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Approaches to Family Therapy

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APPROACHES TO FAMILY THERAPY[1]

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Definition

Marital and family treatment can be defined as a professionally organized attempt to produce beneficial changes in a disturbed marital or family unit by using essentially interactional, nonpharmacological methods. Its aim is the establishment of more satisfying ways of living for the entire family and for individual family members.

Family therapy is distinguished from other psychotherapies by its conceptual focus on the family system as a whole. Major emphasis is placed on acknowledging that individual behavior patterns arise from, and inevitably feed back into, the complicated matrix of the general family system. Beneficial alterations in the larger marital and family unit will therefore have positive consequences for the individual members, as well as for the larger systems themselves. The major emphasis is placed upon understanding and intervening in the family system's current patterns of interaction; the origins and development of these patterns of interaction usually receive only secondary interest.

In many families, some member or members may be "selected" as

"symptom bearers." Such individuals will then be described in a variety of ways that will amount to their being labeled "bad," "sick," "stupid," or "crazy." Depending on what sort of label such individuals carry, they, together with their families, may be treated in any one of several types of helping facility—for example, psychiatric, correctional, or medical.

But there may not always be an *identified patient.* Occasionally a marital or family unit presents itself as being in trouble without singling out any one member. For example, a couple may realize that their marriage is in trouble and that the cause of their problems stems from interaction with each other and not from an individual partner.

The intrapsychic system, the interactional family system, and the sociocultural system can be viewed as a continuum. However, different conceptual frameworks are utilized when dealing with each of these systems. A therapist may choose to emphasize any of the points on this continuum, but the family therapist is especially sensitive to, and trained in, those aspects relating specifically to the family system; he is aware of both its individual characteristics and the larger social matrix.

Family therapy is not necessarily synonymous with *conjoint family therapy* (in which the entire family meets together consistently for therapy sessions). For example, instead of having regular sessions with the entire

family, one of the clinical and theoretical pioneers in the family field has in recent years been experimenting with the almost exclusive use of the healthiest member of the family system as the therapeutic agent for change in the family unit. This therapist has also reported on his use of somewhat indirect means (for example, provocative letters to family members) as an imaginative way to conduct family therapy; that is, to bring about change or movement in a family system.

There are instances in which a family may be seen together while the therapist's frame of reference remains limited to that of individual psychotherapy. Family members in such a setting may be treated as relatively isolated individual entities. In effect then, such a therapist may be practicing conventional individual psychotherapy in a family therapy setting.

Family therapy might broadly be thought of as any type of psychosocial intervention utilizing a conceptual framework that gives primary emphasis to the family system and that, in its therapeutic strategies, aims for an impact on the entire family structure. Thus, any psychotherapeutic approach that attempts to understand or to intervene in an organically viewed family system might fittingly be called "family therapy." This is a very broad definition and admits various points of view, both in theory and in therapy.

Historical Overview of the Differing Approaches

Current approaches have been synthesized from such fields as psychology, psychiatry, sociology, psychoanalysis, game theory, communication theory, Gestalt therapy, and the like. How did this state of affairs come about? The significance attributed to the family's role in relation to the psychic and social distress of any of its members has waxed and waned over the centuries. The important role of the family with regard to individual problems was mentioned by Confucius in his writings, as well as by the Greeks in their myths. The early Hawaiians would meet as a family to discuss solutions to an individual's problem. For a long time in our own culture, however, what we now call mental illness and other forms of interpersonal distress were ascribed to magical, religious, physical, or exclusively intrapsychic factors. It was not until the turn of this century that individual psychodynamics were postulated by Freud to be the determinants of human behavior. Although he stressed the major role of the family in the development of individual symptoms, he believed that the most effective technique for dealing with such individual psychopathology was treatment on a one-to-one basis. At about this same time, others working with the mentally ill began to suggest that families with a sick member should be seen together, and that the mentally ill should not be viewed "as individuals removed from family relationships." Eventually, psychiatric social workers in child guidance clinics, who often saw parents individually or together, began to recognize the importance of dealing with the entire family unit.

In the 1930s a psychoanalyst reported his experience in treating a marital pair. And in the 1940s, Frieda Fromm-Reichmann postulated that a pathologic mother (called the "schizophrenogenic mother") could induce schizophrenia in a "vulnerable" child. This speculation led other psychoanalysts to study the role of the father. Their work suggested that the father also plays an important role in the development of psychopathology. At the same time, Bela Mittelman began to see a series of marital partners in simultaneous, but separate, psychoanalyses. This approach was quite innovative because psychoanalysts had previously believed that this method of treatment would hinder the therapist from helping his patient, since it was thought that neither spouse would trust the same therapist and consequently would withhold important material. Therefore, the other marital partner was usually referred to a colleague.

Outside the field of psychiatry proper, marital counselors, ministers, and others have been interviewing spouses together for some time. In the early 1950s the first consistent use of family therapy in modern psychotherapeutic practice in the United States was reported by several different workers. Nathan Ackerman began utilizing family interviews in his work with children and adolescents; and Theodore Lidz and associates, as well as Murray Bowen, began a more extensive series of investigations of family interactions and schizophrenia. Gregory Bateson and associates, and Lyman Wynne and associates then embarked on the more intensive study of family

communication patterns in the families of schizophrenic patients compared to families in which the patient had another psychiatric disorder.

It was not until the early 1960s, however, that these ideas were integrated into a general theory of family interrelationships, thereby shaping the modern field of family therapy. Various schools of thought developed and journals such as *Family Process* were established. Many people became interested in learning about family therapy and in utilizing its techniques. As a matter of fact, a recent poll taken of California psychologists showed that 90 percent (as expected) practiced individual therapy, but *now* more than 60 percent also practiced family therapy, while only 30 percent were doing group therapy. These statistics illustrate the rise in the growth of the family therapy field in just two decades. During the 1970s the use of family therapy was expanded to include the application of a "broad range of psychiatric problems with families differing widely in socioeconomic origin." The results, however, remained poor until crisis-oriented and short-term methods were developed to meet the needs of these families.

Evaluation Using Differing Approaches

There are several points of view regarding the type and quantity of the evaluative data to be gathered. Some family therapists begin with a specific and detailed longitudinal history of the family unit and its constituent

members that may perhaps span three or more generations. This procedure has the advantage of permitting the family and the therapist to go over together the complex background of the present situation. The therapist will begin to understand unresolved past and present issues, will usually gain a sense of rapport and identification with the family and its members, and may then feel more comfortable in defining problem areas and in planning strategy. The family, for its part, may benefit by reviewing together the source and evolution of its current condition—a clarifying, empathy-building process that was not previously engaged in by its members. The good and the bad are brought into focus, and the immediate distress is placed in a broader perspective. Sometimes a family in crisis, however, is too impatient to tolerate exhaustive history gathering, and in acute situations lengthy data gathering must be curtailed.

Other therapists do not appear to rely heavily on the longitudinal approach, attempting instead to delineate the situation that has led the family to seek treatment and to obtain a cross-sectional view of its present functioning. This procedure has the advantage of starting with the problems with which the family is most concerned, and it will not be as potentially time consuming or as seemingly remote from the present realities as the preceding method. The therapist, however, may not emerge with as sharp a focus on important family patterns, and much of the discussion may be negatively tinged because of the family's preoccupation with its current difficulty.

More experienced (and often more courageous) therapists may severely curtail past history gathering and may also minimize formalized discussions of the family's current situation. They may begin, instead, by dealing from the onset with the family's important characteristic patterns of interaction as they are manifested in the interview setting. They may tend to utilize primarily, or exclusively, the immediate "here and now" observable family transactions. The therapist, understanding these transactions to be characteristic of the family, will clarify and comment on them, and intervene in a variety of ways. This approach has the advantage of initiating treatment right from the outset, without the delay of history gathering. There is often a heightened sense of emotional involvement, and more rapid changes may occur. Sometimes families are overwhelmed by such an approach, however, feeling threatened and defensive. Also, when specific information and patterns are allowed to emerge in this random fashion, the therapist does not always have the same degree of certainty as to whether the emerging family patterns are indeed relevant and important.

To a considerable extent these differences in technique may mirror differences in the therapist's training, theoretical beliefs, and temperament. Most therapists, however, probably use combinations of these approaches as the situation warrants, for there is no evidence of one technique being superior to the others.

Obviously, there is more than one way to evaluate a family—each way potentially useful—depending on the situation. The procedure offered in the evaluation outline depicted in table 20-1 combines, in a somewhat condensed manner, useful aspects of the first two approaches already discussed. It offers a practical alternative to gathering an exhaustive history or to plunging into the middle of the family interaction.

Formulating the Family Problem Areas

When meeting with the family, the therapist experiences its patterns of interaction and uses the data obtained in order to begin formulating a concept of the family problem. Data for these formulations may come from historical material, but just as important will be what the therapist has observed in personal contact with the family. This will help to form a basis for hypotheses and therapeutic strategies. The data gathered from the outline provided (see table 20-1) should permit the family therapist to pinpoint particular areas or aspects of the family that may require attention. In addition, the data assist in laying out a priority system, so that the therapist can decide which areas of the family problem should be dealt with first. The data also clarify therapeutic strategy and the tactics indicated for the particular phases and goals of treatment.

Family Patterns of Communicating Thoughts and Feelings

Depending on the approach, some of the areas of communication to be assessed include: (1) expressions of affection, empathy, and mutual support; (2) areas of sexual satisfaction and dissatisfaction; (3) daily interaction, including the sharing of activities; (4) flexibility of roles, rivalry and competition, and the balance of power; (5) major conflicts in the marital relationship, including development intensity and means of resolving conflict; and (6) relationships to family, including children and friends. To what extent does the family group engage in meaningful and goal-directed negotiations, rather than being engulfed in incoherent, aimless talk?

Table 20-1 Outline for Family Evaluation[2]

I. Current Phase of Family Life Cycle
II. Explicit Interview Data
A. What is the current family problem?
B. Why does the family come for treatment at this time?
C. What is the background of the family problem?
1) Composition and characteristics of nuclear and extended family, e.g. age, sex, occupation, financial status, medical problems, etc.
2) Developmental history and patterns of each family member
3) Developmental history and patterns of the nuclear family unit
4) Current family interactional patterns (internal and external)
D. What is the history of past treatment attempts or other attempts at problem solving in the family?
E. What are the family's goals and expectations of the treatment? What are their motivations and resistances?
III. Formulating the Family Problem Areas
A. Family patterns of communicating thoughts and feelings

B. Family roles and coalitions

C. Operative family myths

D. Family style or typology

IV. Planning and Therapeutic Approach and Establishing the Treatment Contract

Other factors of communication assessment include the general feeling tone of the family and of individual members, dyads, and triads, together with appropriateness, degree of variability, intensity, and flexibility. Questions to be considered might include: To what extent does the family appear to be emotionally "dead" rather than expressive, empathic, and spontaneous? What is the level of enjoyment, energy, and humor? To what extent does there appear to be an emotional divorce between the marital partners? To what extent is the family system skewed around the particular mood state or reaction pattern of one of its members?

Family Roles and Coalitions

Differing models of evaluation ask to what extent does the family seem fragmented and disjointed, as though made up of isolated individuals. Or does the family appear rather to be one relatively undifferentiated "ego mass"? To what extent is the marital coalition the most functional and successful one in the family system? To what extent are there cross-sectional dyadic coalitions that are stronger than the marital dyad? How successfully are power and leadership issues resolved? To what extent is this a schismatic family in which

there are two or more alliances seemingly in conflict with one another?

Operative Family Myths

Some individuals in families are "selected" to be "bad," "sick," "stupid," or "crazy," and often these roles constitute a kind of self-fulfilling prophecy. Families as well as individuals function with a set of largely unexamined fundamental attitudes that have been termed "myths." These markedly influence the family's manner of looking at and coping with itself and the world.

Family Style or Typology

There is no one way of classifying, or making universally applicable the complexity of marital and family life styles. Some of the characterizations presented in table 20-2 may be found helpful, depending on the circumstances and the therapist's approach.

After the evaluation data have been gathered and formulated into hypotheses and goals regarding important problem areas, the therapist is ready to consider what therapeutic strategies will be appropriate.

Differing Approaches to Treatment Elements of Psychotherapy and Their Relationship to Family Therapy

1. A good patient-therapist relationship.

2. Release of emotional tension.

3. Cognitive learning.

4. Operant reconditioning of the patient toward more adaptive behavior patterns by explicit or implicit approval-disapproval cues and by a corrective emotional relationship with the therapist.

5. Suggestion and persuasion.

6. Identification with the therapist.

7. Repeated reality testing or practicing of new adaptive techniques in the context of implicit or explicit emotional therapeutic support.

Family therapy, too, may use all eight of these elements to improve the overall functioning of the entire family. The particular mix of the elements will vary with the specific needs of the family. There is hardly any specific technique of individual or group therapy that could not in some way or another be adapted for use in family therapy.

Currently, there are a number of differing approaches for treating families. Each may emphasize different assumptions and types of interventions. Some therapists prefer to operate with one strategy in most

cases; others may intermix strategies depending on the type of case and the phase of treatment.

The type of strategy is sometimes made explicit by the therapist; in other instances it remains covert; but irrespective of whether a therapist specializes in one approach or is eclectic, some hypotheses will be formed about the nature of the family's difficulty and the preferable approach to adopt.

Table 20-2 Family Style or Typology

Classification 1: Based on rules for defining power
1. The symmetrical relationship In symmetrical relationships, both people exhibit the same types of behavior (which minimize the differences between them), role definitions are similar, and problems tend to stem from competition.
2. The complementary relationship In complementary relationships, the two people exhibit different types of behavior, and this is found most often in the so-called traditional marriage. This form maximizes differences and tends to be less competitive and often highly workable. Unless role definitions are agreed on, however, serious problems can result.
3. The parallel relationship In parallel relationships, the spouses alternate between symmetrical and complementary relationships in response to changing situations.
Classification 2: By Parental Stage
The move from the dyadic marital configuration to the larger, more complex one involving children tends inevitably to bring with it the potential for increased activities. Possible subcategories under this classification are as follows:
1. Before children
2. Early childhood
3. Latency and adolescent children
4. After the children have left home (empty-nest syndrome)
Classification 3: By Level of Intimacy

1. The conflict-habituated marriage is characterized by severe conflicts, but unpleasant as it is, the partners are held together by fear of alternatives.
2. The devitalized marriage has less overt expressions of dissatisfaction, with the marital partners conducting separate lives in many areas. This interaction is characterized by numbness and apathy and seems to be held together principally by legal and moral bonds and by the children.
3. The passive-congenial marriage is "pleasant" and there is a sharing of interests without any great intensity of interaction. The partners' level of expectation from the relationship is not very high, and they derive some genuine satisfaction from it.
4. The vital marriage is intensely satisfying to the spouses in at least one major area, and the partners are able to work together.
5. The total marriage, which is very rare in the investigators' findings, is characterized by similarity to the vital marriage except that the former is more intense and satisfying in the whole range of marital activities.

Classification 4: Personality Style

1. The obsessive-compulsive husband and the hysterical wife. Conflicts of intimacy often become of major importance.
2. The passive-dependent husband and the dominant wife. Power is the central theme of this system.
3. The paranoid husband and the depression-prone wife.
4. The depression-prone husband and the paranoid wife.
5. The neurotic wife and the omnipotent husband. Power is the primary conflict area. The wife's resentment is expressed through depression and a variety of other symptoms.

   These material styles often work very satisfactorily if the needs of the two partners are met and if they are not overly inflexible in their application. Problems arise only when the cost of keeping the system going is too high—when one spouse changes, thereby upsetting the system, or when one partner indicates the desire to change the "rules."

Classification 5: Descriptions of Families in Treatment

No overall concept or model underlies the following six clusters; they are descriptive in nature. Because they were derived from families referred for treatment, the clusters imply a generally maladaptive tendency.

1. Constricted. Characterized by excessive restriction of a major aspect of family emotional life, such as expression of anger, negative affect, or ambivalence. These emotions become internalized into anxiety, depression, and somatic complaints. The presenting patient is often a passive, depressed child or young adult.
2. Internalized ("enmeshed"). Characterized by a fearful, pessimistic, hostile, threatening view of the world, leading to a constant state of vigilance. Such a family

has a well-defined role structure, high family loyalty, and a pseudo-mutual bond between parents.

3. Object-focused. Characterized by overemphasis on the children ("child centered"), the outside community, or the self ("narcissistic"). Motivation for treatment depends on the willingness of the marital couple to form an effective coalition.
4. Impulsive. Characterized by an adolescent or young adult acting out anger toward a parent onto the community or expressing his or her parents' difficulties in a socially unacceptable way.
5. Childlike. Characterized by spouses who have remained dependent on their own families or on the community, based on either inadequacy or immaturity.
6. Chaotic. Characterized by disintegration. Lack of structure, chronic psychosis and delinquency, and low commitment to the family unit.

Various schools of family therapy may differ on where they place their emphasis on the following major treatment dimensions:

1. Past versus present orientation.

2. Verbal interpretations versus action.

3. Growth model versus problem model.

4. General method versus specific plan for each problem.

5. Therapeutic focus on one individual versus focus on two or more individuals.

6. Equality versus hierarchy in therapeutic relationship.

7. Analogical versus digital thinking (Digital thinking concentrates on individual "bits" of behavior; the analogical view is more concerned with multiple levels and contexts of behavior).

Some therapists emphasize reconstruction of past events, whereas others choose to deal only with current behavior as manifested during the therapy session. Some therapists favor verbal exploration and interpretation, whereas others favor utilizing an action or experiential mode of treatment, either in the session itself or by requiring new behavior outside the interview. Some therapists think in terms of problems and symptoms and attempt to decode or understand possible symbolic meanings of symptomatology. Other therapists may focus on the potentials for growth and differentiation that are not being fulfilled. Some therapists utilize one or a limited number of methods in dealing with a whole range of "problems"; others are more eclectic and attempt to tailor the treatment techniques to what they consider the specific requirements of the situation.

With the therapeutic focus on one person, the emphasis is often on the individual's perceptions, reactions, feelings, and on the equality of status between the individual and the therapist. When two people constitute the operative system, attention is directed to interactions and relationships. Therapists who think in terms of a unit of three people look at coalitions, structures, and hierarchies of status and power. The number of people actually involved in the interviews may not be as important as *how many people are involved in the therapist's way of thinking about the problem.*

Three Basic Strategies of Family Therapy

Elsewhere, the authors have singled out three major strategies that are especially useful for beginners.

1. Those that facilitate communication of thoughts and feelings.

2. Those that shift disturbed, inflexible roles and coalitions.

3. Those that aid family role-assumption, education, and demythologizing.

These three strategies are not necessarily mutually exclusive and may overlap. To some extent they represent different frames of reference for understanding and dealing with the same family phenomena. Nevertheless, each strategy seems to offer something unique in its concepts and techniques. In a clinical situation the therapist will be hard put to remain a purist. A therapist's efforts to clarify communication may produce shifts in family coalitions or initiate an exploration of family myths that may lead to a considerable outpouring of previously concealed affect.

Although some specific therapeutic strategies are listed above, there is no one magical phrase or technique that will "cure" the family. Instead, interventions are a series of repetitive maneuvers designed to change feelings, attitudes, and behavior. If the overall goals and strategy are kept in mind, specific interventions will suggest themselves and be modified by the particular circumstances as well as the therapist's own style.

What is unique in family therapy is not so much the specific approach but rather the overall focus and strategy that aims to evaluate and produce a beneficial change in the entire family system.

Models of Family Therapy

The different models of family therapy can be distinguished by their data base, goals, treatment techniques, selection criteria, explanatory concepts, and the stance of the therapist. Over time there has evolved a differentiation of three distinct but overlapping orientations to family treatment, with each one closely related to a different theoretical orientation. These are:

1. *The insight-awareness approach*: Observation, clarification, and interpretations are used to foster understanding (and presumably change).

2. *The structural-behavioral approach*: Manipulations are devised to alter family structure and conduct.

3. *The experiential approach*: Emotional experience is designed to change the way family members see and presumably react to one another.

Insight-Awareness Model

The insight-awareness orientation has also been known as the

"historical," the "psychodynamic," or the "psychoanalytic school." In a real sense, this is the oldest school of family therapy since it grew naturally out of the psychoanalytic tradition. One of the earliest family therapists was a child analyst, Nathan Ackerman, who utilized his analytic background to inform and lend substance to his approach and understanding of families. One has only to read the transcripts of his sessions to appreciate the influence that analytic thinking and techniques had upon his work with families and couples.

By changing the transference distortions, correcting the projective identifications, and infusing insight and new understanding into the arena of interpersonal turmoil and conflict, this school of family therapy attempts to change the functioning and interrelationships of the various members of the family or marital system. The data base is derived from historical material of the current and past generations, from transference/countertransference phenomena, unconscious derivatives, and resistances. A basic assumption is that intrapsychic conflict, interpersonal problem foci, and defensive and coping mechanisms are modeled and taught within the family system. Portions of the data base that are of paramount interest to the practitioners of this model are dream and fantasy material, fantasies and projections about other family members, and transference distortions about other family members and the therapist. Understanding the history and mutations over time of these dynamics is considered crucial to understanding current dysfunction. A broad use of the terms "transference" and

"countertransference" is used here. Such phenomena can be understood in terms of transference on at least five levels: (1) man to woman; (2) woman to man; (3) woman to therapist; (4) man to therapist; (5) couple to therapist. Just as there are multiple transference reactions, there are multiple countertransference responses. It is assumed that understanding of unconscious derivatives and their resistances is usually necessary to effect change.

The theoretical underpinnings of this model are the familiar ones of psychoanalytic thinking, including especially topographical concepts of conscious, preconscious, and unconscious; constructs of the id, ego, and superego; and concepts that focus on the interaction of individuals, such as secondary gain, transference, and projective identification. While early analysts, who opted for a more interactional model (for example, Nathan Ackerman), criticized this model for its lack of attention to, and language for, interactional data, more recent authors in the analytic tradition of object relations (for example, Henry Dicks) have applied these concepts to the understanding and analytic treatment of these interactional problems.

The major techniques of this model include clarification, interpretation, exploration of intrapsychic as well as interpersonal dynamics, and development of insight and empathy. Using such analytic techniques with an individual in the presence of a spouse or other family member represents a

unique development. At the very least, it is possible that while the therapist is addressing an interpretation to one individual, the other members of the family can utilize the interpretative method to explore their own conflicts and difficulties, as well as to begin to understand the family member more fully with the input from the therapist.

The goal is to foster understanding and insight in order to effect change in individuals as well as in the family unit.

Table 20-3. Models of Family Therapy

Model (Approach Or School)	Representative Therapists	Primarily Derived From A Model Of Learning &/or Changing	Data Base	Goals	Techniques
1. Insight-Awareness (also known as Historical, Psycho-dynamic, or Psychoa-nalytic)	Ackerman; Nagy & Spark; Paul; Nadelson;	Understanding	1. History 2. Unconscious derivatives 3. Transference/ counter-transference	Foster understanding and insight to effect change	1. Observation 2. Clarification 3. Interpretation
2. Strategic-behavioral (also known as Systems, Commun-ications, or Structural)	Palo Alto Group (Jackson, Bateson, Haley, Satir); Sluzki; Bowen; Minuchin; M. Erickson; Palazzoli	Observing	1. Sequences 2. Commun-ication 3. Rules 4. History 5. Behavior	Change family structure, communication pattern, and roles, which changes perception and behavior	1. Strategies desensitize and/or condition patient to alter family structure and behavior 2. Observe and transform using directives

3. Experiential (also known as Existential)	Whitaker; Bowen; Nagy	Imitation (via the experience) and identification	1. Observed 2. Shared feelings (including the therapist's feelings)	Change ways family members experience and presumably react to each other	1. Therapist designs and/or participates with family in the emotional experience 2. Empathy

The Strategic-Behavioral Model

This school of family therapy emphasizes understanding sequences, patterns, and structure, with the emphasis on manipulation as a technique to effect change. The data base is derived from elements of the structural school, systems theory, behavioral theory, and communications theory.

The orientation that is unique to the family movement and that has given it impetus is the systems understanding of family function and dysfunction. The family systems approach uses the metaphor of communication theorists such as Gregory Bateson and the computer metaphors of our modern age, such as feedback loops, communication exchange, and so forth. These explanatory concepts lead the practitioner to focus on a data base composed of repetitive interchanges between individuals in a marriage or family that occur in the here and now (as opposed to the interest in the history of the relationship in the psychoanalytic model), and that define, limit, and structure the behavior and experience of the individuals in the system. While the assumption of the psychoanalytic model is that

individuals in a family group can perceive and distort the working of the group, the assumption in this model is that the group is greater than the individuals who compose it, and that the individual is governed and regulated by this greater entity (the family or the marital dyad). This model works on the assumption that there is no such thing as non-behavior—even silence is a means of communication. There is a focus on syntax (ways of communicating), semantics (the meanings of communicative acts), and pragmatics (the effects of communication).

The treatment techniques (or strategies) in this model include: (1) changing family transactional patterns; (2) marking boundaries; (3) escalating stress; (4) assigning tasks both within and outside of the therapy session; (5) focusing on, exaggerating, deemphasizing, or relabeling symptoms; (6) reframing; (7) manipulating mood; (8) clarifying communication; (9) interrupting repetitive interactional patterns; and (10) prescribing paradoxical injunctions. In one way or another, the techniques are intended to interrupt current repetitive interpersonal behaviors and introduce new interactional patterns that will result in the creation of new and more mature, or less symptomatic, interactions and inner states.

The behavioral component of the model grows out of the behavioral orientation that has historically flourished parallel, and in reaction, to the psychoanalytic tradition. The data base for this orientation is quantifiable,

measurable behavior, whether internal (thoughts) or external (actions). Explanatory concepts are those of the behavioristic tradition; for example, stimulus, response, and concepts of learning theory such as classical conditioning, operant conditioning, schedules of reinforcement, and so forth. With the behavioral model becoming increasingly applied to interactional systems such as the family, other concepts have been introduced to expand the model into the interpersonal sphere. Perhaps the most influential has been the behavior exchange model of John Thibaut and Harold Kelley, in which it is postulated that the benefit and cost ratio for each individual is an exchange situation (for example, marriage) has a major influence on the course and outcome of that relationship. The goal in this model is to effect change in discrete, observable, measurable behaviors that are considered problematic by the individuals seeking assistance. As opposed to the psychoanalytic model, which often seems to have more ambitious goals of character change and "insight," this model tends to focus more on discrete problem areas defined by clear behavior patterns. Thus, treatment in this model tends to be briefer and more circumscribed. Emphasis is placed not on pathology but upon behavioral deficits and excesses that are to be changed. If undesired behaviors are eliminated (for example, husband hitting wife), it is not assumed that more social behaviors will necessarily spontaneously emerge, but rather that the therapist might be required to teach new and more adaptive behaviors to the spouses or family members.

Techniques include helping family members learn means of effecting the desired behavior in another member. Some of the major tactics utilized are behavioral contracting based on good faith or *quid pro quo* agreements (if you do this, I will do that), training in communication skills, training in effective problem solving, and combining positive reinforcement with a decrease in destructive interchanges.

The stance of the therapist is quite active since he sees his job as a means to introduce behavior change into the repertoire of the family members. While in the past behaviorists have written little about how they handle individual and family resistance to their suggestions, making them sometimes appear somewhat naive to the experienced clinician, they are increasingly paying more attention to resistance and at times suggest the use of paradoxical injunctions more typically enunciated by the systems theorists. Indeed, it has been suggested that there is a congruence, if not a growing similarity, between the techniques of the behaviorists and the systems interventionists.

This school of family therapy avoids the traditional techniques of individual therapy. It does not concentrate on eliciting historical material, it is not particularly interested in fostering increased awareness or expression of buried feelings, and it does not engage in interpreting psychodynamics. It does not consider understanding and insight to be important or essential in

producing change. Instead, this group of family therapists manipulates variables such as the participants and rules of therapy by active suggestion and direction. They may utilize paradoxical commands and clearly attempt to alter the arrangement and intensity of family coalitions.

The ultimate goal of this technique is not so much to foster understanding and insight as to change family structures, the communication patterns, and roles—changes that will presumably change perception of the individuals in the family unit and ultimately change behavior.

Experiential-Existential Model

This school believes that it is vital for the therapist to be aware of and take into account not only the experience of each member of the family, but also the therapist's experience as an outsider entering the family. Empathy is the key here—that is, the ability of the therapist to experience what a particular family member feels at any given moment in the context of the family. The data base is not only what the therapist sees, but what he and/or the family *feel.*

The data base is derived from situations that the therapist designs, permitting him to participate with the family in an emotional experience. If a subject cannot be discussed, the therapist brings it up. His use of empathy enables him not only to understand what an individual family might be feeling

but allows him sometimes to serve as a model for identification. He may be a role model for a family or an advocate and help the family achieve something. If a family is starving, the family therapist helps change the family by going with them to get food stamps.

Thus, in this form of therapy the therapist offers himself as a real person in order to minimize the distance between himself and the family. He is always on the side of the family, but his behavior is different from any other family member and is designed to promote more functional behavior.

The goal is to change the way family members experience and presumably react to each other. A secondary goal is growth and differentiation of family members.

Relationship of Theory to Therapy

It is important and interesting to note that there is often not a one-to-one match between a practitioner's theoretical position and his therapeutic techniques and performance. This is true, of course, for all fields of therapy and not just family therapy. However, the field of family therapy has been noted for its vigor rather than rigor, as well as for its energetic deployment in all kinds of human problems. There has been less attention to the development of a theoretical understanding of family functioning and family pathology. It follows, then, that while we can isolate three theoretical schools

of family therapy, the practitioners and what they do in a family session can be classified from points of view other than that of their theoretical metaphors or concepts. For example, in one of the earliest and still useful classifications of family therapists, Chris Beels and Andrew Ferber talk of conductors (therapists who take charge and direct the family sessions) and reactors (therapists who wait for stimuli to arise from the family interaction before beginning to shape those interactions with subtle and increasingly direct intervention. In this schema, Nathan Ackerman, Norman Paul, and Murray Bowen can be seen as conductors, while Carl Whitaker and Ivan Nagy are reactors, and Jay Haley and Don Jackson are described as reactors who are also systems purists, a reference once again to the theoretical stance. Both points of view —the theoretical stance of the practitioner and a more descriptive term relating to his style while working with families—are useful in the conceptualization and teaching of this field.

Other Approaches

Certain approaches are associated with innovative therapists. Don Jackson and others of the Palo Alto group focused much of their attention on pathologic communication. Together with Gregory Bateson and others, Jackson wrote about the "double bind" as playing a prominent part in family difficulties. Jay Haley, originally a member of the same group, has recently become more interested in the paradoxical intervention approach of Milton

Erickson. Virginia Satir, long interested in the communication frame of reference, has recently moved into the area of family growth enhancement. A current member of the Palo Alto group, Paul Watzlawick, believes that "illogical," unreasonable action can produce the desired change. He borrows from the concepts of communications, double bind, and action-oriented techniques of problem resolution.

Murray Bowen, a family therapy pioneer, concerned himself on one hand with ideas about the lack of differentiation of various family subsystems and, on the other hand, with the extreme disengagement of many individuals in families—individuals who hardly seem to participate meaningfully in the family. He has used a variety of techniques over the years, including seeing in therapy only the healthiest family member and using that person as the agent, or model, of family change. He has used letters written from one family member to another as an indirect method for stirring up change in family systems.

Carl Whitaker believes in the technique of paradoxical intention and manipulates the family members into believing the therapist has to overpower them, as if they are all engaged in a battle. He believes that the therapist has to deprogram himself and advance his own growing edge in order to conduct effective family therapy. In many ways Carl Whitaker appears to see family sessions in experiential terms with a good deal of

emphasis on “feeling states” during the session and during immediate feedback.

Jerry Lewis, Robert Beavers, and their coworkers have found that well-functioning families may have particular attributes that are lacking in dysfunctional families. A family therapist can apply this knowledge in his work as follows:

1. The therapist works as collaborator, implying respect for the other’s subjective world view. He demonstrates with the treatment family an affiliative rather than an oppositional attitude, and a commitment to negotiation as the basis for treatment.

2. The therapist conveys a belief in complex motivations, especially with respect to the reciprocal nature of human interactions, paying special attention to (and including himself as being involved in) the interactions that occur in the family-treatment setting.

3. The therapist needs to be a model of clarity, spontaneity, non-intrusiveness, and permissiveness with respect to the expression of all types of affects, frequently expressing empathic comments, acknowledging other people’s views, and demonstrating a caring attitude.

An authoritarian style of treatment, in which the therapist sets himself up as the all-knowing and all-powerful manipulator of the family’s

interactions and goals, may at times prove to be helpful, even though it contradicts the model just outlined. People in some sociocultural settings are accustomed to a directive style and may be left confused or unconvinced by an invitation to share authority and responsibility. This directive style may be needed at times with the most dysfunctional families, aiding them in becoming less chaotic and enabling them to move to an intermediate "adequate" stage.

We believe it is wisest to employ a pluralistic approach; that is, tailoring the approach to the problem, rather than using a single approach in all situations.

Specific Techniques

Many specific techniques (in addition to the basic three that have already been described) can be employed during the course of treatment.

Family Tasks

Family therapy focuses on behavioral change. Accordingly, many family therapists routinely prescribe various tasks for the family to perform during the session and, more commonly, between sessions. The rationale for this is to have the family work out and repeat behavior patterns outside the session. The therapist (rather than the family) takes control of the symptom or

problem and helps realign coalitions. For example, family members that have not had any recreational activity together in several years may be asked to take a vacation together, or a husband and wife may be instructed to discuss a family secret.

Special techniques have been devised for helping lower socioeconomic class families, ghetto families, and highly disorganized families. The work of Salvador Minuchin and others indicate that it is both necessary and possible to help these families deal with some of their basic needs by using indigenous populations as family advocates when dealing with social agencies; by mobilizing the most constructive forces in the family system; and by providing training in basic task performance. Such tasks might involve getting the family registered with a housing agency. This serves to train and strengthen the family unit's ability to handle its problems in concrete terms; it also helps to solidify the often shaky and inadequate manner in which the family provides for its elemental needs. In this way the family can gain the experience of accomplishing something meaningful for itself during its daily struggle for existence and stability. These methods may be more useful than the more symbolic, attitudinal, psychological techniques appropriate for middle- and upper-class families.

Prescribing the Symptoms[3]

Don Jackson, John Weakland, and Jay Haley have written about a therapeutic technique in which the therapist "prescribes the symptoms." After the therapist "orders" the family members (or individual) to intensify effect and the frequency of the symptoms, the symptoms begin to lose their autonomy, mystery, and power. Whereas they previously seemed to have been out of control, they now appear to come under the therapist's control. The participants in the behavior become more conscious of them, and often the disruptive behavior lessens or disappears. A marital couple that has engaged in nonproductive arguing may be told to continue fighting and even to increase it; for example, the couple may be ordered to fight about the menu before dinner, so that they can enjoy the food. This injunction jars the continuing process, and they may rebel against the outsider's orders (which is often a necessary step to change).

The therapist is obligated to follow through to make sure that the directions have been followed in the way that was intended. The therapist does this by seeing the family in his office on an ongoing basis, by asking more than one family member what changes have taken place, or by visiting the family at home.

Some therapists write a family prescription after the initial session, telling the members they will receive a message about what the therapist thinks is wrong with the family and what needs to change. This gives the

therapist time that is not available in the heat of the session and creates an opportunity for a more accurate formulation of the family's problems. The prescription is a typewritten letter sent separately to each family member. It may describe what is happening in the family and ask each member to continue his course of action. For example, the therapist agrees with Joe (the identified patient) that he should not move out of the house at present. His parents, however, are told that they should continue to vacillate by alternately supporting his moving out and undermining it. This prescription was sent to a family with a thirty-two-year-old son who kept "messing up" each time he left home, so that he was always forced to return to the family. The prescription had the effect of making Joe angry, of shifting him out of the house, and of identifying what his parents were doing. For some families there is something quite powerful about a well-thought-out message that is "official" and to the point.

Family Reconstruction

An in-depth exploration of family background is believed to improve the therapeutic outcome. All family participants explore their own life histories, learning about themselves and one another in the process. Such techniques as *role playing* and *psychodrama* can be used to bring out significant past events in the lives of families. A "family map" or genogram is used to diagram the family of origin.

Humor and Banter

With the technique of humor and banter, the therapist intentionally makes humorous comments in order to ease a tense moment or to highlight a problem area in the family. The therapist exaggerates aspects of an individual's or a family's behavior. Prerequisites include, but are not limited to, the family and the therapist having a sense of humor and being able to maintain a good rapport.

Including the Family of Origin

James Framo believes that involvement of the family of origin is one of the most effective techniques in family therapy. It is based on the accepted rationale that current family problems are grounded in part on reenactments of previous problems that the husband and wife have had with their own families of origin. The therapist routinely has at least one session with each marriage partner, together with that partner's own family of origin. The individual's spouse and children are not present in order to minimize emotionalism. This enables the therapist to discuss the here-and-now "corrections" with the aim of increasing present relatedness to the spouse's current family. There is usually a great deal of resistance to this technique.

Coaching

With the coaching technique, the therapist acts like a coach in helping the family member make changes. For example, the therapist may explain concepts and theories, give examples, draw diagrams, ask questions, make predictions, or suggest alternatives. The therapist can get up from a chair and stand behind family members whispering instructions or a supervisor can phone instructions into a specially equipped room.

Mourning and Empathy

With the technique of mourning and empathy, the therapist elicits unresolved grief for a parent, child, or relative in order to effect change. This technique is borrowed in part from Gestalt therapy, in which there is an attempt to release long-hidden feelings, expectations, and emotions.

Visits

With the voyages technique (modeled on the home-visit techniques) the therapist travels wherever necessary to bring leverage to the family problem. For instance, he may go to schools, homes, housing projects, churches, clinics, bars, hospitals, and so forth. He meets with individuals or agencies that influence the family (for example, the principal of a school).

Self-Disclosure

In individual psychotherapy the therapist usually does not reveal much information about himself. The therapy is focused on the patient's problems, feelings, and behavior rather than on those of the therapist's. Some family therapists prefer, however, to use themselves as a major instrument in changing the family by revealing material about themselves, their nuclear and extended families, job philosophy, conflicts, goals, and plans.

This technique has not been accepted for most training programs because of the belief that it may create more problems than it solves.

Guided Fantasy

With the technique of guided fantasy, the therapist helps the individual share his internal system of fantasies and thoughts with other family members. The rationale is that "daydreaming" can provide people with a powerful tool for their growth and problem solving. It is important to have each member share his or her inner thoughts with the rest of the family, so that they can be empathic in helping the individual grow.

Family Sculpture

Family sculpture is a technique in which the therapist asks one or all of the members of the family to create at a given moment a physical representation of their relationships by arranging their bodies in space.

Alliances and estrangement can be concretized by such an exercise. The technique can be used as part of the diagnostic workup to generate hypotheses or to represent a concept being worked on concretely during the course of therapy. Both the content of "the sculpture" and the way "the sculptor" (that is, family member) uses mass and form are examined. It is an excellent technique for nonverbal families.

Multiple-Family Group Therapy

The technique of multiple-group therapy brings together several family units into a group just as traditional group therapy brings together individuals. These groups may meet on a regular basis. The size of such groups may vary from three to eight families at any one time. Groups can include infants and those old enough to be living independently, as well as significant others such as grandparents, in-laws, and fiancés. The duration of the treatment on an outpatient basis can be from three months to one year, whereas on an inpatient basis the family might participate in treatment usually only as long as the identified patient remains hospitalized.

This technique seems to work best when there is a good balance between the families who have been in the group previously (that is, more experienced families) and those that have not. A balance between interfamily and intra-family interaction is also desirable.

As part of the process, there is a great deal of mutual disclosure and sharing, as well as peer review and evaluation of what has gone on. Socializing between these families outside of the group formal sessions has been used but with uncertain results.

Gould has summarized the process of such groups as follows:

1. They are sharing and interactional rather than analytical.
2. They are fast moving, experiential, often hectic, and very much in the here-and-now.
3. There is a great deal of crucial interfamily contact that makes it possible for families to learn from one another.

It has been claimed that multiple-family therapy groups, in contrast to individual family treatment sessions, have very few dropouts. They are thought to be especially useful when the family expresses a great deal of denial.

Network Therapy

Ross Speck and his associates have described a novel approach to help the identified patient. Members of the kinship system, friends of the family, and all significant others who bear on the problem, are brought together to work on the problem. This adds healthier voices to the mix. These groups

meet for three to six biweekly sessions lasting about four hours. The meetings are held usually in the identified patient's home, and thirty to forty-five people can be involved.

Psychodrama and Role Playing

Psychodrama and role playing techniques have also been used to help families enact family problems and work out new patterns. They are especially useful in nonverbal families. In role playing or reverse role playing, one partner either plays himself in a hypothetical situation or takes on the role of his partner, often switching roles back and forth and commenting on the observations, feelings, and behavior elicited. Role reversal is believed to be useful for developing empathy in family members.

Gestalt Therapy

In adapting Gestalt therapy to family problems, the therapist stresses that the only real time is the present, and he does not rehash the past. He stresses that each individual is responsible for his or her own behavior (countering the familiar resistance, "I did it only because he or she made me do it"). He stresses that symptoms and conflicts are the here-and-now expressions of unresolved situations of childhood that can be finished in treatment. Significant attention is paid to nonverbal behavior.

Weekend Family Marathons

Weekend family marathons have been reported in which one or several entire family units get together for extended periods (anywhere from eight to twelve hours or longer) with leaders ("facilitators") for a variety of intensive types of encounters, usually including affect catharsis and nonverbal experience.

Behavioral Approaches

Behavioral approaches deal with the means by which certain behaviors can be learned, reinforced, or extinguished, irrespective of the original causes for such behavior. Even relatively minor changes in the behavior of one family member, or in a dyad, may bring about a significant alteration in the behavior and feelings of other family members. External behavioral change may precede internal attitudinal change.

Techniques of behavioral therapy include assertiveness training, operant conditioning, relaxation and desensitization, contingency reinforcement, and cognitive behavior modifications. Family members can be utilized as co-therapists in various behavior modification exercises that are rehearsed initially in the therapist's office and are assigned for practice at home.

Videotape

Therapists often find it beneficial to review their sessions and to have a record of an entire course of therapy. Immediate playback of a videotape helps families attain some psychological distance, makes them increasingly self-aware, helps to correct distortions or conflicts about communication, and is invaluable in revealing the important nonverbal aspects of interactions that might otherwise be lost. Families often comment constructively while viewing their own videotaped interactions and see things that they might deny when a therapist points them out.

Audiotape

Audiotape has also been used as an adjunct to family therapy. A tape of a session can be made and the family can take it home and listen to it, or a tape can be made at home and then played at the session.

One-Way Mirror

The family meets in a room equipped with a one-way mirror. The therapist can leave the family alone and observe its members through the one-way mirror or have one or more selected members, including an estranged member, observe the interactions. The family member comes out of the "heat of battle" and is presumably then able both to distance himself from

what is going on and to change the unwanted behavior in the family system.

Some co-therapists find it useful for one therapist of the team to be in the room with the family while the other therapist observes (alone or with selected family members). The therapy can be interrupted at any time, so that the co-therapists can confer and plan. The therapist who functions primarily as an observer can be very objective, and this will facilitate treatment.

Conclusion

Family therapy is an approach rather than a single technique. It is a group of therapeutic interventions, all focusing on the family, but directed toward a variety of specific therapeutic goals. Therefore the relative importance of a particular guideline depends in large part on the extent to which the therapist uses the family model. For instance, if the therapist treats *all* problems with family therapy, then guidelines are not important. Conversely, when different problems are treated in different ways, then guidelines become crucial.

Until about ten years ago, indications and contraindications for family therapy had been based on ingenious hunches regarding treatment efficacy in a specific situation and on clinical experience (a term once defined as "making the same mistake for thirty years"). More recently there have been some controlled outcome data that define situations in which family or marital

therapy might be the treatment of choice. These situations include:

1. Marital therapy for a marital problem.

2. Marital therapy for sexual dysfunction.

3. Family therapy for certain childhood and adolescent behavior problems.

4. Family therapy for the "chronic patient" (i.e., those in need of long-term continuing care and rehabilitation).

Any final authoritative pronouncement as to when and which family therapy approach should be used must be withheld until more controlled data are available comparing family therapy with other types of treatment.

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Notes

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3 Also called "paradoxical prescription [or] intention," "symptom scheduling," "negative practice," or

“reverse psychology.”