Psychotherapy Guidebook

Family Context Therapy

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DEFINITION

Family Context Therapy is based on the operational principle that families are modifiable through changing the environments within which they live. Families have many environments and are also involved in creating environments for themselves. The environmental forces provide a complex dynamic for the functions of individuals and the total family. Creating changes in these forces to reduce pressures toward destructive functioning and to accentuate pressures toward family adjustment and accomplishment is the adopted task of the family context therapist.

Therapists plan and carry out selective efforts to modify the families' contexts whenever family functions are being limited or destroyed by aspects of the environment, and new environmental resources and opportunities are needed for developing beneficial family processes. Targeted changes are sought in the social, functional, and physical aspects of the community at large, the basic and helping institutions within it, and the families' immediate environments. Though the therapist's primary and direct interventions are in the environment, the higher goals of family problem solving and family

development are reached through the impacts of environmental modifications on the family.

HISTORY

In 1963, I was assigned by the National Institute of Mental Health to a long-term program to reduce the isolation of hospitalized mental patients from their families. This assignment was a response to the growing experience that family group therapy was proving ineffective with the majority of hospitalized patients. Since that time much of my professional work has been turned toward the goals of understanding the problems that create patient isolation, developing and testing methods to reduce isolation, and constructing a theoretical framework to lead to specific techniques for intervention.

In 1964–65, in relation to this program, I was sent by NIMH to study about 150 African and Asian hospitals and other medical facilities, including some for psychiatric patients. In most of the observed settings, families accompany patients and stay with them full-time during the period in hospital. The insights developed during this study (Bell, 1970a) provided the experiential base on which Family Context Therapy was conceptualized, developed, and applied in a range of projects (Bell, 1976, 1977a, 1977b). These projects, and others, extend far beyond families that include mental

patients. Projects have been focused especially on families where one member is institutionalized, as in all types of hospitals, nursing homes, prisons, and shelters.

I presented the rudiments of a formulation of Family Context Therapy in 1969 at the Memorial Conference for Don D. Jackson. An opportunity in 1973 to become free from many years of administrative responsibilities and to turn attention to program development in a hospital gave me a fresh chance for experience and thought, for defining the nature and scope of Family Context Therapy, and for testing methods. The timeliness of this development has been accentuated by the growing acknowledgment of the need to accomplish family-oriented improvements in our community and national life.

TECHNIQUE

Techniques have been and are being developed. Typically, they involve supporting and expanding outside resources for families, facilitating their use, and improving the settings from which resources, energy, and time for improved family relations may be drawn. Inevitably, the methods used to induce environmental changes are multiform and specific to target families. The most common locales for the development and application of change methods are within community institutions. As an illustration, analysis is being made to discover ways to improve family access to various community

institutions. For instance, on the assumption that intensified family involvement in schools will improve the morale of parents, their investment in the work of the school, the performance and success of their children, and the internal functioning of the family, the context therapist takes on the task of devising changes in the school to improve family access. The therapy is accomplished when and if improvements are made in access with positive results for families, which is not always the case.

Most of my work has been and continues within hospitals, changing contexts for all manner of patients. A few interventions, made by colleagues and me, can serve as examples: changing policies, for instance, in regard to visiting; removing physical and other barriers to family access — opening locked doors, easing parking problems, arranging for family meals; educating staff to allow families to do tasks for patients, especially those carried over from home, such as feeding the patient, or serving as monitor; assuring that patients, according to their condition, have the opportunities and privacy for continuing to participate in family life and affairs; and ordering the patient's program and opportunities for family involvement according to anticipated placement, such as return to home, transfer to an extended care facility, or life in the hospital until death.

Such interventions are not random. They are based on many sources, such as direct experiences with families; identification of features of the

hospital or patient programs that have actual or potential impact on families, and the quality of that impact; projections in fantasy of an ideal hospital for patients and families; study of family relations of nonmedical institutions, for models to apply; application of theories and investigations of organizations, their interrelations, and process of modification, from the fields of sociology, ecology, anthropology, and political science, to understand and change the hospital.

Staff are directly involved in the planning of interventions; comprehensive or modest programs for change are set forth; evaluations of timing and of needed supports for change are conducted; complex education efforts and negotiations are commonly undertaken before determining that a change can be instituted; and, when an intervention is made, studies of the extent and frequency of family involvement follow. Through such approaches, hospital culture changes are accomplished for the sake of families.

APPLICATIONS

The first application is in extending the theory of family change. As dramatic as the step from individual psychotherapy to family therapy, Context Therapy provides a corrective to the constriction of family-centered thought.

Second, family context processes suggest therapy methods for many

institutions — prisons, courts, business and industry, recreation, commerce, churches, synagogues, and other religious organizations, to mention a few. Within each institution, the interventions must become specific, however, to its program and staff, and to the families who are associated.

Finally, Family Context Therapy provides a bridge for family therapists to many programs and persons concerned with family welfare, though they are not engaged in family therapy. Collaboration may be eased with family education, Planned Parenthood services, public health services, family social work, community planning, recreation services, institution administration and development, family law and justice, personnel services, religious communities and services, and many others. The efforts will concern such issues as: the relative priorities given to the family as a whole in relation to those directed elsewhere; the family implications of centering resources on individuals, programs, and institutions; and the interactive effects of various programs for family welfare — do they complement, compete, or cancel out each other. All these issues are being raised, but typically in relation to recipients of program resources and services. If the recipient is other than the family, redirection of efforts and resources through Family Context Therapy may accomplish both stated and family objectives.