Portrait of a Man and His Wife, artist unknown, late Fifth Dynasty, circa 2500 B.C., Egypt. Courtesy of Honolulu Academy of Arts, Honolulu, Hawaii. Used with permission.
CHAPTER 1

The Field of Couples and Family Therapy: Development and Definition

Objectives for the Reader

- To understand the historical development of family therapy as it influences present-day theory and practice
- To define family therapy and to begin to differentiate it from individual and group formats and strategies
- To recognize and be able to use basic family system concepts in evaluation and treatment

Introduction

Family life has always been the main building block of human connections, but treating the family has only come into its own in the last 50 years. Families as basic human systems are different in several essential ways from other types of human groups and relationships. Love of and bonding or attachment to family members are to some extent biologically built into the nervous system as survival devices, and our most intense emotions, both positive and negative, are reserved for family members. Emerging research investigating the biology of attachment is growing. Scientists are looking at genetic factors and psychophysiological responses in infants that shape attachment. Hormones oxytocin and vasopressin, known as neuropeptides, are thought to play a role in forming attachments to others (Hanna S, 2014).

Marriages and families perform vital socialization tasks for children and for society at large. It has been a commonsense view that we are all shaped by what we experience in our families of origin (i.e., comprising our parents, siblings, and extended family). For most people what occurs in their current marital or family system is a significant element in their general sense of well-being and functioning. Furthermore, as we discuss in subsequent chapters, the family has important effects on the quality of life and on the course of psychiatric illness (e.g., a mood or psychotic disorder) and medical illness.

In the past four decades, mental health professionals have moved past a singular focus on individual dynamics to examine the enigmatic processes that lead to family distress. They have developed a set of theories grouped loosely under the name systems theory, which examines how people or aspects of a system affect one another. Using this theory, they have devised both a paradigm for explaining human behavior, one that looks past the individual, and a set of techniques for reducing distress and improving family functioning. As we discuss in this book, the mental health field is gradually incorporating these changes so that a comprehensive biopsychosocial model of behavior is becoming a reality.
Development of the Family Therapy Field

Although exciting and often efficacious, family therapy can be confusing for the beginner. Just as psychoanalysis has spawned a range of perspectives that include classical (Freudian), interpersonal, and relational, the family therapy field is differentiated by approaches that include (among others) family systems, structural, strategic, psychodynamic, experiential, cognitive-behavioral, integrative behavioral, behavioral, family focused, emotionally focused, narrative, and psychoeducational. For some, it may be difficult to distinguish the thinking that lies behind the personal styles of charismatic family therapists. For others, it may seem difficult to synthesize a coherent family theory from the variety of existing orientations. Yet, as in any field of academic study or clinical practice, family therapy’s present state can be understood partly by looking at its own evolution. How did this state of affairs come about, and how is it changing today?

In a broad sense, 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 in the development of individual problems was mentioned by Confucius in his writings and by the Greeks in their myths. The early Hawaiians would meet as a kin network (i.e., family) to discuss solutions to an individual’s problem. For a long time in Western culture, however, what we now call mental illness and other forms of interpersonal distress were ascribed to magical, religious, physical, or exclusively individual factors.

It was not until the early 1900s that individual psychodynamics was delineated as a major determinant of human behavior. Although Freud stressed the major role of the family in normal and abnormal development, 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 not as individuals removed from family relationships. In particular, psychiatric social workers in child guidance clinics began to recognize the importance of dealing with the entire family unit around child-focused issues. However, the psychiatric community in general was dominated by Freudian thinking until the late 1960s.

In the psychiatric literature, psychoanalysts reported experiences in treating a marital pair as early as the 1930s. They began to see a series of marital partners in simultaneous, but separate, psychoanalyses in the following decade. This approach was quite unusual because psychoanalysts generally believed that this method of treatment would hinder the therapist in helping the patient, on the assumption that neither spouse would trust the same therapist and consequently would withhold important material. As a result, the other marital partner was usually referred to a colleague. The two earliest marriage counseling centers in the United States began to treat couples in the early 1930s.

The early 1950s, which might be considered the heyday of American social psychiatry, witnessed the first consistent use of family therapy in modern psychotherapeutic practice. In New York, Ackerman began to use family interviews consistently in his analytic work with children and adolescents.

Not until the early 1960s did the modern field of family therapy begin to take shape. A backlash against psychoanalytic orthodoxy coupled with the social activism of the era propelled a handful of early theorists into leading roles in a social revolution within the fields of psychiatry, psychology, and social work. This group assumed that family, group, and community were the keys to effective intervention. Group therapy, family therapy, and milieu therapy in inpatient settings flourished during this period, as did community mental health. Various schools of theory and practice emerged, and leading journals (e.g., Family Process) were established. At
the same time, teaching practices were marked by innovation, as the use of one-way mirrors and videotaped interviews moved the practice of therapy out into the open for study and discussion. As a result, many mental health professionals were drawn to learning about and practicing family therapy.

During the 1970s, the scope of family therapy was expanded to apply to a broad range of psychiatric problems with families differing widely in socioeconomic background. In particular, Minuchin’s contributions to the development of briefer, crisis-oriented methods began to address the needs of families with multiple problems. This was a decade of ferment as well, as traditionalists proposing more psychodynamic or biological models battled with family clinicians over territory, training funds, and the right to the “best” explanation for how psychopathology occurs, is maintained, and is remedied. During this period, researchers also began to look at process variables that contributed to treatment efficacy (Gurman and Kniskern 1978; Wells and Dozen 1978). Finally, the number of available clinical models of marital and family therapy expanded exponentially. During meetings of the American Psychiatric Association, considerable prominence was given to family therapy topics. Interdisciplinary organizations such as the American Orthopsychiatric Association became a home for family therapy presentations. Except for relatively infrequent, small conferences, family therapists presented their major findings at meetings of these other professional organizations and were published frequently in other professional journals until the early 1970s. Later that decade, various clinical techniques in family therapy became more distinctively identified as schools, and family therapy began to become a distinct entity. As the American Family Therapy Association and the American Association of Marital and Family Therapists grew, training conferences nationwide evolved. For many mental health professionals, family therapy seemed to be the right treatment at the right time.

During the 1980s, the early polemics faded and clinicians and researchers continued to establish innovative practices and particular treatment packages for specific individual, marital, and family problems. For example, data had made clear the existence of an important biological component in the etiology of schizophrenia and other mental disorders, and psychopharmacological treatment became an accepted practice. Although most family therapists no longer viewed family therapy as the primary treatment for schizophrenia, they considered family psychoeducation—a particular form of family treatment—to be one important component of a multimodal intervention. In 1988, marriage and family therapy was added to the list of four core mental health professions eligible for mental health traineeships under the Public Health Service Act, Title III, Section 303(d). In addition, issues of gender and culture became more prominent in the field, and the differences and similarities in family function among ethnic groups were addressed clearly for the first time.

Throughout the 1990s, some family therapists expended much effort to establish marital and family therapy as a differentiated, autonomous profession. The marital and family therapy degree is now widely established, and marital and family therapy has become a separate and licensed profession. However, the downside of this is that family psychology, master’s and doctoral degrees in family therapy, and family psychiatry seem to be moving further apart.

Psychology, social work, and counseling psychology have developed active subspecialties in couples and family therapy. At the same time the rapidly developing interest in the biological treatment of psychiatric problems is to a degree overshadowing the development of new effective psychotherapeutic therapies. Couples and family work is more mainstream.

The aim of this book is to continue the tradition of integrating the best of theory and data from all disciplines into a coherent model of family therapy applicable to
trainees and practitioners in all of the mental health professions.

The health of the family therapy field has always resided in its diversity and its unwillingness to simply accept narrow, linear explanations for psychopathology or narrow, linear treatments. As members of a field originally composed of mavericks and rebels, family therapists were initially unwilling to accept the dominant psychodynamic and biological ideas of American psychiatry. However, during the 1990s, the independence of family therapists receded somewhat as mental health professionals of every discipline and theoretical commitment were gradually recognizing that no one perspective owns the truth and that multimodal treatments are frequently necessary, even desirable. There is also a movement toward specificity of treatments, in the development of diagnostic classification systems for families (see Chapter 8) and in the development of selection criteria for the application, focus, duration, and intensity of family and marital interventions. In the 2000s, family therapists are integrating creative new theories like attachment with older models. These approaches are being studied and applied to work with an increasing number of cultural groups and emerging family forms that were previously thought of as “nontraditional.”

The last two decades have witnessed the introduction of a new wave of couples and family treatments that include specific family-focused treatments for Axis I disorders such as eating disorders and bipolar disorder, as well as narrative and more integrative approaches (e.g., integrative behavioral couple therapy and emotionally focused couple therapy). Although treatment techniques have become more differentiated, so that one can speak of major orientations, such techniques must be integrated into a treatment package that is flexible and that meets the needs of individuals and families alike. The family therapy field is generating a body of treatment outcome research, primarily the fruits of systematic research by more behaviorally oriented marital researchers. These research efforts are growing in number and are becoming more sophisticated in design and execution. The findings that family therapy has demonstrated positive results with certain family problems, ranging from schizophrenia to childhood problems, are indeed encouraging (see Chapters 18 and 24 for a full discussion of these issues).

At the same time, an additional clinical and financial issue facing family therapists has been the effect of managed care and the need for treatment selection and provision to be increasingly based on outcome data that demonstrate evidence for efficacy. In many instances, the outpatient family therapist must provide care that is focused and feasible within the limits set by the managed care provider.

Likewise, managed care has had major effects on inpatient family therapy by decreasing the allowed length of stay (and accordingly the number of family sessions). It has also decreased the possibility of family outreach and long-term family support in publicly funded settings. To make matters even more complicated, families are expected to provide more illness monitoring and in-home care to loved ones discharged from the hospital prematurely due to managed care restrictions on length of stay.

The passage of the Affordable Care Act (ACA) will lead to profound changes in the way healthcare services are accessed and delivered. At the time of this publication, many of the specific details regarding implementation of the ACA as it relates to family oriented interventions are unknown. The ACA calls for the expansion of Medicaid and the unveiling of new exchange subsidies for those who have existing coverage. Mental health conditions must be covered the same way physical health services are covered. Many clinicians fear that while managed care insurers will attempt to provide mental health-care coverage to more Americans, the type of interventions covered will be limited and clinicians will not be compensated appropriately.
More closely aligned with the strength-based and systemic thinking of family therapists, the recovery movement is gaining traction in America and is expected to have a transformational effect on professional practice. According to the National Consensus Statement on Mental Health Recovery (2005), recovery is defined as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” An essential aspect of recovery-oriented health care is family-driven care. Family participation is encouraged in all aspects and phases of care.

Rait and Glick (2008) pointed out that consistent with the burgeoning evidence for the value of family interventions, the President’s New Freedom Commission on Mental Health (2003), which established new priorities in the delivery of mental health services, emphasizes family centered care. Current standards of treatment for the seriously mentally ill recognize the importance of family members’ roles in the promotion of long-term recovery. In response to the Commission’s findings, the Veterans Health Administration health-care system, the largest health-care system in the United States, developed an action agenda titled “VA’s Achieving the Promise: Transforming Mental Health Care in the VA.” One of the report’s strongest recommendations was to implement consumer- and family-centered care programs in all Veterans Affairs medical centers (Office of the Assistant Deputy Under Secretary for Health, 2004).

The most important subsequent developments over the past decade was the VA Health Care System’s decision in 2010 following Public Law 110-387 to “include marriage and family counseling in the list of services that be provided ... for the effective treatment and rehabilitation of a Veteran, as part of a Veteran’s hospital care.” VA medical centers must now offer services to couples and families, and the potential impact on the rest of the American health-care system may be significant as evidence-based treatments for couples and families facing relationship issues, physical and psychiatric illness, and parenting challenges have been rolled out at VA medical centers throughout the country.

Finally, the trend toward couples- and family-centered, collaborative, biopsychosocial models of health care for patients with physical illness provides further impetus for family training in psychiatry. Rolland and Walsh (2005) noted that consumers have increasingly advocated for health care that attends to the physical and psychosocial challenges of major health conditions for all family members (not just the sickest person). Heru (2006) suggests that, “improving the family environment has important health implications equivalent to the reduction of risk factors for chronic illness.” As consultants in medical settings, psychiatrists serve an important function in recognizing that chronic illness, disability, terminal illness, and loss represent changes that invariably affect every family member.

**Definition of Couples and Family Therapy**

Family therapy is distinguished from other psychotherapies by its conceptual focus on the family system as a whole. In this view, major emphasis is placed on understanding how the system as a whole remains functional and on understanding individual behavior patterns as arising from and inevitably feeding back into the complex interactions within the family system. In other words, a person’s thoughts, feelings, and behaviors are seen as multidetermined and partly a product of significant interpersonal relationships. From the family systems perspective, alterations in the larger marital and family unit may have positive consequences for the individual members and for the larger systems.

The family system under consideration may be either two- or three-generational, depending on the problem and the model used. A major emphasis is generally placed on understanding
and intervening in the family system’s current patterns of interaction. In some cases, a secondary interest is placed on the origins and development of those patterns (depending on the model).

Couples and family treatment can be defined as a systematic effort to produce beneficial changes in a marital or family unit by introducing changes into the patterns of family interactions. Its aim is the establishment of more satisfying ways of living for the entire family and for individual family members.

In many families, a member or members may be singled out as the 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 either partner individually.

Family therapy might broadly be thought of as any type of psychosocial intervention using a conceptual framework that gives primary emphasis to the family system and aims to affect the entire family structure. Thus any psychotherapeutic approach that attempts to understand or to intervene in a family system might fittingly be called family therapy. This is a very broad definition and allows many differing points of view, in theory and in therapy, to be placed under one heading.

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A continuum exists between the individual’s intrapsychic processes, the interactional or family system, and the larger social/cultural system. Different conceptual frameworks are used when dealing with these different levels. 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—to both its individual characteristics and the larger social matrix.

Although many clinicians agree that problematic interactions may occur in families in which one family member has a gross disturbance, it is not always clear whether the faulty interactions are the cause or the effect of the behavior of the disturbed individual. Some practitioners continue to perceive and treat the disequilibrium in the individual’s psyche as the central issue, viewing the family and larger social system as context, which adds an important dimension to the conceptualization and treatment. Others see and treat as the central issue the disequilibrium in the family, viewing the individual symptoms as the result of, or the attempted solution to, a family problem. There is reason to believe that both views are important. Clinicians should evaluate each clinical situation carefully, attempting to understand the phenomena and select intervention strategies designed to achieve the desired ends.

Core Concepts

General Systems Theory

Like other developing fields of knowledge, the family therapy field has needed to generate its own terminology. Although individual behavior and individual psychodynamics have had a long history and wealth of sophisticated terminology attached to them, the language available to describe specific interactions among people is already substantial. Family therapy is based on a set of theories that combine a general systems view of interactions, a cybernetic epistemology, traces of interpersonal psychiatry, and the most recent contributions of social constructivism. Thus there is a need to begin by delineating the
basic concepts underlying the developments in understanding family process and family intervention. These concepts are not numerous, but their paucity belies the profound shift in focus that occurs when progressing from concepts about the individual to describing a system and its functioning.

The biologist Von Bertalanffy is credited as the first to introduce the principles of general systems theory, which provide an organismic approach to understanding biological beings (Von Bertalanffy 1968). Von Bertalanffy felt that the reductionistic, mechanistic tradition in science was insufficient to explain the behavior of living organisms, because this approach depended on a linear series of stepwise cause-and-effect equations. He developed general principles to explain biological processes that include considerable complexity and levels of organization. General systems theory was described as a “new approach to the unity of science problem which sees organization rather than reduction as the unifying principle, and which therefore searches for general structural isomorphisms in systems” (Gray et al. 1969, p. 7).

Thus a systems approach places an emphasis on the relationship between the parts of a complex whole, and the context in which these events occur, rather than on an isolation of events from their context (Anonymous 1972).

A system is a group of interacting parts. In nature, each system is nested within a larger one (see Figure 1-1). In the most general terms, a living system is organized, exerts control over and adapts to its environment, and possesses and uses energy. Let’s see how these notions apply to families.

**Organization.** The first key concept relevant to living systems is that such systems have a high degree of organization; that is, there is a consistent relationship between the elements or parts of the organism. The systems view implies that the organism or entity is greater than the sum of the separate parts. No single element in the system can be thought of as acting completely independently. One might think of this as the difference between physiology and anatomy. According to Engel (1980),
Each hierarchy represents an organized dynamic whole, a system of sufficient persistence and identification to justify being named. Its name reflects its distinctive properties and characteristics. Each system implies qualities and relationships distinctive for that level of organization and each requires criteria for study and explanation unique for that level.

In order to regulate its exchange with systems outside itself, the living system must have boundaries (Figures 1-1 and 1-2). The membrane around a cell defines the boundary or outer limit of that functional unit. While creating a boundary between the cell and the outside, the cell membrane also provides through its permeability an interactional relationship between the inside and outside of the cell, by selectively allowing transfer of chemicals across itself. Analogously, the organized family system has a membrane, or boundary, between itself and the surrounding neighborhood and community.

This boundary is the set of implicit and explicit rules by which the family keeps information and activities to itself or allows outside information and contact with people in the neighborhood and the community. A family must have clear boundaries to be functional. The same is true for subsystems within the family. For example, in order for the marital subsystem to function, it must have a boundary that separates it from other subsystems such as the sibling subsystem.

A family’s boundary comprises the set of rules by which the family keeps information and activities to itself or allows outside information and contact with people in the neighborhood and the community.
Minuchin (1974) described families as being on a continuum from disengaged (i.e., having inappropriately rigid boundaries) to enmeshed (i.e., having overly permeable, diffuse boundaries). Families in the middle of this continuum (i.e., having clear boundaries) are considered to be the most functional (see Figure 1-3). Although no one-to-one correlation exists between extremes of boundary functioning and symptomatology, extremes are seen as more likely to lead to pathological behavior in one or more members of the family system. Because normative boundaries may vary considerably from one ethnic group to another and still allow development and growth of the child, families need to be considered using the norms of their cultural group as a reference point. For example, it is normal for some groups, such as upper-class English families, to send their children to boarding school by age 9 or 10 years, whereas in other groups children live at home until they are in their 20s or are married.

Recognition of the existence of subsystems within the family system relates to the notion of a hierarchical organization. The system itself is organized on one or many hierarchical levels entailing systems or subsystems (see Figures 1-1 and 1-2).

**Control over and adaptation to the environment.** A second key concept relevant to living systems is that a functional living system must have some means of controlled adaptation to its environment. In 1948, Wiener introduced the notion of cybernetics as a branch of science dealing with control mechanisms and the transmission of information. He pointed out the similarities between the mechanisms of internal control and communication in an animal and in machines. A key concept in cybernetics is that of feedback and the feedback loop. In such a circular sequence of events, element A influences element B, which influences element C, which in turn influences element A.

For example, if the temperature in a room becomes too low, the thermostat initiates a mechanism, which turns on the furnace, which raises the temperature in the room, which registers on the thermostat, which then signals the furnace to shut off. Such mechanisms serve to control the state of the organism or environment (Wiener 1948). Control concepts such as homeostasis and feedback have been used by family theorists to understand and change family systems (Jackson 1957; Minuchin et al. 1975). Corrective feedback (or negative feedback in the language of cybernetic theory) results in a sequence of events that returns a person to a previous, more balanced state (Strauss et al. 1985). Consider the following case example:

*Mr. A, a young father who had bipolar disorder, noted that as his mood became more elevated at home, his wife would become anxious. She would then say things like, “Why don’t you slow down? I’ll help you with the chores.”*

This intervention appeared to help Mr. A to regain control of his activity level and his wife to
A system always has feedback, but the result of a particular behavior is determined partly by each person’s internal processing. Consider this case example:

Mr. B, a 40-year-old patient with schizophrenia, responded to his wife’s request to slow down by becoming angry because he believed she was chastising him. She became more insistent, and he became more angry and upset. She finally started crying, and he calmed down. After a while, whenever he became upset she began crying, which kept her calm, but then she developed depressive symptoms of low mood, anhedonia, and functional impairment.

In this instance, an attempted solution became a problem.

Energy. A third and final key concept relevant to living systems is that of energy and information. Living systems are open systems in which energy can be transported in and out of the system. Instead of a tendency toward entropy and degradation of energy, which happens in non-living systems, living systems have a tendency toward increased patterning, complexity, and organization.

In human open systems such as the family, information (meaning knowledge from outside of the family) acts as a type of energy that informs the system and can lead to more complex interaction. For example, in families open to it, the women’s movement brought many changes in how the spouses reacted to each other. In some families, however, these changes led to confusion and distress, whereas in others they led to improvement in function.

To summarize, a theoretical framework commonly used by family therapists is the family systems approach. The understanding of families is ecological, in that the capabilities of the family are viewed as greater than an arithmetic sum of its parts. Each person is viewed in interactive relations with the other family members, all functioning to maintain the family system coherently but also striving for their own unique goals. The family system is maintained by its members so as to preserve its essential traditions, myths, patterns, identities, and values.

A key concept here is that although to an outside observer some of a family’s behavior may appear crazy or self-defeating, the behavior is assumed to be the family’s best solution to its problems. For example, in Mr. B’s family (see the case example mentioned earlier in this chapter), the wife’s depression seemed to decrease her husband’s symptoms.

The boundaries of the system are determined by the family and sometimes by the therapist. Most family therapists think of a family system as comprising at least three generations; however, a particular subsystem of couple or parents and children can also be seen as a system. In remarried families the system boundaries are more complex and permeable, and the total number of people involved tends to be much larger. Family organization shifts over time.

Often the family returns to an apparent steady state, but it must always deal with the inevitable changes that time and biological development bring. Sometimes it responds to stress with creative solutions but at other times with stagnation. The notion of the evolution of families as life events occur (e.g., when a child goes away to college) differentiates this view of coherence from that of a fixed homeostasis.

Family Systems Theory and Homeostasis Over Time

It can be said that the critical issue for families is which homeostasis to evolve toward, that is, what to preserve of the past (in order to manage the present competently) and what to look forward to in the future. Hoffman (1983) has developed a useful diagram (Figure 1-4), which she calls a time capsule, to illustrate the concepts of (1) how the family (and treating team) interface with the community and with its internal dynamics and (2) how each family has a long history (so-called mythic time) and is evolving constantly.
Hoffman (1983, p. 42) describes the time capsule as follows:

The figure presents a diagram of this construct, sometimes still referred to by me as my Cosmic Sausage, because so much depends on where you cut it. In this case, we will assume that the capsule’s outer skin ends at the boundary of that imaginary entity called the family. The cuts in the cross-section correspond to different dimensions of time: present time, onset time, historical time, mythic time, and future or hypothetical time. At each position depicted by the Time Capsule, “difference” questions work to clarify family alignments in relation to the problem, by revealing five aspects:

1. Family alignments as they relate to the problem in the present
2. Family alignments as they relate to onset of the problem
3. Family alignments as they furnish a historical matrix for the problem
4. The effect on family alignments if the problem were to change
5. Family alignments related to paradigmatic values that the problem metaphorically represents

Information thus gathered can be used both to build a hypothesis and to suggest a positive connotation of the problem in whatever temporal context seems most relevant.

The capsule also contains subcylinders: Rings 1, 2, and 3, indicated within the cross-section, in the present. The idea of the rings is to show that there are several systems interfaces one might have to consider in targeting an intervention, and there

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**Figure 1-4** Hoffman’s time capsule.

Couples and Family Therapy in Clinical Practice

seemed to be an order of priority, too. Interface dynamics within the family took second place to team/family system and professionals from the referring context. As I said before, the interface that seems most important in any interview can be called the “presenting edge.”

To summarize, classical family therapy examines interpersonal relationships—rather than biological, intrapsychic, or societal processes—when attempting to understand human distress. That is not to say that family therapy ignores the intrapsychic or the biological, but its primary vision and interventions are focused on interpersonal relationships. For example, both chemistry and physics use versions of relativity theory and quantum theory. They are not separate disciplines because they embrace unique scientific approaches; rather, they are distinct because each uses its overlapping theories to concentrate on different natural phenomena.

An Integrative Interpersonal Model
An integrative model connects the systems concepts above with Lewis’s work on interpersonal relationships and individual outcome. Our model is based on the notion that there is an ongoing and consistent interplay between psychopathology (related to biological and developmental factors) and the individual relationships with significant others. As Lewis (1998) noted,

At its center this perspective holds that relational structures—the more or less enduring patterns of interaction—either facilitate or impede the continued maturation of the participants. It is important to note that the relationship between an individual and his or her relational system is not linear; rather, individual characteristics influence system properties, and these properties shape individual characteristics.

We discuss Lewis’s ideas about relationships in later chapters (see Chapters 14 and 15).

Differentiation of Family Therapy From Other Psychotherapies

Family therapy as a format of treatment can be distinguished from other psychotherapies by its fundamental paradigm shift, which assumes that people are best understood as operating in systems and that treatment must include, either in person or in theoretical understanding, conceptualization of all relevant parts of the system. From this assumption comes different goals, foci, participants, and so on (Table 1-1). The term family therapy connotes a format of intervention that attempts to include the relevant system members—this means at least the nuclear family but most often the three generation family and perhaps significant others such as lovers, friends, or important adoptive kin (persons without ties of blood or marriage whom the family has designated as members of itself). The presence of family members is considered crucial to addressing the goal of family treatment, which is the improved functioning of the family as an interlocking system and network of individuals. This context allows a focus on the family system as a whole in order to understand current individual behavior as rising from, and inevitably feeding back into, the complicated matrix of the general family system.

The goal of family treatment is the improved functioning of the family as an interlocking system and network of individuals.

The final and the intermediate goals of the family format are different from those in the individual and group formats. The final goal of the family model is improved family functioning and improved individual functioning of its members. This goal is reached, for example, by intermediate goals of improving family communication and decreasing family conflict. Thus the focus of the family model is on the current
<table>
<thead>
<tr>
<th>Therapy format</th>
<th>Intermediate goals</th>
<th>Final goals</th>
<th>Focus</th>
<th>Participants</th>
<th>Length or frequency of sessions</th>
<th>Mean overall duration of treatment</th>
</tr>
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<tbody>
<tr>
<td>Family</td>
<td>Improve family communication; decrease family conflict</td>
<td>Improved family functioning</td>
<td>Family intervention: family coalitions and roles</td>
<td>Nuclear family unit; extended family; 1–2 therapists</td>
<td>Most 1–2 hours per week</td>
<td>2 months–2 years</td>
</tr>
<tr>
<td>Individual</td>
<td>Insight into intrapsychic conflicts; insight into interaction (transference)</td>
<td>Individual personality/symptom change</td>
<td>Unconscious conflicts: individual's thoughts, wishes, and behaviors</td>
<td>1 patient; 1 therapist</td>
<td>1 hour, 1–5 times per week</td>
<td>2 months–5 years</td>
</tr>
<tr>
<td>Group</td>
<td>Sharing with group; improved relating skills in group</td>
<td>Improved individual social functioning</td>
<td>Group participants and feedback</td>
<td>6–8 patients; 1–2 therapists</td>
<td>1½ hours, 1 time per week</td>
<td>6 months–2 years</td>
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family interactions with the various coalitions, boundary difficulties, and other features of systemic dysfunction.

This model assumes that because a large part of a person’s problem is connected to malfunction in the family system, mobilizing and reorganizing the system may be an effective way to solve the problem. In contrast, the final goal of the individual model is personality, symptom, or behavior change in one particular individual. In order to reach such a final goal, the focus of the individual format is often on the individual’s behaviors, unconscious conflicts, or cognitive schema. With this final goal and focus, the intermediate goals of individual intervention (depending on the particular therapeutic strategies) include insight into intrapsychic conflicts or interpersonal interactions with others, or knowledge of one’s individual cognitions/behaviors, and a progressive change therein. The group format has as its final goal improved individual social functioning. The focus (somewhat similar to family treatment) is on current group interaction and intermediate goals but would include the individual sharing with the group and manifesting an improved relating skill with other group members. The following case example illustrates how three different approaches could be applied to the same situation:

Ms. C, a young woman with depressive illness, is living at home and not dating. An individual therapist might determine that Ms. C’s intrapsychic conflicts around dependence and autonomy and her early interactions with her father led her to be afraid of men. The therapist might choose an individual format to increase understanding or a group format to increase interpersonal interaction. A family therapist might see that Ms. C’s grandmother just died, that her mother is grieving and hostile to her father, that she is the youngest child and last one home, and that she is staying at home because her mother desperately needs her as a companion. The family therapist would see the girl with her parents. A psychopharmacologist might see the phenomenology of classic depression and prescribe medication without individual or family treatment.

The strategies and techniques of family therapy (see Chapters 9 and 11)—whether structural, strategic, behavioral, psychoeducational, experiential, supportive, or psychodynamic—overlap with these same techniques as they are used in individual and group formats, but they may take on added dimensions in a family session. For example, in individual insight-oriented psychotherapy, the therapist may interpret an individual’s interaction with his wife as it relates to his earlier developmental interaction with his mother. A family therapist, with both spouses in the room, might also make a related interpretation about the wife’s reaction to her husband’s behavior and how it related to her behavior with him and perhaps to her earlier interactions with her father.

The individual patient, hearing the therapist’s interpretation alone, may integrate it in such a way that his behavior toward his wife changes. The couple hearing the family therapist’s interpretation together can use it to jointly understand and shift their interaction. A therapist using a family-of-origin approach might ask the husband and wife to bring in their parents for a family-of-origin session, so that they could deal with unresolved conflict directly with their families rather than playing it out with each other. In that way, the larger family system is used as a resource instead of a source of aggravation.

The model of psychopathology underlying family treatment is quite different from other forms of intervention. The family model is based on the assumption that personality development, symptom formation, and therapeutic change result, at least in part, from the family’s function as an interdependent transactiveal unit. The individual psychopathology model is based on the view that these factors are determined largely by the dynamic, intrapsychic function of the individual. If one takes
a psychodynamic point of view (or a biological point of view), the individual has been the major focus of attention. In contrast, Schatzman (1975) states in his critique of the individual model that although this model is helpful, it is ultimately inadequate for understanding how people affect one another.

Psychoanalytic theory cannot render intelligible someone’s disturbed experience or behavior in terms of disturbing behavior by someone else on that person. In order to comprehend a relationship between two individuals—husband and wife, mother and child, or father and son—we must take into account that each individual experiences the world and originates behavior. Of course, psychoanalysts know that other persons’ experiences act upon their patients and that certain persons who dealt with their patients as children influenced them greatly by their behavior. But insofar as psychoanalysts speak of object relations, their theory does not adequately account for this influence.

Schatzman’s formulation (although somewhat dated) can be related to other therapeutic models. Modern biopsychiatry is concerned with the biological correlates of emotional disorders, whereas personality psychology and the psychotherapies are concerned with individual psychodynamics and their relation to mental disorders. Family therapy is concerned primarily with the relationships among persons and how these family relationships and disruptions are linked both to physical and mental disorders of individuals and to larger contexts in the community.

Clinical Practice Implications

As Josephson (2008) has written, “Family intervention” is an important clinical process in adult and child psychiatry, and contemporary education must address the multiple ways physicians can assist families. Future models will be successful to the degree they build on the past contributions of systems thinking, and the clue into perspectives of developmental psychopathology. Contemporary education should teach family intervention is not optional but ideally can be integrated with other inventions in a sequential manner emphasizing the relationship between self and system.

Suggested Reading

Grounded in relevant foundational works of neuroscience, the role of various aspects of brain structure and function are explained in the below text and addressed in their direct relevance to the process of couple therapy.


The 4th edition of this classic text discusses comprehensive ways to think about human development and the life cycle.


These two texts examine the intersection between neuroscience and couples and family therapy.


Hanna SM: The Transparent Brain in Couple and Family Therapy: Mindful Integrations with Neuroscience, Routledge, 2014.

References
