was a strong theme. Boszormenyi-Nagy applied Buber’s ideas through his practice of multi-directed partiality. By discussing the issues with each family member in the session, he sought to understand and validate their perspective.
This would lay the foundation for resolving conflicting views and coming to a new synthesis within the family. This new synthesis would lift blame off everyone’s shoulders and exonerate parents and children through an understanding of their unique challenges and dilemmas. Often, parents would exonerate their parents, as they developed systemic empathy for each generation’s unique wounds. An example of this is found in a memoir by the celebrity, Jane Fonda (2005), who resented her mother for committing suicide and abandoning her family when Jane was 12. As an adult, she obtained her mother’s medical records and discovered she had been repeatedly sexually assaulted as a child. This discovery led to an understanding and lifting of blame that Boszormenyi-Nagy calls exoneration.

In 1957, Boszormenyi-Nagy began a family therapy research project at East Pennsylvania Psychiatric Institute that included intensive psychotherapy of hospitalized patients with psychosis. His work included the entire family and addressed communication and behavior patterns. He found that general systems theory ignored ethical issues of trustworthiness and fairness in family life. It was in this setting that he was able to bring his thoughts from Hegel and Buber into the therapy room. Using these ideas about interpersonal polarities, he developed a theory of relational ethics.

RELATIONAL ETHICS

Boszormenyi-Nagy uses four ethical concepts in his work: trust, justice, entitlement, and loyalty. He explores the dynamic balance of fairness, trustworthiness, and loyalty between people. The concept of the parentified child refers to children who have assumed so much responsibility for parental functions that they no longer trust that fairness will prevail. They have learned not to trust adults to take care of them. For example, a 16-year-old girl recounted all the years that she sat home alone while her divorced mother would go to the neighborhood bar after dinner. Finally, she would walk over alone, guide her staggering mother home, and help her to bed. She came into therapy wondering, “Why am I always mad at my mother?” The therapist explored those relational ethics to which she was entitled: trustworthiness in a parent, loyalty from her mother, and fairness in expectations for her as a child. In addition, because her mother was unavailable for family therapy, they explored her social network and found other adults who provided her with love and safety. From these dependable relationships, she could see herself as loveable. Finally, she was old enough to change some of her communication with her mother. She began advocating for herself, “Mom, I really want to spend time with you. Can we go to the movie together?”

LEDGER SYSTEM

Boszormenyi-Nagy helped his families vocalize their personal sense of justice through mapping a ledger system. This is the private sense of justice that all people carry with them. Common beliefs in a ledger system are:

1. After all I’ve done for you, I deserve . . .
2. It’s not right that I always have to be the one who . . .
3. After all I’ve been through, I need . . .

Sometimes, these may be private, subjective beliefs of parents and children that are unknown to others. By exploring perceptions of each person’s contribution and their sense of fairness in that context, families become aware of the balance between giving and getting for each person. From these conversations, Boszormenyi-Nagy could identify whether there was a sense of destructive entitlement for a family member. Substance abuse and aggression can be thought
of as forms of destructive entitlement that stem from perceived injustices. These are given a voice and can be addressed and resolved in therapy. Through addressing a person’s ledger and the perceived imbalances, multi-directed partiality is the therapist’s expression of empathy and validation for the person’s pain. These ledgers become the backdrop for problem-solving and negotiation within the family.

As this model developed, practitioners also recognized that issues of fairness and justice extended beyond the intergenerational family to society. They acknowledged the “societal background of ripped-off, overburdened, abandoned nuclear families” (Boszormenyi-Nagy & Ulrich, 1981, p. 161). Boszormenyi-Nagy believed that injustices at all levels deserved a fair hearing to develop reparation, reconciliation, and justice, even if only at a level of community advocacy in which entitlements (trust, justice, loyalty) can be acknowledged and validated.

Hargrave and Pfitzer (2011) also applied these ideas in their model of restoration therapy. As an approach to resolving childhood wounds and the resulting marital discord, they focus on the power of love and trustworthiness as key elements in individual and couple healing. As marital breakdown is understood in the context of injustices from childhood wounds, each spouse has the opportunity to embrace their entitlement to love and attachment: “I am loveable and worthy.” These are powerful themes for those who have been shamed by attachment injuries, and they become vehicles for changes in self-esteem and marital interaction.

**HYPOTHESES**

Boszormenyi-Nagy (1987) might have assumed that each person in the family is motivated, in part, by a subjective sense of fairness that can be understood only from his or her unique development (relational ethics). This ledger system provides a framework by which the family therapist discovers each person’s subjective justification for his or her current behavior (Boszormenyi-Nagy & Krasner, 1986). Paul’s motivation for skipping school could come from an unspoken sense of entitlement based on some contribution that he perceives himself to be making to the family. For example, having seen his brother drop out of school at age 16 (a perceived privilege), Paul might think he is entitled to the same privilege in return for the loyalty he manifests to his mother against his father. Understandably, Roy and Lilly might also be motivated by a sense of entitlement and justice that comes from their experience in their own families. (“We were expected to obey our parents unconditionally, and we are entitled to the same obedience from our children.”)

**Experiential Family Therapy**

As family therapy literature expanded from the 1970s on, various authors categorized models of practice according to their contextual roots, concepts, or interventions. Experiential family therapists are those who use the therapy hour to generate emotional intensity that is native to day-to-day family life, rather than relying on the atmosphere of formal, office-based work. They evoke the emotions of vulnerability to address parental distress and marital conflict. First-generation experiential family therapists evolved from psychodynamic, existential, and humanistic approaches to psychotherapy. In the 1950s, these pioneers took the new psychodynamic thinking of the day, joined it with general systems theory, and used emotional therapeutic encounters that would facilitate a corrective emotional experience. Franz Alexander, a Viennese student of Ferenczi’s, used this phrase to describe the benefits of using the self of the therapist (countertransference) to explore the pain and vulnerability behind a patient’s defensive behavior. Thereafter, psychodynamic therapists have used the term to
describe the goal of therapy, as it relates to a person’s emotional development. Although Virginia Satir and Carl Whitaker are both described as experiential in their approach to family therapy, each evolved from different traditions.

THE SATIR METHOD

Satir, a social worker, came out of the communication tradition at MRI, where she was co-founder with Jackson and director of training. She later aligned closely with the human potential movement. In 1964, she published the first edition of Conjoint Family Therapy, a pioneering work in family therapy that highlighted her beliefs about human beings as evolving and capable of growth, change, and intimacy with each other. As one of the few women recognized for making pioneering contributions to family therapy, she became “a kind of living legend as family therapy’s most celebrated recruiter and goodwill ambassador . . . perhaps the most imitated family therapist of her time” (Simon, 1992, p. 168). She emphasized the development of positive self-esteem through self-acceptance and the therapist’s role in promoting family relationships that fostered the individuality of each member. More recently, her approach is called Satir Transformational Systemic Therapy.

Satir may have been the first pioneer to explicitly note the importance of strength-based work. Although this is a central part of second- and third-generation family therapies, her emphasis on forming a connection that would provide safety and hope in the face of vulnerability was still new to these emerging approaches. She avoided the labels of pathology and was never critical of any client. Her bond with each client was always based on these assumptions:

1. Self-esteem is the right of all people.
2. Everyone has inner resources to help them grow and change.
3. People are doing the best they can at any point in time.
4. The therapist’s role is to connect with the life force or spirit of each person.

Her famous “Declaration of Self-Esteem” has been published around the world and illustrates her attention to choices that lead to self-acceptance and self-esteem. It ends with the statement, “I own me, and therefore I can engineer me. I am me and . . . I AM OKAY (Satir, 1972). She also developed a process called family sculpting to bring action into the session while processing emotional issues between members. Using her skill in identifying communication patterns, she would help people enact those same patterns with changes that brought about new possibilities (Satir, 1972). Her Self-Esteem Maintenance Tool Kit is a creative use of metaphor and symbol to foster each client’s confidence and hope. Chapter 8 describes these interventions in detail.

CARL WHITAKER

Whitaker came from a psychiatric background in which he worked with schizophrenia and institutionalized boys. As he moved to a group practice setting, he and his collaborators began to see families. Here he developed his ideas of family where he had the freedom to work in novel and creative ways. However, unlike Satir, he was difficult to imitate because of his challenging and controversial personal style. In his work, Whitaker’s primary assumption was that symptoms were attempts at growth and healing. In object relations fashion, the need for growth was tied to normative developmental steps, moving from parent–infant issues to adult–adult experience. His work, sometimes called symbolic-experiential, is noted for his intense involvement through caring and challenge. He considers therapists to be parent symbols
who will provide caring and encourage growth from the current stage forward. He preferred co-therapy to provide an even greater parallel to the parenting process.

Throughout his career, students flocked to him because of his wisdom and forthright opinions. For example, he might say to a farmer, “When did you divorce your wife and marry your tractor?” Or, “Marriage is 50% in love and 50% indifference.” “If you can’t stand loneliness, don’t get married!” “There is no such thing as a person without a relationship” (Whitaker, 1986). Family therapy is always possible. Seeing all persons being in relationship, he would explore their history and their sticking points and provoke reactions that would relate to developmental issues, not the superficial description of the problem. For example, two parents brought a college-age son to therapy because he was burning his arms with cigarettes. Whitaker explored their narratives, asked for some history, sensed their cold distance and then said to the boy, “That’s no way to get warm. Stop doing that.” The boy began to sob. This was interpreted as an invitation for him to express his most basic needs for warmth. Always practical and realistic, he would acknowledge human needs for growth and connection while modeling a common-sense approach. Often, he would see the cultural forces at play that would hinder more authentic communication. During these times, the therapist’s role would be to rebel, to join with the patient’s symptoms as a form of rebellion. From these times, he would proudly earn the reputation of being “crazy” to minimize his patient’s social isolation. Often, he would share his own experience as a lonely boy on a dairy farm in New York (Simon, 1992).

**HUMAN GROWTH AND DEVELOPMENT**

These pioneers share an investment in “spontaneity, creativity and risk-taking . . . a commitment to freedom, individuality, and personal fulfillment” (Nichols & Schwartz, 2001, p. 175). Both believed that when the therapist is open and spontaneous, family members will learn to behave in the same way. Experiential family therapists focus on subjective needs of individuals in the family and facilitate interactions that address the individuality and self-esteem of each member. These clinicians believe that all individuals have the right to be themselves; however, family and social needs might often suppress the individuality and self-expression by which a person becomes fully understood and known in the family (intimacy). As parents are the architects of the family (Satir, 1972), they are responsible for providing sufficient structure and nurturance so that the individuality of each child can be fostered. However, parents often manifest their low self-esteem through embarrassment, helplessness, criticism, or hostility that they feel regarding their children’s struggles.

With empathy and support from the therapist, the parents come to accept their own emotional experience, thereby becoming more intimate and caring. As self-awareness increases, the quality of communication improves, fostering self-esteem and growth in family members. By fostering self-acceptance, the experiential family therapist helps parents to become who they want to be. They can learn to forgive themselves for not being perfect parents or marital partners. As they do this, they can also risk more intimate self-expression with each other. As they learn to tolerate intimacy (and the accompanying risk of conflict), their acceptance of themselves and each other generalizes to their children. Interactions become opportunities for family members to be heard and understood, rather than contests to control or judge.

**HYPOTHESES**

The therapist discovers that Ed does not see himself like either parent. He dropped out of school with his parents’ permission. He felt discouraged about his school performance and did not want the continued humiliation of failure. Thus, he has low self-esteem and lacks confidence...
about his abilities. He never exhibited behavior problems at school or at home. However, as the family discussed ways in which they tried to help Ed with his studies, it emerged that both Lilly and Roy thought Ed was like them because they had no understanding of the math techniques being taught at the high school, and they felt intimidated and helpless in the process. They are viewed as discouraged and feeling powerless about how to help their children. However, they would usually become angry and embarrassed when Ed received his report card, telling him he should ask his teachers for more help. When Ed announced that he wanted permission to drop out of school, Roy had few words to say and Lilly was relieved. This pattern indicates fear of expressing the most personal of emotions and an inability to respond to the discouragement and vulnerability of another. Likewise, this set the stage for Paul’s low self-esteem and his discouragement in school. Parents would become immobilized over his school performance and compare him to his sister. As his self-esteem declined, he sought refuge outside school where he could be alone with his emotions.

SO, WHERE DO I START? TOWARD INTEGRATION

As illustrated in this chapter, practitioners begin with a set of concepts that guide their observations. What is happening in the family? Should there be a preferred approach? First-generation family therapists have many different perspectives on the Nelson family. In contrast to the traditional lens of psychoanalysis, these perspectives were radical for their day — hard to imagine, given how practical and obvious some of them may seem to us now. This is because our society has become more attuned to these levels of analysis and theories of development. Perhaps the earliest example of integration occurred when Stanton (1981) coined the term structural-strategic and then, with Todd, applied that model in their groundbreaking work on drug addiction (Stanton & Todd, 1982). This term is now used frequently to describe those who begin with structural hypotheses about the role of leadership and boundaries, but use strategic interventions, such as directives or assignments, as they develop treatment plans (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Keim, 2014). A number of other integrations appear in later chapters.

Table 1.2 at the end of this chapter summarizes key aspects of these pioneering models. These are the characteristics that have withstood the test of time. Although each model provides different concepts and language, the therapist’s ability to integrate the family’s lived experience with a given theoretical direction may really be at the heart of successful family therapy. As the field of family therapy has developed over the past century, the movement toward distinct schools of thought has given way to integration of these major modes of thinking. As Nichols and Schwartz (1991) noted:

Theoretical positions tend to be stated in doctrinaire terms that maximize their distinctions. While this makes interesting reading, it is somewhat misleading. The truth is that the different systems of family therapy are more alike in practice than their theories suggest. Moreover, each new approach tends to become more eclectic over time. Practitioners start out as relative purists, but eventually discover the validity of theoretical concepts from other approaches and the usefulness of other people’s techniques.

(pp. 512–13)

Thus, contemporary family therapists integrate some or all of these perspectives when they assess a case. The old phrase “All roads lead to Rome” suggests that some general outcomes can be achieved in a variety of ways. Using the hypotheses from each approach, the Nelsons’ situation can be broken down into themes and then into developmentally appropriate steps.
Organization

Structural. Parents’ teamwork may have eroded due to life stressors; relationships are uneven with the children and reflect a lack of leadership.

Strategic. Paul’s behavior may be a symptom (or message) for life-stage adjustments or marital conflict.

Problem-Solving

MRI. Attempted solutions appear ineffective and have now become problematic relationships.

Behavioral. Paul is faced with aversive stimuli from school, positive reinforcements from trips to the gas station and from his sister, and negative reinforcement from his mother.

Emotional Climate

Psychodynamic. Parents’ childhood experiences may leave them without certain skills for parenting discouraged children who want to fit in. They may need support and education for learning to accept themselves and their children’s limitations. Unresolved losses and childhood coping strategies may be underneath the family’s emotionality.

Bowenian. Parents lack differentiation and become emotionally reactive rather than exploring logical options.

Contextual. Paul may feel a sense of entitlement due to his brother’s dropping out of school. He may be engaging in destructive entitlement. Parents may feel betrayed by Ed and Paul, believing that they deserve more respect.

Experiential. Paul’s humiliation and failure at school may be a reflection of parents’ low self-esteem and intimidation in the educational system. Parents’ responses to Ed may stem from a lack of intimacy.

First Steps

1. Start with the goal of returning the family to their best prior level of functioning (strategic, Chapter 6, setting goals).
2. Encourage and coach Dad and Mom to assume leadership in the directions below (structural, Chapter 8, boundaries, new behaviors).
3. Provide an environment of brainstorming to help the family balance fairness in their ledger system and engage in problem-solving the tasks of launching (strategic, contextual, Chapter 8, assigning tasks).
4. Explore Grandpa’s death, his role in the family, and what is necessary for the family to assume the tasks of his role (psychodynamic, structural, Chapter 7, client experience).
5. Create a family history timeline to help the family productively grieve (memorialize Grandpa) and develop a plan to carry on Grandpa’s legacy in the future (psychodynamic, experiential, Chapter 7, client experience, Chapter 9, memorials).
6. Through intergenerational exploration on a genogram, create conversations in which family members can encourage, support, and bond with each other (psychodynamic, experiential, Chapter 7, genograms).
In many cases, the components of each model might be equally relevant. Based on developmental factors, these recommendations suggest an order of therapeutic perspectives rather than an exclusion of one particular perspective. The order ultimately depends on what aspect of the presenting problem is the most pressing for the family. The focus of this chapter is learning how to think systemically from many perspectives. Chapters 2 to 4 will describe how to develop a therapeutic style that will be developmentally appropriate for each client. Chapters 5 to 8 will explain how to progress through the steps of this case and others while developing a treatment plan. Appendix H contains a formal treatment plan for the Nelsons as it might appear for managed care.

Reflecting on the integrative factors that shape his practice, Minuchin (1987) said:

> Recently, I was working with a family with three adult children whose mother committed suicide 20 years ago. I surprised myself by asking them to watch family movies and to mourn the mother’s death. I thought Norman Paul might be proud of me. Another day I was seeing a family with an anorectic child. I found myself remembering some of the writings of Hilde Bruch. I didn’t know she was one of my voices, but so it seems. Naturally pulling many voices together usefully demands an organizing frame. Briefly, the business of family therapy is change. Within this framework the possibilities are many and varied, as are the voices that speak to me. Within the possibilities open to us, the best in us always learns from the best of others. I am pleased to acknowledge that when I say to a man, “When did you divorce your wife and marry your office?”, it is Carl [Whitaker]’s voice speaking. He might not recognize it in my accent, but it is there, as are all the others. (pp. 13–14)

Perhaps if his early career had brought him in contact with hundreds of mid-life families whose mothers had died tragically, he would have pioneered a therapy different from his structural approach. On the other hand, one might also imagine, in the latter case, that his personal style, insight, and daringness would still be inspiring to us today. In 2005, at age 84, he reported that, when he reads his early writing from the 1980s, he can hardly identify with it. “If that is structural family therapy, maybe I’m not a structural family therapist!” (Minuchin, 2005). However, in his last book, before his death at 97 in 2017, the importance of structure continues to shine. He also integrated this with an additional emphasis on the self of the therapist (see Chapter 4) (Minuchin, Reiter, & Borda, 2014).

**Summary**

What is family therapy and how do we know it when we see it? The case study of Lee, a homeless and mentally ill man, provides a real-life demonstration of how family therapy and systemic thinking contributes to contemporary mental health treatment. A review of concepts related to family process, cybernetics, and social ecology provides an overview of how family therapists worked with Lee. Along with communication analysis and collaborative relationships with families, a systems/relational approach keeps the interpersonal elements of a presenting problem in the forefront.

From the beginning of the 20th century, worldwide changes in thinking led to many refinements in mental health treatment. Dating back to the time of Freud, there were those, such as Adler, who focused on the social aspects of personality development and Ferenczi, who focused on the interpersonal aspects of therapist–client relationships. These innovators went
on to influence early childhood educators and social psychiatrists who saw the importance of intervening with families of their patients. One of these was Harry Stack Sullivan, an American psychiatrist who had a seminal role in mentoring family therapy pioneers. Most first-generation family therapists can trace their emerging thoughts to the influence of Sullivan. His followers began developing a more holistic and interpersonal approach to understanding human problems and resolving them. Then came psychologists like Patterson, who applied social learning theory to his work with aggressive children, and the influence of Milton Erickson, the unconventional psychiatrist from Arizona, who became the father of modern-day hypnotherapy. Family therapists were drawn to his theories about how people can change.

These rogue pioneers left their traditional training in many fields and became a coherent network of like-minded systemic thinkers. This led to the development of family therapy, first as early practice, research, and education, then as diverse approaches used with different populations, all with an interpersonal focus. The eight first-generation approaches in this chapter include structural family therapy, strategic family therapy, the MRI approach, behavioral family therapy, psychodynamic family therapy, Bowenian family therapy, contextual family therapy, and experiential family therapy. These are explored for concepts and hypotheses that comprise systemic thinking. Each model provides a lens to analyze a second case study with an acting out adolescent.

Key elements from the GARF provide a language that integrates first-generation models. Integrative treatment recommendations illustrate the decision-making process so that practitioners can tailor a treatment plan to individual cases. The models presented in this chapter and summarized in Table 1.2 are the beginning of the integrative approach that develops across remaining chapters of this book.

Other models of practice have built upon the work of these pioneers to account for gender, race, culture, life transitions, the debilitating effects of post-traumatic stress disorder, divorce, and personal narratives. This suggests that family therapy is a field organized around systemic/reational concepts and is continually open to new and creative refinements in practice. Chapter 2 reviews these second- and third-generation innovations, including the ecosystemic approach that was effective with Lee.

As Minuchin suggests, perhaps the therapist is on a journey of discovery as much as the client is and must be open to shifting directions as new information comes forth. With this goal of openness in mind, take on a spirit of discovery and see what happened to the practice of family therapy as the 20th century came to an end. Chapter 2 shifts from exploring first-generation models to understanding the contribution of postmodern family therapy and third-generation adaptations that tackle some of life’s most vexing challenges.
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CHAPTER 2
The Postmodern Era and Integration

CHAPTER OUTLINE

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AMFTRB Knowledge

02. Models of marital, couple, and family therapy
09. Empirically based approaches to couples and family therapy
12. Family belief systems and their impact on problem formation and treatment
21. Child, adolescent, and adult psychopathology
23. Impact of developmental disorders (including but not limited to child and adolescent, geriatrics, autism spectrum disorders, and pervasive developmental disorders) on system dynamics
24. Trauma (including but not limited to historical, current, anticipatory, secondary trauma response, and multiple/complex)
31. Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD)
After 1970, the postmodern era of philosophy in the Western world began to influence many disciplines. This era is known as one that challenges traditional thought and questions authority. Critiques regarding absolute truth and objective reality became commonplace in many sectors of society. After a century of unprecedented advances in technology, business, science, and medicine, philosophers and social scientists began to examine the effects of this progress. Many areas of health care, social services, and education evaluated their traditional practices and developed innovations that remain today. For example, the training of physicians changed to focus on the latest medical research rather than relying solely on the intuition of senior practitioners. Social services developed many policies that led to greater efforts in child protection. Educators evaluated the process of learning, not merely the content that teachers present.

With respect to mental health treatment in America, psychoanalysis had once recommended weekly sessions over a lifetime. As the number of psychotherapy models grew, payments for service sometimes came from insurance companies and government programs. However, these sources began to question whether unlimited payments were necessary: Does this approach work across an entire group of people? Is there a better way? After 50 years of tradition, this environment changed in the 1980s with the advent of managed care. This practice in funding developed as a challenge to the traditions of unlimited costs in mental health treatment. All psychotherapy services were evaluated for their necessity, cost, and effectiveness. As a result, the funder, not the practitioner, would decide whether the service was necessary. Currently, this extreme has swung back to the middle and third-party payors negotiate with practitioners regarding the best course of treatment.

At the same time, there were also changes in the pathways to treatment. Mandated psychotherapy became commonplace as institutions, such as schools, courts, child-welfare agencies, and employers, sought new ways of achieving their outcomes. Rather than a reluctant spouse who was pressed to attend couple therapy, involuntary clients became more frequent, and courts ordered psychotherapy as a solution for nonconforming behavior. The middle class began using psychotherapy for a range of psychosocial problems, and the income level of clients dropped as diverse families increased caseloads of community therapists. With these emerging challenges, postmodern thought enabled service providers to experiment with new approaches to engagement and goal setting. Just as the pioneers before them, family therapists came upon new ideas about relational work from analyzing therapist–client interactions. Therefore, their theories are more about the process of change and what will bring about the most positive and hopeful outcomes.

Thus, the second generation of family therapists added new dimensions to pioneering approaches, moving therapeutic styles from authoritarian to collaborative. In addition, practitioners began to combine elements of the early models into approaches that could address the complex problems of conduct disorder, substance abuse, and mental illness. These approaches illustrate
the common practice of integration that exists today. An integrative approach organizes different elements from several theories into a coherent format for practice. There are theories of family relationships and theories about how people change in therapy. It begins by examining a family’s worldview and goals, then choosing the systemic/relational approaches that fit best for their context. This mode of thinking first began with the emphasis on constructivism in the pioneering approaches. For example, some families need a quick turn of events. This would suggest the problem-solving approaches from Chapter 1. Others may have come for “answers” as well as a change in behavior. This would suggest an exploration of family organization or emotional climate. Sometimes, integration is the use of a few models in a certain order, such as crisis intervention (problem solving), creating teamwork (organization), and preventing relapse (emotional climate). As this chapter will illustrate, a practitioner’s ability to shift between models is a skill that came about during the second generation.

**Constructivism and Social Construction**

During the 1970s, the heavy influence of the MRI led to continued critiques of mental health practices. Under the broad umbrella of constructivism, family therapists were already challenging the existing mental health establishment. Now, they began to question the limits of their early models. For example, constructivists believe that a given situation can be interpreted in many different ways. They argue that traditional approaches to family therapy represent many different ways of viewing the same case (as in Chapter 1). The question of which view is most correct becomes irrelevant. Instead, constructivists ask which view is most helpful to the family. They suggest that the family’s view of the problem may be the most important to consider because it may be restraining them from discovering more effective solutions. Constructivists emphasize Bateson’s idea that, if brought forth, information about different views within the family is information that moves the family toward change. In Chapter 7, there are directions for constructing a generic genogram that explores differences within the family. As Goolishian and Anderson (1992) pointed out, individuals are thought of as a “storehouse of maps and lenses” (p. 11). Constructivists try to capitalize on this human capacity for change by shifting a client’s attention to alternative ways of thinking.

As an extension of constructivism, social construction theory considers a person’s view to be the product of conversations, dialogs, and interactions. Similar to thoughts from Buber (2010), the meaning a person assigns to a situation comes through social process, not an isolated internal process (Goolishian & Anderson, 1992). This view of the therapeutic process places more emphasis on developing collaborative dialogs with and among clients, rather than on searching for a given reality that is assumed to be flawed. Use of language, from this perspective, is highlighted as a critical element in therapy because the choice of words has influence over what attitudes are formed. This is illustrated in the case of Lee from Chapter 1. Social constructionists often encourage the use of words based in human experience (e.g., stories and conversations) and in the language of the clients (e.g., metaphors from their relationships, work, and neighborhood) to downplay the influence of the therapist. With Lee, it was important to engage him in an informal way, paying close attention to his words, using them whenever possible, and exploring their meaning. Since he used the word entertain, the MFTs explored that word for his validation (e.g., “Sometimes therapists . . .”).

An important emphasis in second-generation family therapy is the nature of the therapist–family relationship. In first-generation models, theories and concepts about symptoms and family process were an important perspective that led to a therapeutic revolt. However, with the postmodern tendency to question authority, second-generation approaches avoided the
idea of theory about normal or healthy families. Such theories were thought to inhibit trust-
earning by encouraging criticism and negative labels. This process is called “pathologizing.”
Instead, the goal is to depathologize the conversation and focus on the family’s strengths and
resources. In addition, there was a challenge to the idea that families needed a symptom bearer:
That the symptomatic member was helping the family in some indirect way. In considering
schizophrenia, the term “schizophrenogenic mother” came under strong attack because it
suggested “mother blaming.” As part of the development of the MRI group, there was never any
research confirmation that confused levels of communication were related to these symptoms.
Thus, the idea that any family needed a person with symptoms, whether schizophrenia, drug
abuse, or childhood aggression, was dropped from mainstream publications and conferences
during this period.

In contrast to the traditional conversations about problems and symptoms, the cybernetic
roots of family therapy produced new scripts. Solution-focused family therapy focused on feedback loops that emphasized client successes. Narrative family therapy used the language of stories and oppression to involve families in a dramatic turn of events. The plot was always the same: how to overcome oppression by pulling together. In the second generation, these two traditions gained increased momentum from enthusiastic practitioners who longed for more positive relationships with their families. They found ways to change the nature of the conversation from pathology and diagnosis to the creative abilities that each family possessed. These goals also became part of many other emerging approaches during this period. They did not use solution-focused or narrative language, but their practices focused on diversity, depathologizing, strengths, client engagement, and outcomes.

**Impact of Diversity**

With respect to addressing the needs of diverse or disadvantaged groups, some family
therapists, such as Minuchin (a Russian-Jewish immigrant raised in Argentina), had always
worked with disadvantaged families. In Chicago, Satir (a tall, awkward teen, raised on a
Wisconsin farm) began a private practice that was primarily with people off the street who
were referred to her because they were considered too unruly for other practitioners (Simon,
1992). However, many second-generation family therapists were from the white, middle
class, so the voices of those marginalized within American culture (e.g., women and people
of color) and those from outside (Europe, South America, Asia, and Australia) were different
and innovative. These perspectives made family therapy more inclusive and individualized.
Clinical guidelines integrated a focus on culture and influences from the larger social
environment. Models resulting from these second-generation trends appear later in this
chapter and in Chapter 3. As mentioned in Chapter 1, these are the ecosystemic approaches
that became effective with Lee. Because he was raised in rural and urban areas during his
childhood, he straddled the diverse worldviews of these cultures. He used to complain, “Don’t
give me any of that modern stuff! I’m old school!”

In addition, other second-generation approaches came from integrations that began in the
1980s. A number of family therapists created models that added some practices needed for
the treatment of substance abuse and mental illness (Liddle et al., 2000; McFarlane, 2002).
These led to treatment research comparing family treatment with other approaches. The
result has been very exciting. Since the 1980s, reports from these projects show positive results
and illustrate the advantages to using integrated family approaches. Through these research
efforts, government agencies notice the value of family interventions (Sprenkle, 2012). These approaches use interventions that address organization, problem solving, and emotional climate. Clinicians can incorporate these ideas into their existing practices. For example, one domestic violence program integrates solution-focused principles into a program that also provides safety measures for survivors and emotion regulation training for perpetrators (Stith, McCollum, & Rosen, 2011). Another program for substance abuse, transitional family therapy, uses structural theory to address parenting teamwork, strategic interventions to interrupt problematic cycles, and intergenerational themes to heal traumatic losses (Horwitz, 1997; Landau-Stanton, 1986; Landau-Stanton & Stanton, 1985).

Now, these integrative models are a bridge between past and future family therapy. Many take structural-strategic or behavioral approaches and integrate specific treatment planning to address conduct disorders, substance abuse, depression, domestic violence, and marital conflict (Sprenkle, 2012). They often pay close attention to the therapeutic alliance and demonstrate the utility of family therapy practice across many populations and settings. In this chapter, they include emotionally focused couple therapy (EFT), cognitive-behavioral couple therapy (CBCT), multidimensional family therapy (MDFT), multisystemic therapy (MST), and multifamily groups for schizophrenia (MFG). These approaches have taken the old and new, integrating postmodern practices that leave stigma and criticism behind. Families develop a sense of hope and strength to overcome some of life’s most difficult challenges.

**MAJOR MENTAL ILLNESS AND THE RECOVERY MOVEMENT**

As postmodernism swept across the United States, there were also developments in the treatment of severe mental illness. Families of the mentally ill challenged traditional practices, and the recovery movement emerged in a number of locations. This movement considers clients to be consumers of mental health treatment who should have a voice regarding the delivery of services. There is encouragement for more egalitarianism with consumers and less reliance on a medical model of care. In community mental health services and in family therapy practice, the medical model is described as one that promotes accurate diagnosis (what is wrong) and authoritative treatment (I know what is best). For over a century, modern medical practice has been extremely successful in relieving the suffering of millions through increased research, technology, and qualified health-care providers. With success has come power. Thus, the recovery movement grew out of a need to balance the power of medical providers with consumers. Treatment planning should highlight the goals of each consumer and include a plan to meet these goals. Previously, only symptom management was the goal. This person-centered approach to treatment planning is highlighted in Chapter 6.

Currently, there is debate across a number of settings about how a recovery approach impacts consumers and families. Given the range of severity among those with chronic, long-term symptoms, there are a number of concerns about taking extreme positions. Many practitioners and family members see the benefit of a balanced program, rather than an either/or approach. This involves the benefits of medication management for chronic symptoms alongside treatment plans that are strength-based, client-centered, holistic, and individualized to maintain hope and lower stigma. Given the postmodern trends that developed in family therapy, these perspectives fit well within the marriage and family therapy (MFT) community. Those, such as William McFarlane, MD, who had an ongoing interest in family approaches provided creative leadership.
Now, those who promote family involvement eliminate parent-blaming and stigma while encouraging medication management and skill training among family members. In this regard, McFarlane (2002) is at the forefront of multifamily groups for schizophrenia (MFG). These emerged from the multifamily group movement of the 1960s (Detre, Sayer, Norton, & Lewis, 1961; Laqueur, 1964). Then, McFarlane also built upon behavioral interventions for families coping with schizophrenia in the 1980s (McFarlane, 1983; Anderson, Reiss, & Hogarty, 1986; Falloon, Boyd, & McGill, 1984; Goldstein, 1981). MFGs are now state of the art for healing parental stress, lowering stressful communications, lowering relapse rates, and creating community for families and consumers. Facilitator training in this approach contains a number of postmodern elements that all second-generation family therapies promote, such as a narrative approach to engaging family members and a solution-focused approach to stress relief. Group psychoeducation and problem-solving also provide a blame-free opportunity to develop teamwork with other families and strengthen family attachments. Current adaptations of this work address other diagnostic categories, such as bipolar disorder, co-occurring disorders, and chronic illnesses (Miklowitz & Goldstein, 1997).


During the 1980s, constructivism (the view that there are many ways to look at a problem) and social constructionism (a theory of how social process influences behavior) were gaining more attention in the field. Family therapists began thinking about how to be better listeners and collaborators. In addition, clinicians began to promote the resources of diverse people. For example, families of color with extended-family ties have important resources that were overlooked in first-generation models (Boyd-Franklin & Bry, 2000). Attention turned from an emphasis upon behavior change alone to the beliefs and values that influence a family’s interactions. For example, Italian family therapists known as the Milan team took the MRI approach and added a focus on how beliefs about the problem evolved. Michael White (1983) took his practice in structural-strategic family therapy and added a focus on the narratives of oppression and social justice. Present-day narrative family therapy emphasizes a client’s phenomenology. It takes some aspects of early models and adds reflection, questioning, and more attention to meaning and story. This attention toward beliefs also included a family’s belief about how to solve the problem. Solution-focused therapy developed from an interest in the process of change and how a shift from problem talk to solution talk could make a remarkable difference in therapeutic outcomes.

Solution-Focused Family Therapy

Solution-focused therapy developed as an adaptation of Milton Erickson’s strategies and the MRI approach. Insoo Kim Berg and Steve de Shazer studied at MRI before founding the Milwaukee Brief Therapy Institute. Bill O’Hanlon was a family therapist who was active in the Milton Erickson Foundation. Michele Weiner-Davis was a prominent couple therapist in Chicago who studied with Berg and de Shazer in Milwaukee. From these innovators came a stream of family therapists who became trained in their approaches and ideas.

This branch of Milton Erickson’s work describes therapy as changing “the viewing” or “the doing” related to a problem (O’Hanlon & Weiner-Davis, 1989). While this may seem similar to cognitive-behavioral therapy, there is also a strong emphasis on the role of the therapist as a consultant, rather than as a hierarchical mental health expert. For Erickson, resistance is an interactional problem in the therapist–client relationship; an “expression of a person’s own
uniqueness” (Erickson & Rossi, 1979). Problems of this nature require the practitioner to be less dogmatic and more accepting of clients’ worldviews and opinions about the problem. De Shazer’s (1984) pioneering article, “The Death of Resistance,” explained an attitude that had been growing within the family therapy community since the days when Haley studied Erickson’s work. Essentially, resistance is in the eye of the beholder. Positive feedback loops lead to change. If practitioners identify resistance as taught by traditional psychoanalytic models, they are invited by family therapists to examine the same behavior from a different lens. What appears to be resistance is really a client’s nonverbal messages about what fits for them. This has been one of the most significant contributions of postmodern family therapy. Challenging the expert traditions in the psychoanalytic movement, postmodern practitioners in many fields take an egalitarian, collaborative stance with clients (Miller & Rollnick, 2013).

Contrary to what is commonly thought, those who developed solution-focused work thought of the model as a more strength-based approach to people and their problems, not a formula for quick results (de Shazer et al., 2007). A few years before her death, Insoo Kim Berg lamented that solution-focused therapy had been “hijacked by managed care” (de Shazer, Berg, & Varga von Kibed, 2003). She feared that strategy and technique would overshadow the basic humanity of the approach. Ironically, this is the most common criticism of some first-generation family therapies. However, solution-focused students are taught Erickson’s early ideas. Individuals can bypass their learned limitations (Erickson & Rossi, 1979). This model recognizes the therapist’s role in assisting a family to identify resources and build on what is already working. The therapist accomplishes this through the liberal use of questions about exceptions as interventions. This is a trend toward competency-based treatment, in which strengths and successes are systematically investigated through questions and highlighted as a central element in treatment. Similar to structural and strategic family therapy, these investigations often take the form of tracking the details of interactional sequences between family members or significant others (Lankton, 1988; O’Hanlon, 1982). However, solution-focused questions explore the interpersonal details of present and future successes. Chapter 7 contains instructions for how to track interactional sequences.

In this model, therapists do not see problems as signs of failure or dysfunction, but rather as an inevitable part of family development. The therapist–family relationship becomes less hierarchical and more like a collaborative problem-solving consultation. A collaborative stance is thought to help clients adopt a more hopeful attitude about solving their problems. In fact, when a solution-focused therapist assesses clients’ motivation, the clients are considered either “visitors or customers” (Berg & Gallagher, 1991). Visitors are often those who do not see the presenting problem as a problem (as in mandated referrals) or who have become defensive when discussing the problem, particularly when a previous history with public agencies has resulted in perceptions of criticism. A customer is a person who wants some change to occur and believes therapy could be a means to that end. However, this model also assumes that client motivation can be mobilized through client–therapist interaction and that visitors can become customers through careful interviewing (Lipchik, 1987). These discoveries are validated by the large body of research on the practice of motivational interviewing, an innovation that developed for engaging substance abusers (Miller & Rollnick, 2013). Chapter 5 contains some basic skills in motivational interviewing.

Consider the sequence and its analysis in Table 2.1. Because solution-focused therapists do not adopt a position of pathology, client perceptions about helping professionals often begin to change. Therapists do not normalize violent or abusive behavior. Rather, the practitioner acknowledges the family’s point of view and addresses problem behavior within the context of the family’s perceptions. The therapist wants to know what a child does when a parent behaves
in a certain way and what happens to the child’s behavior when the parent behaves in an unexpected way. Problem-free interaction sequences are elicited, and these exceptions become the basis for future solutions. In addition, questions about agency identify what the client did to make the sequence successful. Thereafter, scaling questions lead to assignments, tasks, or questions that are designed to maintain and highlight positive changes that are already occurring.

The popularity of solution-focused approaches has come from at least three directions. First, therapists recognize the benefits of a positive approach that breaks from the pathologizing traditions of mainstream mental health practice. Second, managed-care companies find the notion attractive that common problems can be resolved in only a few sessions. Third, students have found the step-by-step instructions of solution-focused workshops easy to learn. However, as solution-focused work has become popular, there has been a trend toward expanding solution-focused practice to include attention to emotion (Kiser, Piercy, & Lipchik, 1993), not just behavior alone. In addition, beginning practitioners are cautioned to consider the client’s worldview – not just about the problem, but also about therapy. For example, when working

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<td>So, you’d like to get your probation officer off your back. Should I list that as one of your goals?</td>
<td>This type of interviewing includes accepting (not necessarily agreeing with) the clients’ view of the problem and using their language.</td>
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<td>What will convince your probation officer that you’re really a changed person?</td>
<td>Once the family’s goals are accepted and listed, each goal is recast in specific behavioral descriptions of what will be different. Clients begin to think in action-oriented terms. Thus, goals become action-oriented.</td>
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<td>What will you have to do to make that happen?</td>
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<tr>
<td>What exactly will you have to do or say?</td>
<td>As this hopeful and collaborative pattern continues, behavior change occurs from a discussion of behaviors related to exceptions, or times when the problem is not occurring. This highlights client strengths and downplays the authority of the therapist.</td>
</tr>
<tr>
<td>What is life like for you when the probation officer isn’t on your back?</td>
<td>Scaling questions help the client focus on a situation as part of a continuum.</td>
</tr>
<tr>
<td>What are you doing when that happens?</td>
<td></td>
</tr>
<tr>
<td>How do you get that to happen?</td>
<td></td>
</tr>
<tr>
<td>On a scale from 1 to 10, with 10 being the best, where would you say you are with respect to getting your probation officer off your back?</td>
<td>Exploring the problem in terms of small steps of progress makes goals reachable.</td>
</tr>
<tr>
<td>What do you have to do to move from a 3 to a 4?</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.1 Sample Solution-Focused Sequence
with victims of trauma, a traditional solution-focused approach may be premature if individuals need an opportunity to review and retell their story of trauma as part of the healing process. Weiner-Davis (2017) considered infidelity a type of trauma and considered this as she applies her groundbreaking solution-focused work, Divorce Busting®, to repairing marriages after infidelity.

Rickert (2006) suggested matching the client approach to the therapeutic approach. If clients are problem-oriented, the therapist should be problem-oriented. If clients seem to be searching for answers rather than understanding or empathizing, the therapist can be more solution-oriented. Exploring directly with the client to determine the best pace and timing for the client’s situation is most desirable. Are they ready to move from the time of trauma to a time of healing? Do they need more time in one stage than another? Berg and Gallagher (1991) encouraged clinicians to focus on the priorities of the client.

Narrative Family Therapy

As one who has continued the constructivist tradition in family therapy, Michael White has also integrated processes that illustrate social constructionist thinking. He evolved from structural-strategic approaches to a Batesonian emphasis on the beliefs that could limit families from pursuing new solutions to their problems. He has been successful in integrating the search for competencies with an analysis of interactional cycles and assignments that instill hope in his clients. He begins with the goal of helping families find a face-saving way out of their present difficulties. In an article, White (1983) indicated how important it is to minimize those interactions in which family members might become defensive. Thus, he accepts multiple views of the problem (constructivist) and sees his role as one who is responsible for leading the family into hopeful and life-changing conversations about their lives (social constructionist).

Describing their work, Epston and White (1992) stated that they do not want to name their work or have it thought of as a school of family therapy. Instead, they expect to explore and change their work on a regular basis; hence, what they might write one year could drastically change the next. This is in keeping with the value they place on a “spirit of adventure” (Epston & White, 1992, p. 89) and how that spirit keeps their work vibrant and rewarding. However, White was the first to introduce narrative ideas to the field of family therapy and has continued as a leader in the narrative trend in family therapy. Experienced family therapists applaud his spirit of adventure and believe that this spirit keeps the profession of marriage and family therapy stimulating and creative. Beginning practitioners should strive to adopt this same spirit to keep their work inspiring and successful.

White most commonly addresses themes of oppression and liberation. This distinguishes his approach from other models covered in this chapter. In working with families, he assumes that the dominant view held by much of the mental health system has led to the depersonalization of his clients. He also assumes that the family is feeling oppressed by the influence of their problems. By using social justice theory regarding oppression and liberation, White helps families to notice their own expert knowledge, that is, to notice those times when the problem did not interfere with their lives. He uses a process described by Bateson (1972) that looks for small exceptions to their negative experiences. This increased awareness of successes is thought to help the family develop a new life story of victory, competence, and leadership.

Although his focus on exceptions sounds similar to solution-focused therapy, White emphasizes the importance of oppression and characterizes the problem as some influence outside the
family. A cycle or pattern is often labeled as the culprit. This might be “a truant lifestyle” or “a tradition of bickering,” or it might be a make-believe character that children can understand, such as a monster or a tiger. This process, called externalization, is one of White’s distinctive contributions to family therapy. As family members overcome these obstacles, they are cast as heroes deserving of celebrations and awards.

A session with White consists of a progression through various sets of questions (see Table 2.2). White adapts easily to the family’s subculture. He would carefully take notes of their words and their language, incorporating these into analysis and into the family’s story of liberation. As therapy proceeds, the family would be invited to think about their lives and problems as an old story that they rewrite together. White would be the audience, director, and editor of an emerging work of art. Family members are the authors and principal characters in the production. White’s use of literary metaphors (i.e., a good story has a plot, characters, drama, intrigue, and so on) reframes family problems by placing the problem into a larger drama (Epston & White, 1992). His use of rituals, games, and assignments has led to creative therapeutic goals as “monster taming” (childhood fears), “beating sneaky poo” (encopresis), and “going from vicious to virtuous cycles” (marital conflict). White prefers thinking of solutions in these terms rather than adopting the dominant language of

<table>
<thead>
<tr>
<th>Therapist Questions</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>How does the problem influence or defeat the family?</td>
<td>Using a similar approach as that of structural, strategic, and the Milan team, White carefully tracks interactional sequences and learns how each person reacts and behaves related to the problem. Attention is on specific behaviors. What do the family members do? The family therapist must be able to visualize how people act and what people say when they are overcome by the problem and when they are overcoming the problem. White would spend much time elaborating upon these few experiences as examples of the family's expert knowledge of how they have influenced and controlled the problem. If someone fails to recognize exceptions, White would use his own observations to begin creating a picture of competence and cooperation.</td>
</tr>
<tr>
<td>What are the times when things go well—when you are challenging the problem?</td>
<td>White provides a benevolent confrontation with present destructive cycles while pointing toward a hopeful future.</td>
</tr>
<tr>
<td>Is it possible that coming here today is a challenge to the problem?</td>
<td></td>
</tr>
<tr>
<td>Would you prefer to be someone who is being held hostage by a truant lifestyle or someone who has battled the influences of a truant lifestyle and won?</td>
<td></td>
</tr>
</tbody>
</table>
traditional mental health practice. The goal is to liberate the family from the oppression of the problem and of larger systems that stereotype and label them. Chapter 9 provides details on how to use a narrative approach for “monster taming” and on how to approach unresolved grief and loss.

Therapy sessions are a time for the family to report on their successes, similar to session use in solution-focused models. When difficulties occur, these sessions are compared to situations that are even worse to help the family members maintain their sense of momentum. For example, if family members remain persistently discouraged about their lack of progress, the sequence might be similar to that in Table 2.3.

Narrative family therapy is known for the way it addresses societal oppression, empowers discouraged families, and diminishes family isolation by using their language, values, experience, and natural support system. It is a counterpoint to existing cultural practices that label and categorize those who need help. The therapist is very active in sessions and leads through his suggestive and interventive questions. The artistry lies in a balance between leading and following what a family brings to the experience.

These approaches emphasize a more indirect approach through using a series of questions. In this way, they disrupt patterns without ascribing negative or underlying intentions. In addition,

Table 2.3 Narrative Focus Upon Strengths

<table>
<thead>
<tr>
<th>Therapist Questions</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did you manage to lecture him for only 10 minutes instead of the usual 45 minutes, like in the old days?</td>
<td>Questions focus on how they were able to stop the old pattern so quickly and what they thought made the difference.</td>
</tr>
<tr>
<td>Even though you’re feeling discouraged, I’m curious about how you were able to develop such insight about the old patterns.</td>
<td>Noticing that “the glass is half full” punctuates even the smallest bit of progress.</td>
</tr>
<tr>
<td>How did you decide to face this situation so directly?</td>
<td>Exploring and extending the progress.</td>
</tr>
<tr>
<td>What difference do you think it will make in your future if you are able to continue this type of awareness?</td>
<td>Highlighting the influence that small steps can have over time by exploring clients’ beliefs about their own progress.</td>
</tr>
<tr>
<td>What would it say about you as parents if you are able to continue exercising this type of awareness?</td>
<td>Anchoring the new story in the future and in a person’s own thoughts and language about self and others.</td>
</tr>
<tr>
<td>Who would most appreciate this story of progress and liberation?</td>
<td>After the family feels a sense of progress, a celebration, ritual, or meeting is planned to anchor the new story within the social network of the family by inviting others to witness and become part of the new story.</td>
</tr>
</tbody>
</table>
they seek to know about the past in a focused and productive way. For solution-focused and narrative family therapists, asking about past exceptions to the problem is important; resources emerge from asking about past successes in coping, relating, or functioning. To enhance understanding, consider Jerry’s case from these perspectives.

**Case 2.1: Jerry, a Gay Man**

Jerry, a 19-year-old Caucasian man, enters a community agency with symptoms of severe depression. He was referred by his doctor because of his level of depression and the report of his family’s recent rejection when he “came out” to them. He has been very close to his parents until this disclosure and has now been cut off from any meaningful contact. His father does not want to see him at all. The client reports difficulty sleeping, changes in appetite, and poor concentration. Though denying active suicidal ideation, he states several times that he wishes he could just go to sleep and never wake up. He cries throughout the intake and reports a previous episode of depression two years ago. He fears that his plan to attend college in the fall is threatened, because his parents were going to pay tuition out of their savings.

During intake, the therapist determines that Jerry wishes to die but has no thoughts of killing himself, nor does he have a plan for such action. He also has no thoughts of harming the family or others. He is the youngest of three children and has been living at home until a month ago when he disclosed his orientation to his parents. Now, he migrates from place to place, staying with friends. To his knowledge, none of his siblings know about the disclosure. There is a wide gap (five years) between him and his next sister. He says his siblings are “into their own lives” (see Figure 2.1). When his doctor suggested this referral, Jerry was afraid the doctor thought he was “crazy.” The referral was explained as “maybe it would be good to talk to someone.” The doctor wanted an assessment before prescribing medication for his depression. Jerry isn’t sure “what good talking will do.” He is unsure whether medication is necessary. However, he came for the first session to see what it was like, because he had never been to “a shrink” before.

![Figure 2.1 Jerry’s Genogram](image-url)
Questions about the definition of the problem help the therapist learn that Jerry is most concerned about his parents’ reactions and his future college plans. Because he doesn’t mention his sexual orientation as a problem, the clinician explores his past close relationship with his parents and defines the problem as conflict resulting from disclosure to parents about his sexual orientation.

From a crisis perspective, a beginning goal is to stabilize Jerry’s mood and explore a plan to address parental rejection. He meets the criteria for major depressive episode. This is discussed as a result of the presenting problem. Asking about sequences of interaction helps the therapist learn that Jerry had planned to tell his parents for some years. Compared to his siblings, he was considered the “model child” and felt pressure to live up to his father’s ideals. A recurring subject of conversation had been about Jerry joining his father in his advertising business after college. He wanted to do this but also wanted to be honest with his family about who he really is. His mother considered him to be a leader in their church. He decided to tell them when they kept encouraging interest in certain female friends. His father was angry and stern. His mother was quiet and sad. He keeps in touch with his mother, but his father does not allow him to come home: “Maybe that will knock some sense into him!” This information addresses culture and beliefs.

Based on Jerry’s level of motivation, the therapist educates Jerry as to what family therapy can do. She gives examples of the ways in which other people in his situation have successfully overcome their challenges. Before making a recommendation about medication, she gathers more information about his previous episode of depression and finds it is related to rejection by another gay teen to whom Jerry was attracted. Because both episodes are tied to specific events with adequate functioning in between, she discusses the pros and cons of medication with Jerry and asks for his opinion. He doesn’t see the need to, and the therapist is able to support his decision. However, his father’s rejection is more dramatic and severe than he had anticipated, so the therapist suggests that they spend one additional session developing a plan for how Jerry can “get through to” his parents. The conservative recommendation from the therapist reassures Jerry that he isn’t “crazy,” and Jerry can see that the therapist is like a coach and a support to help him chart a course for coping with his challenges. He agrees to return.

In the second session, questions explore how Jerry’s parents and siblings feel about his sexual orientation, gay life in general, and so on (i.e., Who might be most/least accepting?). The therapist learns that his oldest sister has a childhood friend who is lesbian and that his older brother has made demeaning comments about a gay person. In addition, his extended family has beliefs that range from criticism to acceptance. This information is about structure and coalitions (i.e., Who might be on his side?).

Finally, the therapist asks Jerry to think about how his disclosure fits into his family’s development and what the advantages might be to having told them now, rather than five years ago or five years later. Jerry pauses and reflects. At first, he is at a loss for words, and then he begins to think about how he dislikes the pressure of living with his family under false assumptions. He also thinks his father depended on him for friendship and that they often went to sports and car activities together, excluding his mother. Jerry thinks his father and mother should spend more time together. He believes neither of them has many friends. (This addresses strategic hypotheses about the meaning of the problem in the family.)

At this point, the therapist explores family members and friends who Jerry has named as the most likely to be accepting (his mother, sister, and two friends). Can Jerry consider inviting them to become part of his support network? Would he like to explore these possibilities in additional sessions? She learns that his father listens to his sister. The therapist maintains a focus on what Jerry considers his most pressing problem. Jerry finds her style empathic and
pragmatic. She doesn’t treat him like he’s “crazy.” He doesn’t feel stigmatized. If she can be a help to him with his family concerns, the process will help his depression and lead him to trust her with additional issues that may be affecting his mental health. Eventually, other family members may attend; they may even invite his father to attend, and the therapist can work with his parents through the intense grief they suffer in the wake of Jerry’s disclosure. With Jerry prepared for this direction, the therapist can become a consultant to his entire family as they negotiate this major transition.

APPLICATIONS

Solution-focused therapists might say that Jerry is a visitor. Thus, it is important to maintain focus on Jerry’s priorities. Then, during a consultation, the process pursues descriptions of how each person acts when things are going poorly, steps that have been taken to improve things, and the predictable and unpredictable ways in which people might respond to each other. Since Jerry was surprised by his father’s response, both parties are now responding in unpredictable ways during this time of crisis. The therapist might help Jerry think through hypothetical situations in which he can envision how he would be acting if things were resolved between them.

One technique for exploring hypothetical possibilities is the miracle question. The therapist asks, “Suppose you wake up tomorrow and things are back to normal with your parents. What would you be doing now? What would your behavior be from day to day?” The therapist can help Jerry choose what behaviors are still possible (i.e., “I’d still be calling Dad at work to tell him about the Dodgers’ game. I’d still be telling Mom about my plans for vacation”). What support would he need from others to follow through with his plan? What can he do to cope if there is a backlash? Developmentally, some options may be more realistic than others, because Jerry and his parents were close before his disclosure. If the relationships had been chronically critical or distant, the therapist might look to relationships in the family that are positive for Jerry, or to those who have a positive influence on his parents. The tone of the sessions would be that of hopeful experimentation with support from the therapist and others.

Similar to solution-focused work, narrative family therapists avoid labels or stereotypes in referring to Jerry’s situation. They make an effort to adopt Jerry’s language and the words he uses to describe himself and others. This approach might consider the problem to be the effects of “coming out” to his parents (externalization). Then, Jerry is invited to fight and challenge these effects so that he doesn’t become oppressed or controlled by them. A specific line of questioning traces interactions during the rough times and the impact of those interactions. These are the effects. The therapist is careful to explore ways in which the client feels oppressed. There is empathy and validation for the ordeal Jerry has experienced. Then, more questions search for ways Jerry has stood up to the effects (i.e., calling his mother, visiting with friends who can encourage him, etc.). He is cast in the role of hero in his own life drama. A significant emphasis in narrative family therapy is on the empowering behaviors and events that demonstrate how the client is already overcoming the problem. This happens in the form of questions that call attention to Jerry’s positive virtues, such as his courage, strength, and persistence.

A narrative family therapist looks for additional people who can serve as an audience to witness and document Jerry’s accomplishments, thus helping Jerry to feel the power of a collective in support of him. These people might be family, friends, or others whom Jerry says
see him the way he wants to be seen. They are invited to encourage and support him, largely through answering the therapist’s questions about how they see Jerry’s strengths and what they view as hopeful possibilities for his future, as he works to overcome the effects of coming out. These signs of success and support are viewed as the alternate story, intended to replace the old problem-saturated story of depression and rejection.

Solution-focused and narrative family therapies are examples of how postmodern thinking influenced the philosophy and practice of family therapy. These innovative approaches to the process of change are popular trends that influence many family therapists today. They have also been combined with first-generation models. For example, Chapter 7 illustrates how Kuehl (1995) used a solution-focused genogram. Chapter 3 outlines a strategy for “just therapy,” an ecosystemic form of narrative family therapy developed for the disadvantaged, indigenous groups of New Zealand. The following second-generation approaches also use a collaborative, depathologized, strength-based approach to their work.

**Emotionally Focused Couple Therapy**

Although John Bowlby’s work on attachment influenced a number of British and American family therapists, his work was not widely embraced during the early years of family therapy practice (Bowlby, 1969; Ainsworth & Bowlby, 1991). However, as divorce, trauma, and violence rates persist, an awareness of the complexity of human development has also steadily increased in the field. Thus, family therapists are revisiting early interpersonal theories of development and finding important keys to therapeutic turning points.

EFT was developed when Dr. Leslie Greenberg, professor of psychology at York University in Canada, began his training in client-centered therapy and witnessed the value of expressing respect, empathy, and genuineness for his clients. Utilizing this orientation as a foundation, he learned to practice authentically listening to and checking his understanding with his clients. He then ventured into several years of Gestalt training and learned more about awareness and the experiential method. Dr. Greenberg had a desire to create a system for mapping out the process-experiential approach to change. His goal was to integrate Gestalt active methods and client-centered relational conditions. He fostered this process during a seven-year period of couples and family therapy and then pursued writing a treatment manual for EFT with his former student Dr. Susan Johnson (Greenberg & Johnson, 1988).

During this collaboration, they began watching videotapes of their work, analyzing the therapeutic process during times when clients seemed to have insights or breakthroughs that led to significant changes in their relationships. Their analysis led to research projects in which their techniques were compared with other models of couple therapy. These results led to the formal development of EFT, a treatment program that follows a manual that applies Bowlby’s (1969) theory of attachment, separation, and loss (Greenberg & Johnson, 1988). In this model, secure interpersonal attachments are considered a primary human motivation. EFT addresses these. The main tasks in EFT are accessing emotional experience and changing interpersonal patterns.

Johnson, a professor of psychology and psychiatry at the University of Ottawa, is now a forerunner in continuing the development of EFT and integrating attachment theory. She published an article, “Listening to the Music: Emotion as a Natural Part of Systems Theory” (Johnson, 1998). This title would almost seem to state the obvious were it not for the fact that many early approaches to family therapy ignored emotion altogether (see Table 1.2). EFT responded to the need for a more clearly delineated and validated marital intervention with
a more humanistic approach. Thus, “unfolding key emotions and using them to prime new responses to one’s partner . . . is the heart of change in EFT” (Johnson, 2004, p. 13). Calling attention to the power of emotion (rather than thoughts or behavior) in relationships, Johnson’s work brings together all the best that family therapy has to offer: sound interpersonal theory congruent interventions tied to theory and research regarding the therapeutic process and outcomes (Johnson et al., 2005).

In this approach, special attention is paid to repairing attachment injuries, those turning points in a relationship when a given partner has felt emotionally abandoned by the other (Johnson, Makinen, & Millikin, 2001). These turning points may be times of transition or crisis, when one partner had a particular need for support from the other and the other was unavailable. Miscarriages, illnesses, accidents, joblessness, and deaths are examples of times when some attachment injuries occur. This conceptualization makes EFT very successful in cases of trauma and couple distress. The important contribution of this work is the attention to emotional impasses and to the power of emotion in the process of attachment, which directs the therapist in developing effective interventions.

An impressive array of empirical research shows favorable treatment outcomes for EFT in a variety of populations, including those suffering from depression and chronic illness (Johnson, 2002; Kowal, Johnson, & Lee, 2003; Sandberg, 2011). EFT is considered a brief intervention that generally consists of 10 to 12 sessions. If additional problems or trauma are involved, therapy may extend to 30 to 40 sessions (Johnson, 2002). Emotion, and how it is expressed between couples and family members, is a key component of EFT and is considered the “music of the dance” between people. In addition, those who receive training in EFT reported increased understanding regarding their personal relationships and attachment wounds. They noted how training and practice in this model helped them to heal their own relational wounds (Sandberg & Knestel, 2011).

EFT comprises a structured three-stage process:

1. **De-escalation** of conflict. Problematic cycles and related emotional states are identified, and emotional experiences are explored in depth.
2. **Restructure** attachment bond. The cycle is viewed as the enemy instead of either partner.
3. **Consolidate** gains. New communication patterns are reinforced.

Table 2.4 outlines the nine steps that constitute the three stages of the treatment process.

**Cognitive-Behavioral Couple Therapy (CBCT)**

In the second generation of practice, family therapists who came from a psychology background built upon Gerald Patterson’s (1971) early work and applied behavioral principles to couples therapy, delinquency, schizophrenia, and bipolar disorder (Barton & Alexander, 1981; Falloon, 1991; Jacobson, 1991; Miklowitz & Goldstein, 1997). Specifically, couple therapy became an area of interest for the treatment of alcohol abuse (O’Farrell & Fals-Stewart, 2006). CBCT began with a process of education, communication training, and behavioral contracts. As the approach has evolved, many clinicians are taught to conduct a **functional analysis** to assess interaction patterns, triggers, and problematic cycles. Although those who practice cognitive-behavioral approaches have not used the language of cybernetics, functional analyses provide a map to understand feedback loops and interactions. Chapter 7 provides
<table>
<thead>
<tr>
<th>EFT Process</th>
<th>Goal of Intervention</th>
</tr>
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<tbody>
<tr>
<td><strong>Step 1: Delineate conflict issues in the struggle between the partners.</strong></td>
<td>Connect with both partners and create an alliance. Assess the nature of the relationship and each partner’s goals.</td>
</tr>
<tr>
<td><strong>Step 2: Identify the negative interaction cycle.</strong></td>
<td>Enter into the experience of each partner and sense how each constructs his or her experience. Track recurring sequences and begin to hypothesize as to the emotional blocks to securing attachment and engagement (fear, hopelessness, sadness).</td>
</tr>
<tr>
<td><strong>Step 3: Access unacknowledged feelings underlying interactional positions.</strong></td>
<td>This represents the music of the dance, that is, the primary emotions that are excluded from individual awareness and not explicitly included in the partner’s interactions.</td>
</tr>
<tr>
<td><strong>Step 4: Redefine the problem(s) in terms of underlying feelings.</strong></td>
<td>Through accessing emotional responses, the therapist begins to uncover the attachment needs reflected by these responses and then reframes the couple’s “problem.”</td>
</tr>
<tr>
<td><strong>Step 5: Promote identification with disowned needs and aspects of self.</strong></td>
<td>Disowned needs are addressed. The intense engagement with one’s own emotions allows the therapist to begin to facilitate a new kind of emotional engagement with the other partner.</td>
</tr>
<tr>
<td><strong>Step 6: Promote acceptance by each partner of the other partner’s experience.</strong></td>
<td>The therapist assists in supporting the other partner to hear, process, and respond to this sharing so that this new experience can become part of, and begin to reshape, the couple’s interactions.</td>
</tr>
<tr>
<td><strong>Step 7: Facilitate the expression of needs and wants to restructure the interaction.</strong></td>
<td>Statements of needs are made from an empowered, accessible position, constituting a shift in interactional positions, which in turn challenges the other partner to engage in the same process.</td>
</tr>
<tr>
<td><strong>Step 8: Establish the emergence of new solutions.</strong></td>
<td>The change events that occurred in the previous steps now have a direct impact on the couple’s ability to problem-solve and cooperate as partners in their everyday life.</td>
</tr>
<tr>
<td><strong>Step 9: Consolidate new positions.</strong></td>
<td>The therapist helps the couple construct a coherent and satisfying narrative that captures their experience of the therapy process and their new understanding of the relationship.</td>
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</table>

(Johnson, 1996)
details on how to track interaction patterns. This skill is an important part of MRI, structural, strategic, behavioral, and EFT approaches. Chapter 9 also provides an example of a functional analysis for children in a school setting.

In 1996, Neil Jacobson and Andrew Christensen published their book, *Integrative Couple Therapy*, in which they integrate cognitive dimensions (e.g., thoughts, expectation, and images) that influence behavior. They expanded their model after examining their research and finding that only 50 percent of couples were improving from traditional behavioral couple therapy. Of particular interest was how thoughts and attitudes serve to both trigger and maintain behavior. As a model for close relationships (e.g., heterosexual, lesbian, gay, bisexual, transgender, and questioning [LGBTQ] community, married, or common law), it addresses the issue of acceptance in working with couples. This model of family therapy attempts to balance traditional behavioral methods for change with an equivalent emphasis on the acceptance of elements that cannot be changed (e.g., developmental histories, traditions, and values).

A sequence using this model might follow these steps:

1. Define the conflict. Look for themes such as closeness/distance, responsibility, etc.
2. Describe negative interaction patterns. Obtain a clear picture of behavioral sequences.
3. Decrease blaming and increase vulnerability. Teach communication of fears, inadequacies, and uncertainties (i.e., “I’m afraid she’ll leave me”).
4. Address other beliefs about significant others. Explore beliefs about why certain situations occur in the family, how family life should be, and what is needed to improve relationships.
5. Teach support and empathy for each partner. Assign reading and provide practice time in sessions.
6. Use behavioral contracting. Ask each partner to make a list of what the other can do to please them. Ask each partner to choose items from the list to begin positive cycles. Assess the couple’s ability to solve problems and spend time in pleasurable activities.

To cognitive-behavioral therapists, a person’s internal process affects behavior (e.g., unspoken self-talk influences what one does). An example of this appears in Chapter 7. Unrealistic expectations of another (spouse, child) often produce undesirable behavior (e.g., anger, criticism). These behaviors may be viewed as a response to the expectations and not necessarily to the behavior of others. In such cases, the spouse may need to develop more realistic expectations to adjust to the situation.

One spouse may think the other is trying to control him or her, and this may lead to arguments over who controls the finances or who should clean the house. Thus, the area of disagreement (finances, cleaning the house) might not be the problem. Rather, the underlying thought (the intent to control) might be the major issue. CBCT has demonstrated its effectiveness in improving couple relationships. Baucom, Epstein, and Rankin (1989) found that cognitive restructuring produces meaningful changes in the way that a couple views their relationship and improves marital adjustment. It appears that when spouses alter their cognitions as well as their behavior, positive change in the relationship is more likely. They identify five forms of problematic cognitions in couple interactions:

1. Selective perceptions of relationship events.
2. Suggested causes for positive or negative relationship events.
3. Inaccurate expectancies of what might occur in the relationship.
4. Inaccurate beliefs about the characteristics of people in their relationships.
5. Unrealistic expectations for others.

As these cognitions surface during a functional analysis, the restructuring process involves challenging these patterns of thought. Similar to other family therapy models, challenging beliefs and behaviors in relationships is a central part of systemic work. Because a variety of MFT approaches use this skill, Chapter 8 provides direction on how to do this. In addition, that discussion will address when to be direct and when to be indirect with these challenges. For example, in the case of Lee, direct challenges to his beliefs were not appropriate, given his level of distress and grief. However, as the therapeutic relationship developed, there were indirect ways in which clinicians helped him to see himself and others in a different light. In general, CBCT is useful when both partners can address their misunderstandings directly.

**Multidimensional Family Therapy**

This groundbreaking model has been developed and used with adolescent substance abusers and their families (Liddle, 2002). The population for multidimensional family therapy (MDFT) has been high-risk, low-income families with a youth who is the identified patient. In these studies, adolescents present a range of high-risk substance behavior. Often, their parents have substance or mental health problems. Studies have compared MDFT with adolescent groups, cognitive-behavioral therapy, and multifamily education. Results show that adolescents improve in all treatments; however, MDFT participants maintained better school performance and family functioning at one-year follow-ups (Liddle et al., 2001). These advantages have earned MDFT a reputation as an efficient, effective treatment for very troubled teens and their families. There are four premises of MDFT:

1. Problems are multidimensional.
4. MDFT assesses and intervenes into multiple systems of development and influence.

The four dimensions of MDFT with their specific topics are the

1. Adolescent (self, family, peers, discrepancy, distress, discouragement, despair)
2. Parents (overall functioning, stress and burden, individual humanity, parental love, guidance, and stance against drugs and delinquency)
3. Family (healthy functioning, new and positive communication, understanding their youth)
4. Extra-familial (school, neighborhood, legal, social, medical, other important influences on youth or parent)

There are two unique elements that set MDFT apart from traditional family therapy. First, therapists are trained to hold separate sessions to join with teens and their parents. Once these sessions have cemented the therapist’s bond with each part of the relationship, family meetings provide an opportunity for relational interventions to unfold. Second, family sessions are
balanced between attention to the pragmatics of behavior management (structural-strategic) and that of the emotional bond between the parent and adolescent (intergenerational attachment). Separate sessions with the teen and parents prepare them for family sessions. Here, enactments are implemented by the therapist. These are interventions that help family members walk through new and positive communication, step by step (Allen-Eckert et al., 2001). Table 2.5 outlines how each of the four dimensions might be addressed in a case. Chapter 8 provides a guide to facilitate successful enactments.

### Multisystemic Therapy

During the 1980s, various approaches emerged that deliberately included therapist interventions aimed at the ecosystem: family-school, family-church, family-peer group, and family-agency relationships (Bronfenbrenner, 1979). Boyd-Franklin (1989) found that successful therapy for an African-American family often involved a “multisystem” approach. Her approach expanded to address the role of the family therapist in nontraditional therapeutic settings, such as schools, medical facilities, and churches (Boyd-Franklin & Bry, 2000). As part of this trend, Henggeler et al. (1998), through extensive research projects with juvenile crime and substance abuse, developed a multisystemic therapy (MST) approach to child and adolescent problems. The model was derived from social-ecological, structural, strategic, and cognitive-behavioral theories (Bronfenbrenner, 1979; Haley, 1976; Kendall & Braswell, 1993; Minuchin, 1974). This home-based approach positions the therapist to significantly reduce crime and substance abuse.

The outcome of MST has been impressive. In a review of multiple studies, 70 to 98 percent of inner-city families were successfully engaged and completed the desired four-month treatment protocol (Cunningham & Henggeler, 1999). Success was the same for Caucasian families and families of color. The authors suggest that their success comes from paying specific attention to the barriers of engagement and to implementing the nine principles of MST. When certain treatment principles are learned, therapists can be systematic and consistent while still

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### Table 2.5 Basic Tasks in MDFT

| **Adolescents** | Help them talk about past hurts, disappointments, etc. with family.  
Help them talk about hopes and desired changes in their lives.  
Get the message across: “There’s something in this for you.” |
| **Parents** | Listen to their stresses and burden.  
Get the message across: “You’re the medicine.”  
Focus on self-care. What can they do to get support and improve their functioning? |
| **Family** | Help adolescents express their hurts etc.  
Help parents listen and apologize.  
Help parents discuss what they can do to improve things.  
Negotiate and support house rules. |
| **Extra-familial** | Guide parents to be more involved in school issues.  
Help parents access services to support youth’s abstinence. |
# Table 2.6 MST Principles

<table>
<thead>
<tr>
<th>MST Principles</th>
<th>Elaboration</th>
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<tbody>
<tr>
<td>1. The primary purpose of assessment is to understand the fit between the</td>
<td>How does the problem make sense? What interactions between the child, family, peers, school, and neighborhood will explain the problem in a nonblaming way?</td>
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<td>identified problems and their broader systemic context.</td>
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<tr>
<td>2. Therapeutic contacts emphasize the positive and use systemic strengths as</td>
<td>Home-based contacts build trust, credibility, and a positive relationship upon which to develop goals and assignments.</td>
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<td>levers for change.</td>
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<tr>
<td>3. Interventions are designed to promote responsible behavior and decrease</td>
<td>Therapists work positively and strategically to help parents increase or change parental supervision and to develop consequences for positive and negative behaviors of the youth.</td>
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<td>irresponsible behavior among family members.</td>
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<td>4. Interventions are present-focused and action-oriented, targeting specific</td>
<td>Overarching goals are the family's long-term hopes for the child. Intermediate goals are day-to-day progress described in behavioral terms.</td>
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<td>and well-defined problems.</td>
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<tr>
<td>5. Interventions target sequences of behavior within and between multiple</td>
<td>Interactional sequences within and between multiple systems are addressed hands-on through the therapist's intensive involvement.</td>
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<td>systems that maintain identified problems.</td>
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<tr>
<td>6. Interventions are developmentally appropriate and fit the developmental</td>
<td>The needs of parents and children alike are considerations for tailoring tasks and goals that are realistic for each family's situation.</td>
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<td>needs of the youth.</td>
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<td>7. Interventions are designed to require daily or weekly effort by family</td>
<td>Intermediate goals are broken down into small, immediate tasks such as assigning chores, giving rewards, or having a meeting about consequences for incomplete chores.</td>
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<td>members.</td>
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<tr>
<td>8. Intervention effectiveness is evaluated continuously from multiple</td>
<td>Given the focus of interventions, their effectiveness can be assessed in a few weeks. The therapist monitors this standard and uses immediate feedback to make midcourse corrections.</td>
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<td>perspectives, with providers assuming accountability for overcoming barriers</td>
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<td>to successful outcomes.</td>
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<tr>
<td>9. Interventions are designed to promote treatment generalization and long-</td>
<td>MST emphasizes the skill development needed for success in the family's social ecology. Skills include assessing future challenges and adapting to forthcoming developmental changes as youth and parents mature.</td>
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<tr>
<td>term maintenance of therapeutic change by empowering caregivers to address</td>
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<tr>
<td>family members’ needs across multiple systemic contexts.</td>
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</table>
tailoring treatment to the family’s culture. Emerging from multiple projects with children and adolescents, the nine treatment principles of MST are shown in Table 2.6.

The therapeutic process begins by linking the goals of the larger system with the individualized goals of the family or guardian system that is caring for the adolescent. For example, the court system has its goals (e.g., prevent reoccurrence of crime and increase school attendance), and the family generally has other goals (i.e., “get the system out of our life,” “make him mind,” “get money to turn on the phone,” etc.). These divergent goals are brought under a general umbrella (e.g., help Jake succeed) that will enable each stakeholder to be part of the same plan. Then, intensive time is spent building trust and credibility with the family (Cunningham & Henggeler, 1999).

Next, goals of the family are broken down into behavioral goals related to strengths of the family. Therapists are trained to be goal- and action-oriented. In addition, weekly supervision by the therapist is aimed at individualizing the process for each family using the concept of “fit” (Schoenwald, Henggeler, Brondino, & Rowland, 2000).

MST is an excellent example of integration, because it uses structural-strategic family therapy, ecosystemic case management, culturally sensitive practice, and systematic data gathering for practice improvement. It also has commonalities with the other models presented in this chapter, such as a focus on behavioral sequences, concrete tasks, and respect for the uniqueness of each family. The emphasis on strengths and the engagement process is compatible with Michael White’s approach and with solution-focused notions of inviting the client to move from visitor to customer through careful interactions that respect the client’s worldview. Although the model does not cite social construction theory as one of its influences, the nine principles of MST are excellent examples of this trend in family therapy.

In the case of Lee, therapists were inspired by MST to use home-based case management as a means of client engagement. Lee was concerned with Granny, and he also had a bus ticket he could no longer use because his baby had died. Given his pattern of unprovoked emotional outbursts in public, work commenced by meeting Granny and by advocating with the bus company for a refund of his ticket. The refund increased the therapist’s credibility. Advocacy continued with long-distance work regarding the culpability of the former girlfriend in his baby’s death. An apologetic county attorney verified a letter to Lee informing him that no charges would be brought against the woman, even though investigators reported suspicious levels of alcohol in her blood. This infuriated Lee, and he spoke often about revenge. These case management activities included risk assessments to determine if Lee was a danger to himself or others. His felony conviction forbade the possession of a firearm. With no immediate plan of retaliation or financial means to travel, case management began to focus on positive ways in which Lee could find justice for his baby. Hardy and Laszloffy (2005) noted the importance of losses that are overlooked or minimized. With this in mind, case management explored ways for Lee to use the internet to advocate for abused children. He designed flyers with a message about holding parents responsible for their child’s welfare and contacted some trusted friends in the community who posted these on bulletin boards and stores. These activities validated the importance of his grief and loss. This gave him a sense of purpose during the early weeks of counseling. More information on Lee’s case appears in Chapters 3, 4, 9, and the Epilogue. As unusual as MST may seem for its home-based goal-setting and client engagement strategies, additional models that took unconventional approaches were also appearing during this time.

**Multifamily Groups for Schizophrenia**

In 1973, a young William McFarlane, MD, went to work in the Vermont State Hospital with Peter Laqueur, MD (1972), the noted founder of multifamily groups. He had been experimenting
with this modality since the 1960s. It would become a career-defining experience. McFarlane learned that Laqueur was ahead of his time, as he noticed families informally lingering and socializing together after visiting their hospitalized family members. There seemed to be a benefit to this, and he decided to organize these opportunities into regular meetings. In solution-focused parlance, this might be considered something the family was already doing to improve the situation. The therapist’s role is to encourage those positive changes already happening. Beels (2002) suggested that these family-inspired activities could be a reason why it was difficult to gain widespread acceptance of the practice. Just as the recovery movement has noted, mental health treatment politics in the 1960s controlled expert-driven approaches, minimizing family and consumer empowerment.

Laqueur noticed something else. In these groups, family members appeared to sidestep certain behaviors that would lead to impasses at home. His interest in family systems and feedback processes led to careful observations of interactions between individuals at home and then within the group. As these meetings continued over a period of months, there were communication changes and an openness to the insights of peers outside a person’s family. The unique mix of consumers, a family peer network, and therapists became a healthy environment of egalitarianism. As this work continued, researchers began to find emotional processes related to recovery. The concept of expressed emotion (EE) began to appear in studies of those in recovery. EE is the presence of criticism and/or overinvolvement as measured by recorded interviews that were coded by trained coders.

During the 1970s, research with thousands of families led to results that showed high levels of EE related to high relapse rates and low levels related to increased rates of stabilization and management (Bebbington & Kuipers, 1994). A trend began that used behavioral skill training to teach families how to lower emotional intensity and decrease stress in the environment. At first, families felt their behavior was being called into question. However, as these projects developed, there was an emphasis on recovery and how families can support their loved one. In addition, families received support and help during crises. Ultimately, there has never been research data showing that family process causes schizophrenia. However, there is much data that shows families can be important resources for recovery (McFarlane, 2002). Likewise, the idea that the program was a cure for schizophrenia was also avoided.

Thus, skill training was a good fit for families who felt blamed for their member’s illness. Instead of speaking about the causes of the disease, practitioners started thinking systemically about solutions. Given the symptoms and functional challenges associated with schizophrenia, they could see the need to address these symptoms in the most productive way. Rather than feeling blamed, families learned signs of an impending relapse and problem-solving skills to avoid the progression of symptoms. Managing symptoms and increasing functionality were the goals.

It was in this context that McFarlane joined the MFG movement. He is now considered an icon in the prevention and treatment of schizophrenia. Over 40 years later, practicing in Vermont, the South Bronx, and Maine, McFarlane (2002) was credited for having written the first book on multifamily groups for schizophrenia (MFG). This is the primary how-to manual for conducting successful programs. In addition, Appendix B highlights free websites that contain additional training materials. At a time when service agencies look for cost-effectiveness and major mental illness continues to consume a large share of mental health treatment budgets, McFarlane’s MFGs bring about consistently successful results across a wide range of severity. Also, managed care research reveals that the annual cost for treating schizophrenia lowers by $500 per family meeting (Christenson, Crane, Bell, Beer, & Hillin, 2014). Thus, family involvement is cost-saving.
MFGs led to outcome studies that showed dramatic improvements in those who had many hospitalizations. McFarlane’s improvements include skilled attention to engage families, a strength-based focus, role-modeling low EE, and strategies that prevent isolation and distrust. In turn, these lead to a reduction in stigma, improved communication, increased social support for parents, and successful crisis and medication management. Ultimately, symptom severity and relapse rates drop. In the 1980s, an unexpected finding was the increase of days on the job by consumers in MFGs compared to traditional services (McFarlane, 2002). For schizophrenia, MFGs are an unconventional success story: They don’t look like “therapy,” they don’t act like “therapy,” but they get therapeutic results.

Clinicians who are set in traditional treatment environments can expand their impact by considering the effective strategies (see below). An MFG facilitator learns a set of skills to encourage low EE and increase problem-solving skills. In fact, the same process in a single-family application also achieves positive results (Anderson et al., 1986; McFarlane, 2002). These skills are easily transferred to other therapy settings and other presenting problems:

1. **Outreach** to connect with family members through psychiatric, social service, and educational facilities.
2. Meet with family members without the symptomatic member and listen sympathetically to their story and level of burden. Carefully note the most stressful experiences they report, and spend one to three sessions exploring the details of past treatments, history of symptoms, etc.
3. Describe how the MFG addresses the turmoil as well as the challenges the family is experiencing. Acknowledge how each person’s situation is different and how the program addresses their individual concerns.
4. Invite family members to attend with reassurance that they will not be pressured to speak or participate. A nondemanding attitude conveys a low-risk environment in the group.
5. Conduct a psychoeducational workshop, for five to eight families, that provides families with information about research on EE, symptoms, treatment, effects on families, medications, and coping strategies.
6. Conduct session one as the beginning of a “healing network” (McFarlane, 2002, p. 127). This helps participants to put their best foot forward with strength-based introductions.
7. Conduct session two to acknowledge how the illness has affected family members, and provide goal setting for healing.
8. Conduct ongoing problem-solving sessions that encourage applications from the initial workshop, camaraderie, teamwork, structure for brainstorming, stress management, and recovery.
9. Provide crisis sessions between group sessions for those families who have an urgent need.

With pragmatic wisdom, the goal of the first group session is for everyone to return for the second session (McFarlane, 2002). This happens because there is careful attention paid to engaging family members, minimizing risk, fostering community, and modeling a strength-based perspective. As participants develop trust and attachment, bi-monthly sessions turn into problem-solving communities, bringing about hope, strength, and new skills. Any practitioner who learns this model develops skills and a philosophy that are valuable in the postmodern
practices of MFT. For schizophrenia, this is a series of steps that gives careful **consideration to the developmental levels** of consumers and family members. Given the symptoms and stresses that inhibit proper brain functioning, MFGs become a “community frontal lobe” (Hanna, 2014, p. 241) to help participants **plan and implement new strategies**. Thus, the practices of this program have universal appeal across a number of problem and symptom categories. In addition, there is flexibility to include other support people when the family is not available and to partner with traditional assertive community treatment (ACT) programs in developing family-assisted assertive community treatment (FACT) programs. There is a tremendous need for family therapists to become involved in these programs.

Recent work has taken these programs to teens and young adults who show early signs of distress **prior to having a first psychotic episode (prodromal symptoms)**. In a five-site study, the evidence shows how prevention is stopping the progression of symptoms and empowering these consumers to avoid a life of debilitating illness (McFarlane, 2002). In these cases, there is outreach to the teen through their interests. One case manager might meet his client at the video game store or a comic book dealer. Developing a sense of friendship is an important first step (Somashekhar, 2014). Then, prodromal family groups and psychoeducation function in the same way as regular MFGs. A case study applying these prodromal practices will illustrate the importance of this work.

**MFGs and Sandy Hook**

In memory of the 26 innocent lives who were killed at the Sandy Hook Elementary School in Newtown, Connecticut, this case study takes information from police, the Federal Bureau of Investigation (FBI), and state reports to describe missed opportunities for prevention that collectively led to this terrible tragedy. The reports represent countless interviews and analyses of school, medical, and mental health records. There is no intent here to sensationalize the shooter or to give him unhealthy notoriety. Instead, it is important to look at known information as a case study in how cutting-edge family intervention can rise to the challenge of violence prevention. This case presents the family as revealed through these documents and a hypothetical application of MFGs for prodromal youth (Eagan et al., 2014; Sedensky, 2013).

Because such tragedies elicit such intense grief and rage, it is often difficult to see through the pain and begin the work of community reparation. What can family therapists do to prevent such attacks? How can treatment providers bring a ray of hope in light of such overwhelming and deadly circumstances? This case highlights the need for practitioners to develop postmodern flexibility with the goal of positive, encouraging relationships with parents and consumers. Long before a person appears dangerous, there are opportunities for outreach and family engagement.

For family therapists, systemic thinking should not stop at the doors of the office. By looking at the social ecology of the family and matching it to cutting-edge treatments such as MFGs, the final tragedy emerges: **All of this was preventable**. Available reports emphasize that no single element predicts mass murder. They highlight missed opportunities with educational oversights and mental health missteps. They also note the possible difficulties with the mother’s health and her interest in guns and recommend family engagement, citing an article written by family therapists (Coatsworth, Santisteban, McBride, & Szapocznik, 2001). However, it was beyond the scope of those reports to recognize the **missed opportunities within family** and extended family for intervention and progress. An array of media and political experts debate the notion of how to foresee a mass murderer. All agree that there is no way. However, those dialogs fail to acknowledge that prediction is not necessary for prevention. **Prevention rather than prediction** has many possibilities.
Instead, it is quite reasonable to **identify at-risk children and teens.** Even more reasonable is that **outreach can make a difference.** Research documents the effectiveness of assessment and outreach. The models of family therapy in this chapter have excellent track records for **engaging even the most reluctant parents.** Chapter 4 describes these cutting-edge interventions that **identify strengths and resources** in a family’s ecosystem. However, such programs are usually outside the culture of psychiatry, which is a **culture of labels and experts.** Chapter 6 discusses ways for MFTs to create a bridge between these professional cultures. At Sandy Hook, the focus remained on finding the right diagnosis, believing that this would lead toward effective treatment. It is in this context that MFGs would be the treatment of choice. Sadly, one report makes this observation:

Parents are often in the position of recognizing that their child may need help, but not knowing what that help should consist of. Parents are very dependent and necessarily reliant on the recommendations and strategies offered by professionals, from their local pediatrician to specialists and service providers. Parents look to the professionals, including teachers, to know what should be done for their child. Parents may initially trust that these “helping systems” will steer them in the right direction and make the difference for their child.

(Eagan et al., 2014, p. 21)

Case 2.2 describes a family in need of services for their son. Appendix A contains a timeline of family history and excerpts from reports and emails that provide a basis for this hypothetical referral to a prodromal MFG. A **specific diagnosis is not necessary** for participation in this prevention program. If a practitioner has no means of forming a multifamily group, **single family applications can also improve a person’s functioning.**

### Case 2.2: Missed Opportunities at Sandy Hook

Peter, 51, and Nancy, 49, seek help for their son, Adam, 17. They have another son, Ryan, 21, who works in New York City. The couple is recently divorced, although they have been separated for seven years when Ryan was 14 and Adam was 10. They seem to agree on most aspects of Adam’s development. Having manifested some unusual behaviors since toddlerhood, Adam has had a checkered history of accomplishments and setbacks. Though shy and awkward, he received A’s and B’s in school. He attended public, private, and home schools as well as community college. He recently graduated after 11th grade in June.

He attends community college but is receiving poor grades, and his symptoms are intensifying. Throughout his life, professionals used the terms **sensory integration disorder, Asperger's syndrome, acute anxiety, pervasive developmental disorder, and obsessive-compulsive disorder.** The terms have changed as he grows. They have been looking for help now because he’s becoming even more withdrawn and has been having extreme reactions when they try to help. He has indicated to Nancy that he does not want contact with Peter, and he communicates with Nancy primarily through email, although their bedrooms are both on the second floor of their home (see Appendix A for their 2008 emails).

They report that he has always been shy, had “weird” behaviors, avoided being touched, and had temper tantrums, but has also had some times when he seemed happy, had a sense of humor with Peter and enjoyed family activities. In sixth grade, he began compulsive hand-washing, which continued. In seventh grade, he read a beautiful poem in public. In 10th grade, he enjoyed being at a technology club with other boys, until the club advisor was laid off at
the high school (see Appendix A for the boys’ comments about him in the club). He finished high school a year early, but he doesn’t seem to be doing well in community college. He would become furious when they try to discuss this with him.

Previous treatment included 20 sessions with a local psychiatrist from 2005 to 2008. Assessment and four treatment sessions were at the Yale Child Study Center (YCSC) from October 2006 to February 2007. Neither of these resources resulted in any substantial or long-term help. Parents indicate they are willing to drive anywhere in the state that might provide a special program that would fit Adam’s needs. Finances are not an issue; they are willing to pay whatever it takes. The problem seems to be that Adam doesn’t seem to fit in any category for services. In a prodromal risk assessment, Adam exhibited 7 of 11 criteria:

1. Social withdrawal and loss of interest in others
2. Uncharacteristic, peculiar behavior
3. Heightened sensitivity to sights, sounds, smells, or touch
4. A vague feeling of being disconnected from one’s surroundings
5. Suspiciousness of others
6. A strong nervous feeling inside
7. A drop in functioning, especially at school or work

Remaining risks are

- Increasing difficulty with concentration or with keeping thinking on target
- Loss of motivation or energy to participate in any activity
- Dramatic sleep and appetite changes
- Unusual or exaggerated beliefs about personal powers or influences

APPLICATIONS

To understand what information came forth from parents, review Appendix A for a timeline, excerpts from reports, and two emails between Adam and Nancy. Using the joining process of MFGs as a guide, there would be one to three sessions to hear the complete story from Peter and Nancy. How have these symptoms emerged and how have they coped with them? What were their feelings about different interventions? What has been helpful or not helpful? These basic questions establish a foundation of teamwork based on sympathy and hope. This is important, given Nancy’s perception of the YCSC’s assessment: “. . . the evaluation did not seem to have ‘even a glimmer of hope attached to it,’ and may have made things worse.” High levels of EE would be expected, given parents’ prolonged distress in searching for the right fit. Eagan et al. (2014) noted how family engagement could have used parents’ strong motivation and teamwork (Coatsworth et al., 2001). In addition, a basic genogram would show deaths in the family and might elicit a discussion about Nancy’s health concerns and how these relate to her grandfather’s death (see Chapter 7 for complete instructions on genograms). These sessions are with parents alone. How Adam becomes involved would follow a non-demanding, low-risk format.

The teamwork in MFGs begins with information exchange. In addition to learning about the parents’ journey, information is presented about prodromal symptoms. Adam would not
need a diagnosis, and he meets eligibility requirements. However, if the practitioner requests records from other treatment providers, they will show that Adam asked the YCSC about the symptoms of schizophrenia (see Appendix A). All parties could agree that they want the best for him and want to increase his ability to function. Another selling point for Peter and Nancy would be the fact that medication is offered but not mandated. Since Adam has had extreme reactions to medications, this flexible approach will be appealing. In regular MFGs, there have been a few cases in which a consumer rejects medication but still makes progress. Finally, Adam requests that his father join him for sessions at the YCSC, but the staff refuse this request (see Appendix A). The notion that parents would be with him during group sessions might appeal to Adam.

In the prevention program, a mentor is assigned to meet with Adam weekly. In ecosystemic fashion, they might meet at the video arcade or someplace of Adam's choosing. Since he likes Dance Dance Revolution, they would most likely play that game. Also, he mentioned hiking as an interest, and there might be hikes as part of his outreach activities (see Appendix A).

Because these are psychoeducational groups, therapists avoid the typical professional role of diagnosing parents, using a traditional psychosocial theory of intervention or taking a hierarchical approach to the relationship. In postmodern tradition, the therapist is a consultant, advocate, and support. Credibility comes from having a knowledge of the symptoms, providing evidence that these strategies improve functioning. The practice of sympathizing with and validating parents' distress is a key to engaging this family. Learning their story is the first step toward an effective alliance. It is a story of vulnerabilities, strengths, victories, and frustrations. Using McFarlane’s experiences with schizophrenia as a guide, many parents are often reluctant to enter into a relationship that even hints of blame. In this instance, a positive alliance during joining sessions can be a matter of life or death.

In group sessions, Peter and Nancy would participate in bimonthly parent group meetings to learn how to cope with and manage unusual behaviors. They would find they are not alone. Other parents are puzzled over the mix of characteristics emerging in their family members. Adam and the other teens attend the group on their own terms, when they feel safe. They will find other participants who also attend the community college. Group facilitators assume the roles of host and hostess, providing a friendly, welcoming environment. An intervention called “matchmaking” helps families find other families and consumers who have common interests. This would help Adam find others who have computer interests, and Peter would find others who like to hike. Because Adam knows how to repair computers, this interest could garner him positive affirmations. Also, the social and academic successes of his 10th-grade year would be areas of strong interest. It would be common for subgroups of families to attend recreational activities together. Peter and Adam might find others who want to hike. Ryan would also be invited to attend. Since the groups are not “therapy” groups per se, there is great flexibility for more social interaction. McFarlane (2002) suggested that this is an important component that enhances family and individual functioning.

Given the conflict between Adam and Peter, discussions provide guidance on conflict resolution. They also address expectations for future functioning. Sometimes consumers have higher expectations for their performance and are aware of stigma. Given Adam’s knowledge of Ryan’s success, he may have been trying to keep up. Peter seemed to be trying to help Adam become more realistic about his abilities. However, if Adam had become self-conscious about stigma, he may rebel against Peter’s implications. These are common issues that MFGs routinely address. What may be a standoff can become temporary with coaching, skill-building, and support for both sides.
In addition, because Nancy’s health concerns seemed to affect Adam, these might receive indirect help. For example, reports in Appendix A note Nancy’s self-reports that she has multiple sclerosis; however, investigations did not find any records documenting this diagnosis. Given her reactions to a medical report and her grandfather’s death, she may have had something more like fibromyalgia or another set of autoimmune symptoms that can become chronic. Some chronic, autoimmune diseases benefit from interventions that lower stress, one of the goals of MFGs (McFarlane, 2002). Lowered EE would lower family stress and benefit all members. The emails in Appendix A reveal Adam’s concern for Nancy’s stress and well-being, giving her advice and support. She apologizes for her emotional outbursts. Participation in a program that helps all family members adopt new coping strategies might have helped the level of burden that has become shared by Adam and Nancy. In addition, MFGs are highly attuned to family members’ sensitivities, and they provide a warm, non-critical, diplomatic, relationship.

The prodromal program extends for two years. Adam would have been 19. This would have spanned the period of time in which Peter remarried and Nancy became more desperate about finding something that would help Adam become independent. With all the travel she described in the last year before Sandy Hook, it may be safe to say she was suffering from burnout. Typically, there would be little attention to the dynamics of Peter and Nancy’s divorce (she filed) unless there was evidence that it was affecting Adam now. One way that MFGs became successful was by avoiding traditional therapy topics and staying focused on skill-building and problem-solving. McFarlane found that raising traditional topics led to dropout, but a focus on pragmatics was a safe method for changing family relationships. Then, when families raise therapeutic issues on their own terms, addressing them can be effective. If Nancy mentions her concerns about health or the relationship with Peter, program staff meet with her outside the group and potentially address these issues with Adam through his case manager’s weekly outreach. Because these prodromal programs are expanding to many states, participation and training for practitioners is becoming more available. Resources for this appear in Appendix B.

At this writing, other mass shooters also fit the profile of “hard to diagnose.” The limits of traditional psychiatry are fully noted by psychiatrists, and they desire the public to understand that they are often helpless when it comes to the escalating history of a mass shooter who has an undetermined disorder (Barnhorst, 2018). Thus, it behooves other mental health practitioners, such as family therapists, to go where others do not go. To this end, McFarlane is a psychiatrist who became an activist early in his career. He has provided a low-cost example of how a postmodern perspective can lead to the same pioneering creativity that first-generation family therapists provided. Remember that others have been successful using single-family adaptations, with the same sequences, even problem-solving sessions (Anderson et al., 1986; Lefley, 2010; McFarlane, 2002). In addition, other postmodern approaches in the second generation create positive environments that help families of at-risk youth.

At the end of this chapter, Table 2.7 provides a summary of this generation and their defining qualities. As the 20th century ended, the second generation had a following of practitioners who became pioneers in their own right, integrating postmodern thought into treatment projects and community settings. They take part of the familiar story (strengths, resources, possibilities) and help families write the next chapter of their lives. Many of these also focus on public health priorities such as conduct disorder and substance abuse. With these successes, third-generation MFTs broaden their view again and focus on the challenges of more groups who need nontraditional services.
Social change has always driven the development of family therapy practice. For example, civil rights for the LGBTQ community has expanded new family configurations worldwide. However, these new families often report a backlash in their communities. In addition, the emergence of more teen suicides and self-harming behavior in the US leads to the need for stronger family attachments that address the unique stresses of contemporary teens (Diamond et al., 2012; Krauthamer et al., 2016). In the 21st century, racial wounds, religious discrimination, and the effects of war have all brought about high levels of trauma symptoms. Thus, brain research and advances in developmental psychopathology outline the tremendous need for trauma-focused, brain-friendly, developmentally appropriate services. Traumatized children, parents, military service members, and survivors of all types need appropriate sources of help for engagement, problem identification, and symptom relief (Hanna, 2014).

With respect to models of treatment, many individuals, like Adam, are still not receiving a form of treatment that fits for them. Unlike the postmodern and integrative models of family therapy, “cookie cutter” modes of treatment fail to individualize to personal worldviews and circumstances. There is much ground to cover before mental health practitioners serve all families and individuals well. The need for practitioners who individualize treatment in a positive, hopeful manner has never been greater.

Postmodern thought in family therapy led to the downplaying of diagnostic categories, but community mental health systems rely on a medical model of diagnosis for reimbursement and funding through use of the Diagnostic and Statistical Manual (DSM; American Psychiatric Association [APA], 2013). This encourages an over-reliance on labels that rarely suggest a clear path to treatment. Thus, Bertram and Dvorak (2000) suggested “talking the DSM talk while walking the MFT walk” (p. 1). MFTs learn how to straddle both worlds in their practices (see Chapter 6 for more details). In some cases, this means working with a specific diagnostic category of clients but assessing the context in which the symptoms occur. The symptoms may be similar, but each systemic story contains strengths, resources, and possibilities. These lead to individualized approaches that are systemic, relational, and depathologizing. This chapter closes with a description of family therapy approaches that help some of these groups.

**Oppositional Defiant Children and Adolescents**

Sadly, the DSM-V has a large umbrella for children and youth with behavior problems. Oppositional defiant disorder (ODD) has become a common diagnosis with broad categories. A number of symptoms are divided into three subgroups:

1. angry/irritable mood (often)
2. argumentative/defiant behavior (often)
3. vindictiveness (at least twice in the past six months) (APA, 2013).

To reach a clinical level, these occur outside of sibling relationships and sometimes only occur with parents. However, when they do occur, behavior is extreme and affects the child’s functioning in various ways. Thus, diagnostic categories have always provided a common language that helps to acquire important services. In addition, a communication perspective...
may analyze the pros and cons of labels, noting that one advantage is the mental focus and validation that parents receive. The most successful treatments provide specific strategies for parents and teachers of children with ODD.

An example of this work is evolving structural strategic family therapy (ESSFT). It is the work of James Keim, MSW, former director of training for Jay Haley’s Family Institute of Washington DC and former project director at MRI. After studying with first-generation strategic and MRI therapists, he became a senior trainer and consultant during the second generation, working with families and behavior disorders. Now, he specializes in the proper diagnosis and treatment of those with ODD who do not respond to traditional parenting strategies or treatment options.

Keim (2014) described a subcategory called oppositional defiant disorder – justice injury (ODD-JI). The added elements of justice injury suggest a pervasive, sincere sense of injustice that is generalized in each triggered response from the child to an authority figure. Many times, it does not begin with misbehavior but with an expressive interactional pattern that reaches extreme levels. This sense of victimization is characterized by a fight–flight trauma response that involves levels of adrenaline and histamine in the body. As a result of the endocrine involvement, memory is blunted and leads to misperceptions of many events. As a result, parent burnout is high when normal parenting and discipline have little effect in these cases.

As with other treatments for ODD, Keim often meets alone with parents and youth to provide diagnostic accuracy and psychoeducation. In fact, he requests that parents attend alone in the event that the child becomes upset and initiates a power struggle. One primary characteristic of ODD-JI includes parents and teachers who are generally successful with most other child concerns. Because of this feature, ODD-JI is thought to develop from subtle vulnerabilities, such as unique information processing styles and unusual perceptual patterns. Sometimes, there may be a mismatch in parent–child cognitive styles. More obvious may be an attachment injury with an identified authority. However, many idiosyncratic elements are easily overlooked or unknown. Because of this, ESSFT provides an opportunity to discover customized responses during difficult conversations.

As with many integrative models, the work is conducted in phases. ESSFT has four phases: (1) alliance and psychoeducation, (2) parent self-care and happiness, (3) reinforcements and trauma arousal, and (4) soothing trauma arousal. In phase one, feedback informed therapy (FIT), a strategy to track the therapeutic alliance, keeps the focus on the parent’s primary concerns (Duncan et al., 2003). Chapter 4 explains more about FIT related to joining.

Parents, teachers, and children are never blamed for the symptoms. Instead, parent preparation to become “co-therapists” for their child involves significant steps in self-care. Asking them to join the treatment team in this way began with Minuchin (1974) in the first generation. Keim (2014) noted that parents routinely feel respected and engaged with this designation. This begins with parents identifying the list of symptoms for ODD-JI and educating the therapist as to why their child fits this diagnosis. The therapist clearly establishes a spirit of teamwork and advocacy, which increases the therapeutic alliance and parent self-esteem and eliminates isolation. There is a strong emphasis upon the idea that no one has done anything incorrectly. Instead, the identified child is different from the average child and needs something different.

A novel part of ESSFT is the Individualized Caregiver Guide. This is a journal with four sections that the parent constructs from weekly sessions. Given that most parents feel abused by
their child, there is a strong emphasis on helping parents recover from these stressful, traumatic interactions. Thus, sections of the guide proceed in this order:

1. Who do you want to be during difficult conversations? What does being at my parenting “best” look like during challenging moments?
2. What does it take for me to be at my parenting best?
3. What doesn’t work when we try to address problem behavior?
4. Experiments to try in place of what doesn’t work.

Keim (2000) provided direction for journaling in each section. Some unusual suggestions related to Section 2 are “escape strategies” for the parent when the child is resisting disengagement (e.g., child may continue an argument and press for a win-lose outcome). Escape strategies help parents maintain their dignity, calmness, and sense of leadership during difficult interactions.

As a third-generation approach, ESSFT has taken the best of first-generation approaches by aligning with the parent (structural) and facilitating pragmatic strategies with scant attention to perceived causes of the problem (strategic). From the second generation, there is a collaborative and supportive stance regarding parent burnout. Then, instead of bypassing the issue of diagnosis, it becomes an opportunity to externalize the problem (narrative family therapy). The focus on a specific group with unique characteristics leads to psychoeducation regarding an important phenomenological and physiological dynamic, justice injury. Addressing phenomenology is also a critical element in successful work with other at-risk youth.

**Depressed and Suicidal Youth**

Attachment-based family therapy (ABFT) developed from the long-standing role that Guy Diamond, PhD, played on the research team of Howard Liddle and MDFT. As the success of MDFT grew for treatment of substance abuse, Diamond began to see a role for these same interventions in the treatment of adolescent depression, suicidality, and self-harming behaviors (Diamond, Diamond, & Levy, 2014). He began to add enhancements that targeted these challenges to adolescent health. Bowlby’s (1969) attachment theory provides a foundation for this model. The goal is to heal adolescent–parent attachment ruptures. In turn, these improved relationships provide a safe environment for youth to process their depression, hopelessness, and traumas.

Expanding on the structure of MDFT in Table 2.5, ABFT identifies five tasks, each taking one to three sessions:

1. **Relational reframe** redirects attention away from the symptom toward increasing attachment. This highlights family strengths and motivates members to engage in the process.
2. **Adolescent alliance-building** uses individual sessions to explore conflicts that have damaged trust and helps the adolescent risk a discussion of these issues with the parents.
3. **Parent alliance-building** uses couple and individual sessions to identify parents’ wounds and provides support and sympathy. In turn, this enables them to become more attuned to their child.
4. **Attachment sessions** begin with the adolescent expressing anger and hurts about previous conflicts or abuse (Diamond et al., 2014). When parents respond with openness, this
encourages adolescents to disclose more. If parents appropriately express regret, this sets the stage for the adolescent to forgive. In addition, when adolescents feel acknowledged by parents, they often increase their acceptance of parental authority.

5. **Competence-promoting** addresses other factors that underlie depression, such as bullying, romances, school performance, and discrimination. With stronger attachment at home, there is a secure base from which to make connections outside the home.

In ABFT, parent sessions include training in the practice of **emotion coaching** (Gottman, Katz, & Hooven, 1997). These steps help to lower the stress physiology of each adolescent. The steps include

1. Become aware of the adolescent’s emotion. “I can see something’s bothering you.”
2. Use the emotion to develop more intimacy. “It’s OK to feel that way. Tell me what happened.”
3. Help adolescents to verbally label their emotions. “Sometimes people feel hurt or betrayed. Is that it?”
4. Listen with empathy. “So, what you’re saying is that it made you mad when I didn’t show up? I’m sorry. I should have handled it a different way. I didn’t mean to hurt you.”
5. Help the adolescent problem solve. “What would you like to see happen now? What can I do to make things right?”

Regardless of whether the issue is with parents or others, as parents are taught how to be emotion coaches, this enables them to participate in productive enactments that begin to heal the adolescent’s wounds. This results in the adolescent’s increased engagement and the parent’s increased attunement in the attachment process. Chapter 8 provides more detail on how to facilitate these enactments. ESSFT and ABFT illustrate how an emphasis on parent skill training can lower parental blame, shame, and stigma. As resources for a problem that is multi-determined, parents receive empathy, support, and coaching for these difficult challenges. Because these approaches avoid stigma, they can also serve as a guide for addressing child and adolescent problems in military families.

**Military Personnel**

In the United States, the long wars of the last two decades and multiple deployments have produced more distressed service members and families than there are clinicians to help them. Finding developmentally appropriate help is a challenge. Veterans often live in small towns and communities where mental health services are scarce. Active duty personnel feel vulnerable with the stigma of post-traumatic stress disorder (PTSD) and often refuse traditional services. They may seek out a chaplain or a family support person to avoid stigma. Yet, many military installations report troubling rates of domestic violence and murder-suicide. This is how third-generation family therapy can help. Very often, families may have an acting out child or a depressed spouse for whom treatment is sought. Through this pathway are many opportunities for child interventions that engage parents, soothe children, lift depression, and build a trusting relationship with the trauma-affected service member. If affected parents become the “personal trainer” for their child’s emotional battles, they will also be learning calming techniques for themselves.

Therefore, **avoiding stigma is the most important key to engagement**. Many veterans and service members do not use the label PTSD, protesting that they do not have a mental disorder
“I’m not crazy!”). Using the terms post-combat stress, or nervous system dysregulation are less offensive. Tying symptoms to the nervous system is more accurate than the label of mental disorder. Even better, what words does the individual use? Stay with those whenever possible. Next, explore available help and whether it was beneficial. Was it a “one size fits all” approach or was there individualization? Often, service members need to tell their stories about what is helpful or not. Innovative MFTs are achieving positive results when they demonstrate their ability to customize. For example, one veteran, Pete, came to counseling because his wife was threatening divorce. He had refused cognitive-behavioral therapy (CBT) and other labeled trauma treatments. He had a steadfast resolve that he did not want to forget the horror of the battlefield and all the comrades he lost. To him, his survival brought an obligation to keep the memory of his fallen brothers alive. Consequently, he had many symptoms that led his wife to threaten divorce.

Slowly, Pete found his own footing. First, he canceled every other week. Seeing this pattern, the therapist suggested that they only meet every other week. She stopped trying to have traditional therapeutic conversations. These led to too much emotional activation. In her mind, she stopped expecting him to “deal” with his issues. He began attending 100%. This was the right pace for him. Then, he became attached to the Beanie Babies (small toy animals stuffed with bean-like material) in the office intended for children. He began a ritual of entering the office, finding the Beanie Babies, and clutching a couple of them in his lap throughout the session. The tactile (somatic) value of this ritual should not be overlooked. Chapter 8 provides somatic interventions that can capitalize on these comforting behaviors. Danger, protection, safety. The body has its own wisdom (van der Kolk, 2014). He could accept calm and soothing without having to give up his memories. His nervous system was healing. Chapters 8 and 9 provide more detail on calming nervous system dysregulation. Eventually, he felt safe enough to allow his wife to join them. For most trauma survivors, the timing and pace of healing is tied to what the body needs. In these cases, slow is fast. Trying to direct the pace of the process can be a therapeutic error in many cases.

Was this family therapy? How do we know? The most common indicator is whether the therapist keeps the entire picture in mind. Is there a constructivist view that allows for many possible pathways to healing? Does the therapist see how the pieces all fit together? For example, she dropped her own framework and followed his nonverbal messages. At a communication level, she began speaking metaphorically to his body, rather than to his mind, discussing various ways to self-soothe. What about the big picture? What were the other influences in his life? How did his wife’s perceptions and responses fit with his symptoms? Opinions of previous treatment providers? His dead soldiers? Instead of insisting on a certain model with a desired outcome, she joined him on his journey and provided a nondemanding way for him to explore other parts of his system without suggesting a right way. A constructivist might say, “Whose idea is it that a person has to give up their memories in order to heal?” Instead, is it possible to keep the memories and deactivate the body? Family therapists have always challenged the status quo. Chapter 9 outlines some approaches to unresolved grief and loss. In this way, the next generation continues to help those who are not served well with traditional modes of thought. In fact, the frequency of trauma symptoms among the military suggests a pressing need for more customized approaches.

Trauma Survivors

Brain research has given mental health professionals many reasons to become proficient facilitators of trauma healing. The human nervous system is visible from a number of scientific observations and systemic thinking originated in biology. For family therapists, one’s social
ecology and the role of physiology in relationships can no longer be overlooked (Hanna, 2014). Gregory Bateson once said, “the major problems in the world are the result of the difference between how nature works and the way people think” (Bateson, 2010). These words of wisdom from the first generation underscore the importance of screening and addressing trauma. Thus, a basic definition of trauma might be defined according to **how nature works**. What are the body’s natural responses to threat, danger, injury, and harm? Rather than focusing on an event or situation, what is the individual’s **biopsychosocial response**? These layers of experience are how nature works.

There are a number of opinions about what constitutes a trauma. The DSM-V has a number of criteria that lead to formal diagnoses, such as “exposure to real or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). The exposure can be witnessing or hearing about a “violent or accidental” incident. Johnson (2002) advocated for an expanded definition of trauma that includes **attachment injuries, betrayals, divorce, etc.** Horwitz (1997) illustrated how the effects of deaths and losses can lead to trauma symptoms without **addressing grief** as part of a network intervention. Extending these ideas, perhaps trauma can be any event or circumstance that leads to recognizable trauma symptoms. It may be a physical, emotional, or psychological wound. A shorthand version is any experience by which the **nervous system becomes overwhelmed**. Different people have a **unique blueprint of vulnerability** and may experience symptoms for reasons that are outside formal diagnoses. If one person has a history of abuse and neglect, an event may elicit more long-term stress responses than those for a person without the same risk factors. Because trauma symptoms are **ghosts in many relationships**, screening for these at the beginning of therapy can help practitioners to understand the layers of risk that make each case unique (Hanna, 2014). Systemic thinking is that which accounts for how these biopsychosocial elements fit together. In many cases, over-reliance on the DSM-V criteria and other linear models will limit the clinician’s ability to individualize treatment and effectively engage the survivor and family (Figley & Figley, 2009).

**IMPORTANCE OF SCREENING**

Appendix D provides an important trauma screening tool. Adverse childhood experiences (ACEs) is used in primary care and mental health as a user-friendly overview of a person’s stressful experiences. As part of a study on obesity, it had surprisingly high correlations (Felitti et al., 1998). It has now gained near universal attention for identifying risk factors that should be included in treatment planning. This is particularly important if the presenting problem does not include trauma. Many clients are unaware that traumatic symptoms are not their fault, and they may identify individual, couple, or child problems that seem to have little to do with trauma. If the topic is raised, they may also prefer to avoid conversations about trauma. **Their preferences should be accepted.** The purpose of the survey is to help the clinician to be **sensitive to someone’s life story**. As illustrated with ESSFT earlier, there are many **indirect ways to help with trauma symptoms** and no need to do further damage by persuading or coercing a person into an undesired conversation. For example, a treatment plan might include self-care directives rather than using the language of symptom management.

In Appendix C, the Post-Traumatic Stress Disorder Checklist – Civilian (PCL-C) has been used widely in researches that study the effects of war, violence, abuse, and neglect. Based on DSM-IV categories for diagnosis of PTSD, it has been a reliable research and clinical instrument for decades. Seventeen items address three categories: **re-experiencing, avoidance, and increased**
arousal. Even without a positive diagnosis of PTSD, these items often identify the intensity of someone’s symptoms and provide a guide for areas that need attention. For example, with our veteran, Pete, these screenings could alert the therapist for the need to proceed slowly. In other cases, those who present with symptoms that may not be common indicators of trauma deserve to receive biological empathy from a biosocial perspective. Brown and Kimball (2013) found that those engaged in self-harm listed trauma, emotional pain, release, and addiction as some components of their phenomenology. These findings illustrate why routine trauma screening is so important.

TRAUMA-SENSITIVE FAMILY THERAPY

Growing trends around the practices called “mindfulness” encourage MFTs to include the elements of focus and relaxation in their normal practices. Just as McFarlane (2002) used the term biosocial to discuss the complexity of schizophrenia, family therapists now have an additional dimension to systemic thinking. Regardless of the term, it represents inclusion of the whole body (including the brain!). Regarding how nature works, the body is built to seek safety and health. Adding a concern for physical safety can increase practitioners’ attunement to hidden anxieties. Some who are most in need of somatic intervention are those affected by war. Some people prefer to sit facing a door or near the door. Others may prefer a corner with a wider view. These instinctive, nonverbal preferences are not always available in every office. However, merely asking about what helps a person to feel physically safe is a good beginning. The response to this question often provides evidence of whether it is an issue for someone. When it is, those clients immediately “feel felt” (Siegel, 2012), a sense of appreciation that someone understands their deepest needs.

While this may seem important for survivors of stalking, rape, harassment, or incest, it can also be a welcome gesture for others who have developed a generalized sense of danger. Some who are most in need of somatic intervention are those affected by war. In addition, recall that Nancy Lanza reported Adam’s extreme fear, even though no one clearly identified any trauma. There is no indication that any provider screened him for trauma. Even with no ACEs reported, Adam would have registered some symptoms on the PCL-C. Regardless of a formal diagnosis, learning about how Adam experienced his body would help a practitioner develop a mind–body perspective. Thus, using the language of safety, danger, and protection is the way to develop an environment of understanding when someone has nervous system disruptions. Screening allows the clinician to rule these dysregulations in or out. This focus leads to biological empathy, that is, the ability to understand a person’s biosocial experience, not emotions alone (Hanna, 2014; Sanders, 1990).

Next, implementing a whole-body focus can take many forms. Some clinicians integrate a focus on the body with strengths and resources. In Levine’s (2010) work, called somatic experiencing, the focus on resources is the first step before addressing any wounds. Ogden and Minter (2000) encouraged a process called mindfulness of sensation (see Chapter 8). Here is an example of this approach regardless of the presenting problem:

FT: Before we begin today, I’m wondering if we could do a little preparation first. Sometimes, addressing difficult issues takes a lot of energy. If we pause and stop to be centered and calm, it helps our creativity. Is that OK?
MOTHER: Yeah, I guess. What did you have in mind?
FT: It’s a meditation exercise that helps to calm us down for about five minutes.
You mean like pills?

Ha! Almost! No, it’s more like a thinking exercise for your mom and dad, and for you, it’s a time to draw a certain kind of picture.

Yeah. I want to draw a clown!

OK. We can do clowns. Can we do some other things too?

Like what?

Well, here’s some paper and crayons. Now listen to what I ask Mom and Dad, and then let’s see if you can draw a picture about you, too. Dad? Are you OK with this?

Sure, why not?

OK. Think of a time during the past week when you felt the most like you want to feel. Maybe less distress? A little more pleasure? Take some time to remember it and get that image in your mind . . . stay with it for a few minutes . . . Mark, while Mom and Dad are thinking, could you draw me a picture of a time this week that made you feel good? Maybe something that happened at home or school that made you happy?

Umm, when we went to the water park!

OK. Go for it. Mom and Dad, have you got a memory going when you felt the most like you want to feel?

(chuckling) I’d rather draw a picture! Just kidding . . .

Hey, whatever floats your boat! . . . just take your time . . . it doesn’t have to be anything dramatic. Just feeling the way you want to feel . . . Sometime during the week . . . Got it? There’s a second part . . . Then, notice the sensations in your body as you remember it. Feel free to close your eyes or relax and slow down. Just give yourself a few minutes to be with that memory and how it felt. We don’t need to hurry. See if you can get in touch with sensations inside while you remember the details . . . the sensations in the body are what we want to revisit. Where in the body . . . is that peace or confidence (use their word, whatever they felt). Track your sensation . . . notice how your breath feels . . .

As a prelude to addressing difficult situations, bringing up resources and positive sensations can keep the brain focused toward the rational, problem-solving part (prefrontal cortex). Even with a young child in the room, the suggestion and follow-through, however it goes, helps families begin to be body-oriented. As sensations are identified, the therapist suggests a goal of holding on to those sensations, however they were named (good in my chest, tingling in my head, calm in my stomach, etc.), just for the sake of feeling good. Ask children to draw the sensation. They can make it anything they would like. What’s it like when you’re at the park? There is no right answer. The intent is to invite a process. Remember Mark asking to draw clowns? Why did the therapist redirect him? One reason was to see what his capacity for redirection might be. He was cooperative, so this is a resource. Another was to align his process with that of the rest of the family (some experience from the week). A third was to model for parents a way of saying “no” indirectly. Some children become allergic to the word. Later in the session, the opportunity to draw clowns can return.

Then, transition into the presenting problem. Is it Mark’s tantrums in kindergarten? Or fighting with other children? After addressing the matter at hand, return to the good memory as an example of how we can calm ourselves when things get rough. Parents can use this at home with Mark, too. Chapter 9 will also provide more examples of how games, art interventions for children, and meditations for adults can affect beliefs, behaviors, and emotions after a stressful event.
In general, somatic methods of trauma healing use the body first, as “the client” and the mind comes second. In severe cases, many survivors cannot speak, nor do they want to speak about the experience. Somatic practitioners never suggest that it is necessary to verbally or mentally relive the experience. Instead, sensations in the body provide message enough. Tracking these sensations and learning how to help the nervous system transition from triggered intensity back to a healthy state of ebb and flow is the ultimate goal. Although intensive work is outside the scope of this book, the basics always begin with breathing, safety, grounding, and mindful focus (see Chapter 8).

At other times, a whole-body focus may involve helping families organize action-oriented experiences, such as recreational outings or memorial celebrations to honor lost loved ones. The focus should be on action and involvement for family and network participants. These help the stress-response system (emotional brain) to work in harmony with the prefrontal cortex (rational brain) by stimulating oxytocin, a calming neuropeptide that increases with social support and connection. Action can involve dance, yoga, art, music, walking, hiking, low intensity sports, and other forms of creativity and teamwork. Celebrations can be informal outings that are dedicated to someone who was lost or formal events that involve the social network.

When families find ways to add these to their routines and make lifestyle changes, rather than remaining stuck in activation, the nervous system swings up and down in more flexible, positive rhythms, and these eventually return the body to lower stress responses. The keyword here is lifestyle. As with any successful wound healing, trauma healing is a process that takes time, involves some sustained repetition (first aid), and proceeds at a pace that matches the severity of the injury. Family psychoeducation can help members to keep expectations low and allow the survivor’s tolerance level to be the guide for what is possible. Discussions about the importance of these activities can motivate and help families organize lifestyle changes. Just as for a person with high blood pressure or diabetes, lifestyle changes can be positive steps toward greater well-being.

These elements of trauma intervention follow the discussion about helping our military with the wounds of war. However, with an expanded definition of trauma, it makes sense that many groups who suffer the effects of family transitions, childhood abuse and neglect, survivors of domestic violence, substance abuse, and groups who suffer from discrimination and poverty all have physiological disruptions that can improve from a whole-body focus (see Chapter 3 for a discussion of race and culture). Among these groups, those who are lesbian, gay, or transgender have unique needs that range from trauma healing (as discussed here) to helping youth and their families with the developmental process of identity formation. In this regard, much like ABFT, effective family therapy interventions play an important role in suicide prevention and positive mental health for children and parents.

**Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Families**

When working with communities that have needs related to sexual attraction, sexual orientation, gender identity, and positions of questioning, it is important to understand the issues that lead to similarity and difference across these groups. Perhaps the most common denominator between these groups is the high rate of suicide among teens who drown in a sense of hopelessness about their future. Thus, issues of privacy and safety are very important for all groups, given the potential risk for discrimination and violence that may exist in a local community. As with trauma survivors, safety, danger, protection, and injury are words that can convey biological empathy and validation for LGBTQ clients (Sanders, 1993; Sanders & Kroll, 2000).
Although combined in this section, understanding each group’s distinctions and accepting each person’s unique journey leads to a systemic-constructivist approach. Without understanding gender diversity, practitioners may fail to recognize a person’s key identity. Each group has a different history regarding their experience of feeling different, coping strategies in a heterosexist society, and how they may relate to family and friends. In addition, it is important to understand some basic concepts.

**Sexual attraction** relates to willingness, desire, and arousal regarding a potential sexual partner. Individuals may have a variety of sexual experiences without claiming any specific orientation. Bisexual individuals report feeling sexual attraction to either sex but may be ostracized by straight (heterosexual) and gay groups. Gay men and women are attracted to the same sex, but societal or family responses may be different for men vs. women in public. Heterosexual people are attracted to the opposite sex and have widespread societal approval for their attraction. **Sexual orientation** is a primary psychological, emotional, romantic, and sexual connection with one gender over another. On occasion, there may be those who experience emotional attachments without sexual desire. Transgender are those whose gender identity is biopsychosocially opposite their male or female genitalia. Although sex hormones may match genitalia, other neurochemicals, such as dopamine, may produce feelings of hope and joy when a person can express their gender identity (maleness or femaleness). Sexual attraction and sexual orientation are separate dynamics from gender identity. **Intersexed individuals** are born with ambiguous genitalia and may undergo some form of sex assignment surgery in infancy, based on physician–family negotiation. As they develop, they may experience variation in their gender identity.

A systemic-constructivist practitioner focuses on how family members experience their relationships in light of one’s social ecology. For each group, there may be many questions about cause and development that surface in each family. Laypeople are free to explore, theorize, and debate various streams of thought. However, licensed practitioners make a commitment to **preserve public health and mental health and to prevent violence**. In the context of this commitment, third-generation family therapists apply constructivist positions that will seek win-win solutions and coping strategies to preserve mental and physical health. These approaches include those that help families to become resources for their LGBTQ children.

The Family Acceptance Project™ (FAP; Ryan & Rees, 2012) uses research about the vulnerability of LGBTQ youth to help rejecting or ambivalent families choose health of the child as their first priority (Ryan & Futterman, 1998). The first goal of the project is to save lives, given high suicide rates for these youths. Individuals who suffer a high level of family rejection are eight times as likely to attempt suicide. The second goal is to highlight family strengths and resources to lower these suicide and mental health risks. Thus, helping families with constructive responses is a life-and-death issue (Diamond et al., 2012).

Research shows that family responses were linked to risk and protective factors for sexual health, HIV infection, substance abuse, depression, suicide, and well-being (Ryan & Futterman, 1998). Data from the project has led to a family-oriented model of wellness, prevention, and care for LGBTQ children and adolescents (Ryan & Rees, 2012). This model addresses the needs of ethnically and religiously diverse families to decrease rejection and increase support. Training is available to families, clergy, and social service providers. There is a faith-based manual to help families navigate emotional transitions as their children evolve (Ryan & Rees, 2012). This and many other resources can be found at https://familyproject.sfsu.edu/.

The manual provides faith-based motivation and education for effective parenting, including “behaviors that help and behaviors to avoid.” Some of these suggestions include items
that discourage abuse and name-calling while encouraging affection, support, and advocacy. Regarding the well-being of LGBTQ adults, these guidelines also provide an informal checklist for **assessing individual risk**. Returning to Jerry’s case, his father may have engaged in two or three behaviors to avoid, but there are also helpful behaviors from his mother, sister, and friends. A review of his social ecology through a genogram discovers these potential allies and forms of safety. The therapist becomes an advocate and a brainstormer. This role depathologizes the problem and normalizes Jerry’s distress. Because the doctor is concerned about Jerry’s level of depression, exploring **what Jerry considers to be the most pressing issue is important**.

Questions about the definition of the problem help the therapist to learn that Jerry is most concerned about his parents’ reactions and his future college plans. Because he doesn’t mention his sexual orientation as a problem, the clinician explores his past close relationship with his parents and defines the problem as conflict resulting from disclosure about his sexual orientation to parents. Working on his family’s responses is his top priority. These steps illustrate how constructivist approaches honor the wisdom of the client. Since he still has contact with his mother and sister, the FAP dos and don’ts may be helpful to them.

In another case, a 25-year-old Caucasian woman was questioning and wanted more information about sexual orientation and ways of thinking about it. She did not identify herself with any group. The family therapist proposed some psychoeducation and bibliotherapy. As she was a creative writer, this fit a woman who valued education and the arts. On a whiteboard, the therapist mapped the range of sexual attraction, sexual orientation, different societal positions, various approaches to research studies, family responses, and different ways that individuals coped with their identities and attractions. Use of a genogram mapped various worldviews that existed in her family and social network. These activities became the basis of conversations until she brought up specific relationship difficulties that she wanted to address. At no time did the client ask for help in deciding who she was or with what group she identified. Her request for information eventually led to new goals related to the pragmatics of her relationships. When it became apparent that she was a survivor of sexual abuse, the topic of therapy changed to healing and coping strategies. Some years later, she came out and found a long-term lesbian partner.

Systemic therapists should consider that each person may have **multiple families**, such as a birth family, a family of choice, a family of procreation, and a marriage. These become potential resources. Other cases will be more specific to issues prior to disclosure and coming out. However, each group or individual has a unique story. Effective family therapy helps each person tell their own story. **To claim this story without shame can be lifesaving.** In considering LGBTQ relationships, Sanders (2001, p. 223) normalized these as “a vehicle for human affiliation,” intimate bonding that is necessary for all humans to survive. He suggests that the inner experience of seeking love and intimacy should be the focus for practitioners working with gay and lesbian couples. Using third-generation family therapy, clinicians have (1) constructivist attitudes to explore many possibilities, (2) strength-based eyes to always see the glass as “half full,” (3) systemic theories to explore the politics and oppression of social ecology, and (4) relational interventions to mobilize a support network. Regardless of the generation, these are examples of thinking systemically.

**SUMMARY**

Toward the end of the 20th century, the field of marriage and family therapy evolved in response to postmodern thought, societal changes, creative practitioners, health-care trends, and ongoing research. A postmodern emphasis led to less technical and more personable
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interactions in family therapy practice. As history reveals, family therapy practice started with concept-oriented strategy (systems/relational) and evolved into the practices of reflection and questioning. This questioning led to dialogs about the importance of gender, race, and culture. These themes are the topic of Chapter 3. Examining these social influences brought new ways of viewing people and their problems. With increasing frequency, family therapists assume that any problem can be seen through multiple lenses (constructivism). Practitioners began to look not only at the possibility of alternative perspectives, but also at the interactional process that leads to adopting new perspectives (social construction).

Approaches developed to focus on strengths, successes, therapist–family relationships, client engagement, and client-directed goals. These are characterized by solution-focused, narrative, and integrative family therapies, such as EFT, CBCT, MDFT, and MST. Alongside these trends in greater collaboration and egalitarianism, the same trends appeared in the family treatment of schizophrenia. Consistent with the recovery movement that developed in public psychiatric settings, MFGs approached the treatment of severe mental illness in respectful and hopeful ways. An analysis of the Sandy Hook shooter’s family experience and cutting-edge MFGs illustrates how this tragic violence could have been prevented.

At the dawn of the 21st century, third-generation family therapy approaches began to address the needs of specific groups, such as those with ODD or suicidality, military personnel, trauma survivors, and LGBTQ families. These approaches are ESSFT, ABFT, FAP, and somatic interventions that involve action and social network involvement. Today, many integrative models incorporate the best and most relevant aspects of first-generation approaches with flexible and collaborative interventions. In all, Chapters 1 and 2 describe 18 approaches to family intervention and psychoeducation. One of the strengths of this list is that many models address specific needs of at-risk groups, and others address the developmental needs of couples and families during times of crisis. When an approach is successful with those who have the greatest need, clinicians can be assured that they have sufficient skills for a full range of difficulties. These models also illustrate common themes of theory and practice. Chapters 3 and 4 help practitioners apply these themes before entering into more advanced interventions.
# CHAPTER 3
Integration of Theory: Common Themes

## Chapter Outline

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AMFTRB Knowledge

04. Family studies and science (including but not limited to parenting, step families/blended families, remarriage, out-of-home placement, and same-sex couples and families)

05. Marital studies and science

14. Family life cycle stages and their impact on problem formation and treatment

17. Strength-based resiliency across the lifespan

37. Implications of human diversity factors on client systems

69. Impact of social stratification, social privilege, and social oppression on client system

70. Influence of prevailing sociopolitical climate on the therapeutic relationship

71. Impact of economic stressors on presenting problems and treatment

AMFTRB Content

01.04 Integrate multiple dimensions of and social justice within a systemic treatment approach.

02.06 Formulate and continually assess hypotheses regarding the client that reflect contextual understanding [including but not limited to acculturation, abilities, diversity, socio-economic status, spirituality, age, gender, sexual orientation, culture, and power differential(s)].

02.07 Assess external factors (including but not limited to events, transitions, illness, and trauma) affecting client functioning.

02.08 Review background, history, context, dimensions of diversity, client beliefs, external influences, and current events surrounding the origins and maintenance of the presenting issue(s).

02.17 Assess the impact of the developmental stage of members of the client system and the family life cycle stage on presenting problem formation, maintenance, and resolution.

03.11 Choose therapeutic modalities and interventions that reflect contextual understanding of client [including but not limited to acculturation, abilities, diversity, socio-economic status, spirituality, age, gender, sexuality, sexual orientation, culture, and power differential(s)].

03.23 Integrate client’s cultural knowledge to facilitate effective treatment strategies.

As shown in Chapters 1 and 2, family therapy has many conceptual models that guide practitioners and help organize their thinking. This diversity, however, can often be overwhelming for the beginner. The structural therapist might assess the boundaries, coalitions,
INTEGRATION OF THEORY: COMMON THEMES

and hierarchy of a family (Minuchin & Fishman, 1981). The intergenerational therapist might focus on family beliefs, conflicts, and losses transferred from one generation to another (Framo, 1981; Paul & Paul, 1975). Trainees must often incorporate concepts and techniques from various schools. This can be confusing – different theoretical models use different terms to describe similar concepts. For example, Bowen’s concept of differentiation is similar to Minuchin’s concept of boundary when speaking of emotional and interpersonal distance. Likewise, certain techniques have proved useful to a number of schools of family therapy. For example, several approaches clarify communication, direct enactments, and reframe the symptom in relational terms (Nichols & Schwartz, 1991).

Learning about these subtleties can challenge the new practitioner, but the pursuit of conceptual purity also has pitfalls. The adoption of a single theoretical framework can limit a family therapist’s effectiveness, encouraging a tendency to distort observations to conform to theoretical precepts. For example, practitioners who are interested in assessing structural boundaries might attend only to specific interactions (e.g., when family members talk for each other). These practitioners can easily organize their observations, but they might miss some important information because it does not fit within that structural boundary framework (e.g., a critical issue raised even though members are talking for each other). To use an old cliche, a person with a hammer starts to think everything is a nail. Families are complex, dynamic organizations who deserve an understanding that comes from multiple dimensions.

In a review of family therapy approaches applied to families with older parents and grown children, Hargrave and Hanna (1997) found most early models of family therapy in their pure form to be lacking:

Structural family therapy tends to ignore longitudinal changes over time with a family, thus ignoring historical factors that play heavily into the development of legacies. Bowenian family therapy does not offer enough pragmatic thinking to intervene in crises brought on by chronic illness. Behavioral family therapy does not have a framework for addressing the phenomenology of losses experienced by elders. Experiential family therapy may be too direct for some families who prefer to cope with changing family roles in silent, persevering ways.

(p. 27)

Although this critique is given in light of the needs of later-life families, similar shortcomings of these various therapy approaches have been seen with respect to minority families, court-ordered cases, and families who are not “therapy wise.” Given that the early approaches came from clinicians socialized according to certain norms in the culture of psychotherapy, it is not difficult to understand how those first approaches became the foundation, but not ultimately the entire structure, of the family therapy movement.

The majority of practicing family therapists do not draw from a single theory or school of techniques (Quinn & Davidson, 1984). Even therapists trained in a single theory eventually incorporate other theories and techniques (Todd & Selekman, 1991). Therapists integrate their own blend of methods based on training, personality, and the population of families they serve. To continue this process of integration, the beginning therapist must identify major themes that provide ways of thinking about relationships, interactions, and problems.
These themes can be organized along a continuum that proceeds from larger to smaller spheres of observation. These differences are sometimes referred to as macro to micro views of family process. The macro view includes broad social factors that affect the interpersonal process, such as gender, race, and culture. As the view narrows slightly, intergenerational and extended family relationships become additional influences on the interpersonal process. In the immediate relationship, as understood by the micro view, looking at relational transitions and structural interactions is possible. Finally, the individual can be studied as a system in its own right – as a collection of biopsychosocial subsystems that operate continuously. Like a camera with a zoom lens, the family therapist must maintain a flexible view to assess from different angles and multiple levels of process. In addition, the problem-solving system may comprise formal family relationships, friendships, or other important associates that can be resources.

This chapter approaches the task of integration by consolidating our models into common conceptual themes and influences that explain the multiple dimensions of family life. Then, Chapter 4 will review common practices, sometimes called common factors, that are universal to all effective forms of family therapy practice. Taken together, practitioners will have an understanding of basic family concepts and basic clinical practices. These are the viewing and the doing of contemporary family therapy. At the end of this chapter, these themes are summarized in Box 3.4.

**Gender**

In 1978, Rachel Hare-Mustin published her pioneering article, “A Feminist Approach to Family Therapy.” Her critique of the field and thoughtful suggestions for a more gender-sensitive approach to family therapy began decades of reflection on how to understand a problem as it relates to societal practices, such as sexism. At the most general level, the feminist movement in family therapy suggested that all families are influenced by patterns of socialization that lead to rules and roles governing family process (power). Goldner (1988) argued that gender should not be a special topic in family therapy but is “at the center of family theory” (p. 17). Because gender influences structure in the family, it should be a fundamental element in family assessment.

Other reviews and critiques followed, including those of the Women’s Project in Family Therapy, a group of feminist colleagues who added their voices of support for changes in hierarchical practices in our therapy and in our professional organizations (Simon, 1992). These were first-generation family therapists who were structural, strategic, and Bowenian in their approaches to practice. While they explored women’s inequalities, they also found imbalances that men had little opportunity to express. As Marianne Walters observed:

> If you define everything in the family in terms of power issues, you are defining the family according to the worldview of men . . . we have to move away from being so fascinated by power issues . . . Feelings of incompetence cut both ways in families. One of the things we’ve been discovering is how incompetent many men feel within their own families.

(Simon, 1992, p. 52)

Thus, each person’s gender experience should be explored. Do both sides have a voice in the relationship? In cases of marital conflict, gender differences are often the core issue and should be identified. For example, Jacobson, Holtzworth-Monroe, and Schmaling (1989) found that women often complain more than men about their current relationship. Indeed, women often desire greater involvement and closeness from their husbands, whereas husbands prefer to
maintain the status quo and create greater autonomy and separateness for themselves. Moreover, women are more likely to seek therapy and push for an egalitarian relationship, whereas men are less likely to seek therapy and are inclined to maintain traditional gender roles.

**Gender Politics and Family Therapy**

In the decades since these first feminist observations, gender issues have evolved professionally and domestically. In terms of numbers across professions, women now dominate psychotherapy and family therapy. Males are the minority in training programs and clinics. Willyard (2011) found that women outnumber men three to one. In an area that emphasizes the need for couple and family participation, building a strong alliance with fathers and husbands is critical. When a heterosexual couple enters the office of a female couple therapist, how is the gender imbalance addressed? Does the male have recourse if the women form an unspoken coalition? Is the process inherently female-friendly? The issues are the same in reverse; however, with the preponderance of female clinicians, this is now a new concern. Thus, there is a need for family therapists to acknowledge the obvious imbalance (e.g. "Since you are outnumbered by women, we need to have a way to balance the female point of view. I will be watchful of this, but if we take advantage of our majority, will you let us know?"). Thus, the role of the therapist should be to monitor gender balance and gender empowerment for each sex.

**EMPOWERMENT FOR MEN**

Does the clinician understand the cultural differences between the sexes? This is especially important as more men are court-referred or engaged in mandated therapy. With respect to men’s issues, Brooks (1998) suggested that the culture of traditional men and the culture of traditional psychotherapy are very different, and therapists will be more successful when they recognize some men’s discomfort with therapy and explore what process could be the most comfortable for a male client. Because the majority of work on gender issues addresses the oppression of women in relationships, Brooks’ advice is rare insight into how men might be disadvantaged by their socialization, society’s portrayals of psychotherapy on television, and the expectations for emotional expression that therapists implicitly hold. He encourages clinicians to remember that men’s socialization involves the need to guard their vulnerable emotions to effectively compete with others. As such, it behooves therapists to emphasize concrete processes in therapy, such as skill building and goal setting.

In addition, issues of vulnerability and dependency deserve more attention in the lives of men. One man checked in after attending anger management classes, stating, “They spent a lot of time talking about controlling my anger, but no one said anything about my fears. I wanted to talk about my fears.” This highlights the reality that many behaviors labeled as “hypermasculine” can be put in a systemic context by exploring the primary emotion (or the attachment issues) underlying the stereotyped behavior. Another man was insistent on training for a sports competition in addition to his demanding work schedule, just as his wife was fighting off postpartum depression. The family therapist (FT) deconstructed his experience:

FT: I have a motto that controlling people are fearful people. As I’m listening to your determination about this event at this time, compared to other times when you could do this . . . Why now?

JOSH: Well, I won’t always be in this kind of shape. It seems like I’m in my prime right now and this will be the last time I can do it.

FT: So, it seems like a do or die thing for you?
JOSH: Yeah.
FT: Can you say more about your fears related to this? I get the sense there’s more to this than just being in shape. What are the fears behind all this?
JOSH: Uh, (pauses) mmm, I don’t know . . .
FT: Let me see if I can find a sentence you can use . . . If I don’t do this right now at this time . . . then . . . what will happen?
JOSH: I guess I would miss the opportunity?
FT: And if I miss the opportunity, then I would be . . . what?
JOSH: Then I would be like my dad. He has missed a lot of opportunities in his life, and I don’t want to be like that. I want to take advantage of all life has to offer before I get old.
FT: OK, so you don’t want to end up like your dad? Maybe you’re feeling a little desperate about that?
JOSH: Right. He’s so unhappy now . . . he could have had a lot more in his life . . .

In Josh’s case, his uncompromising stance was a position of desperation that came from a lifetime of growing up with a mother who came to the rescue and became the breadwinner of the family when his father sank into chronic depression. He considered his father a failure. In addition, his wife’s depression had triggered his resentment toward his father and his resolve to avoid such a fate. For the couple, Josh’s disclosures became a springboard for greater understanding in the marriage, and this led to more support from his wife. They were able to strike a win-win agreement without him feeling threatened about how he could compete and still be available to his family. In part, he supported his wife’s lifelong dream to become a professional artist, and she began to focus on this while he spent more time with his children. Her depression began to lift. When he was training, he no longer felt guilty or driven, and the couple saw their teamwork improve.

EMPOWERMENT FOR WOMEN

Gender inequality for women continues to exist at all levels of society. Household roles may be defined in traditional ways, even though both parents are working as full-time breadwinners. Parental teamwork is often lacking. Women are socialized to consider the relational impact of their behavior more often than men. Consequently, they will often be more conscious about how to manage, mediate, and negotiate relationships in the family. This competence in relationship skills often hides a woman’s vulnerabilities. For example, she may want more intimacy, something that may threaten a man. Challenging the status quo may bring guilt and shame for a woman. These may be overlooked, given her appearance of greater competence. Clinicians can be prepared to validate her courage. A common example of this occurs when a man seeks couple counseling because his wife is threatening divorce. In most cases, women are the initiators of counseling. Thus, when a man initiates due to an impending threat, special circumstances of empowerment exist:

ART: She says she wants to leave, but I think we can work this out.
AMY: Ha! So, now that I’ve served you papers, you want to work things out. What about for the last five years when I’ve told you to stop texting me at work every hour? Or what about when I asked you to help Bobby with his homework, and you told me that’s what a mother is for? Why didn’t you work things out then? I’m done being at your beck and call!
FT: So, it seems pretty hopeless to you?
AMY: (sadly) Yeah, he doesn’t really care about me or the kids.
FT: (to husband) And you think it’s possible to work things out? How would that go?
ART: Well, she gets excited about this stuff, but she usually calms down. I don’t like her office. I think they’re a bad influence on her.

AMY: Hey, you’ve always texted me too much, even when I worked for Charley’s. This isn’t about work! This is about you wanting total control over me, and I’m done.

FT: (to wife) The word smothered comes to mind. Does that fit at all?

AMY: Yes, exactly! He smothers me, and I need space. He never allows me any space!

FT: OK. Let me change the focus for a minute. When you came today, what were you each hoping would happen here?

AMY: He badgered me to come. I told him it was over for me. If you can help him accept the fact that it’s over, that would be a start.

ART: I just think she’s making too much out of this. OK, I’ll stop the texting. Is that what you want?

AMY: You don’t get it, Art. It’s about a lot of things. Mostly, you don’t take me seriously about anything.

FT: So, is this divorce action the first time he’s taken you seriously?

AMY: Just about. We’ve gone round and round for years about the same old things, and nothing changes.

FT: (to husband) What about this issue of taking her seriously? She really seems to be hurting.

ART: I take her seriously. I wouldn’t be here if I didn’t.

FT: Sounds like you’re losing her. Can you think of some things you wish you had done differently? This is your chance to win her back.

ART: I don’t know. The usual. She wants me to talk more. She wants me to help around the house more. I don’t know . . .

AMY: She asked what you think, not what I want. See? He just doesn’t get it!

FT: (to husband) I’m no magician, so I can’t change her mind. But, I have worked with a lot of couples to repair their marriages or negotiate a constructive divorce. I’m wondering if either of you is interested in knowing more about why this isn’t working? Amy, it sounds like you’ve tried everything you could to make things better. That tells me you’ve made quite an investment. I think you deserve some answers in return for your hard work (ledger system). Do you ever wonder why Art hasn’t changed? Sometimes, divorce counseling can draw a picture of the whys. I won’t try to change your decision. So far, you’ve got Art’s attention. Good for you. Since you have kids and all . . . This might be what I have to offer you, since you want to help Art accept the facts (her goal). What I would do is chart out your relationship history and see how I can help Art to understand himself and you better (see Chapter 7, Timelines). Art, this may not be what you had in mind, but one thing I can offer you is the chance to prove that you’re the kind of guy who can learn new things and change. I can tell you care about your family. Even if it isn’t enough to save the marriage, you can prove to yourself that you’re willing to give it your all . . . this can help you become a better person for your family.

In cases like this, when the husband initiates counseling, his agenda is usually to maintain the marriage and the status quo. However, if the threat of divorce is the only thing that has captured his attention, a couple therapist may unwittingly undermine his motivation by encouraging the wife to compromise. Instead, since it only takes one person to end a marriage, she has more power in the current moment, and her agenda (pain) should be the priority. Unbalancing the relationship by supporting her decision is a way of respecting her voice and assessing his potential for change (structural). With one foot out of the marriage (divorce papers), she will only be motivated for certain things. When therapists fail to empower women who are taking a courageous step for the first time, those women have no reason to return to a second session unless the therapist can build some credibility.
However, when the therapist accepts her position (and her pain), some couples rise to the occasion and some husbands are willing for a second chance to prove that they are “the kind of guy who can learn new things and change.” To respect the woman’s position, they return with a “wait and see” attitude. Eventually, if he is able to “win her back” and show greater respect for her needs, divorce counseling can turn into marital counseling, and they are able to address his concerns as freely as hers. Note that unbalancing did not prevent the clinician from providing Art with a face-saving way forward (validating how much he cares; proving that he can learn new things). Thus, Amy can remain empowered and firm while continuing to explore the relationship. In some cases, couples may continue with divorce proceedings. Some husbands even remarry within six months. These illustrate the need for couple therapy during earlier stages of a marriage, when pain levels are not as high, and it is still possible to create a safe place to explore each person’s dependency needs.

GENDER BALANCE

Most other cases of marital conflict are initiated by women. In those cases, empowerment can easily take the form of validating her desire for couple therapy. Then, a gender balance comes about by developing goals that are generated from the man’s concerns, such as avoiding criticism or improving sex. Since men are more visual and kinesthetic, the assessment process in Chapter 7 is especially “male-friendly,” because genograms and timelines provide a concrete and visual representation of an abstract process (Hanna, 2014). This validates women’s priorities while using men’s processes. Just as coaches may map out football plays on a chalkboard, practitioners can map relationships and strategies for change. As Brooks (1998) noted, many men are more comfortable with side-by-side interactions, rather than face to face. By starting out side by side in sessions, their level of threat is minimized. As safety develops, so does vulnerability. As with Art and Amy, men may freeze under the threat of condemnation. However, if given a face-saving way forward, side by side may eventually evolve into face to face. EFT provides an example of this. The process begins with each partner telling the therapist about their experience. The therapist engages each person independently (side by side). As softening occurs over the course of several sessions, the practitioner will eventually suggest enactments in which the couple begins talking directly to the other (face to face).

A final note about balance relates to gender disparities. These are public health issues that are more prevalent in one sex or another (McCarthy, Arnold, Ball, Blaustein, & De Vries, 2012). For example, eating disorder is a life-threatening societal plague that affects women disproportionately. Anorexia bulimia occurs three times more often in women. Anorexia nervosa occurs thirteen times more often in women. Attention deficit hyperactivity disorder occurs ten times more often in boys. Early onset schizophrenia has similar prevalence rates for young men. Addressing gender socialization is an important part of treatment and recovery for all of these challenges. Social and family expectations may place a person at risk. These risk factors may lie dormant until developmental challenges in adolescence or young adulthood create a tipping point. Whether the case is Lee from Chapter 1 or Adam in Chapter 2, these cases deserve therapeutic intervention in which gender risks can be neutralized through constructive family discussions and psychoeducation. The next section contains some suggestions for addressing these influences.

How to Focus on Gender

Should a practitioner address issues of gender directly or indirectly? Gender relevance is dictated by the client. When families do not address gender differences directly, the practitioner should refrain from confrontation. For example, child and adolescent problems may be an opportunity
to explore the impact of gender on developing children, thus introducing parents more indirectly to the issues. Sheinberg and Penn (1991) listed four categories of gender questions:

1. The “norm” the man or woman aspires to and the relational consequences of changing
2. Hypothetical questions about the relational consequences of changing these norms
3. Norms of the couple’s parents and their effects on the couple and their parents
4. Future questions to explore the potential for establishing new norms as well as altering how the problem continues (pp. 36–7)

Practitioners should maintain a curious but hopeful position as they explore and identify patterns of thought and behavior related to gender differences.

Hare-Mustin (1978) offered suggestions for implementing gender-sensitive family therapy by identifying areas that may be relevant to discussions about gender:

**Tasks.** Could role inflexibility regarding tasks be related to the problem?

**Communication.** Are communication styles disempowering for either sex?

**Boundaries.** Have parent–child coalitions developed as a result of disempowerment in the marriage?

**Relabeling.** Can disempowering stereotypes (“nag,” “passive-aggressive,” “macho,” “chauvinist”) be relabeled to account for the context of powerlessness?

**Modeling.** Can the female therapist model more egalitarian relationships with males in the family, and can male therapists affirm female strength within the family?

**Privacy.** What are family rules around females’ personal development and autonomy outside the family?

**Alliance.** What will each family member need from the therapist in order to feel understood and accepted?

As family therapy proceeds from the initial interview, the therapist can consider these questions while exploring the definition of the problem in greater depth. An initial set of questions posed to clients might be:

1. What are some differences between how you each grew up as a female or male in our society?
2. How does your family address the differences between females and males?
3. Are certain traditions in your family more closely related to either women or men?
4. How do you feel about these traditions and practices?
5. Are there any ways you think these ideas and traditions might be related to ______________ (the presenting problem)?

Such a line of questioning acknowledges gender differences in a neutral, exploratory way. Beginning with neutral questions allows families to describe themselves without feeling any pressure to change. Then, if there are extreme positions, such as the hypermasculinity that can contribute to domestic violence and child abuse, a nonjudgmental relationship allows the practitioner to explore both the survivors’ and perpetrators’ beliefs. Current trends in the effective treatment of abuse suggest a focus on both perceptual and behavioral change.
Exploring beliefs and attitudes about gender differences is an important step toward identifying which beliefs and behaviors are ultimately targeted for change.

**Race and Culture**

Whereas gender is the first element that distinguishes human beings, Coates (2015) suggested that race is a label that did not always exist. As a black man in America writing to his son, he suggested that labeling races came about as a result of hierarchy, not identity. Speaking about cultures in power, “The new people were something else before they were white – Catholic, Corsican, Welsh, Mennonite, Jewish...” (p. 7), and for this reason, it is important to continue the theme of empowerment in this discussion of social groups. Whether white, black, or brown today, these labels have emerged from the domination of one group over another.

As mentioned in Chapter 2, second-generation family therapists developed new narratives about the people they served. As the landscape of America changed, psychotherapy became a form of social control for those ordered to mandated counseling from probation and child welfare agencies. Constructivists embraced the voices of marginalized groups and began to explore how white privilege influenced therapy with these groups. Globally, cultural traditions of healing and reconciliation began to influence a variety of practitioners, as postmodern thought challenged dominant psychiatric traditions in the Western world (Campbell, Tamasese, & Waldegrave, 2001).

In 1982, McGoldrick, Pearce, and Giordano were the first family therapists to review ethnicity in a broad way. Their book *Ethnicity and Family Therapy* surveys diverse ethnic groups in terms of their history, values, and other distinguishing cultural characteristics. It explores the process of family therapy for each group, paying particular attention to ways in which therapy can be respectful of cultural norms and values. Often a family’s cultural heritage was overlooked as an important resource and strength that might be at the center of the family’s ability to overcome its current difficulties. Social class was also considered a critical factor in how therapists drew conclusions about the family. Spiegel (1982) summarized some typical therapeutic values:

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Middle-class therapists, no matter what their ethnic origins, have been socialized in terms of mainstream values. The therapist will be future-oriented, expecting clients to be motivated and to keep appointments punctually. He or she will also expect families to be willing to work on therapeutic tasks (Doing), over reasonable periods of time (Future), with the prospect of change before them (Mastery over Nature). All this is to be done while taking a pragmatic view of moral issues (Neutral), and at the very least the therapist will expect to help clients to distance themselves from any overwhelming moral burden or intense feelings of shame. And clients will be expected to separate themselves from enmeshment in the family structure and to develop increased autonomy (Individual).
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McGoldrick and Giordano (1996) analyzed a number of groups:

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Italians rely primarily on the family and turn to an outsider only as a last resort. Black Americans have long mistrusted the help they can receive from traditional institutions except the church... Puerto Ricans and Chinese may somatize when under stress and seek
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medical rather than mental health services . . . Likewise, Iranians may view medication and vitamins as a necessary part of treating symptoms.

(p. 2)

Thus, ethnicity – a sense of shared identity developed over many generations – can be a critical variable in understanding client families and mobilizing their strengths. If clinicians are not aware of differing worldviews and values, they are apt to be critical rather than complimentary of differences exhibited by families out of the mainstream.

In this context, family therapists began to recognize the importance of multicultural narratives. Given the influence of culture on family groups, the next generation added narratives about sociocultural dynamics and how these related to the presenting problem. For example, therapists such as White (1990) use gender and culture as concepts to define the problem and externalize blame. These practitioners come to understand interpersonal dynamics through the lens of socialized cultural practices. Was problem development related to the effects of colonization, oppression, and poverty? Could activities that focused on reconciliation between dominant and subjugated groups have therapeutic results?

These themes gave rise to the ecosystemic models of family therapy that are used today. Multisystemic therapy (MST) is an example of an ecosystemic model that incorporated cultural empowerment practices into projects with inner-city black families (Huey & Polo, 2008; Miranda et al., 2005). For example, once a family is referred from the court, the practitioner asks the family for an accounting of what goals are the most important to them (part of the “do-loop”). Court agenda aside, goal setting turns toward those goals perceived as most pressing to the family. Other ecosystemic models include Boyd-Franklin’s (1989) multisystem approach for black families and the social justice model of Campbell et al. (2001). These add concepts and philosophies that expand the limits of dominant culture approaches (Woods, King, Hanna, & Murray, 2012).

**Black Families**

In 1989, Nancy Boyd-Franklin published Black Families in Therapy: A Multisystem Approach, which called attention to the differential issues of race for African-American families. Boyd-Franklin began a trend of family therapists speaking out about important racial differences. She lists the first five differences as these, which summarize the fundamental premises of her book:

1. There is a great deal of cultural diversity among black families that is often overlooked or misunderstood.
2. African-American culture represents a distinct ethnic and racial experience that is unique for a number of reasons, including history; the African legacy; the experience of slavery, racism, and discrimination; and the victim system.
3. The illusion of color blindness or the “class not race” myth needs to be challenged as both misguided and counterproductive.
4. Many myths about black families in the social science literature paint a pejorative, deficit picture of black family functioning.
5. Clarifying and understanding the strengths of black families is necessary, which can serve as a foundation for therapeutic work. (p. 5)
Sociologists and anthropologists have often listed the strengths of black families as (1) strong kinship bonds, (2) strong work orientation, (3) adaptability of family roles, (4) high achievement orientation, and (5) strong religious orientation (Billingsly, 1968; Hill, 1972; McAdoo, 1981). These are often the protective factors that help black families survive in the face of great odds. Highlighting these as an important part of heritage and ancestry can be empowering for families who are discouraged.

Adding to Boyd-Franklin’s work, Hardy and Laszloffy (1995) punctuated the need for white therapists to learn that trust-building with people of color comes from seeing and acknowledging the existence of racial differences in a relationship, rather than trying to be colorblind (minimizing differences). They believe that positive relationships develop from acknowledging and discussing differences. Then, common ground emerges as the practitioner understands the unique perspective of the family. Colorblindness is often understood by whites as the virtue of believing that all people are created equal. However, for most blacks, the term suggests a myth because black people are created black, and as Coates (2015) told his son, “. . . the question of how one should live within a black body, within a country lost in the Dream, is the question of my life, and the pursuit of this question I have found ultimately answers itself” (p. 12). Thus, a connection develops with a white therapist when the focus stays on understanding and sympathizing with the family’s story of oppression, loss, resilience, courage, pain, etc.

In addition to acknowledging differences between cultural groups, avoiding stereotypes is also important. The practitioner’s intent should be to strike a balance between understanding the common ground of general patterns and clarifying distinctions and variations within the larger group. Boyd-Franklin provided valuable help in this area with African-American families. She noted that negative stereotypes often generate a fear of black men or they suggest most African-Americans actually have issues of poverty rather than issues related to race (Franklin & Boyd-Franklin, 2000; Franklin, Boyd-Franklin, & Kelly, 2006). On these issues, she encourages white therapists to engage in “soul searching” to avoid biases that unwittingly stereotype families. Stevenson (1997) also encouraged therapists to note the subtle micro aggressions that lead to pervasive patterns of discouragement and distrust. Taking that to heart, during the second generation of family therapy, a group of therapists decided to embark on their own journey of soul searching.

**Just Therapy: The Therapy of Social Justice**

As part of the narrative therapy trend in the South Pacific, Charles Waldegrave (1990) told the story of how his agency, the Family Centre in Lower Hutt, New Zealand, developed a family therapy of social justice, or “Just Therapy.” The agency became aware of their colonizing practices – those traditions that assumed dominant culture superiority. They began to see that they would work with a poor family and expect them to go home and be happy in poverty. As a remedy, they began a reorganization that included the native voices of Maori and other Pacific Island people in the development of their therapeutic process. “A ‘just’ therapy is one that takes into account the gender, cultural, social and economic context of the persons seeking help” (p. 5). As white practitioners, they sought cultural experts to educate them about their traditions and healing practices. This led to analyses that revealed poverty and oppression as the root of many psychological problems. In fact, they began to see that these were not psychological at all, but instead, symptoms of social inequities, discrimination, and oppression.

Soon, they were devoting resources to housing development and employment as part of their clinical mission. Staff soon became Maori, Samoan, and European (white) therapists who
would lead sections to address these various perspectives. Imagine an American audience of 3,000 family therapists when Waldegrave (1990) described his organization to the American Association for Marriage and Family Therapy (AAMFT) Annual Conference:

The co-operative work between the cultural sections has led to a number of interesting organizational processes. For example, all the workers in the agency, including those who type and receive people, take home the same salary. All work that involves someone from the Maori or Pacific Island communities is accountable directly to that cultural section. Likewise, gender work including that carried out in men’s groups is directly accountable to the women in the agency. This is to ensure that a therapy is judged as just, primarily by the group that has been treated unjustly. Various ways of doing things that are uncommon to European culture, but central to Maori or Pacific Island cultures, are adopted. For example, we eat communally, make decisions consensually, receive and farewell guests formally and traditionally, and we share and express different forms of spirituality.

The AAMFT audience tried to imagine their community agencies taking on such sweeping transformations. Since they are embedded in an individualistic society, these collectivist practices were definitely a world away. However, learning from the marginalized groups of New Zealand, these therapists have distilled a set of concepts that have important value for all clinicians working with diverse cultures (Waldegrave & Tamasese, 1994). The underlying concepts of just therapy are:

**BELONGING**
This is a person’s and family’s sense of belonging to their people, place, and history. It is a sense of identity through generations. Even when the history is not all good, it is important to claim the liberating aspects that do exist.

**SACREDNESS**
This is a respect for the sacredness of all life, of relationships among people, between people and their environment, heritage, and a higher power. The process of therapy is sacred. Stories brought by vulnerable people are received and honored as a sacred gift.

**JUSTICE**
This is equity between people and the structures that can destroy equality in relationships. Therapy must always account for the family level and the societal level when addressing justice. In therapy, cultural consultants become the experts and the therapist becomes the student.

**SIMPLICITY**
An attribute that existed before the advent of modern science when knowledge became more complex. In the narrative therapy tradition, therapy is about the meaning people give to the problem and the narratives that can shift meanings into solutions. For example, the sickness/patient analogy can complicate symptoms of depression by suggesting a one-dimensional, pathologized meaning that has no language for improvement. Consequently, the meaning ascribed to depression is . . . depressing!