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FAMILY THERAPY

Systemic Approaches to Practice

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FAMILY SYSTEMS THEORY AND PRACTICE

Family systems theory has become an essential framework to understand human functioning and dysfunction in context. Over recent decades, family therapy theory and practice have become more responsive to the growing diversity and complexity of families in our changing world. This chapter first summarizes core concepts in a family systems orientation, with a focus on the interaction of biopsychosocial-spiritual influences, a multigenerational family life cycle perspective, and a conceptual model of family stress and resilience. Family assessment guidelines are offered, including a framework identifying key processes in family functioning and resilience to inform strengths-oriented family intervention. An overview is provided of foundational models of family therapy and more recent collaborative, community-based approaches and evidence-based models. Current practices include varied intervention formats with individuals, couples, and families, from consultation and brief therapy to multisystemic approaches, multifamily groups, and more intensive family therapy.

EVOLUTION OF THE FIELD

The family and larger social forces have been recognized as major influences in individual functioning from the early focus in social work on the person-in-environment. In the mid-20th century, with the ascendancy of the psychoanalytic model in the mental health field, attention narrowed to the early mother-child bond, with maternal deficiencies blamed for individual disturbances throughout life. The richness and complexity of family life tended to be reduced to a pathogenic role of the mother, who was seen in practice, if at all, apart from the treatment of the primary client. A paradigm shift occurred in the late 1950s with the development of general system theory, communications theory, and cybernetics (Bateson, 1979; Watzlawick, Beavin, & Jackson, 1967). Direct observation of whole families in studies of schizophrenia shifted attention from etiological questions of problem origin to ongoing transactional processes that reinforced disturbed behavior or distress. Therapeutic interventions were designed to alter dysfunctional patterns in family sessions. The rapid expansion of theory and family approaches to treat a wide

range of problems led to the emergence of foundational models in the 1970s, each with distinct views of problem maintenance, change processes, and techniques to achieve objectives.

Over recent decades, family therapy theory and practice have been reformulated and expanded by a new generation of family systems scholars and practitioners. With a broad biopsychosocial systemic perspective, greater attention is given to biological and sociocultural influences. Issues concerning race, class, gender, and sexual orientation, neglected in earlier models, are addressed. Systems approaches have become more responsive to the growing diversity of families and the complexity of their challenges. Focus has been redirected from family deficits and dysfunction to family challenges and resources in collaborative approaches aiming to strengthen family functioning and resilience. Although family therapy approaches vary, they share a common grounding in systems theory.

Family Systems Orientation

The practice of family therapy is grounded in a set of basic assumptions about the mutual influence of family members and the interplay of individual, family, and sociocultural processes. Ecological and developmental perspectives are interwoven in viewing the family as a transactional system that functions in relation to its broader sociocultural context and evolves over the multigenerational family life cycle. Stressful events and problems of an individual member affect the whole family as a functional unit, with ripple effects for all members and their relationships. In turn, family processes—in relating and handling problems—contribute significantly to positive adaptation or to individual and relational dysfunction.

Systemic Lens: Relational and Interactional Perspective

Family therapy is not simply a therapeutic modality in which all members are seen conjointly.

A family systems approach is distinguished less by who is in the room and more by the clinician's attention to relationships and systemic patterns in assessment and intervention. Therapists consider (a) how family members may contribute to and are affected by problem situations, (b) how they can be resources in solving problems, and (c) how family bonds and functioning can be strengthened for greater well-being and positive growth.

Regardless of the source of problems, therapists involve key family members who can contribute to needed changes. Individuals may be seen separately or brought together for some sessions in different combinations, depending on therapeutic aims. Therapy may focus on strengthening a couple relationship; it might combine individual and conjoint sessions, as with an adolescent and parents. Siblings, grandparents, and other key extended family members might be involved in some sessions. Family interventions aim to modify dysfunctional patterns, tap family resources, facilitate communication and problem solving, and strengthen both individual and family functioning.

Mutual Influences and Accountability

Family members are interconnected such that each individual affects all others, who in turn affect the first member in a circular chain of influence. Every action is also a reaction: A father's harsh response to a child's tantrum may exacerbate his or her out-of-control behavior. Ongoing conflict between parents over the handling of an adolescent's misbehavior can make matters worse. Parents can become polarized, one overly strict and the other overly lenient, each in reaction to the other. In tracking the *sequence of interactions* around a presenting problem, therapists note repetitive patterns. Whenever parents start to argue, a child—or a pet—demands attention. Regardless of how a sequence began, family members can be helped to pull together as a team in order to handle stresses and problems more effectively. Skilled intervention involves interrupting vicious

cycles to promote virtuous cycles and problem resolution.

Although processes may be circular, not all participants have equal power or influence. Feminist critique of early systems therapy brought recognition of the culturally based, gendered power differential, as well as the generational hierarchy, in families and society, which contributes to abuse of women and children (McGoldrick, Anderson, & Walsh, 1989). Family therapists have become alert not to take a neutral stance or a no-fault circular influence position, which can perpetuate abuse. It is imperative to hold an offending individual accountable for harmful behavior. Therapists also are cautioned not to endanger a partner or children by pressing them to reveal mistreatment in the presence of an offender, who may punish them after the session. The safety and security of vulnerable family members is always a top priority in all family therapy.

Biopsychosocial-Spiritual Orientation

The practice of family therapy, grounded in biopsychosocial systems theory (Bertalanffy, 1968), increasingly addresses the complex interplay of individual, family, and social processes. The profound influence of biological influences in medical and psychiatric conditions and in psychosocial well-being is well established. Yet research finds strong mutually interactive effects of genetic and neurobiological influences with environmental factors (Siegel, 2012; Spotts, 2012). Family relationships and significant interpersonal transactions can have a strong mediating influence over the life course.

Putting an ecological perspective into practice, individual or family distress is understood and treated in sociocultural context. A systemic approach addresses the family's interface with larger systems, such as school, workplace, justice, and health care systems. It attends to cultural, political, and socioeconomic influences and addresses harmful social and institutionalized discrimination, injustice, and

marginalization, based on race, ethnicity, religion, class, gender, sexual orientation, age, or disabilities (McGoldrick & Hardy, 2008). Where problems are primarily biologically based, as in autism, or are largely fueled by social, political, or economic conditions, family distress may result from unsuccessful attempts to cope with an overwhelming situation. For instance, conflict between the parents of an adolescent with bipolar disorder may be fueled by repeated unsuccessful attempts to deal with their child's emotional outbursts. A systemic assessment guides intervention focus on most relevant system levels, with the family as an essential partner in achieving aims.

The significant role of religion and spirituality in physiological and psychosocial distress, healing, and resilience has been documented in a growing body of research on faith beliefs and practices, such as prayer and meditation (Koenig & King, 2012). In family therapy, multifaith as well as multicultural perspectives can guide respectful inquiry to understand spiritual sources of distress and identify potential spiritual resources that fit the client's belief systems and preferences (Walsh, 2009b; Walsh, 2010). Incorporating the spiritual dimension of human experience in theory and practice expands the systemic lens to a biopsychosocial-spiritual orientation.

With multiple influences, clinicians need to be careful not to presume a family causal role in individual symptoms or relational distress. Parents often feel blamed for a child's problems and shamed for their inability to resolve them. Sensitive family intervention addresses family stress and helps members tap resources and find more effective ways to approach their challenges.

MULTIGENERATIONAL FAMILY LIFE CYCLE PERSPECTIVE

In a systemic model, individual and family developments are seen to coevolve over the life course and across the generations (McGoldrick,

Garcia- Preto, & Carter, 2014). Relationships grow and change, boundaries shift, roles are redefined, and new members and losses require adaptation. Each developmental phase poses new challenges. Distress often occurs around major transitions, such as the birth of the first child, entry into adolescence, the launching of young adults, retirement, or elder care challenges. Divorce, single parenting, and stepfamily integration pose additional challenges for many families. The growing diversity of family forms, lifestyle options, and timing of nodal events makes it imperative that no single model or life trajectory be deemed essential for healthy development (Walsh, 2012). Over an expanded life course, family members are increasingly likely to transition in and out of single status, couple bonds, and varied family configurations, adding complexity to all relationships.

Family history and relational patterns are transmitted across the generations, influencing future expectations, hopes, and dreams. Some families become stuck in the past; others cut off emotionally from painful memories and contacts. Well-functioning families are better able to connect their past, present, and future direction. Family therapists help clients make linkages, reconnecting with valued aspects of family and cultural heritage and learning from the past as they chart their future course.

Family Stress, Coping, and Resilience

Individual symptoms and family distress are often triggered by a serious crisis, trauma, or loss within the family or in the larger community, such as the death of a loved one, job or home loss, or major disaster. Distress may be fueled by a disruptive transition, such as migration, family separation, divorce, or stepfamily formation. Families can become overwhelmed by a pileup of stressors or the cumulative impact of recurrent or persistent challenges with chronic illness or harsh conditions of poverty. Major stressors affect the entire family,

often contributing to conflict, abuse, divorce, and both relational and residential instability. Some families are shattered, yet others adapt and even grow stronger out of adversity. The family response can make a difference.

Individual counseling that attends only to a symptomatic member may leave other family members and the family unit at risk. For instance, combat-related trauma can generate secondary trauma for a spouse, marital conflict, and distress for children and other members through ongoing transactions affected by posttraumatic stress;. When the family support system is strengthened, individual and relational healing are fostered. As another example, research finds that the death of a child heightens risk of parental estrangement and divorce. Yet when partners are helped to support each other through the healing process, their bond is strengthened, with positive ripple effects to relationships with children and other family members (Walsh & McGoldrick, 2004).

Family resilience is the ability of the family to rebound from life crises and persistent challenges, emerging strengthened and more resourceful (Walsh, 2003). It involves dynamic processes that foster positive adaptation in the context of significant adversity (Rutter, 1987). The concept of family resilience expands focus beyond a dyadic view—seeing a family member as a resource for individual resilience—to a systemic perspective on risk and resilience in the family as a functional unit (McCubbin, McCubbin, McCubbin, & Futrell, 1998; McCubbin, Thompson, Thompson, & Fromer, 1998; Walsh, 2003).

The concept of family resilience extends theory and research on family stress, coping, and adaptation (McCubbin & Patterson, 1983). A basic premise is that stressful life challenges have an impact on the whole family, and in turn, key family processes mediate the recovery—or maladaptation—of all members and their relationships. Thus, the family's response is crucial. Major stressors can derail the functioning of a family system, with ripple effects for all members and their relationships. Key processes and

extrafamilial resources enable the family to rally in times of crisis, to buffer stress, to reduce the risk of dysfunction, and to support optimal adaptation.

Family resilience entails more than coping, managing stressful conditions, shouldering a burden, or surviving an ordeal. It involves the potential for personal and relational transformation and growth that can be forged out of adversity. By tapping key processes for resilience, families that have been struggling can emerge stronger and more resourceful in meeting future challenges. Members may develop new insights and abilities. A crisis can be a wake-up call, heightening their attention to core values and important matters. It often becomes an opportunity for families to reappraise life priorities and stimulates greater investment in meaningful relationships. In studies of strong families, many report that through weathering a crisis together their relationships were enriched and became more loving than they might otherwise have been.

Research on resilience in families can usefully inform clinical practice. For instance, the presumption that divorce inevitably damages all children has been countered by over a decade of studies finding that fewer than one fourth do poorly. Most children rebound relatively well, and one third are remarkably resilient, thriving in all measures of functioning and well-being (Greene, Anderson, Forgatch, DeGarmo, & Hetherington, 2012). Multiple variables influence children's adaptation, including the predivorce climate, postdivorce parental conflict or cutoff, and financial pressures. Helping parents navigate the divorce process can make a significant difference in risk and resilience. Such studies identifying key family processes can inform collaborative divorce counseling and mediation approaches for positive adaptation (Ahrns, 2004; Bernstein, 2007). Similarly, stepfamily formation is fraught with challenges, contributing to a 60% divorce rate. Research on successful stepfamily processes can inform interventions to lower risks and facilitate integration (Pasley & Garneau, 2012)

ASSESSMENT OF FAMILY FUNCTIONING

Mapping the Family System

In clinical practice, a broad conception of family is needed to encompass the wide range of family structures, relationship options, and cultural diversity in contemporary society (Walsh, 2012). With the aging of society, attention to multigenerational relationships is increasingly important (Walsh, 2014). Clinicians need to be mindful of cultural, personal, and professional assumptions and biases when assessing families, since views of the normal family are socially constructed. The idealized nuclear family model with gendered breadwinner/homemaker roles now is found in only a small band on the wide spectrum of families, yet social expectations can compound a sense of deficiency and failure for those who don't fit that model, especially single parents (Anderson, 2012). Those who don't conform to cultural or religious standards for marriage and family, such as same-sex couples and lesbian, gay, bisexual, and transgendered (LGBT) parents, are gaining wider acceptance yet still face stigma and inequalities (Green, 2012). Studies over the past two decades have found abundant evidence that children can thrive in a variety of family arrangements, including gay parenting (Walsh, 2012). What matters most are stable, caring, and committed relationships and effective family processes.

In the first session, it is important to learn who is in the family system. This includes all household members, nonresidential parents, steprelations, and the extended kin network, as well as other significant relationships (e.g., intimate partner, informal kin, godparents, and caregivers). The *genogram* (McGoldrick, Gerson, & Petry, 2008) (see Chapter 1, "Systems Theory," this volume) and timeline are essential tools for mapping the family system, diagramming relationship and system patterns to guide intervention. Key information is noted, such as alliances, conflicts, triangles, cutoffs, substance abuse, violence, sexual abuse, illness, and traumatic death or losses. In families that have complex

relationships, such as different fathers for several children, it is especially valuable for the clinician—and family members—to see all key members and how they are related on one page. It can bring some coherence to chaotic systems for intervention planning.

A resilience-oriented assessment searches for positive influences and potential resources, positive models, and mentors, as well as problematic patterns and troubled relationships. Inquiry about a family's organizational shifts and coping strategies in response to past stressors, such as major losses, can help one illuminate the family's meaning making, coping, and adaptation with current challenges, such as recent or threatened loss. It is important to identify strengths, such as courage, faith, and perseverance, in the midst of ongoing and past struggles and to draw out positive stories and experiences in overcoming adversity (Walsh, 2006).

Family functioning is assessed in the context of the multigenerational system moving forward over time. It is important to ask about recent and anticipated stressors and disruptive events that may contribute to presenting problems. A family timeline can be sketched to note the timing, sequence, or pileup of stressors and family tensions. Frequently, symptoms coincide with stressful family transitions, relationship changes, additions, or losses and in the context of stressful events, such as the death of a loved one. Because family members may not initially mention such connections, the genogram and timeline can guide inquiry and reveal patterns for further exploration.

Although all change is stressful, strain increases exponentially when current stressors intersect with sensitive multigenerational issues. Nodal events are likely to reactivate past conflicts, particularly when similar challenges are confronted. An impending separation may reactivate past losses. Families may conflate current situations with past adverse experience, generating catastrophic fears. One mother became anxiously preoccupied that her 16-year-old daughter would become pregnant, as she had at the same age. In another case, a husband's conflict over

his wife's desire to have a second child became more understandable on learning that his mother had died in childbirth with his younger sibling: He feared losing his beloved wife. Family intervention explores such covert linkages and untold stories, helping families to heal and draw lessons from their past in order to make positive choices in their current relationships.

Even in brief present and future-focused intervention, it is crucial to note past trauma, such as combat or refugee experience and family histories of traumatic loss, which can contribute to depression, substance abuse, and self-destructive behavior (Walsh, 2007; Walsh & McGoldrick, 2004). Critical events that occurred at the same age or current nodal point in the family system may be particularly relevant. A teenager's drug overdose was incomprehensible to his parents until, in a family session, he revealed his deep bond with his older brother, who had died in a car crash at age 16. For years he had tried to take his place to ease his parents' grief, but, turning 17, he no longer knew how to be, except to join him in heaven.

ASSESSING KEY PROCESSES IN FAMILY FUNCTIONING AND RESILIENCE

Family process research over the past three decades has provided considerable empirical grounding for assessment of family functioning (Lebow & Stroud, 2012; Walsh, 2012). The family resilience framework in Table 7.1 was developed as a conceptual map for clinicians to assess family functioning and to target and strengthen key processes that foster positive adaptation (Walsh, 2003, 2006). This framework, informed by social science and clinical research, identifies key processes for effective family functioning in three domains: (1) family belief systems, (2) organization patterns, and (3) communication processes. Cultural differences must be kept in mind, and any assessment must consider functioning in context, relative to each family's values, resources, and life challenges.

Table 7.1 Key Processes in Family Resilience*Belief Systems***1. Making Meaning of Adversity**

- View resilience as relationally based
- Normalize and contextualize distress
- View crisis as a meaningful, comprehensible, and manageable challenge
- Appraise adverse situations, options, and future expectations

2. Positive Outlook

- Hope, optimistic bias; confidence in overcoming barriers
- Encouragement; affirm strengths and potential
- Active initiative and perseverance
- Master the possible; accept what can't be changed

3. Transcendence and Spirituality

- Larger values and purpose
- Spirituality: faith, rituals / practices, and congregational support
- Inspiration: new possibilities, dreams; creative expression; social action
- Transformation: learning, change, and growth from adversity

*Organizational Patterns***4. Flexibility**

- Adapt to meet new challenges, rebound, and reorganize
- Regain stability, continuity, and dependability through disruption
- Strong authoritative leadership: nurture, guide, and protect members
- Varied family forms: cooperative parenting/caregiving teams
- Couple/coparent relationship: equal partners; mutual respect

5. Connectedness

- Mutual support, collaboration, and commitment
- Respect individual needs, differences, and boundaries
- Seek reconnection and reconciliation of troubled relationships
- Social and economic resources
- Mobilize kin and social and community networks; recruit mentors
- Financial security; work-family balance; institutional supports

*Communication/Problem Solving***6. Clarity**

- Clear and consistent messages (words and actions)
- Clarify ambiguous information; truth seeking/truth speaking

7. Open Emotional Expression

- Share range of feelings (joy and pain, hopes and fears)
- Mutual empathy; tolerance for differences
- Responsibility for own feelings and behavior; avoid blaming
- Pleasurable interactions, respite; humor

8. Collaborative Problem Solving

- Creative brainstorming; resourcefulness
- Shared decision making; negotiation; resolve/repair conflicts
- Focus on goals, concrete steps: build on success; learn from failure
- Proactive stance: prevent crises; prepare for future challenges

Family Belief Systems

Shared belief systems are at the core of all family functioning. Relationship rules, both explicit and unspoken, provide a set of expectations about roles, actions, and consequences that guide family life and members' behaviors. Shared values and assumptions are constructed through transactions with significant others and the larger social world. They are strongly influenced by cultural and spiritual beliefs, which are transmitted across generations. In immigrant families, traditional cultural beliefs, for instance, about spirit possession or faith healing practices, may not be mentioned unless a therapist inquires respectfully about them (Falicov, 2007, 2012, 2013). Multigenerational stories become encoded into family scripts that can rally efforts or fuel catastrophic fears when facing a challenge.

Meaning making, hope, and transcendence. It is important to explore and facilitate family efforts to make meaning of the problem situation: how it came about and how it might be improved. Therapists aim to understand constraining beliefs and narratives and to expand those that open possibilities and facilitate positive change (Freedman & Combs, 1996). Research suggests that clinicians can foster resilience by helping distressed families to (1) view a crisis as a shared challenge that is comprehensible, manageable, and meaningful to tackle; (2) (re)gain a hopeful, positive outlook that fuels initiative and perseverance, with a focus on mastering what is possible; and (3) draw on larger transcendent/spiritual values, purpose, and connection. Families do best when they share a larger worldview, most often through cultural and spiritual beliefs, practices, and community involvement. Spiritual nourishment, transformation, and growth are also found through nature, the expressive arts, and service or social action to benefit others.

Family identity and convictions are conveyed through shared rituals, including celebrations of holidays, traditions, rites of passage, and marriage or commitment ceremonies, as well as routine interactions (e.g., family

dinner, bedtime stories). Rituals provide continuity and also facilitate painful transitions and losses, especially at death, with funeral rites and memorials. Family therapists (Imber-Black, 2012) often use rituals in therapeutic intervention to foster healing and transformation. They are especially valuable where a loss, such as a stillbirth, has not been adequately marked.

Family Organizational Patterns

Family functioning requires effective organization to maintain integration as a family unit, foster healthy development of members, and master life challenges. Varying family structures, such as a two-earner two-parent family, a single-parent family, a divorced joint-custody family, a stepfamily, and a three-generational household must organize family roles and relationship patterns in varied ways to fit their circumstances.

Adaptability—a counterbalance of *flexibility* and *stability*—is required for effective family functioning and resilience. Families need strong leadership with predictable and consistent rules, roles, and patterns of interaction. Families must also adapt to changing conditions or new developmental priorities. Without this flexible structure, families at dysfunctional extremes tend to be either overly rigid and autocratic or chaotically disorganized, unstable, and leaderless. In times of crisis, such as a medical emergency, or disruptive transitions, such as a changing household, flexibility must be counterbalanced by efforts to restabilize, reorganize, and reestablish patterns in daily living. Significant losses may require major adaptational shifts to ensure continuity of family life. For instance, when a breadwinner father is laid off or becomes disabled, family roles change as the mother becomes the sole earner, and he assumes most homemaking and child-rearing responsibilities.

Connectedness, or cohesion, is vital for family functioning and resilience. To function well, families need to balance closeness with respect for separateness and individual differences.

Extremes of enmeshment or disengagement tend to be dysfunctional. However, with varying cultural norms, personal preferences, and situational demands, clinicians must be cautious not to presume that a highly connected couple or family pattern is dysfunctionally enmeshed. Many cultures value high cohesion and prioritize the needs of the family over individual preferences (Falicov, 2012).

Role relations often must be renegotiated in families. Increasingly, couples are striving for equal partnership in marriage and family life, with both spouses in the workplace and sharing child-rearing and household responsibilities. Still, more traditional patriarchal values and role divisions are often upheld by older generations, recent immigrants, and adherents of fundamentalist religions. Research shows that an equitable sharing of authority, responsibility, and privilege in the couple/parental unit fosters healthy relationships (Knudsen-Martin, 2012). In kinship care, when grandparents step in to raise grandchildren, or become legal guardians, renegotiation of roles, relationships, and households is required (Engstrom, 2012). The complexity of divorced and stepfamily configurations poses challenges to sustain workable parenting coalitions across households and to knit together biological and steprelations, including extended kin.

Family structural boundaries need to be clear and firm yet permeable (Minuchin, 1974). Interpersonal boundaries promote differentiation and autonomous functioning. Generational boundaries maintain hierarchical organization in families for effective functioning, leadership, and authority. Children gain competencies by assisting parents with responsibilities, and their role may be vital in single-parent and large families and in cases of parental illness or disability. However, rigid role expectations can sacrifice a child's own development needs. Generational boundaries are blurred when a parent abdicates leadership or uses a child as a parental surrogate. When boundaries are breached most destructively in sexual abuse (Sheinberg & Fraenkel, 2001), it is

imperative to strengthen family structure with clear leadership, authority, and protective boundaries.

The concept of the *triangle* and the dysfunctional process of *triangulation* (Bowen, 1978) refers to the pattern when two members (e.g., spouses/parents) draw in or scapegoat a third person to deflect rising tension. A couple may avoid conflict by uniting in mutual concern about a symptomatic child. A child may serve as peacemaker or go-between for warring parents, balancing loyalties and regulating tension. In high-conflict divorces, one parent may draw a child into a loyalty bond against the other parent. A grandparent-child coalition may be formed against a parent. In more troubled families, such patterns tend to be rigid and replicated in interlocking triangles throughout the system.

Kin and community resources are vital lifelines for family functioning, especially for support through hard times and for multistressed, underresourced families. For transnational families, adaptation and resilience are facilitated by finding ways to sustain connection with loved ones and the community left behind (Falicov, 2007). Friendship networks are especially important for adults living alone and in the families of choice formed in gay and lesbian communities. Faith communities offer valued resources to many families by means of congregational support, spiritual practices, communal rituals, clergy guidance, and involvement in a range of programs and service to others (Walsh, 2009b). Clinicians are encouraged to become acquainted with faith-based resources in their communities.

Communication Processes

Communication processes facilitate all family functioning. Family therapists attend to both content and relational aspects of verbal and non-verbal messages. It is important for family members to communicate openly about practical, emotional, and relational issues. Clinicians

should be mindful of varied cultural norms regarding directness and expressivity of opinions and feelings.

Clarity. Clear and congruent messages conveyed in words and actions are important. In ambiguous situations, such as an unclear medical prognosis or the threat of divorce, anxiety is heightened. When communication is blocked, children sense anxiety, imagine the worst, and commonly express fears through somatic or behavioral symptoms.

Open emotional expression. A climate of mutual trust encourages open expression of a range of feelings and empathic responses, with respect for differences. Troubled families tend to perpetuate mistrust, blaming, and scapegoating. Highly reactive, destructive cycles of conflict can escalate into violence. Cascading effects of criticism, stonewalling, contempt, and mutual withdrawal contribute to despair and divorce. It is important to address with sensitivity areas of conflict and toxic subjects where communication is blocked or distorted, as well as constraints of gender-based assumptions. Expectations that men should be tough problem solvers and not reveal vulnerability, fear, or soft emotions can block their ability to address significant emotionally laden issues and to give and receive emotional support. It is useful to reframe vulnerability as inherent in the human condition and expression of difficult feelings as strength rather than shameful weakness.

Collaborative problem solving is crucial for family functioning and is facilitated in all approaches to family therapy. Systemic assessment attends to the decision-making process and addresses power struggles and control issues. Negotiation and conflict management skills can be honed in therapy. Fairness, respect for differences, and reciprocity are vital for long-term relational harmony.

Families need to master instrumental problems, such as juggling job and child care demands, and meet the socioemotional needs of

members, as by comforting anxious children. They can falter at various steps in the problem-solving process (Lebow & Stroud, 2012): identifying the problem; communicating about it and brainstorming possible solutions; or deciding on an approach, taking action, following through, and evaluating its effectiveness. The family's resilience is strengthened by building on small successes and viewing mistakes as learning experiences. Families become more resourceful as therapy focuses proactively to anticipate, prepare for, and avert future problems.

Family Functioning in Context

Families with diverse values, structures, resources, and life challenges forge varied pathways in coping, adaptation, and resilience. Whether patterns are functional or dysfunctional depends on the *fit* between family processes, the demands of their problematic situation, and their resources. Family-centered institutional policies, structures, and programs of larger systems are essential to support optimal family functioning, from health care, to child and elder care, to workplace flexibility and retirement benefits. It is not enough to help vulnerable families overcome the odds for family resilience; social policy must also change the odds against them in order for families to thrive (Seccombe, 2002).

MAJOR APPROACHES TO FAMILY THERAPY

Table 7.2 presents an outline of major models of family therapy, their views of functioning and dysfunction, change processes, and therapeutic goals. Reflecting the mental health field's focus on psychopathology, foundational family therapy models tended to focus on changing dysfunctional family patterns in the maintenance of individual symptoms. Over the past three decades, the field of family therapy

Table 7.2 Major Approaches to Family Therapy

Family Therapy Model	View of Problems	Therapeutic Goals	Process of Change
<i>Intergenerational/Growth-Oriented Approaches</i>			
Psychodynamic/ Intergenerational Boszormenyi-Nagy Framo Byng-Hall	Symptoms due to shared family projection process; unresolved past conflicts, and losses, loyalty, trust issues in family of origin	Resolve family-of-origin issues ↓ Family projection processes ↑ Individual and relational growth	<ul style="list-style-type: none"> • Insight-oriented, link past / present dynamics • Facilitate resolution of issues in current transactions • Encourage mutual empathy
Bowen Model Bowen Carter McGoldrick	Functioning impaired by unresolved family-of-origin issues, losses: <ul style="list-style-type: none"> • Poor differentiation • Anxiety (reactivity) • Triangles • Cutoffs, conflicts 	↑ Differentiation of self ↑ Cognitive functioning ↓ Emotional reactivity Detriangle: Repair cutoffs, conflicts	<ul style="list-style-type: none"> • Survey multigenerational system (use genogram, timeline) • Plan, coach focused interventions to change self with family • Detoxify, use humor
Experiential Satir Whitaker	Symptoms are nonverbal messages expressing current communication dysfunction in system	Direct, clear communication Genuine expression of feelings Individual & relational growth	<ul style="list-style-type: none"> • Facilitate direct communication • Experiential techniques to reveal conflicts, needs • Catalyze change process
<i>Problem-Solving Approaches</i>			
Structural Minuchin Philadelphia Child Guidance Clinic	Family structural imbalance: <ul style="list-style-type: none"> • Malfunctioning hierarchy, boundaries • Maladaptive reaction to developmental/ environmental changes 	Reorganize structure: <ul style="list-style-type: none"> • Parental leadership, authority • Clear, flexible subsystems, boundaries • Promote adaptive coping 	Shift interaction patterns: <ul style="list-style-type: none"> • Join family • Enactment of problem • Map structure, plan restructuring • Tasks and directives

Family Therapy Model	View of Problems	Therapeutic Goals	Process of Change
<p>Strategic/Systemic Palo Alto group Haley, Madanes Milan approach</p>	<p>Symptoms maintained by family's unsuccessful problem-solving attempts</p>	<p>Solve presenting problem; specific behavioral objectives</p> <ul style="list-style-type: none"> • Change symptom-maintaining sequence to new outcome 	<p>Pragmatic, focused, action-oriented:</p> <ul style="list-style-type: none"> • Interrupt feedback loop • Relabeling, reframing, paradox • Circular questions; curiosity
<p>Postmodern Solution-focused Berg & de Shazer</p> <p>Narrative White & Epston H. Anderson Freedman, Combs</p>	<ul style="list-style-type: none"> • Normality is socially constructed • Problem-saturated narratives • Constrained, marginalized by dominant discourse 	<ul style="list-style-type: none"> • Envision new possibilities; take positive steps to attain • Facilitative meaning-making • Re-author, thicken life stories 	<ul style="list-style-type: none"> • Future-oriented potential • Search for problem exceptions • Collaborative, respectful • Externalize problems to overcome
<p>Behavioral, Cognitive-Behavioral Patterson Alexander, Sexton Epstein, Baucom Datillio</p>	<p>Maladaptive, symptomatic behavior reinforced by</p> <ul style="list-style-type: none"> • Family reward • Negative interaction cycles • Core beliefs (schemas) 	<ul style="list-style-type: none"> • Concrete, behavioral goals • Improved communication and problem solving • Cognitive restructuring of misperceptions 	<ul style="list-style-type: none"> • Therapist guides, shapes • Change interpersonal assumptions • Reward desired behavior • Negotiation, problem-solving skills
<p>Psychoeducational C. Anderson McFarlane</p>	<ul style="list-style-type: none"> • Biologically based disorders; stress/diathesis • Adaptational challenges (e.g., chronic illness, single parents) 	<ul style="list-style-type: none"> • Optimal functioning ↓ stress, stigma, isolation • Master adaptational challenges 	<ul style="list-style-type: none"> • Multifamily groups, social support • Provide useful information • Offer management guidelines • Respectful collaboration
<p>Multisystemic Santistaban et al. Liddle et al. Henggeler</p>	<p>Family, social, larger systems influence adolescent conduct disorders, substance abuse</p>	<ul style="list-style-type: none"> • Reduce risks, problem behaviors • Promote positive youth adaptation 	<ul style="list-style-type: none"> • Family-centered • Collaborative involvement of peers, schools, community programs

has expanded the theory and application of family systems interventions and has refocused attention from family deficits to family strengths. (For a fuller description of models, see Goldenberg & Goldenberg, 2013.) The approaches differ in focus on particular aspects of functioning and well-being: multigenerational patterns and relational dynamics, structural patterns, communication, problem solving, and language and meaning systems. Despite many differences, family systems approaches attend to ongoing transactional processes and relational connections.

Intergenerational Approaches

Early in the field of family therapy, growth-oriented intergenerational approaches to family therapy sought to bridge psychodynamic, object relations, and family systems theories. In *psychodynamically oriented approaches*, therapists attend to the web of dynamic processes in the family network of relationships. In theory, a shared projection process, based on complementarity of needs, influences mate choice as well as couple and parent-child relationship patterns. Unresolved conflict or loss interferes with realistic appraisal and response to other family members. Current life situations are interpreted in light of the parents' inner object world and role models, contributing to distortion, scapegoating, and irrational role assignment. Symptoms can result from attempts by spouses/parents to reenact, externalize, or master through current relationships their intrapsychic conflicts originating in the family of origin.

Assessment and intervention explore the complex multigenerational family patterns and their connection to disturbances in current functioning and relationships. Extended family members may be included in family sessions, or individuals may be encouraged to work on changing key relationships between sessions (Framo, 1980). The therapeutic aim is for family members to deal with one another directly in order to work through unresolved conflicts and

losses rather than by analysis of transference patterns with the therapist. The therapist actively encourages members' awareness of intense conflictual emotions, interprets their sources and consequences, and identifies shared defense mechanisms. The therapist takes charge in preparing, guiding, and processing such highly charged work. Covert family processes are made overt and accessible to resolution through insight and action for emotional working through. The conjoint process builds empathy and mutuality, strengthening couple and family bonds. In application of *attachment theory*, therapists facilitate couple and parental efforts to provide a secure family base for stable, trusting relationships (Byng-Hall, 1995) and emotional attunement (Greenberg & Johnson, 2010).

The *contextual approach* of Boszormenyi-Nagy (1987) emphasizes the importance of covert but powerful family-of-origin loyalty patterns with the aim of reconstruction and healing of wounded relationships. Therapy focuses on the ethical dimension of family relationships, examining the transgenerational legacies of parental accountability and filial loyalty. The therapist seeks to resolve issues and repair relational injuries or injustices through understanding and negotiation of grievances. Families are strengthened by efforts toward trustworthiness and relational equitability.

The *Bowen model* (Bowen, 1978) is a theory of the family emotional system and a method of therapy based on the view that functioning is impaired by poor differentiation, characterized by anxiety and emotional reactivity. This commonly produces conflict, triangulation, or cutoffs in highly charged relationships. Stresses on the family system, especially those caused by death, can decrease differentiation and heighten reactivity. Improved functioning results when emotional reactivity no longer blocks cognitive processes, and there is more genuine relating. The therapeutic goal is to assist individuals in repairing troubled relationships, achieving a higher level of differentiation and reduced anxiety in direct contact. Through a coaching process

(Carter & McGoldrick, 2001), which can be done in individual therapy, a client is coached to change his or her own behavior in relation to other family members, in contacts between sessions. In couple therapy, partners are encouraged to work on their own extended family relationships that are blocking, or intruding into, their relationship. In family therapy, separate and conjoint sessions may be combined, as with an adolescent and parents or stepparents or with adult siblings, around conflicts related to their family of origin. The therapist serves as consultant and coach, preparing and guiding change efforts and toning down reactivity to toxic family issues and contact.

Initially, a family evaluation surveys the entire family field. A genogram and timeline are constructed to diagram the network of relationships, important facts, relationship information, and major events. Client and therapist gain a working knowledge of the family system before undertaking change with an individual or a part of the family. Clients are encouraged to contact family members to clarify obscured or missing information, gaining new perspectives on parents, other members, and family history. Opportunities are pursued in meetings, visits, holiday gatherings, and reunions, as well as letters, phone calls, and Internet contacts. In the process of change, clients redevelop more differentiated personal relationships with family members, repairing cutoffs and changing their own part in emotionally charged cycles. Individuals are encouraged to take an "I position," asserting their own thoughts and feelings without attacking, defending, or withdrawal. Humor is used to detoxify emotional situations. Techniques of detriangling and reversals (expressing the unacknowledged other side of an issue) are two of the many means employed to open up rigid patterns. Sessions may start at weekly or biweekly intervals and be spaced out as work proceeds. Follow-through is essential, given the anxiety generated and the need to handle others' self-correcting reactions that can undermine change. Even when others do not change, clients' own efforts can be

empowering and healing, benefiting other relationships in their lives. Carter and McGoldrick (2001) have expanded this approach to address the impact of larger cultural forces, such as sexism, racism, and social class disparities.

Experiential Approaches

Experiential approaches to family therapy were developed by two leading pioneers, Virginia Satir (1972), who blended a communication approach with a humanistic frame of reference, and Carl Whitaker (1992), who practiced an idiosyncratic style of intervention. Experiential approaches are highly intuitive and relatively atheoretical. As the natural consequence of life experience, old pains can be aroused by current interaction, regardless of awareness or intent. The aim of these growth-oriented approaches is fuller awareness and appreciation of oneself in relation to others, achieved through an intense, affective experience with open communication of feelings and differences. In a phenomenological approach to assessment and intervention focused on the immediate experience, the therapist elicits important information in transactions. The approach encourages exploration, experimentation, and spontaneity of members' responses to each other. Experiential exercises, such as family sculpting and role play, are used to catalyze this process. The therapist is facilitative, following and reflecting family processes and stimulating nondefensive, genuine relating.

PROBLEM-SOLVING APPROACHES

Structural Model

Structural family therapy, developed by Minuchin (1974) and colleagues at the Philadelphia Child Guidance Center, emphasizes the importance of family organization for the functioning of the family unit and the well-being of members. The model focuses on the patterning of transactions in which symptoms are

embedded. Problems are viewed as an indication of imbalance in family organization, particularly a malfunctioning hierarchy with unclear parent and child subsystem boundaries. Commonly, symptoms are a sign of a maladaptive reaction to environmental or developmental changes. Child-focused problems often detour conflict between parents or between a single parent and a grandparent.

Therapy is brief, aiming to strengthen the family structural foundation by modifying dysfunctional patterns for better functioning and coping with life stresses. Presenting problems, a symptom of family distress, usually are resolved as this reorganization is accomplished. Therapy involves three processes: (1) *joining*, (2) *enactment*, and (3) *restructuring*. First, the therapist joins the family in a position of leadership of the therapeutic system, connecting with family members, especially parents, to engage them in the change process. Second, the therapist assesses the family transactions as members enact presenting problems in the interview. Third, based on an interactional diagnosis and structural mapping of the immediate family field, the therapist uses tasks and directives to restructure the family around its handling of problems. The therapist is active in sessions, shifting triangular patterns, blocking dysfunctional coalitions, and promoting healthier alliances. Directives, or tasks involving structural change, are assigned to be carried out between sessions. Efforts are directed to strengthen the parental subsystem (couple, single parent, or parent-grandparent) and reinforce appropriate generational boundaries. Live observation of sessions through a one-way mirror facilitates training and intervention.

The structural model was developed to work effectively with poor, inner-city, multiproblem families presenting child or adolescent concerns. It is especially useful with single-parent and underorganized families. It was also applied successfully to psychosomatic and eating disorders. More recent efforts have also been directed to change traditional child welfare and foster care

systems, criticized for “dismembering families” in fragmented approaches, toward practices that support children’s ongoing connections and knit together biological and foster or kinship care family systems (Minuchin, Colapinto, & Minuchin, 2006).

Strategic/Systemic Approaches

Early strategic and systemic approaches to family therapy were developed by the Mental Research Institute (MRI) group in Palo Alto (Haley, 1976; Weakland, Fisch, Watzlawick, & Bodin, 1974), and by the Milan team (Boscolo, Cecchin, Hoffman, & Penn, 1987). These models regard presenting problems as both a symptom of and a response to current stresses, a communicative act within a repetitive sequence of interactions. Therapy focuses on how a family has attempted to solve its problems, because a misguided attempt may make matters worse. Families often do what they do because they believe it is the best way to approach a problem or the only way they know. The therapeutic task is to interrupt ways of handling the problem that are not working. Therapy focuses on altering the interactional feedback loop that maintains symptomatic behavior. Early strategic approaches assumed that symptoms serve a function in the family and that change depends more on indirect means of influence than on insight or simply improving communication. The therapist’s stance was remote, yet active and pragmatic, planning and carrying out a strategy to achieve specific objectives.

Several techniques are widely used. *Relabeling*, *reframing*, and *positive connotation* involve strategic redefinition of a problem situation to cast it in a new light. They are commonly used to redefine what has been viewed negatively as a well-intentioned attempt to adapt or to protect other family members. These techniques can be useful in shifting a family’s rigid view or response, altering an unproductive blaming process, or overcoming barriers to change. In the reformulation of a problem, new solutions can

become more apparent. *Directives* are carefully designed behavioral tasks for families to carry out between sessions. They are useful in gathering direct information about the ways family members interact and how they respond to change efforts. When well formulated and well timed, they can be highly effective in structural and behavioral change. *Indirect techniques* are seemingly in opposition to objectives but actually serve to move toward them. In paradoxical instruction (no longer widely used) a therapist might prescribe the symptom or direct clients to do the opposite of their intended goal.

The *Milan approach* stresses the importance of learning a family's language and beliefs, seeing the problem through various members' eyes and appreciating the values and expectations that guide their handling of problems and inability to change. The approach follows three principles in conducting family interviews and obtaining useful information for change: (1) *Working hypotheses* are formed about the connection of symptoms with family relationships; (2) *circular questioning* elicits various members' perspectives about relationship patterns, such as who is more connected or concerned about an issue; and (3) *neutrality* was initially advised for the therapist's avoidance of judgment, criticism, or moral alignment with any part of the system. Recognition that therapists can never be neutral led to a therapeutic stance of *respectful curiosity* (Cecchin, 1987).

Behavioral and Cognitive-Behavioral Approaches

Behavioral approaches to family therapy developed from behavior modification and social learning traditions (Patterson, Reid, Jones, & Conger, 1975). Families are viewed as critical learning contexts, created and responded to by members. Therapy attends to transactional rules, behaviors, and conditions under which social behavior is learned, influenced, and changed. Following social exchange principles,

family interactions offer many opportunities for rewarding exchanges likely to enhance relationships. In well-functioning families, maladaptive behavior is not reinforced, and adaptive behavior is rewarded through attention, acknowledgment, and approval. Poor communication and reliance on coercive control exacerbates maladaptive behavior and relationship distress.

Intervention objectives are specified in concrete observable behavior. The therapist guides family members in a straightforward way to learn more effective modes of dealing with one another by changing the interpersonal consequences of behavior (contingencies of reinforcement). Individuals learn to give each other approval and acknowledgment for desired behavior instead of reinforcing maladaptive behavior by attention or punishment. The therapist builds communication skills in negotiation and problem solving, increasing adaptability in varied situations. Within a positive alliance, the therapist assumes a role as educator, model, and facilitator. Numerous studies have documented the effectiveness of this approach with adolescent conduct disorders, particularly the functional family therapy model developed by Alexander and colleagues (Sexton & Alexander, 2003). More recent cognitive-behavioral approaches (Dattilio, 2005) restructure family schemas along with behavioral change and are also effective with couple conflict.

RECENT DEVELOPMENTS IN STRENGTHS-BASED APPROACHES

The field of family therapy has shifted increasingly from a deficit to a strengths perspective and from a hierarchical stance of the therapist as expert to a respectful collaboration with family members. Assessment and intervention are redirected from problems and how they are maintained to solutions and how they can be attained. Therapeutic efforts aim to identify and amplify existing and potential competencies and

resources. Therapist and clients work in partnership to see new possibilities in a problem-saturated situation and to overcome impasses to change and growth. This positive, future-focused stance shifts the emphasis of therapy from what went wrong to what can be done for enhanced functioning and well-being.

These approaches oppose assumptions that symptoms necessarily serve ulterior functions for the family and reject the notion that the therapist must use clever techniques to overcome family resistance to change. Therapists attribute benign intent to all clients, assume that they really do want to change, and strive to overcome constraints. The therapeutic relationship eschews the hierarchical power-based position of earlier approaches. Instead, it is built on trust and respect of families and oriented toward recognizing and amplifying their positive strengths and resources and their untapped potential.

Postmodern Approaches

Postmodern perspectives have heightened awareness that clinical views of normality, health, and pathology are socially constructed. Clinicians and researchers inescapably bring their own values and biases and thus coconstruct the patterns they discover in families. Moreover, therapeutic objectives are influenced by both family and therapist beliefs about healthy functioning (Walsh, 2012). Clinicians and researchers need to be aware of their own implicit assumptions, values, and biases embedded in cultural norms, professional orientations, and personal experience.

Postmodern approaches are based in constructivist and social constructionist views on the subjective experience of reality (Hoffman, 1990). These approaches were influenced by earlier strategic-systemic models but broke away from many core principles. While people are thought to be constrained by their narrow, pessimistic views of problems, limiting the

range of alternatives, therapy refocuses from problems and the patterns that maintain them to solutions and the processes that enable them. Use of the *reflecting team* (Andersen, 1987) in consulting team observation of live sessions fosters a more collaborative approach, whereby families, after the session, can observe the team in discussion of their session and then offer their own reflections.

Narrative and conversational approaches emphasize the therapeutic conversation and process of “restory-ing” a problematic experience (Anderson, 1997; Freedman & Combs, 1996; White & Epston, 1990). At the core of therapy is the postmodern view that reality is subjective and is socially constructed through language. A basic premise is that people strive to make meaning of their experience. The clients’ stories are the primary focus. Meanings are coconstructed in the therapy process. Therapist views, as well as those of clients, are subjective, influenced by culture, personal experience, and professional orientation and assumptions. Therefore, therapists eschew the role of expert in interpreting their clients’ lives; rather, their skills are in listening well to client narratives, being curious about their stories, asking questions to thicken descriptions, and wondering about alternative constructions to expand possibilities. Therapy attends to the ways in which language and meaning reflect cultural values and the larger social context. Space is opened for voices that have not been heard or views that have been marginalized by a dominant discourse. The objective is to construct new narratives, or life stories, that are less constraining and more empowering and satisfying.

The technique of externalization (White & Epston, 1990) serves as a means through language to reframe problem situations toward more empowering constructions that encourage problem resolution. Essentially, it shifts conversation to separate the problem from the symptom bearer, most often a child, lessening internalized guilt, shame, and defensiveness. An external force may be defined as wreaking

havoc on their lives. The therapist aligns with the child and parents, or with a couple, as a therapeutic team who, together, will gain control over and defeat this negative force. Clients are accountable for the choices they make in relation to their problems. The goal is for clients to feel successful and victorious in conquering their problems.

Solution-focused approaches avoid complex formulations when simple assumptions will lead more quickly to change (de Shazer, 1988), contending that complicated problems do not necessarily require complicated solutions. This brief approach generally does not assess or address the impact of stress events or broader family and contextual influences. Therapists search for exceptions to immediate problems: solutions that have worked in other situations and might work now and in the future. Formulaic techniques, such as *scaling* (client ratings to concretize aims and progress) and asking the *miracle question*, are used to refocus from complaints to desired outcomes and the steps needed to reach them. Berg (1997) has described useful applications of this approach for social service settings.

Family Psychoeducational Approach

Family psychoeducational approaches have been empirically demonstrated to be an essential component of effective treatment for schizophrenia (Anderson, Reiss, & Hogarty, 1986) and find valuable application with a range of chronic mental and physical conditions (Gonzalez & Steinglass, 2002; Lefley, 2009; McFarlane, 2002; Miklowitz, 2010; Rolland, 1994). This approach provides family education and support to foster coping and adaptation, with concrete guidelines for crisis management, problem solving, and stress reduction. The rationale is explicitly based on the importance of practical information, social support, and problem-solving assistance through the predictably stressful periods that can be anticipated in

the future course of a chronic illness or major life transition.

With major mental illness, families are engaged as valued collaborators in the treatment process, with respect for their challenges. This approach does much to correct the marginalization and blame-laden causal attributions experienced by many families of the mentally ill in traditional psychiatric settings. In the controlled study by Anderson and colleagues (1986), family intervention combined with drug maintenance and social skills training dramatically reduced relapse rates and improved functioning of individuals with chronic schizophrenia and also reduced family distress. The approach is based on a stress-diathesis model: Environmental stresses interact negatively with a core biological vulnerability to produce disturbed cognitions and behaviors. Assisted by information and support, families are viewed as important caregiving resources for the long-term management of the condition. A highly structured, family-oriented program was designed to avoid treatment dropout, to sustain functioning in the community, and to decrease family stress and relapse rates. Anxiety and tensions in patient-family interactions decrease as families gain knowledge about the illness and confidence about their ability to manage it. The approach focuses on solving immediate problems one at a time, measuring success in small increments, and maintaining family morale.

Family psychoeducational interventions have been adapted to a number of formats, including periodic family consultations, workshops, and brief time-limited or ongoing multifamily groups (McFarlane, 2002). Group formats decrease family isolation and the stigma associated with mental illness as they offer mutual support, sharing of experience, and exchange of useful ideas among families struggling with similar challenges. Brief psychoeducational “modules” timed for critical phases of an illness (Rolland, 1994) support families in digesting manageable portions of a long-term coping process and in handling periodic flare-ups. Such cost-effective

approaches are especially useful with families at high risk of maladaptation or relapse of a serious condition.

Multisystemic Approaches With Adolescent Conduct Disorder

Several evidence-based, multisystemic and multidimensional intervention models offer highly effective approaches with high-risk and seriously troubled youth by involving families and larger-community systems (Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Liddle, Santisteban, Levant, & Bray, 2002; Santisteban et al., 2003; Sexton & Alexander, 2003; Szapocznik & Williams, 2000). These approaches with adolescent conduct disorder and drug abuse also yield improvements in family functioning, including increased cohesion, communication, and parenting practices, and are significantly linked to more positive youth behavioral outcomes than in standard youth service. Multisystemic interventions may take a variety of forms and involve school counselors, teachers, coaches, and peer groups; they may work with police officials, probation officers, and judges to address adolescent and family legal issues. They might help a youth and family access vocational services, youth development organizations, social support networks, and religious group resources.

With families that are often seen as unready, unwilling, or unmotivated for therapy, these approaches engage family members in a strengths-oriented, collaborative alliance. They develop a shared atmosphere of hope, expectation for change, a sense of responsibility (active agency), and empowerment. Rather than seeing troubled youths and their families as resistant to change, attempts are made to identify and overcome barriers to success in the therapeutic, family, and social contexts. Therapeutic contacts emphasize the positive and draw out systemic strengths and competencies for change. Clinicians maintain and clearly communicate an optimistic perspective throughout the assessment and intervention processes.

Collaborative Family Health Care

Family-centered health care is a rapidly growing practice arena. Research has demonstrated that a collaborative team approach—including health and mental health care providers, patients, and their families—fosters optimal biopsychosocial care (Campbell, 2003; McDaniel, Hepworth, & Doherty, 2007). Preventive and integrative approaches to mental health and health care are most effective when supported by families. For military service members with disabilities, particularly posttraumatic stress disorder (PTSD) and traumatic brain and orthopedic injuries, spouses and family members are essential partners for optimal recovery. For persons suffering from serious mental illness, family consultation and psychoeducation facilitate a collaborative approach to treatment, with mutual understanding of aims and concerns (McFarlane, 2002). Strengthening the family support system is crucial for inpatient discharge planning, medication compliance, and optimal community living. Families benefit, as well, when linked with local support groups, online resources, and consumer organizations such as the Multiple Sclerosis Foundation and the National Association for the Mentally Ill (NAMI).

With advances in medicine and the aging of society, families increasingly confront long-term challenges of chronic illness and caregiving. Family systems approaches expand the customary model of individual caregiver (predominantly female), for whom overload can compromise health and well-being, to a *caregiving team* approach, involving siblings and other key family members (Walsh, 2006; 2014). Dementias, particularly Alzheimer's disease, with accompanying ambiguous losses, are especially agonizing for family members (Boss, 1999). End-of-life decision making, as well, poses difficult relational, ethical, and spiritual dilemmas for loved ones. With bereavement, a family-systems approach attends to the reverberations of a significant loss for all members and their relationships and facilitates family healing and adaptation (Walsh & McGoldrick, 2004). A family

approach is especially valuable with complicated losses: those that are sudden and unexpected, untimely (e.g., the death of a child), violent (e.g., a car crash, deliberate harm), stigmatized (e.g., suicide, HIV/AIDS), or not socially supported (e.g., perinatal death, same-sex partners, loss of a pet) (Walsh, 2007, 2009a).

The family systems illness model, developed by Rolland (1994, 2012) and applied in numerous studies, provides a useful framework for consultation, therapy, psychoeducational workshops, and multifamily groups with families facing chronic illness, disability, and loss. Most families lacking a psychosocial map for this experience benefit enormously from information and support in coping with and adapting to a family member's serious illness. Family dynamics, stress and coping, and supportive relationships can influence compliance, disease course, and the well-being of the sick person, caregivers, and others. Therefore, a brief family consultation near the initial diagnosis, at hospital intake and discharge, and at major nodal points and transitions over the course of the illness (e.g., recurrence or progression of the illness, transfer to hospice) facilitates patient and family adaptation and support. With the new era of genomics, family consultation will be needed increasingly for a broad spectrum of medical and psychiatric conditions around genetic testing, living with risk information, making life decisions, and informing other at-risk family members.

Practice Applications of a Family Resilience Framework

A family resilience practice approach aims to strengthen family capacities to overcome adversity. It addresses symptoms of distress and family functioning in the context of serious crisis, trauma, and loss; disruptive life transitions; and stress-laden chronic conditions. Practice applications draw on strengths-based systemic practice principles and methods described above, focusing on therapeutic and preventive efforts for

fostering family coping, adaptation, and positive growth in dealing with life challenges. A basic systemic premise guiding this approach is that individual or shared crises and persistent adversity have an impact on the whole family, and in turn, key family processes can facilitate the recovery and resilience of all members and their relationships. Facilitating the family's ability to master its immediate crisis situation also increases its resourcefulness in meeting future challenges. A number of programs developed by faculty at the Chicago Center for Family Health (Walsh, 2006, 2013) illustrate the wide range of valuable applications of a family-resilience-oriented approach in clinical and community-based intervention and prevention:

- Illness, disability, end-of life, and caregiving challenges
- Complicated traumatic loss, healing, and resilience
- Family-school partnership program for success of at-risk youth
- LGBT challenges with stigma, inequalities
- Positive adaptation to divorce; stepfamily integration
- Job loss, unemployment, and financial hardship
- Combat-related trauma and military family resilience
- Major disasters: facilitating family and community resilience
- Refugee trauma and resilience: multifamily groups for Bosnian and Kosovar refugees
- Complex trauma in war-torn regions: Kosovar Family Professional Education Collaboration (KFPEC)
- Los Angeles Gang Reduction/Youth Development (GRYD) Prevention Program

Such programs in many settings can be designed in varied formats: family consultation, brief or intensive family therapy, multifamily groups, family networks, and community forums. A number of family systems therapists have developed their own resilience-oriented approaches to respond to community-wide disasters (e.g., Saul, 2013). Landau (2007) has designed a consultation model (LINKS) to build

family and community resilience in situations of natural disaster and conflict in many parts of the world.

Strengthening Resilience in Vulnerable Multistressed Families

Many families in poor communities, disproportionately minorities, are buffeted by frequent crises and persistent stresses that overwhelm their functioning (Aponte, 1994). Traumatic losses, abrupt transitions, and chronic stresses of unemployment, housing, discrimination, and health care can fuel despair. With neighborhood crime, violence, and drugs, parents worry constantly about their children's safety. Bleak life prospects, making it hard to break the cycle of poverty, leave parents defeated by repeated frustration and failure. Intertwined family and environmental stresses contribute to school dropout, gang activity, and teen pregnancy. Too often, agencies and schools have viewed multistressed families through their deficits and written them off as unreachable and untreatable.

A family resilience approach is most needed and beneficial with vulnerable multistressed

families (Walsh, 2006). When therapy is overly problem focused, it grimly replicates families' problem-saturated experience. Empowering interventions that enhance positive interactions, supporting coping efforts, and building resources are more effective in reducing stress and enhancing pride and more effective functioning. A compassionate understanding of their struggles can engage parents in efforts to break dysfunctional cycles. By tapping family resources and potential, strengthening bonds for mutual support, and encouraging their best efforts, families can be encouraged to gain hope, confidence, and new competencies to overcome their life challenges. Maintaining a family focus involves a systemic view that addresses their problems, repairs and strengthens bonds, and supports efforts for positive growth (Madsen, 2009; 2011; Minuchin et al., 2006; Ungar, 2004).

Disruptions and losses in relationships with foster or kinship care and reunification increase the risk of youth adjustment problems. A systemic approach is needed to address the shifts, sustain connections, and resolve conflicts in role relations, as the following case vignette illustrates.

Terrell, age 8, was seen in individual therapy for anxiety and poor concentration in school 3 months after he was returned to the custody of his mother, a single parent, following her recovery from drug addiction. Terrell and his siblings had been living with their maternal grandmother, in her guardianship for 2 years. In regaining their mother, the children had now lost their grandmother. Although the grandmother lived nearby, the mother cut off all contact between them, still angry at her for initiating the court-ordered transfer of the children. Now becoming overwhelmed by job and child care demands, she risked losing custody again.

A systemic approach was needed to guide intervention efforts. Sessions with the mother and the grandmother were held to calm the transitional upheaval, repair their strained relationship, and negotiate their changing roles. The therapist facilitated their collaboration across households, with the mother in charge as primary parent. It was crucial to reframe the grandmother's role—not rescuing the children from a deficient mother but supporting her daughter's best efforts to succeed with her children and her job. The children's vital bond with their grandmother was renewed in her after-school child care, thereby also relieving pressure on the mother. The mother's sister, Terrell's godmother, was included in a session, to explore how she might also be a resource. She invited Terrell to play with his cousins on Saturday afternoons, which pleased him and gave his mother the needed respite.

AN EXPANDING FIELD OF PRACTICE

Family-systems-based interventions are finding broad application in community-based services for a broad diversity of clients and a wide range of problems. Despite some differences in strategies and techniques, systemic approaches focus on direct assessment and change to improve individual and relational functioning, well-being, and resilience. Clinicians with a family systems orientation increasingly integrate elements of various models (e.g., Scheinkman, 2008), and most see individuals, couples, and family members in varied combinations depending on particular situations. Cell phones and the Internet offer new possibilities for family contact and involvement. Therapists increasingly use their systemic perspective to collaborate with schools, workplaces, health care, justice, and other larger systems. Growing numbers of family therapists work with low-income and minority families and at-risk youth. Multicultural approaches address the intersections of race, class, gender, and culture in clinical practice (McGoldrick & Hardy, 2008). Therapists address the concerns of LGBT clients (e.g., Green, 2012), immigrant and refugee families (Falicov, 2007), and others suffering discrimination and marginalization in the larger society. Family therapists work to promote social policy and institutional changes needed for families and their members to thrive. Many devote attention and expertise to address social justice and humanitarian concerns in our society and worldwide. Many strive to foster family and community recovery and resilience in regions affected by natural disasters, war, and ongoing conflict. With a systemic orientation, it is essential not only to help families overcome obstacles to their well-being but also to address the hardships and remove the barriers that block their ability to thrive.

A common question, “When is family therapy indicated?” requires reconceptualization. Family therapy is the practice of a systemic orientation, guided by the assumption that an individual’s problems can best be understood and changed in their relational and social context. Positive changes

in stressful transactions will facilitate individual change and growth. A systemic lens can enrich all forms of intervention, from a biomedical model to cognitive-behavioral approaches. Family consultations can facilitate engagement, collaboration, and building of family resources by direct contact with key members in the kin network. For instance, foster care is facilitated when important family members are involved, like a family council, to discuss placement options and collaborate in decision making and ways of supporting children’s experience (Minuchin et al., 2006).

In systemic intervention approaches, therapists aim to promote change directly with significant family members, during or outside sessions. Therapy may selectively focus on specific problems and include those members most crucial for problem solving. More intensive family therapy may be needed in cases of multiple, complex, or entrenched difficulties. With the recognition that complex biopsychosocial problems are often not resolved by a single approach, combined modalities are often indicated. For serious mental illness, research documents the combined effectiveness of psychotropic interventions with individual, family, and group approaches, as noted above. Treatment models for substance abuse, violence, and sexual abuse also require a multimodality approach. Careful planning, timing, and focus are important.

Finally, our knowledge base and practice approaches are informed and enriched through the contributions of both quantitative and qualitative research on family processes and therapeutic process (Lebow & Stroud, 2012; Sprenkle, Davis, & Lebow, 2009; Walsh, 2012). Given the broad diversity of families and their challenges, no single model fits all. Most important, at the heart of the therapeutic endeavor is our common humanity and compassionate relationship with the families we serve, supporting their best potential and positive strivings.

CONCLUSION

This chapter provides an overview of family systems concepts and methods. In recent decades, the theory and practice of family therapy has

expanded to respond to increasing cultural diversity, challenging socioeconomic conditions, varied family forms, changing gender roles, and variable and extended life courses. As the very definition of the family has broadened, so too has the definition of family therapy, to encompass a wide variety of approaches and formats, including family consultation and brief therapy, more intensive family therapy, individual coaching approaches, multifamily groups and workshops, and collaboration with school, workplace, health care, and other larger systems. In all direct practice, a developmental, systemic orientation is valuable as an integrative framework, fostering an understanding of each person in family and sociocultural contexts and facilitating respectful collaboration with families in clinical and community-based interventions for optimal functioning, well-being, and resilience.

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