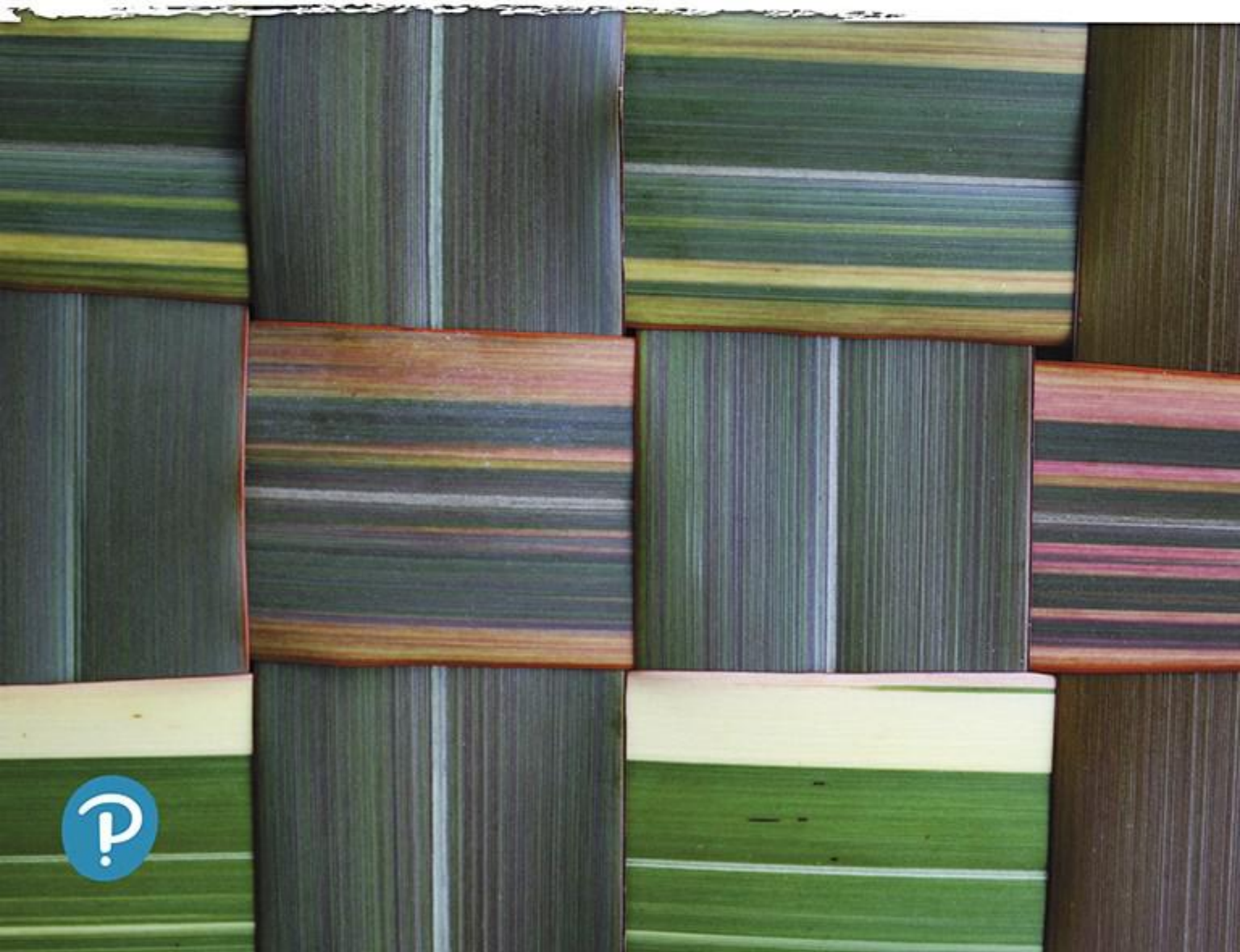
The Merrill Social Work and Human Services Series

7TH EDITION

THE ESSENTIALS OF FAMILY THERAPY

MICHAEL P. NICHOLS SEAN D. DAVIS



The Essentials of Family Therapy

This page intentionally left blank

Seventh Edition

The Essentials of Family Therapy

Michael P. Nichols
College of William and Mary

Sean D. Davis
Alliant University

Director and Publisher: Kevin M. Davis
Portfolio Manager: Rebecca Fox-Gieg
Content Producer: Pamela D. Bennett
Media Producer: Lauren Carlson
Portfolio Management Assistant: Maria Feliberty
Executive Field Marketing Manager: Krista Clark
Executive Product Marketing Manager: Christopher Barry
Procurement Specialist: Deidra Headlee
Cover Designer: Pearson CSC, Carie Keller
Cover Cover Photo: LazingBee/Getty Images
Editorial Production and Composition Services: Pearson CSC
Editorial Project Manager: Pearson CSC, Noribeth Santos
Full-Service Project Manager: Pearson CSC, Billu Suresh
Printer/Binder: LSC Communications, Inc./Willard
Cover Printer: Phoenix Color/Hagerstown
Text Font: 10/12 Times LT Pro

Library of Congress Cataloging-in-Publication Data
Names: Nichols, Michael P., author. | Davis, Sean D., author.
Title: The essentials of family therapy / Michael P. Nichols (College of William and Mary), Sean D. Davis (Alliant University).
Description: Seventh edition. | Hoboken, NJ: Pearson Education, Inc., [2020] | Includes bibliographical references and index.
Identifiers: LCCN 2018057690 | ISBN 9780135168097 (alk. paper) | ISBN 0135168090 (alk. paper)
Subjects: LCSH: Family psychotherapy.
Classification: LCC RC488.5 .N528 2020 | DDC 616.89/156—dc23 LC record available at https://lccn.loc.gov/2018057690

1 19

Pearson

ISBN 10: 0-13-516809-0
ISBN 13: 978-0-13-516809-7

This book is dedicated to the memory
of Salvador Minuchin

This page intentionally left blank

PREFACE

One thing that tends to get lost in academic discussions of family therapy is the feeling of accomplishment that comes from sitting down with an unhappy family and being able to help them. Beginning therapists are understandably anxious and not sure they'll know how to proceed. ("How do you get *all of them* to come in?") Veterans often speak in abstractions. They have opinions and discuss big issues—postmodernism, narrative reconstructionism, second-order cybernetics. While it's tempting to use this space to say Important Things, we prefer to be a little more personal. Treating troubled families has given us the greatest satisfaction imaginable, and we hope that the same is or will be true for you.

NEW TO THIS EDITION

In this seventh edition of *The Essentials of Family Therapy*, we describe the full scope of family therapy—its rich history, classic schools, latest developments—but with increasing emphasis on practical issues. We've also tried to make this edition more useful to students by introducing a number of new teaching points.

Our focus in the seventh edition was to make the key information from each chapter easier to capture and remember. We wanted you to come away from each chapter with a clear understanding of how each theory makes sense of change, and what each theory looks like in practice. Here's how we did that:

- Essential Points at the beginning of each chapter are brief summaries of the main ideas covered in the chapter.
- Questions to Consider at the start of each chapter are designed to help you apply the principles in the chapter to your situation, as well as to start thinking critically about the concepts and techniques as you read the chapter.
- Key terms are highlighted throughout and are also included as an end-of-book glossary in this edition
- Essential Highlights of the chapter are summarized at the end of each chapter.
- A Recommended Reading list is included at the end of each chapter.
- Review Questions and Reflection Questions at the end of each chapter are designed to help you think critically about the principles in the chapter and apply them to your life.
- New case studies with Reflect and Reply questions are designed to help you learn to think about how to apply therapeutic principles. All of the cases presented are drawn from our own practice or from experts in the field.

In addition to making the book more user-friendly, we've added quite a bit of new material in this edition, including:

- Research findings integrated into each chapter.
- A new chapter about research (Chapter 14), which includes a discussion of why research has failed to influence clinical practice and offering suggestions.
- Additional case studies and clinical emphasis throughout.
- Guidelines for productive problem-solving conversations.
- A more concise chapter on Bowen family systems therapy (chapter 4).
- Greater focus on clinical practice.
- New section in Chapter 10 on working with transgender persons.
- Significantly revised cognitive-behavioral chapter (chapter 9), with more focus on recent trends in clinical practice.

Albert Einstein once said, "If you want to learn about physics, pay attention to what physicists do, not what they say they do." When you read about therapy, it can be hard to see past the jargon and political packaging to the essential ideas and practices. So, in preparing this edition, we've traveled widely to visit and observe actual sessions of the leading practitioners. We've also invited leaders in the field to share some of their best case studies with you. The result is a more pragmatic, clinical focus. We hope you like it.

ALSO AVAILABLE WITH MYLAB HELPING PROFESSIONS

This title is also available with MyLab Helping Professions, an online homework, tutorial, and assessment program designed to work with the text to engage students and improve results. Within its structured environment, students see key concepts demonstrated through video clips, practice what they learn, test their understanding, and receive feedback to guide their learning and ensure they master key learning outcomes.

- **Learning outcomes and standards measure student results**. MyLab Helping Professions organizes all assignments around essential learning outcomes and national standards for counselors.
- **Video- and Case-based Exercises develop decision-making skills**. Video- and Case-based Exercises introduce students to a broader range of clients, and therefore a broader range of presenting problems, than they will encounter in their own pre-professional clinical experiences. Students watch videos of actual client-therapist sessions or high-quality role-play scenarios featuring expert counselors. They are then guided in their analysis of the videos through a series of short-answer questions. These exercises help students develop the techniques and decision-making skills they need to be effective counselors before they are in a critical situation with a real client.
- **Licensure Quizzes help students prepare for certification**. Automatically graded, multiple-choice Licensure Quizzes help students prepare for their certification examinations, master foundational course content, and improve their performance in the course.
- **Video Library offers a wealth of observation opportunities**. The Video Library provides more than 400 video clips of actual client-therapist sessions and high-quality role plays in a database organized by topic and searchable by keyword. The Video Library includes every video clip from the MyLab Helping Professions courses, plus additional videos from Pearson's extensive library of footage. Instructors can create additional assignments around the videos or use them for in-class activities. Students can expand their observation experiences to include other course areas and increase the amount of time they spend watching expert counselors in action.

ACKNOWLEDGMENTS

So many people have contributed to our development as family therapists and to the writing of this book that it would be impossible to thank them all. But we would like to single out a few. To the people who taught us family therapy—Lyman Wynne, Murray Bowen, and Salvador Minuchin—thank you. And special thanks with deep gratitude to Douglas Sprenkle and Fred Piercy.

We'd also like to thank some of the expert clinicians who went out of their way to help us prepare this seventh edition: Yvonne Dolan, Jerome Price, Deborah Luepnitz, William Madsen, Frank Dattilio, Vicki Dickerson, and Salvador Minuchin. To paraphrase John, Paul, George, and Ringo, we get by with *a lot* of help from our friends—and we thank them one and all. We are especially grateful to Rebecca Fox-Gieg at Pearson Higher Education for making a difficult job easier.

In addition, we would like to thank the reviewers who offered suggestions for updating this edition: Joseph Herzog, University of West Florida; Steve Johnson, Liberty University; Shanti Kulkarni, The University of North Carolina at Charlotte; and Rahbel Rahman, Binghamton University.

Finally, we would like to thank our postgraduate instructors in family life: our wives, Melody and Elizabeth, and our children, Sandy and Paul and Andrew, Hannah, Rachel, and William.

BRIEF CONTENTS

This page intentionally left blank

CONTENTS

This page intentionally left blank

Becoming a Family Therapist

CASE STUDY: HOLLY

There wasn't much information on the intake sheet. Just a name, Holly Roberts, the fact that she was a senior in college, and her presenting complaint: "trouble making decisions."

The first thing Holly said when she sat down was, "I'm not sure I need to be here. You probably have a lot of people who need help more than I do." Then she started to cry.

It was springtime. The tulips were up, the trees were turning leafy green and purple clumps of lilacs perfumed the air. Life and all its possibilities stretched out before her, but Holly was naggingly, unaccountably depressed.

The decision Holly was having trouble making was what to do after graduation. The more she tried to figure it out, the less able she was to concentrate. She started sleeping late, missing classes. Finally, her roommate talked her into going to the Counseling Center. "I wouldn't have come," Holly said. "I can handle my own problems."

I was into cathartic therapy back then. Most people have stories to tell and tears to shed. Some of the stories, I suspected, were dramatized to elicit sympathy. Most people give themselves permission to cry only with some very acceptable excuse. Of all the emotions we're ashamed of, feeling sorry for yourself tops the list.

I didn't know what was behind Holly's depression, but I was sure I could help. I was comfortable with depression. Ever since my senior year in high school when my friend Alex died, I'd been a little depressed myself.

• • •

After Alex died, the rest of the summer was a dark blur. I cried a lot. And I got mad whenever anyone suggested that life goes on. Alex's minister said that his death wasn't really a tragedy because now "Alex was with God in heaven." I wanted to scream, but I numbed myself instead. In the fall I went off to college, and even though it seemed disloyal to Alex, life did go on. I still cried from time to time, but with the tears came a painful discovery. Not all of my grief was for Alex. Yes, I loved him. Yes, I missed him. But his death provided me with the justification to cry about the everyday sorrows of my own life. Maybe grief is always like that. At the time, though, it struck me as a betrayal. I was using Alex's death to feel sorry for myself.

• • •

What, I wondered, was making Holly so sad? She didn't have a dramatic story. Her feelings weren't focused. After those first few minutes in my office, she rarely cried. When she did, it was more of an involuntary tearing up than a sobbing release. She talked about not knowing what she wanted to do with her life. She talked about not having a boyfriend, but she didn't say much about her family. If the truth be told, I wasn't much interested. Back then I thought home was a place you left in order to grow up.

Holly was hurting and needed someone to lean on, but something made her hold back, as though she didn't quite trust me. It was frustrating. I wanted to help.

A month went by and Holly's depression got worse. I started seeing her three times a week, but we weren't getting anywhere. One Friday afternoon, Holly was feeling so despondent that I didn't think she should go back to her dorm alone. I asked her instead to lie down on the couch in my office and, with her permission, I called her parents.

Mrs. Roberts answered the phone. I told her that I thought she and her husband should come to Rochester and meet with me to discuss the advisability of Holly taking a medical leave of absence. Unsure as I was of my authority back then, I steeled myself for an argument. Mrs. Roberts surprised me by agreeing to come at once.

The first thing that struck me about Holly's parents was the disparity in their ages. Mrs. Roberts looked like a slightly older version of Holly; she couldn't have been much over thirty-five. Her husband looked sixty. It turned out that he was Holly's stepfather. They had married when Holly was sixteen.

Looking back, I don't remember much that was said in that first meeting. Both parents were worried about Holly. "We'll do whatever you think best," Mrs. Roberts said. Holly's stepfather, Mr. Morgan, said they could arrange for a good psychiatrist "to help Holly over this crisis." But Holly didn't want to go home, and she said so with more energy than I'd heard from her in a long time. That was on Saturday. I said there was no need to rush into a decision, so we arranged to meet again on Monday.

When Holly and her parents sat down in my office on Monday morning, it was obvious that something had happened. Mrs. Roberts's eyes were red from crying. Holly glowered at her and looked away. Mr. Morgan turned to me. "We've been fighting all weekend. Holly heaps abuse on me, and when I try to respond, Lena takes her side. That's the way it's been since day one of this marriage."

(Case Study continued)

The story that emerged was one of those sad tales of jealousy and resentment that turn ordinary love into bitter, injured feelings and, all too often, tear families apart. Lena Roberts was thirty-four when she met Tom Morgan. He was a robust fifty-six. The second obvious difference between them was money. He was a successful stockbroker who'd retired to run a horse farm. She was waitressing to support herself and her daughter. It was a second marriage for both of them.

Lena thought Tom could be the missing father figure in Holly's life. Unfortunately, she couldn't accept all the rules Tom wanted to enforce. And so he became the wicked stepfather. He made the mistake of trying to take over, and when the predictable arguments ensued, Lena sided with her daughter. There were tears and midnight shouting matches. Twice Holly ran away for a few days. The triangle nearly proved the marriage's undoing, but things calmed down when Holly went off to college.

Holly expected to leave home and not look back. She would make new friends. She would study hard and choose a career. She would *never* depend on a man to support her. Unfortunately, she left home with unfinished business. She hated Tom for the way he treated her mother. He was always demanding to know where her mother was going, who she was going with, and when she would be back. If she was the least bit late, there would be a scene. Why did her mother put up with it?

Blaming her stepfather was simple and satisfying. But another set of feelings, harder to face, was eating at Holly. She hated her mother for marrying Tom and letting him be so mean to her. What had her mother seen in him? Had she sold out for a big house and a fancy car? Holly didn't have answers to these questions; she didn't even allow them into full awareness. Unfortunately, repression doesn't work like putting something in a closet and forgetting about it. It takes a lot of energy to keep unwelcome emotions at bay.

Holly found excuses not to go home during college. It didn't even feel like home anymore. She buried herself in her studies. But rage and bitterness gnawed at her until, in her senior year, facing an uncertain future, knowing only that she couldn't go home again, she gave in to hopelessness. No wonder she was depressed.

I found the whole story sad. Not knowing much about family dynamics and never having lived in a stepfamily, I wondered why they couldn't just try to get along. Why did they have so little sympathy for each other? Why couldn't Holly accept her mother's right to find love a second time around? Why couldn't Tom respect the priority of his wife's relationship with her daughter? Why couldn't Lena listen to her daughter's adolescent anger without getting so defensive?

That session with Holly and her parents was my first lesson in family therapy. Family members in therapy talk not about actual experiences but about reconstructed memories that resemble the original events only in certain ways. Holly's memories resembled her mother's memories very little and her stepfather's not at all. In the gaps between their truths there was little room for reason and no desire to pursue it.

Although that meeting may not have been terribly productive, it did put Holly's unhappiness in perspective. No longer did I see her as a tragic young woman all alone in the world. She was that, of course, but she was also a daughter torn between running away from a home she no longer felt part of and being afraid to leave her mother alone with a man she didn't trust. I think that's when I became a family therapist.

To say that I didn't know much about families, much less about how to help them, would be an understatement. But family therapy isn't just a new set of techniques. It's a whole new approach to understanding human behavior—as fundamentally shaped by its social context.

THE MYTH OF THE HERO

Ours is a culture that celebrates the uniqueness of the individual and the search for an autonomous self. Holly's story could be told as a coming-of-age drama: a young person's struggle to break away from childhood and provincialism, to take hold of adulthood and promise and the future. If she fails, we're tempted to focus on the young adult, the failed hero.

We were raised on the myth of the hero: the Lone Ranger, Robin Hood, Wonder Woman. When we got older we sought out real-life heroes: Eleanor Roosevelt, Martin Luther King, Nelson Mandela. These men and women stood for something. If only we could be a little more like those larger-than-life individuals who seemed to rise above their circumstances.

Only later did we realize that the circumstances we wanted to rise above were part of the human condition—our inescapable connection to our families. The romantic image of the hero is based on the illusion that authentic selfhood can be achieved as an autonomous individual. We do many things alone, including some of our most heroic acts, but we are defined and sustained by a network of human relationships. Our need to worship heroes is partly a need to rise above inadequacy and self-doubt, but it is perhaps equally a product of imagining a life unfettered by all those pesky relationships that somehow never quite go the way we want them to.

When we do think about families, it's often in negative terms—as burdens holding us back or as destructive forces in the lives of our patients. What catches our attention are differences and discord. The harmonies of family life—loyalty, tolerance, mutual aid, and assistance—often slide by unnoticed, part of the taken-for-granted background of life. If we would be heroes, then we must have villains.

There's a lot of talk these days about *dysfunctional families*. Unfortunately, much of this amounts to little more than parent bashing. People suffer because of what

their parents did: their mother's criticism, their father's distance—these are the causes of their unhappiness. Perhaps this is an advance on stewing in guilt and shame, but it's a long way from understanding what really goes on in families.

One reason for blaming family sorrows on the personal failings of parents is that it's hard for the average person to see past individual personalities to the structural patterns that make them a family—a system of interconnected lives governed by strict but unspoken rules.

People feel controlled and helpless not because they are victims of parental folly and deceit but because they don't understand the forces that tie husbands and wives and parents and children together. Plagued by anxiety and depression, or merely troubled and uncertain, some people turn to psychotherapy for consolation. In the process, they turn away from the irritants that propel them into therapy. Chief among these are unhappy relationships—with friends and lovers, and with our families. Our disorders are private ailments. When we retreat to the safety of a synthetic relationship, the last thing we want is to take our families with us.

PSYCHOTHERAPEUTIC SANCTUARY

It's possible to look back on the days before family therapy and see those who insisted on segregating patients from their families as exponents of a fossilized view of mental disorder, according to which psychiatric maladies are firmly embedded inside the heads of individuals. Considering that clinicians didn't begin treating families until the mid-1950s, it's tempting to ask, What took them so long? In fact, there were good reasons for conducting therapy in private.

The two most influential approaches to psychotherapy in the twentieth century, Freud's psychoanalysis and Rogers's client-centered therapy, were both predicated on the assumption that psychological problems arise from unhealthy interactions with others and can best be alleviated in a private relationship between therapist and patient. Freud wasn't interested in the living family; he was interested in the family-as-remembered. By conducting treatment in private, Freud safeguarded patients' trust in the sanctity of the therapeutic relationship and thus maximized the likelihood that they would repeat, in relation to the analyst, the understandings and misunderstandings of childhood.

The therapy Carl Rogers developed was designed to help patients uncover their real feelings. Unhappily, said Rogers, our innate tendency toward *self-actualization* gets subverted by our craving for approval. We learn to do what we think others want, even though it may not be what's best for us.

Gradually, this conflict between self-fulfillment and need for approval leads to denial of our authentic selves—and even the feelings that signal them. We swallow our anger, stifle our exuberance, and bury our lives under a mountain of expectations.

The Rogerian therapist listens sympathetically, offering compassion and understanding. In the presence of such an accepting listener, patients gradually get in touch with their own inner promptings.

Like the psychoanalyst, the client-centered therapist maintains absolute privacy in the therapeutic relationship to avoid any possibility that patients' feelings might be subverted to win approval. Only an objective outsider could be counted on to provide the unconditional acceptance to help patients rediscover their real selves. That's why family members had no place in the process of client-centered therapy.

FAMILY VERSUS INDIVIDUAL THERAPY

As you can see, there were valid reasons for conducting therapy in private. But although there is a strong claim to be made for individual psychotherapy, there are equally strong claims to be made for family therapy.

Individual therapy and family therapy each offer an approach to treatment and a way of understanding human behavior. Both have their virtues. Individual therapy provides a concentrated focus to help people face their fears and learn to become more fully themselves. Individual therapists recognize the importance of family life in shaping personality, but they assume that these influences are internalized and that intrapsychic dynamics become the dominant forces controlling behavior. Treatment can and should therefore be directed at the person and his or her personal makeup. Family therapists, on the other hand, believe that the dominant forces in our lives are located externally, in the family. Therapy, in this framework, is directed at changing the structure of the family. When a family's organization is transformed, the life of every family member is altered accordingly.

This last point—that changing a family changes the lives of each of its members—is important enough to elaborate. Family therapy influences the entire family; therefore, improvement can be lasting because each and every family member is changed *and* continues to exert synchronous change on each other.

Almost any human difficulty can be treated with either individual or family therapy. But certain problems are especially suited to a family approach, among them problems with children (who must, regardless of what happens in therapy, return home to their parents), complaints about a marriage or other intimate relationship, family feuds, and symptoms that develop at the time of a major family transition.

If problems that arise around family transitions make a therapist think first about the role of the family, individual therapy may be especially useful when people identify something about themselves that they've tried in vain to change while their social environment remains stable. Thus, if a woman gets depressed during her first year at college, a therapist might wonder if her sadness was related to leaving home and leaving her parents alone with each other. But if the same woman were to get depressed in her thirties, say, during a long period of stability in her life, we might wonder if there was something about her approach to life that hasn't worked for her. Examining her life in private—away from troubled relationships—doesn't, however, mean that she should believe that she can fulfill herself in isolation from the other people in her life.

The view of persons as separate entities, with families acting on them, is consistent with the way we experience ourselves. We recognize the influence of others—especially as obligation and constraint—but it's hard to see that we are embedded in a network of relationships, that we are part of something larger than ourselves.

THE POWER OF FAMILY THERAPY

The power of family therapy derives from bringing parents and children together to transform their interactions. Instead of isolating individuals from the emotional origins of their conflict, problems are addressed at their source.

What keeps people stuck is their inability to see their own participation in the problems that plague them. With eyes fixed firmly on what those recalcitrant others are doing, it's hard for most people to see the patterns that bind them together. The family therapist's job is to give them a wake-up call. When a husband complains that his wife nags and the therapist asks him how he contributes to her doing that, the therapist is challenging the husband to see the hyphenated him-and-her of their interactions.

CASE STUDY: BOB AND SHIRLEY

When Bob and Shirley came for help with marital problems, her complaint was that he never shared his feelings; his was that she always criticized him. This is a classic trading of complaints that keeps couples stuck as long as they fail to see the reciprocal pattern in which each partner provokes in the other precisely the behavior he or she can't stand. So the therapist said to Bob, "If you were a frog, what would you be like if Shirley changed you into a prince?" When Bob countered that he doesn't talk with her because she's so critical, it seemed to the couple like the same old argument. But the therapist saw this as the beginning of change—Bob starting to speak up. One way to create an opening for change in rigid families is to support the blamed person and help bring him back into the fray.

When Shirley criticized Bob for complaining, he tried to retreat, but the therapist said, "No, continue. You are still a frog."

Bob tried to shift responsibility back to Shirley. "Doesn't she have to kiss me first?" But the therapist said, "No, in real life that comes afterward. You have to earn it."

In the opening of *Anna Karenina*, Tolstoy wrote: "All happy families resemble one another; each unhappy family is unhappy in its own way." Every family may be unhappy in its own way, but we all stumble over the same familiar challenges of family life. It's no secret what these challenges are—learning to live together, dealing with difficult relatives, chasing after children, coping with adolescence, and so on. What not everyone realizes, however, is that a relatively small number of systems dynamics, once understood, illuminate those challenges and enable families to move successfully through the predictable dilemmas of life. Like all healers, family therapists sometimes deal with bizarre and baffling cases, but much of their work is with ordinary human beings learning life's painful lessons. Their stories, and the stories of the men and women of family therapy who have undertaken to help them, are the inspiration for this book.

Essential Highlights

- Treating Holly's depression made little progress until her family was interviewed and it was discovered that Holly was angry and unhappy with her mother and stepfather. Individual problems often make more sense in relational context.
- While we admire the heroic achievements of individuals, we are often less aware of the network of relationships that influences our own behavior.
- For years, psychotherapists excluded the family in order to provide a safe atmosphere to explore individuals' thoughts and feelings.
- Family therapists, on the other hand, believe that the contemporary family exerts a more significant impact than the internalized effects of the past on family members and their behavior.
- Both family and individual therapy can be effective in treating people and their problems, although some cases seem more amenable to one or the other of these approaches.

Review Questions

1. Why did treating Holly with individual therapy alone reach an impasse?
2. What are the limits of evaluating individuals' behavior as a function of themselves and their personalities?
3. Why did Freud and Rogers exclude the family from treatment?
4. What are the respective strengths of individual and family therapy?
5. What are the primary vehicles of change in family therapy?

Reflection Questions

1. What do you believe is best for real therapeutic change to occur: a brief but decisive intervention into the family system or long-term exploration of one's personality?
2. In a family like Holly's, when conflicts develop between a child and stepparent, what is gained by seeing the problem as triangular (rather than as a result of personalities)? What is gained as seeing the problem as transitional—not fixed, but stuck and in need of readjustment?
3. Does the myth of the hero have a greater influence on young men than on young women? To what extent is this changing?
4. What are some cultural narratives (in novels, TV shows, movies) that still support the myth of the hero? Are storylines featuring women as action heroes opening space for women to be more fully rounded or simply putting them into masculine myths?
5. How could a family systems perspective be incorporated into the treatment offered at a college counseling center?
6. Can you think of times when individual therapy might be more effective than family therapy? Times when family therapy might be more effective than individual therapy?
7. In the United States we often attribute success or failure to an individual's attributes. Can you name some cultures in which success or failure is thought of as more of a group or family affair? How do you think such cultural norms might affect how family therapy is practiced?

Recommended Readings

Minuchin, S. 1974. *Families and Family Therapy*. Cambridge, MA: Harvard University Press.

Nichols, M. P. 1987. *The Self in the System*. New York: Brunner/Mazel.

Nichols, M. P. 2008. *Inside Family Therapy,* 2nd ed. Boston: Allyn & Bacon.

Tolstoy, I. 1887. *Anna Karenina* Translated by Nathan Haskell Dole. New York: Thomas Y. Crowell & Co.

CHAPTER 1

The Evolution of Family Therapy

Essential Points in This Chapter

- Hospital psychiatry, group dynamics theory, the child guidance movement, and marriage counseling were forerunners of family therapy.
- Research on family dynamics and schizophrenia led directly to the development of family therapy.
- Family therapy was founded independently by John Bell, Don Jackson and Jay Haley, Nathan Ackerman, and Murray Bowen.
- In the 1960s through the 1980s the classic schools of family therapy were developed.

As You Read, Consider

- What insights from the family therapy forerunners do you think were most useful?
- Which of the concepts from research on schizophrenia are of most value?
- Which of the pioneers of family therapy were you most drawn to?
- What are some of the motives for blaming parents (especially mothers) for the problems of their children?

In this chapter, we explore the antecedents and early years of family therapy. There are two fascinating stories here: one of personalities, one of ideas. The first story revolves around the pioneers—visionary iconoclasts who broke the mold of seeing life and its problems as a function of individuals and their personalities. Make no mistake: The shift from an individual to a systemic perspective was a revolutionary one, providing a powerful tool for understanding human problems.

The second story in the evolution of family therapy is one of ideas. The restless curiosity of the first family therapists led them to ingenious new ways of conceptualizing the joys and sorrows of family life.

As you read this history, stay open to surprises. Be ready to reexamine easy assumptions—including the assumption that family therapy began as a benevolent effort to support the institution of the family. The truth is, therapists first encountered families as adversaries.

THE UNDECLARED WAR

Although we came to think of asylums as places of cruelty and detention, they were originally built to rescue the insane from being locked away in family attics. Accordingly, except for purposes of footing the bill, hospital psychiatrists kept families at arm's length. In the 1950s, however, two puzzling developments forced therapists to recognize the family's power to alter the course of treatment.

Therapists began to notice that often when a patient got better, someone else in the family got worse, almost as though the family *needed* a symptomatic member. As in the game of hide-and-seek, it didn't seem to matter who was "It" as long as someone played the part. In one case, Don Jackson (1954) was treating a woman for depression. When she began to improve, her husband complained that she was getting worse. When she continued to improve, her husband lost his job. Eventually, when the woman was completely well, her husband killed himself. Apparently this man's stability was predicated on having a sick wife.

Another strange story of shifting disturbance was that patients frequently improved in the hospital only to get worse when they went home.

CASE STUDY: SALVADOR MINUCHIN AND OEDIPUS REVISITED

In a bizarre case of Oedipus revisited, Salvador Minuchin treated a young man hospitalized several times for trying to scratch out his own eyes. The man functioned normally in Bellevue but returned to self-mutilation each time he went home. He could be sane, it seemed, only in an insane world.

It turned out that the young man was extremely close to his mother, a bond that grew even tighter during the seven years of his father's mysterious absence. The father was a compulsive gambler who disappeared shortly after being declared legally incompetent. The rumor was that the Mafia had kidnapped him. When, just as mysteriously, the father

returned, his son began his bizarre attempts at self-mutilation. Perhaps he wanted to blind himself so as not to see his obsession with his mother and hatred of his father.

But this family was neither ancient nor Greek, and Minuchin was more pragmatist than poet. So he challenged the father to protect his son by beginning to deal directly with his wife and then challenged the man's demeaning attitude toward her, which had made her seek her son's proximity and protection. The therapy was a challenge to the family's structure and, in Bellevue, Minuchin worked with the psychiatric staff toward easing the young man back into the family, into the lion's den.

Minuchin confronted the father, saying, "As a father of a child in danger, what you're doing isn't enough."

"What *should* I do?" asked the man.

"I don't know," Minuchin replied. "Ask your son." Then, for the first time in years, father and son began talking to each other. Just as they were about to run out of things to say, Dr. Minuchin commented to the parents: "In a strange way, he's telling you that he prefers to be treated like a young child. When he was in the hospital he was twenty-three. Now that he's returned home, he's six."

What this case dramatizes is how parents use their children as a buffer to protect them from intimacy. To the would-be Oedipus, Minuchin said, "You're scratching your eyes for your mother, so that she'll have something to worry about. You're a good boy. Good children sacrifice themselves for their parents."

Families are made of strange glue—they stretch but never let go. Few blamed families for outright malevolence, yet there was an invidious undercurrent to these observations. The official story of family therapy is one of respect for the family, but maybe none of us ever quite gets over the adolescent idea that families are the enemy of freedom.

SMALL GROUP DYNAMICS

Those who first sought to treat families found a ready parallel in small groups. **Group dynamics** are relevant to family therapy because group life is a complex blend of individual personalities and superordinate properties of the group.

In 1920, the pioneering social psychologist William McDougall published *The Group Mind*, in which he described how a group's continuity depends on the group being an important idea in the minds of its members; on the need for boundaries and structures in which differentiation of function could occur; and on the importance of customs and habits to make relationships predictable.

A more scientific approach to group dynamics was ushered in during the 1940s by Kurt Lewin, whose *field theory* (Lewin, 1951) guided a generation of researchers and agents of social change. Drawing on the Gestalt school of perception, Lewin developed the notion that a group is more than the sum of its parts. This transcendent property of groups has obvious relevance to family therapists, who must work not only with individuals but also with family systems—and their famous resistance to change. Analyzing what he called *quasi-stationary social equilibrium*, Lewin pointed out that changing group behavior first requires "unfreezing." Only after something shakes up a group's beliefs are its members likely to accept change. In individual therapy this process is initiated by the disquieting experiences that lead people to seek help. Once someone accepts the status of patient, that person has already begun to unfreeze old habits. When families come for treatment, it's a different story.

Family members may not be sufficiently unsettled by one member's problems to consider changing their own ways. Furthermore, family members bring their primary reference group with them, with all its traditions and habits. Consequently, more effort is required to unfreeze, or shake up, families before real change can take place. The need for unfreezing foreshadowed early family therapists' concern about disrupting family **homeostasis**, a notion that dominated family therapy for decades.

Wilfred Bion was another student of group dynamics who emphasized the group as a whole, with its own dynamics and structure. According to Bion (1948), most groups become distracted from their primary tasks by engaging in patterns of *fight–flight*, *dependency*, or *pairing*. Bion's **basic assumption theory** is easily extrapolated to family therapy: Some families skirt around hot issues like a cat circling a snake. Others use therapy to bicker endlessly, never really contemplating compromise, much less change. Dependency masquerades as therapy when families allow therapists to subvert their autonomy in the name of problem solving. Pairing is seen in families when one parent colludes with the children to undermine the other parent.

The **process/content** distinction in group dynamics likewise had a major impact on family treatment. Experienced therapists learn to attend as much to *how* families talk as to the content of their discussions. For example, a mother might tell her daughter that she shouldn't play with Barbie dolls because she shouldn't aspire to an image of bubble-headed beauty. The *content* of the mother's message is "Respect yourself as a person." But if the mother expresses her point of view by disparaging her daughter's wishes, then the *process* of her message is "Your feelings don't count."

Unfortunately, the content of some discussions is so compelling that therapists get sidetracked from the process.

Suppose, for example, that a therapist invites a teenage boy to talk with his mother about wanting to drop out of school. Say the boy mumbles something about school being stupid, and his mother responds with a lecture about the need for an education. A therapist who gets drawn in to support the mother's position may be making a mistake. In terms of content, the mother might be right: A high school diploma can come in handy. But maybe it's more important at that moment to help the boy learn to speak up for himself—and for his mother to learn to listen.

Role theory, explored in the literature of psychoanalysis and group dynamics, had important applications to the study of families. The expectations that roles carry bring regularity to complex social situations.

Roles tend to be stereotyped in most groups. Virginia Satir (1972) described family roles such as "the placater" and "the disagreeable one" in her book *Peoplemaking*. If you think about it, you may have played a fairly predictable role in your family. Perhaps you were "the good child," "the moody one," "the rebel," or "the successful child." The trouble is, such roles can be hard to put aside.

One thing that makes role theory so useful in understanding families is that roles tend to be reciprocal and complementary. Say, for example, that a woman is slightly more anxious to spend time together with her boyfriend than he is. Maybe he'd call twice a week. But if she calls three times a week, he may never get around to picking up the phone. If their relationship lasts, she may always play the role of the pursuer and he the distancer. Or take the case of two parents, both of whom want their children to behave at the dinner table. But let's say that the father has a slightly shorter fuse—he tells them to quiet down five seconds after they start getting rowdy, whereas his wife would wait half a minute. If he always speaks up, she may never get a chance. Eventually, these parents may become polarized into complementary roles of strictness and leniency. What makes such reciprocity resistant to change is that the roles reinforce each other.

It was a short step from observing patients' reactions to other members of a group—some of whom might act like siblings or parents—to observing interactions in real families. Given the wealth of techniques for exploring interpersonal relationships developed by group therapists, it was natural that some family therapists would apply a group treatment model to working with families. After all, what is a family but a collective group of individuals?

From a technical viewpoint, group and family therapies are similar: Both are complex and dynamic, more like everyday life than individual therapy. In groups and families, patients must react to a number of people, not just a therapist, and therapeutic use of this interaction is the definitive mechanism of change in both settings.

On closer examination, however, it turns out that the differences between families and groups are so significant that the group therapy model has only limited applicability to family treatment. Family members have a long history and, more importantly, a future together. Revealing yourself to strangers is safer than exposing yourself to members of your own family. There's no taking back revelations that might better have remained private—the affair, long since over, or the admission that a woman cares more about her career than about her husband. Continuity, commitment, and shared distortions all make family therapy very different from group therapy.

Therapy groups are designed to provide an atmosphere of warmth and support. This feeling of safety among sympathetic strangers cannot be part of family therapy, because instead of separating treatment from a stressful environment, the stressful environment is brought into treatment. Furthermore, in group therapy, patients can have equal power and status, whereas democratic equality isn't appropriate in families. Someone has to be in charge. Furthermore, the official patient in a family is likely to feel isolated and stigmatized. After all, he or she is "the problem." The sense of protection in being with a compassionate group of strangers, who won't have to be faced across the dinner table, doesn't exist in family therapy.

THE CHILD GUIDANCE MOVEMENT

It was Freud who introduced the idea that psychological disorders were the consequence of unsolved problems of childhood. Alfred Adler was the first of Freud's followers to pursue the implication that treating the growing child might be the most effective way to prevent adult neuroses. To that end, Adler organized child guidance clinics in Vienna, where not only children but also families and teachers were counseled. Adler offered encouragement and support to help alleviate children's *feelings of inferiority*, so they could work out a healthy lifestyle, achieving confidence and success through social usefulness.

Although child guidance clinics remained few in number until after World War II, they now exist in every city in the United States, providing treatment of childhood problems and the complex forces contributing to them. Gradually, child guidance workers concluded that the real problem wasn't the obvious one—the child's symptoms—but rather the tensions in families that were the source of those symptoms. At first, there was a tendency to blame the parents, especially the mother.

The chief cause of childhood psychological problems, according to David Levy (1943), was *maternal overprotectiveness*. Mothers who had themselves been deprived of love growing up became overprotective of their children.

Some were domineering, others overindulgent. Children of domineering mothers were submissive at home but had difficulty making friends; children with indulgent mothers were disobedient at home but well behaved at school.

During this period, Frieda Fromm-Reichmann (1948) coined one of the most damning terms in the history of psychiatry, the **schizophrenogenic mother**. These domineering, aggressive, and rejecting women, especially when married to passive men, were thought to provide the pathologic parenting that produced schizophrenia.

The tendency to blame parents, especially mothers, for problems in the family was an evolutionary misdirection that continues to haunt the field. Nevertheless, by paying attention to what went on between parents and children, Levy and Fromm-Reichmann helped pave the way for family therapy.

John Bowlby's work at the Tavistock Clinic exemplified the transition to a family approach. Bowlby (1949) was treating a teenager and making slow progress. Feeling frustrated, he decided to see the boy and his parents together. During the first half of a two-hour session, the child and parents took turns complaining about each other. During the second half of the session, Bowlby interpreted what he thought each of their contributions to the problem were. Eventually, by working together, all three members of the family developed empathy for each other's point of view.

Although he was impressed with the usefulness of this conjoint interview, Bowlby remained wedded to the one-to-one format. Family meetings might be a useful catalyst, but only as an adjunct to the *real* treatment, individual psychotherapy.

What Bowlby tried as an experiment, Nathan Ackerman saw to fruition—family therapy as the primary form of treatment. Once he saw the need to understand the family in order to diagnose problems, Ackerman soon took the next step—family treatment. See Figure 1.1 for an analysis of the lessons that were learned from early models.

Then let us examine parallel developments in marriage counseling and research on schizophrenia that led to the birth of family therapy.

MARRIAGE COUNSELING

For many years, people with marital problems talked with their doctors, clergy, lawyers, and teachers. The first professional centers for marriage counseling were established in the 1930s, in Los Angeles, New York, and Philadelphia (Broderick & Schrader, 1991). At the same time, although most analysts followed Freud's prohibition against contact with a patient's family, a few broke the rules and experimented with therapy for married partners.

In 1948, Bela Mittleman of the New York Psychoanalytic Institute became the first to publish an account of concurrent marital therapy in the United States. Mittleman suggested that husbands and wives could be treated by the same analyst and that by seeing both it was possible to reexamine their irrational perceptions of each other (Mittleman, 1948).

Meanwhile, in Great Britain, Henry Dicks and his associates at the Tavistock Clinic established a Family Psychiatric Unit. Here couples referred by the divorce courts were helped to reconcile their differences (Dicks, 1964).

In 1956, Mittleman wrote a more extensive description of his views on marital disorders and their treatment. He described a number of complementary marital patterns, including aggressive/submissive and detached/demanding. These odd matches are made, according to Mittleman, because courting couples see each other's personalities through the eyes of their illusions: She sees his detachment as strength; he sees her dependency as adoration.

The most important contribution from group studies to family therapy was the idea that when people join together in a group, relational processes emerge that reflect not only the individuals involved but also their collective patterns of interaction, known as *group dynamics*. A group therapy approach to families was widely used in the 1960s, but today we realize that families have unique properties that cannot be effectively treated with a group therapy model.

Communications theorists regarded families as goal-directed systems, and analyzed their interactions using *cybernetics* and *general systems theory*. Practitioners focused on the *process* of communication, rather than its *content*. Negative (*homeostatic*) feedback mechanisms were thought to account for the stability of normal families and the inflexibility of dysfunctional ones. Communications analysis was so well received that it has been absorbed into the entire field of family therapy.

FIGURE 1.1 Lessons from the Early Models

At about this time Don Jackson and Jay Haley were exploring marital therapy within the framework of communications analysis. As their ideas gained prominence, the field of marital therapy was absorbed into the larger family therapy movement.

RESEARCH ON FAMILY DYNAMICS AND THE ETIOLOGY OF SCHIZOPHRENIA

Gregory Bateson—Palo Alto

One of the groups with the strongest claim to originating family therapy was Gregory Bateson's schizophrenia project in Palo Alto, California. The Palo Alto project began in the fall of 1952 when Bateson received a grant to study the nature of communication. All communications, Bateson contended (Bateson, 1951), have two different levels—*report* and *command*. Every message has a stated content, as, for instance, "Wash your hands, it's time for dinner," but in addition, the message carries how it is to be taken. In this case, that the speaker is in charge. This second message—**metacommunication**—is covert and often unnoticed. If a wife scolds her husband for running the dishwasher when it's only half full and he says OK but turns around and does exactly the same thing two days later, she may be annoyed that he doesn't listen to her. She means the message. But maybe he didn't like the metamessage. Maybe he doesn't like her telling him what to do as though she were his mother.

Bateson was joined in 1953 by Jay Haley and John Weakland. In 1954, Bateson received a two-year grant from the Macy Foundation to study schizophrenic communication. Shortly thereafter, the group was joined by Don Jackson, a brilliant psychiatrist who served as clinical consultant.

The group's interests turned to developing a **communications theory** that might explain the origin and nature of schizophrenia, particularly in the context of families. Worth noting, however, is that in the early days of the project, none of them thought of actually observing schizophrenics and their families. Once they agreed that schizophrenic communication might be a product of what was learned inside the family, the group looked for circumstances that could lead to such confused and confusing patterns of speech.

In 1956, Bateson and his colleagues published their famous report "Toward a Theory of Schizophrenia," in which they introduced the concept of the **double bind**. Patients weren't crazy in some meaningless way; they were an extension of a crazy family environment. Consider someone who receives two contradictory messages on different levels but finds it difficult to detect or comment on the inconsistency (Bateson, Jackson, Haley, & Weakland, 1956); that person is in a double bind.

Because this difficult concept is often misused as a synonym for paradox or simply contradiction, it's worth reviewing all the features of the double bind as the authors listed them:

1. Two or more persons in an important relationship.
2. Repeated experience.
3. A primary negative injunction, such as "Don't do X or I will punish you."
4. A second injunction at a more abstract level conflicting with the first, also enforced by punishment or perceived threat.
5. A tertiary negative injunction prohibiting escape and demanding a response. Without this restriction the victim won't feel bound.
6. Finally, the complete set of ingredients is no longer necessary once the victim is conditioned to perceive the world in terms of double binds; any part of the sequence becomes sufficient to trigger panic or rage.

Most examples of double binds in the literature are inadequate because they don't include all of the critical features. Robin Skynner (1976), for instance, cited: "Boys must stand up for themselves and not be sissies"; but "Don't be rough . . . don't be rude to your mother." Confusing? Yes. Conflict? Maybe. But these two messages don't constitute a double bind; they're merely contradictory. Faced with two such statements, a child is free to obey either one, alternate, or even complain about the contradiction. This and similar examples neglect the specification that the two messages are conveyed on different levels.

A better example is one given in the original article. A young man recovering in the hospital from a schizophrenic episode was visited by his mother. When he put his arm around her, she stiffened. But when he withdrew, she asked, "Don't you love me anymore?" He blushed, and she said, "Dear, you must not be so easily embarrassed and afraid of your feelings." Following this exchange, the patient assaulted an aide and had to be put in seclusion.

Another example of a double bind is a teacher who urges his students to participate in class but gets impatient if one of them actually interrupts with a question or comment. Then a baffling thing happens. For some strange reason that scientists have yet to decipher, students tend not to speak up in classes where their comments are disparaged. When the professor finally does get around to asking for questions and no one responds, he gets angry. (*Students are so passive*!) If any of the students has the temerity to comment on the professor's lack of receptivity, he may get

even angrier. Thus the students will be punished for accurately perceiving that the teacher really wants only his own ideas to be heard and admired. (This example is, of course, purely hypothetical.)

We're all caught in occasional double binds, but the schizophrenic has to deal with them continually—and the effect is maddening. Unable to comment on the dilemma, the schizophrenic responds defensively, perhaps by being concrete and literal, perhaps by speaking in metaphors. Eventually, the schizophrenic may come to assume that behind every statement lies a concealed meaning.

The discovery that schizophrenic symptoms made sense in the context of some families may have been a scientific advance, but it had moral and political overtones. Not only did these investigators see themselves as avenging knights bent on rescuing *identified patients* by slaying family dragons, but they were also crusaders in a holy war against the psychiatric establishment. Outnumbered and surrounded by hostile critics, the champions of family therapy challenged the orthodox assumption that schizophrenia was a biological disease. Psychological healers everywhere cheered. Unfortunately, they were wrong.

The observation that schizophrenic behavior seems to *fit* in some families doesn't mean that families *cause* schizophrenia. In logic, this kind of inference is called "Jumping to Conclusions." Sadly, families of schizophrenic members suffered for years under the implication that they were to blame for the tragedy of their children's psychoses.

Lyman Wynne—National Institute of Mental Health

Lyman Wynne's studies of schizophrenic families began in 1954 when he started seeing the parents of his hospitalized patients in twice-weekly therapy sessions. What struck Wynne about these disturbed families was the strangely unreal quality of both positive and negative emotions, which he labeled *pseudomutuality* and *pseudohostility*, and the nature of the boundaries around them—*rubber fences*—apparently flexible but actually impervious to outside influence (especially from therapists).

Pseudomutuality is a facade of harmony (Wynne, Ryckoff, Day, & Hirsch, 1958). Pseudomutual families are so committed to togetherness that there's no room for separate identities. The surface unity of pseudomutual families obscures the fact that they can't tolerate deeper, more honest relationships, or independence.

Pseudohostility is a different guise for a similar collusion to stifle autonomy (Wynne, 1961). Although apparently acrimonious, it signals only a superficial split. Pseudohostility is more like the bickering of a situation-comedy family than real animosity. Like pseudomutuality, it undermines intimacy and masks deeper conflict, and like pseudomutuality, distorts communication and impairs rational thinking.

The **rubber fence** is an invisible barrier that stretches to permit limited extrafamilial involvement, such as going to school, but springs back if that involvement goes too far. The family's rigid structure is thus protected by isolation. Instead of having its eccentricities modified in contact with the larger society, the schizophrenic family becomes a sick little society unto itself.

Wynne linked the new concept of *communication deviance* with the older notion of *thought disorder*. He saw communication as the vehicle for transmitting thought disorder, the defining characteristic of schizophrenia. Communication deviance is a more interactional concept than thought disorder and more readily observable. By 1978 Wynne had studied over 600 families and gathered incontrovertible evidence that disordered styles of communication are a distinguishing feature of families with young adult schizophrenics.

Role Theorists

The founders of family therapy gained momentum for their fledgling discipline by concentrating on communication. Doing so may have been expedient, but focusing exclusively on this one aspect of family life neglected individual intersubjectivity as well as broader social influences.

Role theorists, like John Spiegel, described how individuals were differentiated into social roles within family systems. This important fact was obscured by simplistic versions of systems theory, in which individuals were treated like interchangeable parts. As early as 1954, Spiegel pointed out that the system in therapy includes the therapist as well as the family (an idea reintroduced later as **second-order cybernetics**). He also made a valuable distinction between "interactions" and "transactions." Billiard balls *interact*—they collide but remain essentially unchanged. People *transact*—they come together in ways that not only alter each other's course but also bring about internal changes.

R. D. Laing's analysis of family dynamics was more polemic than scholarly, but his observations helped popularize the family's role in psychopathology. Laing (1965) borrowed Karl Marx's concept of **mystification** (class exploitation) and applied it to the "politics of families." Mystification means distorting someone's experience by denying or relabeling it. An example of this is a parent telling a child who's feeling sad, "You must be tired" (*Go to bed and leave me alone*).

Mystification distorts feelings and, more ominously, reality. When parents mystify a child's experience, the

child's existence becomes inauthentic. Because their feelings aren't accepted, these children project a *false self*. In mild instances, this produces a lack of authenticity, but when the real self/false self split is carried to extremes, the result is madness (Laing, 1960).

FROM RESEARCH TO TREATMENT: THE PIONEERS OF FAMILY THERAPY

We have seen how family therapy was anticipated by developments in hospital psychiatry, group dynamics, the child guidance movement, marriage counseling, and research on schizophrenia. But who actually started family therapy?

Although there are rival claims to this honor, the distinction should probably be shared by John Elderkin Bell, Don Jackson, Nathan Ackerman, and Murray Bowen. In addition to these founders of family therapy, Jay Haley, Virginia Satir, Carl Whitaker, Lyman Wynne, Ivan Boszormenyi-Nagy, and Salvador Minuchin were also significant pioneers.

John Bell

John Elderkin Bell, a psychologist at Clark University in Worcester, Massachusetts, who began treating families in 1951, occupies a unique position in the history of family therapy. Although he may have been the first family therapist, he is mentioned only tangentially in two of the most important historical accounts of the movement (Guerin, 1976; Kaslow, 1980). The reason for this is that although he began seeing families in the 1950s, he didn't publish his ideas until a decade later. Moreover, unlike the other parents of family therapy, he had few offspring. He didn't establish a clinic, develop a training program, or train well-known students.

Bell's approach (Bell, 1961, 1962) was taken directly from group therapy. *Family group therapy* relied primarily on stimulating open discussion to help families solve their problems. Like a group therapist, Bell intervened to encourage silent participants to speak up, and he interpreted the reasons for their defensiveness.

MEET THE THERAPIST

JOHN ELDERKIN BELL

One of the first family therapists was John Elderkin Bell, who began treating families in the early 1950s. His approach to family therapy involved a step-by-step plan to treat family problems in stages. His model was an outgrowth of group therapy and was aptly named *family group therapy*.

Bell believed that family group therapy goes through predictable phases, as do groups of strangers. In his early work (Bell, 1961), he structured treatment in a series of stages, each of which concentrated on a particular segment of the family. Later, he became less directive and allowed families to evolve through a naturally unfolding sequence.

Palo Alto

The Bateson group stumbled into family therapy by accident. Once they began to interview schizophrenic families in 1954, hoping to decipher their patterns of communication, project members found themselves drawn into helping roles by the pain of these unhappy people (Jackson & Weakland, 1961). Although Bateson was their scientific leader, Don Jackson and Jay Haley were most influential in developing family treatment.

Jackson rejected the psychodynamic concepts he learned in training and focused instead on the dynamics of interchange between persons. Analysis of communication was his primary instrument.

Jackson's concept of **family homeostasis**—families as units that resist change—was to become the defining metaphor of family therapy's early years. In hindsight, we can say that the focus on homeostasis overemphasized the conservative properties of families. At the time, however,

MEET THE THERAPIST **DON JACKSON**

The vibrant and creative talent of Don Jackson led to his prominent place among the founders of family therapy. A graduate of Stanford University School of Medicine, Jackson rejected the psychoanalytic concepts of his training in favor of cybernetics and communication theory, which he used to develop a pragmatic, problem-solving model of therapy. Jackson described problematic patterns of communication in ways that are still useful today.

Jackson's particular genius was in describing how patterns of communication reflect unspoken rules that govern relationships. According to Jackson, the early stage of a relationship is a kind of bargaining game in which the partners work out the rules that will subsequently govern the nature of their relationship. These "marital quid pro quos" are the bases on which the marriage contract will be written. Jackson died in 1968.

the recognition that families resist change was enormously productive for understanding what keeps patients from improving.

In "Schizophrenic Symptoms and Family Interaction" (Jackson & Weakland, 1959), Jackson illustrated how patients' symptoms preserve stability in their families. In one case, a young woman diagnosed as a catatonic schizophrenic had as her most prominent symptom a profound indecisiveness. When she did act decisively, her parents fell apart. Her mother became helpless and dependent; her father became impotent. In one family meeting, her parents failed to notice when the patient made a simple decision. Only after listening to a taped replay of the session *three times* did the parents finally hear their daughter's statement. The patient's indecision was neither crazy nor senseless; rather, it protected her parents from facing their own conflicts. This is one of the earliest published examples of how psychotic symptoms can be meaningful in the family context. This article also contains the shrewd observation that children's symptoms are often an exaggerated version of their parents' problems.

Another construct important to Jackson's thinking was the dichotomy between *symmetrical* and *complementary* relationships. (Like so many of the seminal ideas of family therapy, this one was first articulated by Bateson.) **Complementary relationships** are those in which partners are different in ways that fit together, like pieces of a jigsaw puzzle: If one is logical, the other is emotional; if one is weak, the other is strong. **Symmetrical relationships** are based on similarity. Marriages between two partners who both have careers and share housekeeping chores are symmetrical. (Incidentally, if you actually find a couple who share housekeeping equally, you'll know you're not in Kansas anymore, Dorothy!)

Jackson's **family rules** hypothesis was based on the observation that within any committed unit (dyad, triad, or larger group), there are redundant behavior patterns. Rules (as students of philosophy learn when studying determinism) can describe regularity, rather than regulation. A corollary of the rules hypothesis was that family members use only a fraction of behavior available to them. This seemingly innocent fact is what makes family therapy so useful.

Jackson's therapeutic strategies were based on the premise that psychiatric problems resulted from the way people behave with each other. In order to distinguish functional interactions from those that were dysfunctional (*problem maintaining*), he observed when problems occurred and in what context, who was present, and how people responded to the problem. Given the assumption that symptoms are homeostatic mechanisms, Jackson would wonder out loud how a family might be worse off if the problem got solved. An individual might want to get better, but the family may need someone to play the sick role. Even positive change can be a threat to the defensive order of things.

A father's drinking, for example, might keep him from making demands on his wife or disciplining his children. Unfortunately, some family therapists jumped from the observation that symptoms may serve a purpose to the assumption that some families *need* a sick member, which, in turn, led to a view of parents victimizing **scapegoated** children. Despite the fancy language, this approach was in the time-honored tradition of blaming parents for the failings of their children. If a six-year-old misbehaves around the house, perhaps we should look to his parents. But a husband's drinking isn't necessarily his wife's fault; and it certainly wasn't fair to imply that families were responsible for the schizophrenic symptoms of their children.

The great discovery of the Bateson group was that there is no such thing as a simple communication; every message is qualified by another message on another level. In *Strategies of Psychotherapy*, Jay Haley (1963) explored how covert messages are used in the struggle for control that characterizes many relationships. Symptoms, he argued, represent an incongruence between levels of communication. The symptomatic person does something, such as touching a doorknob six times before turning it, while at the same time denying that he's *really* doing it. He can't help it; it's his illness. Meanwhile, the person's symptoms—over which he has no control—have consequences. A person with a compulsion of such proportions can hardly be expected to hold down a job, can he?

Because symptomatic behavior wasn't reasonable, Haley didn't rely on reasoning with patients to help them. Instead, therapy became a strategic game of cat and mouse.

Haley (1963) defined therapy as a directive form of treatment and acknowledged his debt to Milton Erickson, with whom he studied hypnosis. In what he called *brief therapy*, Haley zeroed in on the context and possible function of the patient's symptoms. His first moves were designed to gain control of the therapeutic relationship. Haley cited Erickson's device of advising patients that in the first interview they may be willing to say some things and other things they'll want to withhold, and that these, of course, should be withheld. Here the therapist is directing patients to do precisely what they would do anyway and thus subtly gaining the upper hand.

The decisive techniques in brief therapy were *directives*. As Haley put it, it isn't enough to explain problems to patients; what counts is getting them to *do* something about them.

One of Haley's patients was a freelance photographer who compulsively made silly blunders that ruined every picture. Eventually, he became so preoccupied with

avoiding mistakes that he was too nervous to take pictures at all. Haley instructed the man to go out and take three pictures, making one deliberate error in each. The paradox here is that you can't accidentally make a mistake if you are doing so deliberately.

In another case, Haley told an insomniac that if he woke up in the middle of the night he should get out of bed and wax the kitchen floor. Instant cure! The cybernetic principle here: People will do anything to get out of housework.

Another member of the Palo Alto group who played a leading role in family therapy's first decade was Virginia Satir, one of the great charismatic healers. Known more for her clinical artistry than for theoretical contributions, Satir's impact was most vivid to those lucky enough to see her in action. Like her confreres, Satir was interested in communication, but she added an emotional dimension that helped counterbalance what was otherwise a relatively calculated approach.

Satir saw troubled family members as trapped in narrow roles, like *victim*, *placater*, *defiant one*, and *rescuer*, that constrained relationships and sapped self-esteem. Her concern with freeing family members from the grip of such life-constricting roles was consistent with her major focus, which was always on the individual. Thus, Satir was a humanizing force in the early days of family therapy, when others were so enamored of the systems metaphor that they neglected the emotional lives of families.

Satir was justly famous for her ability to turn negatives into positives. In one case, cited by Lynn Hoffman (1981), Satir interviewed the family of a local minister, whose teenage son had gotten two of his classmates pregnant. On one side of the room sat the boy's parents and siblings. The boy sat in the opposite corner with his head down. Satir introduced herself and said to the boy, "Well, your father has told me a lot about the situation on the phone, and I just want to say before we begin that we know one thing for sure: We know you have good seed." The boy looked up in amazement as Satir turned to the boy's mother and asked brightly, "Could you start by telling us your perception?"

Murray Bowen

Like many of the founders of family therapy, Murray Bowen was a psychiatrist who specialized in schizophrenia. Unlike others, however, he emphasized theory more than techniques, and to this day Bowen's theory is the most fertile system of ideas in family therapy.

Bowen began his clinical work at the Menninger Clinic in 1946, where he studied mothers and their schizophrenic children. His major interest at the time was mother–child symbiosis, which led to his concept of **differentiation of self** (autonomy and levelheadedness). From Menninger, Bowen moved to the National Institute of Mental Health (NIMH), where he developed a project to hospitalize whole families with schizophrenic members. It was this project that expanded the concept of mother–child symbiosis to include the role of fathers and led to the concept of relationship **triangles** (diverting conflict between two people by involving a third).

Beginning in 1955, when Bowen started bringing family members together to discuss their problems, he was struck by their **emotional reactivity**. Feelings overwhelmed reason. Bowen felt the family's tendency to pull him into the center of this **undifferentiated family ego mass**, and he had to make a concerted effort to remain objective (Bowen, 1961). The ability to remain neutral and focus on the process, rather than the content, of family discussions is what distinguishes a therapist from a participant in a family's drama.

To control the level of emotion, Bowen encouraged family members to talk to him, not to each other. He found that it was easier for family members to listen without becoming reactive when they spoke to the therapist instead of to each other.

Bowen discovered that therapists weren't immune from being sucked into family conflicts. This awareness led to his greatest insight. Whenever two people are struggling with conflict they can't resolve, there is an automatic tendency to involve a third party. In fact, as Bowen came to believe, a triangle is the smallest stable unit of relationship.

A husband who can't stand his wife's habitual lateness, but who also can't stand up and tell her so, may start complaining to his children. His complaining may let off steam, but the very process of complaining to a third party makes him less likely to address the problem at its source. We all complain about other people from time to time, but what Bowen realized was that this triangling process is destructive when it becomes a regular feature of a relationship.

Another thing Bowen discovered about triangles is that they spread out. In the following case, a family became entangled in a whole labyrinth of triangles.

CASE STUDY: MRS. MCNEIL

One Sunday morning, "Mrs. McNeil," who was anxious to get the family to church on time, yelled at her nine-year-old son to hurry up. When he told her to "quit bitching," she slapped him. At that point her fourteen-year-old daughter, Megan, grabbed her, and the two of them started wrestling. Then Megan ran next door to her friend's house. When the friend's parents noticed that she had a cut lip and Megan told them what happened, they called the police.

(Case Study continued)

One thing led to another, and by the time the family came to therapy, the following triangles were in place: Mrs. McNeil, who'd been ordered out of the house by a family court judge, was allied with her lawyer against the judge; she also had an individual therapist who joined her in thinking she was being hounded unfairly by the child protective workers. The nine-year-old was still mad at his mother, and his father supported him in blaming her for flying off the handle. Mr. McNeil, who was a recovering alcoholic, formed an alliance with his sponsor, who felt that Mr. McNeil was on his way to a breakdown unless his wife started being more supportive. Meanwhile, Megan had formed a triangle with the neighbors, who thought her parents shouldn't be allowed to have children. In short, everyone had an advocate—everyone, that is, except the family unit.

In 1966, an emotional crisis occurred in Bowen's family that led him to initiate a personal voyage of discovery that turned out to be as significant for Bowen's theory as Freud's self-analysis was for psychoanalysis.

As an adult, Bowen, the oldest of five children from a tightly knit rural family, kept his distance from his parents and the rest of his extended family. Like many of us, he mistook avoidance for emancipation. But as he later realized, unfinished emotional business stays with us, making us vulnerable to repeat conflicts we never worked out with our families.

Bowen's most important achievement was detriangling himself from his parents, who'd been accustomed to complaining to him about each other. Most of us are flattered to receive such confidences, but Bowen came to recognize this triangulation for what it was. When his mother complained about his father, he told his father: "Your wife told me a story about you; I wonder why she told me instead of you." Naturally, his father mentioned this to his mother, and naturally, she was not pleased.

Although his efforts generated the kind of emotional upheaval that comes of breaking family rules, Bowen's maneuver was effective in keeping his parents from trying to get him to take sides—and made it harder for them to avoid discussing things between themselves. Repeating what someone says to you about someone else is one way to stop triangling in its tracks.

Through his efforts in his own family, Bowen discovered that differentiation of self is best accomplished by developing person-to-person relationships with as many members of the family as possible. If visiting is difficult, letters and phone calls can help reestablish relationships, particularly if they're personal and intimate. Differentiating one's self from one's family is completed when these relationships are maintained without becoming emotionally reactive or taking part in triangles.

Nathan Ackerman

Nathan Ackerman was a child psychiatrist whose pioneering work with families remained faithful to his psychoanalytic roots. Although his interest in intrapsychic conflict may have seemed less innovative than the Palo Alto group's communication theory, he had a keen sense of the overall organization of families. Families, Ackerman said, may give the appearance of unity, but underneath they are split into competing factions. This you may recognize as similar to the psychoanalytic model of individuals who, despite apparent unity of personality, are actually minds in conflict, driven by warring drives and defenses.

Ackerman joined the staff of the Menninger Clinic and in 1937 became chief psychiatrist of the Child Guidance Clinic. At first he followed the child guidance model, having a psychiatrist treat the child and a social worker see the mother. By the mid-1940s, he began to experiment with the same therapist seeing both. Unlike Bowlby, Ackerman did more than use these conjoint sessions as a temporary expedient; instead, he began to see the family as the basic unit of treatment.

In 1955, Ackerman organized the first session on family diagnosis at a meeting of the American Orthopsychiatric Association. At that meeting, Jackson, Bowen, Wynne, and Ackerman learned about each other's work and joined in a sense of common purpose. Two years later, Ackerman opened the Family Mental Health Clinic of Jewish Family Services in New York City and began teaching at Columbia University. In 1960, he founded the Family Institute, which was renamed the Ackerman Institute following his death in 1971.

Although other family therapists downplayed the psychology of individuals, Ackerman was as concerned with what goes on inside people as with what goes on between them. He never lost sight of feelings, hopes, and desires. In fact, Ackerman's model of the family was like the psychoanalytic model of individuals writ large; instead of conscious and unconscious issues, Ackerman talked about how families confront some issues while avoiding others, particularly those involving sex and aggression. He saw his job as a therapist as bringing family secrets out into the open.

To encourage families to relax their emotional restraint, Ackerman himself was unrestrained. He sided first with one member of a family and then with another. He didn't think it was necessary—or possible—to always be neutral; instead, he believed that balance was achieved in the long run by moving back and forth, giving support now

MEET THE THERAPIST

NATHAN ACKERMAN

Nathan Ackerman's ability to understand families enabled him to look beyond behavioral interactions and into the hearts and minds of each family member. He used his forceful personality to uncover a family's defenses and allow their feelings, hopes, and desires to surface. Ackerman's psychoanalytic training is evident in his contributions and theoretical approach to family therapy. Ackerman proposed that underneath the apparent unity of families there existed a layer of intrapsychic conflict that divided family members into factions.

Together with Don Jackson, Ackerman founded the first family therapy journal, *Family Process*, which is still the leading journal of ideas in the field.

to one, later to another family member. At times, he was unabashedly blunt. If he thought someone was lying, he said so. To critics who suggested this directness might generate too much anxiety, Ackerman replied that people get more reassurance from honesty than from false politeness.

Carl Whitaker

Even among the iconoclastic founders of family therapy, Carl Whitaker stood out as the most irreverent. His view of psychologically troubled people was that they were frozen into devitalized routines (Whitaker & Malone, 1953). Whitaker turned up the heat. His "Psychotherapy of the Absurd" (Whitaker, 1975) was a blend of warm support and emotional goading, designed to loosen people up and help them get in touch with their experience in a deeper, more personal way.

Given his inventive approach to therapy, it isn't surprising that Whitaker became one of the first to experiment with family treatment. In 1943 he and John Warkentin, working in Oakridge, Tennessee, began including spouses and eventually children in treatment. Whitaker also pioneered the use of cotherapy in the belief that a supportive partner helped free therapists to react without fear of countertransference.

Whitaker never seemed to have an obvious strategy, nor did he use predictable techniques, preferring, as he said, to let his unconscious run the therapy (Whitaker, 1976). Although his work seemed totally spontaneous, even outrageous at times, it had a consistent theme. All of his interventions promoted flexibility. He didn't so much push families to change in a particular direction as he challenged them to open up—to become more fully themselves and more fully together.

In 1946, Whitaker became chairman of the department of psychiatry at Emory University, where he continued to experiment with family treatment with a special interest in schizophrenics and their families. During this period, Whitaker organized a series of forums that led to the first major convention of the family therapy movement. Beginning in 1946, Whitaker and his colleagues began twice-yearly conferences during which they observed and discussed each other's work with families. The group found these sessions enormously helpful, and mutual observation, using one-way vision screens, became one of the hallmarks of family therapy.

Whitaker resigned from Emory in 1955 and entered private practice, where he and his partners at the Atlanta Psychiatric Clinic developed an *experiential* form of psychotherapy, using a number of highly provocative techniques in the treatment of families, individuals, groups, and couples (Whitaker, 1958).

During the late 1970s, Whitaker seemed to mellow and added a greater understanding of family dynamics to his shoot-from-the-hip interventions. In the process, the former wild man of family therapy became one of its elder statesmen. Whitaker's death in April 1995 left the field with a piece of its heart missing.

Ivan Boszormenyi-Nagy

Ivan Boszormenyi-Nagy, who came to family therapy from psychoanalysis, was one of the seminal thinkers in the movement. In 1957, he founded the Eastern Pennsylvania Psychiatric Institute in Philadelphia, where he attracted a host of highly talented colleagues. Among these were James Framo, one of the few psychologists in the early family therapy movement, and Geraldine Spark, a social worker who worked with Boszormenyi-Nagy as cotherapist and coauthor of *Invisible Loyalties* (Boszormenyi-Nagy & Spark, 1973).

Boszormenyi-Nagy went from being an analyst, prizing confidentiality, to a family therapist dedicated to openness. His most important contribution was to add ethical accountability to the usual therapeutic goals and techniques. According to Boszormenyi-Nagy, neither pleasure nor expediency is a sufficient guide to human behavior. Instead, he believed that family members should base their relationships on trust and loyalty and that they must balance the ledger of entitlement and indebtedness. He died in 2008.

Salvador Minuchin

When Minuchin first burst onto the scene, it was the drama of his clinical interviews that people found captivating.

This compelling man with an elegant Latin accent would seduce, provoke, bully, or bewilder families into changing—as the situation required. But even Minuchin's legendary flair didn't have the same galvanizing impact as the practical simplicity of his structural model.

Minuchin began his career as a family therapist in the early 1960s when he discovered two patterns common to troubled families: Some are *enmeshed*—chaotic and tightly interconnected; others are *disengaged*—isolated and seemingly unrelated. Both types lack clear lines of authority. Enmeshed parents are too entangled with their children to exercise leadership; disengaged parents are too distant to provide effective support.

Family problems are tenacious and resistant to change because they're embedded in powerful but unseen structures. Take, for example, a mother futilely remonstrating with a willful child. The mother can scold, punish, or reward, but as long as she's enmeshed (overly involved) with the child, her efforts will lack force because she lacks authority. Moreover, because the behavior of one family member is always related to that of others, the mother will have trouble stepping back as long as her husband remains uninvolved.

Once a social system such as a family becomes structured, attempts to change the rules constitute what family therapists call **first-order change**—change within a system that itself remains invariant. For the mother in the previous example to start practicing stricter discipline would be an example of first-order change. The enmeshed mother is caught in an illusion of alternatives. She can be strict or lenient; the result is the same because she remains trapped in a triangle. What's needed is **second-order change**—a change of the system itself.

Minuchin worked out his ideas while struggling with the problems of juvenile delinquency at the Wiltwyck School for Boys in New York. Family therapy with urban slum families was a new development, and publication of his discoveries (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) led to his being invited to become the director of the Philadelphia Child Guidance Clinic in 1965. Minuchin brought Braulio Montalvo and Bernice Rosman with him, and they were joined in 1967 by Jay Haley. Together they transformed a traditional child guidance clinic into one of the great centers of the family therapy movement.

In 1981, Minuchin moved to New York and established what is now known as the Minuchin Center for the Family, where he pursued his dedication to teaching family therapists from all over the world. He also continued to turn out a steady stream of the most influential books in the field. His 1974 *Families and Family Therapy* is deservedly the most popular book in the history of family therapy, and his 1993 *Family Healing* contains some of the most moving descriptions of family therapy ever written. Minuchin died in 2017.

Other Early Centers of Family Therapy

In New York, Israel Zwerling and Marilyn Mendelsohn organized the Family Studies Section at Albert Einstein College of Medicine. Andrew Ferber was named director in 1964, and later Philip Guerin, a protégé of Murray Bowen, joined the section. Nathan Ackerman served as a consultant, and the group assembled an impressive array of family therapists with diverse orientations. These included Chris Beels, Betty Carter, Monica McGoldrick, Peggy Papp, and Thomas Fogarty. Philip Guerin became director of training in 1970, and shortly thereafter, in 1973, he founded the Center for Family Learning in Westchester, where he and Thomas Fogarty developed one of the finest family therapy training programs in the nation.

In Galveston, Texas, Robert MacGregor and his colleagues developed *multiple impact therapy* (MacGregor, 1967). It was a case of necessity being the mother of invention. MacGregor's clinic served a population scattered widely over southeastern Texas, and many of his clients had to travel hundreds of miles. Therefore, to have maximum impact in a short time, MacGregor assembled a team of professionals who worked intensively with the families for two full days. Although few family therapists have used such marathon sessions, the team approach continues to be one of the hallmarks of the field.

In Boston, the two most significant early contributions to family therapy were both in the experiential wing of the movement. Norman Paul developed an *operational mourning* approach designed to resolve impacted grief, and Fred and Bunny Duhl set up the Boston Family Institute, where they developed *integrative family therapy*.

In Chicago, the Family Institute of Chicago and the Institute for Juvenile Research were important centers of the early scene in family therapy. At the Family Institute, Charles and Jan Kramer developed a clinical training program that was later affiliated with Northwestern University Medical School. The Institute for Juvenile Research also mounted a training program under the leadership of Irv Borstein, with the consultation of Carl Whitaker.

The work of Nathan Epstein and his colleagues, first formulated in the department of psychiatry at McMaster University in Hamilton, Ontario, was a problem-centered approach (Epstein, Bishop, & Baldarin, 1981). The McMaster model goes step by step—elucidating the problem, gathering data, considering alternative resolutions,

and assessing the learning process—to help families understand their interactions and build on their newly acquired coping skills. Epstein later relocated to Brown University in Providence, Rhode Island.

Important developments in family therapy also occurred outside the United States. Robin Skynner (1976) introduced psychodynamic family therapy at the Institute of Family Therapy in London. British psychiatrist John Howells (1971) developed a system of family diagnosis as a necessary step for planning therapeutic intervention. West German Helm Stierlin (1972) integrated psychodynamic and systemic ideas for treating troubled adolescents. In Rome, Maurizio Andolfi worked with families early in the 1970s and founded, in 1974, the Italian Society for Family Therapy; Mara Selvini Palazzoli and her colleagues founded the Institute for Family Studies in Milan in 1967.

Figure 1.2 summarizes the major events in family therapy. Now that you've seen how family therapy emerged in several different places at once, we hope you haven't lost sight of one thing: There is a tremendous advantage to seeing how people's behavior makes sense in the context of their families. Meeting with a family for the first time is like turning on a light in a dark room.

THE GOLDEN AGE OF FAMILY THERAPY

In their first decade, family therapists had all the bravado of new kids on the block. "Look at this!" Haley and Jackson and Bowen seemed to say when they discovered how the whole family was implicated in the symptoms of individual patients. While they were struggling for legitimacy, family clinicians emphasized their common beliefs and downplayed their differences. Troubles, they agreed, came in families. But if the watchword of the 1960s was "Look at this"—emphasizing the leap of understanding made possible by seeing whole families together—the rallying cry of the 1970s was "Look what I can do!" as the new kids flexed their muscles and carved out their own turf.

The period from 1970 to 1985 saw the flowering of the classic schools of family therapy when the pioneers established training centers and worked out the

1946	Bowen at Menninger Clinic, Whitaker at Emory, Bateson at Harvard
1948	Whitaker begins family conferences on schizophrenia
1949	Bowlby "The Study and Reduction of Group Tensions in the Family"
1950	Bateson begins work at Palo Alto, VA
1952	Bateson receives grant to study communication in Palo Alto
	Lyman Wynne at NIMH
1956	Bateson, Jackson, Haley, & Weakland "Toward a Theory of Schizophrenia"
1957	Boszormenyi-Nagy opens a family therapy clinic in Philadelphia
1960	Family Institute founded by Nathan Ackerman (renamed the Ackerman Institute in 1971)
	Minuchin begins doing family therapy at Wiltwyck
1965	Minuchin becomes director of Philadelphia Child Guidance Clinic
1967	Henry Dicks *Marital Tensions*
1973	Phil Guerin opens Center for Family Learning in Westchester, NY
1976	Jay Haley opens Family Therapy Institute in Washington, DC
1989	Nancy Boyd-Franklin *Black Families in Therapy*
1992	Monica McGoldrick opens Family Institute of New Jersey
2003	Greenan & Tunnell *Couple Therapy with Gay Men*
2006	Minuchin, Nichols, & Lee *Assessing Families and Couples*
2010	Sprenkle, Davis, & Lebow *Common Factors in Couple and Family Therapy*

FIGURE 1.2 Major Events in the History of Family Therapy

implications of their models. The leading approach in the 1960s was the *communications model* developed in Palo Alto. The book of the decade was Watzlawick, Beavin, and Jackson's *Pragmatics of Human Communication*, the text that introduced the systemic version of family therapy. The model of the 1980s was *strategic therapy*, and the books of the decade described its three most vital approaches: *Change*, by Watzlawick, Weakland, and Fisch;[1] *Problem-Solving Therapy*, by Jay Haley; and *Paradox and Counterparadox*, by Mara Selvini Palazzoli and her Milan associates. The 1970s belonged to Salvador Minuchin. His *Families and Family Therapy* and the simple yet compelling model of *structural family therapy* it described dominated the decade.

Structural theory seemed to offer just what family therapists were looking for: a simple way of describing family organization and a set of easy-to-follow steps to treatment. In hindsight, we might ask whether the impressive power of Minuchin's approach was a product of the method or the man. (The answer is, probably a little of both.) In the 1970s, however, the widely shared belief that structural family therapy could be learned easily drew people from all over the world to what was for a decade the epicenter of the family therapy movement: the Philadelphia Child Guidance Clinic.

The strategic therapy that flourished in the 1980s was centered in three unique and creative groups: the Palo Alto Mental Research Institute's brief therapy group, including John Weakland, Paul Watzlawick, and Richard Fisch; Jay Haley and Cloe Madanes, codirectors of the Family Therapy Institute of Washington, DC; and Mara Selvini Palazzoli and her colleagues in Milan. But the leading influence in the decade of strategic therapy was exerted by Milton Erickson, albeit from beyond the grave.

Erickson's genius was much admired and much imitated. Family therapists came to idolize Erickson the way we as children idolized Captain Marvel. We'd come home from Saturday matinees all pumped up, get out our toy swords, put on our magic capes—and presto! *We* were superheroes. We were just kids and so we didn't bother translating our heroes' mythic powers into our own terms. Unfortunately, many of those starstruck by Erickson's legendary therapeutic tales did the same thing. Instead of grasping the principles on which they were predicated, many therapists just tried to imitate his "uncommon techniques." To be any kind of competent therapist, you must keep your psychological distance from the supreme artists—the Salvador Minuchins, the Milton Ericksons, the Michael Whites. Otherwise, you end up aping the magic of their styles rather than understanding the substance of their ideas.

CASE STUDY: DEVELOPING YOUR OWN APPROACH TO THERAPY

One of us (S.D.) was a nervous wreck when he started seeing clients. How was he going to know what to say? Maybe the answer was to study the experts, to learn to do what they did. So each week he set out to apply what he'd seen to his own clients. Unfortunately, the more he tried to apply what he'd seen the master therapists doing, the worse his sessions seemed to go.

One of his mentors was a therapist who always seemed to know exactly what to say. For two semesters, he tried to discover the secrets of her success. "What's your favorite theory?" "Which are your most effective interventions?" and "What books should I read?" When he asked what she would do with a particular family, she said "I have no idea. I'd listen to them and see where it went." There had to be more to it than that.

In fact, there was more to it than that. In the next months he learned a lot about how families function, how they get stuck, and how to help them get unstuck. But he also learned to be himself in therapy. The great therapists he'd admired knew what they were doing, but they were also being themselves.

Reflect and Apply

1. Is therapy more of an art or a science?
2. What are the risks of trying to imitate other therapists?
3. How does a therapist's personality and theoretical knowledge interact in effective therapy?
4. How can you learn from observing others without submerging your own style and personality?

Part of what made Jay Haley's strategic directives so attractive was that they were a wonderful way to gain control over people—for their own good—without the usual frustration of trying to convince them to do the right thing. (Most people already know what's good for them. The hard part is getting them to *do* it.) So, for example, in the case of a person who is bulimic, a strategic directive might be for the patient's family to set out a mess of fried chicken,

[1]Although actually published in 1974, this book and its sequel, *The Tactics of Change*, were most widely read and taught in the 1980s.

french fries, cookies, and ice cream. Then, with the family watching, the patient would mash up all the food with her hands, symbolizing what goes on in her stomach. After the food was reduced to a soggy mess, she would stuff it into the toilet. Then when the toilet clogged, she would have to ask the family member she resented most to unclog it. This task would symbolize not only what the person with bulimia does to herself but also what she puts the family through (Madanes, 1981).

What the strategic camp added to Erickson's creative problem solving was a simple framework for understanding how families got stuck in their problems. According to the Mental Research Institute (MRI) model, problems develop and persist from mismanagement of ordinary life difficulties. The original difficulty becomes a problem when mishandling leads people to get stuck in more-of-the-same solutions. It was a perverse twist on the old adage, "If at first you don't succeed, try, try again."

The Milan group built on the ideas pioneered at MRI, especially the use of the therapeutic double bind, or what they referred to as *counterparadox*. Here's an example from *Paradox and Counterparadox* (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). The authors describe a counterparadoxical approach to a six-year-old boy and his family. At the end of the session, young Bruno was praised for acting crazy to protect his father. By occupying his mother's time with fights and tantrums, the boy generously allowed his father more time for work and relaxation. Bruno was encouraged to continue doing what he was already doing, lest this comfortable arrangement be disrupted.

The appeal of the strategic approach was pragmatism. Making use of the cybernetic metaphor, strategic therapists zeroed in on how family systems were regulated by negative feedback. They achieved results simply by disrupting the interactions that maintained symptoms. What eventually turned therapists off to these approaches was their gamesmanship. Their interventions were transparently manipulative. The result was like watching a clumsy magician—you could see him stacking the deck.

Meanwhile, as structural and strategic approaches rose and fell in popularity, four other models of family therapy flourished quietly. Though they never took center stage, *experiential*, *psychoanalytic*, *behavioral*, and *Bowenian* models grew and prospered. Although these schools never achieved the cachet of family therapy's latest fads, each of them produced solid clinical approaches, which will be examined at length in subsequent chapters.

Essential Highlights

- For many years, therapists avoided patients' relatives in order to safeguard the privacy of the therapeutic relationship. Freudians excluded the real family to uncover the unconscious, introjected family; Rogerians kept relatives away to provide unconditional positive regard; and hospital psychiatrists discouraged family visits because they might disrupt the benign milieu of the hospital.
- Several discoveries in the 1950s led to a new view—namely, that the family was a living system, an organic whole. Although practicing clinicians in hospitals and child guidance clinics paved the way for family therapy, the most important breakthroughs were achieved by workers who were scientists first, healers second. In Palo Alto, Gregory Bateson, Jay Haley, and Don Jackson discovered that people with schizophrenia weren't crazy in some meaningless way; their behavior was understandable in the context of their families. Murray Bowen's observation of how mothers and their offspring with schizophrenia go through cycles of closeness and distance was the forerunner of the *pursuer–distancer* dynamic.
- These observations launched the family therapy movement, but the excitement they generated blurred the distinction between what researchers observed and what they concluded. What they observed was that the behavior of people with schizophrenia *fit* with their families; what they concluded was that the family must be the *cause* of schizophrenia. A second conclusion was even more influential. Family dynamics—double binds, pseudomutuality, undifferentiated family ego mass—began to be seen as products of a system rather than as features of persons who share certain qualities because they live together. Thus was born a new creature, the *family system*.
- Who was the first to practice family therapy? As in every field, there were visionaries who anticipated the development of family therapy. Freud, for example,

treated "Little Hans" by working with his father as early as 1908. Such experiments, however, weren't sufficient to challenge the authority of individual therapy until the climate of the times was receptive. In the early 1950s, family therapy was begun independently in four different places: by John Bell at Clark University, Murray Bowen at NIMH, Nathan Ackerman in New York, and Don Jackson and Jay Haley in Palo Alto.

- These pioneers had distinctly different backgrounds and, not surprisingly, the approaches they developed were also quite different. In addition to those just mentioned, others who made significant contributions to the founding of family therapy were Lyman Wynne, Virginia Satir, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin.
- What we've called family therapy's golden age—the flowering of the schools in the 1970s and 1980s—was the high-water mark of our self-confidence. Armed with Haley's or Minuchin's latest text, therapists set off with a sense of mission. What drew them to activist approaches was certainty and charisma. What soured them was hubris. To some, structural family therapy—at least as they had seen it demonstrated at workshops—began to seem like bullying. Others saw the cleverness of the strategic approach as manipulative. Families were described as stubborn; they couldn't be reasoned with. Therapists got tired of that way of thinking.
- In the early years, family therapists were animated by confidence and conviction. Today, in the wake of managed care and biological psychiatry, we're less sure of ourselves. What has emerged is "a more participatory, more culturally and gender sensitive, and a more collaborative set of methods that builds on a set of common factors with a stronger evidence base" (Lebow, 2014, p. 368).
- All the complexity of the family therapy field should not obscure its basic premise: The family is the context of human problems. Like all human groups, the family has emergent properties—the whole is greater than the sum of its parts.
- No matter how many and varied the explanations of these emergent properties are, they all fall into two categories: *structure* and *process*. The structure of families includes *triangles*, *subsystems*, and *boundaries*. Among the processes that describe family interaction—*emotional reactivity*, *dysfunctional communication*, and so on—the central concept is *circularity*. Rather than worrying about who started what, family therapists treat human problems as a series of moves and countermoves, in repeating cycles.

Review Questions

1. Briefly describe the clinical forerunners of family therapy.
2. What did researchers on family dynamics and schizophrenia learn that led the way to family therapy?
3. Who were the founders of family therapy, and what were each one's major ideas?
4. How has the field of family therapy changed from its golden age until today?

Reflection Questions

1. What are some practical applications contemporary therapists could draw from the work of John Bell, the Palo Alto Group, Murray Bowen, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin?
2. What are some applications for everyday life that you could draw from the theories and techniques of John Bell, the Palo Alto Group, Murray Bowen, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin?
3. What are some pros and cons of segregating hospitalized mental patients from their families?
4. What are some of the "basic assumptions" operating in groups of which you have been a part?
5. What role did you play in your family growing up? What potential roles went unnoticed or unfulfilled?

Recommended Readings

Bell, J. E. (1961). *Family Group Therapy*. Public Health Monograph No. 64. Washington, DC: U.S. Government Printing Office.

Dicks, H. (1967). *Marital tensions*. New York: Basic Books.

Haley, J. (1963). *Strategies of psychotherapy*. New York: Grune & Stratton.

Hoffman, L. (1981). *Foundations of family therapy*. New York: Basic Books.

Laing, R. D. (1960). *The divided self*. London: Tavistock.

Watzlawick, P. A., J. H. Beavin, and D. D. Jackson. (1967). *Pragmatics of human communication*. New York: Norton.

CHAPTER 2

Basic Techniques of Family Therapy

Essential Points in This Chapter

- During an initial phone call a therapist should find out what the presenting problem is and arrange for a consultation with everyone living in the family household.
- In the first session a therapist should develop a therapeutic alliance and explore the presenting problem.
- In order to move a family from a linear point of view (considering one person as the problem) to a systemic perspective (recognizing the web of interactions in the family), a therapist must gently challenge the family's tendency to attribute problems to only one family member.
- A thorough assessment starts with the presenting problem, but then explores the family's interactions, culture, and social context.
- Ethical obligations require confidentiality, practicing only within a one's areas of competence, and avoiding dual relationships.
- Among the problems that require a specialized approach are marital violence and the sexual abuse of children.

As You Read, Consider

- Which of the guidelines in this chapter do you find unexpected and useful?
- Which of the guidelines in this chapter do you agree and disagree with?
- Which of the suggestions you agree with do you think would be difficult for you to implement?
- What ideas in this chapter might be useful in everyday life, and how?

GETTING STARTED

The Initial Contact

The goal of the initial contact is to get an overview of the presenting problem and to arrange for the family to come for a consultation. Listen to the caller's description of the problem and identify all members of the household as well as others who might be involved. Although the initial phone call should be brief, it's important to establish a connection with the caller as a basis for engagement. Then schedule the first interview, specifying who should attend (usually everyone in the household) and the time and place.

While there are things you can learn to say to encourage the whole family to attend, the most important consideration is attitudinal. First, understand and respect that the worried mother who wants her child to be treated individually or the unhappy husband who wants to talk to you alone has a perfectly legitimate point of view, even if it doesn't happen to coincide with your own. But if you expect to meet with the whole family, at least for an initial assessment, a matter-of-fact statement that that's how you work will get most families to agree.

When the caller presents the problem as limited to one person, a useful way to broaden the focus is to ask how the problem is affecting other members of the family. If the caller balks at the idea of bringing in the family or says that a particular member won't attend, say that you'll need to hear from everyone, at least initially, in order to get as much information as possible. Most people accept the need to give their points of view; what they resist is the implication that they're to blame.[1]

More and more clients are contacting therapists though e-mail or text message. The same principles discussed above apply to these mediums, though there are some unique points worth mentioning. Some clients want to begin therapy before or instead of meeting face to face.

[1]Not all therapists routinely meet with the entire family. Some find they have more room to maneuver by meeting first with individuals or subgroups and then gradually involving others. Others attempt to work with the *problem-determined system*, only those people directly involved. If a therapist suspects violence or abuse, individual sessions may enable family members to reveal what they might not discuss in front of the whole family. The point to remember is that family therapy is more a way of looking at things than a technique based on always seeing the whole family together.

Engaging in long e-mail exchanges prior to meeting with clients is not advisable. Rarely do all parties get heard equally via e-mail. We'll talk more about the problems of *triangulation* later, but there's always a risk to hearing just one person's side to a relationship problem. See Figure 2.1 for a checklist for the initial contact.

Finally, because most families are reluctant to sit down and face their conflicts, a reminder call before the first session will help cut down on the no-show rate.

The First Interview

The goal of the first interview is to build an alliance with the family and develop a hypothesis about what's maintaining the presenting problem. The point isn't to jump to conclusions but to start actively thinking.

Introduce yourself to the contact person and then to the other adults. Ask parents to introduce their children. Shake hands with everyone. Orient the family to the room (observation mirrors, videotaping, toys for children) and to the format of the session (length and purpose). Repeat briefly what the caller told you over the phone (so as not to leave others wondering) and then ask for elaboration. Once you've acknowledged that person's point of view ("So what you're saying is . . . ?"), ask the other members of the family for their viewpoints.

One of the things beginning therapists worry about is that bringing in the whole family may lead to a shouting match that will escalate out of control. The antidote to arguing is insisting that family members speak one at a time. Giving everyone a chance to talk and be heard is a good idea in every case; with emotionally reactive families, it's imperative.

Most families are anxious and uncertain about therapy. They're not sure what to expect, and they may be uncomfortable discussing their concerns with the entire family present. For these reasons, it's important to establish a bond of sympathy and understanding with every member of the family.

1. The goal is to gain an overview of the presenting problem, decide if it's a problem you have some expertise with, and arrange for the whole family to come for a consultation.
2. Make every effort to meet with everyone in the household, at least for the first session.
3. Avoid triangulation by not having any extended contact (by phone or e-mail or in person) with only one party.

FIGURE 2.1 Initial Contact Checklist

A useful question to ask each person is, "How did *you* feel about coming in?" This helps establish the therapist as someone willing to listen. If, for example, a child says "I didn't want to come" or "I think it's stupid," you can say "Thanks for being honest."

In gathering information, some therapists find it useful to take a family history, and many use a **genogram** to diagram the extended family network (see Chapter 4). Others believe that whatever history is important will emerge in the natural course of events; they prefer to concentrate on the family's presenting complaint and the circumstances surrounding it.

Family therapists develop hypotheses about how family members might be involved in the presenting problem by asking what they've done to try to solve it and by observing how they interact. Ideas are as important as actions, so it's useful to notice unhelpful explanations as well as unproductive interactions.

Two kinds of information that are particularly important are solutions that don't work and transitions in the life cycle. If whatever the family has been doing to resolve their difficulties hasn't worked, it may be that those attempts are part of the problem. A typical example is overinvolved parents trying to help a shy child make friends by coaxing and criticizing. Sometimes family members will say they've "tried everything." Their mistake is inconsistency. They give up too quickly.

Despite the natural tendency to focus on problems and what causes them, it is a family's strengths, not their weaknesses, that are most important in successful therapy. Therefore, a therapist should search for resilience (Walsh, 1998). What have these people done well? How have they successfully handled problems in the past? Even the most disheartened families have had times when they were successful.

Although it isn't always apparent (especially to them), most families seek treatment because they have failed to adjust to changing circumstances. If a couple develops problems within a few months after a baby's birth, it may be because they haven't shifted effectively from being a unit of two to a unit of three. A young mother may be depressed because she doesn't have enough support. A young father may be jealous of the attention his wife lavishes on the baby.

Although the strain of having a new baby may seem obvious, it's amazing how often depressed young mothers are treated as though there were something wrong with them—"unresolved dependency needs," "inability to cope," or perhaps a Prozac deficiency. The same is true when families develop problems around the time a child enters school or reaches adolescence or any other developmental shift. The transitional demands on the family are obvious, *if* you think about them.

Young therapists may have no experience with some of the challenges their clients are struggling with. This underscores the need to remain curious and respectful of families' predicaments rather than jumping to conclusions. For example, one young therapist couldn't understand why so many clients with young children rarely went out together as a couple. He assumed that they were avoiding being alone together. Once he had small children of his own, he began to wonder how those couples got out at all!

Family therapists explore the **process** of family interaction by asking questions about how family members relate to each other and by inviting them to discuss their problems with one another in the session. The first strategy, asking *process* or *circular* questions, is favored by Bowenians, and the second, by structural therapists. In either case, the question is, What's keeping the family stuck?

Once a therapist has met with a family, learned about the problem that brings them to treatment, made an effort to understand the family's context, and formulated a hypothesis about what needs to be done to resolve the problem, he or she should make a recommendation to the family. This might include consulting another professional (a learning disability expert, a physician, a lawyer) or even suggesting that the family doesn't need—or doesn't seem ready for—treatment. Most often, however, the recommendation will be for further meetings. Although many therapists try to make recommendations at the end of the first interview, doing so may be hasty. If it takes two or three sessions to form a bond with the family, understand their situation, and determine the feasibility of working with them, then take two or three sessions.

If you think you can help the family with their problems, offer them a **treatment contract**. Acknowledge why they came in and say that you think you can help. Then establish a meeting time, the frequency and length of sessions, who will attend, the presence of observers or use of videotape, the fee, and how insurance will be handled. Remember that resistance doesn't magically disappear after the first (or fourteenth) session, so stress the importance of keeping appointments, the need for everyone to attend, and your willingness to hear about dissatisfactions with the therapy. Finally, don't forget to emphasize the family's goals and the strengths they have demonstrated to meet them. See Figure 2.2 for a checklist for the first session.

The Early Phase of Treatment

The early phase of treatment is devoted to refining the initial hypothesis about what's maintaining the problem and beginning to work on resolving it. Now the strategy shifts from building alliances to challenging actions and assumptions. Most therapists are able to figure out what needs to change; what sets good therapists apart is their willingness to push for those changes.

"Pushing for change" may suggest a confrontational style. But what's required to bring about change isn't any one particular way of working; rather, it's a relentless commitment to helping make things better. This commitment is evident in Michael White's dogged questioning of problem-saturated stories, Phil Guerin's calm insistence that family members stop blaming each other and start looking at themselves, and Virginia Goldner's determined insistence that violent men take responsibility for their behavior.

No matter what techniques a therapist uses to push for change, it's important to maintain a therapeutic alliance. Although the term *therapeutic alliance* may sound like

1. Speak with each member of the family, and acknowledge his or her point of view about the problem and their feelings about coming to therapy.
2. Establish leadership by controlling the structure and pace of the interview.
3. Develop a working alliance with the family by balancing warmth and professionalism.
4. Compliment clients on positive actions and family strengths.
5. Maintain empathy with individuals and respect for the family's way of doing things.
6. Focus on specific problems and attempted solutions.
7. Develop hypotheses about unhelpful interactions around the presenting problem. Be curious about why these have persisted. Also notice helpful interactions that can support the family in moving forward.
8. Don't overlook the possible involvement of family members, friends, or helpers who aren't present.
9. Offer a treatment contract that acknowledges the family's goals and specifies the therapist's framework for structuring treatment.
10. Invite questions.

FIGURE 2.2 First-Session Checklist

jargon, there's nothing abstract about it: It means listening to and acknowledging the client's point of view. It is this empathic understanding that makes family members feel respected—and makes them open to accepting challenges.

Regardless of what model they follow, effective therapists are persistent in their pursuit of change. This doesn't just mean perseverance. It means being willing to intervene, at times energetically. Some therapists prefer to avoid confrontation and find it more effective to use gentle questions or persistent encouragement. But regardless of whether they work directly (and at times use confrontation) or indirectly (and avoid it), good therapists are finishers. Strategies vary, but what sets the best therapists apart is their commitment to doing what it takes to see families through to successful resolution of their problems.

Effective family therapy addresses interpersonal conflict, and the first step is to bring it into the consulting room and locate it between family members. Often this isn't a problem. Couples in conflict or parents arguing with their children usually speak right up about their disagreements. If a family came only because someone sent them (the court, the school, Family and Child Protective Services), begin by addressing the family's problem with these agencies. How must the family change to resolve their conflict with these authorities?

When one person is presented as the problem, a therapist challenges **linearity** by asking how others are involved (or affected). What was their role in creating (or managing) the problem? How have they responded to it?

For example, a parent might say, "The problem is Malik. He's disobedient." The therapist might ask, "How does he get away with that?" or "How do you respond when he's disobedient?" A less confrontational therapist might ask, "How does this disobedience affect you?"

Or perhaps the client says, "It's me. I'm depressed." A therapist might ask, "Who is contributing to your depression?" The response "No one" would prompt the question, "Then who's helping you with it?"

Challenges can be blunt or gentle, depending on the therapist's style and assessment of the family. The point isn't to switch from blaming one person (e.g., a disobedient child) to another (a parent who doesn't discipline effectively) but to broaden the problem to an interactional one—to see the problem as shared and co-maintained. Maybe mother is too lenient with Malik because she finds father too strict. Moreover, she may be overinvested in the boy because of emotional distance in the marriage.

The best way to challenge unhelpful interactions is to point out patterns that seem to be keeping people stuck. A useful formula is "The more you do *X*, the more he does *Y*, and the more you do *Y*, the more she does *X*." (For *X* and *Y*, try substituting *nag* and *withdraw* or *control* and *rebel*.) Incidentally, when you point out what people are doing that isn't working, it's a mistake to tell them what they *should* be doing. Once you shift from pointing out something to giving advice, the clients' attention shifts from their behavior to your advice. Consider this exchange:

> *Therapist:* When you ignore your wife's complaints, she feels hurt and angry. You may have trouble accepting the anger, but she doesn't feel supported.
>
> *Client:* What should I do?
>
> *Therapist:* I don't know. Ask your wife.

Even though family therapists sometimes challenge assumptions or actions, they continue to listen to people's feelings. Listening is a silent activity, rare in our time, even among therapists. Family members seldom listen to each other for long without becoming defensive. Unfortunately, therapists don't always listen, either—especially when they're eager to offer advice. But remember that people aren't likely to reconsider their assumptions until they've been heard and understood.

Homework can be used to test flexibility (simply seeing if it's carried out measures willingness to change), to make family members more aware of their roles in problems (telling people just to notice something, without trying to change it, is often instructive), and to suggest new ways of relating. Typical homework assignments include suggesting that overinvolved parents hire a babysitter and go out together, having argumentative partners take turns talking about their feelings and listening without saying anything (but noticing tendencies to become reactive), and having dependent family members practice spending time alone (or with someone outside the family) and doing more things for themselves. Homework assignments that are likely to generate conflict, such as negotiating house rules with teenagers, should be avoided. Difficult discussions should be saved for when the therapist can act as referee. See Figure 2.3 for a checklist for an early-phase session.

The Middle Phase of Treatment

When therapy is anything other than brief and problem focused, much of the middle phase is devoted to helping family members deal more constructively with each other in sessions. If a therapist is too active in this process—filtering all conversation through himself or herself—family members won't learn to deal with each other.

For this reason, in the middle phase the therapist should take a less active role and encourage family members to interact more with each other. As they do so, the therapist can step back and observe. When dialogue bogs

1. Identify major conflicts and bring them into the consulting room.
2. Develop a hypothesis and refine it into a **formulation** about what the family is doing to perpetuate (or fail to resolve) the presenting problem. Formulations should consider process and structure, family rules, triangles, and boundaries.
3. Keep the focus on primary problems and the interpersonal conditions supporting them. But do not neglect to support constructive interactions.
4. Assign homework that addresses problems and the underlying structure and dynamics perpetuating them.
5. Challenge family members to see their own roles in the problems that trouble them.
6. Push for change, both during the session and between sessions at home.
7. Make use of supervision to test the validity of formulations and effectiveness of interventions.

FIGURE 2.3 Early-Phase Checklist

down, the therapist can either point out what went wrong or simply encourage family members to keep talking—but with less interruption and criticism.

When family members address their conflicts directly, they tend to become reactive. Anxiety is the enemy of listening. Some therapists (e.g., Bowenians) attempt to control anxiety by having family members talk only to them. Others prefer to let family members deal with their own anxiety by helping them learn to talk with each other less defensively (by saying how they feel and acknowledging what others say). However, even therapists who work primarily with family dialogue need to interrupt when anxiety escalates and conversations become destructive.

Thus, in the middle phase of treatment the therapist encourages family members to begin to rely on their own resources. The level of anxiety is regulated by alternating between having family members talk with each other or with the therapist. In either case the therapist encourages family members to get beyond blaming to talking about what they feel and what they want—and to learn to see their own part in unproductive interactions.

What enables therapists to push for change without provoking resistance is an empathic bond with clients. We mentioned the working alliance in our discussion of the opening session, but it's such an important subject that we would like to reemphasize it. Although there is no formula for developing good relationships with clients, four attitudes are important in maintaining a therapeutic alliance: calmness, curiosity, empathy, and respect.

Calmness on the part of the therapist is an essential antidote to the anxiety that keeps families from seeing their dilemmas in a broader perspective. Calmness conveys confidence that problems, however difficult, can be resolved. Curiosity implies that the therapist doesn't know all the answers. The curious therapist says in effect, "I don't fully understand, but I'd like to."

Empathy and respect have been reduced to the status of clichés, but since we think both are essential, let us be clear about what we mean. People resist efforts to change them by therapists they feel don't understand them. That means that a therapist who can't step into his or her clients' shoes and get a sense of what the world looks like to them will find it difficult to make progress. Some therapists are all too ready to say "I understand" when they don't. You can't fake empathy.

Instead of telling an overprotective mother that you understand her worrying about her children, be honest enough to ask, "How did you learn to be a worrier?" or say, "I've never been a single mom. Tell me what it is that scares you."

Finally, respect. What passes for respect in therapists isn't always sincere. Being respectful doesn't mean treating people with kid gloves, nor does it mean accepting their version of events as the only possible way to look at the situation. Respecting clients means treating them as equals, not patronizing them or deferring to them out of fear of making them angry. Respecting people means believing in their capacity for change. See Figure 2.4 for a checklist for a middle-phase session.

Termination

Termination comes for brief therapists as soon as the presenting problem is resolved. For psychoanalytic therapists, therapy is a long-term learning process and may continue for years. For most therapists, termination comes somewhere between these two extremes and has to do with the family feeling they have achieved what they came for and the therapist's sense that treatment has reached a point of diminishing returns.

In individual therapy, where the relationship to the therapist is often the primary vehicle of change, termination

1. Use intensity to challenge family members, ingenuity to get around resistance, and empathy to overcome defensiveness.
2. Avoid being so directive that family members don't learn to improve their own ways of relating to each other.
3. Foster individual responsibility and mutual understanding.
4. Make certain that efforts to improve relationships are having a positive effect on the presenting complaint.
5. When meeting with subgroups, don't lose sight of the whole family picture, and don't neglect any individuals or relationships—especially those contentious ones that are tempting to avoid.
6. Does the therapist take too active a role in choosing what to talk about? Have the therapist and family developed a social relationship that has become more important than addressing conflicts? Has the therapist assumed a regular role in the family (an empathic listener to the spouses or a parent figure to the children), substituting for a missing function in the family? When therapists find themselves drawn to taking an active response to family members' needs, they should ask themselves who in the family should be taking that role, and then encourage that person to do so.

FIGURE 2.4 Middle-Phase Checklist

focuses on reviewing the relationship and saying good-bye. In family therapy, the focus is more on what the family has been doing. Termination is therefore a good time to review what they've accomplished.

It can be helpful to ask clients to anticipate upcoming challenges: "How will you know when things are heading backward, and what will you do?" Families can be reminded that their present harmony can't be maintained indefinitely and that people have a tendency to overreact to the first sign of relapse, which can trigger a vicious cycle. To paraphrase Zorba the Greek, life *is* trouble. To be alive is to confront difficulties. The test is how you handle them.

Finally, although in the business of therapy no news is usually good news, it might be a good idea to check in with clients a few weeks after termination to see how they're doing. This can be done with a letter, phone call, or brief follow-up session. A therapeutic relationship is, of necessity, somewhat artificial or at least constrained. But there's no reason to make it less than human—or to forget about families once you've terminated with them. See Figure 2.5 for a termination checklist.

FAMILY ASSESSMENT

The reason we're reviewing assessment after the general guidelines for treatment is that assessment is a complex subject, deserving of more consideration than it usually gets.

The Presenting Problem

Every first session presents the fundamental challenge of being a therapist: A group of unhappy strangers walks in and hands you their most urgent problem—and expects you to solve it.

1. Has the presenting problem improved?
2. Is the family satisfied that they have achieved what they came for, or are they interested in continuing to learn about themselves and improve their relationships?
3. Does the family have an understanding of what they were doing that wasn't working and how to avoid the recurrence of similar problems in the future?
4. Do minor recurrences of problems reflect lack of resolution of some underlying dynamic or merely that the family has to readjust to function without the therapist?
5. Have family members developed and improved relationships outside the immediate family context as well as within it?

FIGURE 2.5 Termination Checklist

"My fifteen-year-old is failing tenth grade. What should I do?"
"We never talk anymore. What's happened to our marriage?"
"It's me. I'm depressed. Can you help me?"

There are land mines in these opening presentations: "What should we do?" "What's wrong with Johnny?" These people have been asking themselves these questions for some time, maybe years. And they usually have fixed ideas about the answers, even if they don't always agree. Furthermore, they have typically evolved strategies to deal with their problems, which, even if they haven't worked, they insist on repeating. In this, they are like a car stuck in the mud with wheels spinning, sinking deeper and deeper into the mire.

The stress of life's troubles makes for anxiety, and anxiety makes for inflexible thinking. Thus, families who come for therapy tend to hold tenaciously to their assumptions: "He (or she) is hyperactive, depressed, bipolar, insensitive, selfish, rebellious," or some other negative attribute that resides inside the complicated machinery of the stubborn human psyche. Even when the complaint is phrased in the form of "*We* don't communicate," there's usually an assumption of where the responsibility lies—and that somewhere is usually elsewhere.

Exploring the presenting symptom is the first step in helping families move from a sense of helplessness to an awareness of how, by working together, they can overcome their problems. It may seem obvious that the first consideration should be the presenting complaint. Nevertheless, it's worth emphasizing that inquiry into the presenting problem should be detailed and empathic. The minute some therapists hear that a family's problem is, say, misbehavior or poor communication, they're ready to jump into action. Their training has prepared them to deal with misbehaving children and communication problems, and they know what needs to be done. But before therapists get started, they should realize that they're *not* dealing with misbehaving children or communication problems; rather, they're dealing with a unique instance of one of these difficulties.

In exploring the presenting complaint, the goal for a systemic therapist is to question the family's settled certainty about who has the problem and why. Therefore, the first challenge for a family therapist is to move families from *linear* ("it's Johnny") and *medical model* thinking ("he's hyperactive") to an *interactional* perspective. To initiate this shift, a therapist begins by asking about the presenting problem. These inquiries are not merely aimed at getting details about the condition as described but open up the family's entrenched beliefs about what the problem is and who has it.

Helpful questions convey respect for family members' feelings but also skepticism about accepting the identified patient as the only problem in the family. Helpful questions continue to explore and open things up. Helpful questions invite new ways of seeing the problem, or the family generally. Unhelpful questions accept things as they are described and concentrate only on the identified patient. To be effective in this first stage, a therapist's attitude should be "I don't quite understand, but I'm interested. I'm curious about the particular way you organize your life." A therapist who is too ready to ingratiate himself or herself by saying, "Oh, yes, I understand," closes off exploration.

The next thing to explore is the family's attempts to deal with the problem: What have they tried? What's been helpful? What hasn't been helpful? Has anyone other than those present been involved in trying to help (or hinder) with these difficulties? This exploration opens the door to discovering how family members may be responding in ways that perpetuate the presenting problem. This isn't a matter of shifting blame—say, from a misbehaving child to an indulgent parent.[2] Nor do we mean to suggest that family problems are typically caused by how people treat the identified patient.

In fact, what family therapists call *circular causality* is a misnomer. The shift from linear to circular thinking not only expands the focus from individuals to patterns of interaction but also moves away from cause-and-effect explanations. Instead of joining families in a logical but unproductive search for who started what, circular thinking suggests that problems are sustained by an ongoing series of actions and reactions. Who started it? It doesn't matter.

Understanding the Referral Route

It's important for therapists to understand who referred their clients and why. What are their expectations? What expectations have they communicated to the family? It's important to know whether a family's participation is voluntary or coerced, whether all or only some of them recognize the need for treatment, and whether other agencies will be involved with the case.

When therapists make a family referral, they often have a particular agenda in mind. For example, a college student's counselor referred him and his family for treatment. The young man had uncovered a repressed memory of sexual abuse and assumed that it must have been committed by his father. The family therapist was somehow supposed to mediate between the young man, who couldn't

[2]It's always worth remembering that even actions that perpetuate problems usually have benign intentions. Most people are doing the best they can.

imagine who else might have been responsible for this vaguely remembered incident, and his parents, who vehemently denied that any such thing had ever happened. Did the counselor expect confrontation, confession, atonement? Some sort of negotiated agreement? What about the boy himself? It's best to find out.

It's also important to find out if clients have been in treatment elsewhere. If so, what happened? What did they learn about themselves or their family? What expectations or concerns did previous therapy generate? It's even more important to find out if anyone in the family is currently in treatment. Few things are more likely to stall progress than two therapists pulling in different directions.

Identifying the Systemic Context

Regardless of who a therapist elects to work with, it's imperative to have a clear understanding of the interpersonal context of the problem. Who all is in the family? Are there important figures in the life of the problem who aren't present? Perhaps a live-in boyfriend? A grandmother who lives next door? Are other agencies involved? What's the nature of their input? Does the family see them as helpful?

Remember that family therapy is an approach to people in context. The most relevant context may be the immediate family, but families don't exist in a vacuum. It may be important to meet with the teachers of a child who's having trouble at school. There are even times when the family isn't the most important context. Sometimes, for example, a college student's depression has more to do with what's going on in the classroom or dormitory than with what's happening back home.

Stage of the Life Cycle

Most families come to treatment not because there's something inherently wrong with them but because they've gotten stuck in a life-cycle transition (see Chapter 4). Sometimes this will be apparent. Parents may complain, for example, that they don't know what's gotten into Janey. She used to be such a good girl, but now that she's fourteen, she's become sullen and argumentative. (One reason parenting remains an amateur sport is that just when you think you've got the hang of it, the kids get older and throw you a whole new set of curves.) Adolescence is that stage in the **family life cycle** when young parents have to grow up and relax their grip on their children.

Sometimes it isn't obvious that a family is having trouble adjusting to a new stage in the life cycle. Couples who marry after living together for years may not anticipate how matrimony stirs up unconscious expectations about what it means to be a family. More than one couple has been surprised to discover a sharp falling off in their sex life after tying the knot. At other times significant life-cycle changes occur in the grandparents' generation, and you won't always learn of these influences unless you ask.

Always consider life-cycle issues in formulating a case. One of the best questions a therapist can ask is, "Why now?"

Family Structure

The simplest systemic context for a problem is an interaction between two parties. She nags and he withdraws. Parental control provokes adolescent rebellion, and vice versa. But sometimes a dyadic perspective doesn't take in the whole picture.

Family problems become entrenched because they're embedded in powerful but unseen structures. Regardless of what approach a therapist takes, it's wise to understand the family's **structure**. What are the **subsystems** and the nature of the **boundaries** between them? What is the status of the boundary around the couple or family? What **triangles** are present? Are individuals and subsystems protected by boundaries that allow them to operate without undue interference—but with access to support?

In enmeshed families, parents may intrude into sibling conflicts so regularly that brothers and sisters never learn to settle their own differences. In disengaged families, parents may not only refrain from interrupting sibling quarrels but also fail to offer sympathy and support for children who feel bad about a sibling's treatment.

Here, too, there is a temporal dimension. If a wife goes back to work after years of staying home with the children, the parental subsystem is challenged to shift from a complementary to a symmetrical form. Whether or not family members complain directly about these strains, they're likely to be relevant.

Communication

Although some couples come to therapy saying they have "communication problems" (usually meaning that one person won't do what the other one wants), working on communication has become a cliché in family therapy. But because communication is the vehicle of relationship, all therapists deal with it.

Although conflict doesn't magically disappear when family members start to listen to each other, it's unlikely that conflict will get solved *before* they start to listen to each other (Nichols, 2009). If, after a session or two (and the therapist's encouragement), family members still seem unable to listen to each other, talk therapy will be an uphill battle.

Family members who learn to listen to each other with understanding often discover that they don't need to

change each other (Christensen & Jacobson, 2000). Many problems can be solved, but the problem of living with other people who don't always see things the way you do isn't one of them.

Drug and Alcohol Abuse

The most common mistake novice therapists make regarding substance abuse is to overlook it. Substance abuse is especially common with people who are depressed or anxious. It's also associated with violence, abuse, and accidents. Although it may not be necessary to ask every client about drug and alcohol consumption, it's critical to inquire carefully if there is any suspicion that this may be a problem. Don't be too polite. Ask straightforward and specific questions.

Questions that may help uncover problem drinking (Kitchens, 1994) include the following:

- Do you feel you are a normal drinker?
- How many drinks a day do you have?
- How often do you have six or more drinks?
- Have you ever awakened after a bout of drinking and been unable to remember part of the evening before?
- Does anyone in your family worry or complain about your drinking?
- Can you stop easily after one or two drinks? Do you?
- Has drinking ever created problems between you and your partner?
- Have you ever been in trouble at work because of your drinking?
- Do you ever drink before noon?

These same questions can be asked about substances other than alcohol. If a member of a family who's seeking couples or family therapy is abusing drugs or alcohol, talk therapy will not likely be the answer to the family's problems.

Domestic Violence and Sexual Abuse

If there is any hint of domestic violence or sexual abuse, the therapist should look into it. The process of questioning can start with the family present, but when there is a suspicion of abuse or neglect, it may be wise to meet with family members individually to allow them to talk more openly.

Most states require professionals to report any suspicion of child abuse. Reporting suspected abuse can jeopardize a therapeutic alliance, but sometimes therapy needs to take second place to the interests of safety. Any clinician who considers not reporting suspected child abuse should consider the possible consequences of making a mistake.

Perpetrators and victims of childhood sexual maltreatment don't usually volunteer this information. Detection is up to the therapist, who may have to rely on indirect clues. Further exploration may be indicated if a child shows any of the following symptoms: sleep disturbance, encopresis or enuresis, abdominal pain, an exaggerated startle response, appetite disturbance, sudden unexplained changes in behavior, overly sexualized behavior, regressive behavior, suicidal thoughts, or running away (Edwards & Gil, 1986).

Extramarital Affairs

The discovery of an extramarital affair is a crisis that will strike many couples sometime in their relationship. Infidelity is common, but it's still a crisis and can destroy a marriage.

Extramarital involvements that don't involve sexual intimacy, although less obvious, can sabotage treatment if one or both partners regularly turn to third parties to deal with issues that should be worked out together. (One clue that an outside relationship is part of a triangle is that it isn't talked about.) Would-be helpful third parties may include family members, friends, and therapists. For example, a couple came to therapy complaining that the intimacy had gone out of their relationship. It wasn't so much a matter of conflict; they just never seemed to spend any time together. After a few weeks of slow progress, the wife revealed that she'd been seeing an individual therapist. When the couple's therapist asked why, she replied that she needed someone to talk to. When he asked why she hadn't told him, she said, "You didn't ask."

Gender

Gender inequalities contribute to family problems in a variety of ways. A wife's dissatisfaction may have deeper roots than the family's current problems. A husband's reluctance to become more involved in the family may be as much a product of cultural expectations as a flaw in his character.

Every therapist must work out individually how to avoid the extremes of naively ignoring gender inequality or imposing his or her personal point of view on clients. One way to strike a balance is to raise questions but allow clients to find their own answers. You can raise moral questions without being moralistic. It is, however, not reasonable to assume that both partners enter marriage with equal power or that complementarity between spouses is the only dynamic operating in their relationship.

Conflict over gender expectations, whether discussed openly or not, is especially common, given the enormous shifts in cultural expectations over recent decades. Is it still considered a woman's duty to follow her husband's career,

moving whenever necessary for his advancement? Is it still true that women should be strong, self-supporting, and the primary (which often turns out to be a euphemism for *only*) caregivers for infants and young children?

Regardless of the therapist's values, do the gender roles established in a couple seem to work for them? Or do unresolved differences, conflicts, or confusions appear to be sources of stress? Perhaps the single most useful question to ask about gender equality is, "How does each of the partners experience the fairness of give-and-take in their relationship?"

It's not uncommon for differences in gender socialization to contribute to conflict in couples (Patterson, Williams, Grauf-Grounds, & Chamow, 1998), as the following case study illustrates.

CASE STUDY: KEVIN AND COURTNEY

Kevin complained that Courtney was always checking up on him, which made him feel that she didn't trust him. Courtney insisted that she asked about what Kevin was doing only in order to be part of his life. She expected the same interest in her life from him. She wasn't checking up on him; she just wanted them to share things.

When Courtney asked Kevin too many questions, he got angry and withdrew, which made her feel shut out. Happy not to be interrogated any further, Kevin didn't notice how hurt and angry Courtney was until finally she exploded in tearful recrimination. Kevin felt helpless in the face of Courtney's crying, and so he did his best to placate her. When he reassured her that he loved her and promised to tell her more about what was going on in his life, she calmed down and peace was restored. Until the next time.

For couples like Courtney and Kevin, gender socialization contributes to a pursuer–distancer dynamic. Men are typically socialized to value independence and to resist anything they see as an effort to control them. Thus, Kevin interpreted Courtney's questions about his activities as attempts to restrict his freedom. Courtney, on the other hand, was socialized to value caring and connection. Naturally, she wanted to know what was going on in Kevin's life. She couldn't understand why he got so defensive about her wanting them to check in with each other.

While it's a mistake to ignore gender socialization in favor of family dynamics, it's also a mistake to assume that gender socialization isn't influenced by family dynamics. In the preceding example, the enmeshed family that Courtney grew up in reinforced the notion that family members should share everything and that having independent activities was disloyal. Kevin's reluctance to tell his wife everything he was doing resulted partly from his coming from a family with two bossy and controlling parents.

Culture

In assessing families for treatment, therapists should consider the unique subculture of a family (McGoldrick, Pearce, & Giordano, 2005) as well as how unquestioned assumptions from the larger culture may affect a family's problems (Brown, 2009). In working with minority families, it may be more important for therapists to develop *cultural sensitivity* than to actually share the same background as their clients. Families may come to trust a therapist who has taken the time to learn about their particular culture as much as one who happens to be of the same race or nationality (Blow, Sprenkle, & Davis, 2007).

One way to develop cultural sensitivity is to make connections after working hours. For example, a white therapist could attend an African American church service in the community where his or her clients live, go to a Latino dance, or visit an Asian community center. Doing these things won't make you an expert, but it may demonstrate to client families that you care enough to respect their ways. It's also important to take a *one-down position* in regard to cultural and ethnic diversity—that is, to ask your clients to teach you about their experience and traditions, rather than play the role of expert.

The challenge for a practitioner is twofold: learning to respect diversity and developing sensitivity to some of the issues faced by members of other cultures. Numerous books that describe the characteristics and values of various racial and ethnic groups are available, many of which are listed in the section on multiculturalism in Chapter 11. In addition to these academic books, novels such as *Love in the Time of Cholera*, *Beloved*, *The Scent of Green Papaya*, *The Brief Wondrous Life of Oscar Wao*, and *The Joy Luck Club* often bring other cultures vividly to life.

It's important to realize that no matter how respectful of other cultures you think you are, we all have blind spots and biases. Learning to recognize the blind spots and biases is important and seeking supervision from someone who isn't afraid to challenge you is a very useful corrective.

In working with clients from other cultures, it's more important to be respectful of differences and to be curious about other ways of doing things than to attempt to become an expert on ethnicity. However, while it's important to respect other people's differences, it can be a problem to accept uncritically statements to the effect that "We do these (counterproductive) things because of our culture." Unfortunately, it's difficult for a therapist from another culture to

assess the validity of such claims. Perhaps the best advice is to be curious. Stay open-minded, but ask questions.

THE ETHICAL DIMENSION

Most therapists are aware of the ethical responsibilities of their profession:

- Therapy should be for the client's benefit, not to work out unresolved issues for the therapist.
- Clients are entitled to confidentiality, and so limits on privacy imposed by requirements to report to probation officers, parents, and managed care companies should be made clear from the outset.
- Therapists should avoid exploiting the trust of their clients (and students) and therefore must make every effort to avoid dual relationships.
- Professionals are obligated to provide the best possible treatment; if they aren't qualified by training or experience to meet the needs of a particular client, they should refer the case to someone who is.

Whenever there is any question or doubt regarding ethical issues, it's a good idea to consult with a colleague or supervisor.

Although most therapists are aware of their own responsibilities, many think less than they might about the ethical dimensions of their clients' behavior. This is an area where there are no hard-and-fast rules. However, a complete and conscientious assessment of every family should include some consideration of family members' entitlements and obligations. What obligations of loyalty do members of a family have? Are invisible loyalties constraining their behavior? (Boszormenyi-Nagy & Spark, 1973). If so, are these loyalties just and equitable? What is the nature of the partners' commitment to each other? Are these commitments clear and balanced? What obligations do family members have with regard to fidelity and trustworthiness? Are these obligations being met?

A good place to start understanding the ethical responsibilities of clinical practice is by studying the guidelines of your profession. The *Ethics Code of the American Psychological Association* (APA), for example, outlines these principles:

- Psychologists offer services only within the areas of their competence, based on education, training, supervision, or professional experience.
- Where there is evidence that an understanding of age, gender, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of services, psychologists have or seek out training and supervision in these areas—or they make appropriate referrals.
- When psychologists become aware of personal problems that might interfere with their professional duties, they take appropriate measures, such as obtaining professional assistance and determining whether they should limit, suspend, or terminate their work-related duties.

The *Code of Ethics for the National Association of Social Workers* (NASW) mandates the following:

- Social workers should not engage in dual relationships with clients or former clients.
- Social workers should not solicit private information from clients unless it is essential to providing services.
- Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.
- Social workers should terminate services to clients when such services are no longer required.

The American Counseling Association (ACA, 2014) covers many of the same issues as the APA and NASW, but it provides further mandates related to social media, such as:

- Counselors are not allowed to maintain a relationship with current clients through social media.
- Counselors must wait five years after the last clinical contact to have a sexual or romantic relationship with a former client or family member of a client. This applies to both in-person and electronic interactions.

While some of these principles may seem obvious, they provide fairly strict guidelines within which practitioners should operate. When it comes to working with couples and families, however, complications arise that create a host of unique ethical dilemmas. When, for example, should a family therapist share with parents information learned in sessions with a child? If a twelve-year-old starts drinking, should the therapist tell the parents?

Recently, professional codes of conduct have added guidelines to address issues involved in treating couples and families. For example, the APA specifies that when a psychologist provides services to several people in a relationship (such as spouses or parents and children), he or she must clarify at the start which individuals are clients and what relationship he or she will have with each one. Moreover, if the psychologist may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), he or

she must attempt to clarify and change or withdraw from the roles as appropriate.

The NASW states that when a social worker provides services to a couple or family members, he or she should clarify with all parties what professional obligations he or she has to the various individuals receiving services. Also, when a social worker provides counseling to families, he or she should ask all parties to agree to each individual's right to confidentiality.

The American Association for Marriage and Family Therapy (AAMFT, 2001) publishes its own code of ethics, which covers many of the same issues as the codes of the APA and NASW. The AAMFT, however, directly addresses complications with respect to confidentiality when a therapist sees more than one person in a family. Without a written waiver, a family therapist should not disclose information received from any family member, even to other family members, presumably. As with many things, however, it may be easier to expound ethical principles in the classroom than to apply them in the crucible of clinical practice. For example, it's clear that therapists must protect their clients' right to confidentiality. But what if a woman reveals that she's having an extramarital affair and isn't sure whether to end it? When she goes on to say that her marriage has been stale for years, the therapist recommends a course of couples therapy to see if the marriage can be improved. The woman agrees. But when the therapist then suggests that she either break off the affair or tell her husband about it, the woman adamantly refuses. What should the therapist do?

One way to resolve ambiguous ethical dilemmas is to use your own best judgment. In the case of the woman who wanted to work on her marriage but wasn't willing to end her affair or inform her husband, a therapist might decline to offer therapy under circumstances that would make it unlikely to be effective. In that case, the therapist would be obligated to refer the client to another therapist.

Subprinciple 1.6 of the *AAMFT Code of Ethical Principles* states the following:

> Marriage and family therapists assist persons in obtaining other therapeutic services if a marriage and family therapist is unable or unwilling, for appropriate reasons, to see a person who has requested professional help.

And Subprinciple 1.7 makes the following statement:

> Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

Given the same set of circumstances, another therapist might decide that treating the couple even though the woman refused to end her affair might make it possible for the woman to break off the affair later or to talk to her husband about it. In this scenario, the therapist would be bound by the principle of confidentiality not to reveal what the woman discussed in private.

While the outlines of ethical professional conduct are clear, the pressures on practitioners are often powerful and subtle. When dealing with clients who are having an affair or considering divorce (or marriage, for that matter), therapists may be influenced by their own unconscious attitudes as well as the clients' projections. What would you assume, for example, about a therapist whose depressed, married clients all tended to get divorced after their individual therapy? What might you speculate about the level of satisfaction in that therapist's own marriage?

Trusting your own judgment in an ambiguous ethical situation risks imposing your own values on what should be a professional decision. The principles of sound ethical practice are wider, and may be stricter, than most people's private morality and good intentions. When in doubt, clinicians should ask themselves two questions. First, "What would happen if the client or important others found out about my actions?" Thus, for example, strategically telling two siblings, each in a separate conversation, that only he or she is mature enough to end the fighting between them violates the "what if?" principle, because it's entirely possible that one or both siblings might brag to the other about what the therapist said. (Trust us!)

The second question is, "Can you talk to someone you respect about what you're doing (or considering)?" If you're afraid to discuss with a supervisor or colleague that you are treating two married couples in which the wife of one is having an affair with the husband of the other or that you're considering lending a client money, you may be guilty of the arrogance of assuming that you are above the rules that govern your profession. Feeling compelled to keep something secret suggests that it may be wrong. The road to hell is paved with the assumption that this situation is special, this client is special, or that you are special.

The following red flags should signal potential unethical practices:

- *Specialness*—believing that something about the situation is special and that the ordinary rules don't apply.
- *Attraction*—feeling intense attraction of any kind, not only romantic but also being impressed with the status of the client.
- *Alterations in the therapeutic frame*—having longer or more frequent sessions, engaging in excessive

self-disclosure, being unable to say no to the client, and other things that signal a potential violation of professional boundaries.

- *Violating clinical norms*—not referring someone in a troubled marriage for couples therapy, accepting personal counseling from a supervisor, and so on.
- *Professional isolation*—not being willing to discuss your decisions with professional colleagues.

CASE STUDY: PAUL AND NICOLE

At first Maria treated Paul and Nicole like any other couple in therapy. As the treatment unfolded, however, she began to sympathize more and more with Paul. Why was Nicole so critical? Didn't she appreciate having a husband who was so hard-working, loyal, and attractive? Maria, who'd recently ended a long-term relationship in which she seemed to provide all the support, thought Nicole's complaints about Paul's emotional unavailability were unfair and unwarranted. Sure, Paul did withdraw from time to time, but who wouldn't in the face of all that criticism?

Reflect and Apply

1. What's going on with Maria?
2. Left unchecked, what are the risks of Maria's feelings?
3. Put yourself in Maria's shoes. What other kinds of red flags not mentioned in this vignette might Maria notice to alert her to something being off?
4. Do you think feeling attraction for clients is normal or shameful?
5. What should you do if you notice that you are feeling attracted to a client?

FAMILY THERAPY WITH SPECIFIC PRESENTING PROBLEMS

Once, most family therapists assumed their approach could be applied to almost any problem. Today, it has become increasingly common to develop specific techniques for particular populations and problems.

The following sections address special treatment approaches for two frequently encountered clinical problems: marital violence and sexual abuse of children. While we hope these suggestions will provide some ideas for dealing with these difficult situations, remember that responsible therapists recognize the limits of their expertise and refer cases they aren't equipped to handle to more experienced practitioners.

Marital Violence

The question of how to treat marital violence polarizes the field like no other. The prevailing paradigm is to separate couples, assigning the offender to an anger management program and treating his partner in a battered women's group (Edelson & Tolman, 1992; Gondolf, 1995). Traditional couples therapy is seen as dangerous because placing a violent man and his abused partner in close quarters and inviting them to address contentious issues puts the woman in danger and provides the offender with a platform for self-justification (Bograd, 1992; Hansen, 1993). Treating the partners together also implies that they share responsibility for the violence and confers a sense of legitimacy on a relationship that may be malignant.

The argument for seeing violent couples together is that violence is the outcome of mutual provocation—an escalation, albeit unacceptable, of the emotionally destructive behavior that characterizes many relationships (Goldner, 1992; Minuchin & Nichols, 1993; Stith, McCollum, Amanon-Boadu, & Smith, 2012). When couples are treated together, violent men can learn to recognize the emotional triggers that set them off and to take responsibility for controlling their actions. Their partners can learn to recognize the same danger signals and to take responsibility for ensuring their own safety.

Because few systemic therapists advocate treating couples together when the violence has gone beyond pushing and shoving, some of the debate between advocates of a systemic versus an offender-and-victim model is between apples and oranges. Michael Johnson (1995) argues that there are two types of partner violence in families. The first is *patriarchal terrorism*, which is part of a pattern in which violence is used to exercise control over the partner. Patriarchal terrorism is frequent and severe and tends to escalate over time. The second type is *common couple violence*, which doesn't involve a pattern of power and control. This violence erupts as a response to a particular conflict, is more likely to be mutual, tends to occur infrequently, and tends not to escalate. Nevertheless, many feminist thinkers remain opposed to couples therapy when any form of violence is present (Avis, 1992; Bograd, 1984).

In the absence of empirical evidence showing gender-specific group treatment to be safer or more effective than couples therapy (Brown & O'Leary, 1995; Feldman & Ridley, 1995; Smith, Rosen, McCollum, & Thomsen, 2004; Stith et al., 2012), clinicians remain split into two camps when it comes to the treatment of marital violence. Rather than choose between attempting to resolve the relationship issues that lead to violence or concentrating on providing safety and protection for the victims, it's

possible to combine elements of both approaches—not, however, by doing traditional couples therapy.[3]

In working with violent couples, there must be no compromise on the issue of safety. However, this doesn't have to mean choosing between therapeutic neutrality (and focusing on relationship issues) or advocating on behalf of the victim (and focusing on safety). It's possible to pursue both agendas. Relationship issues can be construed as mutual, but the perpetrator must be held responsible for the crime of violence. As Pamela Anderson said when her husband Tommy Lee was arrested for domestic battery, "It takes two people to start an argument; but it only takes one to break the other one's nose."

In the initial consultation with couples in which there is a suspicion of violence, it's useful to meet with the partners together and then separately. Seeing the couple together permits you to see them in action, while speaking with the woman privately allows you to inquire whether she has left out information about the level of violence or other forms of intimidation to which she has been subjected.

Violent men and battered women trigger strong reactions in anyone who tries to help them. When such couples seek therapy, they are often polarized between love and hate, blaming and feeling ashamed, wanting to escape and remaining obsessed with each other. Thus, it's not surprising that professional helpers tend to react in extremes: siding with one against the other, refusing ever to take sides, exaggerating or minimizing danger, treating the partners like children or like monsters—in other words, splitting into good and bad, just like the dynamics of the couples themselves. In order to form an alliance with both partners, it's important to convey respect for them as persons, even if you can't condone all of their actions.

To assess the level of violence, it's important to ask direct questions: How often do conflicts between the two of you end in some kind of violence? When did this happen most recently? What's the worst thing that's ever happened? It's important to find out if any incidents have resulted in injuries, if weapons have been used, and if the woman is currently afraid.

In addition to assessing the level of violence, a therapist must evaluate the partners' ability to work constructively in therapy. Is the man willing to accept responsibility for his behavior? Is he argumentative or defensive toward his partner? Toward the therapist? Is the woman willing to take responsibility for her own protection, making her physical safety the first priority? Are the partners able to talk together and take turns, or are they so emotionally reactive that the therapist must constantly interrupt to control them?

If a therapist decides to treat the couple together, it's essential to establish zero tolerance for violence. One way of doing this is to make therapy contingent on no further episodes of physical aggression. Virginia Goldner and Gillian Walker (Goldner, 1998) define the first couple of sessions as a consultation to determine whether it's possible to create a "therapeutic safety zone," where issues can be confronted without putting the woman in harm's way. They use these initial sessions to focus on the risk of violence and the question of safety, reserving the right to terminate the consultation and propose other treatment alternatives if they feel the case is too dangerous for couples therapy.

With most couples it's useful to encourage dialogue as a way of exploring how the partners communicate. But violent couples tend to be emotionally reactive, and when that's the case, it's better to have them take turns talking to the therapist.

One of the best antidotes to emotionality is to ask for specific, concrete details. A good place to start is with the most recent violent incident. Ask each partner for a detailed, moment-to-moment description of exactly what happened. Be alert for linguistic evasions (Scott & Straus, 2007). A violent man may describe his actions as the result of his partner's "provocation" or of "built-up pressures." Thus, it's not he who hits his wife; it's the pressures that are the culprit. A more subtle form of evasion is for the violent partner to describe the problem as his impulsivity. When arguments escalate, he starts to "lose it." In this formulation, the man's impulsive actions are not a choice he makes but an unavoidable consequence of emotions welling up inside him. To this kind of evasion, a therapist might respond, "When you say you start to 'lose it,' let's think about what you mean. What happened inside of you at that moment that you felt justified in breaking your promise never to hit her again?" The therapeutic task is to hold the man accountable for his violence, while also trying to understand him in complex and sympathetic terms. This double agenda is in contrast to either a shaming approach, which only exacerbates the man's rage, or trying to understand the couple's dynamics, without also holding the man responsible for his actions.

Once both partners have begun to own responsibility for their actions—he for choosing to control his violent impulses, she for taking steps to ensure her safety—it becomes possible to explore the relationship issues that lead to escalating emotional reactivity (Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002). This does *not* mean, however, that at a certain point violent couples can be treated just like any other couple. Exploring the interactional processes that both partners participate in

[3]The following guidelines draw on the work of Virginia Goldner and Gillian Walker, codirectors of the Gender and Violence Project at the Ackerman Institute.