HANDBOOK OF FAMILY THERAPY

EDITED BY THOMAS L. SEXTON & JAY LEBOW

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Integrative, research-based, multisystemic: these words reflect not only the state of family therapy, but also the nature of this comprehensive handbook. The contributors, all well-recognized names who have contributed extensively to the field, accept and embrace the tensions that emerge when integrating theoretical perspectives and science in clinical settings to document the current evolution of couples and family therapy, practice, and research. Each individual chapter contribution is organized around a central theme: that the integration of theory, clinical wisdom, and practical and meaningful research produce the best understanding of couple and family relationships, and the best treatment options. The handbook contains five parts:

- Part I describes the history of the field and its current core theoretical constructs
- Part II analyzes the theories that form the foundation of couple and family therapy, chosen because they best represent the broad range of schools of practice in the field
- Part III provides the best examples of approaches that illustrate how clinical models can be theoretically integrative, evidence-based, and clinically responsive
- Part IV summarizes evidence and provides useful findings relevant for research and practice
- Part V looks at the application of couple and family interventions that are based on emerging clinical needs, such as divorce and working in medical settings.

Handbook of Family Therapy illuminates the threads that are common to family therapies and gives voice to the range of perspectives that are possible. Practitioners, researchers, and students need to have this handbook on their shelves, both to help look back on our past and to usher in the next evolution in family therapy.

Thomas L. Sexton, PhD, ABPP, is Professor Emeritus at Indiana University. He is one of the model developers of Functional Family Therapy and editor of *Couple and Family Psychology: Research and Practice*.

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Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2016
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

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Library of Congress Cataloging-in-Publication Data
Handbook of family therapy (Sexton)
Handbook of family therapy / edited by Thomas L. Sexton and Jay Lebow. — 2nd edition.
p. ; cm.
Includes bibliographical references and index.
I. Sexton, Thomas L., 1953-, editor. II. Lebow, Jay, editor. III. Title.
[DNLM: 1. Family Therapy. 2. Couples Therapy. WM 430.5.F2]
RC488.5
616.89′156—dc23
2015001700

ISBN: 978-0-415-51801-7 (hbk)
ISBN: 978-1-138-91762-0 (pbk)
ISBN: 978-0-203-12358-4 (ebk)

Typeset in Minion
by Swales & Willis Ltd, Exeter, Devon, UK

To Al Gurman

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1.

THE EVOLUTION OF FAMILY AND COUPLE THERAPY

Jay Lebow and Thomas L. Sexton

It all started with a simple observation. By expanding one's "lens" from the individual to the entire family, new treatment opportunities and new ways of understanding the seemingly mysterious mechanisms of relationships emerged. By moving the focus of attention from the individual to a relational focus came a new clarity in defining and understanding the "space between" the people in families. In doing so, therapy became a process in which behaviors and interactions were described in terms of a recursive process of mutual influence. For most early family therapists, this also meant "an emphasis on what is happening in the here and now rather than why it is happening or in terms of a historical focus." Thus, the patterns within relationships became the primary target and goal of most early family therapies.

This simple observation and the complex thinking that came quickly after marked the beginning of a paradigm shift akin to a scientific revolution. A paradigm shift, as Kuhn suggests, occurs when anomalies that could not be explained by the prevailing majority view begin to emerge and become significant. Such a scientific revolution occurs when an alternative belief system ushers in a new way to see the world, a different perspective, and new meaning for events otherwise considered not important. The early principles of systems theory and its application to family therapy led to an alternative and comprehensive belief system based on communication, cybernetics, and relational process.

Family therapy has evolved a great deal since the publication of the first handbook overviewing family therapy in 1971. Although the core foundational systemic concepts remain, the practice of family therapy looks much different today than it did fifty years ago. Family therapy has morphed over time from a provocative challenger to the mental health establishment to a widely practiced set of methods that represent best practices in relation to a variety of problems and issues. Further, whereas early family therapy was largely about the argument between proponents of various models regarding who had the "right" theory and best method of practice, today's family therapy includes emerging consensus about many issues in the field. Family therapy has also moved from an alternative therapy to a set of methods that often coordinate and integrate with other methods of treatment (see, for example, Chapters 12, 16, and 28). Further, some family treatment models have emerged to become among the best illustrations of evidence-based treatment that combine cutting-edge science while embracing the complexity and artfulness of clinical implementation of those models (see Chapters 12–20).

Handbooks of Family Therapy

For the last fifty years, handbooks of family therapy have chronicled the evolution of this paradigm. Each has reported on the then present emerging epistemologies, theoretical foundations, models of clinical practice and the state of the research in the field.

The first embryonic handbook, *Progress in Group and Family Therapy*, edited by Clifford Sager and Helen Singer Kaplan (1971), was not even fully devoted to family therapy, sharing a volume with group therapy. Paired with the contemporaneous *Book of Family Therapy*, edited by Andrew Ferber, Marilyn Mendelsohn, and Augustus Napier (1972), three themes emerge from these early volumes. First, there is the shock of the new, the revolutionary flow of new ideas and methods. Second, there is the emergence of the underlying focus on systems theory as a base of conceptualizing families. Third, there are the unruly developments in many directions and models, with much debate beyond agreement about the core importance assigned to families and systems theory. Finally there is what is missing: research or any focus on gender or culture. These volumes are filled with what then were new concepts and terms: boundaries, communication, information processing, entropy, negentropy, equifinality, equipotentiality, morphostasis, morphogenesis, and positive and negative feedback, all emerging ways to understand the "system." (Years later we can also note that it required a family therapy dictionary to understand the meanings of this new language—Lyman Wynne and colleagues actually produced one (Simon, Stierlin, & Wynne, 1985)). These two early handbooks point to what then was a marvelous explosion of ideas and methods, but limited by the presence of very little integration or science assessing those ideas.

Alan Gurman and David Kniskern's (1981) *Handbook of Family Therapy* marked the emergence of family therapy as an established discipline. Notably, unlike its predecessors with their idiosyncratic content, it was organized to be used as a course text with a suggested chapter outline that would elicit each chapter authors' positions about a core set of questions. Gurman and Kniskern's first volume primarily consisted of articulations of the rich array of the recently emergent family therapy models. These models ranged widely from the "black box" structural and strategic models with which that era is now so readily identified, to intergenerational models of Bowen, Framo, and Boszormenyi-Nagy; to the psychoanalytic based approaches of Skynner and Sager; to the behavioral models of Jacobson and Heiman; to the experiential approach of Whitaker. Beyond the underpinning of systems theory and the importance of family, these approaches agreed about very little. Gurman and Kniskern's first volume also included Alan Gurman's first comprehensive effort to bring the frame of evidence-based practice (i.e., that evidence was essential to the assessment of treatments) to family therapy.

It is impossible for the contemporary reader to grasp the impact of this volume. It is fairly safe to say that every family therapist of that time owned this giant tome. (The then popular Behavioral Science Book Club made it their award for joining the Club. How wise you would look with that five pound book.) As I (JLL) write this paragraph looking at a quite worn highlighted and underlined copy from that time, I fondly recall the hundreds of hours of discovery that I and innumerable others devoted to reading this book! For me (TS) the volume was a window into a new world. These were the words of the masters, all in one place with Alan Gurman and David Kniskern's brilliant commentary (this may be the only volume in the history of the field in which the editors not only edited but also commented on the chapters within the chapters themselves). Oh, yes, the problems of the times must also be mentioned. Almost every author was male and only Harry Aponte of the authors was a person of color. Culture was barely mentioned, and even in a volume edited by Alan Gurman, there was very little research presented either assessing treatments or as a basis for the many claims made about social systems.

Gurman and Kniskern later produced a second volume (1991) which is primarily notable for its early attention to issues that cross theoretical boundaries. It contains the first chapter written on the history of couple and family therapy and

chapters on treating divorcing and remarriage families (in early recognition of the need for different expectations and treatments for these family forms). It also featured a chapter on ethnicity and family therapy by Monica McGoldrick and colleagues, and one by Evan Imber Black on a larger systems perspective. In these chapters, the voices of women, who rarely were heard from in earlier volumes, gained prominence. That book is also notable for William Doherty and Pauline Boss' still definitive chapter on values and ethics in family therapy and Howard Liddle's chapter on training which, as Breunlin points out in Chapter 27 of this volume, still remains the best summary about training in the field even though it is now twenty years old.

By the time of Tom Sexton, Gerald Weeks, and Michael Robbins' (2003) *Handbook of Family Therapy*, the landscape of family therapy was becoming increasingly integrative, research based, and multisystemic. The emphasis on broad "schools" of therapy was augmented by greater attention to "Common Factors" that are intrinsic to all family therapies and perhaps paradoxically as well to more specifically focused, manualized clinical models. In addition, this volume pointed to the emergence of a number of the models of family and couple therapy as "evidence based." The evidence-based models included in both couple (Behavioral Marital Therapy/Integrative Couple Therapy, Emotionally Focused Couple Therapy) and family (Functional Family Therapy, Multisystemic Therapy, and Multidimensional Family Therapy, among others) therapy demonstrated that systemically based treatment models did produce significant clinical changes in a wide variety of areas including delinquency, adolescent drug use, management of adult chronic schizophrenics, and depression. This volume also showed that family therapy, a provocateur in its earliest days, was now mainstream and that it had some of the most effective treatments to be developed for some of the most difficult cases. During this era, from a much different direction, some of the core ideas in family therapy were challenged by postmodern epistemological perspectives. The Sexton, Weeks, and Robbins volume contains the first summary in a handbook of those models. Postmodern approaches are now a vital part of that spectrum, and have broadly helped move the field to an emphasis on collaboration.

Jay Lebow's (2005) *Clinical Handbook of Family Therapy* of about the same time pointed to the explosion of specific methods for family therapy targeted toward specific problems. Twenty-three different such models are included. Almost all of these models have a foundation in evidence; each worthy of a designation of at least "probably efficacious" in evidence-based language with several qualifying as well established. Family therapy had evolved a series of practical effective methods for impacting on a broad array of specific problems.

A New Era

In the decade since the last two handbooks of family therapy, the landscape has continued to evolve with the emergence of many points of agreement and transcendent concepts and intervention strategies that mark a consensus among most of those who teach and practice family therapy (Lebow, 2014). What were early arguments in the history of family therapy between proponents of various models about who had the "right" theory and best method of practice have segued into consensus about many issues in the field. Family therapy has also moved from an alternative "outsider" therapy to a set of methods that often coordinate and integrate with other methods of treatment.

One point of consensus is the core importance of the central concepts of systems theory such as feedback and mutual influence at the center of the practice of family therapy. Another is the crucial role of the therapeutic alliance and the other common factors in couple and family therapy (Lebow, 2014; Sprenkle, Davis, & Lebow, 2009). For example, whereas there once were family therapies that disregarded the therapeutic alliance (Watzlawick, Weakland, & Fisch, 1974), today's approaches universally speak to this tenet. A third is the crucial role of culture for practice in the world of families. Other points of consensus include the importance of the family life cycle, understanding the recursive relation of systemic change and individual changes, the relationship between these changes and neurological

processes, and the inclusion of at least some understanding of the importance of such theories as attachment, social exchange, and social learning. Although once hotly debated, the importance of linking research and practice (Sexton et al., 2011) and including some notion of evaluating outcomes as therapy progresses (see Chapter 26) now have become commonplace. Further, a shared common base of intervention strategies and techniques that is the toolkit for the couple and family therapist, including such elements as reframing, enactment, and examining genograms, has emerged (Lebow, 2014).

This is not to say there is full agreement across best practices. While there may be complete agreement about some issues (e.g., dual relationships; ensuring safety in the context of family violence), this shift is less about all family therapists following the same methods as about cross-pollination across approaches so that each approach influences and is influenced by the others. There remain many important points of difference. In parallel with a similar trend in other therapies, some look to build on a developing base of empirically supported therapies targeted to specific conditions. Others eschew this position, suggesting that formulation or even the ideology of the therapist about what is crucial should dictate the manner of working. Some approaches accentuate a focus on emotion, others on behavior and cognition, and yet others on internal dynamics and multigenerational processes. Some see family therapy as fully identified with the promotion of social justice, whereas others practice family therapy in ways that are socially conservative, and yet others view family therapy as ideally neutral about all issues of values. Some approaches are purposefully highly directive and structured, whereas others are as non-directive and unstructured as was Carl Rogers.

Also, despite some movement, the reliable and informative results of the cumulative research knowledge still often do not find their way into the mainstream of either clinical practice or training and education. Indeed, it is not uncommon, now more than four decades since the publication of the first research findings in the field, to encounter concerns about the role of research in practice. For example, practitioners continue to argue that researchers are not clinically responsive, whereas the researchers argue that practitioners are not systematic. The gap is also reflected in the fact that it is common to find new "hot" ideas being touted in practice publications and on the lecture circuit that have no support in either the rich theory or research of the field. As Gurman, Kniskern, and Pinsof (1986) noted, "Despite numerous attempts at seduction and mutual courtship, it remains the case that clinicians and therapy researchers have failed to consummate a 'meaningful' and lasting relationship, as has been observed, commented on, and lamented repeatedly" (p. 490).

We suggest that the current era of family therapy is founded upon the convergence of three powerful and sometimes independent "threads": 1) the specificity and sophistication of clinical practice; 2) ecologically valid clinical research into the change mechanisms and outcomes of therapy; and 3) a broadening of systemic theory and epistemological development. The major challenge remains: To find a way to "savor the dialectic" within our complex field and accept and embrace the inevitable tensions that emerge when integrating theoretical perspectives (e.g., postmodern and manualized protocols), and science in clinical settings (e.g., randomized clinical trials vs. community effectiveness and case study methods) (Sexton et al., 2003). If we can "savor the dialectic," we can accept that putting science into practice and practice into science is an inevitable and enduring quality of our profession. From our perspective, this era is one in which our different epistemological perspectives are united by a common purpose that demands a more inclusive embodiment of methodologies, perspectives, and conceptual models. Inclusiveness and respect for different perspectives has been a central theme of family therapy, lost in the struggle of what Sprenkle and Blow call "our sacred models" (2004). We suggest that an inclusive acceptance of difference and "savoring the dialectic" represent themes of a maturing field that will include all good ideas while the field distances itself from unscientific and theoretical approaches to family therapy.

Family therapy has changed a great deal across the various handbooks of family therapy. Some notable specific approaches that were the

center of chapters in earlier handbooks, such as Sager's Marriage Contracts (Sager, 1976), Framo's family of origin method (Framo, 1976), and symbolic-experiential therapy (Napier & Whitaker, 1988), have lost attention since the deaths of their founders. These approaches remain influential in terms of specific concepts and ideas or strategies and techniques that have been imported into other approaches, but these methods themselves are now rarely encountered in practice. Even behavioral couple and family therapy (Jacobson & Martin, 1976), one of the approaches with the most evidence for efficacy, has largely been succeeded by enhanced cognitive-behavioral and integrative behavioral approaches (Baucom, Epstein, Kirby, & LaTaillade, 2010; Christensen, Jacobson, & Babcock, 1995). A variety of specific techniques such as paradoxical intervention (Haley, 1963), sculpting (Papp, Scheinkman, & Malpas, 2013) and psychodrama (Papp, 1990) are also far less often encountered than earlier. Co-therapy, which was seen as a core adaptation of system concepts to therapy, long ago faded in the context of fee for service and demands for justification of cost-benefit for insurance reimbursement or agency expenditure. Other ideas that were merely germinating at the time of the earliest handbooks, such as the potential of psychoeducation (Anderson, Hogarty, & Reiss, 1980), parent training (Patterson, Chamberlain, & Reid, 1982), feminist revisions of family therapy (Silverstein & Goodrich, 2003), and adapting methods to specific cultures, have become essential aspects of everyday practice. A few approaches from the early handbooks remain widely practiced, albeit in forms that have evolved over time. These include Functional Family Therapy, Behavioral Parent Training, and the (behavioral) treatment of sexual dysfunction. Notably it seems that among the early methods it is mostly the behavioral ones that remain most widely practiced. However, this seems less the product of the superiority of those ideas and methods than a by-product of behavioral therapies being less dependent on charismatic treatment developers (and therefore having an easier time transcending their retirements) and the continuing adaptation that has occurred in behavioral methods over time. It should be added that footprints of many early family therapies are encountered everywhere. It is impossible to see a family therapy without some echo of structural therapy, and most of today's family therapies are profoundly influenced by aspects of treatments such as Bowen Therapy, contextual therapy, and experiential therapy.

Over the years, there also has been an exponential growth in clinical intervention research. In fact, the research foundations of family therapy now comprise a comprehensive and systematic body of clinical research that can and does capture the complexity of the relational and clinical practice of family therapy. The field has moved well beyond the early outcome studies to complex investigations of actual clinical processes and community-based outcome investigations of family therapy practices with "real" therapists, in actual clinical settings, with diverse clients, in many specific contexts. In fact, over the last three decades family therapy has developed a rich research foundation built on ecologically valid, clinically relevant process and outcome research. Family therapy researchers now "set the bar" for clinically relevant and multisystemic, community-focused, diversity-oriented clinical research (Sexton et al., 2011). The work in the last decade makes it evident that family therapy has become what Liddle, Bray, Levant, and Santisteban (2002) called "family intervention science," which is predicated on the growing body of outcome and process research studies that meet the highest standards of research methodology, and is indeed moving forward. Further, much of today's family therapy builds on the now sizable base of relationship science.

This Book

It is out of this changing context and long history that this version of *Handbook of Family Therapy* emerges. Like any living dynamic system, family therapy has evolved and changed. Thus, many of the primary practice models used to approach work with couples and families have undergone significant refinements as a result of both theory development and clinical research. The maturation of couple and family work is also represented by the fact that there are now clinical models that

have more than thirty years of sustained, systematic, and theoretically guided outcome and process research available to inform clinical practice. The field has also ventured into increasingly specialized arenas slowly expanding its realm of practice. These advances also represent a developmental trajectory from the early period of revolutionaries and theoretical zealots to the current era of mature multisystemic clinical models that integrate research, theory, and clinical wisdom in a systematic way (Sexton et al., 2003).

This book documents the current evolution of couple and family theory, practice and research. We hope that this volume can serve as a marker of and stimulus to pursue the new era. There remain clear differences in emphasis in approaches to practice. This *Handbook of Family Therapy* assumes a pluralistic view of the field. Different approaches flourish and there clearly is a range of effective ways of intervening. The goal is to provide a volume that has unique contributions and yet contains a common thread that ties the presentations together to address the theoretical foundations, the foundational, and evidence-based models of treatment, the research foundations, and the most salient innovations that have the potential to usher in the next evolution.

Organization of the Volume

This edition is organized around a central theme: the integration of clinical wisdom, practical and meaningful research, and theoretical integration produces not only the best understanding of couple and family relationships but also the best treatment option. Therein we create a core thread around which the chapter authors will comment. The volume contains five parts: Foundational frameworks, founding theoretical principles and core models, evidence-based practice, research foundations, and emerging areas of practice.

Part I: Foundational Frameworks in Family and Couple Therapy

This part is intended to describe both the "genealogy" of family therapy (its historical roots) and its current core theoretical constructs. As such, it lays the broad foundation of the evolutionary dynamic systems theme of the volume. The part is intended to take readers from the history to the current core theoretical models of the field of couple and family therapy. It presents four core foundations of family therapy. The first, by Alan Carr, presents the core systemic principles of family therapy, highlighting how these have changed and evolved just as have the practices and theories of the field. Froma Walsh offers a chapter centered on an understanding of family resilience, which has emerged as a close second to systems theory among ideas in its pervasive influence on family therapy. Her discussion of normal family development also provides a critical context for understanding the problems of family functioning and helps set therapeutic targets that aid families in becoming empowered to help themselves. More recently, neurobiology has emerged as a crucial further understanding for family therapy, accentuating the biological substrate of relationships. The neurobiology of relationships described by Mona Fishbane provides a unique sociobiological perspective on understanding and shaping interventions targeted at families. In the current landscape of family therapy, culture has also emerged as a transcendent framework. Early notions that universal family processes trumped culture are now informed by the extension of family therapy across the world. In the final chapter in this part, Celia Falicov presents an integrated view of including culture as an essential understanding in family therapy.

Part II: Foundational Theoretical Principles and Core Clinical Models

There remain a core of broad schools of treatment that form the foundation of couple and family therapy. The chapters in this part range from earlier structural and multigenerational models to more recent postmodern and integrative practices. While there are many theories, these were chosen for inclusion because they best represent the range of broad schools of practice in the field that remain in common practice. To provide continuity in the presentation of information, each chapter author was asked to organize their content using the following outline:

1. History and background of the approach
2. Major theoretical constructs
3. Proposed etiology of clinical problems
4. Methods of clinical assessment
5. Clinical change mechanisms/curative factors
6. Specific therapeutic interventions
7. Effectiveness of the approach
8. Future developments/directions

Part III: Evidence-Based Clinical Treatment Models

Several of the most widely disseminated recent approaches in couple and family therapy cross the boundaries of the theories described in Part II, aimed at pragmatically finding the most effective methods for intervening with specific problem areas. Contributors to this part, the leading experts in these treatment approaches, describe these models, their origins, specific clinical protocols for change and practice, current innovations and adaptations, and supporting research evidence. The clinical models presented here show how the advances in clinical research have an impact on practice through systematic, comprehensive research-based clinical treatment models. This section is not intended to be a comprehensive list of the "evidence-based approaches" but instead provides the best examples of family and couple therapy approaches that illustrate how clinical models can be both theoretically integrative, evidence-based, and clinically responsive.

Many of the early evidence-based family therapy approaches were developed for delinquent and troubled youth (e.g., Functional Family Therapy, Multisystemic Therapy, Multidimensional Family Therapy, Brief Structural Family Therapy). There are now evidence-based treaments for eating disorders (e.g., Maudsley Treatment), for couples (e.g., Emotionally Focused Couple Therapy/ Enhanced Cogntive-Behavioral Couple Therapy), and for families experiencing severe mental illness (e.g., psychoeducational approaches). In each of these areas the leading model developers in each area were asked to organize their presentation using the following outline:

1. History and background of the approach
2. Major theoretical and research-based constructs
3. Research evidence that supports the model
4. Research-based treatment protocol
5. Methods of model evaluation
6. Implementation of the model in community/practice settings

Part IV: Research Foundations

Over some sixty years later, the research that serves as the foundation of understanding and intervening with families and couples has grown exponentially. In part fueled by a specification and sophistication of research methods, strategies, and contexts, we now have a significant research foundation that is represented not by single studies but by "levels of evidence" that, in some areas, provide comprehensive and clear guidance for clinical practice. At the onset of the field of family therapy, relational science had not even been named and there were few relevant findings for therapists to consider. Today, salient findings abound and are widely disseminated, and the tasks become to separate well-established findings from the headline-grabbing replicated report, and to incorporate findings into practice. Each chapter was written to summarize the evidence and provide useful findings relevant for research and practice. In this volume we separate family and couple research into two different chapters. This was due to the exponential growth in research studies in each area. We also present findings regarding common yet critical elements of the process and change mechanisms research. The chapter by Friedlander, Heatherington, and Escudero fills in the "black box" of therapy with common therapeutic processes and change mechanisms.

Part V: Emerging Domains

As our understanding of how successful family therapy works, application of both couple and family interventions has developed based on emerging clinical needs. For example, with emergence of health care reform, family therapists and psychologists are now finding themselves working in medical settings. Similarly, as divorce rates hover around 50%, the importance of working with divorced and remarried families has become

a common clinical problem for family therapy. Other emerging domains represent the advancements in technical innovation that have become measurement feedback systems which are beginning to become tools for clinical decision making based on evidence and data from clients and therapist. Finally, the future of our theoretical developments may indeed be the meta-level theoretical paradigms.

A Tribute

This volume is also a tribute to Alan Gurman, the prime mover in the reshaping of family therapy from an unruly cauldron of great and questionable ideas and methods to an organized evolving field of study. What an idea Alan had! To bring all the disparate voices of family therapists together in one place and to offer comments to the most renowned authors of that time about such things as commonalities. It is not an understatement to say that Alan's work as an editor of handbooks and the *Journal of Marital and Family Therapy* launched family therapy as a "serious" field of study. Alan was the consummate editor in the field of family therapy. At a time when family therapy was practiced in disparate duchies with little contact, Alan brought proponents of different theories together. He even bridged the gap between the academic centered behavioral treatments and the other early treatments with their family institute roots even though these family therapists functioned in distinct domains. Alan also first brought a consideration of evidence into family therapy and should be credited with much of the impetus for the research that has amassed in support of family therapy. He was the great supporter of couple and family therapy yet also challenged the field where challenges were needed. Developments such as the search for evidence among postmodern therapists and focus on emotion and meaning in behavioral treatments probably can ultimately be traced to Alan's fingerprints. He will be very much missed.

Conclusion

This book seeks to illuminate the threads that are common to family therapies and yet also to hear from the many voices that speak to the range of perspectives. It summarizes the most important research relevant to couples, families, and couple and family therapy; the most crucial theoretical frameworks for viewing couples, families, and couple and family therapies; the widest circulated broad theoretical frameworks for approaches to couple and family therapy; specific evidence approaches to couple and family therapy, and a sampling of how family therapy adapts in a few very important specific domains. We hope it invigorates you as much as the early handouts about family therapy invigorated us.

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PART I

FOUNDATIONAL FRAMEWORKS IN FAMILY AND COUPLE THERAPY

2.

THE EVOLUTION OF SYSTEMS THEORY

Alan Carr

Insights from systems theory and cybernetics have informed the development of couple and family therapy from its inception. In this chapter, the evolution of ideas from systems theory within the context of couple and family therapy will be considered.

Family therapy emerged simultaneously in the 1950s in different locations in the United States and the United Kingdom, and within a variety of different health services, health professions, therapeutic and research traditions (Carr, 2012; Sexton & Lebow, 2013). The central insight that intellectually united the pioneers of family therapy was that human problems are essentially interpersonal not intrapersonal; consequently their resolution requires an approach to intervention which directly addresses relationships between people. This insight contravened the prevailing view that all psychological problems are manifestations of essentially individual disorders requiring individually focused therapy.

Family therapy initially emerged partly in response to the ineffectiveness of exclusively individually oriented treatment approaches, and partly in response to research findings which pointed to the role of family factors in the etiology of psychological disorders. The later development of family therapy has continued to be influenced by these factors, and also by others such as family-oriented health and social welfare policies (such as the US family preservation movement), the popularization of family therapy by charismatic pioneers in live international training workshops, and the professionalization of family therapy around the world.

The pioneers of family therapy came from many professions including social work, psychiatry, and psychology. They worked in a range of clinical services including psychiatric centers, child guidance clinics and marriage counseling services. Not surprisingly, in their work with couples and families, they drew on ideas and practices from prevailing theoretical traditions including psychoanalysis, experiential-client-centered therapy, and behavior therapy. However, they also drew on ideas from two exciting new conceptual frameworks: general systems theory and cybernetics.

General Systems Theory

General systems theory was developed in the mid-1940s by Ludwig von Bertalanffy (1968) as a framework within which to conceptualize the emergent properties of organisms and

complex non-biological phenomena which could not be explained by a mechanistic summation of the properties of their constituent parts. In this context, a system is a set of related parts that work together in a particular environment to perform whatever functions are required to achieve the system's objectives. Systems take in information and energy to allow them to achieve their goals, and use feedback to regulate themselves and guide this process. General systems theory was proposed in reaction to reductionism which incorrectly assumed that complex phenomena could be understood exclusively in terms of the properties of their constituent parts. Von Bertalanffy argued that systems, such as the human body, interact with their environments, and that in doing so they acquire qualitatively new properties through emergence. Rather than reducing an entity (e.g., the body) to the properties of its parts (e.g., cells), systems theory focuses on the pattern of relationship between the parts which connect them into a whole. It is this pattern of relationships or organization that determines a system. Von Bertalanffy proposed that the same principles of organization underlie phenomena studied by different scientific disciplines (physics, biology, psychology, sociology) and that this provides a rationale for scientific unification.

Cybernetics

One characteristic of viable systems is their capacity to use feedback about past performance to influence future performance. Norbert Wiener (1948/1961) coined the term *cybernetics* (from the Greek word *kubernetes*, meaning pilot or rudder) to refer to the investigation of self-regulating, feedback processes in complex systems. If general systems theory addresses the question: *How is it that the whole is more than the sum of it parts?*, cybernetics addresses the question: *How do systems use feedback to remain stable or to adapt to new circumstances so that systems achieve their goals?* From the outset cybernetics was concerned with the similarities between autonomous, living systems and machines. In the years following the Second World War, the emergence of computer technologies focused the attention of pioneers in this field to the engineering approach, where it is the system designer who determines what the system will do. However, later cyberneticists interested in human systems, emphasized the distinction between observed systems (such as machines) and observing systems (such as human organizations). In the early 1970s this movement became known as second-order cybernetics. While first-order cybernetics assumes that systems are passive phenomena that can be observed and manipulated, second-order cybernetics recognizes that social systems are conscious and capable of interacting intentionally with the observer. Heinz von Foerster (1981), Humberto Maturana and Francisco Varela (Maturana, 1991; Maturana & Varela, 1987) were highly influential proponents of second-order cybernetics.

Gregory Bateson

The British anthropologist Gregory Bateson is arguably the single most influential figure in the history of family therapy, and is largely responsible for the introduction of systems theory into the field of couple and family therapy (Bateson, 1972, 1979, 1991; Bateson & Bateson, 1987; Bateson & Ruesch, 1951). Starting in the 1950s in Palo Alto, California, Bateson proposed that general systems theory combined with insights from cybernetics could offer a framework within which to conceptualize family organization and processes and thereby offer an explanation for problematic behavior. Bateson's familiarity with general systems theory stemmed from his interest in his father's work as a biologist. His interest in cybernetics arose from his involvement in the Macy Foundation conferences in the 1940s where he met Norbert Wiener, founder of cybernetics.

Despite the pre-eminence of his position within the field of family therapy, Bateson never engaged in clinical practice, nor was he particularly interested in the development of the family therapy movement. His interests were far broader. His work on family systems was only one aspect of an extraordinary research program

that addressed phenomena as diverse as tribal rituals, animal learning, communication in porpoises, and the analysis of paradoxes. The central aim of his research program was to develop a unified conceptual framework within which mind and material substance could be coherently explained. He referred to this worldview as an ecosystemic epistemology.

In many respects the early years of family therapy from the 1950s to the 1970s are characterized by a paradigm shift (Kuhn, 1962) from a predominantly individualist conceptual framework to an ecosystemic epistemology. That is, there was a shift from viewing mental health problems as located inside the individual and individual interventions as the appropriate treatment, to an alternative perspective where problems are viewed as arising from, and being maintained by, patterns of family interaction, and as being best treated with interventions that target the whole family rather than the symptomatic individual.

Bateson's research group at Palo Alto in the early 1950s included Jay Haley, founder of strategic therapy, Don Jackson, John Weakland, and John Fry, all of whom went on to set up the Mental Research Institute (MRI) and develop what is often referred to as MRI brief therapy (Colapinto, 2013). Both strategic therapy and MRI brief therapy were grounded in systems theory and cybernetics. Among the many early conceptual contributions which Bateson's group made, two were particularly influential. These concerned the conceptualization of communication as a multilevel process and the application of this idea within the context of the double bind theory of schizophrenia.

Levels of Communication

Bateson's group pointed out the parallels between the distinction made in computer science between *digital* and *analogue* communication, and *verbal* and *non-verbal* behavior in humans and noted that every message has a *report* and *command* function (Bateson & Ruesch, 1951; Watzlawick, Beavin, & Jackson, 1967). Thus, the actual words in a message (e.g., Its time for dinner) are a verbal report and similar to digital communication in computer science insofar as each word is a discrete sign, arbitrarily signifying a particular meaning. In contrast, each message entails a *metacommunication* about the relationship between speakers which is usually conveyed non-verbally (e.g., I am in a hierarchically superior position to you and am commanding you to sit down and eat your dinner). This non-verbal command function is similar to analogue communication in computer science insofar as the non-verbal aggression and force with which the words are said are directly proportional to the degree to which speakers are asserting their hierarchically superior position. Also, there is nothing arbitrary about the relationship between the non-verbal display of aggression and the meaning of the command (i.e., I am hierarchically superior to you and expect you to obey me). Bateson's group noticed that psychological problems commonly occurred in families where there were frequent inconsistencies between report and command functions of messages about significant issues. The double bind theory, described below, is one example of this process.

Inspired by the philosophical writings of Whitehead and Russell (1910/1913), Bateson's group argued that report and command functions of messages belong to different logical levels. If report and command functions are inconsistent, one way out of the paradox is to metacommunicate about the inconsistencies between the report and command functions (Watzlawick, Weakland, & Fisch, 1974). Whitehead and Russell had used a similar device to solve the paradox posed by the proposition *This statement is false*. If you draw a box around the proposition, you may then outline the implications of the 'proposition in the box' being either true or false. That is, you may metacommunicate about both the meaning of the proposition which occupies one logical level, and statements about the truth or falsity of the 'proposition in a box' which occupies a different logical level.

The Double Bind Theory

In the *double bind theory*, Bateson's group proposed that schizophrenic behavior occurs in families characterized by particular rigid and repetitive patterns referred to as double binds (Bateson, Jackson, Haley, & Weakland, 1956). In such families, double binds involve parents

issuing a child with a primary injunction which is typically verbal (e.g., Come here and I will hug you); concurrently the parents issue a secondary injunction that contradicts the primary injunction and which is typically conveyed non-verbally (e.g., If you hug me, I will be disappointed in you or be angry with you); there is also a tertiary injunction prohibiting the child from escaping from the conflictual situation or commenting upon it, and this is often conveyed non-verbally (e.g., If you comment on these conflicting messages or try to escape from this relationship, I will punish you). Once children have been repeatedly exposed to the double binding family process, they come to experience much of their interactions with their parents as double binding even if all of the conditions for a double bind are not met. This theory was extremely important for the development of family therapy because it offered a sophisticated and coherent explanation for the links between family process and abnormal behavior and an account that pointed to the necessity of considering communication occurring simultaneously at multiple levels.

There were problems with the double bind theory. Subsequent research has shown that other types of problematic communication characterize families containing children with schizophrenia, notably criticism and overinvolvement and these affect the course of the disorder, particularly the relapse rate, more than its onset (Hooley, 2007). The double bind theory was also a dyadic and linear formulation that did not take the role of all family members into account and which did not consider the reciprocal influence of children on parents. Double bind family processes could not be reliably rated, so reliable empirical support for the theory has never been established. However, it was a preliminary attempt to use systems theory to explain the family processes underpinning psychosis.

The Application of Ideas from General Systems Theory and Cybernetics to Families and Family Therapy

General systems theory and cybernetics when applied to families and family therapy suggested a series of propositions to Bateson's group, and to others in the family therapy movement over the past sixty to seventy years. These propositions entailed by an ecosystemic epistemology, which are described below and summarized in Table 2.1, are by no means a single integrated framework. Nor are all of these propositions incorporated into all of the foundational theoretical models considered in Part II or all of the evidence-based clinical treatment models considered in Part III of this handbook. Where there is a divergence of views within the field about these propositions I have pointed these out below.

The family is a social system which supports the survival and welfare of its members. Within most family therapy models, it is assumed that families function as systems or organized wholes comprising a group of interdependent family members. Other social systems, such as work groups or sports teams, may be established to fulfill functions such as manufacturing goods, providing services, or competing in games. In contrast, the primary objective of a family system is supporting the survival of its members. Since the first paper in the field—Nathan Ackerman's (1937) "The family as a social and emotional unit"—family therapy has been primarily concerned with supporting the survival and welfare of family members.

The family system includes both its constituent family members and the relationships between them. Family members are interdependent, and express this interdependency through their relationships with each other. These relationships include the spouses' relationship as marital partners, partners' relationship as co-parents, parent–child relationships, sibling relationships, and relationships with the extended family. These relationships are vital aspects of the family system, since they support the welfare of family members and the survival of the family system. In practice, family therapists, regardless of their theoretical orientation, focus on understanding and enhancing the quality of family relationships.

The family is a system with boundaries and is organized into subsystems. Within the structural

family therapy tradition, Salvador Minuchin proposed that distinctions may be made between parental and child subsystems (Minuchin, 1974; Minuchin et al., 1967; Minuchin, Nichols, & Lee, 2007). Providing children with care and control in a coordinated way is a key function of the parenting subsystem. Acquiring knowledge, skills, and emotional maturity during childhood and adolescence in preparation for the transition to adulthood are objectives of the child subsystem. Minuchin proposed that problems arise in families when boundaries between parent and child subsystems are unclear, and, for example, when children or adolescents take on the role of being the primary support for a vulnerable parents. Such young people are referred to as "parental children."

The boundary around the family sets it apart from the wider social and cultural system, of which it is one subsystem. The broader system in which the nuclear family is embedded includes the extended family, parents' work organizations, children's schools, children's peer groups, involved helping professionals, the wider community, the family's ethnic group, the prevailing culture, and the family's religious or spiritual community. The idea that individuals are nested within family systems, and families are nested within broader social and cultural systems, has been elaborated by the developmental psychologist Uri Bronfenbrenner (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Multigenerational family therapy, pioneered by Murray Bowen (1985) and Ivan Boszormenyi-Nagy (Bosormenyi-Nagy & Spark, 1973), emphasizes the importance of relationships with the extended family in problem formation and resolution. Monica McGoldrick (McGoldrick & Hardy, 2008) and Celia Falicov (2013) were among the first to propose that clients' ethnicity and culture must be taken into account in the practice of family therapy. Froma Walsh (2010) proposed that family therapy may be enhanced by drawing on clients' spiritual resources. The importance of taking account of the larger professional health care, educational and justice systems of which families are part was advocated by Evan Imber-Black (1988) and is central to modern evidence-based practice models such as Scott Henggeler's Multisystemic Therapy (Henggeler & Schoenwald, 2013) and Howard Liddle's (2013) Multidimensional Family Therapy.

While systems theory offers a way of viewing the individual as nested within multiple larger social systems, it also offers a framework for considering aspects of the individual as subsystems of that individual. In this context, personal attributes such as beliefs, self-regulatory styles, emotions, abilities, traits, genetic vulnerabilities, and neurobiological processes may all be considered as subsystems of the individual. In an interesting development capitalizing upon this proposition, Richard Schwartz (1995) has developed an internal family systems model of practice in which therapy focuses on helping clients who have experienced trauma recognize different conflicting "parts" of their personalities, and empowers a core "self" to coordinate these "parts" of the overall personality.

To facilitate adaptation and survival, the boundary around the family must be semi-permeable to allow information and resources to enter and leave the family. Within most family therapy models, families are conceptualized not as closed systems, but as open systems which exchange information and resources with the larger system of which they are part. A family's boundary must be impermeable enough for the family to survive as a coherent system. For example, spouses may commit to an exclusive sexual relationship, and parents may commit to provide adequate care and control for their children. In doing so, relationships will be sufficiently strong to hold family members together in a way that protects them from external threats to their survival. Where family boundaries are too permeable, infidelity between spouses may occur or children may be neglected. A range of systemic interventions have been developed to address the problems of child neglect (Rubin, 1012) and infidelity (Baucom, Snyder, & Coop Gordon, 2009).

A family's boundary must be permeable enough to permit the intake of information and resources required for continued survival. For example, family boundaries must be permeable enough to permit children to go out to school to acquire education, for parents to go out to

work to earn money to support the family, and for friends and relatives to visit the family to provide social support and so forth. Where boundaries are too impermeable, family members may develop constricted lifestyles and become socially isolated. Systemic therapy can help families characterized by impermeable boundaries cope better with internal and external challenges. A range of family therapy approaches have been developed to help such families with internal challenges including disability and illness (Rolland, 1994, 2011; McDaniel, Hepworth, & Doherty, 1992) and mental health problems (McFarlane, 2002, 2013), and external challenges such as unemployment, lack of adequate educational placements, social isolation, and immigration (McGoldrick & Hardy, 2008).

The behavior of each family member, each family subsystem, and the wider system of which the family is part, is determined by the pattern of interactions that connects all family members. Bateson (1972, 1979) referred to the pattern of relationships between people as *the pattern that connects* and it is his most acclaimed insight. Everybody in a family and the wider system of which it is part is connected to everybody else, and a change in one person's behavior inevitably leads to a change in all family members. That is, the behavior of family members is interdependent. Bateson took the view that this pattern of organization must be respected. Therapists may use observation and interviewing processes to understand it and describe their insights to family members. However, attempts to change the pattern through the unilateral exercise of power may lead to unintended consequences which may threaten the integrity of the system. This position has been adopted by therapists within the collaborative, social constructionist tradition, who view themselves as part of the family therapist system, and base their practice on the second-order cybernetics of observing systems (Anderson, 2003, 2013). In contrast, therapists who view themselves as outside the family system being treated, and base their practice on the first-order cybernetics of observed systems, argue that once therapists understand problem maintaining patterns, these may be altered through the use of carefully designed direct or paradoxical interventions. This position is taken by therapists from a number of traditions, notably strategic family therapists (Colapinto, 2013). These two differing positions have been referred to as aesthetic and pragmatic approaches to family therapy (Keeney & Sprenkle, 1982). The highly influential Milan family therapy team originally adopted a position grounded in the first-order cybernetics of observed systems (Selvini Palazzoli et al., 1978, 1980). However, in 1980 the team split into two factions with Mara Selvini Palazzoli and Guiliana Prata retaining the team's original position (Selvini, 1988; Selvini et al., 1989) and Gianfranco Cecchin and Luigi Boscolo basing their practice on the second-order cybernetics of observing systems (Boscolo et al., 1987; Boscolo & Bertrando, 1992; Cecchin, 1987; Cecchin, Lane & Ray, 1992). Social-constructionist approaches to family therapy have a greater affinity for the second-order cybernetics of observing systems position. All of the evidence-based approaches to family therapy presented in Part III of this volume adopt a first-order cybernetics of observed systems position, although there is no reason why practice models based on second-order cybernetics could not be empirically tested.

Patterns of family interaction are rule governed and recursive. A useful distinction may be made between overt and covert family rules. Overt rules are clearly stated (if not always implemented); for example, "The children's bedtime is 9 o'clock on weekdays." Covert rules are never stated and very rarely violated; for example, "If mother and father disagree, a child must misbehave to distract them from their conflict." Recursive patterns of family interaction are usually governed by covert rules which may be inferred from observing repeated episodes of family interaction (Carr, 2012), or mapping out family relationships using genograms (McGoldrick, Gerson, & Petry, 2008). Identifying these recursive patterns is a core family therapy skill common to many family therapy traditions. Many schools of family therapy focus their interventions on disrupting these recursive problem-maintaining patterns of family interaction. These patterns of interaction may occur over the course of periods as brief as an

hour or as long as a number of years (Breunlin & Schwartz, 1986). A recursive pattern lasting no more than an hour may involve a mother becoming embroiled in an anxious conversation with her daughter about her abdominal pains, which intensify and result in a parental argument and the daughter refusing to attend school when the father criticizes the daughter for disobedience. A recursive intergenerational pattern lasting years may involve mothers and daughters developing close anxious relationships, and fathers oscillating between cooperative and conflictual relationships with their daughters and wives. Some schools of family therapy, such as the strategic, structural, behavioral, and functional approaches, focus predominantly on recursive patterns of interaction that span relatively brief periods ranging from a few minutes to a few weeks (Colapinto, 2013; Epstein & Datillio, 2013; Sexton, 2013). Multigenerational approaches to family therapy, in contrast, focus on recursive patterns that are repeated across family generations (Skowron, 2013).

The proposition that patterns of family interaction are recursive applies to both positive and negative behavior, to solutions and problems, to family resilience and vulnerability. As family therapy has developed, there has been a gradual shift from focusing on recursive negative, problematic patterns rooted in family vulnerabilities to recursive positive, solution-oriented patterns based on families' strengths and resilience. Steve deShazer's seminal work on solution-focused therapy (deShazer, 1985, 1988; deShazer & Dolan, 2007), Michael White's narrative therapy (White & Epson, 1990; White, 1995, 2007, 2011) and Froma Walsh's (2006, 2012) resilience-based approach to family therapy have been central to this trend.

Because recursive patterns of family interaction are of the form A leads to B leads to C leads to A, the idea of circular causality is used when describing or explaining family interaction. Descriptions and explanations of families that involve linear (or lineal) causality, of the form A leads to B, from a systems theory perspective, are considered incomplete and inaccurate. Instead, the idea of circular causality is used to remove the concept of blame from family therapy discourse. For example, if a family with a child who displays behavior problems is referred for therapy, the notion of circular causality allows the family therapist to avoid blaming the child's problems on parental mismanagement of the child. Rather, the therapist may view the parents' ineffective management of the child's problems as a legitimate response to the child' frustrating behavior and the child's behavior problems as a response to parental frustration.

This use of the concept of circularity is therapeutically expedient for many difficulties. However, it becomes problematic when dealing with cases of family violence and abuse. It is clearly unethical and unjust to argue that a child provoked parental abuse or a wife provoked spouse abuse. Strategic family therapists, such as Jay Haley (Haley 1991, 1997; Haley & Riceport Haley, 2007), and feminist family therapists, such as Rachel Hare-Mustin (1978) and Deborah Leupnitz (2002) argue that mutuality of influence does not entail equality of influence. Thus, the concept of circularity is only clinically useful in family therapy when considered in conjunction with the concepts of hierarchy and power. Family members do influence each other, but this influence is not equal since some members have more power than others. The hierarchical organization of family members in terms of their power to influence other family members may be based on the generation to which they belong, the coalitions they have with members of more powerful generations, and their gender.

Empirical research on family processes suggests that the idea of circular causality may be an oversimplification, and that problematic family behavior in some instances may involve escalating spirals of interaction. In his research on coercive family processes that maintain aggressive behavior, Gerald Patterson (1982) has shown that patterns of family interaction which appear circular may be more accurately described as spiral. These patterns involving escalating displays of aggressive behavior on the part of parents and children. Aggression escalates because in each episode parents or children find that increased levels of punishment on the part of the parent or defiance on the part of the child are required

to bring the episode to a conclusion by making the other person withdraw. This withdrawal negatively reinforces aggressive behavior, and increases the probability of its recurrence at an escalated level.

The overall patterning of rule-governed family relationships may be described in terms of family roles, routines, and rituals; dimensions of family functioning such as flexibility, cohesion, and communication; and problematic family processes such as triangulation or demand-withdraw couple interaction. Family roles include those of husband, wife, father, mother, son, daughter, and so forth. Within the field of family therapy, distinctive dysfunctional family roles have also been identified. For example, Virginia Satir (1983) distinguished between four roles characterized by the problematic communication styles of blaming, placating, distracting, and computing. Blamers deny their role in family problems and avoid taking responsibility for resolving conflict. Placaters consistently defuse rather than resolve conflict by covering up differences and being overly "nice." Distractors avoid rather than resolve conflict by changing the subject or pretending to misunderstand. Computers avoid emotionally engaging with others by taking an overly intellectual approach to resolving family conflicts.

Family routines include those for sleeping, waking, washing, eating, working, visiting others, and engaging in leisure activities on a daily, weekly, monthly, or annual basis. Family rituals are stylized routines with special significance to mark transitional events in the individual and family lifecycle such as birth, adoption, illness, death, marriage, separation, starting and concluding relationships, commencing and completing educational courses or work experiences, and so forth (Imber-Black, Roberts, & Whiting, 2003). For effective family functioning, family roles, routines, and rituals must meet the needs of individual family members, support the survival and welfare of the family, fit with the microculture of the family, and also fit with the wider culture within which the family is situated. Difficulties may arise when family roles, routines, and rituals do not meet these requirements. For example, where traditional patriarchal family roles support the survival of the family but stifle the needs of individual family members; or where family roles, routines, and rituals of an ethnic minority family do not fit with those of the dominant culture.

Many theoretical models of dimensions of family functioning have been developed. Of these, David Olson's integrative circumplex model is one of the most comprehensive and also has a particularly strong evidence base (Olson & Gorall, 2003). In this model families are conceptualized as varying along the dimensions of flexibility (which refers to the capacity for flexible problem-solving with coherent leadership), cohesion (which refers to emotional closeness), and communication. Optimal adjustment is shown by families with moderate levels of flexibility and cohesion, and high levels of effective communication. In contrast, problems are more common in families with low levels of effective communication and extremely high or low levels of flexibility and cohesion. Rigid or chaotic patterns of family organization typify families with extremely high or low levels of flexibility. Enmeshed or disengaged patterns of family organization typify families with extremely high or low levels of cohesion.

Of the wide range of problematic family processes that have been identified in many different systemic practice traditions, there is a consensus that the demand-withdraw pattern is one of the most common among distressed couples, and that triangulation typifies many families with child-focused problems. With the demand-withdraw pattern, when one partner demands intimacy, the other withdraws, and the frequent repetition of this recursive pattern is associated with relationship distress (Eldridge & Christensen, 2002). With triangulation, a child becomes drawn into a conflictual parental relationship; their role in this triangle maintains their problematic behavior; and in some instances stabilizes the parents' conflictual relationship or inappropriately meets the needs of one or both parents (Dallos & Vetere, 2012; Flaskas, 2012).

Within family systems there are processes which both prevent and promote change. Processes that

prevent and promote change are referred to as homeostasis (or morphostasis) and morphogenesis respectively. For families to survive as coherent systems, it is critical that they maintain some degree of stability or homeostasis. Thus, families develop recursive behavior patterns that involve relatively stable rules, roles, routines, rituals, and mechanisms that prevent disruption of this stability. It is also essential that families have the capacity to evolve over the course of the lifecycle and meet changing demands necessary for healthy development, adaptation, and survival. Thus families require mechanisms for making transitions from one stage of the lifecycle to the next and for dealing with unpredictable and unusual demands, stresses, and problems (McGoldrick, Carter, & Garcia-Preto, 2011). Often families which lack such morphogenetic forces come to the attention of clinical services. The idea that individual psychological problems displayed by a particular family member, such as behavioral problems or substance use, may serve a protective homeostatic function for the whole family was introduced into family therapy by Don Jackson (1957). Jackson noted that in some cases when a symptomatic family member improved, other family members developed difficulties which sometimes abated when the symptomatic member left treatment and deteriorated. This idea is still accepted within the strategic family therapy tradition, although it is no longer widely accepted within the broader systemic therapy field, because of its limited clinical usefulness and lack of empirical support (Dell, 1982).

Within a family system one member (the identified patient) may develop problematic behavior when the family lack the resources for morphogenesis. The symptom of the identified patient serves the positive function of maintaining family homeostasis. In the seminal paper "The question of family homeostasis," Don Jackson (1957) argued that when the integrity of the family system is threatened by the prospect of change, in certain instances one family member may develop problematic behavior which serves an important function in maintaining family stability. The idea that problematic behavior and the pattern of family interaction associated with it may serve an adaptive function for the family system is central to some, but not all models of family therapy including strategic therapy, functional family therapy and psychodynamic family therapy (Colapinto, 2013; Scharff & Savage-Scharff, 2013; Sexton, 2013). A specific application of this idea was elaborated by Jay Haley (1997) in his influential book *Leaving Home*. He proposed that in some families characterized by covert marital discord, older teenagers develop problematic behavior which prevents them from developing autonomy and leaving home, because leaving home might lead to the covert marital discord becoming overt and to a dissolution of the family. This idea that an identified patients' symptoms serve a positive function for the family as a whole gave rise within the strategic therapy tradition and within the original Milan systemic family therapy group to paradoxical interventions (Campbell, Draper, & Crutchley, 1991; Colapinto, 2013). With the original Milan group's paradoxical interventions, the function of the symptom for the integrity of the system was described to the family; the dangers of change and problem-resolution were highlighted; each family member was advised to continue to play his or her role in the recursive interaction pattern of which the symptom is part; and finally the identified patient was advised to continue to engage in symptomatic behavior until some alternative is found. For example, a family with an anorexic girl was informed that the teenage girl's refusal to eat was a generous self-sacrificing gesture vital for holding the family together. It offered the girl a way of insuring that her parents would remain together, since it was clear she suspected that their loyalties to their own families of origin would force them to separate. It offered each of the parents a way of jointly expressing love for their daughter while showing loyalty to their own families of origin. As long as the daughter starved herself, the father, like his own father, could express his paternal love by being stern with his daughter and disagreeing with his wife's permissive approach. As long as the daughter starved herself, the mother, like her own mother, could express her maternal love by being gentle and understanding of her daughter while disagreeing with her husband's sternness. It therefore seemed important for the girl

to continue to starve herself, and for the parents to hold to their positions until some alternative way of dealing with these complex family issues became clear.

The idea that a dysfunctional family system causes the problem that a family brings to therapy and this problem serves a homeostatic function in maintaining the stability of the dysfunctional family has been challenged within the field of family therapy by both the postmodern and the psychoeducational traditions. For example, Harlene Anderson and her colleagues, arguing from a postmodern social-constructionist collaborative family therapy perspective, proposed that the idea of system-determined problems be replaced by the notion of problem-determined systems (Anderson, 1997; Anderson, Anderson, Goolishan, & Windermand, 1986). Their central idea is that when a person encounters a challenge or difficulty, for whatever reason, this becomes a problem when the person and members of their social network engage in conversation about it in a way that constructs it as a problem. Problems are constructed in language systems; and therapists and clients in collaborative dialogues co-construct transformations, solutions, or new problem-free narratives.

In psychoeducational family therapy approaches for conditions such as schizophrenia or bipolar disorder, it is not assumed that these conditions serve a homeostatic function within the family. Rather, it is assumed, on the bases of available research evidence, that a complex constellation of genetically determined neurobiological factors and environmental factors may predispose people to developing such conditions, that life stresses and lifecycle transitions may precipitate their onset, that patterns of family interaction and personal coping strategies may inadvertently maintain these problems once they occur, and that the development of positive patterns of family interaction, adaptive coping skills, and the use of psychotropic medication may help resolve them (McFarlane, 2013). Psychoeducational family therapy, which is an evidence-based approach, focuses on helping families understand the role of various predisposing, precipitating, maintaining, and protective factors relevant to the psychological disorder their family member has, and on fostering adaptive patterns of family interaction through problem-solving and communication skills training.

In clinical practice, cases may be encountered from time to time in which symptoms appear to serve a protective homeostatic function, by for example, preventing parents from separating. However, the hypothesis that all symptoms serve a protective homeostatic function has found little empirical support, has limited clinical usefulness, and consequently is no longer widely accepted within the field of family therapy.

Negative feedback or deviation reducing feedback maintains homeostasis and subserves morphostasis. In families referred for treatment, Jackson assumed that the symptom serves a positive function in maintaining the integrity of the family system, because he observed that when patients began to improve and this was noticed by family members, this feedback led to patterns of family interaction that intensified problems within the family and so maintained the status quo (Jackson, 1957, 1965). For example, he described the case of a husband who insisted his wife engage in individual psychotherapy because of her frigidity. After some months of therapy she felt less sexually inhibited and concurrently the husband became impotent. In some families where children have conduct problems, the young person's behavioral difficulties unite parents and diffuse marital tensions. However, initial improvement in the young person may sometimes result in marital conflict becoming more overt, which in turn may result in deterioration in the young person's behavior, leading the parents to set aside their conflict and unite to address the child's relapse. Different family therapy models address these sorts of recursive homeostatic behavior patterns in different ways (Carr, 2012). Some focus mainly on replacing destructive recursive patterns with more adaptive ones (e.g., functional family therapy (Sexton, 2013)). Others focus on helping families develop new belief-systems and narratives which liberate them from destructive recursive patterns (e.g., social constructionist approaches (Anderson, 2003, 2013)). Still others help family members understand and cope with underlying factors that keep them trapped

in recursive patterns such as unresolved family of origin issues or personal vulnerabilities (e.g., multigenerational (Skowron, 2013) or psychoeducaitonal approaches (McFarlane, 2013)).

Positive feedback or deviation amplifying feedback subserves morphogenesis. If too much deviation amplifying feedback occurs, in the absence of deviation-reducing feedback then a runaway effect or a snowball effect occurs. In some forms of family therapy, notably that evolved by the MRI group, attempts are made to initiate small instances of deviation amplifying feedback by asking clients to set small achievable goals (Segal, 1991). The assumption is that if these are reached, a snowball effect may occur, and the achievement of small goals will lead to the attainment of larger goals.

Individuals and factions within systems may show symmetrical and complementary behavior patterns which fragment systems. Bateson (1972) described a process called schizmogenesis in which pairs of individuals or pairs of factions within a social system develop recursive patterns of behavior over time thorough repeated interaction. Within these recursive behavior patters, the role of each member becomes quite distinct and predictable until the system fragments. He described two types of schizmogenesis which he termed symmetrical and complementary patterns. With symmetrical behavior patterns, the behavior of one member (or faction) of a system invariably elicits a similar type of behavior from another member (or faction) and over time the intensity of symmetrical behavior patterns escalate until the members (or factions) separate. For example, a marital couple may become involved in a symmetrical pattern of blaming each other for their marital dissatisfaction and ultimately separate. With complementary behavior patterns, the increasingly dominant behavior of one member (or faction) of a system invariably elicits increasingly submissive behavior from another member (or faction) and over time the intensity of the complementary behavior pattern increases until the members (or factions) separate. For example, over time an increasingly caregiving husband and an increasingly depressed wife may eventually reach a stage where the relationship is no longer viable because of the mutual anger and disappointment experienced by partners. Healthy and viable family systems and relationships are characterized by a mix of symmetrical and complementary behavior patterns. Where pairs of members (or factions) within family systems engage exclusively in symmetrical or complementary behavior patterns, the integrity of the system will be threatened. In such instances, the introduction of even a small amount of the missing behavior pattern may increase the viability of the system. For example, a couple engaged in a symmetrical process of mutual blaming may become more viable if each partner makes a caring gesture toward the other on a small number of occasions. In a similar fashion, if a couple engaged in a complementary process of illness and caregiving engage in a few transactions where the roles are reversed, then the viability of the relationship may be enhanced. Within the therapeutic relationship, complementary client–therapist relationships in which the more the therapist helps the more debilitated the client becomes may in some instances be productively altered by the therapist taking a one-down position. That is, the therapist may point out that he or she is puzzled by the problem and at loss to know how to proceed at this point and he or she may then speculate that a period of observation without intervention may be most appropriate. Strategic therapists have used Bateson's concepts of symmetrical and complementary schizmogenesis to develop practices such as these (Colapinto, 2013; Haley, 1963; Madanes, 1991).

Positive and negative feedback is new information, and new information involves news of difference. Bateson (1972) argued that information is news of difference and that this is commonly provided through a process of double description. That is, if two descriptions are given of the same events, then the difference in perspectives provides news of difference and this may help family systems to change so as to adapt to their problematic circumstances. Bateson referred to such information as the *difference that makes a difference*. Inviting each family member to offer their unique perspective on the family's situation, reframing individual problems as family

difficulties, and offering family psychoeducation about physical or mental health conditions from which family members suffer are examples of interventions that introduce news of difference into family systems. The Milan group and others have developed a variety of types of circular questions which are explicitly designed to introduce news of difference into family systems (Brown, 1997). These included asking each family member to describe an interaction between another two family members; asking each family member to rank-order other family members in terms of a particular characteristic; asking each family member to describe the difference between episodes within which the problem occurs and does not occur; or asking each family member how the future (when the problem is resolved) will differ from the past and the present.

Within systems, a distinction may be made between first-order change and second-order change (Davey, Duncan, Kissil, Davey, & Fish, 2011). With first-order change, the rules governing the interaction within the system remain the same, but there may be some alteration in the way in which they are applied. First-order change is continuous or graded. With second-order change, the rules governing relationships within the system change and so there is a discontinuous stepwise change in the system. For example, a family in which a 13-year-old boy who walked to school, was regularly late, and was scolded by both teachers and parent for this tardiness, might solve this problem by the parents asking the child to walk to school more quickly on pain of further scolding. This solution would represent first-order change, because the rules about the pattern involving the child's tardiness and the parents' scolding remain essentially unchanged. If, however, the parents and teachers jointly invited the boy to take responsibility for getting himself to school on time and offered a prize at the end of the month if he was on time 75% of the time, this would represent second-order change because the rules about the pattern involving the child's tardiness and the parents' response to this would have been radically altered. In most cases, family therapy is concerned with facilitating second-order change.

When families move from one stage of the lifecycle to the next, they have to engage in second-order change (McGoldrick, Carter, & Garcia-Preto, 2011). That is, they have to replace many of the rules, roles, and routines of the earlier stage with new ones. In the example just given, the first-order change solution might be appropriate for a family with a pre-adolescent boy, but the second-order change solution is more suited to a family containing an adolescent child, since in adolescents need to learn to take more responsibility for self-management.

Within systems theory, a distinction may be made between first- and second-order cybernetics; between observed and observing systems. This distinction was implicit in Bateson's work and made explicit by Heinz von Foerster (Howe & von Foerster, 1974). In family therapy based on first-order cybernetics, it is assumed that a therapist may independently observe, assess, and intervene in a family system without becoming part of a new system that includes the family and the therapist. In second-order cybernetics, it is assumed that when a therapist engages in therapy with a family, a new therapeutic system is formed which includes the therapist and the family. Within this system, patterns of mutual influence develop, which are primarily constructed in language, and these may subserve morphostasis or morphogenesis. That is, therapists and families may engage in therapeutic conversations that maintain the problem as well as patterns that lead to problem resolution. Structural and strategic approaches to family therapy have been based more on first-order rather than second-order cybernetics (Colapinto, 2013). Social-constructionist approaches have been based more on second-order cybernetics (Anderson, 2003, 2013).

Within social systems recursive patterns, present in one part of the system, replicate isomorphically in other parts of the system. This issue, implicit in the work of Bateson, has been made explicit and relevant to the practice of family therapy, systemic consultation, and family therapy supervision by others. Multigenerational family therapy proposes that patterns of family interaction may be replicated across generations (Skowron,

2013). This position is supported by research on the intergenerational transmission of violence and child abuse (Uslucan & Fuhrer, 2009). Multisystemic family therapists have observed that problem-maintaining patterns of interaction within the family may be replicated within the wider social system (Henggeler & Shonewald, 2013). For example, in a case of school refusal, a family-based pattern involving a strong mother–child coalition and a peripheral father may be replicated in the wider system with a strong coalition between a school counselor and the family and a peripheral relationship with the class teacher. Within family therapy supervision in the case just described, the triadic pattern involving the parents and child may be replicated in the supervisory system with a strong coalition between the parents and the therapist to which the supervisor becomes peripheral (Todd & Storm, 2012). On the positive side, adaptive patterns of family interaction such as secure attachment may be intergenerationally transmitted (Cassidy & Shaver, 2008). In families involved with multiple agencies, where there are well-articulated procedures for interagency cooperation, this pattern of cooperation may come to be replicated within the family (Imber-Black, 1988). In supervision, where there is a collaborative relationship between the supervisor and the therapist, this may become to be replicated in the therapist's relationship with the family (Todd & Storm, 2012).

Application of Research Findings to the Practice of Systemic Therapy

Increasingly the practice of family therapy is informed by the growing evidence base for its effectiveness, and factors associated with the etiology and outcome of particular problems for which clients seek help. Two important additional propositions which concern the link between systemic research and clinical practice are elaborated below.

Only probabilistic statements may be made about the impact of interventions on social systems. Available evidence from couple and family therapy outcome research indicates that for a range of common child- and adult-focused problems systemic interventions are effective in about 66–75% of cases (Carr, 2009a, 2009b). Findings from process research suggest that these distal positive outcomes are mediated by positive proximal changes in family behavior, belief systems, and emotional aspects of family relationships; which in turn are facilitated by strong therapeutic alliances and the judicious use of a range of therapeutic techniques, such as reframing, enactment, or psychoeducation (Friedlander, 2013). Despite these broad research findings, we can never know with absolute certainty what impact any specific intervention or technique will have on a family. This is because, according to systems theory, in some instances different interventions may have the same impact, because systems have the property of equifinality. It is also because according to systems theory, in some instances the same intervention leads to different outcomes, because systems have the property of equipotentiality.

The probability that systemic interventions will be effective is partly determined by the balance of risk and protective factors within the system. Research on families and psychopathology has identified a wide range of risk and protective factors for many problems commonly treated with family therapy such as delinquency, substance use, psychosis, mood disorders, and so forth (Cohen & Cicchetti, 2006; Ingram & Price, 2010). Some are static (e.g., the early onset or positive family history for a particular disorder) and some are dynamic (e.g., membership of a delinquent peer group, or living in a family where there is limited supervision of adolescent behavior). Some evidence-based family therapy practice models explicitly aim to decrease certain dynamic risk factors and increase protective factors. For example, psychoeducational family therapy for psychosis (McFarlane, 2013) aims to reduced the level of expressed emotion within the family (which is an established risk factor for relapse) and thereby delay relapse (Hooley, 2007). Multisystemic (Henggeler & Shonewald, 2013), multidimensional (Liddle, 2013), and functional family therapy (Sexton, 2013) all aim to decrease contact with deviant peers, which is an established risk factor for adolescent delinquency and substance use, and enhance parenting skill, which is an established protective

Table 2.1 Propositions from systems theory and cybernetics relevant to the practice of couple and family therapy

Domain	*Propositions*
System	• The family is a social system which supports the survival and welfare of its members. • The family system includes both its constituent family members and the relationships between them (the whole is more that the sum of its parts).
Boundaries	• The family system has boundaries and is organized into subsystems. • The boundary around the family sets it apart from the wider social and cultural system of which it is one subsystem. • To facilitate adaptation and survival, the boundary around the family must be semi-permeable to allow information and resources to enter and leave the family.
Patterns	• The behavior of each family member, and each family subsystem, is determined by the pattern of interactions that connects all family members. • Patterns of family interaction are rule governed and recursive. • Because recursive patterns of family interaction are of the form A leads to B leads to C leads to A, the idea of circular causality is used when describing or explaining family interaction. • The overall patterning of rule-governed family relationships may be described in terms of family roles, routines, and rituals; dimensions of family functioning such as flexibility, cohesion, and communication; and problematic family processes such as triangulation or demand-withdraw couple interaction.
Stability and change	• Within family systems there are processes which both prevent and promote change. These are referred to as homeostasis (or morphostasis) and morphogenesis.
Stability	• Within a family system one member (the identified patient) may develop problematic behavior when the family lack the resources for morphogenesis. The symptom of the identified patient serves the positive function of maintaining family homeostasis. • Negative feedback or deviation-reducing feedback maintains homeostasis and subserves morphostasis.
Change	• Positive feedback or deviation amplifying feedback subserves morphogenesis and may lead to a runaway or snowball effect. • Individuals and factions within systems may show symmetrical behavior patterns and complementary behavior patterns fragment systems. • Positive and negative feedback is new information, and new information involves news of difference. • A distinction may be made between first-order change and second-order change; between behaving differently according to the system's rules and changing the rules.
Complexity	• Within systems theory, a distinction may be made between first- and second-order cybernetics; between observed and observing systems. • Within social systems recursive patterns, present in one part of the system, replicate isomorphically in other parts of the system.
Application of research to practice	• Only probabilistic statements may be made about the impact of interventions on social systems. • The probability that systemic interventions will be effective is partly determined by the balance of risk and protective factors within the system.

factor for a range of adolescent problem behaviors (Catalano, Haggerty, Hawkins, & Elgin, 2011; Dishon & Patterson, 2006).

Closing Comments

The propositions described above and summarized in Table 2.1 derived from systems theory and cybernetics have evolved within the broad field of couple and family therapy. They are by no means a single integrated framework. Nor are all of these propositions incorporated into all of the foundational theoretical models considered in Part II or all or the evidence-based clinical treatment models considered in Part III of this handbook. However, they do represent most of the important aspects of systems theory that have evolved within the field of family therapy.

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3.

A FAMILY DEVELOPMENTAL FRAMEWORK

Challenges and Resilience Across the Life Cycle

Froma Walsh

This chapter presents an overview of a family developmental framework, with attention to the growing diversity and complexity of family systems over a lengthening life course. A family resilience framework is described, extending family stress theory to understand and facilitate core processes for positive adaptation with highly stressful life challenges. Issues that commonly arise in various family life-cycle phases and transitions are briefly considered.

The Changing Landscape of Family Life

Our understanding of family development and our clinical approaches to strengthen families must be attuned to our times and social contexts. Over recent decades, families and the world around them have been undergoing tumultuous changes and new challenges. A reshaping of contemporary life now encompasses multiple, evolving family cultures and structures. Demographic trends reveal increasingly diverse and complex patterns in family life and a more ambiguous and fluid set of categories traditionally used to define the family (Cherlin, 2010; Walsh, 2012c), including:

- varied family forms and households
- varied gender roles, identity, and relationships
- growing cultural diversity and socioeconomic disparities
- varied and expanded family life course.

Although most data reported here are based on research in the United States, these patterns are increasingly widespread, especially in developed and rapidly changing societies worldwide.

The Varying and Expanded Family Life Course

The family life course is becoming ever more lengthened and varied. The average age of first marriage in the United States has risen to over 28 for men and 26 for women (US Census Bureau, 2010). Childbearing is also increasingly delayed, especially for women with advanced education and careers. Two or three committed long-term couple relationships,

along with periods of cohabitation and single living, have become increasingly common (Cherlin, 2010). With greater longevity, four- and five-generation families add both opportunity and complexity in balancing members' needs and family resources (Bengtson, 2001).

Three decades of research have provided clear evidence that families and their children can thrive in a variety of kinship arrangements: in stable single-parent, bi-nuclear, and stepfamilies; in kinship care; and with gay as well as straight parents (Cherlin, 2010; Green, 2012). Yet, over time, adults and their children are increasingly likely to transition in and out of varied households and kinship arrangements, adding complexity to all relationships. Because multi-stress environmental conditions and repeated instability heighten risks for maladptation and child problems, many families need to overcome socioeconomic barriers, buffer disruptive transitions, and weave together supportive kin networks for resilience in their life passage (Walsh, 2016).

A Family Developmental Perspective

The Family as a System Moving Through Time

Families comprise a complex web of kinship ties within and across households and generations. Family systems encompass the entire multigenerational network, and may be defined by blood, legal, and/or historical ties; formal and informal kinship bonds; residential patterns; and future commitments.

A family developmental systems perspective considers the functioning of the family in terms of basic transactional processes in and between human systems, dependent on an interaction of biopsychosocial variables (Bertallanfy, 1968). As recent epigenetic and socioneurobiology studies confirm (D'Onofrio & Lahey, 2010; Feder, Nestler, & Charney, 2009; Spotts, 2012), individual predispositions may be enhanced or countered by interpersonal and sociocultural influences. Family processes support the integration and maintenance of the family unit and its ability to carry out essential tasks for the growth and well-being of its members, especially the nurturance, guidance, and protection of children, elders, and other vulnerable members. Individual and family development co-evolve over the life course and across the generations. Relationships with parents, siblings, spouses, children, and other family members grow and change, boundaries shift, roles are redefined, and new members and losses require adaptation.

Thus, this approach views family functioning in relation to the needs of members and in sociocultural and temporal contexts. Through multilevel dynamic processes over time, families forge varied coping styles and adaptational pathways, fitting individual and family values, priorities, challenges, and resources.

Views of Normality: Chronological Time, Social Time, and Historical Time

Our notions of normality—both typical and optimal—are socially constructed, influenced by subjective worldviews and by the larger culture and historical times (Walsh, 2012c). Family and social time clocks are influential in setting expectations and goals in life and contribute to feeling successful and in sync with age peers.

Chronological ages tend to be associated with normative milestones, such as reaching maturity, marrying, having children, and retirement. Transitions to the next decade in life—turning 30, 40, or 60—can hold heavy meaning. Yet, with medical advances and biological and social changes, traditional mileposts have been shifting and age-appropriate norms blurred. A variety of reproductive strategies now assist older adults in having children. Most adults aged 65–75 are healthy and productive, do not consider themselves "elderly," and are expanding later life possibilities.

Varying cultural norms influence family life-cycle patterns, intertwined with socioeconomic factors that impact career and marital options, family stability, and life expectancy. Gender, class, ethnicity, race, and religion structure our developing relationships and our role expectations

for marriage and family life. Multigenerational family legacies also influence family members' worldviews, including their expectations about life passage and their hopes and dreams.

Normative (typical, expectable) passage over the life course is also profoundly influenced by the historical era in which individuals grow up, come of age, and grow old. Each generational cohort is distinct as it evolves through time, influenced by the social, economic, and political tides of its era (Elder & Shanahan, 2006). Major societal and global events, such as war or famine, impact various age cohorts differently, shaping their identity and life aspirations. The recent economic downturn and job market transformations severely impact young adults in establishing successful adult careers, marriage prospects, and childrearing plans, with forecasts of a lower standard of living than that of their parents. For older adults, it threatens jobs and financial security for their later years.

Beyond Normative Models of Human Development: A Social Constructionist Lens

In the mid-20th century, influential models of human development and the family life cycle were developed from a Euro-American perspective, reflecting cultural ideals and typical patterns in their times (Walsh, 2012c). Normative studies were standardized on white, middle-class intact families, headed by a heterosexual married couple with traditional gendered breadwinner/homemaker roles. That model of family life became reified as a universal standard, essential for healthy development. Yet today, it is only a small band on a wide spectrum of family structures.

Likewise, those formulations sanctioned and privileged a standard sequential progression of stages in individual, marital, and family development over the life course. Those who followed other pathways tended to be stigmatized and pathologized, with their lives regarded as deviant, deficient, incomplete, harmful, or even sinful. Pejorative labels, such as "working mothers" or "fatherless family" have persisted. Single women and those without children have been viewed as having incomplete lives; "childless" couples considered selfish; stepparents regarded as not "real" or "natural" parents; and gay parenting assumed to harm children.

Individual models of healthy lifespan development were based on male standards, and generalized from small studies of more affluent, educated men. Separation, autonomy, and career success—values associated with masculinity—were primary markers of positive development and adult maturity. The prioritizing of relationships and the care and nurturing of others were viewed as the primary attributes in female development. Yet, Vaillant's (2002) longitudinal studies of male Harvard graduates throughout adulthood concluded that strong relationships were the overriding key to men's positive development and life satisfaction. Feminist scholarship heightened recognition of the value of relational connectedness and interdependency in human development, eschewing the stereotyping of attributes as feminine or masculine to expand the full potential for men and women.

A social constructionist lens is imperative to appreciate the multiplicity of contemporary family forms and the intersection of cultural influences, life options, and timing of nodal events that make each individual and family developmental pathway unique. Above all, no single model or life trajectory should be deemed ideal or essential for positive development (Walsh, 2012c).

Family Challenges and Resilience

Over recent decades, efforts to understand risk and resilience in human adaptation have come to the fore in the fields of mental health and developmental psychology. *Resilience*—the ability to withstand and rebound from crisis and prolonged adversity—involves dynamic processes fostering positive adaptation within the context of significant risk and stressful conditions (Masten, 2013). Beyond coping and recovery, these strengths and resources in dealing with serious life challenges can yield positive growth.

The preponderance of resilience theory, research, and practice has been individually focused (Luthar, 2006). Early studies in child development described character traits that enabled some individuals to overcome childhood

trauma or maltreatment to lead loving and productive lives. Developmental models also tended to focus predominantly on the influence of the mother–infant dyadic bond and early childhood factors with insufficient attention to the broader family network, the larger environmental context, and significant experiences over the life course.

As studies of risk and resilience expanded to a wide range of adverse conditions and social contexts—impoverished circumstances, chronic illness, traumatic life events, war and combat zones, and natural disasters—it became clear that individual vulnerability and resilience involve the dynamic interplay of multiple influences and multilevel risk and protective processes—individual, interpersonal, socioeconomic and cultural influences—over time (e.g., Luthar & Brown, 2007; Masten, 2013; Rutter, 1987). Longitudinal studies found that even among high-risk youth who did poorly in adolescence, many were able to turn their lives around in young adulthood or later in midlife, revealing the potential to gain resilience throughout the life course (Werner & Smith, 2001).

Current developmental approaches to individual resilience attend broadly to dynamic, multi-level, and process-oriented variables over time, reflecting a theoretical shift toward a *relational developmental systems* framework in life course human developmental science (Masten, 2013; Walsh, 2011). Advanced computer programs for data analysis address these complex mutual interactions along developmental pathways. This systems orientation has many parallels with a family resilience framework, suggesting the potential for integration of individual and family level approaches (Masten & Monn, 2015).

Relational Resources for Individual Resilience

Notably, the crucial influence of significant relationships have stood out across studies of individual resilience (Walsh, 2003). Those who overcame adversity typically reported that their resilience was nurtured by strong bonds and mentoring by adults, such as coaches and teachers, who were invested in their positive development. Troubled youth who turned their lives around in adulthood credited a strong bond with a life partner or involvement in a faith community (Werner & Smith, 2001). Family functioning, particularly in caregiving quality, was identified as a crucial protective influence (Rutter, 1987). Yet most studies, narrowly focused on parenting, have not considered potential family-wide resources.

A family systems orientation has broadened attention to the entire relational network, identifying potential resources—"lifelines for resilience"—in the immediate and extended family. Individual resilience might be nurtured in bonds with siblings, parents or other caregivers, spouses, grandparents and godparents, aunts and uncles, and other informal kin (Ungar, 2004; Walsh, 2003). Even in troubled families, islands of strength can be found. Family assessment and intervention seek to identify and recruit those members who could provide a nurturing, mentoring relationship with at-risk youth: believing in their worth and potential, supporting their best efforts, and encouraging them to make the most of their lives.

The Concept of Family Resilience

Beyond the role of family members as resources for individual resilience, the concept of family resilience focuses on vulnerability, risk, and resilience in the family as a functional unit (Walsh, 2003, 2012a). Theory and research on family resilience extend family systems research and developmental theory on family stress, coping, and adaptation (Hawley & DeHaan, 1996; Patterson, 2002).

A basic premise in this systemic orientation is that highly stressful events, disruptive transitions, and persistent, multi-stress conditions impact the whole family. In turn, key family processes mediate the adaptation—or maladaptation—of all members, their relationships, and the family unit. Major stressors or a pile-up of stresses can derail the functioning of a family system, with ripple effects for all members and their relationships. The way a family deals with stress is crucial: key transactional processes for resilience enable the family system to rally in troubled times to anticipate and prepare for threats on the

horizon and to buffer disruption, reduce the risk of dysfunction, and support optimal adaptation.

Family resilience can be defined as *the ability of the family to withstand and rebound from disruptive life challenges, strengthened and more resourceful* (Walsh, 2003). More than managing stressful conditions, shouldering a burden, or surviving an ordeal, resilience involves the potential for personal and relational transformation and growth that can be forged out of adversity. By mobilizing key processes for resilience, even struggling families can emerge stronger and better able to meet future challenges. Members may develop new insights and abilities. A crisis can be a wake-up call, heightening attention to important matters. Many report that a major life challenge became an opportunity for reappraisal of their priorities, stimulating greater investment in meaningful relationships and pursuits. Their experience often sparks compassionate actions to benefit others or address harmful conditions (Lietz, 2013; Walsh, 2016).

Studies of strong families have found that relationships were deepened and enriched through weathering a crisis as a shared challenge (Walsh, 2003). Gottman's research found that successful couples approached tough times as a team; partners emphasized their "we-ness" and the strength they drew from each other. They viewed hardships as trials to be overcome together and believed that their struggles strengthened their bond as their shared efforts and pride in prevailing brought them closer (Driver, Tabares, Shapiro, & Gottman, 2012).

Multi-level Systems Dynamics in Family Risk and Resilience

From a systems orientation, family vulnerability, risk, and resilience are viewed in light of multiple, multilevel recursive influences in dealing with highly stressful experiences and social contexts. Family distress may result from unsuccessful attempts to cope with an overwhelming situation, such as a serious illness, disability, or death in the family or the wider impact of neighborhood blight or a large-scale disaster (Walsh, 2007).

Families living in poverty, largely in minority and marginalized groups, are most vulnerable to environmental conditions that heighten risks for serious illnesses, disabilities, and caregiver strain, as well as early mortality (Conger, Conger, & Martin, 2010; Walsh, 2012b). Moreover, the wide income gap in our society has produced a "marriage gap" (Cherlin, 2010). Those with low employment and earnings prospects are more likely to have children on their own or with cohabiting partners and are less likely to marry and more likely to divorce when they do. Persistent unemployment and recurring job transitions increase risks of family conflict and violence, substance abuse, residential instability, and child problems.

The family, peer group, community resources, school or work settings, and other social systems can be seen as nested contexts for nurturing and sustaining resilience (Bronfenbrenner, 1979; Ungar, Ghazinour, & Richter, 2013). Even highly vulnerable families, struggling with financial strains or crushing hardships, most often have many strengths and supporting bonds in extended kin and social networks and involvement in faith communities (Boyd-Franklin & Karger, 2012; Orthner, Jones-Sanpei, & Williamson, 2004). The vital role of cultural and spiritual resources (McCubbin & McCubbin, 2013; Walsh, 2009c) is especially crucial for those facing racial and socioeconomic barriers or other forms of discrimination.

A family resilience perspective, similar to Falicov's (2012) multidimensional framework, considers the intersection of cultural and developmental variables, locating each family within a complex ecological niche. A holistic assessment includes the varied contexts to understand the constraints and possibilities in each family's position, identifying common elements with other families in similar situations while also considering a family's unique perspectives, aims, challenges, and resources.

Key Processes for Family Resilience

The Walsh Family Resilience Framework (2003, 2012a) was developed as a conceptual map to guide assessment, intervention, and prevention in clinical and community practice. This framework is informed by three decades of

social science and clinical research on resilience and well-functioning family systems. Nine core processes for resilience were identified and then organized within three domains of family functioning: *family belief systems*, *organizational patterns*, and *communication/problem-solving*. Key processes can be targeted to strengthen family capacities to rebound from stressful life challenges (Walsh, 2016). Interventions aim to build family strengths as immediate problems are addressed, thereby reducing risk and vulnerability. As the family becomes more resourceful, the relational unit and its members gain ability to meet future challenges.

Family Belief Systems

Family resilience is fostered by shared beliefs: that facilitate members' abilities (1) to *make meaning* of their stressful situation and options; (2) to (re)gain a *positive*, *hopeful outlook*, and (3) for *transcendence*, through larger values, spiritual beliefs and practices, and sense of purpose. Families can be helped to gain a sense of coherence (Antonovsky & Sourani, 1988), recasting a crisis or hardship as a shared challenge that is comprehensible, manageable, and meaningful to tackle. Normalizing and contextualizing members' distress as common or understandable in their situation can depathologize their reactions and reduce blame, shame, and guilt. Affirming family strengths in the midst of difficulties counters a sense of helplessness, failure, and despair as it reinforces shared pride, confidence, and a "can do" spirit. Family members' mutual encouragement bolsters efforts to take initiative and to persevere in attempts to overcome barriers. Energies are focused on mastering the possible, accepting that which is beyond their control, and tolerating uncertainties. Shared spiritual resources—such as transcendent values, deep faith, contemplative practices (e.g., prayer, meditation), congregational involvement, and connectedness with nature—strengthen resilience and family bonds (Walsh, 2009c). Many find meaning through creative arts expression or in social action to alleviate suffering or repair harmful conditions. Difficult life challenges can be transformative, yielding valuable learning and new priorities, purpose, and positive growth.

Family Organizational Resources

A (4) *flexible family structure* (e.g., role functioning) enables adaptation to meet life challenges. In navigating disruptive changes, families need to *restabilize and reorganize*, with strong leadership to provide security, continuities, and dependability for children and other vulnerable family members. (5) *Connectedness* (cohesion) builds mutual support, commitment, trust, and teamwork. (6) *Extended kin and social networks, and community resources, and larger systems' structural supports* are critical "lifelines for resilience." It is not enough to help vulnerable families to "overcome their odds"; it is crucial to "change the odds" to enable them to thrive.

Communication Processes

Resilience in families is facilitated through (7) *clear, consistent information* about their adverse situation and options. (8) *Open emotional sharing* with empathic response strengthens bonds. *Pleasurable interactions and humor* offer respite from suffering and struggle, revitalizing energies and spirits. Through (9) *collaborative problem-solving*, families negotiate differences and take concrete steps toward achieving their aims. Families become more resourceful by learning from mistakes and shifting from a crisis-reactive mode to a *proactive stance*, anticipating and preparing to meet future challenges.

The Developmental Context of Family Resilience

The impact of adverse situations and family adaptational strategies vary over time and in relation to individual and family life-cycle passage: 1) families navigate varied pathways to meet emerging challenges over time; 2) a pile-up of multiple stressors can overwhelm family resources; 3) the impact of a crisis may vary depending on its timing in individual and family life passage; 4) a family's past experiences of

adversity and response can generate catastrophic expectations or can serve as models of resilience.

Emerging Challenges and Varied Pathways Over Time

Most major stressors are not simply a short-term single event, but involve a complex set of changing conditions with a past history and a future course (Rutter, 1987). Such is the experience of divorce, from an escalation of predivorce tensions, to separation and reorganization of households and parent–child relationships. Subsequent stressful transitions are common with relocation, remarriage, and stepfamily integration (Greene, Anderson, Forgatch, deGarmo, & Hetherington, 2012; Pasley & Garneau, 2012).

Given this complexity, no single coping response is invariably most successful; varied strategies may prove useful in meeting emerging challenges. In assessing the impact of stress events, it is important to explore how family members approached their situation: from their proactive steps to immediate response and long-term strategies. Some approaches may be functional in the short term but may rigidify and become dysfunctional over time or as conditions change. For instance, with a father's stroke, a family must mobilize resources and pull together to meet the crisis, but later they need to shift gears to adapt to chronic disability and attend to other members' needs (Rolland, 2012). Family resilience thus involves varied adaptational pathways extending over time, from a threatening event on the horizon, through disruptive transitions, and multiple shockwaves in the immediate aftermath and beyond.

Cumulative Stresses

Some families may do well with a short-term crisis but buckle under the cumulative strains of multiple, persistent challenges, as with chronic illness, unrelenting conditions of poverty, or complex, ongoing trauma in wartorn regions. Multi-stressed families, often in low-income, under-resourced, single-parent households, are especially vulnerable (Walsh, 2016). A pile-up of internal and external stressors can overwhelm most families, heightening their risk for subsequent problems in cascade effects (Masten & Cicchetti, 2010; Patterson, 2002).

One couple's escalating conflict and the husband's heavy drinking brought them to therapy. It was essential to situate their crisis in the context of the family's barrage of strains and losses over the past two years: the husband's job loss, with the loss of family income and health benefits, and a stroke suffered by the maternal grandmother, who had been their mainstay in raising their three small children, one with developmental disabilities. The family was reeling from crisis to crisis, with mounting pressures. Resilience-oriented couple counseling helped them to contextualize their distress in light of the pile-up of stressors and losses, and facilitated their mutual support, role reorganization, and team efforts, mobilizing extended family and community resources to master ongoing challenges.

Multigenerational Family Life-Cycle Passage

A family developmental assessment of functioning and distress attends to the multigenerational family system as it moves forward over time (McGoldrick, Garcia Preto, & Carter, 2015). Relationships with parents, siblings, spouses, children, and extended family members evolve and change over the life course and across the generations. The meaning and implications of a crisis for all members and their relationships should be considered. For instance, when one couple suffered a stillbirth, the impact was devastating throughout the kinship network: all had eagerly awaited this birth of the first son to the first son in a large Greek extended family.

Life's many crises and transitions generate emotional disequilibrium and often require structural reorganization and relational realignments, particularly with the addition or loss of family members, and as subsystems are redefined and updated. Successful family functioning over the life course depends on strong relational connections and flexibility in structure, roles, and responses to new developmental priorities and challenges (Walsh, 2012b, 2016). As patterns that were functional in earlier life phases no longer

fit, new options can be explored. With the loss of functioning or death of significant family members, others are called upon to assume new roles and responsibilities. In doing so, they can develop new competencies and enhanced sense of worth.

Mild to moderate disruption is commonly experienced with normative family developmental transitions, such as the birth of the first child (Cowan & Cowan, 2012). Non-normative stressors, which are uncommon, unexpected, or untimely in chronological or social expectations tend to be much more disruptive, especially the death of a child, the premature loss of a parent, or early spousal loss (Walsh & McGoldrick, 2013; Walsh, 2015b).

Stress is intensified in transition periods from one developmental phase to another as families and their members redefine and realign their relationships. Hadley, Jacob, Milliones, Caplan, and Spitz (1974) found that symptom onset frequently occurred at times of family developmental transitions involving the addition or loss of family members

Although all normative change is to some degree stressful, with highly disruptive events or multi-stress conditions even well-functioning families can falter. Transitional crises and immediate distress are common, yet they do not produce long-term dysfunction for the majority of children and their families. How a family prepares for anticipated challenges, buffers stress and manages disruption, effectively reorganizes, and reinvests in life pursuits will influence the immediate and long-term adaptation for all members and their relationships (Walsh, 2016, 2012a).

The counterbalance of continuity and change is extremely important (Falicov, 1988). Shared rituals are valuable in facilitating disruptive transitions, such as funeral rites and memorial events that mark the death of a loved one, honor the life, and offer community support for the bereaved to carry on their lives (Imber-Black, 2012).

Well-functioning families tend to have an evolutionary sense of time and a continual process of growth, change, and losses across the life course and the generations (Beavers & Hampson, 2003). This perspective helps members to see disruptive events and transitions also as milestones on their shared life passage. Families may lose time perspective when they are having problems. Some become stuck in the past or cut off from it; others magnify the present moment, overwhelmed and immobilized by their immediate situation; others, with catastrophic fears, become fixed on a dreaded future.

Legacies from the Past

Distress is heightened when current stressors reactivate painful memories and emotions from past experiences. Family members may lose perspective, conflating immediate situations with past events, and become overwhelmed or cut off from painful feelings and connections. Past adversity, such as relational abuse or war-related and refugee trauma, influence future expectations: catastrophic fears heighten risk of complications whereas stories of resilience can inspire positive adaptation. Reaching the age that a parent died can be fraught with anxiety, leading some to expect the worst while others start new health regimens, thereby gaining resilience. (Walsh & McGoldrick, 2004, 2013). The convergence of developmental and transgenerational events should be explored (McGoldrick et al., 2015).

One couple sought therapy because of intense fighting over the husband's vehement opposition to the wife's wishes for a second child. Genogram construction revealed that the husband's mother had died in childbirth with his younger sibling, a devastating loss he had suppressed and shared with no one. In exploring that experience, with his wife's empathic understanding, he realized his catastrophic fear of losing *her* and their bond deepened as they charted their future course.

Research Considerations and Practice Applications

Systems-oriented family process research over recent decades has provided some empirical grounding for assessment of effective couple and family functioning (Lebow & Stroud, 2012). However, family models and typologies tend to be static and acontextual, offering a snapshot of interaction patterns within families at one point

in time. It is essential to understand family functioning in social and temporal contexts.

A family resilience framework offers several advantages. First, by definition, it focuses on strengths under stress, in response to crisis, or in prolonged adversity. Second, it is assumed that no single model of healthy functioning fits all families or their situations. Functioning is assessed in context: relative to each family's values, structural and relational resources, social contexts, and life challenges. Third, processes for optimal functioning and the well-being of members may vary over time as challenges emerge or recede and families evolve over their life course. Although most families do not measure up to ideals, a family resilience perspective is grounded in a deep conviction in the potential of all families to gain resilience out of adversity.

The flexibility of the concept of resilience, the complexity of multilevel systemic assessment over time, and the varied practice applications and formats, pose daunting challenges for family assessment and intervention research. Given cultural and family diversity, and the probability that some processes may be more useful than others in dealing with varied challenges, intervention approaches and findings from a particular study focus or context may not be generalizable to other populations and life challenges. Despite these constraints, a family resilience framework is finding broad application in community-based interventions (e.g., Landau, 2007; Saltzman et al., 2011; Saul, 2014; Walsh, 2013). Numerous studies are increasing our understanding of core processes in family resilience in a wide range of high-risk conditions. Assessment tools and practice formats need to be adapted to fit varied situations.

Family Life Phases: Challenges and Resilience

The impact of a crisis in the family will likely vary for members and for the family unit depending on their concurrent life phase-related priorities and concerns. In every family, parental life challenges intersect with their children's developmental needs and concerns at their life phase. For instance, the death of a grandparent near the birth of a child poses incompatible demands for bereaved parents to attend both to grieving and to forming attachments with their newborn (Walsh & McGoldrick, 2004). A parent's serious illness, disability, and caregiving needs can derail educational or career plans of a young adult child (Rolland, 2012). For siblings at different developmental phases, differing concerns may be salient at the time of a family crisis. Over time, as children mature, new concerns may arise. A mother's diagnosis of breast cancer aroused intense loss issues for an 8-year-old daughter; as she later approached puberty, anxiety surfaced over her own future risk of breast cancer. Families need to be sensitive to such developmental issues and the need for open, ongoing, age-appropriate communication over time.

Without prescribing a normative model of progressive life cycle stages, it is nonetheless helpful to understand salient challenges that commonly emerge for couples and families at various life phases and transitions.

Couples Over the Life Course

The transition to marriage or commitment to a life partner is more varied today, with cohabitation increasingly common before or in lieu of marriage. More couples are opting not to raise children, defining their relationship as family. Many adopt a pet instead of, or in preparation for, childrearing (Walsh, 2009b). An emerging trend is "living apart together": couples in stable relationships who maintain separate residences (Cherlin, 2010), some by preference and others by necessity, such as partners living at a distance for jobs.

Couples today, less bound by family traditions, are freer to develop a wide variety of intimate committed relationships and gender arrangements (Sassler, 2010). They increasingly marry across race, cultural background, and religious orientation. Yet, negotiating family of origin relationships can be painfully challenging when parents disapprove of a bond, as for gay, lesbian, or transgender couples from more conservative families and faiths (LaSala, 2007).

Traditional marriage vows "till death do us part" are harder to keep over a lengthening life

course (Walsh, 2012c). Couples who raise children can anticipate another twenty to forty years together after their launching from home. While divorce rates are high—now stabilized at around 45% of marriages—perhaps it is more remarkable that over half of first marriages do last a lifetime. Couples increasingly celebrate sixty and even seventy years together. Relational resilience is required to weather the storms of life and to meet changing priorities. In youth, romance and passion tend to stand out in choosing a partner. For those raising children, relationship satisfaction is linked more to sharing family joys and responsibilities. In later life, needs for companionship and caregiving come to the fore.

For couples, the launching of young adult children involves a reappraisal and restructuring of their relationship and household as they take stock and look ahead. Some who have stayed in unhappy marriages while raising children decide to leave. Most divorces in mid-life are now initiated by women, with more financial independence than wives in past eras. Yet numerous studies have found that marital satisfaction—which tends to be lowest for those with children in adolescence—rebounds for most to high levels after their launching. Adjustments with retirement require reorientation of life priorities and renegotiation of household responsibilities for couples. Most find greater relationship satisfaction in their later years, with more time for individual and shared leisure and pursuits, a sense of shared history, and bonds with grandchildren.

With these developments over time, resilient couples approach marriage less as an institution and more as a dynamic partnership over the life course (Walsh, 2016). Successful relationships require periodic renegotiation of roles, mutual expectations, and priorities, as couples actively shape and reshape their bonds to fit changing needs and preferences

Families and Early Childhood

Adults move up a generation when they become parents to their children. This transition to parenthood is commonly accompanied by declining marital satisfaction and a reversion to more traditional gender roles by dual-career couples (Cowan & Cowan, 2012). New attachment and attention to the newborn take priority, reducing time and energy for personal needs or couple intimacy. Common strains involve conflict over different parenting styles and role expectations, which are often influenced by family of origin, cultural, or social class norms. With the vast majority of two-parent households headed by dual-earner couples, family resilience requires flexibility, collaboration, and good communication in navigating the ongoing demands of childcare, household maintenance, and jobs. Most fathers today are more involved in childrearing than were their own fathers, yet mothers continue to carry a disproportionate share of household maintenance, coordination, childcare, and eldercare. Most couples' values of gender equality are still, in practice, a work in progress.

Single-parent families, headed by an unmarried or divorced parent, now account for over 25% of all households in the United States. Nearly half of all children—and over 60% of ethnic minority children in poverty—are expected to live for at least part of their childhood in one-parent households, predominantly headed by mothers (Cherlin, 2010). There has been a decline in unwed teen pregnancy, while increasingly, young adult and older single women have been deciding to parent on their own when lacking suitable partners for childrearing. Inconsistent financial support and children's sense of abandonment by non-residential fathers have been major factors in child maladjustment. Children generally fare well in financially secure single-parent homes where there is strong parental functioning and support by extended kin networks (Anderson, 2012).

Grandmothers commonly provide essential childcare for working parents and those unable to do so, due to mental illness, substance abuse, or incarceration. For those who assume guardianship in kinship care (Engstrom, 2012), multistress demands take a toll on their own health, especially for those already burdened and on a limited income.

Families With Adolescents

With adolescence, family and parenting roles and relationships must shift to respond to a teenager's

changing cognitive, emotional, physical, and social needs. As youth strive for more autonomy and prefer time with peers, parents need to establish qualitatively different rules and boundaries than those with younger children. Dispelling outdated views of adolescence as a period of storm and turmoil, most teenagers experience little conflict or rebellion.

Yet close adolescent–parent relationships, guidance, and monitoring remain crucial to positive development, especially for those in high-risk communities (Gorman-Smith, Tolman, Henry, & Florshim, 2000; Steinberg, 2001). Those who lack supportive family bonds are at greater risk for developing problems of substance abuse, pregnancy, school drop-out, and gang involvement (Liddle, Rowe, Diamond, Sessa, Schimidt, & Ettinger, 2000). Trusting bonds, reliable structure, and open communication enable adolescents to share their interests and concerns and to depend on support and a sense of security. Teenagers need parents and other adult family members to learn about life, to discuss their own emerging identity issues and social concerns, and to help them make informed choices regarding their education and peer relations.

Establishing strong yet permeable rules, limits, and boundaries can be challenging, especially around issues of authority, privacy, and the use of cellphones and the internet. Management of a youth's serious medical condition, such as diabetes, can be fraught with conflict over control and treatment adherence. Pernicious peer bullying or risk of sexual assault may require parental intervention. The high risk of suicide by gender nonconforming teens is significantly lower for those with family acceptance.

Families in Early Adulthood and Midlife

Family bonds and intergenerational relations for most are mutually beneficial, dynamic, and coevolving throughout adult life (Bengston, 2001). With the launching of young adults and the structural contraction of the family unit from a two-generational household, most parents adjust well to this "empty nest" transition, welcoming increased freedom from childrearing responsibilities and reorienting attention to their own needs and priorities.

In our society, the primary developmental tasks in emerging adulthood involve establishing autonomy and forging personal life goals through education and/or initial commitments in worklife and intimate bonds. Those who have had highly conflictual or abusing families may cut off contact or flee reactively into other relationships. Yet, most are able to separate and individuate while renegotiating and realigning their relationships for close connection and interdependence as autonomous adults. However, the harsh economic climate and financial debts incurred in advanced education have brought many young persons back home to live as they figure out career options. For families that have lovingly raised children with serious developmental disabilities or mental illneess, young adulthood poses daunting challenges in providing essential support while encouraging their offspring to make the most of their lives (Walsh, 2016).

Families in Later Life

Despite American society's stereotypes in ageism, focused on deterioration and decay, medical advances and neuroscience findings of neuroplasticity support the many possibilities for functioning and positive growth into later years (Cozolino, 2008; Walsh, 2012b). Most older adults today remain healthy and happy well into their seventies, enjoying greater leisure, and finding meaning and fulfillment in new pursuits and active involvement with friends and family. The subjective sense of future time shifts as they reorient priorities in consideration of time left in life (Carstensen, 2006).

The vast majority of older adults maintain close connection with their family members, even those living far apart. The importance of sibling relationships commonly increases over adulthood (Cicirelli, 1995), as do social connections. For most older adults, grandparenthood or other generative involvements offer a new lease of life (Mueller & Elder, 2003). Those without children forge a variety of significant bonds with siblings, cousins, nephews and nieces, godchildren, close friends, and social networks. Aging gay and lesbian persons meet needs for intimacy in varied ways, influenced by their past experiences,

present life circumstances, and social environment (Cohler & Galatzer-Levy, 2000). With growing societal acceptance, many are coming out openly in their later years. In our mobile world, many relationships are carried on at a distance and sustained through frequent cellphone and Internet contact. Yet, uprooting for jobs or retirement can strain direct caregiving abilities and support in times of crisis.

The family as a system, along with its elder members, confronts major adaptational challenges in later life (Walsh, 2015a). Each family's approach evolves from its earlier patterns and cultural worldview. Systemic processes over the years influence their ability to adapt to losses and flexibly meet new demands. Once functional patterns may no longer fit changing priorities and constraints. Changes with retirement, illness, death, and widowhood alter complex relationship patterns, often requiring family support, adjustment to loss, reorientation, and reorganization. Such challenges also present opportunities for relational transformation and growth.

Increasingly, older adults must continue working past retirement age for financial security. Loss of needed income and benefits threatens self-sufficiency and later-life plans. With the ethos of self-reliance and stigma of dependency in our dominant culture, most older adults are reluctant to ask for or accept financial assistance from their adult children or burden them with their needs. Issues of pride and shame keep many from even telling their children that they are financially strapped or can no longer live independently.

With advanced age, chronic illness and disability pose significant family caregiving challenges, particularly with dementias, which affect nearly half of adults over 85 (Qualls & Zarit, 2009). Especially anguishing for family members are the ambiguous losses with Alzheimer's disease, called "the long goodbye" (Boss, 1999). As the illness progresses, loved ones may not even be recognized or are confused with others, even with those long deceased.

Prolonged caregiving takes a heavy toll, primarily on women, most often designated the primary caregiver. Most are at midlife, in the workforce, and juggling child and eldercare responsibilities (Brody, 2004). Others are past retirement, with limited resources, caring for very aged elders. As family size is decreasing worldwide, multigenerational networks become increasingly top heavy, with fewer adult children available for caregiving. A family systems approach broadens the individual caregiver model to involve family members as a *caregiving team*, each contributing according to abilities, proximity, and resources (Walsh, 2012b, 2015). The sharing of responsibilities and challenges can become an opportunity to strengthen bonds and heal old rivalries.

Intergenerational relations are often strained when elders have difficulties around declining abilities or dependency needs (e.g., refusing to give up driving when unsafe). Even when older parents are quite frail, losing mental or physical capacities, this should not be seen as an intergenerational role reversal, nor should parents be labeled as "childlike." Parents, with many decades more life experience, remain parents to their children in the generational hierarchy. The importance of dignity, respect, and involvement for elders is paramount (Walsh, 2012b).

A priority for resilience of elders and their families is to draw out sources of meaning and satisfaction and to integrate the varied experiences of a lifetime into a coherent sense of self, relational integrity, and life's worth. King and Wynne (2004) introduced the concept of *family integrity*, referring to older adults' developmental striving toward meaning, connection, and continuity within their multigenerational family system. It involves three competencies: (1) dynamic transformation of relationships over time, responsive to members' changing life cycle needs; (2) resolution or acceptance of past conflicts and losses; and (3) shared creation of meaning by passing on positive legacies across generations.

Divorce, Single-Parenting, and Remarriage

Divorce entails a complex set of changing conditions over time (Amato, 2010). Longitudinal studies have tracked family patterns associated with risk and resilience in the predivorce climate, through separation and divorce processes, subsequent reorganization, and, for most, later

stepfamily integration. Claims that divorce inevitably damages children, based on small clinical samples, have not been substantiated in large-scale, carefully controlled research (Greene et al., 2012). Although some studies have found a higher risk of problems for children in divorced families than those in intact families, fewer than one in four from divorced families shows serious or lasting difficulties. In high-conflict and abusive families, most children whose parents divorce fare better than those whose families remain intact. Moreover, economic strains and other factors heighten risks for maladjustment. Above all else, children's healthy adaptation depends on the strong functioning of their residential parent, household stability, and the quality of relationships with and between parents before and after divorce (Ahrons, 2004).

Divorce involves ambiguous loss: the couple's marriage and the family unit are dissolved, yet ex-spouses with children remain parents. Positive adaptation is facilitated by grieving what is lost (including past hopes and dreams) and dealing with hurt, anger, blame, and guilt. Family processes over time are a roller coaster with peaks of emotional tension at subsequent transition points. Parents can make a difference in the way they manage and communicate the decision to divorce and their custody, financial, and visitation arrangements, with reliable follow-through. Despite marital grievances, it is crucial for parents not to triangulate children as go-betweens, in loyalty conflicts, or in demonizing the other parent. They do best when parents cooperate, if not collaborate, across households over time, as each child celebrates milestones, such as graduation, or suffers difficulties. Continuing contact with important extended family members is encouraged.

Most divorced adults go on to remarry or repartner, a transition requiring negotiation of step-relations and realignments with families of origin (Pasley & Garneau, 2012). Challenges in stepfamily formation contribute to a 60% divorce rate in remarriage. Solidifying the new couple relationship is a priority, without vilifying the ex-spouse, which triangulates children in a loyalty conflict, commonly expressed by resisting or turning against the stepparent. Adaptation is facilitated when the biological parent assumes the primary parenting role and the new partner take a supportive role, gradually building a trusting, caring relationship with children. Stepfamily integration typically takes several years.

Death and Loss of Loved Ones

From a family systems perspective, death and loss involve transactional process including those who die and all who survive in a shared multigenerational family life cycle, recognizing both the finality of death and the continuity of life (Walsh and McGoldrick, 2004, 2013). The death of the last member of the eldest generation is a family milestone, as those in next generation become the family elders.

Most people hope for a natural death, but medical technologies prolonging life and the dying process pose unprecedented family challenges, complicated by moral and religious issues. Agonizing end-of-life decisions can spark intense and long lasting family conflict (Rolland, 2012). Increasingly, death follows a long, progressively worsening illness and disability. It is crucial for individuals and their loved ones to address needs for dignity and control in the dying process, supported by palliative and hospice care for pain alleviation, comfort, and solace. Clinicians can help families to discuss important end-of-life concerns and make the most of precious time together (Walsh, 2016).

A death in the family involves multiple losses: the person, the meaning of each particular relationship, missing role functions (e.g., breadwinner), and special position (e.g., only child or single parent). Survivors commonly experience a hole in the fabric of their family. An untimely loss of a child, spouse, or parent shatters hopes and dreams for the future and often sparks a sense of injustice. It is hardest for elders to accept the loss—and their own survival—of children or grandchildren, reversing generational life-cycle expectations. The death of an adolescent can be agonizing for family members, most commonly occurring from risky behavior, accidents, suicide, or homicide. An untimely or traumatic loss is often accompanied by "shattered assumptions" in family members' worldviews, such as expectations of predictability, security, and trust (Walsh 2007).

Spousal bereavement is a highly stressful transition. Despite initial profound grief and challenges in daily living, most surviving spouses cope well and are quite resilient over time. Most become more competent and independent, valuing supportive bonds with family, friends, faith communities, and companion animals (Walsh, 2009a, 2012b; Walsh & McGoldrick, 2013). Men tend to have greater initial difficulty and often repartner soon after bereavement. With early spousal loss in parenting years, well-intentioned relatives may encourage precipitous replacement to provide support and a second parent for children, yet this risks attachment difficulties in the new relationships. Positive adaptation is fostered by facilitating shared grief processes and by pacing investments in new relationships and disruptive moves from homes and communities.

Family adaptation to loss involves sharing grief, gaining meaning and perspective, reorganizing family life, and reinvesting in new and renewed bonds and pursuits (Walsh & McGoldrick, 2013). Current bereavement approaches view healthy grief not as a detachment from the lost loved one, but rather a transformation from physical presence to continuing bonds in spiritual and symbolic connections, sustained by memories, stories, and deeds. With grief, there is commonly an oscillation in focus between grief processes and attention to immediate life demands (Stroube & Schut, 2010). Families may need help in respecting members' varied reactions, coping styles, and pace. Mourning processes have no orderly sequence, timetable, or final resolution. Facets of grief commonly resurface at birthdays, anniversaries, and other milestones. The multiple meanings of a death are transformed over the life cycle and integrated with other life experiences. Work with families facing loss requires appreciation of diverse cultural and spiritual beliefs and preferences.

Clinical Implications

With the growing diversity of relationships and households in society, our view of "family" must be expanded to fit the lengthened and varied life course, attuning therapeutic approaches to the challenges and preferences that make each individual, couple, and family unique. Clinicians can help family members learn to live successfully in complex and changing relationship systems, buffer disruptive transitions, and make the best of stressful life experiences.

Families most often come for help in crisis, but they may not connect presenting problems and distress with relevant stressors. A genogram and timeline are valuable tools to visualize complex family systems and to track significant events and changes over time in order to understand and address problems in family developmental context (McGoldrick, Gerson, & Petry, 2008). Reactivation of past painful experiences at significant nodal points can be addressed. Recent or threatened crisis events, a pile-up of stressors, and changes in family or household composition should be explored to understand their implications.

One divorced custodial father sought therapy for difficulties he was having with his oppositional 11-year-old daughter (Walsh, 2016). The therapist initially focused unsuccessfully on improving his parenting skills with her. Called in as a consultant, I constructed a family genogram and timeline, which facilitated developmental exploration. After a bitter parental divorce, two years earlier, the father had cut off his daughter's contact with her mother and continued to demonize her, still furious over her past extramarital affair. He plunged into a new intimate relationship with a woman who was now pressuring him to get married and trying to win over the daughter's affections. The meaning and impact of these relational knots needed to be untangled and dealt with for the daughter and family relations to move forward from the past and into the future.

With a family developmental perspective, clinicians show interest in each family's life journey, listening to stories of crisis or hardship with compassion for their struggles, suffering, and losses, and with affirmation of their courage, caring, and best efforts. With a resilience orientation, it is important to rebalance a problem focus to identify and enhance strengths and resources that can facilitate positive adaptation. It is crucial to identify and draw on extended kin, social, and community networks and cultural and

spiritual resources. By targeting interventions to strengthen key transactional processes for resilience, families can become more resourceful in dealing with crises, navigating disruptive transitions, weathering persistent stresses, and meeting future challenges. As clinicians, we can help families find coherence in the midst of complexity and restore continuities in the aftermath of upheaval. We can encourage their efforts for meaning, purpose, joy, and connections, with conviction in their potential to forge personal and relational growth from their life challenges.

The paradox of resilience is that the worst of times can also bring out the best in response. A crisis can yield learning, transformation, and growth in unforeseen directions. It can awaken family members to the importance of loved ones and spark them to heal grievances. Professionals can support family efforts to envision and strive toward a better future and, where hopes and dreams have been shattered, to imagine new pathways ahead, seizing opportunities for invention, transformation, and positive growth.

In families torn by past grievances, conflict, or estrangement, normative family challenges, such as parental caregiving, are often more complicated. A developmental systemic perspective and future orientation can be especially helpful in times of crisis, as in the following case:

In one family, the adult daughter sought therapy concerning her agonizing dilemma. Her father, in a medical crisis, had asked her to donate her kidney to save his life. In exploring her complicated feelings, she tearfully described her father's alcoholism that had caused his crisis, her anger at his abusive behavior when drunk, and his failure to heed their pleas to stop drinking. I suggested we convene a session with her siblings to see how they might approach this crisis as a collaborative caregiving team. She was dubious. The meeting proved difficult to schedule, as they had gone their separate ways after leaving home and were reluctant to respond to their father's plight.

When we met, I broadened the discussion focus forward with future-oriented questions, wondering if they had considered other challenges ahead that might arise in caring for *both* aging parents or if either were widowed. They had avoided looking ahead, but coming together in this crisis opened discussion of new relational possibilities and realization of the need to collaborate over the coming years. The oldest brother then volunteered his kidney for their father, saying he was less conflicted, remembering good times with their father before his problem drinking. The others stepped up to support him and all agreed to keep in contact and to come together around their parents' future needs, forging a new solidarity.

The importance of family ties in adulthood has been neglected in research, clinical training, and practice, which emphasize early developmental phases: young couples and families raising children. At the launching of the young adults, attention follows the younger generation into their own life course and family formation, relegating the parent generation to the margins, as extended kin. Parents never cease to be parents, with lifelong concern for the well-being of their children and any grandchildren. The term "family of origin" connotes an older generation left behind, with clinical interest in past influence.

It is also crucial not to define a child or family identity by one milestone on their life passage—labels such as "child of divorce," or "broken family" can be pejorative and trapping of those moving on with their lives, overshadowing previous or future years of satisfying relational life. Our developmental lens needs to be expanded to the full life course and the interdependence of multigenerational connections that extend from the past into the future.

A facilitated family life review (Walsh, 2015, 2016) can assist families in the integration of family life phases and transitions, updating relationships and facilitating acceptance of life and loved ones. Sharing reminiscences can be a valuable experience for family members, incorporating multiple perspectives and subjective experiences of their lives over time. Recalling hopes and dreams, important milestones, and their satisfactions, pride, and regrets enlarges

the family story and fosters empathic understanding. Earlier conflicts or hurts that led to cut offs or frozen images and expectations can be reconsidered from new vantage points; misunderstandings and faulty assumptions can be clarified. As they mature, family members are often more open and honest about earlier transgressions or secrets and more readily acknowledge and regret past mistakes and hurts, opening possibilities to heal old wounds. Family photos, scrapbooks, genealogies, reunions, and pilgrimages can assist this work. Stories of family history and precious conversations can be videotaped, preserved, and transmitted to younger generations. Wisdom can be drawn from past hardships and stories of resilience can inspire the journey ahead.

We are relational beings; most lives are enriched by a variety of intimate relationships and significant kin and social bonds within and beyond households. The shared construction of identity and meaning is a lifelong process as individuals and their families organize, interpret, and connect experiences over time.

Conclusion

A family developmental framework views each family's functioning in relation to its broader sociocultural context and evolution over the multigenerational life cycle.

We must be sensitive to the culture and time in which families and their members live and the contribution of critical events and structural sources of meaning.

Crisis and challenge are inherent in the human condition. Although some families are overwhelmed by stressful life events, disruptive transitions, or persistent hardship, most emerge strengthened and more resourceful, able to love well and raise their children well. How the family deals with adversity as a functional unit is critical for all members' positive development and the future of the family. Many adaptational pathways are possible, with more resilient families using a variety of coping techniques, effective problem-solving strategies, and flexibility in dealing with internal and external stress events and conditions. Resilience does not mean bouncing back unscathed, but struggling well, effectively working through and learning from adversity, integrating the experience into life's journey.

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4.

THE NEUROBIOLOGY OF RELATIONSHIPS

Mona DeKoven Fishbane

Interpersonal Neurobiology

Family therapists have long adopted a multilevel systemic view, highlighting not only interior family dynamics, but also larger contextual issues. Neurobiology brings to this multilayered discourse the micro level of brain/body processes. Interpersonal neurobiology (Siegel, 1999, 2012) integrates brain, body, and relationships, exploring the recursive impacts of our physical-neurological selves and social processes, embedded within the larger sociocultural context. This chapter focuses on the neurobiology of relationships, with implications for clinical practice.

Neuroscience is a burgeoning and fast-changing field, or rather group of fields. With new technologies that allow scientists access to the human brain in action, we are able to "peek inside" the skull and understand cognitive and emotional processes as never before. In addition to the EEG, which measures electrical activity in brain cells, newer scanning devices such as the functional MRI (fMRI) allow real-time measurements of the brain as it functions. When an area of the brain is active, it requires oxygen, delivered by the blood. The fMRI measures blood flow to the brain. Other new technologies include Diffusion Tension Imaging (DTI), which tracks connections between neurons (yielding maps called the "connectome").

There are several sources of neuroscience data with relevance for human functioning. The first is the neuroimaging just mentioned. A second source is animal research, especially with rodents and primates (Panksepp & Biven, 2012; de Waal, 2005). This work provides insights about subcortical processes of emotion and the fight/fight/freeze response. When it comes to higher cognitive processes, this research is less relevant, since other animals lack the advanced prefrontal cortex (PFC) that allows humans to engage in higher thinking and flexible and nuanced responding to complex situations. A third source of neuroscience data comes from studies of people who have suffered brain damage from accident, disease, or surgery (Damasio, 1994). Their tragic losses allow scientists to understand which areas of the brain are linked to specific functions. Fourth, scientists understand brain–body processes by studying hormones such as cortisol coursing through the blood (Gunnar & Quevodo, 2007; Kiecolt-Glaser & Newton, 2001). Finally, recent studies of genetics and genetic variations are yielding new insights into individual differences in brain and behavior (Rodrigues, Saslow, Garcia, John, & Keltner, 2009). And epigenetics—the study of the interaction between genes and environment—explores how experience changes the activity of genes by turning the genes on or off (Siegel, 2012).

Evolution and Survival

From an evolutionary point of view, for all animals the goal is to survive and pass their genes on into the next generation. We humans are animals, more specifically mammals, and even more precisely primates. We share 98% of our genes with chimpanzees (Gibbons, 1998). The major difference is in the prefrontal cortex, the seat of higher reasoning; this area is so highly developed in humans that Daniel Siegel (2010) has called it the "cortex humanitas."

While we have these special human capacities that allow us to create culture, art, and science, we also carry within us aspects of our evolutionary past; indeed, our "inner lizard" and "inner mammal" are often running the show when we are upset and reactive. Like all other animals, we instinctively move toward things that are pleasant and away from things that are dangerous or toxic. Our fight/flight and freeze responses originate deep within our brain stem and emotional brain, triggered automatically to protect us (Panksepp & Biven, 2012). It is precisely these automatic self-protective reactions that get us in trouble in intimate relationships, even though they evolved to save our lives. We will explore the interaction between automatic, reflexive behaviors and the more thoughtful responses powered by the prefrontal cortex; this is where the action is in therapy, as we help clients make choices in keeping with their values, rather than react on automatic pilot.

In addition to fight or flight, humans and other mammals have another set of instincts that have been called "tend and befriend" (Taylor, 2002) and the "care and connection" system (Uvnas-Moberg, 2003). More typical of females as they care for their offspring, tend and befriend leads us to seek out others for comfort and protection when we are stressed—and to offer care as well. Fueled by the hormone and neurotransmitter oxytocin, this connecting instinct is as important for survival as fight or flight. As Dacher Keltner (2009) has pointed out, survival of the fittest does not mean survival of the toughest or meanest; it refers to the best fit between an organism and its environment. And the environment in which humans have evolved is social. It is our social and emotional intelligence that allows us to thrive with our fellow humans. Kindness, compassion, and care are key skills for survival in our highly social environmental niche.

The Relational Brain: Wired to Connect

The nature vs. nurture debate has largely been put to rest by neuroscience: it is both/and. Erik Kandel (2006) won the Nobel Prize for showing how experience and learning change the brain. It happens at the level of synapses (the connections between neurons, or brain cells); everything we do, everything we learn affects how neurons connect with each other. And the impact even extends to the genetic level. Gene expression is affected by experience (Siegel, 2012). Epigenetics is the study of the interaction of genes and environment. Current research on individual differences, for example, focuses on how genetic predispositions are impacted by upbringing, including neglect or abuse (Siegel, 2012). Nurture matters.

The baby's brain is wired through connection with parents and other caregivers, a process explored by Schore (2003). The baby is born with many more neurons than the adult has; through experience, the baby's neurons become connected with each other. Neurons that are not connected die off, in a natural process called apoptosis. Human infants are born essentially premature relative to other mammals. They require intensive caretaking for years before they are able to function on their own. And how they are cared for shapes their brains. While babies are born with temperaments, experience joins with genetic predispositions to create personality and other individual characteristics. Secure attachment and attunement are vital for proper brain development in the early years. The communication at this stage of life is primarily right brain to right brain (Schore, 2003), as parents communicate to their infants in singsong "motherese," with prosody and tone of voice more important than the actual words spoken. Early in life, the parent regulates the baby's emotions. Eventually, this "dyadic regulation" (Siegel & Hartzell, 2003) develops into self-regulation as the child matures and learns how to self-soothe.

We do not outgrow our need for others in adulthood. Interdependence, not independence, characterizes healthy functioning throughout the life cycle. Social neuroscience studies the ways in which interpersonal experience impacts our physical and psychological well-being. Social rejection triggers pain centers in the brain (Eisenberger & Lieberman, 2004). And the quality of our connections with others affects our body. As we will see below, positive, satisfying relationships are associated with health and longevity; unhappy relationships and loneliness lead to illness and earlier death.

Attachment is key for both child development and adult well-being (Cozolino, 2006; Siegel, 2012). We need to be able to rely on trusted others when we are stressed or vulnerable. Secure attachment is associated with social, emotional, and cognitive flourishing at all ages; insecure attachment (e.g., anxious or avoidant attachment) is associated with psychological distress. Love is considered an attachment relationship (Hazan & Shaver, 1987; Johnson, 2004; Solomon & Tatkin, 2011); the pursue-distance cycle so typical of unhappy couples often reflects an anxious-avoidant attachment dance (Fishbane, 2013). Secure attachment with our partner can help regulate us when upset (Beckes & Coan, 2011). While it is important to self-regulate—a prefrontal function we will explore shortly—we do not outgrow our need for soothing from others. Receiving care and soothing is only half the story; giving care is the other half. It turns out that generosity triggers reward centers in the brain (Moll et al., 2006). It feels good to do good.

Brain 101

Interconnected Neurons

There are billions of neurons in the human brain. Each neuron connects with up to 10,000 other neurons at synapses, the space between them (Cozolino, 2006). There are trillions of synaptic connections, making the human brain the most complex entity in the universe. The neuron is composed of a cell body as well as incoming and outgoing extensions called dendrites and axons. Information comes into the cell body from other neurons through the dendrite; within the cell, it travels down through the axon as electrical energy. At the end of the axon, the information is converted into chemicals (neurotransmitters) that are released into the synapse and picked up by the receiving neuron.

Neurons, or gray matter, are far outnumbered in the brain by glia, or white matter. White cells, once thought to provide only the mundane tasks of delivering nutrients to and cleaning waste from neurons, are now seen as facilitating communication between neurons (Fields, 2009). One type of white cell wraps myelin, a fatty sheath, around axons. Myelinated axons allow for much faster and more efficient communication between neurons. This process of myelination is incomplete in the adolescent brain (explaining some of the erratic and immature behavior of teenagers) (Steinberg, 2005). Myelination continues into adulthood, and is responsive to experience.

Habits and Change

When circuits of neurons activate at the same time, they are more likely to do so in the future. This is expressed in Hebb's Theorem, "neurons that fire together, wire together" (Siegel, 1999). This is the neural basis for habit; the more you hike on a path, the deeper the rut becomes. Thus, in a profound sense, we are what we do, as our behaviors, repeated over and over, are reflected in circuits of neurons that have become associated together in our brain. It is helpful for family and couple therapists to understand this process in order to craft interventions for change. We are wired for habit; the brain is "an anticipation machine" (Siegel, 2010), always looking for familiar patterns. "Resistance" in clients can be seen in this light; holding onto the familiar is natural to our neural makeup.

But we are not prisoners of our neural or behavioral ruts. We are wired for change as well; the brain is an "organ of adaptation" (Cozolino, 2006). Neuroplasticity, the ability of the human brain to change, continues throughout life. Neuroplasticity includes synaptogenesis (the creation of new synapses), neurogenesis (the birth of new neurons from neuronal stem cells), and myelinogenesis (the wrapping of myelin around the axon); all occur in response to experience,

and can continue throughout life (Siegel, 2012). We will consider ways to nurture neuroplasticity, key for change in therapy.

The Tripartite Brain

The human brain evolved by re-using older brain parts for new purposes. MacLean (1990) identified three interrelated parts of the human brain shaped by evolution. The deepest and oldest layer of the brain, the brain stem (or "reptilian" brain), connects with the body and controls reflexes. The next level up, the mammalian brain, includes the limbic system, especially the amygdala and hippocampus. The amygdala, along with lower brain areas, modulates the fight/flight/freeze reponse. The hippocampus is involved in forming explicit memories and in learning. The highest (and outermost) level of the brain is the thin layer of the neocortex. The front part of the cortex, the prefrontal cortex (PFC), controls the complex thought, judgment, and self-regulation that are the hallmarks of the human species (Siegel, 2012). It is the PFC that allows us to make choices, have "response flexibility" (Siegel, 2010), and live according to our values.

The amygdala, our emotional sentry, is constantly scanning the environment for danger. Visual information enters the eyes and goes to the thalamus, the sensory relay station in the brain. From there it goes on a slow route to the occipital (visual) cortex at the back of the brain, where a distinction is made about what has been seen (LeDoux, 1996). The problem with this slow route is that by the time we have figured out what we have seen, we could be dead if it is a dangerous predator. Fortunately, we also have a quick route by which the information goes from the thalamus directly to the amygdala, which acts in a "quick and dirty" manner (LeDoux, 1996), making snap decisions about what to avoid or attack. The amygdala is all about survival. In this regard, the amygdala is biased toward the negative, seeing danger where it may not exist. This keeps us safe in the jungle, but it may cause havoc in our living room when we feel hurt or insulted by our partner. Once it assesses danger, the amygdala, along with the brain stem, sets off the alarm. The sympathetic nervous system and the HPA (hypothalamic–pituitary–adrenal) axis are activated, releasing the stress hormones norepinephrine and cortisol into the bloodstream (Sapolsky, 2004). This is the well-known fight-or-flight response. According to the Polyvagal Theory (Porges, 2007), the vagus nerve that runs between body and brain participates in this process as well. If safety is assessed, the "smart vagus" leads to a relaxation of facial muscles and vocal tone, as the social engagement system is activated. If life-threatening danger is assessed, with no opportunity for fight or flight, the primitive vagus activates a dissociative shutdown, the equivalent of an animal playing dead to escape its predator.

There is a complex interplay between PFC and amygdala. On the one hand, the amygdala "highjacks" the brain during an emotional meltdown (Goleman, 1995), overwhelming higher brain functioning. Furthermore, the amygdala modulates emotional memory. Thus, if we feel threatened or upset in the present moment, old amygdala memories may become stirred up, increasing our level of agitation. Since the amygdala does not come with a "time stamp" (Badenoch, 2008), we are often unaware that the current upset is intensified by an older painful memory. These moments involve an overlap between present and past (Scheinkman & Fishbane, 2004).

But we are not just victims of our amygdalas. We are blessed with a PFC that regulates and calms the amygdala. The central part of the PFC, the ventromedial prefrontal cortex (vmPFC) and the orbitofrontal cortex (OFC), communicate directly with the amygdala and are key in emotion regulation. In both depressed and violent individuals, this middle PFC area is unsuccessful at regulating the amygdala (Bufkin & Luttrell, 2005; Johnstone, van Reekum, Urry, Kalin, & Davidson, 2007). In the healthy brain, it is precisely the prefrontal regulation of the amygdala that allows us to pause and make choices about how to respond; we are not doomed to react on automatic pilot (Siegel, 2012).

The interplay between automaticity and choice, and between unconscious and conscious processes, is central to human brain functioning. Even perception is a complex blend of the two. We do not see the world as it is, but rather as we

construe it. Or, as neuroscientist Bach-y-Rita (quoted in Doidge, 2007, p. 15) put it, "we see with our brain, not with our eyes." Expectations shape what we perceive; in a famous experiment, subjects told to count the number of times players wearing white shirts threw the ball in a game of catch completely missed a woman in a gorilla suit walking across the field (Simons & Chabris, 1999). Cultural beliefs also affect perception, as we will see below.

Memory involves both conscious and unconscious processes. Explicit memory—in which we consciously remember experiences and facts—relies on the hippocampus, which only develops at eighteen months to two years of age; implicit or unconscious memory involves the amygdala and related areas, and is functioning in infants (Siegel, 2012). An adult client might become reactive when implicit emotional memories are triggered in the amygdala in a current interaction. Because the memory is not explicit or available to conscious awareness, the client may be unaware of the source of the intensity of feeling, which can be out of proportion to the current interaction. In other parlance, this is a transference reaction. The clinician helps the client separate the present from the past in the safe context of therapy.

The brain has two hemispheres, connected by a group of fibers called the corpus callosum. The left hemisphere specializes in logic, language, and linear thinking: the right hemisphere is deeply connected to body processes and to emotional experience, specializing in the gestalt or "gist" of things (Siegel, 2012). In the left prefrontal cortex is an area that narrates our experience; called "The Interpreter" (Gazzaniga, 2008), it gives us a storyline. When The Interpreter tries to explain our emotional reactivity, it often turns into a self-justification that may have little to do with why we actually became upset. The role of The Interpreter was first identified by Gazzaniga in split-brain patients, whose corpus callosum was cut due to illness or surgery for epilepsy. In these patients, the left hemisphere literally had no access to decisions made by the right hemisphere. Nevertheless, a story was created by the left to explain the decisions of the right. In a well-integrated brain, the communication between the hemispheres allows for a balance of gist and detail, of feeling and logic.

The Brain Is Embodied

There is a bidirectional flow between the brain in the skull and the rest of the body. Information travels from the viscera (heart, lungs, intestines) to the brain, giving literal meaning to "butterflies in the stomach" and an "aching heart." Visceral feedback comes into the brain and is processed by the insula, deep inside the cortex. This "interoception," or inner perception, is considered crucial to both emotional awareness and empathy. Reading our body lets us know how we feel (Craig, 2009; Damasio, 1994); as we will see, it also lets us in on how others are feeling.

Neuroscientists study brain–body processes by examining hormones and neurotransmitters and their impact on behavior, health, and well-being. We consider a few of these now. Cortisol, a major stress hormone, has been researched extensively (Gunnar & Quevodo, 2007). A little cortisol over the short term can be beneficial. It aids survival as part of the fight–flight response. In mild doses and for brief periods, cortisol also helps us perform at peak capacity. But prolonged release of cortisol, prompted by chronic or severe stress, damages cells in the hippocampus, which has many cortisol receptors.

A natural antidote to cortisol is oxytocin, both a neurotransmitter in the brain and a hormone in the blood (Uvnas-Moberg, 2003). Released with orgasm, childbirth, lactation, massage, gentle touch and empathy, oxytocin lowers cortisol and promotes a sense of well-being. Oxytocin, more prevalent in females, is associated with the tend and befriend response discussed above. It has been called "the cuddle chemical" (Taylor, 2002) and is considered key to attachment, as it promotes bonding between mother and child. Vasopressin, a cousin to oxytocin, is more prevalent in males. In animals, vasopressin leads to mate guarding and territoriality. Neuroscientists have studied prairie voles, monogamous rodents found in the Midwest. Unlike their more promiscuous cousins the montane voles, prairie voles have oxytocin and vasopressin receptors in reward centers of their

brains (Young & Wang, 2004). It feels good for them to bond with "that special someone." These critters tend to mate for life; if a mate dies, the survivor often remains alone instead of forming a new liaison.

Stress and Trauma

The stress response evolved in animals for acute, short-term crises. In his aptly named book *Why Zebras Don't Get Ulcers*, Robert Sapolsky (2004) notes that the zebra either gets eaten for lunch by a predator or escapes and eats its own lunch. The stress response developed to help creatures survive in these acute, intense emergencies. But we humans carry chronic, long-term stress. We fret over our careers, our finances, our kids, and our relationships. This chronic stress can damage our immune systems, compromising health and shortening lives. According to McEwen (2006), a little stress—what he calls "allostasis"—can be good for us, increasing alertness and facilitating learning. But excessive stress—"allostatic load"—is damaging, associated with cardiovascular disease and other illnesses. Research on spousal caregivers with a partner suffering from dementia finds that the caregiver spouse often experiences long-term, unremitting stress that compromises the immune system (Kiecolt-Glaser et al., 2003). Chronic stress can shorten telomeres, the protective covering at the ends of chromosomes. Shorter telomeres are associated with an increased likelihood of disease and shorter lifespan (Epel et al., 2004; Kiecolt-Glaser & Glaser, 2010).

The most devastating stress is trauma during childhood, when the brain is developing. Neglect and abuse of the young child negatively affect the growing brain, leading to impairment in social-emotional and cognitive functioning (Perry, 2001, 2002; Teicher, Andersen, Polcari, Anderson, & Navalta, 2002). Interpersonal trauma has the worst impact, especially when the child is abused physically, sexually, or emotionally by a parent or other family member. And neglect is as damaging to the growing child and its brain as abuse. The brain, as we have seen, is wired through attuned, loving, safe interactions with parents and other caregivers. Without this nurturing, the child's brain often does not develop properly (Schore, 2003). In addition to intra-familial trauma, children suffer from larger contextual traumas such as poverty, violence, or war. Poverty has been found to have a negative impact on the developing brain (Hackman & Farah, 2009).

Trauma can cause severe neurobiological impacts in adulthood as well. Post-traumatic stress disorder from war or other forms of violence can impair memory and cognitive function (Vasterling et al., 2002). Traumatic memories may be processed implicitly, without being integrated into explicit memory. Fragments of implicit memories get triggered in flashbacks, often overwhelming the traumatized person. It has been suggested that trauma might potentiate a faster amygdala response by increasing the speed and efficacy of the thalamic–amygdala pathway (LeDoux, 1996). While this may have evolved to keep us safe in threatening conditions, like so many other brain processes shaped by evolution, it has a down side, in this case a hyper-reactivity to stress. Scientists are studying genetic differences in oxytocin receptors that predispose some individuals to greater stress reactivity (Rodrigues, Saslow, Garcia, John, & Keltner, 2009).

Relationships and Health

The field of psychoneuroimmunology explores the interplay between psychology, relationships, the brain, and the immune system. It turns out that the quality of our connections with others has a powerful influence on our health. Positive relationships—including marriage—are associated with better physical and mental health, and greater longevity; unhappy relationships are associated with poor health and higher mortality (Robles & Kiecolt-Glaser, 2003; Slatcher, 2010). The pathways for this health-and-relationships connection include the immune system and inflammatory processes. Just as short-term stress can be helpful, short-term inflammation aids in reparative processes like wound healing. However, like chronic stress, chronic inflammation—associated with stressful relationships—leads to deterioration in health (Kiecolt-Glaser, Gouin, & Hantsoo, 2010). Loneliness is also associated with poor health outcomes (Cacioppo & Patrick, 2008).

Social support strengthens the immune system (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002). Expressions of compassion and care release oxytocin, lowering the stress hormone cortisol. Scientists have studied the health benefits—and risks—of marriage. The bottom line: Intimate relationships affect our health, for better or worse. The "commingled physiology" (Sbarra & Hazan, 2008) of intimate partners can be salutary or damaging, depending on the quality of the relationship. This is especially the case for women. In general, marriage is beneficial for health and longevity (Waite & Gallagher, 2000). But this is truer for men. For women, it depends on the quality of the relationship (Graham, Christian, & Kiecolt-Glaser, 2006).

Happy couples are less likely to become physiologically aroused during conflict than unhappy couples (Gottman, 2011). Couples high in relationship satisfaction are able to navigate their differences without becoming emotionally and physically dysregulated. Distressed couples, by contrast, get caught up in cycles of reciprocal negativity, often entering a state of Diffuse Physiological Arousal (DPA), with a rapid heart rate, and being unable to think clearly (Gottman, 2011). And levels of stress hormones in newlyweds predict the likelihood that they will be divorced ten years later (Kiecolt-Glaser, Bane, Glaser, & Malarkey, 2003). There is a recursive relationship between the quality of our relationships and our ability to regulate ourselves emotionally.

The Emotional Brain

Descartes' famous maxim from the seventeenth century, "I think therefore I am," privileged the rational brain. Our ability to reason does indeed differentiate us from other animals. But neuroscientists have pointed to Descartes' error, identifying the huge role of emotion in our lives (Damasio, 1994). "I feel therefore I am" has been offered as a corrective to Descartes (Cacioppo & Patrick, 2008). Most of our experience, including emotion, is automatic and beneath awareness. This frees our higher brain, the prefrontal cortex—which uses a lot of energy—to focus on complex tasks and reasoning. Subcortical processes such as the limbic system and brain stem are running the show much of the time. Integration between emotion and reason are vital for human functioning.

Scientists consider emotions to have survival functions (Damasio, 2010): Emotions lead us toward what is pleasant, and away from danger. Panksepp (1998) has identified seven emotional operating systems in the brain: Lust, Care, Play, Seeking, Panic, Fear, and Rage. Each has its own evolutionary purpose, and its own neurobiological pathways and neurochemicals. Neuroscientists debate how much continuity there is between humans and other animals when it comes to emotion. Panksepp is the most vocal proponent of animal emotions, identifying the roots of human laughter in "rat laughter," high-pitched squeals of pleasure his rats emit when Panksepp tickles them. He also notes other similarities between humans and animals, such as distress cries at separation, and the rough-and-tumble play of juvenile males (human and otherwise). The highly developed human prefrontal cortex sets us apart from other species, and with it our ability to self-regulate and make considered judgments. But many of the subcortical aspects of our emotional experience we do share with other animals.

Emotions are embodied, "full of blood, sweat, and tears" (LeDoux, 1996, p. 42). William James (1884) long ago proposed that we do not cry because we are sad or tremble because we are afraid; rather, we are sad because we cry, and are afraid because we tremble. Our body experience lets us know how we feel. Current thinking supports a similar, though more nuanced, view (Damasio, 2010). A stimulus is perceived by the brain, leading to a body response; the body information comes back up to the brain into the insula. This process of interoception in the insula allows us to "read" and name our feelings. Thus there is a brain–body loop in the experience and awareness of emotion. Within the brain, scientists have tried to locate specific emotions in specific areas. But it appears that emotion circuits are distributed throughout the brain, involving limbic areas like the amygdala (a major player in many emotions, especially fear), brain stem, and prefrontal cortex (Davidson & Begley, 2012).

Emotions serve as communication between people. There are facial muscles dedicated to

expressing emotion, and neurons in the brain that specialize in reading emotion in the faces of others. Both of these processes happen quickly and beneath awareness. There are universal emotions understood by cultures throughout the world. These include surprise, fear, anger, disgust, sadness, and happiness. Each culture has its own "display rules" of when and how to express these emotions (Ekman, 2003). As we pick up the emotions of others, we are affected by them, at times experiencing "emotional contagion" (Hatfield, Cacioppo & Rapson, 1993). This occurs beneath awareness, and can be deleterious if the other is conveying negative or toxic emotions. Interpersonally, reactivity in one family member or partner can be picked up and felt by another without either being aware of what is happening.

Researchers have found individual differences in emotional responding. Richard Davidson noted variations in "affective chronometry" (Davidson, 2000). This involves how quickly one gets upset, how intense the upset is, and how long it takes to calm down. Davidson and colleagues have also found differences in prefrontal asymmetry; persons with greater left prefrontal activation at rest tend to be more positive and resilient; those with right prefrontal activation tend to be more negative, and are more likely to withdraw in the face of novelty (Jackson et al., 2003). Finally, Davidson has identified individual differences in six dimensions of what he calls "affective style" (Davidson & Begley, 2012). These dimensions include: Outlook (positive, negative); Resilience (how quickly one recovers when upset); Self-Awareness (how tuned in one is to one's own physical-emotional experience); Sensitivity to Context; Attention (how focused one is); and Social Intuition (how tuned in one is to social cues). Davidson has identified the brain areas involved in each of these dimensions, and he notes that these dimensions are not fixed. They are amenable to change, especially through practices such as mindfulness meditation.

Emotion Regulation

Having emotions is one thing; knowing how to regulate them is another. A failure to self-regulate is a problem in many forms of psychopathology, most notably anxiety and depressive disorders. Self-regulation is vital for healthy relationships. Neurobiologically, emotion regulation involves the prefrontal cortex, especially the middle PFC, calming and inhibiting the amygdala (Siegel, 2012). People with PFC damage are unable to regulate their amygdalas, resulting in socially inappropriate behavior. The most famous example, cited throughout the neuroscience literature, is Phineas Gage, a railroad worker in the 1880s who suffered a horrible accident in which a tamping iron was driven through his skull, damaging his middle PFC (Damasio, 1994). Remarkably, Gage was able to walk and talk while recovering. He seemed fine, despite a huge hole in his skull and brain. But it soon became apparent that he was far from okay. With a damaged vmPFC and OFC, Gage was no longer able to regulate his emotions. He acted erratically, losing his job, marriage, and semblance of himself: "Gage was no longer Gage" (Damasio, 1994).

Most people are blessed with a normally functioning PFC, which allows for self-regulation. One way to regulate emotion is to name it; this activates the PFC and de-activates the amygdala (Creswell, Way, Eisenberger, & Lieberman, 2007); we can "name it to tame it" (Siegel, 2010). Another successful emotion regulation technique is Cognitive Reappraisal. Similar to the therapeutic intervention of reframing, reappraisal activates the PFC and lowers amygdala activation (Ochsner & Gross, 2005). Suppression, in which we try to hide our feelings, is not an effective emotion regulation strategy; in a couple, for example, it leaves both the suppressor and the partner physiologically agitated (Gross, 2002). However, suppression in an Asian cultural context does not necessarily have these negative effects; when emotion suppression serves group harmony and is in keeping with cultural values, it can be a positive emotion regulation tool (Butler, Lee, & Gross, 2007).

Mindfulness is a powerful path to emotion awareness and regulation. Neuroscientists and psychologists, led by Richard Davidson and Jon Kabat-Zinn, have incorporated mindfulness meditation practices from Buddhist traditions within Western treatment modalities. These researchers have studied Buddhist monks as they meditated in the fMRI machine, and have taught

meditation to non-practitioners as well, studying their brains pre- and post-training. The results include improved immune function, increased left prefrontal activation, increased resilience and positive outlook, and greater cognitive flexibility and attention (Davidson & Begley, 2012; Davidson et el., 2003; Kabat-Zinn, 2003). Mindfulness is associated with marital satisfaction and mental health (Wachs & Cordova, 2007).

Emotion regulation includes having a "window of tolerance" for affect (Siegel, 1999). "Affective competence" (Fosha, 2000) allows us to experience our emotions without becoming dysregulated. Some people become overwhelmed when emotional; they are able to "feel but not deal"; others become numb, able to "deal but not feel." The goal is "feeling and dealing while relating" (Fosha, 2000). Neurobiologically informed therapy helps clients learn how to identify their own emotions and manage them effectively.

Emotion regulation is more than just an intrapsychic phenomenon. Others help us calm down as well, through the "interpersonal social regulation of emotion" (Beckes & Coan, 2011, p. 983). Social Baseline Theory suggests that being with our trusted others allows us not to get upset in the first place; in this view, social proximity is our default strategy for regulating our emotions, so we do not have to over-tax our PFC, which is metabolically costly (Beckes & Coan, 2011). When our trusted others are not available, or if we are in a relationship where trust is scarce, we must rely solely on self-regulation. In healthy relationships, there is a balance between self-regulation and mutual care and soothing (Greenberg & Goldman, 2008).

The Neurobiology of Empathy

Empathy is key to our survival as social creatures, allowing us to understand the emotions and motivations of others; indeed, Darwin considered empathy (or sympathy as he called it) to be of vital importance (Keltner, 2009). Neuroscientists have identified four components of empathy (Decety & Jackson, 2004). The first, resonance, is an automatic process of interpersonal attunement, beneath awareness. Some researchers emphasize the role of mirror neurons in this process. Discovered in monkeys in the 1990s in Italy, these neurons fire when the monkey is eating—and when watching an experimenter eating. The human mirror neuron system was identified some years later (Iacoboni, 2008), and there are scientists who consider it a basis of empathy (Gallese, 2009). Others point to different brain areas involved in empathic resonance, such as the insula. In resonance, there is an "embodied simulation" (Niedenthal, 2007), feeling in one's own body what the other is feeling. Thus attunement to another requires attunement to one's own emotions; these two kinds of resonance share neural circuitry (Siegel, 2007).

The second component of empathy is cognitive. This involves putting oneself in the other person's shoes, an intentional process mediated by the prefrontal cortex. There are individual differences in levels of empathic accuracy (Ickes, 2003). Women often score higher than men on empathic accuracy, but researchers have found that this has to do with motivation (Ickes, Gesn, & Graham, 2000). When male subjects were motivated to be empathically accurate (by getting paid for empathic accuracy or by being told that women find empathic men sexy), the men became as empathically accurate as the women (Klein & Hodges, 2001; Thomas & Maio, 2008).

The third aspect of empathy is self-regulation. Without the ability to regulate one's own pain when feeling another's pain, empathy gives way to personal distress (Eisenberg, 2010). The final, and related, component of empathy is a boundary between self and other. When watching another in pain, one's own pain centers are activated. Both the insula and somatosensory cortex are involved. But, as shown on fMRI, the overlap is not complete; there are areas of the somatosensory cortex that are activated only for one's own pain, not for empathic pain for another (Lamm, Decety, & Singer, 2011). The brain knows the difference between self and other. Therapeutic work on boundaries and differentiation of self (Bowen, 1978) builds on this neural ability.

Gender Matters

While there are some innate differences between males and females, they are small. As one neuroscientist put it, "Men are from North Dakota,

women are from South Dakota" (Eliot, 2009, p. 13). Males and females share 99.8% of their genes, and are more alike than different in their abilities and in their brains (Hyde, 2005). From birth, boys tend to be more physically active and a bit fussier. And boys and girls have different play interests. While these differences are informed by hormones, socialization plays a huge role in shaping male and female brains (Eliot, 2009).

In utero, male and female fetuses start out the same—until about eight weeks, when the male gonads kick in and start releasing testosterone. Fetal testosterone, according to some neuroscientists, most notably Simon Baron-Cohen (2003), leads to differences in play interests in childhood, and to empathy differences. This research is controversial, and the field of the neuroscience of sex differences is in flux. The passions run high in these scholarly debates, with some emphasizing innate differences (Baron-Cohen, 2003) and some highlighting the role of socialization (Eliot, 2009; Fine, 2010). As we have already noted, nature and nurture are intertwined and mutually recursive. This is certainly the case with sex differences.

It turns out that how children play shapes their brains (Eliot, 2009). Boys are drawn to rough-and-tumble play, building with blocks, and playing ball. These games all develop physical skills and three-dimensional abilities that are important in math, science, and engineering. Data in the past found males scoring higher in math; but when females are exposed to similar experiences and are encouraged to perform, the gender differential in math disappears. Worldwide, cultures with gender parity have the greatest equality in math performance between the genders (Guiso, Monte, Sapienza, & Zingales, 2008). When it comes to verbal ability and empathy, females often have the edge. Girls tend to play with dolls and to engage in intimate, empathic conversations with each other, leading to greater verbal fluency with emotions and empathy. And mothers tend to engage more with their daughters verbally, especially around emotions. So, through experience, female brains are often highly developed for empathy and emotional expression. Teaching boys to be competent in the empathy department is vital for their social and emotional intelligence as adults.

Males and females tend to approach empathy differently; hormones may play a role. Women use their amygdalas and mirror neuron systems more than men during empathy tasks, a sign of greater emotional resonance (Cheng et al., 2008; Derntl et al., 2010). Men are more cognitive in their approach to empathy; brain areas that separate self from others are activated as men take the other's perspective (Cheng et al., 2008; Derntl et el., 2010; Schulte-Ruther, Markowitsch, Shah, Fink, & Piefke, 2008). Oxytocin, more plentiful in women, is associated with empathy (Zak, 2012). Administering oxytocin to men intranasally (which allows the oxytocin to get into the brain) increases emotional empathy (resonance) in the men (Hurlemann et al., 2010).

Testosterone negatively correlates with empathy, and men have a lot more testosterone than women (Zak, 2012). In a recent longitudinal study in the Philippines, men with higher testosterone were more likely to partner and become fathers. But once they had children, their testosterone levels dropped; the more involved they were in caring for their children, the lower their testosterone (Gettler, McDade, Feranil, & Kizawa, 2011). This makes evolutionary sense; high testosterone increases the men's interest in and chances of mating, and lower levels allow them to care for their offspring.

Testosterone fuels the sex drive in both men and women (for females, estrogen plays a role as well). Men, with their much higher testosterone levels, have higher libidos, and are more likely to visit prostitutes and to use pornography (Ngun, Gharamani, Sanchez, Bocklandt, & Villain, 2011; Peplau, 2003. Gay couples have more sex than straight couples, who in turn have more sex than lesbian couples (Gotta et al., 2011). In men, high testosterone correlates with leadership and dominance; it also correlates with risky and antisocial behavior, and drug and alcohol abuse (Archer, 2006).

Culture Matters

Cultural neuroscience is a field in itself, exploring how the larger environment shapes the brain.

This influence ranges from perception to neural correlates of self-identity. Context matters, as the human brain is particularly plastic (malleable), deeply affected by social interactions and expectations. Thus, "human brains are biologically prepared to acquire culture" (Ames & Fiske, 2010, p. 72). Most of the studies in cultural neuroscience compare Asians (e.g., Chinese, Japanese) and Euro-Americans. In keeping with cultural norms, Eastern subjects perceive holistically, with an emphasis on context; whereas Western subjects see the individual figure more prominently than the background. And Asians have an interdependent view of the self, seen in both fMRI scans and in psychological measurements; Euro-Americans maintain a more independent, self-vs-other view (Zhu, Zhang, Fan, & Han, 2007).

The "contact zone" (Wexler, 2006) between people of different cultures and races—and the neurobiology of intercultural tension—have been a focus of research. Racial prejudice, shaped by culture, is reflected in activation of the amygdala, a key brain area involved in the fight/flight response; greater amygdala activation correlates with greater prejudice (Phelps et al., 2000). Empathy is higher for one's own racial in-group than for members of other races, as measured by fMRI activation (Xu, Zuo, Wang, & Han, 2009). Despite automatic tendencies to prejudice, our higher brain can overcome instinctual amygdala activation through conscious and intentional goals and beliefs (Wheeler & Fiske, 2005).

Immigration poses specific challenges to the adult brain. Shaped by one culture, a person confronting the new sights, smells, customs, and language of a foreign land can be overwhelmed; "culture shock is brain shock" (Doidge, 2007, p. 299). Immigrants often create environments in the new country that are similar to the old, "transform[ing] the receiving culture into more familiar places" (Falicov, 2003, p. 293).

Throughout the world, cultural practices are quickly evolving, especially with the ubiquitous presence of the Internet and devices for 24/7 communication. We are, in a sense, engaged in a vast social (and neurobiological) experiment, as young brains are being shaped by these new practices and technologies. Humans evolved for face-to-face communication; eye contact and tone of voice are key to our ability to read others' emotions and intentions. But communicating through "devices" that convey none of these subtle non-verbal channels deprives us of vital interpersonal information. A recent study found that empathy has plummeted among college students (Konrath, O'Brien & Hsing, 2010). The Internet is having a significant impact on couples, as online access has created a high frequency of addiction to Internet pornography. These addicts are rewiring their own brains, unable to have fulfilling sexual relations with their real-life partners (Doidge, 2007). Our devices can be used to nurture our social connections—or they can be used to turn away from them.

Implications for Therapy

Incorporating "news from neuroscience" (Fishbane, 2008) in clinical practice is helpful in several ways. First, it can inform the therapist's view of development, healthy relationships, and relational distress. Second, understanding neurobiology—including ways the brain is wired for habit as well as for change and adaptation—can help the clinician shape effective interventions. Finally, offering clients "neuroeducation" (Fishbane, 2008) about their own reactivity and capacity for self-regulation increases their sense of empowerment in the change process.

We have emphasized the role of emotion and emotion regulation; these processes are central to all therapy, including couple and family therapy. Couples co-regulate each other for better or worse (Solomon & Tatkin, 2011); emotion dysregulation is a significant source of distress in intimate relationships. When partners get caught in cycles of reactivity with each other, they do the "limbic tango" (Goleman, 1995), becoming physiologically flooded, heart rate often exceeding 100 beats per minute (Gottman, 2011). Because of the rapidity and automatic nature of these amygdala responses, partners are frequently unaware how or why they got upset. It happens in a flash, as they escalate and become more and more reactive. A similar process of rapid reactivity informs distressed family relationships.

The therapist can explain the role of the amygdala in these moments. Clients with temper

meltdowns find it reassuring to learn that it was their amygdala that got them dysregulated—and that we all have an amygdala that gets agitated when it senses danger. This frame is normalizing and de-shaming. For clients who are unaware of their emotions, the work focuses on paying attention to body processes and sensations. For example, clients prone to temper outbursts that come on suddenly can learn to identify the prodomal cues of a meltdown before it gets out of control—noting their own clenched teeth, for example, or rapid heartbeat. For clients who never learned to identify or manage their feelings, slowing down their own inner process and learning to identify their body emotions is vital.

A neurobiologically informed therapy helps clients shift from reflexive reactivity to a more reflective stance (Scheinkman & Fishbane, 2004), so they are better able to choose how to respond and interact. Neuroeducation addresses ways the PFC can calm down the amygdala. Techniques such as naming the emotion (which, as we have seen, activates the PFC), focusing on the breath (slow diaphragmatic breathing activates the calming parasympathetic nervous system), or mindfulness meditation are particularly helpful. I have developed an imagery exercise which involves picturing one's PFC coming in to calm the rowdy amygdala. Clients find this exercise empowering; imagining the PFC soothing the amygdala like a good parent soothes a child is a form of "parenting yourself from the inside out" (Siegel & Hartzell, 2003). When partners in a couple are agitated and dysregulated, Gottman and Gottman (2006) suggest taking a break to calm down before attempting to process their reactivity with each other. This time out allows amygdalas to calm down and PFCs to come back online. Having a repair conversation is unproductive if partners—or parents and children—are still in a state of emotional dysregulation (Siegel & Hartzell, 2003).

Nurturing the "we" of a relationship is key to couple satisfaction; unhappy partners often have a "me-vs-you" attitude (Fishbane, 2013; Gottman, 2011). This stance reflects the values of the dominant culture in the United States, which emphasizes competition and individualism. But this perspective is not in keeping with our neurobiology, which is profoundly relational and interdependent: "We are building a culture of separateness that is at odds with our biology" (Johnson, 2008, p. 253). Understanding our social brain helps clinicians to challenge problematic assumptions and practices, and to develop interventions that promote mutual care and healthy interdependence. Similarly, working toward healthy interdependence—rather than separation—is a useful frame in therapy with adolescents and their parents.

Couple therapy addresses ways partners can "get meta" (Fishbane, 2013) to their inner neurobiological process and to their interactional dance of reactivity. I use the Vulnerability Cycle Diagram (Scheinkman & Fishbane, 2004) to map out the couple's dance, as we identify their vulnerabilities and survival strategies. Couples find it empowering to draw their own recursive interactive cycles, naming the individual and joint dynamics that fuel them. Drawing the vulnerability cycle brings prefrontal thoughtfulness and perspective to the couple's limbic tango. It also externalizes the dance (Scheinkman & Fishbane, 2004; White, 1989); partners face their impasse together as a team, developing a "joint platform" from which to view their dynamics (Wile, 2002). The Vulnerability Cycle Diagram can be used in a similar fashion with adolescents and their parents, or in multigenerational family sessions. The diagram allows clients to gain perspective on their interpersonal and intrapsychic dynamics.

As we deconstruct a moment of reactivity in therapy, we also identify overlaps between the present and the past (Scheinkman & Fishbane, 2004). Recall that the amygdala processes emotional memories; these can get activated in the present moment, beneath awareness. At times, old, unfinished business, often from the family of origin, gets stirred up during an impasse in a couple's interaction. When I sense this is happening, I ask clients "the magic question" (Fishbane, 2013): "Is this bind you are in right now familiar to you? Have you felt this way before, perhaps when you were a child?" If asked sensitively, this question may generate reflection about old wounds that are becoming activated in the present. When clients can reflect on the ways in which past issues are getting triggered, their PFC

is engaged, and reactivity is calmed. At times the magic question identifies unresolved intergenerational issues, and we may do some family-of-origin work to address them (Fishbane, 2005, 2013).

Partners in distressed relationships often feel like victims, blaming each other for their misery. This can occur in couples as well as families. Feeling disempowered, they engage in power struggles, become domineering, or disengage. In therapy, we work on developing "relational empowerment" (Fishbane, 2011), which includes skills of emotion regulation and empathy. Learning how to speak one's needs respectfully, and hear the needs and concerns of the other as well, is vital to relationship satisfaction. With clients who never mastered the basics of empathy—often the same individuals who do not know how to identify their own emotions—therapy focuses on empathy skills. Interventions are crafted based on the four neurobiological levels of empathy discussed above. Eye contact is particularly important, as we read others' emotions in their faces, especially in the eye region (Baron-Cohen, 2003). Exercises that include eye contact between partners or family members increase empathy and emotional awareness. Rather than empathy being a vague or mysterious process, it becomes operationalized and concretized as specific skills, "tools for your toolbox" (Fishbane, 2007).

Neuroeducation with couples includes understanding the life cycle of love and its neurobiology. Neuroscientists have studied "madly in love" subjects in the fMRI machine as they gazed at pictures of their beloved. The research found that romantic love is like a drug; it activates the same reward centers in the brain as heroin (Aron et al., 2005; Bartels & Zeki, 2000). Evolutionary anthropologist Helen Fisher (2004), the co-author of some of these studies, posits three stages of love. The first, Lust, gets us to mate; it is fueled by testosterone. The second phase, Romantic Love, is fueled by dopamine and norepinephrine, and leads us to "that special someone." Finally, Attachment, fueled by oxytocin and vasopressin, leads us to bond with a partner and raise offspring together, the whole point of this evolutionary process. (Fisher's love story does not deal with childless gay or straight couples; they presumably benefit from the process minus the offspring.) Normalizing these stages and normative transitions is helpful to partners who may think that they are in the wrong relationship because they no longer feel the jazz of early passionate love.

Alas, passionate love does tend to fade with time; and relationship satisfaction—including both passionate love and its tamer cousin, companionate love, decline over the years (Hatfield, Pilemer, O'Brien, Sprecher, & Le, 2008). Having children exacerbates this decline (Twenge, Campbell, & Foster, 2003). This rather depressing finding makes it all the more imperative that couples find a way to proactively nurture their love if it is to survive and thrive. "Proactive loving" (Fishbane, 2013) involves self-responsibility as well as mutual responsibility for the relationship. Nurturing love is a full-body experience. It is important for the couple to enhance the release of oxytocin, the bonding and soothing hormone, in their intimate life. Lovemaking, massage, hugs, and empathy all release oxytocin, lowering the stress hormone cortisol and increasing the sense of closeness between partners. Many couples go for long periods of time with no touching or sex. They are deprived of the elixir of oxytocin, and are letting their love wither. Encouraging safe and vibrant intimacy is vital in couple therapy. Shifting from a passive view of love ("falling into" and "falling out of" love) to a stance of proactive loving allows couples to become intentional co-authors of their lives together (Scheinkman & Fishbane, 2004).

The changes that make a difference in couple and family relationships—and in all therapy—involve deep processes of the emotional brain. This is "limbic revision" (Lewis, Amini, & Lanon, 2000). Simple changes of behavior or cognition, while important, are not enough. For clients to risk changing at a deeper level, they must experience the therapy as safe, so their amygdalas can let down their guard. I work to create a clinical space that is a blame-free, shame-free zone. Trust is vital; the therapist needs to be balanced, connecting respectfully and empathically with all clients in family and couple sessions. Holding a stance of "multilateral partiality" (Boszormenyi-Nagy & Spark, 1973) allows the therapist to side with both partners or all family members at the same time.

The change process in therapy is complex. Clients come to change (or to change each other, in the case of some couples and families!), but are often ambivalent about the process. Therapists regularly struggle with client "resistance." Given what we know about the brain and its proclivity for the familiar, "resistance" is simply circuits of neurons firing in familiar patterns. This is normal and basic to our neurobiology. But, as we have seen, brain change is part of our natural endowment as well. Understanding the dynamics of neuroplasticity is helpful for both therapist and clients. The good news, as we have seen, is that neuroplasticity can continue well into adulthood—if it is nurtured. Physical exercise, paying attention, and learning new things all facilitate change in the brain. Doing same-old, same-old, however, results in "hardening of the categories" (Cozolino, 2008), and a downhill slope in terms of brain function. We lose neurons as we age; if we do not compensate by challenging ourselves and learning new things, we will experience significant cognitive decline. So for clients to change, they need to stretch themselves outside of their comfort zone.

I have developed an exercise called "The Fork in the Road" (Scheinkman & Fishbane, 2004) that addresses this issue. I ask a client who is struggling to change an old, unproductive pattern of reacting to imagine standing at a fork in the road. One path leads to the habitual behavior, the other to a more thoughtful, empowered response. Clients have reported using this imagery technique when they are beginning to get defensive with their partner or other family members; they picture the fork in the road, take a breath, and choose the other path. These moments are exciting for clients, as they take an activist approach to change, reaching for their best self, and authoring the person they want to be in the relationship.

For new habits to become the "new normal," they need to be overlearned (Goleman, 1995), practiced over and over again. Research from stroke rehabilitation has found that "massed practice" with stroke-affected limbs can result in recovery of function even decades after the stroke (Taub et al., 2006). To ensure neuroplastic change, we need many repetitions of new behaviors—whether we are stroke victims or partners seeking change in our relationship. It is common in couple therapy for an "aha" session that seems to change everything to be followed by a return to old habits in subsequent weeks. It is only with dedicated practice, over and over again, that lasting change occurs (Atkinson, 2005). Even with successful change, down the road, when clients are stressed or fatigued, they may revert back to old habits. Predicting this and planning for strategies to deal with these moments is important.

From the viewpoint of neurobiology, change is not simple. At one level, we are going against our nature, as our brains seek the familiar. But if we work with the forces of neuroplasticity, change is indeed possible. Understanding the dynamics of the emotional brain and relational processes—working with the neurobiology of relationships—can transform and deepen a systemic approach to therapy with couples and families.

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5.

THE MULTICULTURALISM AND DIVERSITY OF FAMILIES

Celia Jaes Falicov

The widespread impact of globalization around the world challenges practitioners everywhere with understanding and integrating gender, race, social class, ethnicity, sexual orientation, and other diversity variables in clinical practice. This challenge has never been greater than now since, increasingly, psychotherapists provide mental health care to a wider and more diverse range of families in many countries. The fit between the culture of therapy and the culture of the clinician and even the clinical supervisor must be considered with the recognition that psychotherapy is a cultural and sociopolitical encounter. This chapter presents a systemic and postmodern framework to guide a diversity approach to psychotherapy theory and practice. Most of the conceptual and practical applications presented are based on clinical experiences with diverse groups of clients within North America, but it is likely that the framework itself applies to other client groups in the Western hemisphere.

Historical Attention to Multiculturalism and Diversity

Attention to diversity and multiculturalism and the call for cultural sensitivity or competence in mental health services are not new. The civil rights movement demanded that institutions be more responsive and less discriminatory toward minority clients, and the nationwide development of community mental health programs in the 1970s attempted to expand services to economically disadvantaged and culturally marginalized groups.

Early on, family therapy, as other forms of psychotherapy, tended to look at the patterns of family life as universal. Furthermore, the particular approach promoted by each school or brand of theory and practice was regarded by its proponents as universally valid. Nevertheless, family therapy also emphasized contextual and ecological issues in family life (Auerswald, 1968). Early research and scholarly writings that focused on economically disadvantaged families highlighted the importance of sociocultural context in understanding family life (Aponte, 1976, 1994; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Montalvo & Gutiérrez, 1988; Sluzki, 1969). Other notable contributions include the work of Papajohn and Spiegel (1975) that compared value orientations of various ethnic groups.

The enduring emphasis on contexts made family therapy particularly poised to question universality and to incorporate diversity and multiculturalism. Over time, this task has been undertaken in a variety of ways: McGoldrick and colleagues' (McGoldrick, Giordano, & Pearce, 1996; McGoldrick, Giordano, & Garcia-Preto, 2005) examination of ethnicity in families; Boyd-Franklin's (2003) multisystemic approach for black families; the feminist critique of family therapy (Hare-Mustin, 1978; Walters, Carter, Papp, & Silverstein, 1988); the attention paid to gay and lesbian families (Green, 2012); and my own work, which proposes a comprehensive integrative definition of culture (Falicov, 1983, 1988, 1995, 2014a) to incorporate cultural diversity perspectives in all aspects of training and clinical work.

Starting in the mid-1990s, attention to diversity became further influenced by incorporating newer, postmodern epistemologies that stress a social constructionist lens, a strength-based orientation, and a collaborative engagement with clients along with a greater emphasis on self-reflexivity for the clinician (Falicov, 2014a; McGoldrick & Hardy, 2008).

The historical progression of diversity concerns places family therapy squarely within the multicultural movement. This position requires a constant navigation between the perils of relying on stereotypical generalizations about collective identities that do not capture intergroup variation, or the opposite, that is, remaining only at the level of individual description case by case. The latter could be acceptable were it not for the ever-present risk of ignoring that clinicians have cultures derived from their professional and personal values and they also have culture-specific methods of assessment and intervention which could lead to errors of treatment with diverse families. Without the benefit of self-reflection that acknowledges those biases, injustices may be committed by lack of awareness of what could be cultural and sociopolitical in clients as well as in practitioners' values and behaviors.

In the past decade, significant contributions have also come in the form of the introduction and testing of cultural adaptations of mainstream approaches (i.e., cognitive-behavior therapy) for the treatment of individuals and families from diverse cultural groups (Bernal & Domenech Rodríguez, 2009, 2012; Falicov, 2009b; Parra-Cardona et al., 2012). Family-oriented clinical researchers stress the importance of searching for compatibility between treatment and clients' cultures by using bilingual–bicultural professionals whenever possible and including cultural diversity factors and contextual stressors. The interest in adapting treatments to cultural and contextual differences reflects the necessary and desirable integration of modernist, scientific-oriented views with the social constructionist, postmodern perspectives inherent in incorporating cultural perspectives to clinical theory and practice as proposed in this chapter.

Collective Identities: A World of Variation

Defining specific "collective identities" such as ethnic, class, gender, or social identities appears at first glance both possible and practical. We look at the worldviews, values, and customs of certain groups, and assume these traits to be normative and stable, albeit in a rather stereotypical way. We talk about how Latinos value family closeness and interdependence, how Anglo-Americans are time-conscious and schedule-oriented, how the Irish like to tell stories and drink. However, on close examination, deciding about sameness and difference is not so simple.

Even if one could describe characteristics that make up something like "Jewishness" or "Mexicanness" or "Blackness," ethnic identities are profoundly modified by other variables that affect behavior, experience, and worldviews. The cultural experiences of African-American women are very different from those of African-American men. A Puerto Rican elder who practices "*espiritismo*"—a belief on the ability of invisible spirits to materialize—as a way of coping with the loss of her granddaughter to cancer has a different connection to her heritage than the Puerto Rican mother who only trusts her Roman Catholic priest for advice about her drug-addicted son.

Gender, race, class, sexual orientation, religion, nationality, disability, and even cohort (the historical generation into which a person is born) all contribute to cultural and sociopolitical identities. Consistencies of language, meaning or belief systems, worldviews, and experiences often lend a sense of familiarity and

community for people who share the same culture or contextual location. But inconsistency, variation, and novelty exist along those dimensions as well. Transnational lifestyles made possible by the existence of increasingly sophisticated global technologies of communication have made cultural exchanges and influences much more prevalent than it was possible in the past (Falicov, 2007, 2008). Identities are also influenced by the constructs supplied by the dominant discourses, which often discriminate and marginalize cultural differences.

Taking the variations in cultural and sociopolitical influences into account, and the myriad cultural blends that result, helps avoid treating cultures and contexts as static. Given this incredibly complex, moving construct we vaguely call the "culture" of a person or a family, how do we address its relevance and place for families that seek psychotherapy? How do we arrive at a framework generic enough and specific enough to encompass similarities and differences germane to clinical theory, research, and practice?

The framework presented in this chapter is based on systemic and postmodern foundations. It attempts to acknowledge wide variation within collective identities and yet allow for some generalizations in the culture of clients and the culture of practitioners useful for their encounter in clinical theory, research, and practice. The framework is intended to be applicable to a large variety of groups on the basis that the parameters of comparison issued are more universal than culturally specific, although specific aspects may emerge precisely by drawing comparisons among groups.

The answer proposed here to the questions of how clinicians can orient themselves in the array of issues related to cultural and sociopolitical diversity is provided by MECA, the Multidimensional-Ecosystemic-Comparative Approach (Falicov, 1995, 1998a, 2012, 2014a)

Systemic and Postmodern Foundations of MECA as an Approach to Diversity

MECA is based on the idea that we are all multicultural persons rather than belonging to a single group that can be summarized with a single label: Latino, lesbian, Lutheran or black. In reality, each person belongs, participates, and identifies with multiple groups that provide or impede particular experiences and bestow particular values. Furthermore, persons are also denied access or are excluded from certain settings and these exclusions also shape their experiences.

The following definition of culture underlines the multidimensionality and fluidity of culture:

> Culture refers to those sets of shared world views, meanings, and adaptive behaviors derived from simultaneous membership and participation in a variety of contexts, such as language; rural, urban or suburban setting; race, ethnicity, and socioeconomic status; age, gender, sexual orientation and sexual variance, religion, disability, nationality; employment, education and occupation, political ideology, stage of migration/acculturation, partaking of similar historical moments and ideologies.
>
> *(Falicov, 1983, pp. xiv–xv)*

Exclusion from various contexts can also be part of the cultural and sociopolitical experience (Falicov 1995, 1998, 2014a).

This multidimensional view reflects more fairly the meaning of the word "diversity" than any one dimension alone. Individuals and families partake of and combine features of the many contexts listed in the definition. It is the combination of multiple contexts and partial perspectives that shapes and defines each person's culture, rather than any of those separately. Nor does some monolithic "culture" exert an inexorable influence upon the individual. Each person is raised in a plurality of cultural subgroups that exert a multiplicity of influences depending on the degree of contact with each subcultural context. Cultural similarities and differences reflect inclusion in or exclusion from various groups.

MECA Embedded Constructs: A Cultural Diversity Lens, a Sociopolitical Lens and an Ecological Niche

Embedded in the definition of culture above are several important constructs (i.e., a cultural

diversity lens, a sociopolitical lens, and the construct of ecological niche). A *cultural diversity lens* promotes respect for clients' cultural locations and preferences and critically examines existing models of families, theories and techniques used in psychotherapy with a view to their application to minority clients; a *social political lens* focuses on the effects of power differentials in societal discrimination (due to gender, economic, and racial inequities and to gender orientation and variance) on individual and family well-being and on the relationship between clients and therapists; and the construct of *ecological context* stirs practitioners toward a complex cultural and sociopolitical description of each client and each clinician by taking into account the multiplicity of contexts to which each one belongs and their areas of overlap or cultural consonance and dissonance between them.

A Cultural Diversity Lens

One of the first effects of bringing culture into the therapy room is that it upsets our theoretical applecart. It challenges what traditional schools of thought—psychoanalytic, systemic, structural, strategic, and so on—consider as universal. Views about how families function, how problems develop, and how change is facilitated by those approaches may be "local" ideas originated by various "schools of thought" or "cultures" (Fancher, 1995) within the professional standard clinical practices. It follows from this that clients' beliefs or behaviors that are part of a cultural meaning system other than the one in which the therapist has been schooled could potentially be judged as dysfunctional or at least problematic. Consideration of differences is at the core of the newer principle of therapeutic respect whereby the client's life requires description rather than categorization (Anderson & Goolishian, 1992; Freedman & Coombs, 1996; Madsen, 2007; Sexton & Alexander, 2003; White, 1993).

To avoid confusing other cultural ways with dysfunction, a multicultural therapist incorporates a critically questioning attitude toward the Euro American biases inherent in most professional training. This means accepting that theories and interventions stem from one local ecological niche and are not the standard by which all families can be evaluated. Instead, a practice based on curiosity and respect for cultural diversity (Lappin, 1983) explores the healing resources within the client's culture and develops a stance of empathic "sociological imagination" (Wright Mills, 1959). When we attend to issues of ethnicity or religion, critical questions are raised about the customary assumptions of mainstream psychotherapy. For example, in family therapy, issues of boundaries, hierarchies, communication styles, or life-cycle norms may come into question and lead to transformations and accommodations of taken-for-granted concepts and techniques (Gergen, Gulerce, Lock, & Misra, 1996).

A Sociopolitical Lens

Diversity-oriented theory and practice comprises more than respect for multiple meanings or diverse cultural values about family life. A sociopolitical or social justice component is also essential. Members of minority groups—African Americans, Latinos, LGBT—have been consistently marginalized and denied their own voice in determining the conditions of their lives (Aldarondo, 2007; Young, 1990) in ways that cause health and mental health distress.

In the clinical arena, this social justice position directs the attention to life conditions, power differentials, and discrimination practices that limit social and economic opportunities, promote internalized racism, and affect psychological development and mental health for those who are poor or marginalized. Without a lens that includes social inequities, cultural differences may be used as "explanations" for economic failure, domestic violence, or poor school performance, while the larger negative effects of poverty and social discrimination are downplayed.

A sociopolitical lens is not limited to impoverished clients. For example, in the past, a case of anorexia nervosa was viewed as "idiosyncratically" linked to an "overinvolved" mother and a "peripheral" father without awareness of the social demand for the gender specialization of each parent and the social demands for thinness in young women (Bordo, 1997). More recently, a number of therapists are considering cultural

and sociopolitical discourses to be central to the treatment of anorexia and other eating disorders (Epston, 1994). A social justice practice connects mental health issues with experiences of social oppression and aims to empower families in their interactions with larger systems and cultural discourses, including those in the psychotherapy field (Hardy & Lazzloffy, 1994; Korin, 1994).

An Ecological Niche

Taken altogether, cultural and social participations and exclusions make up a client's and also a therapist's "ecological niche." Including culture and sociopolitical issues in clinical practice requires service providers to locate themselves and their clients in terms of race, class, religion, sexual orientation, occupation, migration experiences, nationality, and ethnicity. Describing an ecological niche is equally important for "mainstream" clients who are white, middle class and Protestant. Cultural location should not be described only for minority groups and imply that culture and society influence only marginalized groups while dominant groups are regarded implicitly as the standard norm.

The construct of ecological niche makes it apparent that human beings share "cultural borderlands" (Anzaldúa, 1987; Rosaldo, 1989) or zones of overlap with others. By virtue of sharing the experiences of contexts such as race, social class, occupation, religion, or ethnicity, discrete groups dissolve and partial groupings and bridges of human connectedness emerge. A middle-class first-generation Vietnamese agnostic biologist may have more in common with another university educated biologist, even though the latter is white, than with a Vietnamese immigrant who is Roman Catholic and is employed in a manicure salon. The first two share a greater number of cultural borderlands than the second two, in spite of the fact that the latter are both Vietnamese. The notion of ethnic or racial matching between therapist and client becomes more complex within this framework, because therapists and clients can share other forms of connectedness through their cultural borderlands.

With the Multidimensional Ecosystemic Comparative Approach (MECA), therapists make a holistic assessment of all the contexts to which the family belongs and draws from the family their understanding of the resources, the constraints, and the cultural dilemmas those multiple contexts create. These types of collaborative explorations render a picture closer to what the anthropologist Clifford Geertz (1973) dubbed a "thick" description, rather than relying on identity labels and a priori knowledge about collective groups. Aiming for "thick descriptions," the observer draws conclusions based on each person's descriptions of their own complex locations using their own cultural categories of understanding rather than utilizing the labels and categories of the observer. Underlying MECA is the idea that the therapy encounter is really an encounter between the therapist's and the family's cultural and personal constructions. A therapist's views about family and family problems and resources stems from his/her ecological niche, which includes their own cultural and contextual variables as well as their preferred brand of theory and professional subculture.

Toward Postmodern Integrative Attitudes

A social constructionist postmodern approach enhances the integration of multiculturalism and diversity to the work with families. Two salient features are the adoption of a not-knowing stance and a focus on the strengths of diverse and multicultural families.

A Knowing and Not-Knowing Stance

An ethnically focused position encourages clinicians to inform themselves of many details about particular cultures. This position can be contrasted to a "not-knowing" stance in therapy. "Not-knowing" approaches are based on curiosity, and on dialogue that takes into account all meanings—cultural and personal—as they emerge in the therapeutic situation. Yet there are families where "credibility" and direction from a "knowing" agent "fits," particularly in more hierarchical cultures than the United States as people may turn to experts for concrete guidance and advice.

These two positions seem to be unnecessarily polarized. A dialectic, both/and approach, which combines a "not-knowing" stance with

"some-knowing" or information about diversity and specific cultures, including the clinician's own diversity and culture, allows for more complexity and effectiveness. This integration of attitudes can provide the most beneficial means of working with diverse and multicultural clients, as the following case illustrates.

Behind the one-way mirror, an emerging power struggle was brewing between a family therapy trainee at a well-known training institution and the Bernals, a Puerto Rican immigrant family. The therapist insisted that the father's delusions should be treated with psychotropic medication. But the family politely refused pharmacotherapy and could not answer why. Suspecting there was a plausible cultural belief or practice behind the resistant behavior, I suggested to the therapist that she ask the family if they had other health or religious resources that might be helpful to the husband's condition. The wife then said she believed her husband would get better because prayer would help him. I suggested the therapist adopt a curious stance by asking the family, "How does prayer work?" To this, the mother replied that she met twice a week with her friends to pray at a local storefront church, and all of their prayers together swelled up to a powerful, luminous energy that could counteract the dark forces that had overtaken her husband's psyche. The family's refusal to accept medication could now be understood positively as linked to their belief systems about effective treatment of delusions. Furthermore, their "cure" connected the mother to her social network of co-nationals, which were clearly supportive and helpful. This new meaning decreased the polarization with the therapist, and opened the door for collaboration in stages.

Having some knowledge of cultural details attuned the consultant to the possibility that religion may be playing a role in the family's resistance to the clinician's mainstream medical cure for delusions. A therapist with a "not-knowing" approach toward culture might have arrived eventually at the same place. The family, meanwhile, conscious of difference with the dominant culture views, might not have ever volunteered their prayer practice unless asked. One might be tempted to say the first therapist would have done better. Not necessarily. The ethnic-focused therapist may have stopped at simple respect for the family's cultural solution once the family mentioned prayer. A "not-knowing", curious stance was very helpful in taking the inquiry further by asking how prayer works concretely in the family's particular subculture of religion. Weaving back and forth between these stances—one informed by some cultural knowledge and the other guided by curiosity—could clarify the family's fears that medication would preclude their prayers from working. The therapist could then ally with the family to better define what kind of help they needed and would be willing to accept from the clinic.

In a both/and position, involving "some-knowing" and "not-knowing," the therapist must be comfortable with other "double discourses"—an ability to connect with the universal human similarities that unite us beyond color, class, ethnicity, or gender, while simultaneously recognizing and respecting diversity due to color, class, ethnicity, or gender. This "double discourse" may be explicit or implicit, foreground or background, expanding or shrinking the cultural emphasis depending on the case at hand. Consistent with the reality of shifting multiple contexts, there is no list of "dos" and "don'ts" when working with ethnic, gender, racial, or religious groups. There is only one "do" and one "don't"—*do* ask, and *don't* assume. We must relate to each other's universal humanity, while not forgetting about each other's remarkable cultural contexts.

A Focus on Strengths

Multicultural and diverse families, such as economically disadvantaged immigrants, have been portrayed with a deficit model that points to problematic areas in family relationships. Without minimizing the serious challenges and risks that such families face, I focus on their resilient responses and underline the importance of working with their many strengths. These may include strong family and community bonds and systems of help, healthy maintenance of cultural rituals, capacity for hard work, and pride in good parenting.

A "relational resilience" lens proposed by Walsh (2006) is very helpful with multicultural and diverse families because it shifts the perspective

from viewing distressed families as damaged to seeing them as challenged and it affirms their potential for growth. Many immigrant families demonstrate capacity to survive and even thrive; they have ethnic and network resources, situational triumphs, loving capacities, and courage to face racial or ethnic prejudice and economic injustice. Strength-based explorations offer a more solid, hopeful ground for trust in the practitioner's capacity to appreciate and help a family.

MECA Generic Domains

MECA focuses on dimensions that family therapists generally use to orient themselves about basic aspects of relational life to be taken into account when trying to understand presenting problems. The four domains identified in MECA are migration and acculturation, ecological context, family organization, and family life cycle. MECA is based on the belief that the contents of these domains are culturally constructed but that the domains themselves as general phenomena probably exist in all societies. In the clinical situation, an assessment includes conversations about possible connections between the presenting concerns and the various domains covered in MECA. From these conversations a contextual picture of the family emerges that includes cultural dilemmas that may be connected with the presenting issues, or cultural and personal strengths that may be helpful in finding solutions. Clinicians who become familiar with these four domains acquire *migration and culture-specific competencies* as described in the following sections.

Migration and Culture-Specific Competencies

Migration and Acculturation

Many immigrants leave their countries reluctantly. Their motivations include primarily improving their desperate economic situation or escaping political oppression and organized violence. A number of consequences ensue from the migration experience. These include uprooting of various meaning systems, ambiguous losses and gains, resilient adaptations and rituals, forms of acculturation and family organization dilemmas.

The Uprooting of Meaning Systems

Personal stories, views of reality, and adaptive behaviors are all anchored in the lived experiences of one's race, ethnicity, or social class within national contexts. Perhaps the most fundamental dislocation of migration is the uprooting from known structures of cultural meanings tied to those national contexts. These structures of meanings and beliefs have been likened to the roots that sustain and nourish a plant (Marris, 1980).

The uprooting of established meaning systems and exposure to new life constructs have long been linked to various types of psychological distress for immigrants, including culture shock (Garza-Guerrero, 1974); marginality, social alienation, and psychological conflict (Grinberg & Grinberg, 1989; Shuval, 1982); psychosomatic symptoms such as palpitations, dizziness, insomnia, anxiety and depression (Warheit, Vega, Auth, & Meinhardt, 1985). Post-traumatic stress may occur if migration involved trauma; for example, for asylum seekers or for political refugees who have witnessed or have been victims of mass destruction.

Ambiguous Losses and Gains

The experiences of loss, grieving, and mourning that accompany migration have been likened to the processes of grief that accompany other types of losses, particularly the death of loved ones. However, the experience of migration loss seems to be better captured by the construct of ambiguous loss (Boss, 1999). Migration is a stressful event that brings with it losses of all kinds: gone are the support of family, friends, and community; gone is the ease of the native language, the customs, foods, and multiple connections with one's own country itself. These physical absences are real, yet, unlike the losses of death, with migration it is always possible to fantasize an eventual return or a forthcoming reunion with loved ones. Immigrants also hope that the added burdens will be lifted when their hard work will be rewarded with improved economic or educational conditions or new political or cultural freedoms. The contradictory elements create a persistent mix of emotions: sadness and elation, absence and presence, despair and new hope. Ambiguity becomes

inscribed in immigrants' lives, an ambiguity that must be constantly learned to live with.

Resilient Adaptations and Rituals

Most immigrants and refugees demonstrate enormous capacity for resilient adaptations. The need to reestablish a sense of coherence and make meaning out of adverse circumstances is manifested in the emergence of what may be thought of as spontaneous rituals which renew presences across absences by recreating the familiarity of old spaces, sounds, faces, smells, and other cultural rituals in the new land (Falicov, 2002, 2012, 2014a, b). These rituals of connection, recreation, memory, and cultural preservation illustrate the ambiguous nature of immigrant's losses and continued attachments. Yet, embedded in these spontaneous rituals there are resilient both/and dual visions or "solutions" that symbolize learning to live with the ambiguity of never putting a final closure to migration. Work with immigrants can greatly profit from an exploration of the place of rituals in their lives. It seems possible that either the abandonment of cultural rituals or an excessive reliance on their performance at the expense of new adaptations may signal difficulties around migration. The creation of therapeutic rituals to deal with migration issues holds promise of dealing with migration impasses (Imber-Black, Roberts, & Whiting, 2003; Falicov, 2002, 2014a, b; Woodstock, 1995).

Acculturation and Biculturalism Theories

Acculturation theory assumes that immigrants gradually shed their original culture and language in favor of a better "fit" that correlates with mainstream culture and mental health. Acculturation theory has been challenged recently after several studies indicated that immigrants from several countries who try to "Americanize," or assimilate rapidly, actually have *more* psychological problems and drug use than those who retain their language, cultural ties, and rituals, at least partially (Escobar, 1998; Falicov, 2014a; Organista, 2007; Portes and Rumbaut, 2006).

Furthermore, social ills such as drugs, alcohol, teen pregnancy, domestic violence, gangs, and AIDS, which affect discriminated groups, appear more frequently in the second and third generations than in the first (Smorowski, David-Ferdon, & Stroupe, 2009), presumably because the initial protection of a firm cultural and family identity was still intact in the immigrant generation.

Biculturalism, a different model involving cultural alternation and hybridization is based on a different assumption than acculturation theory, that is, that it is possible to know two languages and two cultures, and to appropriately use this knowledge for different contexts without giving up one for the other, or that it is possible to integrate parts of cultures (LaFramboise, Coleman, & Gerton, 1993; Schwartz Unger, Zamboanga, & Szapocznik, 2010; Smorowski & Bacallao, 2011). Communications made possible by globalization have transformed immigration into a two-home, trans-context life style for many immigrants (Falicov 2007, 2008; Turner, 1991). Studying Mexicans in Redwood City, CA, Rouse (1992) observed a "cultural bifocality," that is, the capacity to see the world through two different value lenses, such as maintaining language and ethnic values within the family, while also learning and using English and American values when dealing with larger systems. Intrafamily conflict may emerge as family members acquire the new values or retain the old ones at different rates.

Dilemmas of cultural meanings, beliefs, and expectations are often the subtext of many individual and family consultations and may also cause misunderstandings with larger systems, including therapists' discourses. Dual visions of continuity and change or double discourses appear also in the sociopolitical arena. Double consciousness, Du Bois' (1903) description of the awareness of African Americans about who they really are in their own group in contrast with the prejudicial ways in which they are seen by others, helps to understand the feelings and experiences of living in two worlds.

Family Organizational Dilemmas

In addition to dilemmas of cultural meanings, beliefs, and expectations, migration precipitates family organization dilemmas, primarily because of separations and reunifications between extended

and nuclear family but also among nuclear family members, such as when father or mother migrates first alone to be reunited later with the children (Falicov, 2014a, b). Both men and women experience difficulties during migration and both use mechanisms that appear to follow gender socialization, such as depression or psychosomatic problems in women and alcohol dependency and violent behaviors in men.

Separations are tied to practical reasons and economic limitations, but there may be other powerful less conscious reasons, such as loyalty toward the family of origin. Regardless of the reasons, separations may differentially affect individuals and families. For example, separations may increase closeness between some family subsystems whereas it weakens bonds among other family groupings, both among those who left and among those who stayed. Increased nuclear closeness cushions from culture shock and supplements role functions left vacant, but ultimately these reorganizations may limit the reincorporation of separated family members as it happens with children who become closer to their grandmothers than to their biological parents. Individual development may also be curtailed through either excessive closeness or excessive distance from significant figures.

Reunifications are often traumatic for all involved, especially children that may present with stomach pains, sleep disturbances, temper tantrums, or defiant behaviors that become the precipitant for clinical consultations. Among many migration-specific practice ideas are therapeutic rituals that can be used at the time of reunification to help the family bridge the absences and temporal gaps of the separations is a "catching up life narrative" (Falicov, 2014a, b). It consists of a family story-telling whereby each member presents facts, anecdotes, photos, objects, or drawings of their lives apart. Therapist and family weave all these elements in a written story form, which is repeatedly read and modified until a final product is arrived at, sometimes adding a "feed-forward" (Penn, 1985) section that predicts an affirming future family form. Apprehension about the future may be assuaged by previewing a possible more stable future where the family will continue to be together rather than suffer new separations.

Gender and generation dilemmas can also affect family organization. Gender dilemmas may occur when wives remain isolated in their homes and do not learn English, or conversely, when they encounter economic and gender freedoms denied before. Both situations can unleash couple's conflicts. Generational hierarchies may be stressed and even overturned when children serve as language intermediaries with the host society and cultural translators for their parents. Often this hierarchical reversal is limited to certain areas, but in some situations it may become pervasive and eventually weaken parental authority, particularly if the parents abdicate their cherished values.

A clinician who intervenes in these situations of cultural dilemmas or conflicts by quickly becoming an agent of mainstream acculturation may create more rather than less emotional distress. Maintaining continuity by supporting the "wisdom of no-change" and thus, not overburdening an already unstable situation with more suggestions for "adaptive" change, may be more indicated for overstressed families (Falicov, 1993). Promoting acculturation goals may in effect colonize clients by imposing "modern" values without awareness of cultural biases, as for example, when the therapist supports the "Americanized" second generation against "old-fashioned" parents.

Ecological Context

Paying attention to ecological context entails examining the stresses that ensue from interactions with the immediate milieu and the societal institutions. It also requires our appraisal of social networks, spiritual supports and cultural belief systems, such as locus of control about dealing with life situations.

Ecological Stresses

Bombarded with differences from the main culture, diverse minority families tend to gravitate toward elements of their own ethnicity, race, and class in urban enclaves that serve as a buffer against culture shock and discrimination. But the illusion of a safe haven may be offset by the fear of detection and deportation in the case of

undocumented immigrants, and of physical threat and social unrest in inner-city neighborhoods. Middle-class families have their own set of stresses in isolated suburbs, with pressures of competition and maintaining affluent and overworked lifestyles.

Interactions with institutions, such as school, work, and health systems are challenging experiences for many marginalized adults and children. They may experience incompatibility between home and institutions in primary languages, difference in cognitive and relational styles, and meaning or belief systems that may cause conflict, confusion and a sense of inferiority. Teachers, employers, physicians, and therapists also experience dissonance when they struggle to understand and serve culturally diverse families. A shift from a positive to a disenchanted or oppositional attitude occurs after children and parents become aware of institutional marginalization or racism, increasing the possibility of school dropout or work unemployment (Falicov, 2014a; Ogbu, 1987; Suárez-Orozco and Suárez-Orozco, 1995; Suárez-Orozco, Suarez-Orozco, & Todorova, 2008). Practitioners need to explore the family's experiences and evaluations of larger systems interactions, whether these are teachers, priests, medical doctors, therapists, or employers and the impact of these experiences on their outlook about the present help being offered.

Common constraints of immigrants are social and cultural isolation; ignorance about community resources; and tensions between home norms and those of the school, peer group, or work situation. To inquire about such ecological issues, the therapist may explore the family's neighborhood (housing, safety, crime, gangs); racial acceptance; employment (income, occupation, job stability); extended family and friendship networks; school and parent–teacher relationships; church attendance or other spiritual practices.

Disruption and Reconstruction of Social Networks

Relocation can disrupt the emotional support, advice, and material aid that social networks provide for all families but particularly for impoverished families. Enduring intimate relationships, whether husband–wife or parent–child, are taxed with many more requests for companionship from each other than before (Sluzki, 1969). Lacking the watchful eye of nearby relatives, parents compensate with restrictions on adolescents' activities, which may aggravate intergenerational conflicts (Smith, 2006; Smowrowski and Bacallao, 2011). Because social networks are essential for physical and emotional well-being (Sluzki, 2008), particularly in situations of stress, therapists must assess the family's social interactions and sources of support and community involvement.

Religion, Spirituality and Traditional Healing

Religion and spirituality are the most transportable and least costly elements in the immigrant's and the minority family's knapsack. In fact, the performance of soothing rituals, such as prayer, may contain elements of resilience for many impoverished groups. The church or temple in the ethnic neighborhood also provides community support in the form of a sanctuary for undocumented immigrants, a center for crisis counseling, activist groups and community celebrations. Priests, pastors, or rabbis who officiate at life-cycle celebrations, communions, baptisms, and weddings may become resources for stability and a sense of community (Aponte, 1994; Falicov, 2009a).

For many ethnic groups, traditional healing practices and indigenous spirituality coexist with mainstream religion and medical practices. Folk healers are consulted for many common and uncommon maladies but are turned to primarily for "folk or traditional illnesses," which are often thought to have psychological or interpersonal roots. It is important for clinicians to develop nonjudgmental ways of inquiring about these sources of help and assume a collaborative attitude toward them.

The use of religion or spiritual resources is one example of a positive cultural mechanism for coping with suffering that should not be automatically attributed to passive fatalism

(Boss, 1999; Comas-Díaz, 1989; Falicov, 2009a). Turning to spiritual solace can also be seen from a sociopolitical perspective. Fanon (1967) suggests that when self-determination is limited, as is the case with non-dominant groups, placing oneself under the protection of benevolent and powerful figures may help counteract fear, powerlessness, and lack of agency.

Locus of Control

The notion that little in life is under one's control is a worldview quite different than the Euro-American belief that much in life can be modified through personal will or intervention. It is important for clinicians to consider that the ecology of lower socioeconomic status can disempower individuals and limit their hopeful outlook. The belief in an external locus of control should not be taken as a deficit but rather as a realistic and philosophical form of coping by trying to accept circumstances that may be beyond one's control. This may mean an attitude of learning to live with a problem rather than insisting on resolution, a notion that may be foreign to practitioners who have internalized an optimistic positive action outlook.

Assessment and Practice Tools

A Migration Narrative

Obtaining a *migration narrative* provides the clinician an entrée into the individual members' migratory experiences, their dreams and hopes, and their strategies for coping with massive changes (Falicov, 2012; 2014a). To assess the changes in family composition and the meaning of the migration, the therapist might ask how long each family member has resided in the United States; who immigrated first, who was left behind, who came later, or is yet to be reunited; what motivated the migration and how they went about planning for it; what stresses and joys were experienced by various family members at various stages, and what strengths and resources they discovered. It is important to inquire about who was left behind and their reactions to the migration because they are also members of a social system in transformation, affected by and affecting those who migrated.

While ambiguity permeates the immigrant's experience, the degree of agency people experience in making the decision to migrate may have important consequences for psychological distress. The migration narrative should start temporally in the premigration stage to clarify various members' participation and feelings about the decision. Immigrants who feel coaxed or forced or manipulated to migrate may display more symptoms of anxiety and depression than those that were fully cognizant and accepting of their decisions. In telling a migration narrative, family members may find meaning to their uprooting in terms of their unique personal history that incorporates gains as well as losses.

MECA Maps and MECA Genograms

The MECA map is primarily a training tool used to represent the cultural and contextual sociopolitical maps of the family or those of the clinician. It is simply constructed by placing the four domains (migration–acculturation, ecological context, family organization, and family life cycle) in four rectangles (always in the same order). In the center of the MECA map, the clinician can put a circle indicating the family, or the clinician, or the supervisor.

The four rectangles representing each domain are filled with the information gathered in conversation with each family. To compare areas of similarity and difference with the family, a therapist can fill in his or her maps in each rectangle on a separate piece of paper and look at the maps with the family. This side-by-side viewing could alert all involved to possible areas of error or potential difficulties in the interaction that may need to be clarified to create a therapeutic alliance.

The MECA genograms combines the family genogram at the center, surrounded by the four rectangles describing the MECA domains as in the MECA maps. A useful permutation is to put the elements of the therapist's MECA map on the family's MECA genogram. To do this, a second set of rectangles is drawn at the bottom of the first set on the same page to

represent the therapist maps in the same four domains as the family's and to provide a quick visual comparison. Consistent with a strength-based approach, the MECA genogram provides an opportunity to discuss individual stories of struggle and triumph. These stories can provide past and present positive role models for family members. More detailed and graphic illustrations of these instruments appear in Falicov (2014a). One illustration (Figure 5.1) appears later in this chapter.

If these maps reveal that ecological constraints and tensions sap the family's strengths to cope, the clinician may temporarily become a "social intermediary" or "matchmaker" between the family and various communal institutions (Falicov, 1988, 2013; Minuchin, 1974). The clinician can help the family mobilize to use existing networks or facilitate building new reciprocal ones. Priests may offer spiritual support, particularly when dealing with physical illness, old age, and death. Relatives or compatriots can be advocates for a child or for the family in dealing with institutions and a temporary relief for parents. The aim is to collaborate in empowering the family to deal with larger systems and insist on receiving adequate services.

Family Organization

Cultural preferences and limited financial resources have traditionally motivated families from impoverished countries (many Latin American and Asian countries) and discriminated groups (African Americans, or single mothers) to live in close proximity to extended family networks that can provide emotional and practical support. They form a larger kin and kith network than the isolated nuclear middle-class family, that is, the prototype of family psychology depictions of normal family life. Family compositions and definitions of who is a family member may differ from the mainstream (Watts-Jones, 2010) and in the case of immigrants it is useful to explore the family network they had in their countries.

Traditional family organization affects family bonds along several dimensions of interaction: a) collectivism and individualism; b) gender and generation hierarchies; c) communication styles and emotional expressivity (Falicov, 2014a).

Collectivism and Individualism

Family collectivism is inscripted in the cultural discourse of many ethnic groups, such as Latinos, African Americans, Asians, and even many European groups, such as Italian or Greeks. Under these values, family boundaries easily expand to include grandparents, uncles, aunts, or cousins. Children who are orphaned or abandoned, or whose parents have migrated, or divorced, may be incorporated in the family, along with adults who have remained single, or have become widowed or divorced. Strong sibling ties are stressed from a young age and throughout life. Any member of this large network can be involved in the presenting problem or can become part of the solution. A family may bring a relative to a psychotherapy session or a medical visit providing an entrée for practitioners to understand the social network around the family and expand their professional definitions of family composition and family resources.

Family interdependence involves sharing nurturing and disciplining of children, shared financial responsibility, companionship for lonely or isolated members, and communal problem-solving. Concomitantly, there is a low reliance on institutions and outsiders. The idea of a "familial self" (Roland, 1988) is useful in understanding many individuals' dedication to family unity and family honor and the celebration of family rituals. An adult son or daughter who may unwittingly curtail his or her chances for marriage in order to take care of an ailing parent may be responding to his/her familial self and not necessarily be inappropriately self-sacrificing.

The process of separation/individuation, so highly regarded in American culture, may be de-emphasized in other cultures in favor of close family ties. Deficit views tend to pathologize this type of family closeness and label it as enmeshment. However, family closeness may reflect cultural interactional preferences that contribute to resilient adaptations. Furthermore, in traditional settings, individuation may take place while blending with family closeness, via marriage,

work, or simply having personal opinions and a sense of personal self along with a familial self. Therapists who insist on stressing the client's individual needs as pitted against family needs may run counter to internalized cultural preferences.

Gender and Generation Hierarchies

When family loyalty and collective cooperation are stressed culturally, usually there is also an emphasis on clear family hierarchies. Childrearing practices of ethnic or disadvantaged groups may reflect this emphasis on hierarchies. Punishment, shaming, belittling, deception, promises, and threats may be used in response to young people's misbehavior.

Unquestioned respect for authority runs counter to the democratic, egalitarian discourses of psychotherapists, who may negatively judge parents who are showing concern and caring according to their cultural ways or they are simply using the only repertoire of childrearing practices to which they have been exposed. The parents may also react and negatively judge the "permissiveness" of American society, perhaps unwittingly personified in the individualistic democratic discourses of the clinical practitioner. Transparency in the therapeutic dialogue helps clarify the benevolent intent on both sides. Even in patriarchal systems, a child's well-being is the responsibility of both parents and therefore even traditional men can be persuaded to participate in conversations about children's well-being.

While a patriarchal view of gender roles persists among many Asian, Latin American, and other immigrants, more complex transitional dynamics are evolving. For example, a double standard of gender socialization and sexuality persists (Falicov, 1992, 2010, 2014a), yet it has long been documented that decision-making often is shared by both parents, or it may involve a process in which the mother alone, or the father alone commands much authority (Kutsche, 1983; Ybarra, 1982).

Immigrant and ethnic family life is increasingly characterized by a wide range of structures and processes, from patriarchal to egalitarian, with many combinations in between. It is not unusual to encounter situations where the father tries to exert authority by disciplining the children and compelling them to obey the mother, while she tends to defend and protect them. This interactional pattern may generate father–mother–child triangulations that need to be seen culturally and contextually, rather than simply regarded as "pathological." Triangulations may be successful in resolving conflicts indirectly in ways that are culturally syntonic even if they run counter to family therapy notions about generational boundaries, as when a family member asks another to intercede in a conflict rather than confronting her or his opponent directly (Falicov, 1998).

Communication and Emotional Expressivity

Indirect, implicit, or covert communication is consonant with some groups' collectivistic emphasis on family harmony, on "getting along," and on not making others uncomfortable. For other traditional groups, assertiveness, and open differences of opinion may be the norm. From their own cultural discourses about communication, clinicians may regard the first collectivistic cultures as too stifling of individual expression and the second type of culture as too dismissive of the feelings of others. Yet, both are legitimate ways of handling interpersonal relationships within some cultural groups.

Because of power differentials and respect for authority, clients may feel that it is impolite to disagree with the therapist. Encouraging the family to express their reactions, both positive and negative, to the therapist's opinions helps to establish a tone of mutuality. Manifesting real interest in the client, rather than gaining data via referral sheets, or obtaining many behavioral details about a problem is essential to build personal relationships that carry emotional expressivity.

Cultural preferences along three elements of traditional cultural discourses, namely, collectivism, hierarchies, and indirect communication, may stir up dilemmas when younger generations incorporate Euro-American discourses, or when the family comes in contact with the institutions of mainstream culture such as the values upheld

by psychotherapists. The appropriate role for clinicians is to become a *cultural family intermediary* (Falicov, 1988, 2013). Traditional value preferences can appear to be constraining to individual development, but clinicians should not assume that their cultural preferences are objectively better. Professional discourses are often based on mainstream values, such as individualism, that should not be privileged or imposed. Working toward changes in family organization discourse is only valid if it stems from informed collaboration with specific clients.

Family Life Cycle

Families from diverse cultures and socioeconomic levels may differ from the dominant interpretations of the life cycle. The meaning of the stages and transitions, the developmental tasks and the rituals of the individual and the family life cycle may all be heavily guided by culture, custom, and traditional practice (Falicov, 2005, 2014a). How the life cycle is lived is highly dependent not only on cultural mores but also on the totality of a family or individual ecological niche. For example, the timing of procreation may be significantly different for gay men and women who, given societal discrimination, may need to arrive to an older and settled period of the life cycle to engage in parenting when compared to heterosexual couples, who readily meet societal approval for their union and procreation.

Many groups may differ from the dominant culture's view of the life cycle by experiencing a longer state of interdependence between parents and children and a more relaxed attitude about children's achievement of self-reliance skills (these attitudes are often mistaken for overprotection); the absence of an independent living situation for unmarried young adults; the absence of an "empty nest" syndrome or a middle-age crisis and a refocusing on marital issues; and a continuous involvement, status, and usefulness of elders in the family. Any of these traditional developmental expectations may persist alongside the new considerations of individual pursuits and romantic love espoused by the younger generations, sometimes causing intergenerational tensions.

For many traditional families, leaving home occurs primarily through marriage, and boundary or loyalty issues with families of origin are common, particularly because the second generation has begun to stress husband–wife exclusivity. The relationship between the mother-in-law and daughter-in-law may enter in conflict given the differences in cultural codes.

Some developmental impasses can be linked to the stresses of migration. Leaving home can become more problematic when parents have depended on their older children to be intermediaries with the larger culture. Younger siblings, too, may cling to an older one who appears to be more culturally understanding than the parents. Normal life-cycle events, such as the death of a loved one, either in the country of origin or the adoptive country, may precipitate additional stress by rekindling the ambiguities of migration and the questioning about the wisdom of being so far away from loved ones (Falicov, 2014a).

Because professional discourses often embody different cultural expectations about how to navigate life-cycle stages and transitions, therapists need to be aware and self-reflexive about their own normative evaluations about age-appropriate behaviors in their clients. Once the life-cycle dilemmas within the family or with other institutions are deconstructed and discussed, the clinician may attempt to become a "cultural mediator," encouraging conversation between parents and offspring about developmental expectations and their loyalties to both cultures.

The presence of two or three generations, each speaking a different language and holding different cultural values while partaking in some common customs and traditions, is both very enriching and resourceful. The challenge is how to merge and blend differing life-cycle cultural codes. It is not unusual for a Latino, a Greek, or an Italian group of adult siblings to hold vastly different connections to their parent's language and cultural rituals and to have also varied degrees of adherence to the mainstream culture and language.

Gender differences also appear in perceptions of life-cycle meanings. While studies of twenty years ago reported a slower pace of language cultural change in immigrant women than in men, more recent studies indicate that

women adapt to cultural changes faster than men. Women are not only more likely to adopt new life-cycle values, particularly those that grant them greater personal freedoms such as employment or divorce, but they also may become more inclined to settle in this country than they did in the past even against their spouses' wishes (Hondagneu-Sotelo, 1994).

Case Illustration of MECA Assessment and Clinical Practices

The clinical case that follows illustrates the use of MECA domains for assessment and intervention relevant to the issues the family presented. The MECA genogram in Figure 5.1 summarizes the main issues found in the four MECA domains.

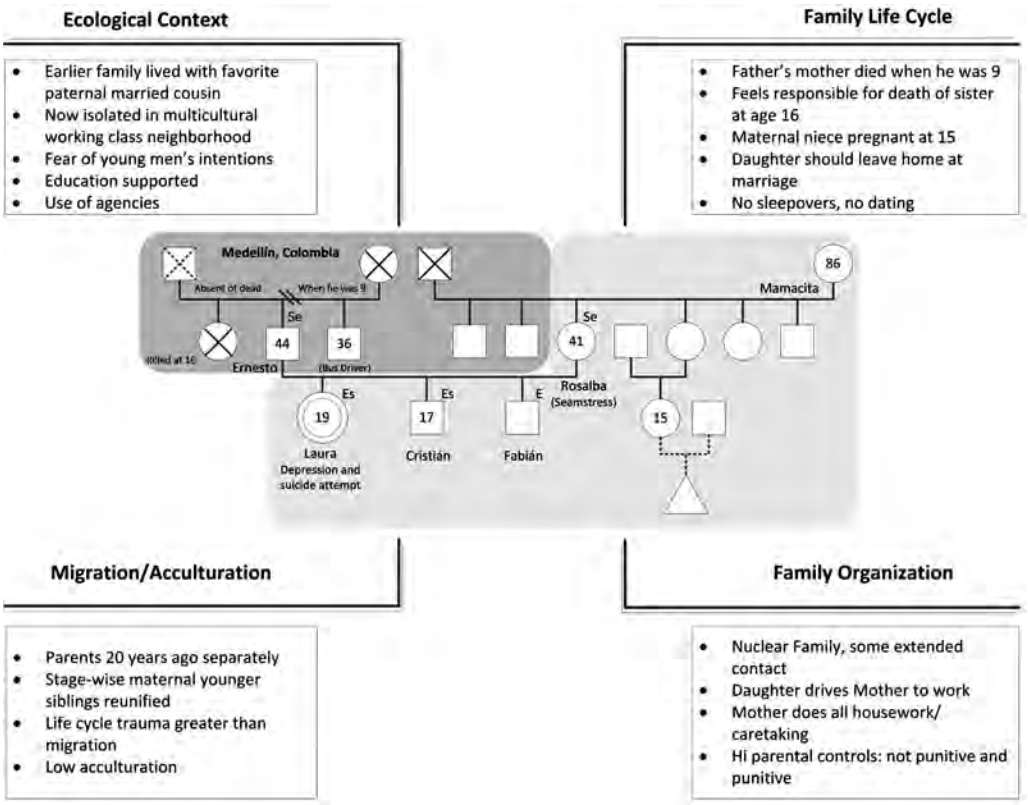

Figure 5.1 MECA Genogram of Gordillo-Ríos Family

Presenting Problem and Precipitant. The Gordillo Ríos, a Colombian family, came to therapy for depression in their 19-year-old daughter, Laura. She had recently made a suicide attempt by ingesting a bottle of aspirin and a box of Sudafed pills. This attempt had followed an altercation with the parents when they prohibited Laura from spending a planned night at a friend's house, allegedly because the friend's parents had gone out of town. Laura appeared as an obedient daughter who always said yes to her father's rules of arriving home before 10pm and always said yes to her mother's request that she call to let her know where she was and at what time she was returning home. Yet, she not always truly complied, as she often came later than agreed upon, forgot to call and avoided answering her cell phone when called by her mother. Sometimes she came in at 2 or 3am, staying chatting with friends in a car or at somebody's home.

Migration. From the migration narrative we learned that the parents had migrated in their late teens separately twenty years ago, the mother with other family members, the father alone. The families had reconstituted in the migration trajectory and therefore there was little contact and sense of loss related to the country of origin. The children were all born in the Unite States but Laura had been more steeped than her brothers in the parents' extended family, particularly because the maternal grandmother lived with them and shared a room with Laura for many years.

Ecological Context. When asked about their controls on Laura, the parents said the neighborhood had many dangers. Being a bus driver in this neighborhood, the father gave many negative examples of young men's bad behavior toward young women. Laura's mother argued that when she was Laura's age, she would only occasionally go to a dance and only if she was chaperoned and did not understand why Laura wanted to be out so much. Money was tight particularly in a precarious economy and the parents felt that Laura's phone and car gasoline were additional unnecessary expenses.

Ecological Fears. The parents had many examples of dangers in the neighborhood, humiliation, and dating violence in the lives of girls. They did not feel that they had a protective social network to rely on either. Their cultural preferences were certainly exaggerated by their ecological fears.

Family Organization. The father tended to dominate the session by lecturing the daughter about why she needed to come home earlier. In a condescending way, he also lectured the mother and the daughter about how to manage their relationship and how the mother could be more clear about rules regarding Laura's activities. The parents believed that Laura should know the rules about a girl's appropriate behavior, and did not believe that Laura's depression could be related to the parental controls.

Parent–Adolescent Cultural Differences. Laura found the gender treatment differences between Cristián, her 17-year-old brother, and herself to be intolerable. He was allowed to come home late at night after drinking, going to dances, and spending time in the back of cars with girls. To add to the controls, this younger brother had been designated by the parents to supervise Laura's activities when boys were around. When Laura would finally express her frustration to her parents over the obvious "double standard," her parents would get mad at her for her "disobedience" along with intimations that she was on the brink of becoming a woman of ill repute, "una loca" (a somewhat loose or crazed woman) for wanting to go out with her friends at night. One time they gave her a slap in the face. But these accusations were not typical, more frequently the parents said they distrusted others, such as her friend's parents for going out of town and leaving the young women unsupervised. The parents' rigid stance was compounded recently by the fact that Laura's cousin, Gloria, had recently become pregnant at 15. One time Laura wanted to develop a friendship with a male coworker in her summer job, and invited him to the house to watch TV with everybody. But the parents became uncomfortable because they thought that they were touching the sides of their arms when sitting in the couch. In their estimation, the most minimal physical contact would stimulate a young man's temptations and therefore work against Laura's safety. Parents recognized that "our mentalities are different than hers," but believed that it was Laura who needed to comply.

Family Life Cycle. Later on, the father revealed that his life-cycle trauma related to migration was not as "significant as his own mother's death," in Medellín, Colombia when he was nine years old, a loss of a different magnitude that was followed by other family losses. At that time, his father became more intensely involved with alcohol and eventually abandoned the children. Being the oldest child, Laura's father took over the enormous responsibility to raise his siblings. At age 16, his sister who was a year younger than him stayed out for the night and suffered a violent street

death. He was devastated and could never forgive himself.

Thus, personal narratives and realistic ecological context risks, along with aspects of cultural family organization, all were converging on the father's fears and controlling behavior toward Laura.

Separation Anxiety. Laura was going to community college and the parents did not predict that she might leave San Diego after school. Rather they thought she would always be around to help them. The mother had never learnt to drive and Laura drove her everywhere, having to plan her schedule according to the mother's. Both parents could not sleep at night if Laura was out and many of their interactions revolved around worrying over their daughter being out. They both complained bitterly about their anxiety caused by not knowing where Laura was, but were not aware of the possibility that their deeper anxiety over a future separation and over past family losses may have been playing a significant role.

Practice Ideas for the Gordillo Ríos Family

The MECA domains assessment of the Gordillo Ríos family revealed that migration issues were no longer at the forefront of family concerns, but were now represented in ecological context, family organization, and family life-cycle stressors. In a recent publication (Falicov, 2014a), I have described how immigrant parents, through a combination of cultural differences, ecological fears and separation anxiety with their adolescent children, exert very tight controls when the time approaches for a major developmental shift toward granting more autonomy to the teenager. I have shortened these three elements to the acronym CEFSA (Culture, Ecological Fears, and Separation Anxiety), three elements that are highlighted in this case description.

Laura's depression could be interpreted in the context of parental constant surveillances that were blocking her desires for greater autonomy. Later, Laura said that "everything" could be resolved "if only they [her parents] would give me some space." Laura could be thought as *encerrada* or "lockdown" (Smith, 2006). Her parents were concerned and involved, caring in many ways and supportive of her studies, so she wanted to please them. But they also treated her with such immutable controls that she felt she could not have a normal life like all the young adults she knew (Zayas, 2011).

The clinical practices for this case included the therapist acting as a *cultural family intermediary* and labeling their difficulties as issues of cultural transition that besieged them. I articulated the legitimacy of the parents' concerns and of Laura's need for more space to grow up. They were all encouraged to reach compromises between polarized positions with specific tasks such as the parents allowing Laura more freedom than they had been giving her. In exchange, Laura will let the parents know her whereabouts and her friendships, stressing quid pro quos and the notion of reciprocity. In relation to the issue of cultural differences within the family, Laura was able to find online helpful self-help books for Latina teens that shared her predicament. Family strengths were emphasized, such as caring, wanting the best for each other, and having raised very good children that were torn between pleasing parents and/or responding to societal preferences outside the family.

Summary

Deciding about sameness and difference between cultures, races, and ethnicities is not so simple because gender, class, sexual orientation, religion, nationality, and even cohort (the historical generation into which a person is born) all contribute to an individual's identity. A Multidimensional-Ecosystemic-Comparative Approach (MECA) assists clinicians to orient themselves to this array of factors related to an individual's cultural and sociopolitical diversity. There are three constructs embedded in the definition of multiculturalism and diversity, they are: a cultural diversity lens, a sociopolitical lens, and an ecological niche. A *cultural diversity lens* promotes respect for clients' cultural preferences and critically examines

existing models of families and theories and techniques used in psychotherapy with a view to their application to minority clients. A *social political lens* focuses on the effects of power differentials in societal discrimination on individual and family well-being and on the relationship between clients and therapists. The construct of *ecological context* stirs practitioners toward a complex cultural description of each client and each clinician by taking into account the multiplicity of contexts to which each one belongs and their areas of overlap or cultural consonance and dissonance.

The four domains identified in MECA are migration and acculturation, ecological context, family organization, and family life cycle. MECA is based on the belief that the contents of these domains are culturally constructed but that the domains themselves as general phenomena probably exist in all societies. It is important for clinicians to obtain information about the four domains in MECA throughout therapy in order to fully understand an individual's identity and culture and how presenting issues may be connected with cultural dilemmas and contextual sociopolitical stressors.

A more beneficial approach when using MECA with diverse clients is combining a "not-knowing" stance with "some-knowing" or information about specific cultures, including the clinician's own culture as this may allow for more complexity and effectiveness. A focus on family strengths complements this approach. This chapter also includes suggestions for clinical assessment and interventions and an extensive clinical case illustration.

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PART II

FOUNDATIONAL THEORETICAL PRINCIPLES AND CORE CLINICAL MODELS

6.

COGNITIVE-BEHAVIORAL COUPLE AND FAMILY THERAPY

Frank M. Dattilio and Norman B. Epstein

Historical Development of Cognitive-Behavior Therapy with Couples and Families

The cognitive-behavior therapies (CBT), as applied to intimate relationships, now have a history that spans more than fifty years. Writings by Ellis and his colleagues (e.g., Ellis & Harper, 1961) emphasized the important role that cognition plays in relationship distress, based on the premise that dysfunction occurs when partners maintain unrealistic beliefs about their relationship and make extreme negative evaluations about the sources of their dissatisfaction (Ellis, 1977; Ellis, Sichel, Yeager, DiMattia, & DiGiuseppe, 1989). During the 1960s and early 1970s, behavior therapists began utilizing principles of learning theory to address individual problematic behaviors with both adults and children. Many of the behavioral principles and techniques that were used in the treatment of individuals were soon applied to distressed couples and families. For example, Stuart (1969), Liberman (1970), and Weiss, Hops, and Patterson (1973) described the use of social exchange theory and operant learning strategies to facilitate more satisfying interaction in distressed couples. Similarly, Patterson (1971; Patterson, McNeal, Hawkins, & Phelps, 1967) applied operant conditioning and contingency contracting procedures to develop parents' abilities to control the behavior of aggressive children. Later, behaviorally oriented therapists added communication and problem-solving skills training components to their interventions with couples and families (e.g., Falloon, Boyd, & McGill, 1984; Jacobson & Margolin, 1979; Stuart, 1980). Research studies confirmed the premise of social exchange theory (Thibaut & Kelley, 1959), indicating that members of distressed couples exchange more displeasing and less pleasing behavior than do members of non-distressed relationships, and that behavioral interventions (e.g., behavioral contracts, communication training) designed to shift the balance toward more positive interactions increase partners' satisfaction (see Epstein & Baucom, 2002, for a review). Findings by researchers such as Christensen (1988) and Gottman (1994) identified the importance of reducing distressing avoidant behaviors, in addition to aggressive acts.

Couple and family therapists (e.g., Dicks, 1953; Haley & Hoffman, 1968; Satir, 1967) recognized the importance of intervening with cognitive factors, as well as with behavioral interaction patterns, long before most major theories of family therapy came into existence. However, it was not until the late 1970s that cognitions were introduced as an auxiliary

component of treatment within a behavioral paradigm (Margolin & Weiss, 1978). During the 1980s, cognitive factors became an increasing focus in the couple research and therapy literature, and cognitions were addressed in a more direct and systematic way than in other theoretical approaches to family therapy (e.g., Baucom, 1987; Baucom, Epstein, Sayers, & Sher, 1989; Beck, 1988; Dattilio, 1989; Epstein, 1982; Epstein & Eidelson, 1981; Fincham, Beach, & Nelson, 1987; Weiss, 1984). Established cognitive assessment and intervention methods from individual therapy were adapted for use in couple therapy, to identify and modify distorted or inappropriate perceptions, inferences, and beliefs that partners experience about each other (Baucom & Epstein, 1990; Dattilio & Padesky, 1990; Epstein, 1982, 1992; Epstein & Baucom, 1989). As in individual therapy, cognitive-behavioral couple interventions were designed to enhance partners' skills for evaluating and modifying their own problematic cognitions, as well as skills for communicating and solving problems constructively (Baucom & Epstein, 1990; Epstein & Baucom, 2002; Rathus & Sanderson, 1999).

Epstein and Baucom (2002) expanded the cognitive-behavioral couple therapy (CBCT) model to incorporate additional phenomena, encouraging balanced attention to intrapersonal, dyadic interpersonal, and environmental influences on relationship dysfunction. In the intrapersonal realm, greater focus has been placed on individuals' emotional experiences that influence the person's cognitive and behavioral responses to his or her partner. In addition, Epstein and Baucom (2002) emphasized basic needs and motives (e.g., intimacy, achievement) that each member of a couple brings to the relationship. Furthermore, there are three types of couple-based approaches to assisting individuals who experience individual psychopathology: partner-assisted interventions, disorder-specific couple interventions, and couple therapy (Baucom, Shoham, Mueser, Daiuto, & Stickel, 1998). Epstein and Baucom (2002) describe the goals and clinical procedures used in the three approaches. In partner-assisted interventions, the partner is coached in taking on the role of assisting the symptomatic individual in carrying out aspects of interventions for the depression, anxiety, or other form of psychopathology. For example, in the treatment of panic disorder, both members of the couple would be given psychoeducation regarding the disorder and its treatment, and the partner would assist the anxious individual in engaging in exposure exercises. Epstein and Baucom (2002) note that this approach focuses on one member of a couple as the "identified patient," so the therapist needs to make efforts to maintain balance in his or her therapeutic relationships with the two partners. In contrast, disorder-specific couple interventions focus on identifying and modifying patterns in a couple's interactions that elicit or maintain an individual's psychopathology symptoms. For example, if a couple has arguments about an individual's drinking, which usually trigger more drinking, the intervention could focus on eliminating the arguments and substituting constructive interactions. The treatment focuses specifically on those symptom-related patterns rather than broader aspects of the couple's relationship. Finally, because overall relationship distress has been identified as a risk factor for the occurrence of a variety of forms of psychopathology, traditional CBCT for relationship distress can be used to improve the individual's symptoms. For example, for couples in which individual depression and relationship distress co-occur, behavioral couple therapy has been found to reduce both problems (Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008). Further examples of the use of CBCT to address problems in individual functioning are described later in this chapter.

Epstein and Baucom's (2002) enhanced CBCT model also takes into consideration the manner in which members of a couple respond to physical and interpersonal environmental demands (e.g., job stresses) and use available resources. Overall, broad "macro" level interaction patterns and core relationship themes are addressed, such as partners' conflict regarding differences in their needs for intimacy, as well as the traditional CBCT emphasis on "micro" behaviors occurring in specific situations.

Jacobson and Christensen (1996) developed another modification of traditional CBCT that emphasizes striking a balance between interventions designed to induce change and those that focus on partners developing acceptance of characteristics in each other that are unlikely to change. Traditional CBCT behavioral change procedures for communication and problem-solving training are combined with acceptance-based strategies involving strategic techniques (e.g., reframing a partner's distressing behavior as having positive intent) and humanistic techniques (e.g., encouraging empathy for each other's personal sources of stress). The acceptance strategies are intended to reduce partners' tendencies to blame each other for relationship problems and reduce their attempts to pressure each other to make changes.

Another major trend for CBCT has been its application beyond its focus on improving general relationship distress to addressing dyadic processes associated with individuals' presenting problems that traditionally were treated only with individual therapy, such as alcohol abuse, depression, anxiety disorders, and eating disorders. Birchler, Fals-Stewart, and O'Farrell (2008) have integrated behavioral couple therapy procedures (e.g., increasing exchanges of pleasing and caring behavior, increasing shared rewarding activities, improving communication and problem-solving skills, avoiding threats of separation, focusing on the present, avoiding physical aggression) with interventions focused on a partner's substance use (e.g., self-help meetings, medication, behavioral contracts between spouses to promote abstinence). In the treatment of depression, CBCT approaches have been used to decrease negative couple interactions and enhance mutual emotional support, either in conjunction with individual therapy or as the primary intervention (Beach et al., 2008; Whisman & Beach, 2012). Regarding the treatment of anxiety, family-focused therapy for anxiety disorders involves using couple or family therapy with a CBT emphasis as an adjunctive intervention with standard individual or group CBT treatments (Chambless, 2012). In particular, Chambless uses couple therapy that includes psychoeducation about the individual's anxiety disorder and how its symptoms affect and can be affected by relationship patterns, communication skills training, problem-solving training, preparation for coping with the individual's symptoms, and reduction of the couple's accommodation of their daily interactions to the individual's anxiety. Similarly, Monson and Fredman's (2012) cognitive-behavioral conjoint therapy for post-traumatic stress disorder (PTSD) includes psychoeducation regarding reciprocal effects between an individual's PTSD symptoms and couple interactions, increased attention to positives in the relationship, emotion regulation techniques, use of communication skills to reduce emotional numbing and avoidance, improvement of problem-solving skills, and conjoint cognitive restructuring to change beliefs that maintain PTSD symptoms as well as relationship problems.

Bulik, Baucom, Kirby, and Pisetsky (2011) developed a CBCT program for anorexia nervosa that combines interventions specific to the eating disorder (e.g., the partner's provision of emotional support to the individual reinforcing appropriate eating and other healthy behaviors, avoiding punishment) with traditional CBCT procedures to enhance overall couple functioning (e.g., problem-solving and communication skill training, especially regarding the individual's body image). CBCT procedures also have been used to assist couples dealing with severe physical illness. For example, Baucom et al. (2009) developed a CBT-based relationship enhancement program for women being treated for breast cancer and male partners. Individual couples are taught communication skills that are especially applied to expression and listening regarding cancer-related topics (e.g., fear of mortality, medical decisions, sexuality, body image). They also are taught problem-solving skills that they can apply to making medical treatment decisions, provided with psychoeducation regarding psychological and physical effects of treatment on partners' sexual functioning, and guided in focusing on ways to find meaning and personal growth in their experiences with cancer. Thus, CBCT has become a mainstream approach to assisting couples with a wide range of challenges from both within and outside their relationships.

Finally, CBCT has been applied to relationship problems that can severely affect the

well-being of the members of the couple, as well as the stability of their relationship. Baucom, Snyder, and Gordon (2009) developed a CBT-based program to help couples who are dealing with infidelity to cope with the often traumatic experiences, gain insight into the factors that led to an affair, and make good decisions regarding the future of the relationship. CBCT also has been applied as a viable treatment for partner aggression. Couple therapists must make a key clinical decision about when it is appropriate and safe to treat partners together when physical aggression has occurred. Traditionally, many clinicians strongly argued that couple therapy should never occur when there has been any physical violence, based on the concern that treatment could elicit further violence and great harm by males toward their female partners. However, studies have indicated that many couples, especially in clinic samples, engage in mutual aggression involving high rates of mild to moderate physical aggression and even more psychological aggression (e.g., demeaning verbal attacks) by both partners (Jose & O'Leary, 2009). Increasingly, conjoint couple interventions, the majority of which have been forms of CBCT, have been used to treat these highly prevalent forms of partner aggression and have been found to be safe and effective (LaTaillade, Epstein, & Werlinich, 2006; O'Leary, Heyman, & Neidig, 1999; Stith, McCollum, & Rosen, 2011).

In addition to advances in couple therapy, behavioral approaches to family therapy have similarly been broadened to include members' cognitions about one another. Ellis (1982) was also one of the pioneers in introducing a cognitive approach to family therapy, with his rational-emotive approach, whereas Bedrosian (1983) wrote about the application of Beck's model of cognitive therapy (Beck, Rush, Shaw, & Emery, 1979) in understanding and treating dysfunctional family dynamics. In the past four decades, the literature on CBFT expanded rapidly (Alexander, 1988; Dattilio, 1993, 1994, 1997, 2001, 2010; Epstein & Schlesinger, 1996; Epstein, Schlesinger, & Dryden, 1988; Falloon et al., 1984; Huber & Baruth, 1989; Robin & Foster, 1989; Schwebel & Fine, 1994; Teichman, 1981, 1992), and is currently included as a major form of treatment in family therapy textbooks (e.g., Bitters, 2009; Goldenberg & Goldenberg, 2000; Nichols & Schwartz, 2013).

Substantial empirical evidence has accumulated from treatment outcome studies indicating the effectiveness of CBCT, although most studies have focused primarily on behavioral interventions and only a handful examined the impact of cognitive restructuring procedures (Baucom et al., 1998; Christensen, Atkins, Baucom, & Yi, 2010; Halford & Snyder, 2012). Research literature on effectiveness of cognitive-behavioral family therapy (CBFT) is lean overall. Faulkner, Klock, and Gale (2002) conducted a content analysis of articles published in the marital/couple and family therapy literature from 1980 to 1999. Unfortunately, none of the 131 studies that were reviewed examined CBFT, in particular interventions that included forms of cognitive restructuring. Outcome studies have demonstrated the effectiveness of behaviorally oriented family interventions, namely psychoeducation and training in communication and problem-solving skills, in the treatment of major mental disorders (e.g., Falloon et al., 1984; Miklowitz & Goldstein, 1997; Mueser & Glynn, 1999). There also has been research on behavioral interventions for families with aggressive interaction behaviors (Patterson, 1982) and the application of operant principles to parent–child interactive therapies for conduct problems (Sanders & Dadds, 1993; Webster-Stratton & Hancock, 1998), as well as child anxiety and aggression (Dadds, Barrett, Rapee, & Ryan, 1996), depression (Brent, Holder, & Kolko, 1997; Birmaher, Brent, & Kolko, 2000), and eating disorders (Wardle, Cooke, Gibson, Sapochnik, Sheiham, & Lawson, 2003). Effective CBT-oriented parenting strategies have also been used successfully in the treatment of Attention Deficit/Hyperactivity Disorder (Barkley, 1997; Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004).

Major Theoretical Constructs

The roots of CBCT and CBFT can be traced to several major sources that have provided foundations for understanding influences of cognition, emotion, and behavior on the quality of intimate

relationships. The following are brief descriptions of the major CBT constructs derived from those sources.

Information Processing

Conceptions of the cognitive processes that can influence the quality of close relationships have been informed by basic theory and research on human information processing. Piaget's (1960) observations about the cognitive processes that children use to learn about the world had a major impact on our understanding of cognitive processes in adults as well. George Kelly (1955) proposed that individuals develop "personal constructs" or basic concepts that they use to categorize life experiences (e.g., identifying people along dimensions such as friendly–unfriendly and assertive–meek), and these constructs help them interpret their world and anticipate future events. CBT therapists have incorporated the models of Piaget and Kelly in their conceptions of the cognitive processes involved in family members' development of schemas about each other and intimate relationships. Information-processing models of cognition have been applied to conceptions of various clinical disorders such as depression and anxiety (e.g., Alloy, Abramson, Walshaw, & Neeren, 2006; Riskind, Rector, & Casssin, 2011), as well as interpersonal relationship problems (e.g., Fincham, Garnier, Gano-Phillips, & Osborne, 1995). For example, cognitive psychology research has shed light on processes through which individuals' existing schemas (relatively stable concepts about objects and events) can bias their causal inferences and expectancies regarding future events. Cognitive psychology literature has contributed to cognitive-behavioral therapists' awareness of potential sources of distortion in their clients' cognitions about events, including those that occur in their couple and family relationships.

Adlerian Theory

The early theoretical work of Alfred Adler provided much of the basis for cognitive-behavioral therapy in general, and CBT with couples and families in specific. Adler applied his theory of individual psychology (Adler, 1964) to understanding marital relationships. Adler's view of individual personality and behavior was holistic and systemic, looking at individual functioning within the larger social context in which it occurs. Many believe that it is unfortunate that Adler did not label his theory "system psychology" while the term was still available (Nicoll, 1989). Adler (1978) theorized that all people have a need to develop a close intimate relationship with at least one individual, for their own benefit, as well as ultimately for the benefit of the community, society, and humankind. Adler believed that the formation of marriages and families provides connections for society between the past and the future. He suggested that success in marriage is a task requiring attitudes in both spouses of equality, cooperation, and mutual responsibility, as well as skills for communication and problem solving in a cooperative manner. According to Adler, individuals commonly enter relationships with unrealistic beliefs based on societal myths (e.g., need to be in control), and these beliefs interfere with successful relationships. In therapy Adler focused on the purposeful nature of each family member's behavior and the consequences their actions have on other members. Dysfunctional interaction involves each person trying to obtain or maintain a more advantageous position over the other(s). Adler focused on shifting skewed interaction patterns that interfered with a couple's ability to develop an egalitarian relationship.

The role of an Adlerian therapist is to teach individuals and families how to function more constructively in life. Cognitive-behavioral therapists take this role a step further and collaborate with clients to facilitate change. The therapist strives to gain insight into the functions that the presenting problem behavior has served for all family members. The therapist identifies constructive or dysfunctional beliefs and other cognitions that each family member holds about the relationship and then gives the family feedback about the significant themes that seem to contribute to the family tension. Next, the therapist coaches the family in alternative ways for dealing with conflict, which modify the family's interaction patterns. Homework assignments between sessions facilitate lasting change. Although cognitive-behavioral therapists have given insufficient credit to Adler's

work, it clearly provided the groundwork on which much of cognitive-behavior therapy with couples and families is based.

Social Learning Theory and Social Exchange Theory

CBCT and CBFT have a strong foundation in theory and research on the processes through which behavioral, cognitive, and emotional responses are learned. Work on classical conditioning by Pavlov (1927) and Watson (1925), followed by Wolpe's (1958) application of classical conditioning principles to the treatment of phobias (assumed to be fear responses conditioned to objectively neutral stimuli) through systematic desensitization demonstrated the relevance of learning processes in human problems. Skinner's (1953) work on operant conditioning demonstrated how individuals' responses are also controlled by their consequences (punishment, reinforcement, and extinction). Operant conditioning principles have been applied to behavioral couple and family therapy when parents are trained to control their children's actions by systematically varying the consequences (e.g., Forehand & McMahon, 1981; Patterson, 1971; Webster-Stratton & Herbert, 1994) and when members of a couple are guided in reinforcing responses that they desire in each other (e.g., Jacobson & Margolin, 1979; Liberman, 1970; Stuart, 1969). Even when the explicit goal of parent training has been to modify a child's behavior, the interventions develop more constructive actions on the parents' part, so that they involve the entire family and have a systemic quality. Patterson and his colleagues (Patterson, 1982; Patterson & Forgatch, 2005) identified mutual exchanges of coercive behavior between parents and adolescents by conducting observational research on family interactions, and they developed systemically oriented therapeutic interventions for these "coercive family systems." Similarly, contingency contracting used by behavioral marital therapists (BMT) (Jacobson & Margolin, 1979; Liberman, 1970; Stuart, 1969) involves the mutual exchange of positive behavior by the two partners and thus modifies the dyadic pattern in a couple's relationship.

Social learning theory (Bandura, 1977; Bandura & Walters, 1963; Rotter, 1954) integrates principles from social, developmental, and cognitive psychology, along with principles of learning theory derived from experimental psychology. In addition to classical and operant conditioning, social learning theory emphasizes the efficiency of observational learning, in which an individual learns how to perform both simple and complex responses by observing another person modeling the responses. An individual may not imitate a modeled behavior unless he or she anticipates receiving reinforcement for doing so or believes that it is appropriate to behave in that manner. Social learning theorists focus on ways in which children learn interpersonal behavior patterns through their exposure to family-of-origin dynamics. They also propose that human learning is mediated by cognitive processes, such as expectancies regarding the probability that one's actions will be followed by particular consequences (reinforcement or punishment).

Social exchange theory (Thibaut & Kelley, 1959) posits that individuals' satisfaction in close relationships depends on the ratio of positive to negative behaviors they receive from their significant others. Members of a couple or family tend to reciprocate levels of positive and negative behavior; for example, if one member of a couple acts negatively toward the other, the other person is likely to respond in kind. Sometimes family members reciprocate negativity or positivity immediately (e.g., thanking a family member for doing a favor for them), whereas sometimes reciprocity is delayed (e.g., holding a grudge about the manner in which one's partner behaved and retaliating for it later). Research on couple relationships has supported these aspects of social exchange theory (see Epstein & Baucom, 2002, for a review). Cognitive-behavioral therapists have used interventions such as behavioral contracts and communication training in order to maximize family members' positive exchanges and minimize negative ones.

Systems Theory

Cognitive-behavioral therapists often focus on specific instances of linear relations, such as an association between an individual's relationship standards (e.g., "Partners should spend most of their leisure time together, rather than pursuing

individual interests") and his or her response to a family member's actions ("We're furious that you made plans with your friends instead of the family!"). Nevertheless, current CBCT and CBFT models address the interrelatedness and mutual influences among parts of a family. Circular causal aspects of recurring behavioral patterns among family members, which include all of the members' cognitions, emotional responses, and behavior, are of central concern (Epstein & Baucom, 2002; Dattilio, 2010). Understanding a couple's or a family's functioning involves attending to multiple layers of the relationship system, including characteristics of each spouse or family member (such as personality characteristics, motives, psychopathology, and unresolved issues from his or her family of origin), interaction patterns that the couple or the family has developed (e.g., mutual attack, demand-withdrawal, mutual avoidance), and aspects of the couple's or the family's interpersonal and physical environment (e.g., extended family, jobs) that influence the relationship(s). Thus, a systems perspective on family functioning has become an integral part of cognitive-behavioral theory and therapy. When devising interventions, therapists must anticipate their potential impact on all members of the family. In addition, therapists must consider potential barriers to change that are based on characteristics of the individuals (e.g., depression), the established relationship patterns (e.g., escalating arguments that interfere with effective problem solving), and factors in the environment (e.g., intrusive in-laws) (Epstein & Baucom, 2002).

Etiology of Clinical Problems

Within a CBT model, etiological factors in the development of clinical problems commonly include aspects of the family members' cognitions, emotions, and behavioral responses (Baucom & Epstein, 1990; Dattilio, 1998; Epstein & Baucom, 2002). The following are major components of these factors.

Automatic Thoughts, Underlying Schemas, and Cognitive Distortions

Baucom, Epstein, Sayers, and Sher (1989) developed a typology of cognitions that have been implicated in relationship distress. Although each type is a normal form of human cognition, each is susceptible to being distorted or extreme (Baucom & Epstein, 1990; Epstein & Baucom, 2002). These include (a) *selective attention*, an individual's tendency to notice particular aspects of the events occurring in his or her relationship and to overlook others; (b) *attributions*, inferences about the factors that have influenced one's own and the partner's actions (e.g., concluding that a partner failed to respond to a question because he or she wants to control the relationship); (c) *expectancies*, predictions about the likelihood that particular events will occur in the relationship (e.g., that expressing feelings to one's partner will result in the partner being verbally abusive); (d) *assumptions*, beliefs about the natural characteristics of people and relationships (e.g., a wife's generalized assumption that men do not have needs for emotional attachment); and (e) *standards*, beliefs about the characteristics that people and relationships "should" have (e.g., that partners should have virtually no boundaries between them, sharing all of their thoughts and emotions with each other). Because there typically is so much information available in any interpersonal situation, some degree of selective attention is inevitable, but the potential for family members to form biased perceptions of each other must be examined. Inferences involved in attributions and expectancies are also normal aspects of human information processing involved in understanding other people's behavior and making predictions about others' future behavior. However, errors in these inferences can have negative effects on family relationships, especially when an individual attributes another's actions to negative characteristics (e.g., malicious intent) or misjudges how others will react to his or her own actions. Assumptions commonly are adaptive when they are realistic representations of people and relationships, and many standards that individuals hold, such as moral standards about avoiding abuse of others, contribute to the quality of family relationships. Nevertheless, inaccurate or extreme assumptions and standards can lead individuals to interact inappropriately with others, as when a parent holds a standard that children's and adolescents' opinions and

feelings are not to be taken into account as long as they live in the parents' home.

Beck and his associates (e.g., Beck et al., 1979; Beck, 2011) refer to moment-to-moment stream of consciousness ideas, beliefs, or images as automatic thoughts; for example, "My husband left his clothes on the floor again. He doesn't care about my feelings," or, "My parents are saying 'no' again because they just like hassling me." Cognitive-behavioral therapists make note of how individuals commonly accept automatic thoughts at face value, as opposed to examining their validity. Although all five of the types of cognition identified by Baucom et al. (1989) can be reflected in an individual's automatic thoughts, cognitive-behavioral therapists have emphasized the moment-to-moment selective perceptions and the inferences that are involved in attributions and expectancies as the most likely to be within a person's awareness. Assumptions and standards are thought to be broader underlying aspects of an individual's worldview, considered to be schemas in Beck's cognitive model (Beck et al., 1979; Beck, 2011; Leahy, 1996).

The cognitive model proposes that the content of an individual's perceptions and inferences is shaped by relatively stable underlying schemas, or cognitive structures such as the personal constructs described by Kelly (1955). Schemas include basic beliefs about the nature of human beings and their relationships, and they are assumed to be relatively stable and may become inflexible. Many schemas about relationships and the nature of couple and family interactions are learned early in life from primary sources such as family of origin, cultural traditions and mores, the mass media, and early dating and other relationship experiences. The models of self in relation to other that have been described by attachment theorists appear to be forms of schemas that affect individuals' automatic thoughts and emotional responses to significant others (Johnson & Denton, 2002). In addition to the schemas that partners or family members bring to a relationship, each member develops schemas specific to the current relationship.

As a result of years of interaction among family members, the individuals often develop jointly held beliefs that constitute a *family schema* (Dattilio, 1994). To the extent that the family schema involves unrealistic assumptions and standards, it may result in dysfunctional interactions among family members. An example of this might be family members who jointly hold an assumption that another member has a basic trait of being unreliable. Consequently, they may take on many of that person's responsibilities and unknowingly may be enabling unreliable behavior, contributing to its persistence.

Schemas about relationships are often not articulated clearly in an individual's mind but do exist as vague concepts of what is or should be (Beck, 1988; Epstein & Baucom, 2002). Those that previously have been developed influence how an individual subsequently processes information in new situations; for example, influencing what the spouse or family member selectively perceives, the inferences that he or she makes about causes of others' behavior, and whether the person is pleased or displeased with the family relationships. Existing schemas may be difficult to modify, but repeated new experiences with significant others have the potential to change them (Epstein & Baucom, 2002; Johnson & Denton, 2002).

In addition to automatic thoughts and schemas, Beck et al. (1979) identified cognitive distortions or information-processing errors that contribute to cognitions becoming sources of distress and conflict in individuals' lives. In terms of Baucom et al.'s (1989) typology, they result in distorted or inappropriate perceptions, attributions, expectancies, assumptions, and standards. Table 6.1 includes descriptions of these cognitive distortions, with examples of how they may occur in family interactions.

There has been much more research on attributions and standards than on the other forms of cognition in Baucom et al.'s (1989) typology (see Epstein & Baucom, 2002, for a review of findings). A sizable amount of research on couples' attributions has indicated that members of distressed couples are more likely than are members of nondistressed couples to attribute their partner's negative behavior to global, stable traits; negative intent; selfish motivation; and a lack of love (see Bradbury & Fincham, 1990, and Epstein & Baucom, 2002, for reviews). In addition, members

of distressed relationships are less likely to attribute positive partner behaviors to global, stable causes. These biased inferences can contribute to family members' pessimism about improvement in their relationships and to negative communication and lack of problem solving. One area of research on schemas has focused on potentially unrealistic beliefs that individuals may hold about marriage (Eidelson & Epstein, 1982). Baucom, Epstein, Rankin, and Burnett (1996) assessed one major type of relationship beliefs, the relationship standards that individuals hold about boundaries between partners, distribution of control/power, and the degree of investment one should have in the relationship. They found that individuals who were less satisfied with the manner in which their standards were met in their couple relationships were more distressed and communicated more negatively with their partners.

Deficits in Communication and Problem-Solving Skills

There is considerable empirical evidence that members of distressed couples and families exhibit a variety of negative and ineffective patterns of communication involving their expression of thoughts and emotions, listening skills, and problem-solving skills (Epstein & Baucom, 2002; Walsh, 1998). Expression of thoughts and emotions involves self-awareness, appropriate vocabulary to describe one's experiences, freedom from inhibiting factors such as fear of rejection by the listener, and a degree of self-control (e.g., not succumbing to an urge to retaliate against a person who upset you). Effective problem solving involves the abilities to define the characteristics of a problem clearly, generate alternative potential solutions, collaborate with other family members in evaluating advantages and disadvantages of each solution, reach consensus about the best solution, and devise a specific plan to implement the solution. Thus, effective couple or family problem solving requires both good skills and goodwill.

Deficits in communication and problem solving may develop as a result of various processes, such as maladaptive patterns of learning during socialization in the family of origin, deficits in cognitive functioning, forms of psychopathology such as depression, and past traumatic experiences in relationships that have left an individual vulnerable to disruptive cognitive, emotional, and behavior responses (e.g., rage, panic) during interactions with significant others. Research has indicated that individuals who communicate negatively in their couple relationships may exhibit constructive communication skills in relatively neutral outside relationships, suggesting that chronic issues in the intimate relationship are interfering with positive communication (Baucom & Epstein, 1990).

Excesses of Negative Behavior and Deficits in Positive Behavior Between Partners or Among Family Members

Negative and ineffective communication and problem-solving skills are not the only forms of problematic behavioral interaction in distressed couples and families. Members of close relationships commonly direct a variety of positive and negative acts toward each other that are instrumental (perform a task to achieve a goal, such as completing household chores) or are intended to affect the other person's feelings (e.g., giving him or her a gift) (Baucom & Epstein, 1990; Epstein & Baucom, 2002). Although there typically are implicit messages conveyed by such actions (e.g., regarding caring), they do not involve explicit expression of thoughts and emotions. Research has demonstrated that members of distressed relationships direct more negative acts and fewer positive ones toward each other than do members of non-distressed relationships (Epstein & Baucom, 2002). Furthermore, members of distressed couples and families are more likely to reciprocate negative behaviors, resulting in an escalation of conflict and distress (Jacobson & Margolin, 1979; Patterson, 1982; Weiss & Heyman, 1997). Consequently, a basic premise of CBT is that the frequency of negative behavior must be reduced and the frequency of positive acts should be increased. Because negative behaviors tend to have a greater impact on relationship satisfaction than do positive behaviors (Gottman, 1994; Weiss & Heyman, 1997),

they have received more attention from therapists. However, an absence of negatives leaves many clients less distressed but longing for more rewarding interactions.

Although couple and family theorists and researchers have focused on micro-level positive and negative acts, Epstein and Baucom (2002) propose that in many instances an individual's relationship satisfaction is based on more macro-level behavioral *patterns* that have significant meaning for him or her. Some core macro-level patterns involve boundaries between and around a couple or a family (e.g., less or more sharing of communication, activities, and time), distribution of power/control (e.g., across situations and time, how the parties attempt to influence each other, and how decisions are made), and the level of investment of time and energy that each person puts into the relationship. As we noted earlier, individuals' relationship standards concerning these dimensions are associated with relationship satisfaction and communication, and the couple and family therapy literature suggests that these behavior patterns are core aspects of family interaction (Epstein & Baucom, 2002; Walsh, 1998).

Epstein and Baucom (2002) have also described negative interaction patterns between members of couples that commonly interfere with the partners' fulfillment of their needs within the relationship and that research has indicated are associated with relationship distress. These patterns include mutual (reciprocal) attack, demand-withdrawal (one person pursues and the other withdraws), and mutual avoidance and withdrawal. Epstein and Baucom propose that therapists often must help clients reduce these patterns before they will be able to work together collaboratively as a couple to resolve issues such as different preferences for togetherness versus autonomy.

Deficits and Excesses in Experiencing and Expressing Emotions

Although the title "cognitive-behavioral therapy" does not refer to family members' emotions, assessment and modification of problematic affective responses are core components of this therapeutic approach. Epstein and Baucom (2002) provide a detailed description of problems that involve either deficits or excesses in individuals' experiencing of emotions within the context of their intimate relationships, as well as in their expression of those feelings to their significant others.

Some individuals pay little attention to their emotional states, and this can result in their feelings being overlooked in their close relationships. Alternatively, in some cases an individual who fails to monitor his or her emotions may suddenly express them in a destructive way, such as abusive behavior toward others. The reasons vary as to why an individual might be unaware of emotions but may include learning in the family of origin that expressing feelings is inappropriate or dangerous, the individual's current fear that expressing even mild emotion will lead to losing control of one's equilibrium (perhaps associated with post-traumatic stress disorder or another type of anxiety disorder), or holding an expectancy that one's family members simply do not care how one feels (Epstein & Baucom, 2002).

In contrast, some individuals have difficulty regulating their emotions, and they experience strong levels of emotion in response to even relatively minor life events. Unregulated experience of emotions such as anxiety, anger, and sadness can decrease the individual's satisfaction with couple and family relationships, and it can contribute to the person interacting with family members in ways that increase conflict. Factors contributing to unregulated emotional experience may include past personal trauma (e.g., abuse, abandonment), growing up in a family in which others failed to regulate emotional expression, and forms of psychopathology such as borderline personality disorder (Linehan, 1993).

It is important to identify specific cognitions that a family member holds about the expression of intense emotion that may contribute to unregulated expressiveness. Some individuals are unwilling to regulate their emotional expression, particularly when they feel justified in being angry. They believe (hold an assumption) that if they do not vent their emotions in a forceful or direct manner, they will become ill by holding them in (Dattilio, 2010), or other family members are likely to ignore them. In such cases, the

therapist would attempt to address the evidence supporting the person's underlying belief and attempt to have him or her consider an alternative view in which more regulated emotional experience and expression can be psychologically and even physically healthy. In addition, family members who receive unregulated emotional expression commonly find it distressing and either respond aggressively or withdraw from the individual. If an individual's unbridled emotional expression is intended to engage others to meet his or her needs, the pattern actually often backfires (Epstein & Baucom, 2002; Johnson & Denton, 2002).

In contrast to individuals who fail to regulate their emotions, the inhibited individual's family members may find it convenient not having to deal with the person's feelings. However, in other cases, family members may be frustrated by the person's lack of communication, and they may pursue the person, resulting in a circular demand-withdraw pattern. Although in the short term the individual who is emotionally unexpressive may successfully avoid unpleasant confrontations with other family members, in the long run he or she lives with some degree of frustration and unhappiness, which the therapist can point out.

Difficulty Adapting to Life Demands Involving the Individuals, Relationship Issues, or the Environment

Epstein and Baucom's (2002) enhanced CBCT approach integrates aspects of family stress and coping theory (e.g., McCubbin & McCubbin, 1989) with traditional CBT principles. A couple or a family is faced with a variety of demands to which it must adapt, and the quality of its coping efforts is likely to affect the satisfaction and stability of its relationships. Demands on the couple or the family may derive from three major sources: (a) characteristics of the individual members (e.g., a family has to cope with a member's clinical depression; parents must cope with an adolescent's growing desire for autonomy); (b) relationship dynamics (e.g., members of a couple have to resolve or adapt to differences in the two partners' needs, as when one is achievement- and career-oriented and the other focuses on togetherness and intimacy); and (c) characteristics of the interpersonal environment (e.g., needy relatives, a demanding boss) and physical environment (e.g., neighborhood violence that threatens the well-being of one's children). Cognitive-behavioral therapists assess the number, severity, and cumulative impact of various demands that a couple or a family is experiencing, as well as its available resources and skills for coping with those demands. Consistent with a stress and coping model, the risk of couple or family dysfunction increases with the degree of demands and the deficits in resources. Given that the family members' perceptions of demands and their ability to cope also play a prominent role in the stress and coping model, cognitive-behavioral therapists' skills in assessing and modifying distorted or inappropriate cognition can be very helpful in improving families' coping.

Methods of Clinical Assessment

Individual and joint interviews with the members of a couple or a family, self-report questionnaires, and the therapist's behavioral observation of family interactions are the three main modes of clinical assessment (Dattilio, 2010; Epstein & Baucom, 2002; Snyder, Cavell, Heffer, & Mangrum, 1995). Consistent with the concepts that we described previously, the goals of assessment are to: (a) identify strengths and problematic characteristics of the individuals, the couple or the family, and the environment; (b) place current individual and family functioning in the context of its developmental stages and changes; and (c) identify cognitive, affective, and behavioral aspects of family interaction that could be targeted for intervention. Our description of assessment methods necessarily is brief in this chapter, but readers can find extensive coverage of procedures in sources such as Baucom and Epstein (1990), Epstein and Baucom (2002), and Rathus and Sanderson (1999).

Initial Joint Interview(s)

One or more joint interviews with the couple or the family are an important source of information

about past and current functioning. Not only are they a source of information about the members' memories and opinions concerning characteristics and events in their family, but interviews also give the therapist an opportunity to observe the family interactions first hand. Although a family may alter its usual behavior in the presence of an outsider who is a stranger, even during the first interview it is common for members to exhibit some aspects of their typical pattern, especially when the therapist engages them in describing issues that have brought them to therapy. Cognitive-behavioral therapists approach assessment in an empirical manner, using initial impressions to form hypotheses that must be tested by gathering additional information in subsequent sessions.

Therapists generally begin the assessment process by convening as many of the family members who are likely to be involved with the presenting concerns as possible. Rather than insisting on everyone's attendance in order to begin therapy, the therapist focuses on engaging those members who are motivated to attend and then working with them in engaging absent members. Similar to therapists with other systems-oriented models, CBT therapists assume that difficulties that a family presents in ensuring all members' attendance may be a sample of a broader problematic family process. Thus, from the initial contacts the therapist is observing the family process and forming hypotheses about patterns that may be contributing to the problems that brought the family to therapy. It should be emphasized, however, that, ideally, both members of a couple or all members of a family should attend the session if possible.

During the initial joint interview, the therapist asks the family as a group about its reasons for seeking assistance at this time, about each person's perspective on those concerns, and about any changes that each member thinks would make family life more satisfying. The therapist also asks about the family's history (e.g., how and when the couple met, what initially attracted the partners to each other, when they married (if relevant), when any children were born, and any events that they believe have influenced them as a family over the years). Applying a stress and coping model to assessment, the therapist systematically explores demands that the couple or the family has experienced, based on characteristics of individual members (e.g., a spouse's residual effects from childhood abuse; a child's academic problems associated with a learning disability), relationship dynamics (e.g., unresolved differences in partners' desires for intimacy and autonomy), and their environment (e.g., heavy job demands on a parent's/spouse's time and energy; an adolescent being bullied by peers). The therapist also inquires about resources that the family has had available to cope with those demands and any factors that influenced its use of the resources; for example, a belief in self-sufficiency that blocks some people from seeking or accepting help from outsiders (Epstein & Baucom, 2002). Throughout the interview, the therapist gathers information about family members' cognitions, emotional responses, and behavior toward each other. For example, if a husband becomes withdrawn after his wife criticizes his parenting, the therapist may draw this to his attention and ask what thoughts and emotions he just felt after hearing his wife's comments. He might reveal automatic thoughts such as, "She doesn't respect me. This is hopeless," and feelings of both anger and deep sadness. Similarly, a therapist may explore the same dynamic with a child who withdraws from his or her parent after being chastised by them.

Questionnaires

Cognitive-behavioral therapists commonly use standardized questionnaires to gather information about family members' views of themselves and their relationships. Often therapists ask family members to complete questionnaires before the joint and individual interviews, so that the therapist can ask for additional information about questionnaire responses during the interviews. However, it should be noted that this varies depending on the age and sophistication of children in a family. As with interviews, individuals' reports on questionnaires are subject to biases, such as blaming others for family problems and presenting oneself in a socially desirable way (Snyder et al., 1995). Nevertheless, judicious

use of questionnaires can be an efficient means of quickly surveying family members' perceptions of a wide range of issues that might otherwise be overlooked during interviews. Then, issues that are noted on questionnaires can be explored in greater depth through subsequent interviews and behavioral observation. The following are some representative questionnaires that may be useful for assessment within a CBT model, even though many were not developed specifically from that perspective. Resources for reviews of a variety of other relevant measures include Touliatos, Perlmutter, and Straus (1990), Jacob and Tennenbaum (1988), Grotevant and Carlson (1989), and Fredman and Sherman (1987).

A variety of measures has been developed to provide an overview of key areas of couple and family functioning, such as overall satisfaction, cohesion, communication quality, decision making, values, and level of conflict. Examples include the Dyadic Adjustment Scale (Spanier, 1976), the Marital Satisfaction Inventory-Revised (Snyder & Aikman, 1999), the Family Environment Scale (Moos & Moos, 1981), the Family Assessment Measure-III (Skinner, Steinhauer, & Santa-Barbara, 1983), and the Self-Report Family Inventory (Beavers, Hampson, & Hulgus, 1985). Because the items on such scales do not provide specific information about each family member's cognitions, emotions, and behavioral responses regarding a relationship problem, the therapist must inquire about these during interviews. For example, if scores on a questionnaire indicate limited cohesion among family members, a therapist may ask the members about (a) their personal standards for types and degrees of cohesive behavior, (b) specific instances of behavior among them that did or did not feel cohesive, and (c) positive or negative emotional responses that they experience concerning those actions. Thus, questionnaires can be helpful to a therapist in identifying areas of strength and concern, but a more fine-grained analysis is needed to understand specific types of positive and negative interaction and the factors affecting them.

An advantage of general couple and family functioning inventories is that their subscales provide a profile (through formally calculated norms or informal perusal by the assessor) of areas of strength and problems within a family. Also, some family members are likely to report concerns on questionnaires that they would not mention during joint family interviews. As with interviews, this raises important ethical issues about setting clear guidelines regarding confidentiality of information that individual family members share with the therapist. However, many inventories are long, and therapists must decide whether they can gather comparable information more efficiently through interviews.

A number of questionnaires developed specifically from a CBT perspective can also be helpful in assessment of a couple or a family. For example, Eidelson and Epstein's (1982) Relationship Belief Inventory assesses five common unrealistic beliefs that have been found to be associated with relationship distress and communication problems in couples: (a) disagreement is destructive; (b) partners should be able to mind-read each other's thoughts and feelings; (c) partners cannot change their relationship; (d) innate gender differences influence relationship problems; and (e) one should be a perfect sexual partner. Baucom et al.'s (1996) Inventory of Specific Relationship Standards assesses the degrees to which individuals hold standards for their couple relationships regarding boundaries (degree of autonomy versus sharing), distribution and exercise of power/control, and investment of time and energy into the relationship. Roehling and Robin's (1986) Family Beliefs Inventory assesses unrealistic beliefs that adolescents and their parents may hold concerning each other. The parents' form assesses beliefs that: (a) if adolescents are given too much freedom, they will behave in ways that will ruin their future; (b) parents deserve absolute obedience from their children; (c) adolescents' behavior should be perfect; (d) adolescents intentionally behave in malicious ways toward their parents; (e) parents are blameworthy for problems in their children's behavior; and (f) parents must gain the approval of their children for their childrearing methods. In turn, the adolescents' form includes subscales assessing the beliefs that: (a) parents' rules and demands will ruin the adolescent's life; (b) parents' rules are unfair; (c) adolescents should have as much autonomy as they desire; and (d) parents should

have to earn their children's approval for their childrearing methods. In addition, a number of instruments have been developed to assess partners' attributions concerning causes of events in their couple relationships (e.g., Baucom, Epstein, Daiuto, Carels, Rankin, & Burnett, 1996; Pretzer, Epstein, & Fleming, 1991).

There are few self-report questionnaires that provide information about specific types of behavior that partners perceive occurring in their relationship. Christensen's (1988) Communication Patterns Questionnaire is most relevant for a systemic view of couple interaction, because the items ask about the occurrence of dyadic patterns regarding areas of conflict, including mutual attack, demand-withdrawal, and mutual avoidance. In addition, the revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) provides information about a range of verbal and non-verbal forms of aggressive behavior in couple relationships that many individuals choose not to reveal during interviews. We typically administer the CTS2 in conjunction with our interview with each partner and discuss any problematic behavior that is revealed. To date, no questionnaires are available to assess family members' moment-to-moment or typical emotional responses to each other (except overall level of distress), so we rely on interviews to track the emotional components of family interaction.

As noted earlier, even though all of these cognitive and behavioral measures are individuals' subjective reports of their experiences in their relationships, they can provide useful information about aspects of couple and family interaction that are not otherwise observable to the therapist. We do not use any of them routinely in clinical practice but believe they can be helpful as an adjunct to careful interviewing.

Individual Interviews

An individual interview with each member of a couple or a family (with the exception of young children, for whom this is not likely to be feasible) is often conducted next, to gather information about past and current functioning, including life stresses, psychopathology, overall health, coping strengths, and so on. Often family members are more open about describing personal difficulties such as depression, abandonment in a past relationship, and so forth, without other members present. However, a therapist must establish explicit ground rules regarding confidentiality of information gathered from individuals, including conditions under which parents are entitled to ask the therapist about contents of interviews with children and adolescents. Individual interviews give the clinician an opportunity to assess possible psychopathology that may be influenced by problems in the person's couple or family relationships (and in turn may be affecting family interactions adversely). Given the high co-occurrence of individual psychopathology and relationship problems (Chambless, 2012; L'Abate, 1998; Whisman & Beach, 2012), it is crucial that couple and family therapists be skilled in assessing individual functioning or make referrals to colleagues who can assist in this task. The therapist can then determine whether joint therapy should be supplemented with individual therapy. As we noted, therapists must set clear guidelines for confidentiality during individual interviews, because keeping secrets such as a spouse's ongoing infidelity places the therapist in an ethical bind and undermines the work in joint sessions. Consequently, we tell couples and family members that we will not keep such secrets that are affecting the well-being of other family members, and parents will be informed about a child's behavior that places him or her in danger. However, when a therapist learns that an individual is being physically abused and appears to be in danger, if the victim is an adult, the focus shifts toward working with that person to develop plans to maintain safety and steps to exit the home when the risk of abuse increases and to seek shelter elsewhere. If the victim is a child, the therapist must follow statutes for mandated reporting, while taking into account the possibility that reporting itself may place a child at risk for further abuse.

Behavioral Observation

We have already described how the therapist has opportunities to observe couple and family

interaction patterns during the initial joint interview; for example, the style and degree to which members express their thoughts and emotions to each other, who interrupts whom, and who speaks for whom. In a CBT approach, assessment is ongoing throughout therapy, and the therapist observes family process during each session. These relatively unstructured behavioral observations are often supplemented by a structured communication task during the initial joint interview (Baucom & Epstein, 1990; Epstein & Baucom, 2002; Kerig & Lindahl, 2001). Based on the information that the couple or the family provides, the therapist may select a topic that all of the family members consider an unresolved issue in their relationship and asks them to spend ten minutes or so discussing it while the therapist video records them. The family members might be asked merely to express their feelings about the issue and respond to each other's expression in any way they see appropriate, or they might be asked to try to resolve the issue in the allotted time. Typically, the therapist leaves the room, to minimize influencing their interactions. Such recorded problem-solving discussions are used routinely in couple and family interaction research (Kerig & Lindahl, 2001; Weiss & Heyman, 1997), and even though family members often behave somewhat differently under these conditions than they do at home, they commonly become engaged enough in the discussion that aspects of their usual interaction emerge. This is another source of information about family members' emotional responses to each other, as when an individual rapidly exhibits anger whenever others disagree with him or her. Without conducting detailed formal coding procedures, therapists can use behavioral coding systems that were developed for research purposes, such as the Marital Interaction Coding System (MICS-IV; Heyman, Eddy, Weiss, & Vivian, 1995), and Kategoriensystem für Partnerschaftliche Interaktion (KPI; Hahlweg, Reisner, Kohli, Vollmer, Schindler, & Revenstorf, 1984) for couples, and the Family Interaction Macro-coding System (FIMS; Kaugars et al., 2011) and Iowa Family Interaction Rating Scales (IFIRS; Melby et al., 1998) for families, as guides for identifying types of positive and negative couple and family verbal and non-verbal behaviors. Examples of such codes are: approve, accept responsibility, denial, interrogation, lecture/moralize, positive physical contact, warmth, complain, putdown, cross-complaining, parental structuring of task, pressure others to agree, and parental promotion of dialogue and collaboration. As with observations of family interaction during interviews, the therapist considers these data to be interaction samples that might be typical of the family process but that require verification through repeated observations and reports from the family members about interactions that occur at home.

Identification of Macro-level Patterns and Core Relationship Issues

The therapist collects information over the course of joint and individual interviews, plus family members' responses to questionnaires, and looks for broad "macro-level" patterns and themes that may reflect core relationship issues. Thus, the therapist takes an empirical approach to assessment, using initial observations to form hypotheses but waiting until repetitive patterns emerge before drawing conclusions about a family's central problems and strengths. For example, during the first joint family session, parents may describe setting firm limits on an adolescent daughter's behavior, and the therapist may hypothesize that there is a clear power hierarchy in the family. However, in an individual interview the daughter may reveal that she can easily bend the rules and talk her parents out of punishments, and in other joint family sessions the parents may fail to respond when the daughter repeatedly interrupts them. Evidence has accumulated that the parents have relatively little power.

Assessment Feedback to the Couple or the Family

CBT is a collaborative approach, in which the therapist continually shares his or her thinking with the clients and develops interventions designed to address their concerns. After collecting information from interviews, questionnaires, and behavioral observations, the therapist meets

with the family and provides a concise summary of the patterns that have emerged, including (a) their strengths, (b) their major presenting concerns, (c) life demands or stressors that have produced adjustment problems for the family, and (d) constructive and problematic macro-level patterns in their interactions that seem to be influencing their presenting problems. The therapist and the family then identify the family's top priorities for change, as well as some interventions that have potential to alleviate the problems. This is also an important time for the therapist to explore potential barriers to couple or family therapy, such as members' fears of changes that they anticipate will be stressful and difficult for them, and to problem solve with the family regarding steps that could be taken to reduce the stress.

Clinical Change Mechanisms and Specific Therapeutic Interventions

Educating Couples and Families about the Cognitive-Behavioral Model

It is very important to educate couples and families about the CBT model of treatment. The structure and collaborative nature of the approach necessitate that the couple or the family members clearly understand the principles and methods involved. The therapist initially provides a brief didactic overview of the model and periodically refers to specific concepts during therapy. In addition to presenting such "mini-lectures" (Baucom & Epstein, 1990), the therapist may ask the clients to read relevant books such as Beck's (1988) *Love Is Never Enough*, Markman, Stanley, and Blumberg's (2010) *Fighting for Your Marriage*, Patterson and Forgatch's (2005) *Parents and Adolescents Living Together*, and Dishion and Patterson's (2005) *Parenting Young Children With Love, Encouragement, and Limits.* Those books for parents focus on the application of the social learning paradigm developed by Gerald Patterson. It is also important to explain to couples and family members that homework assignments will be an essential part of treatment and that readings are one type of homework assignment that helps orient them to the model of treatment. Knowing the model keeps all parties attuned to the process of treatment and reinforces the notion of taking responsibility for their own thoughts and actions.

The therapist informs the clients that he or she will structure the sessions in order to keep the therapy focused on achieving the goals that they have agreed to pursue during the assessment process (Epstein & Baucom, 2002; Dattilio, 1994, 1997, 2010). Part of the structuring process involves the therapist and the couple or the family setting an explicit agenda at the beginning of each session. Another aspect of structuring sessions involves establishing ground rules for client behavior within and outside sessions. Examples of rules regarding session structure are that individuals should not tell the therapist secrets that cannot he shared with other family members, all family members should attend each session unless the therapist and the family decide otherwise (e.g., when the therapist holds sessions only with parents in order to develop their parenting skills before attempting to use them with their children), and aggressive verbal and physical behavior is unacceptable.

Interventions to Modify Distorted and Extreme Cognitions

Teaching Members to Identify Automatic Thoughts and Associated Emotions and Behavior

A crucial prerequisite to modifying family members' distorted or extreme cognitions about themselves and each other is increasing their ability to identify their automatic thoughts. After introducing the concept of automatic thoughts that spontaneously flash through one's mind, the therapist coaches couples and family members in observing their patterns of thought during sessions that are associated with their negative emotional and behavioral responses to each other. In the CBT model, monitoring one's subjective experiences is a skill that can be developed further. In order to improve the skill of identifying one's automatic thoughts, clients are typically asked to keep a small notebook (or similar electronic device) handy between sessions and to jot down

a brief description of the circumstances in which they feel distressed about the relationship or are engaged in conflict. This log should also include a description of the automatic thoughts that came to mind, as well as the resulting emotional response and any behavioral responses toward other family members. We typically use a modified version of the Daily Record of Dysfunctional Thoughts (Beck et al., 1979), initially developed for the identification and modification of automatic thoughts in individual cognitive therapy. Through this type of record keeping, the therapist is able to demonstrate to couples and families how their automatic thoughts are linked to emotional and behavioral responses and to help them understand the specific macro-level themes (e.g., boundary issues) that upset them in their relationships. This procedure also increases family members' awareness that their negative emotional and behavioral responses to each other are potentially controllable through systematic examination of the cognitions associated with them. Thus, the therapist is coaching each individual in taking greater responsibility for his or her own responses. An exercise that often proves quite useful is to have couples and families review their logs and indicate the links among thoughts, emotions, and behavior. The therapist then asks each person to explore alternative cognitions that might produce different emotional and behavioral responses to a situation.

Identifying Cognitive Distortions and Labeling Them

It is helpful for family members to become adept at identifying the types of cognitive distortions involved in their automatic thoughts. One exercise that is often effective is having each partner or family member refer to the list of distortions in Table 6.1 and label any distortions in the automatic thoughts that he or she logged during the previous week. The therapist and client can discuss the aspects of the thoughts that were inappropriate or extreme and how the distortion contributed to any negative emotions and behavior at the time. Such in-session reviews of written logs over the course of several sessions can increase family members' skills in identifying and evaluating their ongoing thoughts about their relationships.

If the therapist believes that a family member's cognitive distortions are associated with a form of individual psychopathology, such as clinical depression, the therapist must determine whether the psychopathology can be treated within the context of couple or family therapy, or whether the individual may need a referral for individual therapy. As noted earlier, procedures for assessing the psychological functioning of individual family members are beyond the scope of this chapter, but it is important that couple and family therapists be familiar with the evaluation of psychopathology and make referrals to other professionals as needed.

Testing and Reinterpreting Automatic Thoughts

The process of restructuring automatic thoughts involves the individual considering alternative explanations. In order to accomplish this, the individual must examine evidence concerning the validity of a thought, its appropriateness for his or her family situation, or both. Identifying a distortion in one's thinking or an alternative way to view relationship events may contribute to different emotional and behavioral responses to other family members. Questions such as the following are often helpful in guiding each family member in examining his or her thoughts:

- From your past experiences or the events occurring recently in your family, what evidence exists that supports this thought? How could you get some additional information to help you judge whether your thought is accurate?
- What might be an alternative explanation for your partner's behavior? What else might have led your partner to behave that way?
- We have reviewed several types of cognitive distortions that can influence a person's views of other family members and can contribute to getting upset with them. Which cognitive distortions, if any, can you see in the automatic thoughts you had about . . . ?

Table 6.1 Common cognitive distortions

Cognitive Distortion	*Explanation*
Arbitrary Inference	Conclusions that are made in the absence of supporting substantiating evidence: often involved in invalid attributions and expectancies. For example, a man whose wife arrives home a half-hour late from work concludes, "She must be doing something behind my back." Distressed spouses and family members often make negative attributions about the causes of each other's positive actions. For example, if a teenager starts to improve his or her behavior, parents may wonder about an ulterior motive.
Mind Reading	This is a type of arbitrary inference in which an individual believes he or she knows what another person is thinking or feeling without communicating directly with the person. For example, a husband noticed that his wife had been especially quiet and concluded, "She's unhappy with our marriage and must be thinking about leaving me."
Selective Abstraction	Information is taken out of context and certain details are highlighted, whereas other important information is ignored; involved in selective attention to family interaction. For example, a woman whose son fails to answer her greeting in the morning concludes, "He is ignoring me," even though the son cleared a place for her at the breakfast table when she entered the room. An individual's schema concerning another family member may produce "tunnel vision," in which he or she notices only the aspects of the other's behavior that are consistent with the global conception of the other person. For example, the previously mentioned mother may notice only the instances of her son's failing to engage with her, if she believes that the son has a trait of "self-centeredness."
Overgeneralization	An isolated incident is considered to be a representation of similar situations in other contexts, related or unrelated; often contributes to selective attention. For example, after being told that she cannot go out Saturday night, an adolescent girl concludes, "My parents won't let me have any social life."
Magnification and Minimization	A case of circumstance is judged as having greater or lesser importance than is appropriate; often leading to distress when the evaluation violates the person's standards for the ways family members "should" be. For example, an angry father becomes anxious and enraged when he discovers that his son has been given detention at school for fighting in the schoolyard, as he thinks, "He's turning into a juvenile delinquent."
Personalization	External events are attributed to oneself when insufficient evidence exists to render a conclusion; a special case of arbitrary inference commonly involved in misattributions. For example, a mother finds her family not eating as much of the meal at dinner as she had anticipated and concludes, "They hate my cooking."
Dichotomous Thinking	Also labeled "polarized thinking," experiences are classified into mutually exclusive, extreme categories, such as complete success or total failure; commonly contributing to selective attention, as well as violation of personal standards. For example, a husband has spent several hours working on cleaning the couple's cluttered basement and has removed a considerable number of items for inclusion in a yard sale. However, when the wife enters the basement, she looks around and exclaims, "What a mess! When are you going to make some progress?" and the husband becomes angry that his efforts have not been appreciated.
Labeling	The tendency to portray oneself or another person in terms of stable, global traits, on the basis of past actions; negative labels are involved in *attributions* that family members make about causes of each other's actions. For example, after a wife has made several errors in family budgeting and in balancing their checkbook, the husband concludes that, "She is a careless person," and he does not consider situational conditions that may have led to those errors.

For example, an adolescent who believed that his parents were being unrealistic in their restrictions on his activities reported the automatic thoughts, "They enjoy restricting me. I never get to do anything," which were associated with anger and frustration toward his parents. The therapist coached him in identifying that he was engaging in mind reading, and that it would be important to learn more about his parents' feelings. The therapist encouraged him to ask his parents to describe their feelings, and both replied that they felt sad and guilty about having to restrict their son, but that their fears for his well-being, based on his past drug involvement, were outweighing their urge to let him have more freedom. The son was able to hear that his inference may not be accurate, and the therapist noted to the family members that they probably would benefit from problem-solving discussions to address the issue of what types of restrictions were most appropriate. Similarly, the therapist coached the son in examining his thought, "I never get to do anything," leading to the son's recounting several instances in which his parents did allow him some social activities. Thus, the son acknowledged that he had engaged in dichotomous thinking. The therapist discussed with the family the danger of thinking and speaking in extreme terms, because very few events occur "always" or "never."

Thus, gathering and weighing the evidence for one's thoughts are integral parts of CBT. Family members are able to provide valuable feedback that will help each other evaluate the validity or appropriateness of their cognitions, as long as they use good communication skills, which will be described later. After individuals challenge their thoughts, they should rate their belief in the alternative explanations and in their original inference or belief, perhaps on a scale from 0 to 100. Revised thoughts may not become assimilated unless they are considered credible.

Testing Predictions with Behavioral Experiments

Although an individual may use logical analysis successfully to reduce his or her negative expectancies concerning events that will occur in couple or family interactions, often first-hand evidence is needed. Cognitive-behavioral therapists often guide family members in devising "behavioral experiments," in which they test their predictions that particular actions will lead to certain responses from other members. For example, a man who holds an expectancy that his wife and children will resist including him in their leisure activities when he gets home from work can make plans to try to engage with the family when he arrives home during the next few days and see what happens. When these plans are devised during joint family therapy sessions, the therapist can ask the other family members what they predict their responses will be during the experiment. The family members can anticipate potential obstacles to the success of the experiment, and appropriate adjustments can be made. In addition, public commitments that family members make toward cooperation with the experiment often increase the likelihood of its success.

Using Imagery, Recollections of Past Interactions, and Role-playing Techniques

During therapy sessions, when family members attempt to identify their thoughts, emotions, and behavior that occurred in past incidents outside sessions, they may have difficulty recalling pertinent information regarding the past circumstances and each person's responses, particularly if the family interaction was emotionally charged. Imagery or role-playing techniques or both may be extremely helpful in reviving memories regarding such situations. In addition, these techniques often rekindle family members' reactions, and what begins as a role play may quickly become an in vivo interaction. Although recounting of past events can provide important information, the therapist's ability to assess and intervene with family members' problematic cognitive, affective, and behavioral responses to each other as they occur during sessions affords the best opportunity for changing family patterns (Epstein & Baucom, 2002).

Family members can also be coached in switching roles during role-playing exercises, in order to increase empathy for each other's experiences within the family (Epstein & Baucom, 2002). For example, spouses can be asked to play each other's role in recreating an argument that

they recently had concerning finances, or a parent and adolescent can be asked to switch roles when discussing a conflict about the adolescent's curfew time. Focusing on the other person's frame of reference and subjective feelings provides new information that can modify one spouse's view of the other. Thus, when a husband played the role of his wife, he was able to better understand her anxiety and conservative behavior concerning spending money, based on her experiences of poverty during childhood.

Many distressed couples have developed a narrow focus on problems in their relationship by the time they seek therapy, so the therapist may ask them to report their recollections of the thoughts, emotions, and behavior that occurred between them during the period when they met, dated, and developed loving feelings toward each other. The therapist can focus on the contrast between past and present feelings and behavior as evidence that the couple was able to relate in a much more satisfying way and may be able to regenerate positive interactions with appropriate effort.

Imagery techniques should be used with caution and skill and probably should be avoided if there is a history of abuse in the relationship. Similarly, role-play techniques should not be used until the therapist feels confident that family members will be able to contain strong emotional responses and refrain from abusive behavior toward each other.

The "Downward Arrow" Technique

This is a technique used by cognitive therapists (e.g., Beck et al., 1979; Beck, 2011) to track the associations among an individual's automatic thoughts, in which an apparently benign initial thought that a person reports may be upsetting because it is linked to other, more significant thoughts. For example, a child may report strong anxiety associated with the automatic thought, "My dad will yell at me if I don't get mostly A grades in school." The intensity of the emotional response becomes more clear when the therapist asks a series of questions of the form, "And if that happened, what would it mean to you?" or, "What might that lead to?" and the child eventually reports, "He'll get so upset with me that he'll think I'm a loser and will wish he had someone else as a son." Couples and family members can evaluate how likely the expected catastrophe is to occur. In some cases, this will lead to modification of the individual's underlying catastrophic expectancy; in other cases, it may uncover a real problem in family interaction such as a need for the child's father to consider changing his judgmental and rejecting behavior.

The downward arrow technique is also used to identify the underlying assumptions and standards beneath one's automatic thoughts. This is done by identifying the initial thought, having individuals ask themselves, "If so, then what?" and moving downward until the individuals identify the relevant core belief. Thus, the child in the previous example might also have developed perfectionistic standards for his performance in academics and other activities, based on his parents' belief systems, and even if his father would not reject him, the son's negative automatic thoughts may be tied to an underlying belief such as, "I am a failure if I don't get high grades."

Interventions to Modify Behavior Patterns

The major forms of interventions used to reduce negative behavior and increase positive behavior are: (a) communication training regarding expressive and listening skills, (b) problem-solving training, (c) parenting training, (d) homework assignments, and (e) behavior-change agreements. We describe each of these briefly further on, and readers can consult texts such as Guerney (1977), Robin and Foster (1989), Baucom and Epstein (1990), Webster-Stratton and Herbert (1994), Jacobson and Christensen (1996), Epstein and Baucom (2002), Forgatch and Patterson (2005), and Kazdin (2005) for detailed procedures.

Communication Training

Improving couple and family skills for expressing thoughts and emotions, as well as for listening effectively to each other, is one of the most common forms of intervention across theoretical

approaches to therapy. In CBT it is viewed as a cornerstone of treatment, because it can have a positive impact on problematic behavioral interactions, reduce family members' distorted cognitions about each other, and contribute to regulated experience and expression of emotion. Therapists begin by presenting instructions to couples and family members about the specific behaviors involved in each type of expressive and listening skill. Speaker guidelines include acknowledging the subjectivity of one's views (not suggesting that others' views are invalid); describing one's emotions, as well as one's thoughts; pointing out positives as well as problems; speaking in specific rather than global terms; being concise so that the listener can absorb and remember one's message; and using tact and good timing (e.g., not discussing important topics when one's partner is preparing to go to sleep). The guidelines for empathic listening include exhibiting attentiveness through non-verbal acts (e.g., eye contact, nods), demonstrating acceptance of the speaker's message (the person's right to have his or her personal feelings) whether or not the listener agrees, attempting to understand or empathize with the other's perspective, and reflecting back one's understanding by paraphrasing what the speaker has said. Each family member receives handouts describing the communication guidelines that he or she can refer to whenever needed during sessions and at home.

Therapists often model good expressive and listening skills for clients. They may use video examples, such as those that accompany Markman, Stanley, and Blumberg's (2010) book, *Fighting for Your Marriage.* During sessions, the therapist coaches the couple or the family in following the communication guidelines, beginning with discussions of relatively benign topics so that negative emotions will not interfere with constructive skills. As the clients demonstrate good skills, they are asked to practice them more as homework, with increasingly conflictual topics. As family members practice communication skills, they receive more information about each other's motives and desires, an important source of information to disconfirm some distorted cognitions about each other. Following the guidelines also often increases each individual's perception that the others are respectful and have good will.

Problem-Solving Training

CBT therapists also use verbal and written instructions, modeling, and behavioral rehearsal and coaching to facilitate effective problem solving with couples and family members (Epstein & Baucom, 2002; Forgatch & Patterson, 2005; Webster-Stratton & Herbert, 1994). The major steps in problem solving involve: (a) achieving a clear specific definition of the problem in terms of behaviors that are or are not occurring, (b) generating specific behavioral solutions to the problem without evaluating one's own or other family members' ideas, (c) evaluating the advantages and disadvantages of each alternative solution and selecting a solution that appears to be feasible and attractive to all members involved, and (d) agreeing on a trial period for implementing the selected solution and assessing its effectiveness. Homework practice of the skills is important for their acquisition (Dattilio, 2002; Epstein & Baucom, 2002).

Parenting Skills

The social learning approaches to intervention with parent–child relationships that were developed by Patterson (1982) continue to be used widely in a number of formats (e.g., Dishion & Patterson, 2005; Forgatch & Patterson, 2005; Kazdin, 2008; Patterson & Forgatch, 2005; Webster-Stratton & Herbert, 1994). The emphasis is on educating parents about operant learning principles, developing their ability to observe children's behavior systematically, setting constructive limits on children's behavior, coaching them in using skills such as reinforcing positive child behavior and ignoring negatives or using non-aggressive punishment, and implementing effective time-outs. Although at first it may appear that the focus is mostly on changing children's behavior (which may reduce parents' defensiveness about being in therapy), the educational and skills-building aspects of these programs clearly produce major constructive changes in parents' approaches to interacting with their children, thus creating family system changes.

Homework Assignments

The use of homework, or out-of-session assignments, is not a new development in the field of psychotherapy and has been used by other therapeutic approaches for years. Homework assignments are a major therapeutic technique when working with families. In fact, cognitive-behavior family therapists have identified homework assignments as being a cornerstone to treatment in family therapy (Schwebel & Fine, 1994; Dattilio, 1998, 2002). Research in family therapy has also indicated that homework assignments are crucial for change in couple and family therapy (Dattilio, Kazantzis, Shinkfield, & Carr, 2011). Homework serves to keep the effects of therapy alive between sessions and promotes a transfer of changes achieved during sessions to daily living. In essence, homework helps to galvanize that which is learned during the therapy process.

Practice serves to heighten awareness of various issues that have unfolded during the course of treatment. These assignments can increase the expectations for family members to follow through with making changes rather than simply discussing change during the course of therapy and then not following through at home.

There are various types of homework assignments used with families. Some of the more common involve activity scheduling, biblio- or video-therapy assignments, self-monitoring, behavioral task assignments, and/or identification and challenging of one's dysfunctional thoughts.

Behavior-change Agreements

Contracts to exchange desired behavior still have an important role in CBCT and CBFT. Therapists try to avoid making one family member's behavior change contingent on another's, so the goal is for each person to identify and enact specific behavior that would be likely to please other family members, regardless of what actions the other members take. The major challenge facing the therapist is encouraging family members to avoid "standing on ceremony" by waiting for others to behave positively first. Brief didactic presentations on negative reciprocity in distressed relationships, the fact that one can have control only over one's own actions, and the importance of making a personal commitment to improve the family atmosphere are some interventions that may reduce individuals' reluctance to "make the first positive contribution." A key exception to the avoidance of contingencies in behavioral contracts is the use of behavior charts and token economy systems in parent training programs (Kazdin, 2005; Webster-Stratton and Herbert, 1994), in which parents identify specific positive child behaviors to reinforce and negative child behaviors to ignore or punish.

Interventions for Deficits and Excesses in Emotional Responses

Although CBT is sometimes characterized as neglecting emotions, this is not the case, and a variety of interventions are used, either to enhance the emotional experiences of inhibited individuals or to moderate extreme responses (see Epstein & Baucom, 2002, for detailed procedures). For family members who reportedly *experience little emotion*, the therapist can: (a) set clear guidelines for behavior within and outside sessions, in which expressing oneself will not lead to recrimination by other members; (b) use downward arrow questioning to inquire about underlying emotions, as well as cognitions; (c) coach the person in noticing internal cues to his or her emotional states; (d) repeat phrases that have emotional impact on the person; (e) refocus attention on emotionally relevant topics when the individual attempts to change the subject; and (f) engage the individual in role plays concerning important relationship issues in order to elicit emotional responses. With individuals who *experience intense emotions* that affect them and significant others adversely, the therapist can: (a) help them compartmentalize emotional responses by scheduling specific times to discuss distressing topics; (b) coach the individual in self-soothing activities such as relaxation techniques; (c) improve people's ability to monitor and challenge upsetting automatic thoughts; (d) encourage individuals to seek social support from family and others; (e) develop their ability to tolerate distressing feelings; and (f) enhance skills for expressing emotions constructively so that others will pay attention.

Effectiveness of Cognitive-Behavioral Couple and Family Therapy

Research on CBCT Outcomes

An evaluation of the effectiveness of CBCT must take into account the fact that there have as yet been few outcome studies that have tested protocols that include cognitive restructuring components, and those studies that did include some attention to partners' cognitions used very brief cognitive restructuring procedures with limited similarity to those used in clinical practice. Reviews of outcome studies (e.g., Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dunn & Schwebel, 1995; Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003, 2005) have identified a large number of studies that evaluated traditional Behavioral Marital Therapy (BMT; Jacobson & Margolin, 1979), more recently labeled Traditional Behavioral Couple Therapy (TBCT), which includes the behavioral components of CBCT: communication skill training, problem-solving training, and some form of structured positive behavior exchanges (e.g., contracts). Those BMT/TBCT protocols included minimal or no systematic cognitive restructuring *or* interventions targeting emotional responses that have become important foci in Enhanced Cognitive-Behavioral Couple Therapy (ECBCT; Baucom, Epstein, LaTaillade, & Kirby, 2008; Epstein & Baucom, 2002). The reviews consistently have demonstrated that the behavioral components of CBCT are effective in improving relationship satisfaction and the quality of couples' behavioral interactions.

Some reviews (Baucom et al., 1998; Dunn & Schwebel, 1995) separated the studies that included a cognitive restructuring component from all of those that were strictly behavioral, whereas others either lumped the CBCT treatment studies with the TCBT ones (Shadish & Baldwin, 2005) or did not mention studies evaluating CBCT interventions other than the acceptance-based procedures (which appear to target partners' cognitions about each other) included in Integrative Behavioral Couple Therapy (IBCT; Christensen & Jacobson, 2000; Jacobson & Christensen, 1996; Lebow et al., 2012).

Of the studies that have examined outcomes for cognitive restructuring interventions, Huber and Milstein's (1985) study compared a cognitive intervention that targeted unrealistic relationship beliefs (assumptions and standards) with a wait-list control condition, and it demonstrated that the cognitive restructuring condition led to more positive cognitions and higher relationship satisfaction than the control. Halford, Sanders, and Behrens (1993) compared effects on partners' behavior and cognitions of twelve to fifteen 1.5-hour sessions of traditional BMT and an enhanced BMT that included cognitive restructuring, exploration of affect associated with negative couple interactions, and treatment generalization enhancement. The cognitive restructuring component involved identifying partners' maladaptive relationship beliefs and attributions and using cognitive therapy procedures for Socratic questioning, challenging, and self-instructional training. Therapists were permitted flexibility in the amounts of each type of intervention in the Enhanced BMT condition, depending on each couple's needs. Both conditions were successful in decreasing negative behavior and cognition, although degrees of those changes were not correlated with improvement in relationship satisfaction. Given the design used, it is not possible to determine how much cognitive restructuring the couples received, or how much the cognitive interventions contributed to the treatment outcomes.

Two studies by Baucom and colleagues (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990) investigated whether adding cognitive restructuring modules to BMT's traditional behavioral components would enhance the outcomes. In order to keep the total amount of therapy received constant across conditions, the investigators substituted some sessions of cognitive interventions for behaviorally oriented sessions. For example, in the Baucom et al. (1990) study, all treatment conditions involved twelve weekly sessions, with fewer sessions of each type of intervention when a condition involved multiple types of interventions. Thus, the BMT alone condition included twelve sessions of communication skills training, problem-solving, and quid pro quo contracts, whereas the Cognitive

Restructuring plus BMT condition included six sessions of cognitive restructuring (three sessions focused on broadening partners' attributions for causes of their relationship problems, two sessions examining unrealistic relationship standards that might be affecting their relationship, and a final session integrating three cognitive restructuring concepts) followed by six sessions of the BMT behavioral interventions. The Cognitive Restructuring plus BMT plus Emotional Expressiveness Training (skills for expressing emotions and listening empathically) condition included three sessions of each of the three components.

The overall results of the studies by Baucom and colleagues indicated that all of the conditions increased relationship satisfaction more than a waitlist control condition, but all of the active treatment conditions were equally effective. There also was some evidence that cognitively focused interventions tended to produce more cognitive change and behavioral interventions tended to modify behavioral interactions more. Although some writers have concluded from such findings that cognitive restructuring does not enhance effects of behaviorally oriented interventions (Baucom et al., 1998; Halford et al., 1993), it is important to note that substituting cognitive restructuring sessions for BMT sessions produced equal overall effectiveness. Furthermore, it seems likely that the small number of sessions of each type of intervention that were allowed in the conditions involving multiple components may have weakened the effectiveness of each component. Epstein (2001) noted that there is a need for research on a truly integrated CBCT that targets each couple's particular cognitive, behavioral, and affective problems in proportion to their intensity, rather than providing a fixed number of sessions of each type of intervention to all couples. Also, Whisman and Snyder (1997) argued that tests of cognitive interventions in the few existing studies have been limited by a failure to assess the range of problematic cognitions (selective attention, expectancies, attributions, assumptions, and standards) identified by Baucom et al. (1989). Studies have also been limited to samples of predominantly white, middle-class couples, so the effectiveness with other racial and socioeconomic groups is unknown. An exception was the CBCT intervention evaluated as part of the Couples Abuse Prevention Program (CAPP) conducted by Epstein and colleagues (LaTaillade et al., 2006; Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011) in a racially and socioeconomically diverse community clinic sample recruited on the basis of their psychological and mild to moderate physical aggression. The CBCT protocol that included psychoeducation regarding forms and consequences of partner aggression, anger management, cognitive restructuring, communication training, and problem-solving training produced improvements in relationship satisfaction, negative attributions, trust, self-reported partner aggression, and coded negative communication behavior. The cognitive change was associated with positive changes in aggression, but the study did not identify the relative contributions of the various treatment components to those outcomes. Thus, research on the effectiveness of CBCT has been encouraging, but there are many unanswered questions.

Research on CBFT Outcomes

CBFT approaches to family therapy have focused mostly on treatment of particular disorders in individual members, rather than on alleviating general conflict and distress within the family. For example, many studies have demonstrated the efficacy of training parents in behavioral interventions for their children's conduct disorders (Forgatch & Patterson, 2010; Kazdin, 2005), based on a social learning model that was described earlier in this chapter, although a high attrition rate indicates limitations in the approach (Estrada & Pinsof, 1995). There also has been empirical support for behavioral family therapy for childhood attention deficit hyperactivity disorder (ADHD) (Kaslow, Broth, Smith, & Collins, 2012), although the parent training component for dealing with the child's symptoms of inattention, impulsivity, hyperactivity, and non-compliance typically is used in conjunction with other interventions (e.g., medication and self-control training) that specifically target those ADHD symptoms (Barkley, 1998). There also is strong evidence for the effectiveness of CBFT

in the treatment of childhood anxiety disorders (Kaslow et al., 2012). Functional Family Therapy (Alexander & Parsons, 1982), which includes major components of CBFT (communication training, assertion training, anger management) and focuses on modifying dysfunctional family interaction patterns, has supported findings from many treatment studies (Henggeler & Sheidow, 2012). O'Farrell and colleagues have extended their Behavioral Couple Therapy for alcoholism to a Behavioral Family Counseling version, which has yielded positive results in a pilot study for improving both substance use and relationship quality (O'Farrell, Murphy, Alter, & Fals-Stewart, 2010).

Psychoeducational behavioral family therapy for major mental disorders in both adolescents and adults, such as schizophrenia and bipolar disorder (Falloon et al., 1984; Miklowitz & Goldstein, 1997; Mueser & Glynn, 1995), includes components of: (a) psychoeducation concerning the etiology, symptoms, risk factors for symptom exacerbation (e.g., life stresses, including family conflict), and current effective treatments; (b) communication skill training; (c) problem-solving skills training; and (d) management of relapses and crises. These components are largely based on CBFT principles and procedures, which address family members' *cognitions* (providing them with a clear understanding of the causes and course of a disorder, fostering realistic attributions for causes of a family member's symptoms as well as realistic expectancies for the individual's current and future functioning), *emotions* (frustration, anger, anxiety, depression) that can contribute to "expressed emotion" regarding the individual with the disorder, and *behavior* (communication and problem-solving skills). Research conducted in several countries with families from various racial and socioeconomic groups has demonstrated the efficacy of this approach in reducing family stress and patient relapse (Baucom et al., 1998; Lucksted, McFarlane, Downing, Dixon, & Adams, 2012).

Thus, CBFT principles and methods have been adapted to the treatment of a variety of problems that families face in coping with forms of dysfunction in individual members and have demonstrated their effectiveness, including family of origin issues, such as estrangement (Dattilio & Nichols, 2011). Given this rapid growth in applications of CBFT, it is striking that little research has yet been conducted on CBFT for difficulties in the family as a whole, either in adapting to developmental life-stage changes (e.g., children reaching adolescence; issues arising from the formation of a stepfamily) or in coping with external stressors affecting the family (e.g., parental unemployment; the death of a family member). Furthermore, the versions of CBFT most often used have focused on the behavioral components, with considerably less attention paid to assessment and intervention with family members' cognitions that may be contributing to presenting problems. Unfortunately, the lack of research on CBFT, similar to the limited number of studies conducted on generic CBFT for couple relationship distress, is likely due at least in part to funding considerations, as funding priorities for extramural grants mostly focus on populations with particular psychiatric disorders or specific physical diseases (Dattilio, 2003). Given the compelling evidence that family processes have major impacts on members' psychological and physical well-being, there is a great need for more basic research on the effectiveness of CBT interventions for improving couple and family functioning.

Future Developments and Directions

Integration and Cognitive-Behavior Therapy

Therapists today are confronted with a broad range of theoretical orientations, more than at any other time in the history of family therapy, and at times proponents of different approaches have taken adversarial positions, proclaiming the superiority of their models to others (Dattilio, 1998). As noted earlier, the current empirical evidence tends to indicate that various theoretical approaches have comparable degrees of effectiveness, although most approaches have not as yet been tested or compared with others (Baucom et al., 1998; Sprenkle, 2012). In some respect, these circumstances provide the impetus for

therapists to explore integration of approaches to couple and family therapy, with the understanding that no one model fully captures the complexity of intimate human relationships. The findings regarding models' comparable effects also underscore the importance of studying common factors that contribute to the effectiveness of couple and family therapy across models (Sprenkle, Davis, & Lebow, 2009).

CBT has clearly come of age as an empirically established approach that is increasingly adopted by couple and family therapists (Dattilio, 2010). Because the cognitive-behavioral model has always been amenable to change, and because it shares with many other models of treatment an assumption that changes in family relationships involves shifts in cognitive, affective, and behavioral realms, it has great potential for integration with other approaches (Dattilio, 1998).

The flexibility and integrative potential of CBT with couples and families has been increasingly recognized in the family therapy field. For instance, in a national survey conducted by the American Association for Marriage and Family Therapy (AAMFT), couple and family therapists were asked to report "their primary treatment modality" (Northey, 2002, p. 448). Of the twenty-seven different modalities that were mentioned, the most frequently identified modality was cognitive-behavioral family therapy. More recently, a survey, partnered with Columbia University, reported that of the 2,281 responders, 1,566 (68.7%) stated that they most often use CBT in combination with other methods (*Psychotherapy Networker*, 2007). These data reflect the utility and effectiveness of CBT with couples and families. Recent developments in CBCT and CBFT more fully capture circular processes that involve cognitive, affective, and behavioral factors, as well as influences of broader contextual factors such as the family's interpersonal and physical environment (Epstein & Baucom, 2002). Some works have underscored CBT's integrative power in the treatment of individuals (Alford & Beck, 1997) and of couples and families (Dattilio, 1998, 2010). In turn, cognitive-behavioral therapists have increasingly integrated concepts and methods from other approaches; for example, concepts of system boundaries, hierarchy (control), and the family's ability to adapt to developmental changes emphasized in structural family therapy (Minuchin, 1974) are prominent in Epstein and Baucom's (2002) work with couples.

In general, it may not be plausible to integrate a cognitive-behavioral approach completely with various other models, due to some incompatibilities of the approaches' concepts and methods (see Dattilio, 1998, for a review). For example, solution-focused therapists largely eschew attention to current and historical aspects of families' presenting problems, instead emphasizing efforts toward implementing desired changes (see Nichols & Schwartz, 2013, for a review). Although cognitive-behavioral therapists also want to build on clients' existing strengths and enhance their problem solving, they assess and intervene with cognitive, affective, and behavioral aspects of problematic patterns that are often ingrained and difficult to change. Because negative responses are often over-learned, and research has demonstrated that family members' positive and negative actions tend to have independent effects on relationship satisfaction (Epstein & Baucom, 2002), cognitive-behavioral therapists assume that focusing on increasing positive behavior will often be insufficient to decrease negative patterns. Thus, practitioners of alternative approaches need to determine the extent to which cognitive-behavioral concepts and methods enhance or are counter to key aspects of their models. As researchers continue to empirically test the effects of adding interventions derived from other models, the potential for integration in clinical practice should grow.

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7.

STRUCTURAL FAMILY THERAPY

Jorge Colapinto

The distinctive features of Structural Family Therapy are its emphasis on the power of family and social context to organize individual behaviors, and the central role assigned in therapy to the family, as the generator of its own healing.

Development of the Model

Wiltwyck

Like the individuals and families that it endeavors to serve, Structural Family Therapy was shaped by the contexts where it developed. In the early 1960s Salvador Minuchin set up a family-oriented treatment program at the Wiltwyck School for Boys, a correctional facility located in upstate New York and serving young delinquents from poor New York City neighborhoods. *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) documents how the context of the institution inspired two seminal features of the model.

One of them was the attention paid to *family structure.* Wiltwyck's clients came from unstable, disorganized, and isolated families. Improvements achieved during the youngsters' stay at Wiltwyck tended to dissipate when they returned to their families (Minuchin, 1961). However, families from the same neighborhoods that did not have delinquent children showed more stable, consistent, and predictable interactions, and were more connected to others. The observation that families contribute to organize (or disorganize) the behavior of their members led to a therapeutic approach aimed at families rather than isolated individuals.

The other essential characteristic of Structural Family Therapy that emerged from the Wiltwyck experience was the reliance on *action* as the main vehicle for therapeutic change. The typical Wiltwyck client was "the ghetto-living, urban, minority group member who is experiencing poverty, discrimination, fear, crowdedness, and street living" (Minuchin et al. 1967, p. 22). Verbal, insight-oriented treatments did not fit the concrete and action-oriented style of their families. Role playing, in-home treatments, and other non-traditional "more doing than talking" approaches served as models for the development of alternative techniques (Minuchin & Montalvo, 1966, 1967). One example that would become a distinctive feature of Structural Family Therapy was the "enactive formulation" (later known as *enactment*), whose name derived from Bruner's (1964) classification of experiential modes.

> For instance, in one family session a therapist found himself under heavy attack. He then changed his seat and sat among the family members. Pointing to the empty chair, he said, "It was very difficult to be there being attacked by you. It makes me feel left out." The therapist might have described in words alone that he felt left out of the family; instead, he changed his seat to be among the family members and then commented on his feelings. He sensed that although his verbal statement would pass unnoticed by all but the most verbal members of the family, his "movement language" would be attended to by everyone.
>
> *(Minuchin et al., 1967, p. 247)*

The Wiltwyck experience also sensitized Minuchin to the power that *social context* exercises on families. "Is there a relationship," he posed, "between the undifferentiated communicational style at the family level, the inhibition of cognitive exploration in the child and his reliance on the adult as problem-solver, and at the social level, the undifferentiated mapping of the world by the poor, who are surrounded and trapped by institutions designed by and for the middle classes?" (Minuchin et al. 1967, p. 372). In retrospect, Minuchin would look at the Wiltwyck years as a reminder that therapy cannot solve poverty (Malcolm, 1978). Still, the knowledge gained at Wiltwyck informed structural strategies for empowering underorganized families (Aponte, 1976), and later led to the utilization of structural thinking and action to promote family-friendly changes in the procedures of child welfare organizations (Colapinto, 1995; Minuchin, Colapinto, & Minuchin, 1998).

Philadelphia Child Guidance Clinic

In 1965, Minuchin left Wiltwyck to assume the directorship of the Philadelphia Child Guidance Clinic. Serving a heterogeneous urban population, the facility made Structural Family Therapy available to a wider spectrum of families and problems. The Clinic's association with a children's hospital provided a context for the application of the structural approach to the treatment of psychosomatic conditions (Minuchin, Rosman, & Baker, 1978). Families of diabetic children who required frequent emergency hospitalizations were found to show patterns of enmeshment, overprotection, rigidity, and conflict irresolution, and family interventions proved more effective than individual therapy in helping patients manage their condition (Baker et al., 1975). Similar connections were found in cases of asthmatic children who suffered recurrent attacks or became excessively dependent on steroids (Liebman, Minuchin, & Baker, 1974c; Minuchin et al., 1975; Liebman et al., 1976, 1977), and in cases of anorexia (Liebman, Minuchin, & Baker, 1974a, 1974b; Minuchin et al., 1973; Rosman, Minuchin, & Liebman, 1975, 1977; Rosman, Minuchin, Liebman, & Baker, 1976, 1977, 1978).

Unlike the disorganized and unstable families of Wiltwyck, families with psychosomatic children tended to be too rigidly organized and too stable. In therapy, it was necessary to deconstruct the family's patterns, to allow for greater flexibility. Action techniques originally adopted in Wiltwyck to facilitate communication with "non-verbal" clients were now used to challenge clients who talked too much (Minuchin & Barcai, 1969). Thus Structural Family Therapy moved further away from the classical conception of therapy as a reflective, calm endeavor, protected from the untidiness of everyday relational life, and towards a more committed practice, where the therapist actively participated in the family drama, raising the emotional temperature as necessary to facilitate the transformation of established interactional patterns.

The wide variety of clinical experiences offered by the clinic helped expand the model and make it more precise. In 1972, in an article entitled "Structural Family Therapy," Minuchin formulated the approach's central concepts: dysfunction is located in the transactional context rather than on the individual; the present of the family is more relevant than its history; "reality" is constructed; therapy consists of realigning the transactional structure of the family. The classic *Families and Family Therapy* (Minuchin, 1974) develops these themes in detail and illustrates them with abundant clinical material.

In 1975 Minuchin left the position of director and set up the clinic's Family Therapy Training Center, which over the next years offered

workshops, conferences, summer practica, and year-long externships to practitioners interested in learning the model. As Minuchin recalls in *Family Therapy Techniques* (Minuchin & Fishman, 1981), teaching at the Center emphasized the specific techniques of Structural Family Therapy, and avoided "burdening the student with a load of theory that would slow him down at moments of therapeutic immediacy" (p. 9). However, Structural Family Therapy is not a collection of free-standing techniques; it is a way of thinking and a therapeutic stance (Colapinto, 1983, 1988). In recognition of this, the "technical" chapters in *Family Therapy Techniques* are prefaced and followed by conceptual frameworks that put techniques in their place. "Close the book now," Minuchin concludes. "It is a book on techniques. Beyond technique, there is wisdom which is knowledge of the interconnectedness of things" (Minuchin & Fishman, 1981, p. 289).

Family Studies and the Minuchin Center for the Family

In 1983, Minuchin left the Philadelphia Child Guidance Clinic and founded the Family Studies Institute in New York, from where he endeavored to apply the structural paradigm to the work with larger systems that impact the lives of low-income families. Thus he was returning to a concern of the Wiltwyck years, when he experienced the disempowerment of families by the very same agencies that seek to help them. The key structural notions of boundaries, coalitions, and conflict resolution were put to the task of changing the relationship between families and agencies, so that the families could retrieve their autonomy and resume responsibility for the welfare of their children (Minuchin et al., 1998).

Following Minuchin's retirement in 1993, Family Studies was renamed the Minuchin Center for the Family, which remains dedicated to the further development of Structural Family Therapy (Colapinto, 2006; Fishman, 1993, 2008; Fishman & Fishman, 2003; Greenan & Tunnell, 2003; Lee, Ng, Cheung, & Yung, 2010; Lappin & Reiter, 2013; Nichols & Minuchin, 1999; Simon, 1995, 2008) and of family-friendly programs in human services organizations (Colapinto, 1995, 1998, 2003, 2004a, b, 2007, 2008; Lappin, 2001; Lappin & VanDeusen, 1993, 1994; Lappin & Steier, 1997).

Theory of Family

Family Structure and Dynamics

> Family structure is the invisible set of functional demands that organizes the ways in which family members interact. A family is a system that operates through transactional patterns. Repeated transactions establish patterns of how, when, and with whom to relate, and these patterns underpin the system. When a mother tells her child to drink his juice and he obeys, this interaction defines who she is in relation to him and who he is in relation to her, in that context and at that time. Repeated operations in these terms constitute a transactional pattern.
>
> *(Minuchin, 1974, p. 51)*

The family's structure is the key to understanding behaviors, including problematic behavior. If a mother cannot get her child to obey, the structural therapist does not focus on psychodynamics ("She cannot assert her authority because of her low self-esteem"), but on context: both the mother's apparent ineffective parenting *and* her low self-esteem are part of a larger drama that includes her two children and a father who alternates between aloofness and authoritarianism.

At the most general level of organization, family structures range from *overinvolved* to *disengaged*. In overinvolved families there is excessive closeness among the members. Indicators include communication entanglement, exaggerated worry and protection, mutual loyalty demands, lack of individual identity and autonomy, and paralysis in moments of transition when novel responses are needed. "The family system is characterized by a 'tight interlocking' of its members. Their quality of connectedness is such that attempts on the part of one member to change elicit fast complementary resistance on the part of others" (Minuchin et al., 1967, p. 358). At the other end of a continuum, disengagement denotes a lack of mutual support, underdevelopment of nurturing and protection

functions, and excessive tolerance of deviant behavior. "Observing these families, one gets the general impression that the actions of its members do not lead to vivid repercussions. Reactions from the others come very slowly and seem to fall into a vacuum. The overall impression is one of an atomistic field; family members have long moments in which they move as in isolated orbits, unrelated to each other" (Minuchin et al, 1967, pp. 354–355).

There are not "purely" enmeshed or disengaged families. Typically, families exhibit both enmeshed and disengaged areas of transaction. Early in the development of the model, Minuchin articulated enmeshment and disengagement as two phases of one process:

> Usually the mother has been exhausted into despair and helplessness by her need to respond continually in terms of "presence control." She has been so overburdened that by the time the family comes to the community's attention, all one can witness is an overwhelming interactional system in which the mother attempts to resolve her plight by fleeing into absolute abandonment or disengagement from her children . . . Unaware that this state of affairs was part of a natural process, we centered our attention primarily on the apparent disengagement, the relinquishment of executive functions, until we fully realized the other strains, reflected in the enmeshment processes discussed previously.
>
> *(Minuchin et al., 1967, p. 215)*

Various *subsystems* coexist within the family: the parents, the siblings, the females, the males. Each family member participates in several subsystems: husband and wife form the spouse subsystem, which constitutes a powerful context for mutual support—or disqualification. They also participate with their children in the parental subsystem, organized around issues of nurturance, guidance, and discipline. The children, in turn, are also members of the sibling subsystem, "the first social laboratory in which children can experiment with peer relationships. Within this context, children support, isolate, scapegoat, and learn from each other" (Minuchin, 1974, p. 19).

Boundaries define who interacts with whom about what. A boundary can be depicted as an encircling line around a subsystem that shields it from the rest of the family, allowing for self-regulation. Children should not participate in the spouse subsystem so that the parents can work through their conflicts. The sibling subsystem must be relatively free from parental interference so that the children can accommodate to each other. Like the membrane of a cell, good boundaries are defined well enough to let the members of a subsystem negotiate their relationship without interferences, but also flexible enough to allow for participation in other subsystems. "If the boundary around the spouses is too rigid," for instance, "the system can be stressed by their isolation" (Minuchin & Fishman, 1981, p. 57).

The *hierarchy* of a family reflects differential degrees of decision-making power held by the various members and subsystems. In a well-functioning family, the parents are positioned above their children—they are "in charge," not in the sense of arbitrary authoritarianism, but in the sense of guidance and protection: "Although a child must have the freedom to explore and grow, she will feel safe to explore only if she has the sense that her world is predictable" (Minuchin & Fishman, 1981, p. 19). While some form of hierarchical arrangement is a condition of family functioning, families can function with many different kinds of hierarchy. "A parental subsystem that includes a grandmother or a parental child can function quite well, so long as lines of responsibility and authority are clearly drawn" (Minuchin, 1974, p. 54). Hierarchical patterns that are clear and flexible tend to work well; too rigid or too erratic patterns are problematic—in one case the children's autonomy may be impaired, in the other they may suffer from a lack of guidance and protection.

The various positions that family members occupy in the family structure—the lenient and the authoritarian, the passive and the active, the rebellious and the submissive—*fit* each other, like pieces in a jigsaw puzzle. *Complementarity* is the concept that denotes the correspondence of behaviors among family members. It may be a positive feature, as when parents work as a team, or a problematic one, as in some authoritarian/

lenient combinations. Although the notion of complementarity may appear to be synonymous with that of circular causality, there is an important difference. Circular causality designates a *sequential* pattern that can be represented with a series of arrows (A→B→C→A), while complementarity refers to a *spatial* arrangement: A's, B's and C's shapes fit each other. The difference is not trivial; it underlies the structural therapist's preference for tackling *spatial* arrangements (literal and metaphorical) among family members, rather than *sequences* of behavior. A mother explains: "I have to be extra soft with Andy because Carl is so rough, they need to have somebody who does not scare him." Carl reciprocates: "I have to be firm because Anne lets Andy run all over her."

Family Development

Structural Family Therapy views the family as a living organism, constantly developing and adapting to a changing environment. Distinctive of structural family therapy is the use of biosocial metaphors—taken from Lewis Thomas' essays on animal life, Arthur Koestler's *holon*, Ilya Prigogine's theory of change in living systems—rather than physical models to describe family dynamics. The chapter on families in *Family Therapy Techniques* opens with a quotation from Thomas: "There is a tendency for living things to join up, establish linkages, live inside each other, return to earlier arrangements, get along whenever possible. This is the way of the world" (Thomas, 1974, p. 147).

The family structure develops over time, as family members accommodate mutually to each other's preferences, strengths, and weaknesses. "The origin of these expectations is buried in years of explicit and implicit negotiations among family members, often around small daily events. Frequently the nature of the original contracts has been forgotten, and they may never have even been explicit. But the patterns remain—on automatic pilot, as it were—as a matter of mutual accommodation and functional effectiveness" (Minuchin, 1974, p. 52). In accounting for the development of family patterns, the model privileges current context over history, and the history of the current family over the childhood experiences of the parents. The family's relational patterns are not seen as a mirror replication of those of previous generations, or as having been fixed in the parents' early life, but as the result of the continuous process of transformation and adaptation that turned yesterday's children into today's adults.

As a biosocial system, the family must maintain stability while at the same time transforming itself. *Homeostasis* designates the tendency to conserve the family's relational structure. Once the complementary roles of Anne, Andy, and Carl have been set, deviations from the script will be countered by corrective movements. "I do try to ignore Andy's demands sometimes," says Anne; "but then Carl starts to roll his eyes and I end up giving in for the sake of peace." Homeostasis, however, does not fully describe the family: counterdeviation moves notwithstanding, the family system tends to evolve toward increasing complexity. *Adaptation* designates the ongoing change of the family structure in response to needs generated by its own evolution—members are born, grow, develop new interests, leave—as well as by changes in its milieu—a move to another town, a change or loss of job, divorce, remarriage, a marked improvement or deterioration in the financial situation of the family. In the process, boundaries are redrawn, subsystems regroup, hierarchies shift, relationships with the extrafamiliar are renegotiated. For instance, when children reach adolescence and the influence of the peer group grows, issues of autonomy and control need to be renegotiated.

In well-functioning families, adaptation triumphs over homeostasis. These families can mobilize coping skills that have remained hidden underneath established complementary patterns. Faced with an increasingly demanding and rebellious Andy, Anne may bring into play the assertiveness that she demonstrates in other relationships; Carl may allow his tender side to show through the apparent gruffness. A well-functioning family is not defined by the absence of stress or conflict, but by how effectively it handles them as it responds to the developing needs of its members and the changing conditions in its environment. Conversely, a family becomes

dysfunctional when homeostasis trumps adaptation. The family then gets "stuck" in a relational structure that no longer works. Anne, Carl, and 12-year-old Andy continue dealing with each other as they did when Andy was 5. Structural explanations for a family's inability to adapt range from unawareness—the dysfunctional patterns persist by inertia because family members cannot think of alternative ways, or do not see how they are connected to the presenting problem—to conflict avoidance—family members fear the consequences of bringing the conflict into the open.

The Individual in the Family

The family is the "matrix of identity" (Minuchin, 1974, p. 47), the primary context where children develop their selves as they interact with parents, siblings, and other family members.

> The child has to act like a son as his father acts like a father; and when the child does so, he may have to cede the kind of power that he enjoys when interacting with his younger brother. The subsystem organization of a family provides valuable training in the process of maintaining the differentiated "I am" while exercising interpersonal skills at different levels.
>
> *(Minuchin, 1974, pp. 52–53)*

As this process unfolds, some individual traits are selected and others discouraged. But the latter remain latent, potentially available to be activated within future contexts. "The individual's present is his past plus his current circumstances. Part of his past will always survive, contained and modified by current interactions" (Minuchin, 1974, p. 14). The resulting image of the adult individual differs from the traditional psychodynamic one. The self is not visualized as a series of concentric layers surrounding a core of identity ("She *is* passive"), but as a "pie chart" where "passivity" represents one slice and coexists with others—including an "assertive" one (Colapinto, 1987). Qualities that may not manifest within one context, may be shown in others. Anne's ineffectiveness with Andy is not seen as the manifestation of deep-seated low self-esteem, but as part of her role within her family. Anne may appear incompetent in the presence of her husband, Carl, but not when alone with the children. She may think poorly of herself in the context of her family, but be self-confident with her colleagues at work. Carl may be a heartless disciplinarian when responding to conflict between and Andy and Anne, but show a tender side when playing with the children. Andy may display more maturity when functioning as the older sibling than when relating to his parents.

Theory of Therapy

The pie metaphor is an essential ingredient of the structural approach to therapy. The viability of the therapeutic endeavor rests on the assumption that even when families get "stuck" in their development, the potential for a resumption of growth is still inherent in the family itself—in the areas of the individual selves that have become deselected through a history of mutual accommodations. The structural therapist believes that there is more than meets the eye—that the overanxious parents are able to draw a boundary around their conflicts, the inconsistent mother to persevere, the distant husband to show affection, the depressed wife to engage in an interaction—if the relational patterns that block the actualization of those potentials are removed.

Four tenets of Structural Family Therapy derive from this premise. *First*, the family is not a mere recipient but the *protagonist* of therapy—its own change agent. Regardless of how much or how little responsibility it has for creating the problem, the family always possesses the keys to the solution. The practice of Structural Family Therapy does not require the physical presence of the family at all times, but it does require that the therapist "think" family, even when working with subsystems or even the individual child or the individual parent.

Second, the job of the therapist is to *catalyze* change, to help the family recover the "slices" that have been historically deselected. A structural arrangement that renders an "ineffective" mother and an "authoritarian" father is not good; better aspects of the respective selves must be

retrieved. This requires a proactive stance; the structural therapist cannot afford the comfortable position of the neutral observer, but must actively influence the family. When structural therapists set up enactments, prescribe changes in the seating arrangement, block family members from interrupting a transaction, unbalance, or induce crises, they are not just applying disembodied techniques. They are using themselves as the primary instrument of change.

Third, therapeutic change proceeds *from the relation to the individual*; change in interactions is a condition of psychological change rather than the other way around. It is not necessary for Anne to work through the historical roots of her low self-esteem before she can become a competent parent; if Carl does not interfere in her relationship to Andy, she can actualize her latent competency. The structural therapist "confirms family members and encourages them to experiment with behavior that has previously been constrained by the family system. As new possibilities emerge, the family organism becomes more complex and develops more acceptable alternatives for problem solving" (Minuchin & Fishman, 1981, p. 16).

Fourth, the therapist must help families develop new patterns—not just dismantle the old ones. The structural therapist does not endeavor to extricate individuals from family binds, but to make those binds more nuanced, allowing for both belonging and differentiation. When the therapist encourages more distance between a mother and a child, it is not to isolate either one, but to make room for them to participate in other subsystems—child/father, wife/husband, child/siblings. Restructuring techniques are rooted in the belief that individual differentiation is not achieved through retrenchment into oneself, but through participation in multiple subsystems. The goal is not the self-sufficiency of the "rugged individual," but the mutual reliance of the network.

The Therapeutic Process

Structural therapists relate to their client families in three modes—joining, assessing, and changing patterns of interaction—that can only be separated artificially. They assess as they join, intervene as they assess, and tend to their joining as they intervene.

Joining

In joining mode, the therapist gains the acceptance of the family, as a temporary member with permission to influence the system from within. The therapist is in a better position to identify, question, and help expand the transactional patterns of the family if he or she experiences them "from the inside." Joining is "the glue that holds the therapeutic system together" (Minuchin & Fishman, 1981, pp. 31–32).

Joining is a stance more than a technique. It involves respectful curiosity; respect for the rules that govern distances and hierarchies within the family—for instance, addressing the parents before the children; sympathy toward expressions of concern, sadness, anger, fear, even rejection of therapy; sensitivity to corrective feedback, and trust in the latent strengths of the family.

But joining is not just being supportive of the family. The therapist needs to be accepted, but not to the point of becoming totally *inducted* into the family and rendered impotent to help. To communicate that therapy can make a difference, joining must include some measure of differentiation from the family. This may consist of a challenge to the family's presentation of the problem ("You say that you have had it with your son, but as I listen to you it is clear that you are very concerned for him"). Or the therapist may subtly join with the less dominant family members, adopting their language or mimicking their mood. Support and challenge need to balance each other, so that the efforts to make a difference do not alienate the family. The therapist's challenging interventions are probes; if the family rejects a challenge, the therapist pulls back and tries a different route.

Assessment

In Structural Family Therapy, assessment neither follows joining nor precedes interventions, but coexists with both. The therapist learns about the family as he or she joins them, and the tone and content of the inquiry is already an intervention.

Assessment begins before the first face-to-face meeting with the clients, through a preliminary *mapping* of the family system: Who are the members? What are their genders and ages? How are they related? Answers to these questions convey preliminary information about the "shape" of the family—whether it is a single-parent family, a one-child family, a reconstituted family; whether it includes babies, teenagers, or elderly parents.

When meeting with the family, the therapist *tracks* their interactions looking for patterns, paying attention to the process being displayed more than to the verbal content. "When a family member is talking, the therapist notices who interrupts or completes information, who supplies confirmation, and who gives help" (Minuchin & Fishman, 1981, p. 146). The therapist may also observe that a mother and daughter do not relate as such but more like siblings, that the parents do nothing when the children run around the room, that a grandmother caresses her granddaughter while talking disapprovingly of the child's mother. Gradually the map becomes populated with information about "coalitions, affiliations, explicit and implicit conflicts, and the ways family members group themselves in conflict resolution. It identifies family members who operate as detourers of conflict and family members who function as switch boards" (Minuchin & Fishman, 1981, p. 69).

Sharing the assessment with the family ("I can see that your daughter responds differently to each one of you") introduces another element of challenge, as the problem is *reframed*; the parents who brought to therapy an "uncontrollable" daughter are shown that the girl fights with the mother but promptly obeys the father. "Families present themselves as a system with an identified patient and a bunch of healers or helpers. But when they dance, the lens widens to include not only one but also two or more family members. The unit of observation and intervention expands. Instead of a patient with pathology, the focus is now a family in a dysfunctional situation. Enactment begins the challenge to the family's idea of what the problem is" (Minuchin & Fishman, 1981, p. 81). It can also provide, both to the family and to the therapist, evidence of the family's latent strengths ("You told your daughter to put that toy back, and she did.").

In addition to tracking the spontaneous transactions of the family, the therapist can also direct them ("Discuss that with your wife, and make sure that your daughter doesn't distract you.").

> When the therapist gets the family members to interact with each other, transacting some of the problems that they consider dysfunctional and negotiating disagreements, as in trying to establish control over a disobedient child, he unleashes sequences beyond the family's control. The accustomed rules take over, and transactional components manifest themselves with an intensity similar to that manifested in these transactions outside of the therapy session.
>
> *(Minuchin & Fishman, 1981, p. 78)*

Here-and-now tracking can be complemented with an inquiry about events at home, the "there-and-now" ("What happened this morning, before you all decided that Carlos was not going to school?"), and also extended into the past, the "there-and-then." In accordance with structural theory, the development of the current family is granted more relevance than the childhood experiences of its adult members, Anne's weak parenting may be a response to her perception of her husband as "rough," which in turn has grown from their shared experience as a couple—"He has a temper," she has learned over the years. Tracking family history can also uncover forgotten strengths: "How did you manage to raise the children by yourself before you remarried?"; "What was most enjoyable about spending time with your son, before he started to go out with friends you don't like?"

Unlike some other systemic approaches, Structural Family Therapy recognizes the need for individual assessment of the family members. "The systems model could carry the practitioner into rigidities that mirror the mistakes of linear therapists, denying the individual while enthroning the system" (Minuchin et al., 1978, p. 91). But the structural assessment of the individual differs from traditional forms. Following the pie metaphor, the structural therapist does not look for what the individual "is," but for her or

his different ways of being in different subsystems. What kind of a husband is he to his wife? A father to his son? A son to his mother? And more importantly, how else could he be, what are the qualities that have been deselected in the course of the family's development?

Changing Patterns of Interaction

Structural family therapists promote change in families through two kinds of interventions: *challenging* existing patterns of transaction, and supporting the *enactment* of healthier patterns. Blocking a father's interference in the relationship between mother and children ("Let your wife handle it.") goes hand in hand with the encouragement of a different interaction ("You said that you would like the children to play with the puppets—make it happen.").

Challenging is not to be confused with flexing muscles. Although some rigid patterns may call for intense confrontation, in most situations the challenge is more subtle. It can consist of any intervention that makes it difficult for the family to continue engaging in its usual modes of transaction: "Discuss this with your wife and don't let your daughter distract you"; "Don't check with your mother when you are talking to your father." What is being challenged are not the motives of the participants, but the constricting patterns of relationship that prevent the actualization of their potentials, and the belief that those are the only possible ways of relating.

A challenge must satisfy three conditions:

1. *Joining.* The family needs to trust the therapist before they can accept the challenge; the therapist must feel comfortable with the family before he can challenge, and be sensitive to the corrective feedback that that may come.
2. *Purposefulness.* The therapist must be clear about the direction of the structural change that is being sought. "The only thing I can do," says the mother, "is go there and stay playing with them." "No, do it so that the children are involved in playing there and you are here, with your husband and me. Make a difference between the children who play and the adults who talk."
3. *Conviction.* The therapist must believe that the expected change is possible. Challenging the Anne/Carl/Andy pattern will not succeed if not supported by the therapist's confidence that Anne can handle Andy without Carl's intervention. This does not need to be a leap of faith—it can be based on evidence gathered in the course of tracking.

The therapist's direct intervention in the family process being played out in the session best expresses the model's preference for *enacting* healthier patterns of interaction rather than just talking about them. *Boundary making* is a form of enactment where the therapist modifies patterns of proximity and distance by directing some members to participate in a transaction, and excluding others. This disrupts the operation of conflict avoidance patterns, and encourages the emergence of underutilized skills within the subsystem in question—such as a couple that is being protected from interruption from the children, or children who are being protected from interruption from the parents.

Examples of boundary making are the prescription of a rearrangement of chairs that results in the formation of a group of people facing each other and giving their backs to the rest, or asking a family member to watch in silence from one corner of the room or from behind a one-way mirror.

Sometimes just getting two members of the family to interact without interference from others is sufficient to allow for the emergence of new patterns: siblings, for instance, can develop their own way of solving their conflicts without parental arbitration. More often, the therapist must intervene actively on the process, prolonging the duration of a dyadic interchange, raising a hand or standing between people to block interruptions or distractions, removing an empty chair between spouses, or changing the composition of the bounded subsystem. The therapist can also create enactments "from scratch." If the family includes a mother who appears to have no control over her children and to depend on the father for law and order, the therapist may set up a scenario that requires the mother to organize the children's play, and then block the rescuing

attempts of the father until mother succeeds in her own way.

The structural therapist does not prescribe what to say and do; the mother will not get instructions on *how* to organize the children's play—not even elementary tips such as the observation that it is virtually impossible to organize the play of two active toddlers without leaving one's chair. In accordance with the pie metaphor of the self, the development of new patterns of transaction does not require teaching the clients new skills, but just setting up a context where they can or must actualize skills that have been so far deselected in the course of the family's process. It's not that mom doesn't know that she has to get up from her chair; but that usually she doesn't need to, because her husband takes over. However, the structural therapist does comment on the enactment, not by way of prolonged interpretations, but by *punctuating* stumbling blocks ("She gave you that look again and you dropped the issue.") and successes ("Good, now you got the children to play on their own and we can resume our conversation.").

Intensity

To sustain an enactment, the therapist needs to resist the pull of the family's established ways. If the mother makes only a feeble attempt to organize the children and turns to the therapist for conversation, the therapist may answer by reminding her of the task at hand: "You said you wanted the children to play by themselves." Depending on how rigid the family patterns are, the therapist may need to be more or less active. Encouraging clients to try behaviors that upset the equilibrium of the family requires tolerance to the natural intensity of family life, and readiness to increase that intensity when needed.

> The therapist's intervention can be compared to an aria. Hitting notes is not enough. The aria must also be heard beyond the first four rows. In Structural Family Therapy, "volume" is found not in decibels but in the intensity of the therapist's message . . . when family members show in a session that they have reached the limit of what is emotionally acceptable and signal that it would be appropriate to lower the level of affective intensity, the therapist must learn to be able not to respond to that request, despite a lifetime of training in the opposite direction.
>
> *(Minuchin & Fishman, 1981, pp. 116–118)*

Extending the time of an enactment (waiting for the mother to organize the children) and repeating a message ("You said you wanted the children to play by themselves.") are relatively simple ways of raising intensity. When more is needed, it can be achieved through *unbalancing*—for instance, by supporting a devalued family member against another. In this case "the family member who changes position in the family by affiliation with the therapist does not recognize, or does not respond to, the family signals" (Minuchin & Fishman, 1981, p. 162).

The most intense intervention is the *crisis induction*, the purposeful creation of a situation that forces the family to face a chronically avoided conflict. The crisis is induced "by allowing a pattern that has been repeated often at home to play itself out in the concentrated time of the therapeutic session" (Minuchin et al., 1978, p. 167), and then intervening forcefully. In a lunch session with the family of an anorectic adolescent, as parents and daughter stage a three-way fight over whether and how much the daughter should eat, the therapist confronts the parents: "The problem here is you two! You say, 'You should eat,' and you say, 'You shouldn't eat.'" After having each parent try separately to get the daughter to eat—and fail– the daughter is declared the victor and the parents' shared defeat serves to draw a boundary around the spouse subsystem: "Well, you know you are on a really difficult boat. You will get out of this boat only by pulling together." The parents leave "feeling the continued seriousness of the situation, but also, with a feeling of something accomplished, and of hope . . . They now felt that they were dealing with a conflict between an adolescent girl and her parents, rather than with a mysterious individual disease" (Minuchin et al., 1978, p. 180).

An enactment, no matter how intense, does not bring about change by itself. A challenging

intervention such as "The problem here is you two!" shakes the family out of their homeostatic arrangement and opens new possibilities—in this case the daughter, following the session, asked for a big meal and ate everything—but consolidating the structural change—thickening the boundary around the parental subsystem, making more room for an adolescent's autonomy, shifting to a different way of negotiating power and control—requires more work. New ways of relating need to be experienced repeatedly until they hold; each successful enactment contributes to the expansion of the family's repertoire, showing that change is possible and what it might look like.

Case Example

Sonia, a 35-year-old single mother, had lost custody of her four children due to her use of drugs. When she became pregnant with her fifth child, Sonia tested positive again but then entered a rehabilitation program that offered her a chance to keep the baby. Because the program had a family orientation, Sonia was able to maintain regular if infrequent contact with her other children, and develop a relationship with their temporary custodians. After giving birth and successfully completing the program, Sonia set out to reconstitute her family.

The first child to return was Tanya, by then 8 years old. However, within a few weeks Sonia started to complain that the stress of dealing with Tanya was "jeopardizing my recovery." She felt that Tanya should return to foster care, but was persuaded by her social worker to have a family consultation.

Paula, the social worker, reported that Sonia had grown up in three different foster homes herself, not forming strong bonds in any. "Deep down," said Paula, "she doesn't want to be a mother, because she wasn't mothered herself. She has unrealistic expectations of Tanya, basically wants to be left alone." Upon graduating from the program, Sonia was referred to an individual therapist to work on her "attachment issues," but dropped out after a few sessions.

I met six times with Sonia, her children, Paula, and workers from the agencies involved with the other children.

In the first session, Sonia explains her predicament: "Tanya is getting on my nerves. She doesn't do anything by herself. When she first came back she was so independent, she would comb and wash herself. Now I have to do it." As Sonia talks in a detached, impatient tone, Tanya sits downcast across the room. Meantime, her older sister stands next to Sonia, the youngest circulates between her mother and the workers, and the two boys busy themselves on the blackboard.

While Sonia's statement may sound to Paula as evidence of Sonia's "attachment issues," I look at it in the context of the family's developmental history—or lack thereof—and its relation to the larger structure or the child welfare system. Sonia and her children have not been together as a family long enough to develop stable patterns of interaction. Years ago the child protection agency granted Sonia a sort of "leave of absence" from parenting, so she could focus "on her own needs"—meaning the need to be sober, but not the need to raise her children. As her children adapted to life elsewhere, Sonia did not have a chance to hone her parenting skills; actually, her substance abuse counselors encouraged her to focus exclusively on her recovery and not be distracted by anything that might interfere with compliance with the program—including her children. Given this context and history, there is no need to blame the difficult reunification on Sonia's childhood experiences.

Paula challenges Sonia, reframing Tanya's behavior while at the same time recognizing that Sonia *can* be nurturing: "Don't you think that maybe Tanya is trying to get some nurturance from you, the same you give Tina?" Sonia protests: "But I do that! Sometimes I baby her!" So, I think, not all is clinginess and irritation—there is more in the pie than meets the eye. I ask for a description of the different pattern: "How do you baby her?" "I let her come to my bed, I hold her, I caress her," answers Sonia, her voice shifting from harsh to tender.

Is Sonia describing "good" nurturance, or "bad," regressive enmeshment? Paula, interested in Sonia's inner experience, cautiously poses a neutral question: "How do you feel about that?" Almost simultaneously, making a judgment that at this moment in the development of the family

closer contact is good, I ask for an enactment: "Can you show how you baby her?"

Sonia summons Tanya to her lap, initiating an affectionate interaction that the rest of us witness. Eventually the other children converge on the dyad, forming a tight group around Sonia. When Paula tries once again to explore feelings, I playfully block the move: "Would you like to be there too?" I want to extend what I see as the family's enactment of reunification. For the duration of the sequence, Sonia is not a recovering addict who happens to have children, but a mother who happens to be recovering from addiction. The family spontaneously starts reminiscing about their life years ago, before the children were removed from Sonia's care. They talk about food, play, sibling rivalry. Sonia is pleasantly surprised: "How can you remember so much? You were so little."

Again, one enactment is not enough to correct a dysfunctional pattern. But it does provide the family and the therapist with the evidence that alternative ways of relating are within the family repertoire. Even if Sonia reverts to a preference for more distance from her children, they may refuse to allow it. "Cut it out! Leave me alone!" says Sonia, but she is laughing and keeps her arms around them. "Why are you all over me?" "Because," says one of the children, "you're our mom!"

There was no more discussion of a possible return of Tanya to foster care. The remaining sessions framed the problem as one of a difficult transition rather than individual deficits, and featured additional "enactments of reunification"—discussions of the children's school and social life, stories about the extended family, planning for the return of the remaining children. A recommendation was made, and followed, to accelerate the pace of reunification and support it with home-based services, which required coordination and collaboration among the various agencies that were involved in the life of the family.

The road for Sonia and her children was not without its bumps. Cory, the oldest son, eventually became truant and got involved with older teenagers that the school suspected of dealing drugs. This time, however, Sonia did not threaten with an expulsion from the family but called Paula ("I am having another of those transitions," said Sonia), who helped her reassert parental leadership over Cory.

"Development," Minuchin reminds us, "always involves new challenges, new contexts, and inevitable periods of disequilibrium while individuals and social systems find new patterns of adaptation." Some families and individuals are able to continue to cope and change.

> Out of some mixture of competence in their own makeup, paralearning from the therapy, and fortunate circumstances in their outside life that support the transition [while others] need intermittent help as they move into new circumstances, away from the family, at least until viable mechanisms for negotiating change in new contexts are learned . . . This model of continued treatment is analogous to the practice of the family practitioner, who is available as issues arise. In the long run, it seems an economic approach to therapy.
>
> *(Minuchin et al., 1978, pp. 202–203)*

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8.

PSYCHODYNAMIC APPROACHES TO COUPLE AND FAMILY THERAPY

Janine Wanlass and David E. Scharff

Introduction

Psychoanalytic approaches to couple and family therapy emphasize listening for and responding to unconscious material, understanding the role of early relationships in partner selection and family communication, identifying intergenerational contributions to family difficulties, exploring shared familial defensive strategies, employing interpretation to foster the development of insight about family patterns and projective processes, and working with transference and countertransference reactions to illuminate family dynamics. Unlike individual psychoanalysis, the "patient" is the family system as a whole, comprising combined individual histories and sets of interpersonal relationships that support and inhibit family growth across each family's unique developmental trajectory. In the family therapy setting, repressed feelings and behavior rooted in earlier experiences with families of origin are repeated. As family members together develop conscious understanding of these past experiences, fixed projective processes can become more adaptive and fluid, unresolved painful feelings can be expressed and addressed, and problematic internal representations can be reworked in a manner that facilitates improved family functioning.

In this chapter, we will briefly review the shared components of psychodynamic approaches to couple and family therapy, describe a contemporary object relations perspective on couple and family treatment, provide clinical vignettes and discussion to illustrate this treatment method, and describe the potential benefits and common challenges for families and therapists working from a psychodynamic perspective.

History and Background: Early Beginnings

Psychoanalytic approaches to couple and family therapy share a common beginning and battle similar widely held misperceptions. Certainly, the work of Sigmund Freud is the starting point for this theoretical perspective, and many of Freud's ideas and techniques are applicable to contemporary practice. Several of the early pioneers in family therapy, such as Ackerman, Bowen, Minuchin, Selvini-Palazzoli, Shapiro, Watzlawich, Wynne, and Zinner, graduated from analytic training programs. Satir was influenced by the Chicago Institute of Psychoanalysis, Jackson, Riskin, Andolfi, and Byng-Hall completed some analytic training,

and Rycoff and Wynne incorporated the work of Harry Stack Sullivan in their understanding of family dynamics. Although some disavowed their early analytic beginnings to establish their own family therapy approaches, the residue of their early training is apparent in their ideas about family functioning and proposed mechanisms of psychic change (J. Scharff, 1995).

Freud's technique papers (Freud, 1911, 1912, 1913, 1914, 1915) and clinical writings offer general guidelines useful to couple and family practitioners. He emphasized a way of listening to our patients in which we attend to both non-verbal and verbal communications, remaining open to the multiple meanings and points of view. He posited the value of uncovering and responding to unconscious material as it emerges in the mind and body of the patient and therapist. Freud viewed therapeutic change as an outcome of the patient's ability to develop insight, promoting greater understanding of self and other, and freeing one from the pulls of unconscious repetition. Such insight was accomplished by the interpretation and working through of intrapsychic conflict expressed in free associative material, patient resistances, dream sequences, fantasies, and the transference relationship. He advocated tracking the affect during a session, which serves as a clue to underlying unresolved conflicts emerging from the patient's history (Scharff & Scharff, 1987, 1998). Although devised from individual analysis, these ideas remain applicable to family contexts.

However, some aspects of classical analytic theory hindered its acceptance and usefulness in systemic family work. For example, the emphasis on instincts that demand gratification or management to comply with social norms offered a narrow view of development. The centrality of the infant's sexual and aggressive drives as the primary motivating force within the personality negated the importance of parent/infant attachment and family relationships on personality formation. Additionally, classical psychoanalytic approaches were based on a restricted clinical population, an "abnormal" norm, creating the potential to overpathologize ordinary experience and emphasizing deficiencies over adaptive strengths. The characteristics of healthy family relationships, important for clinicians as a point of contrast in assessing psychopathology, remained largely unexplored and unarticulated. Similarly, the privileging of the intrapsychic over interpersonal, social, and cultural influences on psychic structure oversimplified the complexity of human experience and supported individual psychoanalysis and psychotherapy as the exclusive route for therapeutic change.

The pervasive dominance of classical Freudian theory and its relentless focus on the intrapsychic left little room for theorists who valued interpersonal phenomena, prompting some pioneering family therapists in the United States to venture outside traditional analytic practice (Scharff & Scharff, 1987). For example, Ackerman (1938, 1966) moved treatment from an individual focus to a family unit focus, incorporating ideas from systems theory to explore intergenerational conflicts, stages of family development, and social influences on family functioning. Believing that marital difficulties often resulted from early relationship problems with parents, Framo (1976) developed family-of-origin treatment, bringing two generations of family members into the therapy room to resolve past issues influencing present conflicts. He focused almost exclusively on the parental marital relationship as the solution to family problems. Similar to Sullivan (1953), Ackerman and Framo expanded the therapeutic focus from the intrapersonal to the interpersonal realm, arguing that therapeutic change could not be accomplished through individual intervention alone. Along with other prominent voices in the developing family therapy field like Minuchin (1974) and Haley (1971), emerging psychodynamic family therapists demanded a broader theoretical lens that embraced systemic factors, both for their etiological contribution and as an avenue for change (Scharff & Scharff, 1987).

Such criticisms regarding the limited applicability of classical psychoanalytic theory to a family therapy context have been further amplified by prevalent and popular misperceptions of analytic clinical practice. For example, a common

stereotype of an analyst is a neurotic, withholding, silent figure that interacts distantly and minimally with the patient—a blank slate for the patient's projections. Although this was certainly true of many analysts seeing individual patients in the past, such an approach is neither typical nor recommended in current analytic practice. More recently, the valuing of brief, empirically based treatments created yet another attack on analytic therapies as expensive, unending, unfocused, and lacking empirical support. Although Shedler (2010) effectively and comprehensively refuted such claims about treatment efficacy, his research findings are not widely known. Analysts themselves have contributed to this plethora of misinformation in their general reluctance to pursue empirically based research (Fonagy, 2003) and explain in ordinary language how psychoanalytic therapy works. Current research is making up for lost ground, not only in substantiating the efficacy of psychodynamic therapy for individuals, but also now in regard to couples (D. Hewison, Tavistock Centre for Couple Relationships. Personal communication, 2013).

Contemporary psychoanalytic couple and family therapy has gravitated toward object relations approaches, which counter the restrictive intrapsychic focus of classical Freudian theory, offer a perspective more conducive to couple and family work, and confront public misperceptions of the limited usefulness of analytic treatment. An object relations approach to couple and family work combines aspects of traditional psychoanalytic object relations theory, attachment theory and research, link theory, psychodynamic group theory, chaos theory, developmental theory, and systems theory. Fairbairn's relational theory of intrapsychic structure, Bowlby's findings about attachment relationships, Winnicott's ideas about the centrality of the mother–infant relationship, Klein's concepts of projective and introjective identification, Bion's thinking about containment and group functioning, Dicks' construct of the joint marital personality, and the intergenerational influences of link theory first articulated by Pichon-Rivière and extended by Kaës are used to conceptualize and understand family dynamics (Scharff & Scharff, 1987, 1991, 2011).

Primary Theoretical Constructs

Consistent with contemporary psychoanalytic models of couple and family treatment, object relations theory uses the therapist–patient relationship to understand early relational influences on the formation of internal psychic structure and examines how those individual structures interact within a systems framework in both adaptive and maladaptive ways (Scharff & Scharff, 1987, 1991, 2005). To provide a basis for understanding contemporary psychoanalytic couple and family therapy, the guiding central theorists and core concepts of will be presented.

Fairbairn's Relational Theory of Psychic Structure

Ronald Fairbairn believed that infants are born with a fully formed ego, prepared both to relate and to seek autonomy within their family system (Fairbairn, 1944). The child's inner world and internal self-structure is formed and organized through experiences with primary objects and the defense mechanisms of splitting and repression. Fairbairn posited three categories of internal object relationships within the self: (1) the ideal object or central ego relationship, which exists in our conscious awareness and provides feelings of confidence and satisfaction; (2) the rejecting object relationship, which is repressed in our unconscious and associated with feelings of hate, anger, rage, sadness, and hurt; and (3) the exciting object relationship, found in our unconscious and associated with feelings of neediness and longing (Fairbairn, 1963: Scharff & Scharff, 2005).

Each object relationship contains internalized representations of an external object, part of the individual's own ego, and the affects associated with these self-other experiences. For example, a frustrated mother yells at her child in the grocery store. In an attempt to maintain the mother as a good object, the child takes the bad feelings and negative perceptions of the mother inside. The child splits off the rejecting bad maternal object, along with a part of the self and the child's angry and hurt feelings. This rejecting object constellation is repressed, protecting the

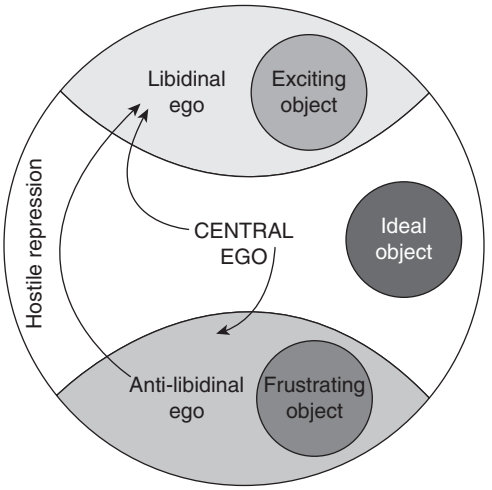

Figure 8.1 Fairbairn's model of psychic organization. Copyright 1982 David Scharff

child from the constant exposure to the painful feelings. Another example might be the animated, charismatic father who rarely spends time with his children, leaving them to long for his attention and praise. The father's seductive liveliness becomes part of his son's exciting object constellation, again repressed so the son can manage his painful longing for a father who provides just a taste of the relationship his son desires.

Fairbairn contended that the ideal object relationship represses the other two, which continually push toward consciousness in the service of becoming a whole, integrated self (Scharff & Scharff, 2005). He thought the rejecting object relationship repressed the exciting object relationship, seen in family therapy when a teenager asserts she does not care about her mother's apparent indifference. The teen's longing for a loving, caring exchange is disguised in her outward dismissal of her mother's importance. In an extension of Fairbairn's ideas, the exciting object relationship can also act to repress a rejecting object relationship. For instance, a couple may use sex to end a fight without working through the substance of the conflict or to bury feelings of contempt (Scharff & Scharff, 1991).

This dynamic self influences and is influenced by relationships with others and life experiences. If most of the central ego remains conscious and available, learning and social interactions help solidify existing strengths and modify negative experiences. But if splitting and repression dominate, leaving little of the central ego available for use, old bad object constellations can become entrenched and create a closed, internal system. This can be seen in the father who constantly reprimands his son for ordinary infractions, such as forgetting to bring home a schoolbook or dawdling when called for dinner. Unable to consider developmental needs and temperament differences, the father tells the mother the son hates him and is openly defying his authority. Unconsciously, he is identified with his own father, who beat him severely for minor mistakes. The repressed, rejecting object constellation is dominating the father's interactions, leaving little room for a different perspective on his son's behavior and affirming the father's feelings of worthlessness. In psychoanalytic family treatment, the therapist hopes to identify and challenge this closed system, opening space for learning from new experiences and shifting existing internal object constellations.

Winnicott's Findings on Infant Development

Donald Winnicott theorized from his vantage point as a pediatrician who was attuned to the infant's needs and developmental trajectory. His frequently quoted remark, "There is no such thing as an infant [without the mother]," reminds us of the infant's total dependence on the caregiver for survival and highlights the central importance of the parent–infant relationship in infant development (Winnicott, 1960, p. 39). According to Winnicott, the mother–infant relationship embraces both mind and body, forming a psychosomatic partnership where loving and valuing can be expressed. This psychosomatic connection in infancy forms the template for emotional relating throughout life and intimate sexual relating in adulthood (D. Scharff, 1982).

Winnicott distinguished between two types of maternal care: (1) the environmental mother, who attends to the infant's physical and emotional needs for survival, providing nurturance as she holds the infant in her arms and mind; and (2) the object mother, who directly engages the

infant in focused relating through her gaze and voice, becoming a receptacle for the infant's emotional expressions of love and hate (D. Scharff, 1992). These maternal functions and holding capacity are demonstrated by the psychoanalytic therapist's provision of a safe treatment space, with clearly defined boundaries and limits, and respectful, accessible emotional engagement with the family as a whole and with family members as individuals.

Winnicott suggested that as the infant develops, the infant's relationship with her caregiver gradually becomes more psychological than psychosomatic. The skin-to-skin contact so essential for relating in infancy gives way to what Winnicott referred to as potential space or transitional space, corresponding to the beginnings of self and other differentiation. In this space, the infant has transitional objects, such as a precious blanket that the infant drags from place to place, refusing to give it up to be laundered. This potential space allows for creative interactions between self and other, evidenced in play, imagination, dreaming, and affective exchanges (Winnicott, 1971).

Typically, in families seeking psychoanalytic treatment, this creative play space has collapsed due to family trauma, psychopathology, or unresolved mourning, leaving the family or couple locked into rigid, defensive, unsatisfying ways of interacting. For example, a young couple with a 4-year-old child lost a baby at 8 months. In a session, the couple seemed detached and deadened, engaging only minimally as their 4-year-old built a tower of blocks. Getting no response, the 4-year-old quickly abandoned his building project, and instead lined up the blocks in rows by shape. Unable to engage his parents, he moved to an ordering task, no doubt trying to impose some structure on his internal sense of fragmentation. Unable to grieve, this couple's blocked mourning shut down their creative potential to express, relate, and problem solve, which impinged on the child's creative thrust as well.

Klein's Concept of Projective Identification

Drawing from her work with young children, Melanie Klein (1946) theorized that infants spend the early months of life overwhelmed by anxiety, inhabiting what she termed as a paranoid-schizoid state of mind. In this position, they experience the mother as either good or bad, a part-object who can be life affirming or destructive. Controlled by the death instinct, the infant projects her aggressive, dangerous, and unacceptable aspects of the self into the mother. The mother is identified with the persecutory experience and misperceived by the infant as the source of the threat. This is the first phase of projective identification. In the second phase, the infant fears retaliation by the mother who has been infused with these frightening feelings and bad parts of the self. In the last phase of the projective identification process, the infant takes in this view of the mother through introjective identification. During this third phase, a good enough mother is able to diffuse the toxicity of the negative feelings, allowing the baby to take in the difficult psychic material in a form that can be metabolized. (J. Scharff, 1992; Scharff & Scharff, 1998, 2005).

An ordinary example would be the mother who patiently cradles the overly hungry, wailing infant as she struggles to latch onto the breast. The infant projects her distress and hate into the mother, who unconsciously accepts the difficult feelings without reprisal. She speaks to the infant in hushed tones and gently puts the breast back in the infant's mouth. "Oh, did you just get too hungry? Here, let's try again." The infant's distress and anger are taken in by the mother, detoxified, and returned to the infant in less-threatening form. The infant also projects into the mother good aspects of the infant self for safekeeping, from which the mother returns warm feelings that affirm the infant's loving and worthy essence. "Putting out and taking back appreciated goodness and detoxified badness is the infant's way of building a relationship and forming a durable personality" (Scharff & Scharff, 2005, p. 117).

Sometimes a parent may reject or be unable to complete this detoxification process, leaving the infant to manage an amplified version of these difficult feelings on her own. For example, the mother who feels inadequate quickly gives up when the overly hungry child will not feed,

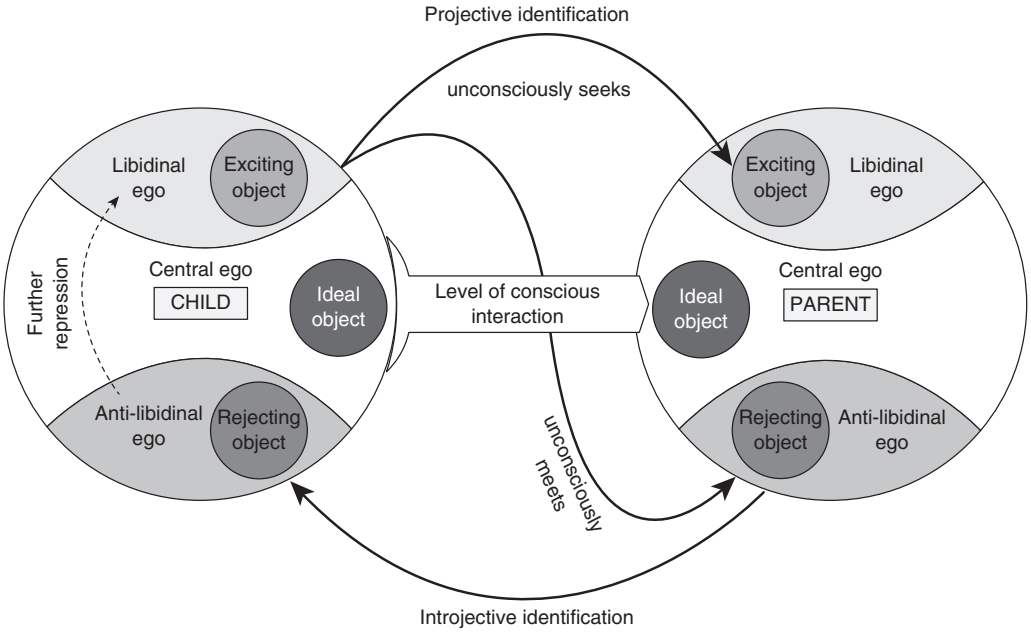

Figure 8.2 Projective and introjective identification in the child–parent relationship. Reprinted from *The Sexual Relationship: An Object Relations View of Sex and the Family*, courtesy of Routledge and Kegan Paul. Copyright Jill Savege Scharff and David E. Scharff, 1982

experiencing the infant's distress as an accusation and handing her to her father to feed. The drug-addicted parent ignores the hungry infant's distress, leaving her alone in her crib for hours. When the parent is consistently unavailable, the infant's mind fragments into a dissociated place to manage overwhelming affects or becomes overly self-reliant to compensate for the parent's absence. This can be seen in the neglected infant who no longer cues the adult for care or shows a muted response to physical pain. We see it in couple relationships where there is a shared defense against dependency, protecting the partners from vulnerability, yet limiting emotional intimacy.

As the infant develops, he is able to integrate good and bad characteristics of self and other, moving into what Klein called the depressive position (Hinshelwood, 1994). From this stance, the infant experiences guilt for potential damage done to the other and extends efforts at reparation. Although the depressive position may be viewed as more mature than the paranoid-schizoid position, both serve an adaptive purpose and each can dominate our interactions at any point in time. For example, one might argue that an understanding and forgiving depressive position in combat could be life threatening, while a depressive position in diplomacy might help prevent the battle altogether. Within a family system, a paranoid-schizoid position might help a child protect himself from an abusive parent, but it may also keep the child stuck in identification with the bad object.

In psychoanalytic couple therapy, couples are often trapped in a rigid paranoid-schizoid position, bringing the partner for the therapist to fix and blaming the other for the source of the problem. Each partner in the couple places the "problem" in the other, unable to see his or her own part in the couple's difficulties or contain the other's projections. At times, their shared system of projective identification may support the view of one partner as the "identified patient" and the other as "healthy," perpetuating power imbalances and an unhealthy couple dynamic (Vincent, 2007; Wanlass, in press). In a family system, the interplay of projective identifications

may find expression in a physically symptomatic child or in a defiant adolescent who becomes the family scapegoat. What the parental couple cannot face or the family cannot express gets unconsciously located in a particular family member. For example, in one family a severely anorectic girl unconsciously became "sick" to pull her fighting parents together, to bury intolerable expressions of aggression and sexuality, and to express her rage at her parents' self-absorption.

Bion's Ideas on Thinking and Containment

As he studied the process of thinking itself, Wilfred Bion expanded Klein's ideas about mother–infant interactions. He noted that when the infant projects difficult feelings into the mother, she is not destroyed by this aggressive act, but contains these pieces of infant experience through her unconscious "reverie" or the process of thinking about and making sense of the child's distress. Thus, the mother becomes the mental "container," returning the infant's anxieties in more structured form, making the feelings more manageable for the infant. Bion uses the word "contained" for the originally threatening and distressing anxieties the infant experiences. Most importantly, the infant identifies with the mother's thinking capacity or containing function, building the infant's psychic structure to cope more effectively with distress and adversity. Thus, the infant is not just soothed by the mother, but also takes in a structure for managing and making sense of experience. This is the way the child's mind is built (Scharff & Scharff, 1998, 2005).

From a psychoanalytic couple therapy perspective, couples typically enter treatment when the containing function of their couple relationship has broken down. They tend to act and react, rarely able to think about or process their difficulties. For example, the wife may not connect her fatigue and lack of sexual desire to her unacknowledged aggression about her husband's late hours at work. When she falls asleep during sex, her husband angrily retorts that he does not see any reason to come home at night. They start fighting, acting and reacting to each other with little understanding of what drives their couple behavior. She comes from a family where her parents were distant and detached, while his parents had multiple extramarital affairs. Although she says she wants closeness, the wife's emotional and sexual distance repeats her parents' detached style of relating. The husband's sexual dissatisfaction and hurt feelings of rejection could easily push him into an affair, matching the dysfunctional relating of his parents. The psychoanalytic couple therapist provides a containing function until this capacity can be developed or reclaimed by the couple. The couple is encouraged to consider underlying and often unconscious motivations for behaviors, moving from a place of judging and reacting toward understanding. With the help of the therapist, the couple examines the models of couple relating that they have internalized, and the way this influences their current relating.

Bion (1959) was also interested in the ways that groups function. He stated that within every group, subgroups are formed that serve an emotional purpose for the group and may help or hinder group work. His three types of subgroupings are dependency constellations, fight–flight formations, and exclusive pairings. In a dependency group, the group wants the leader to take care of the group, telling them what to do, organizing their tasks, and remaining in a parental position. In a fight–flight group, the group reacts to the authority of the group leader by fighting against it or fleeing from it in a shared avoidance or shut down. In a pairing group, the selected dyad enacts a group fantasy that this coupling will bring forth a new leader to replace the frustrating, dissatisfying old leader.

Bion's ideas can be applied to family groups, both as a means of understanding family dynamics and as a way of conceptualizing transference–countertransference interactions with the therapist. For example, a couple may adopt a dependency position with the therapist, waiting for the therapist to tell them what to do and how to fix their problems. In a family's development, a similar dependency position may be appropriate when children are young and naturally dependent on parents for survival, but may hinder a child's emancipation during young adulthood. The college student who text-messages mom multiple times a day or calls over simple decisions is not supported developmentally toward autonomy by a family system rigidly fixed in a

dependency mode. Fighting against authority may be useful in advancing through adolescence and establishing an independent sense of self, but it may hinder a marital couple from reaching interdependence or prevent a young adult from accepting a typical corporate work hierarchy. Similarly, parents locked in fight–flight mode toward authority may resist any interpretations from the therapist, fleeing treatment before progress can be made. A pervasive, exclusive pairing between a therapist and one member of a couple can sabotage treatment altogether, undermining therapist neutrality. The therapist can become polarized, seeing only one point of view and colluding with a dysfunctional couple dynamic.

Bowlby and Attachment Theory

John Bowlby (1969, 1973, 1980, 1988) viewed attachment as adaptive and essential to the infant's survival and development. The infant is born with competencies geared toward engaging in a relational exchange with a caregiver. Behaviors such as cooing, grasping, gazing, rooting for the breast, and smiling pull the caregiver toward the infant. An attuned, reliable, accessible caregiver conveys to the infant that adults can be trusted, providing internal safety for the child and allowing for the activation of exploratory and affiliative behaviors essential to development. Bowlby contended that the child forms an internal working model of the parent, accessible in times of distress. The peacefully sleeping baby carries inside an experience of his mother's cradling arms and comfort. If the mother is chronically unable to respond, such as in cases of severe depression, addiction, or abandonment, the infant's sense of safety is compromised, interfering with the development of affective regulation capacities, the creation of a relational template, and the formation of a cohesive sense of self.

Mary Ainsworth developed, refined, and applied the strange situation research paradigm, extending Bowlby's ideas into a categorization system for attachment styles. She identified three primary attachment styles: secure, insecure-avoidant, and insecure-ambivalent/resistant (Ainsworth, Blehar, Waters, & Wall, 1978). Mary Main and colleagues further expanded Ainsworth's ideas (Main & Hesse, 1990; Main & Solomon, 1987), defining the additional category of disorganized attachment and creating the Adult Attachment Inventory to measure attachment patterns in adults (George, Kaplan, & Main, 1985).

Clulow (2001, 2006, 2007) and Fisher and Crandell (2001) applied the central ideas and research findings from attachment theory to their work treating couples. Clulow (2007) suggested examining the secure base potential of the couple relationship, often fractured at the onset of treatment and necessitating establishment of a secure base in the therapeutic space where internal working models can be examined. Paying attention to couple behaviors around separations and reunions, both with each other and with the therapist, provides important information about couple relating and attachment histories. For example, during the therapist's planned vacation, does the couple experience her as the abandoning or narcissistic mother of their childhoods? Do they minimize their longing for the therapist by fighting with each other, much like siblings left alone without a parent?

Fisher and Crandell (2001) focused on the pairing of adult attachment styles in a couple as a template for understanding their intimate interactions. For instance, in a dismissive/preoccupied couple pairing, the partner with a dismissive attachment style may project the neediness for the relationship into the other and withdraw in the face of conflict. The preoccupied partner likely pursues the dismissive other, finding it difficult to disengage from the conflict, often provoking the dismissive other to get some type of emotional connection. This paired attachment pattern can be processed and understood, both in the ways it repeats childhood attachment styles and for the ways that it modulates closeness within the couple.

Couple Representations: Joint Marital Personality, Internal Couple, Selfdyad, and Couple State of Mind

Psychodynamic practitioners working with couples have suggested several concepts to capture the ways the couple relationship is represented internally. Comparing the marital couple to the mother–infant dyad, Henry Dicks (1967) proposed the "joint marital personality," where two separate personalities

come together to form a marital personality that is more than just the sum of its parts. Drawing from Fairbairn's theory, this joint marital personality has a central ego, where both partners are represented in mature, functioning ways, and two repressed object relational systems. In these repressed, split off systems, one partner is identified as the exciting object, for which the other partner provides the corresponding libidinal ego, and one partner represents the rejecting object, with the other partner as the corresponding anti-libidinal ego.

In other words, within this shared couple system, an aspect of the partner is treated as a part of the self. In a sense, each partner unconsciously choses the other for this capacity to resonate with these projected aspects of the self. In healthy couplings, the partner can both identify with these projected aspects and separate from them, but in dysfunctional pairings, partners become locked in to these projected views, which stifles couple and individual growth. Often the unwanted aspects are projected outside the couple into a child, who becomes the family scapegoat, protecting the marriage at her own personal cost.

The concept of an "internal couple" (Scharff & Scharff, 1991, 2005) emerges from an integration of Klein and Fairbairn. The child's experiences with her parental couple are internalized as a psychic structure and modified across the child's developmental trajectory as her relationship with her parents matures and she is exposed to other couples. When parents have a healthy relationship, this internal couple may be experienced by the child as loving life partners, devoted to caring for the other and experiencing pleasure in their coupling. This internal couple may be cherished and loved or envied and attacked. In poorly functioning marriages, the child may internalize a warring or a disconnected parental couple, creating anxiety and distress. The child unconsciously carries these versions of internal couples into her adult relationships as a template for couple relating (Scharff & Scharff, 2005).

Richard Zeitner (2011) uses the term "self-dyad" to describe an internal object formed through the projective identificatory processes of both intimate partners. He contends that each partner "falls in love" and unconsciously locates in the other a quality essential for psychic functioning, typically complementary to some aspect of the self-perceived as needing support. For instance, an individual who feels inadequate about his intellectual capacities may unconsciously choose a partner whom he views as intellectually superior. His partner may unconsciously select him for his agreeable nature, given she experiences herself as difficult interpersonally. The two partners then fuse or mesh these self-features into a selfdyad, containing aspects of their separate selves, but distinguishable from the two partners creating it. This selfdyad formation allows each partner to experience a sense of expansiveness and completeness through the other. In healthy relationships, the selfdyad shifts as the partnership evolves and continues to provide a nurturing self-object relatedness for both partners.

Mary Morgan (2005) proposed the idea of a "couple state of mind" that has relevance for psychodynamic work with couples and families. In her work as a couple psychotherapist, she observed that some couples present for treatment with a sense of connection and creative potency. From the outset, the therapist relates to them as a couple, known to us as individuals but also as a pair. Such couples tend to carry inside a view of them together, and they think and relate from this couple frame, evident in their subtle, non-verbal exchanges and the ways they hold their partner in mind. More commonly, therapists treat couples that present as disconnected individuals with little sense of their combined potential. This separateness is evident in the therapist's countertransference, where the therapist can only envision the couple as two distinct individuals. A therapist can easily become polarized in an exchange with one partner or see a couple dynamic as created by one person. Holding a "couple state of mind" as the therapist reminds the psychoanalytic practitioner that the couple dynamic is jointly created and helps us move the couple toward a position where each other's needs and viewpoints can be considered and understood.

Multidimensional Perspectives: Systems Theory and Chaos Theory

Just as Bion's ideas on group process can be applied to couple and family interactions or

attachment styles can characterize couple's ways of relating, psychoanalytic couple and family therapy draws from systems theory and chaos theory to help explain bi-directional and non-linear influences within individual and family systems. Drawing from the work of von Bertalanffy (1950) and Prigogine (1976), we understand that an organic system is open to feedback from the environment, which changes the system and moves it toward a higher level of organization. This is the natural evolutionary state of systems, unless some series of events overwhelms the system and prevents such growth.

Psychoanalytic family therapists focus on individual intrapsychic "systems," where the constellation of internal objects within any one individual is constantly in a state of change and influenced by multiple relationships. Drawing from Ackerman's early work (1938, 1966), psychoanalytic family therapists concurrently explore interpersonal family "systems," adding a greater level of complexity with the interaction of individual systems, dyadic systems, and group systems. Differing from Freud who thought that the individual "system" was governed by homeostasis and mostly pulled for negative feedback, contemporary analytic family work aligns with nature, where more complex systems with non-linear patterns evolve over time.

For example, consider the ways a parent and marital dyad is influenced by and influences a particular child. One mother expressed feeling competent as a parent with her first child, who was naturally easy going, flexible, and compliant. She felt completely incompetent as a parent with her second child, who had a more argumentative personality and inquisitive nature. She asked the question, "How could I have changed so much? Is it me or is she just a difficult child?" Consider just a few of the systemic variables operating in this brief example. A second child comes into the family with a competitive rival in her older sister, who has established a comfortable space in the family system with a mother who is similar in temperament. The father in this home was more available following the first child's birth, but he now holds a higher status career job, creating pressure, absence, and marital tension. The novelty and wonder of having a baby present with the first child's birth is a bit less dramatic with the second child's arrival. Although she is more experienced, mom is more fatigued, caring now for a toddler and new baby simultaneously. As the second child matures, Dad identifies with her challenging nature and inquisitive mind, pulling him toward a pairing with his second daughter and leaving mom feeling rejected and misunderstood. All of this happens outside conscious awareness, generating a multiplicity of influences within each individual and among different parts of the family system.

Chaos theory, adapted from the world of physics and mathematics, extends the linear mutuality of systems theory to a non-linear realm as applied to couple and family dynamics (Scharff & Scharff, 1998, 2011). Positive feedback pushes the existing family system into a state of disequilibrium, allowing it to reorganize into an organizational structure with new ways of communicating and new psychic defenses. Although parts of the system may revert to old patterns under stress, the system as a whole becomes more resilient and generative. The beginnings of systems within a chaos framework, however, are particularly vulnerable to small changes in conditions that can inhibit growth, like an infant who suffers throughout life as a result of a mother's early lack of attunement (Scharff & Procci, 2002). But if the system can remain open to feedback, a mature system is more flexible and resilient, just like a functioning, mature couple can handle ordinary arguments and disagreements without fracturing their couple container.

Chaos theory also introduces the concept of "strange attractors," which is valuable in understanding the complexity of family relationships. Strange attractors are patterns of random, non-repeating points with paradoxical characteristics: they have predictable overall form made up of unpredictable details. Although not precisely predictable, they give us ideas of the organizing patterns of the system that produces them. Strange attractor patterns in couples can be compared to systems of turbulent flow in nature, like leaping flames in a forest fire that appear, then seem to dissolve into randomness, then reappear in ordered form (Scharff & Procci, 2002). In a marriage, individual sets of early

object relationships operate as strange attractors, unconsciously drawing a couple together in ways that escape conscious awareness. Like flames in a forest fire, these attractors show up in seemingly random pockets of the couple's experience, yet often contain an overarching organizing theme or structure. Once these organizing factors can be understood, change is possible within a once rigid system.

During an initial couple therapy session, a couple articulates the known reasons for their attraction—similar interests, shared goals, sexual chemistry, proximity, similar cultural upbringings— but they fail to notice factors that are identified only much later in treatment. For instance, in some couples, each partner has an unexplored history of trauma, vaguely known to the other, but mostly hidden away as historical fact. When they become parents, this traumatic history is activated, inflaming conflicts between them in ways they cannot logically understand. Although their unconsciously shared experience of prior trauma is now the strange attractor organizing their interactions, the couple cannot see this organizing variable. In the countertransference, the couple therapist finds herself wondering about past trauma, eventually leading to exploration and working through of these past experiences. At one point, the wife in one couple remarked to her husband, "I think our traumatic histories brought us together in ways we couldn't have understood. I guess, now we have to decide if we are going to continue to relate through trauma or find some other stronger connection between us."

Pichon-Rivière and the Link

Over the past 50 years, as English psychoanalytic writers were extending object relations constructs to couple and family work, a parallel process was occurring in South America and parts of Europe, utilizing the ideas of "el vinculo" or link theory (D. Scharff, 2011; Scharff & Scharff, 2011). Similar to chaos theory in its bidirectional qualities, each person within the link both organizes and is organized by the link. According to Pichon-Rivière, there are two axes for relating and understanding. Along the horizontal axis, each individual person is joined to the family and their immediate surrounding social world. Indeed, Pichon-Rivière developed this theory while seeing patients with their families and social groups. We can think of this as our contemporary social world of influence. For instance, we might consider how Internet technology and cell phones influence the frequency and type of sibling contact within a family system. Along the vertical axis, each person is joined to previous generations and historical events. We can think of this as our historical realm of influence. For instance, how does a great-grandparent's move west to escape religious persecution and his loss of multiple children affect a particular great-grandson's personality, choice of partner, and family functioning? How does the Cultural Revolution that wreaked havoc in the lives of Chinese parents and grandparents influence young Chinese couples today? Others have taken up the question of intergenerational influence (Faimberg, 2005; Ferro, 1999; Fraiberg, Adelson, & Shapiro, 2003), but link theory has a means of conceptualizing these ideas that seems to capture their full complexity, much like Bronfenbrenner's (1981) ecological theory of child development.

For practitioners of psychoanalytic family therapy, link theory affirms the importance of family involvement, both in formal couple or family therapy and in parent consultations for child work. It encourages exploration of past-generational history as it emerges in the treatment and consideration of relevant political, social, and cultural events past and present. Most significantly, it prompts us as psychoanalytic therapists to hold potential intergenerational links and historical contexts in our minds, enlarging our perspective about individual and family struggles.

A Clinical Example: Roger and Cathy

Roger (40) and Cathy (35) were referred for treatment by a mutual friend of the couple, following Cathy's discovery of Roger's brief affair with a co-worker. Cathy made the initial phone contact, offering little information other than "my marriage is in trouble." When they arrived for the consultation, Cathy seemed anxious, speaking

quickly and continuously in that first clinical hour. Although Roger stated that he wanted to work on his marriage, I (JW) was not convinced, guessing that he had complied with Cathy's insistence they seek help. Initially, I had trouble understanding what brought them to treatment, as Cathy described their "communication difficulties" in vague terms. She mentioned that the couple "struggled" after the birth of their youngest child who was now 4. When I asked Roger and Cathy to describe the "struggle," Cathy noted, "Oh, you know, the usual problems of having a new baby—no sleep, little sex, jealous older siblings, demanding work schedules." Thinking that their "baby" was now 4, I wondered what had occurred in the interim. Noting Roger's near silence, I asked if he agreed with Cathy's assessment. He responded, "Yes, but the reason we're here is I had an affair." His curt, direct statement in the midst of her sea of jumbled words startled me. Cathy commented that she avoided bringing it up right away, worried he would feel hurt or embarrassed, "Like I'm blaming him for all our problems." Roger continued, "I never meant for it to happen. I certainly wasn't looking for someone to cheat with, but Jenna was just there, someone to talk to."

As the session continued, I learned that Cathy felt overwhelmed balancing work stressors and the demands of caring for three children. Feeling her own mother had been neglectful, Cathy focused almost entirely on the children's needs to the exclusion of their couple relationship and her own needs. Although not stated directly, I sensed Cathy was angry with Roger for his limited involvement in scheduling the children's daily activities and weekend family events. Roger denied having a drinking problem, but Cathy felt his "one to two drinks a night" interfered with his family involvement. Frustrated, Roger again interrupted Cathy's flood of words, an edge of anger in his voice, "I'm not an alcoholic. My mother drank all the time, so I know the difference. I'm a cheater like my mother yes, but an alcoholic, no." Feeling the sting of his reprimand, Cathy looked at me, "I know I'm part of the problem. I don't really know how to be close. I worry about the kids all the time, and I know it drives him crazy, but I can't stop." As the session ended, Roger noted that his parents have a "good relationship," while Cathy's parents divorced when she was 7. I felt immersed in a competition, as though each partner were trying to pass the dysfunction award to the other. Roger made the last comment: "I don't know how my dad put up with her all those years, drinking herself into oblivion."

How can psychoanalytic theory help us understand this couple interaction and their underlying couple dynamics, even in this first meeting? Drawing from Fairbairn and Dicks, there is a predominance of bad object relationships in this pairing, both in the individuals themselves and in the joint marital personality. Cathy takes up a great deal of space without much emotional presence, and her longing for approval is palpable in her words and in the therapist's countertransference. Her fragmented self-structure and eclipsed central ego is reflected in her verbal communication, which lacks cohesion and direction. Like the neglected child, the way she both pulls for relating and negates herself is evident in her lack of overt complaint about Roger's affair, in her overinvestment in the needs of others at her own expense, and in her self-critical demeanor. Although she must be angry with both her mother and Roger, she has difficulty directly expressing any negative feeling. Given her report of childhood neglect and her way of interacting within the session, it seemed to the therapist that she was unlikely to have experienced a good enough mother who could contain her overwhelming anxiety and impart a thinking function. In this session, Cathy displays a preoccupied attachment style that disorganizes under stress.

In contrast, Roger demonstrates a dismissive attachment style, offering little elaboration of his emotional experience, minimizing his dependency needs, and mostly remaining out of emotional contact with the therapist who struggles to read his emotional states. This avoidance is peppered with episodic announcements, defining his experience in the black/white terms of the paranoid-schizoid position. He splits his parents into good/bad, wondering why his father put up with his mother, but showing no curiosity about why his mother drank excessively or had affairs. His views of his parents' relationship seem

contradictory, telling the therapist they had a "good relationship" while describing conflict and acting-out. He moves into the depressive position briefly, when he expresses guilt and regret about his affair. The therapist feels his anguish over actions that align him with the mother he detests. This is an example of how a bad maternal object becomes fused with a part of the self, repressed to manage the painful affects, yet acted out in his sexual behavior.

The therapist experiences this couple more like a pair of young siblings than lovers or parents. This indicates to the therapist something about the couple's developmental functioning, speaking to unmet childhood needs for nurturance and feeding. They seem to have little sense of themselves as a couple, lacking a "couple state of mind" (Morgan, 2005) and its creative potential. This is apparent in the therapist's difficulty fantasizing about the ways they parent or intimately relate. In the session, they rarely look at each other when speaking, directing their words more to the therapist than to each other.

There is a sense of profound loneliness and sadness in both partners. Cathy diverts her needs for intimacy to her children, using them for comfort that sidesteps adult sexuality. Roger projects his dependency needs into Cathy and alcohol, splitting off his sexual desire outside the marriage, perhaps protecting his sense of vulnerability. The couple seems caught in a closed system lacking creative space, and bad feelings predominate in a repetitive cycle. They either blame the other or themselves, exhibiting anxiety that gets channeled into non-productive rumination in Cathy or edgy aggression in Roger. He holds her anger; she holds his neediness.

From the standpoint of chaos and link theories, we just see hints of possible organizing patterns that may help explain the couple's unconscious fit and current difficulties. We hear that Roger's mother had affairs and a drinking problem, which would represent a potential vertical link, but we know nothing of his grandparents' generation. In Roger's startling, blunt entrance into the session, the therapist wonders about his conception—was it planned, a surprise? This idea gains additional footing given Cathy's explanation that their problems began at the birth of their third child. Cathy made no mention of her father, leaving the therapist thinking about absence and emotional withdrawal.

What is the nature of their internal couple representations? Roger told us that Cathy's parents divorced when she was 7, and the therapist wondered about the ages of this couple's children. Is the oldest child 7? Despite Cathy's insistence about her devotion to their children, there is no mention of the children by name in this first session. The therapist finds herself forgetting at times that the couple has children, leaving her to question if they are attended to but not seen as developing individuals in this family system. And what of the couple's social, economic, and cultural standing? They did not inquire about the therapist's fee before coming in, nor did they balk at the amount. Roger is Caucasian; Cathy is Latina. What does this ethnic difference mean to them and how does it play out in their families of origin and, in the current horizontal link, with their extended families now?

Psychoanalytic constructs and the perspective of contemporary object relations theory provides a means of understanding this couple's dynamics, although we can only hypothesize at this early juncture. As psychoanalytic practitioners, we allow ourselves to conjecture, while being open to shifts in perspective and alternative viewpoints as the treatment provides us with greater understanding. How is this accomplished? What are typical treatment goals, assessment strategies, and intervention techniques of an object relations approach to couple and family therapy?

The Object Relations Treatment Approach

Etiology of Clinical Problems

The object relations approach to treating distressed families and couples could be considered "symptom friendly." We view symptoms not as problems to be eradicated, but rather like a beacon of light in a storm. Symptoms signal families that something is wrong or needs attention, causing distress that motivates couples and families to seek help. These "beams of light" help guide the

therapist through layers of anxiety and defense until the unconscious roots of the family's struggles are uncovered and understood. The therapist attends to the meaning of the symptom, both for the symptom bearer and for the couple dyad or family system. For example, a bulimic teen's self-induced vomiting may be her vehicle for evacuating negative feelings while also protecting her parents from acknowledging their marital difficulties.

Additionally, there are times when the therapist may need to directly address the management of a symptom, such as a couple's sexual dysfunction or a teen's substance abuse. Management of a symptom may require non-analytic interventions for an analytic purpose, such as placement in a detoxification facility, enrollment in an intensive outpatient program, or attendance at AA meetings to provide structure and support for the alcoholic teen. When the sources of the difficulty are worked through, the symptom generally lessens or dissipates, no longer needed to sound the alarm.

The etiology of a couple or family problem is usually multi-determined and unique to each family; however, some common factors prevail, such as a problematic unconscious couple fit, compromised containment and growth potential in the projective–introjective identificatory system, couple conflict displaced onto the children, chronic medical or psychiatric illness within the family system, and significant losses or traumas that remain unprocessed.

Problematic Unconscious Couple Fit

For most couples, falling in love means engaging in denial, a suspension of knowing about the difficult qualities in one's partner and oneself that may impede healthy coupling. Instead, we see the ideal mate, similar in background or different in ways that we believe will benefit the relationship. We operate from our conscious awareness, feeling the physical attraction, experiencing the emotional connection, and thinking of the reasons to be together. But attraction also occurs at the unconscious level, based on the interaction between repressed inner object relationships that influence the long-term quality of the couple match (Dicks, 1967). The pathology potential lies dormant and unrecognized until the couple commitment is solidified and life events move unconscious material to the surface. The central ego functioning of the couple is invaded by the return of these repressed bad object relationships, eliciting feelings of rejection by the partner or cravings for a better union.

For instance, a young woman feels delighted that her fiancé seems so focused on making her happy, asking at every juncture about her preferences and needs. Five years into the marriage, she finds herself annoyed. What she once viewed as thoughtfulness, she now experiences as indecision and inadequacy, a person lacking a sense of self and unable to stand on his own. After the birth of their first child, his dependency feels suffocating. Her husband cannot understand his wife's negativity, contrasting with the lively, effusive, hopeful image of her he held when they dated. Now, he experiences her as critical of his every move, making him more attentive to her wishes, which seems to further inflame their conflict. The conscious reasons for their pairing—similar values and life goals, similar educational levels, similar interests, different but attractive personality styles—now seem irrelevant or a source of stress. Unconsciously, she has chosen a partner who helps her recreate her fused pairing with her mother, a bad object constellation accompanied by anger, disappointment, and sadness. He has selected a partner who becomes critical when stressed, much like the father of his childhood. This couple is in danger of repeating the distant, unsatisfying relationships of their own parents. Although all couplings have unconscious elements, for this couple their unconscious fit threatens the sustainability of the marriage.

Compromised Containment and Growth Potential in the Couple and Family's Projective–Introjective Identificatory System

The object relations model for healthy intimate partnerships and functioning family systems embraces a balance of satisfaction and distress. Periodic distress is viewed as an ordinary part of living, and discomfort often acts as a motivator

for growth and change. Dysfunction within these systems happens when this balance is upset and distress becomes constant and overwhelming—within the couple, parent–child pairings, sibling pairs, or the family as a whole. Typically, this breakdown in functioning results from conditions such as: 1) the loss of mutual gratification in the projective and introjective identification processes; 2) the inability of the parent/spouse to adequately contain projections from their spouse or child; 3) decreased flexibility within the internal object representational systems, as internal bad objects become more fixed and less responsive to modification from experience; 4) the splitting off of aspects of the love object once located in the spouse and now experienced in a less-threatening context, such as an overinvestment in a child, a work project, a obsessive hobby, or an extramarital affair; 5) an acting out of the parents' strained or absent sexual relationship in sibling incest, a parent's sexualization of a child, a teen's promiscuity, or an avoidance of developmentally appropriate sexual interest and expression in family members (Scharff & Scharff, 1997).

Couple Conflict Expressed Through a Child

Child therapists often speak of the ways children bring their parents to treatment, unconsciously developing symptoms that demand attention to the family's difficulties. Parents who would not enter treatment themselves often respond to the vulnerability of an ill child or the family disruption it creates and seek help for their child. In many cases, the child holds a displaced, unmetabolized aspect of the couple conflict. In individual treatment, the child may improve; however, such improvement is limited and easily slips away if the marital issues are not addressed. Such was the case with a child who developed school phobia in the second grade. She was frightened to leave her home, worried that something would happen to her parents in her absence. Her parents initially denied any family distress, recent losses, or past traumas that would account for the child's intense fears. But through her play, she presented stories of baby animals left alone without parents or children getting hurt while their parents argued. Over time, the parents revealed chronic marital dissatisfaction, which actually led to a 6-month trial separation when the girl was 3. Her worries about loss were well-founded, both in the potential for her parents to separate and in the way they had never formed a couple state of mind (Morgan, 2005), which would allow them to foster an intimate partnership as lovers and parents. Once the parents could reclaim their projected marital conflict, the child was freed from her excessive worries.

Chronic Medical or Psychiatric Illness

Chronic illness in a family member creates ongoing stress within the family system, particularly when significant caregiving time must be devoted to the ill family member. Siblings and partners of the ill person often experience resentment and guilt that is difficult to express. The couple or family readily becomes polarized into roles of "sick" and "well," with the "well" members coming to treatment to support the "ill" other. For example, a wife comes to treatment to help her husband overcome his drug addiction or parents ask what they can do to support their medically non-compliant diabetic son. Certainly, these are valid reasons to seek help, but they can hide the dynamic meanings of the illness within the family system (Vincent, 2007; Wanlass, in press).

Consider the unconscious fit of "sick" and "well" partners, including the ways weakness, "madness," or dependency can be located exclusively in one partner. The well partner projects her "sickness" into the other, which may contribute to relapse in addiction or unacknowledged depression in medical caregivers. The addict cannot escape his identification with the bad object, as the couple adopts a shared view of "his problem." Aspects of the family experience of living with an addict remain unprocessed, as children avoid upsetting dad for fear he will drink or partners collude in enabling behaviors that hide the severity of the problem. The caregiver of a seriously ill partner feels drained by the constant dependency and unequal power distribution within the couple. She cannot see she is depressed or complain about her circumstances, because she is not the one with cancer or chronic pain. Where can she

voice the loss she feels of the vibrant other and the coupling she once enjoyed? Additionally, the form the illness takes may reflect something of the family dynamic, such as a wife's pull toward cocaine to bring liveliness into an emotionally deadened marriage or a child's paralyzing, psychosomatic pain in a family that cannot accept or express negative emotions. Illness in a family presents a significant challenge for the object relations family therapist, as he must attend to the concrete problems resulting from the illness, while contemplating the dynamic impact, meaning, and function of the illness within the family context (Wanlass, in press).

Unprocessed Loss and Trauma

One of the most common etiological factors contributing to family difficulties and destabilization is loss and trauma. As Faimberg (2005), Pichon-Rivière (Scharff & Scharff, 2011), and Scharff and Scharff (2011) articulate, this trauma can be carried forward in unmetabolized form from prior generations or can occur in the family system at any point in its developmental trajectory. The type, circumstances, and timing of the trauma is important, as a family with young children may struggle differently with the sudden loss of a parent than a family with older, already launched children. A stillbirth of a child may be further complicated by unprocessed losses from a prior generation, overloading the grieving process. A parent who drives the car that crashes into an embankment and kills two of his children may be haunted by guilt, withdrawing from the family and creating yet another loss to manage. What is traumatic for one family may be manageable for another, such as families who seem to find resilience after a divorce while others experience divorce as the traumatic death of everything good.

The loss of a family member, especially one who was loved ambivalently, one who suffered a long deterioration or decline, or one who died suddenly creates a more complicated grief reaction for family members, sometimes throwing an entire family into depression or creating a symptomatic child who carries the grief. When a family deals with a progressive, debilitating, terminal illness in a family member, death often brings relief that the suffering is over, a sense of displacement as the time-consuming extensive caretaking ends, guilt over earlier wishes and fantasies that the ill person would die, and loss that though anticipated is keenly felt. Family members can become paralyzed in an idealization of the dead family member, preventing them from moving forward in the mourning process. When family members die suddenly or unexpectedly, the family is robbed of the chance to say goodbye. Family members are sometimes haunted by their last interaction such as an argument on the day of the deadly car accident. When the lost family member is loved ambivalently, guilt feelings are magnified in those left behind. In such cases, part of the grief work for family members is about giving up the fantasized relationship never experienced in reality as well as expressing the conflicting feelings about the person lost.

Any loss of the family home by flood, fire, hurricane, or invasion disturbs the family's equilibrium and sense of safety. The family is uprooted, losing cherished belongings and a comforting space. The chronology of the family history, represented in children's old school papers, antiques passed through the generations, photographs across the lifespan, and material objects from special occasions are destroyed, leaving the family feeling disoriented and adrift. This loss is compounded exponentially when family members or pets are killed, harmed, or lost in the disastrous event.

Although these etiological factors are discussed separately, more commonly such factors combine to account for family dysfunction and distress. This discussion is hardly exhaustive, provided more as examples of contributing causal factors rather than as a comprehensive list of possibilities.

Typical Treatment Goals

In object relations couple and family therapy, treatment goals are unique to each couple and family system and often change over the course of treatment as the family's repetitive patterns, shared defenses, underlying assumptions, and adaptive strengths are better understood. In general, we hope to facilitate improvement in

the family's containing capacities, allowing family members to take back disowned projections and enabling the projective identificatory cycle to operate more from a depressive than a paranoid-schizoid position. In practical terms, this means that family members can more easily see their part in creating both difficult and loving interactions, extend greater empathy, generosity, and understanding toward self and other, communicate more openly and effectively, and foster a balance between affiliation and autonomy that allows both for greater intimacy and greater differentiation of needs. Individual family members recover aspects of the self that free them to love and be loved, enhancing the creative potential of the family or couple as a unit to manage developmental tasks and challenges as they appear.

Approach to Clinical Assessment

Clinical assessment begins in the first interaction and extends throughout the couple or family's course of treatment. Similarly, the tasks that we pursue and the methods we employ in this opening phase of treatment are equally applicable in the later treatment stages.

Setting a Treatment Frame

We establish a therapeutic frame by communicating clearly about treatment arrangements and consistently maintaining our agreed format. This means that we decide on a regular frequency, time, and place to meet, and we outline our policies about fees, billing practices, and missed appointments. In working with families, we typically schedule between one and four assessment sessions, and we prefer to see the entire family, even when that includes very young children. For example, we want to see how a family reacts to their new baby. Does the child organize the family? Do the siblings ignore her? Both during the assessment and throughout the treatment, we will still meet with the family when one member is absent from the session, because we believe this replicates typical family life.

With couples, however, we make it clear from the beginning that we will not meet individually with one partner unless this is a pre-arranged part of the assessment or treatment process. To suddenly do individual therapy with one partner may undermine the therapist's neutrality and ability to work with the couple (Scharff & Scharff, 1991). Within the assessment process, we attend to the potential dynamic meanings of attempts to bend the treatment frame, such as pulls to go overtime in sessions or repeated requests for changes in session times. For instance, is the pull to extend the session an expression of the couple's desperation, dependent longings, inability to be satisfied, or entitlement? What does it mean when a family who typically pays on time "forgets" to make a payment? These are family communications that need to be analyzed and understood.

Establishing a Working Alliance

The object relations couple and family therapist adopts a stance of benevolent curiosity (Hall, 1998), accepting whatever the family presents with a calm, interested, respectful demeanor. The focus is on relationships within the family and between the family and the therapist, rather than on individual family members. The therapist works to maintain a balance, giving equal attention to children as well as to parents, and noticing when that balance is off-kilter, such as when one partner in a couple dominates the session time or when children disappear from the dialogue. The therapist refrains from injecting personal information or providing answers to personal questions, opening the space for family members' projections and fantasies.

Within the first session, the therapist attends to resistances that might undermine a return for a second session, such as ambivalence around the agreed upon session times or a feeling of distrust experienced through the therapist's countertransference. Speaking directly about such issues with the family enhances safety by demonstrating that negative feelings can be put into words and difficult topics can be addressed without retaliation from the therapist. In essence, the therapist is helping the family talk about rather than act out their unconscious resistance to the process.

Using a Non-Structured Interview Format

During the assessment process, the object relations couple and family therapist follows the naturally emerging narrative and discourse of the family rather than imposing a structured format. We want to notice how the story emerges, who tells the story, what aspects of the story are excluded by one family member and added by another, and family members' affective responses during the telling. Pauses in the narrative often suggest areas of conflict or troublesome memories. If important areas are omitted, such as Roger's affair in the clinical excerpt presented earlier, we ask family members to consider the meaning of such an omission. During the sessions, we are interested in all types of unconscious family communication—facial expressions, vocal inflections and voice tone, physical gestures, dreams, and children's play sequences.

Observing Defensive Patterns

Patterns of family behavior outside the therapy session reoccur within the therapy session, allowing the therapist to experience the family dynamics and the ways the family defends against anxiety-provoking aspects of living or unmetabolized family trauma. This might include expression of ordinary needs and feelings, like the need to rely on others for help or feelings of anger toward a parent, or expression of unmetabolized trauma, such as a family's inability to talk about a physically violent altercation between the parents. Defensive patterns can be displayed in many forms: a couple who uses a scapegoated child to avoid their marital conflicts; a family who quickly counters any expression of negative feelings; a family who organizes around the caretaking of one family member; a couple who unconsciously collude to avoid discussion of certain topics; or a family who dismisses the importance of the therapist's absence only to miss two sessions on the therapist's return. Once identified through the therapist's experiences with the family, the therapist works on making these unconscious anxieties conscious in the family's awareness, leaving them less vulnerable to an automatic retreat to these defensive patterns and better prepared for future developmental challenges.

Using Core Affective Moments to Develop Hypotheses about Underlying Anxieties and Conflicts

In the assessment phase, the object relations couple and family therapist forms tentative hypotheses about the underlying sources of family turmoil. In addition to observing patterns of defense, the emergence of affect in a couple and family session guides the therapist's work in uncovering underlying conflict. The therapist may ask if this feeling is connected to any earlier experiences, both in the life of the family being treated and in parents' families of origin.

Sometimes, the feeling is so powerful that it consumes the couple or family and therapist, an experience we call a core affective exchange (Scharff & Scharff, 1991). Such intense affect in a current relationship signals the replay of an important early experience that was not understood or even consciously recalled, so that it is repeated instead of remembered. Bringing these core affective moments to conscious awareness allows the family to face the past and detoxify emotional trigger points. Within the context of the assessment, the therapist may only discover hints at underlying unconscious material without fully understanding their unconscious relevance. For instance, a father may be overwhelmed with grief in recounting a story he has told many times about his son's birth, bringing the whole family to tears. He tells us he is confused, as there is nothing sad about the story. Although we may speculate that this has some connection to his own birth, his relationship with his parents, or an unmourned loss within the extended family system, only later in the treatment will we comprehend the full meaning of this marked, affective expression.

Working with Transference and Countertransference

The key to therapeutic action and the primary mechanism of change within the object relations couple and family treatment approach is working with transference and countertransference. We gather the reactions of the family as a whole and of family members as individuals to the therapist, noticing what gets projected. We call

this the "transference." This transference creates corresponding "countertransference" feelings, ideas, and behavior in the therapist, and is used to inform and guide interventions (Scharff & Scharff, 1997). Drawing from Winnicott's (1960) conceptualization of the environmental and object mother, we posit two types of transference/countertransference interactions: contextual and focused. In the contextual transference, the family reacts to the therapist's holding environment and provision of therapeutic space. For example, several family members complain about the inconvenience of the therapy time or the parents express that the therapist does not seem to understand their distress and difficulty in managing their teenage son.

In the focused transference, which typically emerges as treatment progresses, the family displaces intense feelings onto the therapist as an object for intimate relating. For example, in one couple session 6 months into treatment, the husband exploded at the therapist and his wife (also a therapist), stating, "You two just go ahead and talk your shrink talk. I've grown up with shrinks for parents, people who think they understand but have no idea what's really going on." In this moment, the therapist was experienced as aligned with his wife, becoming the persecuting parental couple of his childhood. In family work, the contextual transference dimension tends to dominate, as the focused transference/countertransference positions are often projected and held within the family itself, but in couple work there is greater oscillation between the contextual and focused transference (Scharff & Scharff, 1987, 1991, 1998, 2005).

Testing Responses to Interpretations, Making Recommendations, and Transitioning to a Referral or Further Treatment

As the assessment phase progresses, therapists make interpretations of family interactions and evaluate family members' responses to these trial interpretations. At this juncture, the therapist is assessing whether or not this family is a good fit for psychodynamic work. If family members value and can engage in thinking about problems in a psychological way, including considering motivations and examining the meaning and function of interactions, the family may benefit from further psychodynamic work. In this instance, the therapist discusses some preliminary ideas about the family's struggles and collaborates with the family to arrange continued treatment. If the fit is not good, either because of appointment time options, personal incompatibility, or a wish for a more short-term, skill-based treatment approach, the family should be referred to a colleague.

Therapeutic Interventions and the Therapist's Role

Once the family and therapist collaboratively decide that further treatment is warranted, the methods and conditions of the assessment phase are extended into the treatment: providing a safe therapeutic environment with a firm frame, following affect as a guide, attending to defense patterns, examining transference and countertransference, and working with unconscious material in fantasies, play, and dreams. Although the complexity of this process is difficult to capture, we will highlight some of the central components in our way of working.

Use of the Therapist's Self

The use of the therapist's self is the most critical component in our therapy technique. To make use of ourselves in this way, we need: 1) to engage in our own personal psychotherapy or psychoanalysis to understand our own family history and object relations; 2) to participate in extensive clinical training to develop the necessary clinical skills and theory base for our interventions; and 3) to invest in ongoing supervision and consultation to identify blind-spots and maintain perspective on our clinical work. As object relations couple and family therapists, we maintain a position of neutrality or involved impartiality within the family system, with no preference toward one family member or another and no predetermined agenda for a particular outcome, such as for a couple to remain married. We demonstrate "negative capability" (Scharff & Scharff, 1991, 2005),

meaning that we tolerate and value a position of uncertainty and confusion, allowing hypotheses to emerge from our experiences with the family for confirmation or revision, rather than imposing a prefabricated "answer" to the family's difficulties that would preempt further exploration of their unique dynamics.

Transference and Countertransference

Extending from the assessment phase, negative capability and the therapist's neutrality promote the continued development of transference/countertransference exchanges between the family or couple and the therapist. Transference communications from the couple or family produce corresponding countertransference ideas, feelings, behaviors, and reactions in the therapist. Just like with transference, these countertransference responses by the therapist can be either contextual or focused in form. Additionally, we attend to our identifications (Racker, 1968) within the countertransference, or the ways we relate or connect with what the family portrays. For example, the therapist may identify with a child's feelings of helplessness as his parents' argue, allowing the therapist to experience part of what the child is feeling but not expressing. As treatment progresses and the family's relationship with the therapist deepen, transference reactions often intensify as the family draws closer to their core conflicts. For example, a family who overvalues autonomy as a defense against their dependency longings may react acutely to the therapist's absence once treatment is established. The therapist may experience this longing in her countertransference guilt feelings prior to leaving on vacation or in the family's emotional distancing upon her return.

Making Interpretations

Within any given therapy session, we make many types of interventions such as clarifying comments, statements that link affect with content, remarks that sequence one idea with another, and ideas that explain how the past influences the family's life now. In essence, the therapist "interprets" what is happening in the family, based on her countertransference responses, what she knows of the family history, and the interactions she observes in the session. We put the underlying anxieties or family conflict into words, developing a shared narrative of experience. If the therapist's tact, timing, and dosage are appropriate and the family is able to hear and take in what the therapist has to say, these interpretations draw together historical and current perspectives in a way that generates insight and new understandings.

Working Through

In object relations couple and family therapy, cognitive understanding alone does not produce change. The affective experience within the treatment process, the articulation of a shared narrative of understanding, the incorporation of new objects in the form of the therapist, and the gradual shift in the family and individual members' inner object worlds are essential to the change process. As our conscious understanding grows, we re-work old relational scripts through a new lens.

A Clinical Example: The Carter Family

Forty-three-year-old Lauren telephoned, requesting an appointment for her 10-year-old son Tom, a diabetic child who resented his condition and performed poorly in school. Lauren noted that Tom was diagnosed with diabetes at age 7, having suffered for approximately a year with vague physical symptoms. She remarked, "We should have known something was seriously wrong." As she wondered aloud if Tom might be depressed, I (JW) wondered the same of Lauren, experiencing her flat affect, nagging guilt feelings, and frequent self-attack. I explained the assessment process, setting up an appointment with Lauren and her husband, one with Tom alone, and one with the family as a whole. As Lauren readily agreed to this initial treatment frame, I sensed her desperation, a mother uncertain how to help her son.

Lauren arrived alone for the initial appointment, stating with irritation that her husband Greg, age 46, had a "work emergency in his lab" and might join us as the session progressed.

A research scientist, Greg held a tenured academic position at a local university. Lauren remarked that Greg had struggled to get tenure. "People just read him wrong. They think his emotional distance means he doesn't care, but he's just a guarded person." A corporate officer in a pharmaceutical company, Lauren was obviously professionally successful, but I wondered if she could take in her accomplishments.

The couple married 15 years ago and had three children: Tom (10), Doug (7), and Mandy (4). I learned that while all pregnancies were planned and medically unremarkable, Greg was emotionally and physically absent after the birth of his sons. When Tom was born, Greg was preoccupied with his application for tenure and working long hours. Lauren described clinging to her new baby for comfort, "an antidote to the loneliness." Just before Doug's birth, Greg's younger brother was killed in a car accident. Greg felt somewhat responsible, as he had asked his brother to take his place on this trip with their parents due to work demands. When the car was struck by a drunk driver, Greg's mother and stepfather were unhurt, but his brother died instantly. Greg named his son Doug after his dead brother.

With just ten minutes left in the session, Greg arrived, apologizing for his lateness and voicing his concerns about Lauren. "I think she's too hard on herself. Yes, we have problems with our kids, but doesn't everybody?" Expecting a distant, removed, character, I was surprised by his warmth and charm. He looked at his wife adoringly, making it difficult for her to stay angry about his late arrival. In the last few minutes, they provided additional developmental history about Tom and further elaborated their concerns. Lauren commented, "He's about a year behind academically. He missed quite a bit of school when he was 6 and 7. It took a while to find out what was wrong." Greg chimed in, "I'm afraid that was my fault really. Lauren kept insisting something was wrong with Tom, and I thought she was overreacting."

What have we learned so far? Greg missed the "birth" of the session, a behavioral repeat of the preoccupied-with-work stance Lauren described following Tom's birth. We discovered a significant family loss, the death of Greg's brother just prior to Doug's birth. Although announced by Lauren as part of the family history, I had little sense of how the family processed this event. They named a child after the dead brother, a child who seemed nearly invisible in the discussion of family members. In my mind, I pictured Tom and Mandy, a gentle but frustrated soul and a cheery, entertaining imp, but Doug? Was he the family ghost, the dead brother never grieved? Lauren seemed strongly identified with Tom, apparent in my countertransference confusion about who was depressed. Was Tom as plagued by bad, rejecting object constellations as Lauren? What was the meaning and impact of Tom's illness in this family?

Greg's warm, charming entrance into the session seemed dissonant with Lauren's description of him as guarded and distant. His attempt to express concern for his wife was quickly rebuffed. Was he the exciting object, longed for but hard to capture? Was their focus on Tom an escape from their marital conflict? Was Lauren projecting her own distancing into Greg? And what of Tom's non-compliance with his insulin protocol? Was this an expression of anger about being sick? Anger at his mother's need for him as an emotional partner? In my countertransference, I had the sense that anger was not easily tolerated in this family system, whisked away by work demands or entertaining charm. I felt a deep sadness, a heaviness I could not yet explain.

Tom's individual session provided further clues about the family system. A strikingly attractive child, he greeted me without making eye contact. After some hesitation, he picked up blocks and began building a series of complex, artistic structures. He told me he was an architect, designing houses in various parts of the country. While the homes were ornate and colorful on the outside, their interior spaces were dark and empty. As he played, he slowly disclosed some of his difficulties—how being diabetic was "just one big pain," how his parents viewed him as smarter than he was, how his "super smart" little sister dominated the family focus. When I said that having a little sister was sometimes difficult, he quickly countered his expression of negative feelings. "Most of the time she's pretty fun, but she is on the dramatic side. I'm really lucky. I have

a good family—great parents." Noticing that his brother had not appeared in his narrative, I wondered aloud about the absence. Tom replied, "Doug's pretty quiet." At this point, there were three completed block structures. Tom pulled a block away from each of them, and the structures remained standing. "Here, you do it," he said. As I pulled on a block, the structures came crashing down. Tom responded, "They look sturdy, but they're not. No internal supports to keep them up. I sort of set you up, you know."

The following week, Tom continued this block play in the family session, where Mandy did take center stage with puppet play and Doug unobtrusively made meticulous pencil sketches of mountain landscapes. As the children played, only Mandy pulled for interaction with her parents and me. The parents were attentive to their children, admiring their play and cautioning Mandy to use her "inside voice." The family seemed over-contained, much like Tom's artistic structures and Doug's realistic landscapes. Responding to a powerful sense of absence, I commented that there were no people in the landscapes or houses. The boys merely nodded. Mandy kept trying to engage her brothers and parents in the puppet play, finally moving to me as last resort. Mandy commented that the animal puppets were planning a picnic, but forgot to bring food. She asked if I had any food, but she quickly moved away from me to create food on her own.

As the assessment period ended, I thought family therapy would be the most effective treatment approach. This freed Tom from the "identified patient" role, helping the parents see that both Doug and Mandy carried aspects of the family's struggle. Additionally, family therapy kept the parents centrally involved, placing them in a position to learn through their children's play about disowned aspects of themselves and their marital relationship. It gave the children and parents a safe place to express negative affect, such as Tom's anger about his illness, Lauren's depression, and family grief about the death of Greg's brother.

During the course of family therapy, I learned more about Greg and Lauren's early histories. Lauren's parents drank to excess, had multiple extramarital affairs, and fought continuously. Her older brothers were viewed as failures, dropping out of high school and leaving home at 16 and 17. This history with her brothers amplified Lauren's anxiety about Tom's academic difficulties. When Lauren was Tom's age, her father became chronically ill, dying in her early twenties. Lauren's mother both needed her and resented her, envious of her attractiveness, freedom, and youth. Greg came from a family of boys, third in a sibling group of seven. His father abandoned the family when Greg was in junior high, and his mother became an alcoholic. Much like Tom, Greg struggled academically in elementary school, although he became successful at school in later years. Greg's brother Doug was just 18 months younger than Greg, his primary friend and confidant. The family never mourned Doug's death.

As Greg and Lauren spoke in the family sessions, Tom and Doug listened very carefully. In those moments, their play lessened, background noise against a conversation they wanted to hear. Doug moved in and out of emotional connection and visibility, as though slowly coming to life. He asked questions about his dead uncle, leading both parents to cry over the loss. Mandy moved between people, alternately offering comfort to her parents and her dolls. Gradually, her family began to understand that her dramatic escalations were a message that something important was being avoided.

What can we understand about object relations family therapy and this family in particular from these brief clinical vignettes? Family losses, unacknowledged and never mourned, edged into consciousness through the children's play—a picnic with no food, houses and landscapes devoid of people, children playing in parallel but not interacting relationally. Doug was indeed the ghost child, carrying unresolved grief and loss, both from his uncle's death and from his parents' childhood histories. His needs were initially invisible to his parents, as they mistook his depression for a quiet, thoughtful demeanor. Only in retrospect could they question their decision to name him after a beloved but dead brother. As the "problem child," Tom exposed the family's vulnerabilities. The elaborate exterior and empty interior space

of Tom's "homes" were a perfect representation of this family, admired on the outside as accomplished and loving, but plagued with an empty, dead interior space. His aggression toward his parents could not be spoken, played out in the transference with me. He "set me up" to crash his artistic creations, much like he felt "set up" by his parents. And Mandy? Mandy frantically tried to breathe life into her family group, where food, nurturance, and play seemed in short supply. Mandy and her father made an exciting object pairing, acting out in exaggerated form the displaced desire and longing from the marital dyad.

Greg and Lauren had no internal model of a functioning intimate partnership or parental couple, drawn together by an unconscious fit in their histories of warring, narcissistic parents. Greg kept his distance from Tom, too easily reminded of his own childhood struggles with learning. Tom's illness created difficult feelings in Lauren—a reminder of her father's deterioration, an identification with her mother's resentment and helplessness, and anger over Greg's dismissal of her concerns. Initially, Greg and Lauren resisted any interpretation about problems in their marital dyad, viewing me as reading them incorrectly, much like Lauren's characterization of Greg's work colleagues.

But unlike their parents, Greg and Lauren were eventually able to consider their psychological impact on their children, using treatment to understand and take back the projected aspects of themselves. This was accomplished through a steady treatment frame, the therapist's use of her countertransference reactions and identifications, the shared experience of core affective moments like Doug and Greg's exchange about their dead uncle/brother, and interpretations linking past and present, such as the way Greg distanced from Tom to avoid the pain of his own past academic struggles.

Potential Benefits, Common Challenges, and Future Directions of Psychoanalytic Couple and Family Therapy

Psychoanalytic treatment approaches are not a magic answer to family and couple problems. Such an approach is most effective for clinicians and families who value in-depth work, examining repetitive patterns, unconscious motivations, displaced projections, and intergenerational deposits. It offers growth and understanding, not cure. Although Tom's family improved significantly, his parents still struggled to form a working intimate partnership. Common challenges for the psychoanalytic couple and family therapist include helping the family commit to a long-term process, filled with periodic confusion and regressions. The therapist needs to accept and respect that the family decides the focus and course of treatment. Sometimes it is difficult to give up our own ideas of what we want for a particular family or couple. Additionally, the psychoanalytic couple and family therapist is continually faced with containing high intensity affect and unmetabolized trauma, a position that can be both interesting and emotionally exhausting. Finally, the psychoanalytic couple and family therapist must value, tolerate, and even embrace the uncertainty of not-knowing, a stance that can be difficult to hold and defend in a culture that requests evidence of therapeutic effectiveness from the outset of treatment.

What is the future of psychoanalytic couple and family treatment? We find that in the United States requests for family therapy have dropped, while couple work is on the rise. Perhaps this is a temporary shift, or perhaps family work will take place more as an adjunctive therapy in substance abuse treatment programs, adolescent residential treatment centers, or child-based interventions. The emergence of broader systemic concepts such as the those captured in the interpersonal unconscious, link theory (Scharff & Scharff, 2011), and the intergenerational transmission of trauma (Faimberg, 2005) hold the promise of a more contextually informed family and couple treatment, incorporating sociocultural elements that influence individual and family development. Finally, the increased investment of psychodynamic practitioners in conducting research to support and illustrate our treatment methods can only add to the clinical conversation in developing more effective treatments for couples and families.

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9.

MULTIGENERATIONAL FAMILY SYSTEMS

Elizabeth Skowron and Jessica Farrar

Background and History

Since their introduction in the 1950s and 1960s, multigenerational approaches to family therapy have occupied a central role in the field, and though they reflect varying nuances and emphases, their foundational themes remain consistent. Most importantly, multigenerational theories and their associated interventions are based on the notion that the emotional processes in a family system shape dynamics that influence the trajectory of both individual and family development across generations. These underlying relational patterns persist and compound from one generation to the next, even as the individual family members change, grow, and die. Although the notion that parents' psychological being will inevitably affect their children in some way is nothing new, the concept of the multigenerational transmission process goes beyond the idea that problems and patterns are merely handed down from parents to children, but rather that all members are part of a much larger, dynamic emotional system. In other words, families are considered as ongoing multigenerational systems rather than discrete, nuclear entities.

The term "multigenerational" refers to approaches that focus on three or more generations of a family; "transgenerational" and "intergenerational" are also sometimes used. Therapists working within these traditions tend to broaden their conceptual scope to include the extended family, consider the role of intergenerational processes in shaping current functioning, and work with individuals and their family members. Multigenerational theorists assert that individuals carry with them unresolved emotional reactivity to their parents, leaving them vulnerable to repeat identical patterns in every new relationship they enter. These unresolved issues with one's original family are considered the most important unfinished business en route to achieving growth-in-connection to their multigenerational family system (Nichols, 1984).

Murray Bowen, Ivan Boszormenyi-Nagy, James Framo, Betty Carter, and Monica McGoldrick, among others, have led the way in developing family systems approaches that extend beyond the nuclear family to emphasize understanding and working with intergenerational family processes. Their multigenerational approaches to family therapy may be utilized when intervening with individuals, couples, nuclear, and extended families systems. All assert to varying degrees that individuals exist within the emotional field of their extended

families of origin, with the present shaped in part by family relationship processes that have been passed down through the generations. Their work has gained increasing attention from academic researchers and training programs, with advances made in recent decades by clinical researchers in the United States and abroad on testing the basic concepts in these theories.

Bowen, Boszormenyi-Nagy, and Framo are considered the pioneers of intergenerational family therapy as a field. All three were psychoanalytically trained and their theoretical innovations were shaped by that training and by their work with families with schizophrenia and other severe mental illnesses. Thus emerged a cadre of approaches (i.e., Bowen's family systems therapy, Boszormenyi-Nagy contextual family therapy, and Framo's family-of-origin therapy) in the 1950s and 1960s that sought to achieve new understandings of individuals, the systems in which they relationally exist and operate, and the reciprocal influence of the two. Another commonality among these theorists was their emphasis on therapists needing to work on themselves within their own multigenerational family systems (i.e., gaining insight, becoming less emotionally reactive, re-engaging with parents as an adult peer) as a prerequisite for leading others through this process.

According to multigenerational approaches to family therapy, the basic building block of complex social groups is the multigenerational family. When considering a family vis-á-vis the context of its multigenerational past, predictable patterns begin to emerge; while the players may shift across generations, these patterns are thought to persist over time (Kerr, 1983). In fact, relationships with family members persist even when they are no longer living, as highlighted by the opening quote drawn from a Broadway play in Framo's (1992) book on family-of-origin therapy: "Death ends a life, but it does not end a relationship, which struggles on in the survivor's mind toward some resolution, which it may never find" (Anderson, 1970). Furthermore, relationship patterns are considered to have an inherently cross-generational trend, and are perpetuated into future generations (Framo, 1992). Bowen, Boszormenyi-Nagy, and Framo all stress some version of the idea that only when we are able to "clear the cobwebs" from our relationships in our family of origin are we free to grow and improve in our present relationships.

From an evolutionary perspective, humans are deeply social beings that depend on relationships for survival and for emotional and psychological well-being. Early in life, banishment or isolation from the primary social group has dire consequences, limiting access to resources and increasing vulnerability to environmental threat. Into adulthood, symptoms that develop as a result of reducing social contact are thought to serve a function for maintaining social and psychological proximity to others. For example, the consequences of loneliness and social isolation are grim, as they can compromise the capacity to manage stress and self-regulate, and lead to physical and mental health problems (e.g., Cacioppo, Berntson, Sheridan, & McClintock, 2000; Shonkoff et al., 2012). It is with this in mind that multigenerational approaches to family therapy privilege a focus on understanding the patterns of emotional connections in family relationship systems across generations, rather than specific individual symptoms and syndromes. As James Framo (1992) aptly points out, symptoms are merely a minor piece of an intricate and ongoing complex.

Grounded in natural systems theory, Bowen's approach conceptualizes the family as the emotional unit of functioning. Bowen theory provides a framework for understanding the functioning of human emotional systems on the basis of emotional processes at work in one's nuclear family and across the generations of an extended family system. Two counterbalancing life forces lie at the center of Bowen theory: a force toward individuality, grounded in our instinctual drive to be an individual in our own right, self-contained, independent and autonomous, and a force towards togetherness, rooted in our instinctual need to be connected with others and part of the group. This notion of balancing our inherent drive toward togetherness while simultaneously striving for autonomy and

individual well-being is a recurring theme in the multigenerational theories. Bowen (1978) conceived of this phenomenon as differentiation of self, a fundamental property of family relationship systems, reflecting an ability to experience intimacy while preserving a clear sense of self in one's significant relationships. Across generations the level of differentiation in our family of origin is thought to influence our choice of romantic partners and shape the emotional processes that unfold in our nuclear families of choice. Framo (1970) also emphasized the ongoing conflict between autonomy and our needs to be accepted by others, and believed that this is the primary source of psychological distress. Boszormenyi-Nagy conceptualized problems (to which he referred to as "disjunction" rather than "dysfunction") emerging as a result of an imbalance in fairness in relationships and a disintegration of trustworthiness (Nelson, 2003).

Whereas conventional approaches to understanding families focused primarily on individual functioning and extend to dyadic relationships between parent and child or romantic partners, multigenerational approaches conceptualize the family in the larger context of relationship triangles (Bowen, 1978) and the broader family system. Betty Carter and Monica McGoldrick, who trained with Murray Bowen, also emphasize the multigenerational patterns and processes that shape individual functioning. Together with Virginia Satir, they are unique among the early leaders in the field in that their work is grounded in rich feminist and multicultural perspectives. They are best known for advancing conceptions of the family life cycle framework which describes the developmental stages that families pass through and expanded it to incorporate the stages of divorce and remarriage (e.g., Carter & McGoldrick, 2004). They also advanced and refined the use of the family genogram as a tool to map the basic facts and relationship processes involving closeness, distance, and conflict across multiple generations of a family (McGoldrick, Gerson, & Shellenberger, 1999). The family genogram is among best-known tools in family therapy, and is not restricted to a multigenerational therapeutic approach but is utilized by therapists with varying orientations to family therapy.

In his contextual family therapy, Boszormenyi-Nagy specifically chose to use the word "context" when referring to his particular therapeutic approach because, "while an individual is a discrete and unique biological entity, dynamically each person's life derives meaning through reference to a social context" (Boszormenyi-Nagy & Krasner, 1980, p. 767). In addition to emphasizing multigenerational patterns that emerge over time, Boszormenyi-Nagy also incorporated the idea of relational fairness as a prominent piece of conceptualizing individual and family dynamics. Boszormenyi-Nagy's contextual family therapy takes an integrative approach, as it includes relational ethics and transactions, individual psychology, and biology. The four key components of "context," according to Boszormenyi-Nagy are as follows: 1) facts, which include things that undisputedly have happened or exist, such as births, marriages, divorces, genetic and cultural components; 2) individual psychology; 3) systemic transactions or transactional patterns, which are the ways people consistently interact with one another; and finally, 4) relational ethics, which is the balance between considering one's own interests equally with the interests of others (Boszormenyi-Nagy & Krasner, 1980, 1986; Nelson, 2003).

Framo, who worked closely with Boszormenyi-Nagy in the 1950s and 1960s, developed an object relations approach to multigenerational family therapy in which he focused on how family-of-origin issues play a role in marital problems and child problems. Specifically, Framo described the goal of his work as integrating "dynamic and systems concepts, and intrapsychic and interpersonal dimensions, thereby providing a conceptual bridge between the personal and the social" (Framo, 1992, p. 111). The object relations concept of projective identification remains especially relevant in his approach (Framo, 1970, 1992; Nelson, 2003), as one of the goals of family-of-origin therapy is to identify and work through negative introjects, or internal representations of early caregivers that we project onto those with whom we are currently in relationships. The idea is that by working through unresolved issues in our family-of-origin, we are then free to grow in our current intimate relationships

in a more healthy, authentic way. Framo advocates for bringing parents and adult children together, when possible, for lengthy sessions that are focused on working through any unfinished business that is preventing them from moving forward in other significant relationships.

Theoretical and Research-Based Concepts

Bowen Theory

Of the many multigenerational approaches to family systems that have been developed, arguably the most comprehensive is Bowen family systems theory. Although Bowen's goal was to describe and understand human behavior within a relational context, he was actually quite reluctant initially to advance a particular approach to therapy as Bowen was invested in developing a new theory of human behavior, not a new method of therapy per se (Kerr, 2008b). In his Anonymous (1972) paper followed by his major text on family therapy, *Family Therapy in Clinical Practice*, published in 1978, Bowen outlined the six major concepts in his theory and their clinical application (i.e., differentiation of self, emotional cutoff, triangles, nuclear family emotional system, family projection process, and multigenerational transmission process).

Bowen took an evolutionary perspective on health and functioning in family systems. He recognized that as humans, we are highly social beings predisposed toward cohesion in our social groups for maximizing survival through access to shared food, resources, and protection. Due to our evolutionary-based inclinations toward group living, we evolved finely tuned sensitivities to social cues specific to acceptance, inclusion, and approval, likely due to the fact that our survival (historically speaking) has been largely contingent upon functional, enduring connections with others in our social group (Kerr, 2008b). Paradoxically, while our sensitivities to social connection serve an adaptive function from an evolutionary perspective, they also can be a major source of stress and dysfunction within our relationships. The implications of our emotional interdependence on others are that any tensions, anxiety, or conflict we experience in our relationships can intensify emotional reactivity and hinder our functioning.

Differentiation of Self

Bowen asserted that one's life-course is largely contingent upon two interrelated concepts: the level of differentiation of self and the level of anxiety in one's family system. Differentiation of self is viewed as a fundamental property of family systems with levels thought to be roughly consistent across members in the system. Differentiation operates in both internal and interpersonal spaces. More highly differentiated individuals are aware of their emotions and can experience strong feelings, but also can shift toward calm, thoughtful reflection and deliberative reasoning regarding their circumstances (Bowen, 1978; Kerr & Bowen, 1988). In essence, differentiation involves a capacity to self-regulate emotion and behavior within oneself, which in turn, enables authentic, mature intimacy, and clear self-definition. Bowen questioned the utility of discrete diagnostic categories of functioning and disorder and instead conceptualized functioning along a continuum of health that he termed "differentiation of self."

On an interpersonal level, differentiation of self reflects an ability to balance the dialectical tension between forces for individuality and togetherness, and thus achieve intimacy while preserving a clear sense of self in one's significant relationships (Bowen, 1976, 1978; Titelman, 1998). More highly differentiated individuals are thought to achieve emotional intimacy in their relationships without experiencing fears of feeling smothered and to maintain autonomy without fears of abandonment (Kerr & Bowen, 1988). In less differentiated relationships, there is more anxious monitoring of the other going on, such as when a child acts up in response to an escalating parental argument, or when a parent sweeps in to protect his shy child from a novel social situation, or when an individual outwardly adopts the political or religious beliefs of a significant other for the sole purpose of maintaining harmony in the relationship rather than as a function of their own personal convictions. Less differentiated individuals are more dependent on their relationships to stabilize and calm themselves,

and are more sensitive to the attention, approval, expectations of others (Kerr, 2008c). Bowen also theorized that individuals tend to seek out mates who are similarly matched in terms of their emotional maturity. He explained that it was because,

> the lifestyle and thinking and emotional patterns of people at one level [of differentiation] are so different from people at other levels that people choose spouses or close personal friends from those with equal levels of differentiation.
>
> *(Bowen, 1978, p. 473)*

More highly differentiated persons are thought to be capable of supporting the best interests of others without feeling a loss of self-direction or selfhood in the process (Schnarch, 1997b). Greater differentiation of self also enables one to maintain connections during conflict or with those who hold different opinions, and to resist the use of emotional cutoff or relational control to maintain calm (Schnarch, 1997b; Skowron & Friedlander, 1998). Likewise, such parents are capable of providing support and nurturing their children's age-appropriate autonomy and developing their children's capacities for self-regulation of emotion and behavior.

At its core, differentiation of self is akin to the level of emotional maturity one is able to achieve in significant relationships, including the family of origin, work, and peer relations, and with members of one's nuclear family of choice. According to Kerr (1981), feelings of too much separateness from others will stimulate movement toward greater emotional closeness, whereas feeling too much togetherness can trigger efforts to recover some individuality. Finding a way of maintaining a balance amidst these two forces is the primary goal of those working on themselves in their family system within the framework of Bowen's approach.

Along similar lines, Williamson's (1982) concept of personal authority in the family system refers to "the achievement of peer-like intimacy in interactions with all persons, including parents, while maintaining an individuated stance" (Harvey & Bray, 1991, p. 300). Williamson (1982) argued that personal authority is achieved when adult children manage to renegotiate their relationships with parents on the basis of mutual respect, collaboration, and choice, rather than based on obligations, or the use of intimidation or fear (Harvey & Bray, 1991). This renegotiation occurs in adulthood, and focuses on shifting power in the parent–adult child relationship to support mutual, peer-like relationships to emerge (Williamson, 1981).

Within Bowen theory, differentiation of self is conceptualized on two levels: basic and functional. The basic level of differentiation is developed during childhood and is relatively stable throughout a person's lifetime. Functional levels of differentiation involve the artificial inflation or deflation of one's level of functioning on the basis of borrowing and trading of "self" in relationships. One might appear to be more highly differentiated in the context of one relationship, but less so in others; this is also referred to as "pseudo self." At lower levels of differentiation, Bowen posited that we engage in more borrowing and trading of "self" in our relationships with others. Functional levels of differentiation, therefore, may fluctuate relative to one's basic level of differentiation, as they can increase or decrease based on the particular relationship system(s) in which one is involved. As Kerr (1983) noted, the issue is not whether we should or should not be regulated by other's emotions, rather that the goal is to become capable of self-regulating within the emotional field.

Bowen (1978) conceptualized differentiation of self as existing on a scale ranging from low to high. Those low on the scale of differentiation experience a "miserable, stuck together state" and tend to have a propensity toward explaining things in terms of "I feel" rather than "I think," and are more likely to base major decisions on how they feel in the moment. While families and other social groups have an undeniably strong influence on our thoughts, feelings, and behavior, individuals respond to various pressures to conform quite differently, based on their emotional maturity. Some manage to remain calm and maintain more of a "self" in their relationships, while others succumb to acting in accord with the group expectations for them regardless of the suitablity of said expectations. A common

misconception that Bowen and others address is that the idea that someone high on the differentiation scale would be a cold, unfeeling person (Kerr, 1985; Titelman, 1998); this is not at all the case. Rather, a highly differentiated individual has the capacity to experience strong emotions and have engaging and meaningful relationships with family members, but also maintains a sense of agency about the extent to which the surrounding emotional field will have an affect (Kerr, 1983).

Emotional Cutoff

Emotional cutoff is closely related to differentiation of self and reflects anxious maneuvering designed to regulate the extent of one's proximity to others. Cutoff operates between individuals and subsystems and over multiple generations of a family, and can be manifested physically and emotionally, though these are not mutually exclusive. Increasing physical distance is one way to achieve cutoff, and the other is by remaining in close physical proximity but channeling psychological and emotional energy away from relationships with family members. A few examples of emotional cutoff are withdrawing into books, hobbies, substance use, or a romantic affair. Although the cutoff person may appear to be in a state of emotional stability, he or she is actively avoiding the resolution of relationship tensions. Though these tensions may not be readily apparent, they persist in a state of dormancy. Individuals who gravitate toward cutoff to manage anxiety in relationships are more prone to becoming overly dependent on new relationships with people outside of the family (significant others, for example) for emotional security and satisfaction.

To the question of how differentiation of self develops, the process of differentiating is thought to have its roots in early childhood and to become firmly established once a person reaches adulthood (Bowen, 1978; Kerr, 1983; Skowron et al., in press). The foundation for differentiation of self is laid down in infancy and is manifested in early childhood as a child's developing capacity for self-regulating their emotions and behavior. Bowen posited that children of parents who are more highly differentiated will have more energy freed up to dedicate to growth and development beyond the immediate scope of the family's emotional needs. Early in life, infants rely on parents and other external sources for assistance in regulating their internal states, and into toddlerhood and the preschool years, children gradually internalize the capacity to self-regulate (Thompson, 1991; Winsler, Diaz, Atencio, McCarthy, & Chabay, 2000). As the developmental needs of a child shift across infancy, toddlerhood, and into the preschool years, parents and children in more differentiated families are able to transition from exclusive parental regulation of the child's needs toward co-regulation, with children eventually achieving age-appropriate capacities for self-regulation. More highly differentiated parents are thought to continue providing supportive, comforting behaviors when their young child experiences distress, but also encourage his or her increasing proclivities toward age-appropriate autonomous behavior. In less differentiated families, parents struggle more with the challenges of simultaneously providing support for their child's autonomy and needs for comfort and connection, and behavioral exchanges between parent and child tend to take on an anxious automaticity (Kerr, 2008b). The "freer" a child has been while growing up from being caught up in family emotional fusion, the less that child has had his/her development governed by the emotional aspects of relationships. Bowen (1970a) describes it as having the energy free to go forward with individual development while remaining in good contact with others.

In more recent years, Kerr (2008c) elaborated on the three E's of Bowen theory—*Emotional Programming*, *Emotional Regression*, and *Emotional Objectivity*—in his postgraduate training lectures at Georgetown. *Emotional programming* refers to the development of automatic response repertoires that emerge and develop over time in a family relationship system, which get internalized and enacted by offspring. Walter Smith describes this as the paradox of Bowen theory, "Each of us is responsible for our behavior, even if it is an aspect of a broader family emotional process" (2003, p. 352). *Emotional regression* involves the escalation of chronic anxiety, which compromises functioning of our more recently evolved, higher-order executive

regulatory systems, and leaves more primitive, automatic behaviors to dominate, resulting in system overload and the development of symptoms. *Emotional objectivity* is an important ingredient for progress in differentiating a self in one's important relationship systems. Kerr defines emotional objectivity as the ability to describe the functioning of an emotional system—one in which you participate in a calm, thoughtful, and factual manner. The process of differentiation depends on this capacity to look at a system of which you are a member, recognize your role in perpetuating challenges or problems, and use this knowledge to guide mature, intentional action. Differentiation of self and emotional cutoff come into play when considering the concept of relationship triangles.

Triangles

Another important contribution from Bowen theory (1978) is the concept of the relationship triangle, which is considered to be the smallest, stable unit of human relations. When two people are unable to resolve problems between them, one or both will tend to pull in a third (e.g., one's child, an affair, work, a therapist) to diffuse anxiety and conflict and thus form a triangle; hence the activity of triangles is inherently governed by emotional process (Kerr, 1983). Common examples of triangling include engaging in office gossip, having an affair, anxiously focusing on your child, and even some cases, ways of engaging in individual psychotherapy. All emotionally significant relationships contain triangles operating in some manner, whether the third party is another person, a memory, hobbies, or any number of possibilities (Nichols & Schwartz, 2007). The tendency for people to engage in triangles is instinctual, and is thought to originate out of our evolutionary needs for closeness by serving to a) relieve tension, b) displace conflict, and/or c) manage intimacy (Bowen, 1978; Guerin, Fogarty, Fay, & Kautto, 1996).

Bowen asserted that relational triangles are ubiquitous, and as humans we are predisposed to form and participate in them. The intensity of triangling is thought to be shaped by the level of differentiation of self in the system, such that more intense triangles are observed in less differentiated relationship systems (Kerr, 1983). Triangles are both natural and functional, as they serve to ease tension, yet they become problematic when they allow for the avoidance of conflict by freezing problems in place. Triangles serve as a "stabilizing distraction" that prevents the resolution of conflict within a dyad (Guerin et al., 1996). When conflict is observed between two members of a system, it is useful to look for the triangles currently operating, because participation in relationship triangles hinders the natural growth and change that healthy relationships require over time.

Although conventional approaches to family therapy often focus on dyads, multigenerational approaches consider how primary and secondary triangles may be operating in the broader relationship system. Guerin et al. (1996) provide an excellent discussion of the clinical applications of working with triangles in a therapeutic context and noted that there are three different types of triangles in a family setting that correspond directly with the respective mechanisms through which tension in the family system may be expressed. The first involves a *child- or adolescent-centered triangle*, which essentially involves projection of the family system's stress onto the child. This can manifest itself in myriad ways, with a child exhibiting behavioral difficulties, problems performing in school, interpersonal distress with peers, or through physical symptoms, for example. The second type of triangle is the *spousal triangle*, characterized by marital conflict. Bowen describes a cyclical, maladaptive pattern that may emerge in which the attempt at balancing togetherness and separateness is not adeptly navigated but may vacillate from one extreme to another. Too much fusion, or emotional over-involvement will cause the couple to attempt to find equilibrium via distancing; fighting and emotional cutoff are two methods employed in achieving this end. In response to the discomfort caused by distancing, the couple may again move toward one another in extreme closeness or emotional fusion, and begin the cycle again. The third type of triangle involves *individual dysfunction*, which may occur in both partners, but is likely to be more prominent in one

of the two. The dysfunction may be in the form of physical, emotional, or social distress or any combination of these. In other words, triangles can serve as a mechanism for symptom activation. "A person emotionally trapped in a triangle is likely, by virtue of being trapped, to suffer some loss of function," whether psychological or physiological (Guerin et al., 1996, p. 31).

Triangles also may impact the chronicity of symptoms—being locked into a dysfunctional triangle is one way of perpetuating distress. Symptoms that are highly related to one's position in a triangle are at risk of being more resistant to direct intervention, and must be approached more holistically, through a focus on treating the symptom in a manner that adequately attends to the context within which it is presenting. Efforts to improve one's functioning and modify one's position in the triangle may upset the status quo and lead to "change back" messages from the system. When an individual gets "caught" in a triangle that reinforces certain ways of thinking and behaving, it may limit awareness of alternatives and contribute to maintaining a sense of equilibrium. As such, triangles serve as a vehicle for non-compliance with therapeutic interventions and can contribute to a therapeutic impasse (Guerin et al., 1996). Together, these represent several reasons why a working understanding of relationship triangles is useful for effective intervention with children, adolescents, couples, and families.

From a therapeutic standpoint, one of the benefits of thinking about triangles is that it keeps the focus on relational processes rather than allowing one to get mired down in a focus on content. Knowledge of triangles, how they operate, and the function they serve, can ultimately help a therapist to remain detriangled in therapy, whether they are working with an individual who presents with relationship difficulties, or working with couples and families. Understanding the patterns in a triangle and the functions they serve helps to illuminate the individual and dyadic problems more clearly (Guerin et al., 1996).

Nuclear Family Emotional System

The concept of the nuclear family emotional system describes the basic relationship processes that govern where symptoms emerge in a family. Bowen (1978) asserted that human activity is governed by our emotional systems to a larger degree than we are willing or able to admit. Specifically, when anxiety in a family system is high, problems are thought to emerge in the form of symptoms, conflict between spouses, or anxious focus on a child (Bowen, 1978). These basic relationship processes are triggered by tension/stress in the system that are "expressed by" or "located within" certain members or relationships in the family. Bowen observed that the more parents are cut off from their families of origin, the more intense will be the relationship processes that manifest in the nuclear family. The severity of problems that develop, where they develop, and the number of family members affected are contingent on factors such as the family's aggregate level of differentiation of self, stressors from external as well as internal forces, and family patterns of adapting to stress.

Kerr (2008a) theorized about the processes that unfold as individuals from distinct multigenerational family systems join to create a nuclear family emotional system. During the initial courtship phase of a romantic relationship, forces for emotional togetherness tend to reign, and both partners enjoy comfortable emotional contact and intimacy. Over time as the newness of the relationship wears away, one partner may grow distracted or preoccupied with other matters and the other may become anxious about the growing distance and feel prompted to move toward the other in an effort to re-establish the original closeness. The other may further distance to calm self, and a pursuer–distancer dynamic may be initiated in what Kerr (2008a) describes as an anxiety-driven process in which both people participate and both shape. Over time, one member may tend to absorb more of the relationship-generated chronic anxiety and feel blocked from a sense of adequate emotional contact with his or her mate. The more stress/tension that is "absorbed" by one person or one relationship in the system, the less others must absorb or carry, serving as a sort of buffer for the rest of the system and freeing up the other members of the family to maintain their functioning (Kerr, 2008a). However, the relationship processes outlined in Bowen theory serve to "solve" this dilemma.

Regarding *dysfunction in one spouse*, Bowen described a process in which one spouse pressures the other to think and act in a particular way (i.e., as more submissive and passive, or as more dominant and responsible, etc.), and the other yields to the pressure and accommodates. The spouse who yields to pressure from the other may submit and take on a passive stance in the relationship, or could be pressed into taking on a more responsible, dominant role of managing the other, for example. Regardless of the position that the more accommodating spouse takes, he or she is yielding "self" in the process and is thought to be more likely to develop symptoms—emotional, physical, or social—under stress. Though this partner is behaving in a harmony-promoting manner, he or she is simultaneously absorbing relational stress and anxiety. The phenomenon goes something like this is: "*If you act in a particular way (e.g., nervous and needing my help), I'll feel better and calm down (e.g., I'm less anxious when I'm taking care of others). If I'm calmer because I'm now taking care of you, then you can relax and calm down as well.*" Dysfunction in one spouse involves yielding to pressure from the other to underfunction, and this in turn serves to calm the other, which then decreases the tension in the system. This reciprocal process in which one spouse overfunctions while the other underfunctions is solidified into an ongoing pattern that becomes mutually reinforcing over time and more entrenched in the system, as each partner becomes more defined by their role. This relationship-based management of emotional reactivity, whether it takes the form of over-protection, over-functioning, or alternately, as blaming the other—involves the process of externalizing discomfort felt by oneself and projecting it onto the marital relationship and partner.

Marital conflict can signal healthy relationship functioning when it comes from a position of emotional maturity involving thoughtful disagreement between two individuals. However, marital conflict as a relationship process can serve to bind tension in the couple—for example, when spouses externalize their anxiety and discomfort onto the other, focus on what is wrong in the other, and try to control one another while simultaneously resisting the other's attempts to control (Kerr & Bowen, 1988).

Tension in the family system may also be expressed via *impairment in one or more children*, typically among more vulnerable or sensitive members. Parents may anxiously focus on one or more of their children or seek closeness with one of their children in response to distance or cutoff in the marriage. This type of child focus is thought to serve a calming function for the parents but more importantly, in the system. Anxious child focus may appear protective in nature, or take on a more negative and critical tone. Regardless, it has the effect of aligning spouses together in an effort to "deal with" the (child) problem, while also freeing up the other children in the family to enjoy higher functioning.

As in the case of over/under functioning spouses, the patterns in childfocus become self-perpetuating, with a child's actual behavior reinforced by messages from parents and vice versa. For example, a child may continue to get the message of "*we don't think you are able to handle new, age-appropriate responsibilities, because we've always helped you manage yourself in the past, so going forward, you need us to help you manage new situations.*" The family emotional process creates a system organized around the symptomatic child (i.e., child underfunctioning and parent over-involvement, or child acting out and parent walling off), with relationship processes serving to perpetuate the dysfunction in the child. According to Bowen (1970b) the most difficult family problems to treat are those that center around a parent–child triangle with focus on a symptomatic child. Parents may be reluctant to recognize their roles in the problem: this inadvertently supports the child focus, and obscures other problems in the system, including marital tension, conflict, or distancing. Bowen hypothesized that families can respond to tension in the system by developing any of these relationship patterns, though he suggested that families who seem to rely on a single pattern (e.g., child focus or marital conflict or symptoms in a spouse) tend to have more difficulty improving their functioning, even with the help of therapy, whereas families observed

demonstrating more than one type of these relationship processes are more responsive to intervention.

Multigenerational Transmission Process

According to this concept, the level of differentiation of self in the family is transmitted across generations of the family through emotional processes rooted in evolutionary forces, and maintained through patterns of family interaction. Kerr describes multigenerational process as "Emotional Programming," whereby processes are laid down as automatic through the relational systems (parent–offspring attachment), internalized, and enacted by offspring. In order to cope with threats to the stability of our relationships, Kerr (2008b) argued that we have evolved finely tuned sensitivities to social cues that in turn, alert us to threats to our security in important relationships. At lower levels of differentiation, greater fusion between thinking and feeling processes leaves us less able to take one another's perspective, and as parents, less able to read our children's cues. Kerr (2008a) offers one example of relationship sensitivities in the context of marital interactions; a wife asserts herself in relationship to her husband. She sees and hears her husband's facial expressions and tone of voice and interprets them as signs of disappointment. As a result, she says and does more things to please and submit to him. The husband then brightens up, and as a result she feels less threatened (Kerr, 2008a). This exchange begins with the wife asserting autonomy, which elicited anxiety in her husband, followed by the husband's criticism of his wife. The wife sees that she has disappointed him and moves to take a one-down affiliative stance—when she submits, he calms down, and takes a warm, controlling stance. As the interchange ends, the couple has resumed a complementary stance vis-à-vis one another, and as a result, the husband has calmed and the wife then feels calmer, though she has given up her earlier autonomous position. Ultimately, both are dependent on the other to manage self.

Another example of emotional process in parenting is the relational transfer of anxiety between parent and child that unfolds through a series of increasingly complementary interchanges. Here, more anxious (i.e., less differentiated) parents misread child cues, which leads to role reversals in which the child adjusts his or her behavior to match cues from the parent. The child relies on his or her parent for signals indicating how to behave in ways that maintain relationship calm, and in doing so, maintains a pattern of reliance on the other to regulate their own emotions and behavior. In short, parent and child learn to calm themselves, not by each managing themselves, but rather by adjusting their own behavior in order to regulate the other. Bowen explained:

> the process begins with anxiety in the mother. The child responds anxiously to mother, which she misperceives as a problem in the child. The anxious parental effort goes into sympathetic, solicitous, overprotective energy, which is directed more by the mother's anxiety than the reality needs of the child . . . Once the process has started, it can be motivated either by anxiety in the mother, or anxiety in the child.
>
> *(1978, pp. 380–381)*

In this example, the child becomes attuned to the parent's anxiety and acts in a way that the parent is pulling for, which reduces the parent's upset. In response, the child's level of anxiety decreases as a function of the parent's. In other words, at lower levels of differentiation, more borrowing and trading of self is thought to occur and there is more emotional pressure to respond to the other in complementary ways. The scenario is repeated countless times and explains the development of the pseudo self and an overreliance on an orientation to looking outward toward the other to regulate self. Framo (1992) used the metaphor of "clearing the cobwebs" to describe his approach to working with patterns in the present that are linked to a family's multigenerational transmission process. He described the ways in which problems in a family are displaced downward, and that only after the cobwebs have been cleared is

there space to begin making progress in the current relational issues.

Empirical Support for Bowen Theory

Many of the theoretical concepts in Bowen theory have been operationalized in research to varying degrees, and hold relevance for the field of family therapy. Differentiation and emotional cutoff have been the subject of most research to date (e.g., Miller et al., 2004). Several efforts have been made to operationalize these concepts, and many stand out as rigorously constructed and tested. In the case of differentiation of self, despite general agreement among theorists that it has far-reaching implications for understanding psychological health and well-being (Guisinger & Blatt, 1994; Kerr & Bowen, 1988; Nichols & Schwartz, 2007), psychometrically sound measures of the constructs have only recently been developed. The most commonly used to date is the Differentiation of Self Inventory (DSI; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003), a 46-item self-report measure of differentiation of self in adults (ages 25+), their significant relationships, and current relations with family of origin, and comprises four subscales: Emotional Reactivity, "I" Position, Emotional Cutoff, and Fusion with Others. Higher scores on each subscale and the full scale reflect greater differentiation of self (i.e., less emotional reactivity, greater ability to take an "I" position in relationships, less emotional cutoff, or less fusion with others), with lower scores indicated lower levels of differentiation of self. The DSI has been translated into over a dozen languages, including Chinese, Farsi, French, Hungarian, Italian, Japanese, Polish, Portuguese, and Spanish.

Grounded in multigenerational theories (Boszormenyi-Nagy & Ulrich, 1981; Bowen, 1978; Framo, 1992; Williamson, 1981), the Personal Authority in the Family System Scale (PAFS; Bray, Williamson, & Malone, 1986) is a 132-item self-report measure most commonly used to assess an individual's ability to function autonomously in the family system while maintaining age-appropriate connections with parents and significant others (Anderson & Sabatelli, 1990). The PAFS distinguishes between intergenerational and spousal/peer relations, and includes a focus on the concept of personal authority in its assessment of the interpersonal dimensions of differentiation. Separate versions of the measure exist for use with adults and late adolescents. Factor analysis of the PAFS items has shown support for a factor structure corresponding to its subscales, except for considerable overlap observed between Fusion and Intimacy scales (Lopez & Gover, 1993). The PAFS neglects to assess the phenomenon of emotional cutoff in relationships, whereas the DSI does not distinguish between differentiation of self in one's relationships with parents versus romantic partners.

Research conducted using the PAFS and DSI provides compelling support for the basic tenets of the multigenerational perspectives across a range of socioemotional and physical indices of health and adjustment. For example, greater differentiation of self has been linked with fewer psychological and physical health problems (e.g., Bartle-Haring & Gregory, 2003; Skowron, 2000; Skowron & Friedlander, 1998; Skowron, Stanley, & Shapiro, 2009), greater self-regulation of attention and behavior, adult attachment security, healthy parenting, and lower marital distress, conflict, and family violence (Skowron & Friedlander, 1998; Skowron, 2000; Skowron, Kozlowski, & Pincus, 2010; Skowron & Platt, 2005; Skowron & Dendy, 2004; Thorberg & Lyvers, 2006; Wei, Vogel, Ku, & Zakalik, 2005; Parsons, Nalbone, Killmer, & Wetchler, 2007). Lower emotional reactivity and emotional cutoff as measured with the DSI are associated with greater affect regulation (Wei et al., 2005), and effortful control of attention and behavior (Skowron & Dendy, 2004). There is even evidence suggesting that differentiation of self impacts health-related behavior, enhances physical health (e.g., Murray, Murray, & Daniels, 2007; Peleg-Popko, 2002), and serves as both moderating and mediating factors between stress, coping, and adjustment in emerging adults (Knauth, Skowron, & Escobar, 2006; Murdock & Gore, 2004; Skowron, Wester, & Azen, 2004). Likewise, greater personal authority has been associated with less psychological distress and fewer health problems (Harvey, Curry, & Bray, 1991), greater marital satisfaction, and better psychosocial

development (Cebik, 1988). Joint factor analyses of the DSI and PAFS measures yielded the presence of two related factors: *Self-Regulation*—comprising DSI scales characterized by less emotional reactivity and the ability to take an I position in relationships; and *Interdependent Relating*—marked by greater personal authority, intergenerational intimacy and less intergenerational fusion on the PAFS and less emotional cutoff on the DSI, that together predicted greater well-being among both women and men (Skowron, Holmes, & Sabatelli, 2003). On the question of gender, Williamson, like Bowen, posited no relationships between gender and the ability of adult children to achieve personal authority in their relationships with parents and partners. However, some research (e.g., Garbarino, Gaa, Swank, McPherson, & Gratch, 1995) suggests that young adult women may have greater difficulty than men in developing personal authority in their families of origin.

Although a central tenet of Bowen theory is that romantic partners are more similar in their levels of differentiation, the research has yet to provide support for this proposition in married heterosexual (Skowron, 2000) or lesbian couples (Spencer & Brown, 2007). However, further tests of the similarity hypothesis need to be conducted in happily married, intact couples vs. separated and divorced couples to provide a definitive test of the theoretical assertion that people partner at similar levels of differentiation of self. In sum, findings to date suggest that levels of couple differentiation of self are strong predictors of marital quality, while the role of match in levels of differentiation of self has not been supported.

Considerable research exists documenting the impact of marital conflict both on children and on the quality of parent–child relations (see Erel & Burman, 1995; Krishnakumar & Buehler, 2000, for meta-analytic reviews), though few studies have directly operationalized and tested family systems propositions about triangling in family systems (cf. McHale, 1997; McHale, Kuersten-Hogan, Lauretti, & Rasmussen, 2000). Research on triangles has employed self-report and observational methods, and the PAFS (Bray, Harvey, & Williamson, 1987) contains a nuclear family and a multigenerational triangulation scale that have been used in a number of research studies. Likewise, longitudinal research on triangulation of adolescent children into their parents' conflicts has been conducted using the Children's Perception of Interparental Conflict questionnaire (CPIC; Grych, Seid, & Fincham, 1992). Results suggest that adolescents who report feeling more triangled into their parents' conflicts engaged in more self-blame and experience negative relationships with their parents over time than did children who were not more heavily involved in triangles (e.g., Fosco & Grych, 2010).

Research also shows that family-of-origin experiences may impact children's abilities to effectively self-regulate (e.g., Calkins, Smith, Gill, & Johnson, 1998; Gottman & Katz, 2002; Lunkenheimer, Shields, & Cortina, 2007; Maughan & Cicchetti, 2002; Skowron et al., 2011). Children's capacities for self-regulation of emotion and behavior are critical for positive pro-social development and functioning and shape the development of psychological and physiological symptoms (e.g., Denham et al., 2003; Eisenberg & Morris, 2002; Kopp, 1982, 1989; Thompson, 1994). For example, maternal differentiation of self has been shown to predict children's cognitive functioning, self-esteem, and pro-social behavior in a low-income urban sample of families, even after accounting for neighborhood violence, family life stress, and parent education (Skowron, 2005). Lower family stress and greater maternal differentiation significantly predicted less child aggression (Skowron, 2005). Bornstein and Suess (2000) observed that physiological regulation in mother and young children become more highly correlated over time from birth, with children's experiences of maternal caregiving over time likely playing an important role in shaping children's developing autonomic responses. Evidence emerging from our lab also suggests a central role for parent's warm support for child autonomy (i.e., differentiation of self) to enhance autonomic and attention forms of self-regulation in preschool children (Skowron et al., 2011; Skowron et al., in press; Skowron & Khurana, forthcoming). Lower emotional cutoff in parents also has been linked to lower separation anxiety in Israeli-Druze children (Peleg, Halaby, & Whaby, 2006).

Research suggests that parental level of differentiation shapes a child's developing capacities for self-regulation to a level of emotional functioning on par with the parent's own emotional maturity. Although direct and indirect evidence supports the notion that parents' differentiation of self is linked to their young children's capacities for self-regulation, the interpersonal mechanisms through which differentiation of self is transmitted across generations remain to be clarified. Countless studies have sought to clarify the multigenerational mechanisms through which parenting practices and other behaviors are transmitted across generations of a family, these transmission processes remain poorly understood (e.g., Conger, Belsky, & Capaldi, 2009; Serbin & Karp, 2003). Is Bowen theory correct in asserting that levels of differentiation are transmitted across generations of a family? If so, how do children come to acquire levels of differentiation roughly similar to those of their parents: through biological or relationship processes, or both?

Crucible Therapy

In his family systems approach to sex therapy and intimacy, David Schnarch (1991, 1997b, 2002) draws on aspects of Bowen theory, particularly differentiation of self, to frame healthy and satisfying intimate relationships. Schnarch's (1991) "Crucible Therapy" extends Bowen theory to focus on sex and intimacy, and his approach successfully integrates sex therapy and marriage/couple therapy to assist couples in navigating the normal but difficult growth processes and inevitable conflicts that occur in most intimate relationships. Rather than emphasizing communication skills training, he argues that the path to intimacy is through the process of differentiation—which he describes as "keeping a hold of your individuality" or "holding onto yourself" in romantic relationships. Schnarch describes differentiation of self as the capacity to be in a close relationship and to take responsibility for oneself; in other words, to self-soothe, rather than to insist that your partner or others are responsible for soothing your anxieties (Schnarch, 1997b). In contrast, more emotionally reactive, less differentiated individuals tend to demand that others in their close relationships help them soothe their own anxiety, and are willing to sacrifice selfhood in order to do so.

Contextual Family Therapy

"People stay tied to their families of origin long after it appears that family members have ended their connections with each other, either by choice or perforce" (Boszormenyi-Nagy & Krasner, 1980, p. 768). While Boszormenyi-Nagy, similar to Bowen, posited that individuals are guided by socioemotional systemic patterns developed and passed on over the course of multiple generations, he also argued that trustworthiness and relational fairness played an integral role in these systems (Nelson, 2003). Relational ethics, according to Boszormenyi-Nagy, are the fundamental force holding social systems together; when balanced appropriately and fairly, they are the glue of systems ranging from families to society. Simply put, relational ethics are the dynamics of "fairness, reliability, and trustworthiness" at play in significant relationships (Boszormenyi-Nagy & Krasner, 1986, p. 173).

Ledger, Obligations, Entitlements, Loyalties

Boszormenyi-Nagy proposed that family functioning was dependent upon a balanced ledger of obligations and entitlements, which is defined as "the balance between the accumulating of merits and debts of the two sides of any relationship" (Boszormenyi-Nagy & Krasner, 1986, p. 417). According to Boszormenyi-Nagy, though family members are never fully free of obligations, there is a natural waxing and waning process of debts and merits that fluctuates throughout a family's life cycle (Boszormenyi-Nagy & Krasner, 1986; Nelson, 2003). Entitlements are what each family member is owed, and can be broken down into what is owed simply for being born (e.g., consistent, trustworthy caregiving) and what is earned by being a consistently trustworthy family member. Balancing of family ledgers is an ongoing, dynamic process and something that may take

multiple generations to achieve, as imbalance in one generation tends to be passed down and enacted in subsequent generations in the form of both spoken and unspoken legacies and legacy expectations (Boszormenyi-Nagy & Krasner, 1980, 1986; Nelson, 2003). Boszormenyi-Nagy and Krasner (1980) describe merits as returns on "prior investments of trustworthiness" in a relationship, assets are the "sum total of past and present investments," and debits are "the sum total" of any form of physical or emotional maltreatment or behavior that undermines the trustworthiness of a relationship (p. 772).

The concept of loyalty is also important for contextual family therapy (Nelson, 2003), in which loyalty involves a sense of commitment based on perceived indebtedness to others in the family, given the balance in the relationship ledger of obligations vs. entitlements, not as a "sense" of what we feel toward someone based on our feelings of attachment, but rather as a commitment based on perceived indebtedness (Boszormenyi-Nagy & Krasner, 1986, p. 15). Overt loyalties are much healthier, as the views of members' debts and entitlements to others are more explicit, allowing greater awareness of the family dynamics at play and empowerment in navigating those dynamics (Nelson, 2003). Covert, or invisible loyalties are problematic because they remain hidden from consciousness despite being powerful governing forces in relationship transactions. Split loyalties also cause considerable tension in a family system, and involve a member acting in accord with loyalty to one family member that is inherently disloyal to another (Boszormenyi-Nagy & Krasner, 1986). For example, a child with feuding parents may experience distress while trying to remain loyal and keep a balanced ledger in her relationships with each parent. The goals of contextual therapy are to bring invisible and split loyalties into the realm of awareness in order to enable their resolution.

Disjunction, Stagnation, and Rejunction

Disjunction (Boszormenyi-Nagy's preferred term for "dysfunction") occurs when there is a breakdown in trustworthiness of relationships, due to ongoing imbalances in the family ledger; this occurs when one or more family members in consistently unable to balance consideration for self with consideration of others (Boszormenyi-Nagy & Krasner, 1986). Stagnation, a term that is conceptually akin to the Bowen's state of being undifferentiated, results when family members are not able to develop autonomy and an ability to act responsibly and ethically in their relational transactions (Nelson, 2003). Boszormenyi-Nagy describes relational stagnation as a family member's "lack of individuation" and as a state of being disengaged from the ethical processes of the system ((Boszormenyi-Nagy & Krasner, 1986, p. 282). Rejunction, the opposite of disjunction, is the ultimate goal of contextual family therapy. This can occur only when family members are willing to become reengaged with one another in the process of balancing ledgers and are able to hold themselves accountable for the ethical dimensions of their relational transactions (Nelson, 2003).

Clinical Practice in Multigenerational Family Therapies

Within the scope of multigenerational family therapies, one finds a variety of approaches to intervention, and they espouse direct work with an individual (e.g., Bowen, 1978; McGoldrick & Carter, 2001; Kerr & Bowen, 1988), couples (Schnarch, 2007b), or multiple generations of a family (Boszormenyi-Nagy, 1974; Framo, 1992). All of these approaches consider individuals within a broader multigenerational perspective that guides where, how, and with whom to intervene. However, these approaches vary in the types of techniques they employ and the extent to which they call for working with multiple members of a family at the same time in a room together.

Each of the multigenerational approaches to family therapy tend to privilege efforts to gain new understanding about relationship patterns and processes in one's nuclear and extended family system and one's role in those processes, and learn to think systemically about problems. All psychological therapies aim to facilitate therapeutic change through new understandings (i.e., insight or new ways of thinking about the

problem) and through new experiences during and outside of the therapy hour. Depending on the particulars of the approach, one or the other of these avenues for therapeutic change is privileged. The goals of multigenerational therapies are to gain insight into relationship processes in the family system and individuals' unique roles in them, thus enabling them to take greater responsibility for themselves in their relationships, to develop person-to-person relationships with more family members, and to avoid relying on triangling to manage conflict and tension intra- and interpersonally. Greater understanding of clients' problems is possible through exploration of their multigenerational relational context and the roles they play in it. According to Kerr (2008c), getting beyond blame of others and achieving personal responsibility for self-in-relation requires an understanding of the natural reciprocity that occurs in relationships. Whereas a linear causal perspective might lead to the conclusion that another's behavior causes internal distress, a modest move toward systems thinking might be expressed in terms of, "*OK, I'll admit that I react to you and that makes you feel worse, but you are still to blame!*" By adopting a family systems perspective, individuals are able to move beyond blame and come to conclude that, "*We co-create this process.*" Bowen theory is typically employed when conducting "family therapy with one person," Crucible therapy is conducted with both members of a couple present, and Framo's family of origin therapy involves members of the extended family of origin in session.

Most approaches call for a family assessment early in therapy, with therapist and client(s) together mapping the nuclear and extended family system via construction of a family diagram (Kerr & Bowen, 1988), also widely referred to as a family genogram (McGoldrick et al., 1999; Hardy & Lasloffsky, 1995). The family genogram contains information about the basic facts of a family across at least three generations, and most importantly, documents the relationship processes that are present and that extend across the generations. Important processes to document and explore include the primary parent–child triangle and patterns of closeness and distance and conflict and cutoff in the nuclear and extended family. It is thought that knowledge of basic multigenerational family facts and identification of key relationship processes facilitate important learning about relationship patterns in one's family system and one's role in perpetuating them. These insights enable the achievement of greater Emotional Objectivity (i.e., to ability to describe the functioning of an emotional system of which one is a member, in calm, thoughtful and factual manner; Kerr, 2008c). Formal diagnosis using the DSM is de-emphasized to focus on dimensional aspects of functioning, and because symptoms tend to alleviate when work on general level of functioning in a family system is successfully undertaken.

Likewise, an assessment of the stages of the client's family life cycle are particularly relevant for understanding the salient developmental tasks facing the client and his/her family in their current life-cycle stage, with implications for family reorganization. The basic stages of the family life cycle include: 1) launching a single young adult, which involves the young adult accepting greater emotional and financial responsibility for self; 2) joining of two family systems through formation of a new couple, involving creation of a new nuclear family and re-aligning relationships with families of origin; 3) families with young children, in which new members are accepted into the system and considerable reorganization occurs in the nuclear and extended families to adjust to new parenting and grandparenting roles; 4) families with adolescents, requiring boundary shifts to allow more independence of growing children while remaining in connection; 5) launching adult children; and 6) families in later life, who are tasked with accepting shifting generational roles among family members (Carter & McGoldrick, 2004). The family life-cycle framework includes the stages of divorce and remarriage that many families face today, and considers ethnicity, gender, and social class (Carter & McGoldrick, 2004).

Often, clients present for therapy during a family life-cycle transition, when a combination of chronic anxiety in the system intersects with the acute stress of navigating a major transition. Following initial assessment of a family's

life-cycle stage and mapping of multigenerational family patterns, work in sessions focuses on helping clients understand basic systems concepts and planning thoughtful re-engagement with one's nuclear and extended family system. In general, the effort to differentiate a self within one's family system depends on having *more contact* with family members, and *contact with more* family members than typically is the case. Much of the work occurs outside of therapy sessions, involving clients returning home to work on themselves in the context of their family relationships. When the pain of tolerating things as they are exceeds the pain of attempting new behaviors that support greater emotional maturity in one's dealings with family members, openings for new experience become possible. Through successful efforts to change one's automatic emotional responses to family members and significant others, lasting behavioral change then becomes possible. Change in the broader family system may follow when one member successfully undertakes efforts to differentiate a self, and remains in good emotional contact with their family.

Bowen spent his professional career developing, refining, and teaching his theory of family systems functioning, and by comparison devoted less time and attention to developing a set of techniques for therapy. Initially he conducted family therapy with all members of a family present in the room and even experimented with family group therapy. Over time, he shifted to work directly with smaller units of the family, primarily with individuals or a couple. Bowen differed from most systems therapists in believing that meaningful change did not require the presence of the entire family. Instead, he believed that change can be initiated by individuals or couples who are capable of affecting the rest of the family.

The goal of Bowen theory-informed therapy is to develop greater personal responsibility and to achieve autonomy and mature connection with others. Differentiation of self is the vehicle for transforming relationships. In Bowen theory-informed therapy, clients aim to get more factual and more emotionally objective about their relationship systems, gain greater understanding of themselves in the relationship systems within which they operate, focus on working on themselves in those relationships and not focus on changing others, become more of a self in all relationships, and maintain contact with those systems while doing so. Across the spectrum of approaches, multigenerational family therapists focus on strengthening differentiation of self in the system, whether they frame their focus on enhancing clients' capacity for personal responsibility (Boszormenyi-Nagy & Ulrich, 1981), autonomous behavior, close emotional connections with others (Bowen, 1978), or resolution of multigenerational cutoffs (Framo, 1992). Developing greater capacity for differentiation of self in relationships also figures prominently in Schnarch's Crucible Therapy (1991, 1997b, 2002).

One of Bowen's most important and original contributions to the practice of family therapy was his focus on the person of the therapist. As the first family therapist to emphasize the importance of therapist emotional maturity and knowledge of oneself in the context of one's family relationships as important precursors to effective therapist practice, Bowen believed that it was particularly important for therapists to work on themselves in their own families of origin before they inserted themselves into other people's families As outlined in his Anonymous (1972) paper, Bowen worked out major aspects of his theory experientially. Efforts to improve one's mature function in one's own family of origin can lead to significant improvements in the quality of one's nuclear family relationships and a heightened capacity for introspection, thereby enhancing one's effectiveness with clients (e.g., Framo, 1992; Kerr, 1983). The most important relationships in which to achieve greater awareness of self and systems processes are within primary triangles in one's *nuclear family* (e.g., self, spouse, and children) and *multigenerational family* (e.g., self, parents, and siblings (Kerr & Bowen, 1988).

Kerr further elaborated on the central role of the therapist's emotional functioning in conducting effective therapy. He emphasized the importance of emotional objectivity, staying calm and self-defined, and thinking within a systems

framework about individual and relationship problems. If a therapist can stay calm and self-defined, maintain a systems perspective on the problems, and refrain from moving in to solve the family's problems, Kerr believed that this stance is experienced by clients as naturally calming, and enables them to experience a change in their way of being in relationships, and to think more clearly about their problem and their role in maintaining it. Framo also highlighted the function of family-of-origin work in increasing a therapist's capacity for empathy with her clients (1992).

In general, multigenerational therapists focus on helping their clients learn a bit of theory and through guided coaching, and help clients gaining greater awareness of their functioning in their larger family system. Work is devoted to developing more emotional maturity in relationships with important others. When a client's anxiety is high, a therapist is more vulnerable to feeling anxious as well, slipping back into linear cause-and-effect thinking. For example, this may take the form of seeing an adolescent identified patient through the parents' eyes only and failing to consider the reciprocal influence of parents on the adolescent's functioning. Therapists guided by linear, cause–effect thinking are more likely to move in to give advice about how parents should manage their adolescent. This approach may result in calmer parents and temporary improvements in functioning, but fail to support needed change in basic levels of functioning.

In Bowen therapy and Framo's family of origin therapy, members are encouraged to examine how they translate their internal tension, reactivity, anxiety, and worries into interpersonal ones. Queries into family-of-origin processes help clients to explore past and current patterns in their family relationships and facilitate awareness of how their ways of relating with parents and siblings play an ongoing role in other relationship struggles with spouse, children, parents, and colleagues (Framo, 1992). Important therapeutic tasks involve identifying the presence of triangles operating and who is involved, followed by efforts to deconstruct the triangle's structure and track their flow of movement. Systems therapists are trained to support spouses in strengthening their ability to manage anxiety, tension, and conflict internally, and to resist the urge to fight out tensions with each other (Schnarch, 1997a), and parents to resist engaging in anxious focus on one of their children (Donley, 2003). With some success, work may then turn to efforts to de-triangle (i.e., change those habits of complaining to a parent about siblings, stop getting needs for closeness met through contact with children rather than time with spouse, or end the tendency to listen as one parent complains about the other).

Once the presence of triangle is acknowledged, how does one go about detriangling? Bowen (1978) argued that strengthening one's ability to think about feelings is essential for improving the level of differentiation of self—a key component of the detriangling process. Similarly, Kerr posited that any successful effort to improve one's level of differentiation, reduce anxiety, and avoid triangling in response to stress, strongly depends on a person developing more awareness of and control over his or her emotional reactivity (Kerr & Bowen, 1988). Learning about the principles of differentiation of self and emotional systems, maintaining regular contact with family-of-origin, and identifying and extricating oneself from primary relationship triangles are all ways to increase functional levels differentiation, and consequently relieve psychological and physiological symptoms.

This may seem relatively simple, however, Bowen (1978) warned that individual efforts to de-triangle will likely be met with a homeostatic "change-back" response from the family system that consists of three messages: 1) "You're wrong," 2) "Change back," and 3) "If you don't, there will be (negative) consequences." Calm persistence is needed in the face of these "change back" responses, and an individual's ability to maintain equanimity in the face of the family's "change back" messages without fighting back or withdrawing are conducive for achieving greater success in the efforts to differentiate a self. Bowen believed that, "if one person in a family system can achieve a higher level of functioning, and stays in emotional contact with the others, another family member and another and another will take

similar steps" (1978, p. 218), thereby raising the system's overall level of differentiation. All multigenerational theories emphasize the power of these homeostatic responses to change in family systems. Along these lines, Boszormenyi-Nagy pointed out that one predictable outcome of family systems therapy is that when one member changes, or begins to successfully work through their particular problem, inevitably other members' "pathology" will begin to surface and will required some attention (Boszormenyi-Nagy & Krasner, 1986, p. 200). Thus, the notion of focusing on the bigger picture of systemic functioning is important to keep in mind in order to avoid getting mired down in a narrow focus on symptoms and diagnostic categories.

Detriangling in child-focused families often requires loosening up boundaries between a disengaged parent and child to promote greater contact between them, while simultaneously working toward opening up contact between spouses. For example, the process of detriangling in a family may be facilitated by a distant parent's efforts to develop more of a person-to-person relationship with his son or daughter, in which he and his child focus on one another, rather than engaging with the child about how his/her behavior negatively affects or worries the mother (Kerr & Bowen, 1988). Interestingly, a recent study demonstrated that the strength of a therapist–adolescent (identified patient) alliance in family therapy predicted symptom reductions (i.e., adolescent drug use), but only in the presence of a positive parent–therapist alliance rating (Shelef, Diamond, Diamond, & Liddle, 2005). Such a finding lends support to the theoretical notion that resolution of child-focused triangles can result in treatment success.

One key to detriangling is the ability to see problems in relationships as systemic or circular in nature, rather than reverting to cause and effect thinking. For example, consider a married, heterosexual couple attending therapy for the wife's depression. One session, the husband arrives and announces that he canceled his wife's credit cards *because* he is sick and tired of her belittling him (e.g., she calls him "a control freak"). His wife retorts that he deserves the criticism *because* he tries to control her. Traditional linear-causal thinking leads the husband to conclude that he controls *because* she criticizes, whereas the wife believes that she criticizes him *because* he controls her. A therapist who is not familiar with circular causal or systems thinking may also be inclined to view the problem in linear causal terms, and unwittingly side with one spouse against the other in an unsuccessful effort to determine who is more correct, and who needs to change.

A therapist informed by any of the multigenerational theories will tend to view the couple's conflict through a systemic lens, as mutually reinforcing and self-sustaining (e.g., control begets criticism which begets more control and more criticism, and so on), with no single cause or effect. A therapist's ability to see the problem in systemic terms protects her from seeing a villain and victim, keeps her from taking sides, and supports her focus on interrupting their mutually sustaining pattern of hostile dominance and submission, driven by their underlying emotional reactivity to one another. Multigenerational systems' thinking helps a therapist to maintain good emotional contact with each spouse as they work together on lowering their emotional reactivity to one another and each differentiate a self in the relationship.

In Schnarch's Crucible Therapy (1991, 1997b), work focuses on helping each partner "hold onto him/herself" and strengthen their capacities for handling anxiety and conflict internally. The therapist restrains the couple from fighting out tensions with one another. Schnarch uses a four-prong approach when working with distressed couples to help them achieve greater sexual intimacy and pleasure. In sessions, couples learn to 1) hold on to their values in the face of opposition from their partner, 2) be able to soothe themselves in the face of hurt and anxiety, 3) be able to stay non-emotionally reactive when their partner is anxious or otherwise provocative, and 4) learn to tolerate the pain involved in personal and relationship growth.

Bowen (1978) described the formation of a "therapeutic triangle" when working with couples, in which the therapist joins with each spouse and remains in good contact with each partner while employing a series of process questions

to explore the couple's underlying problem and their relationship patterns. Bowen postulated that when a family comes into contact with an emotionally neutral individual, reactivity among members is inevitably reduced (Bowen, 1978). Emotional neutrality is the ability to remain calm in the presence of intense feelings—one's own and those of others (i.e., clients)—without acting to reduce discomfort by changing the other's viewpoints or behavior (Kerr & Bowen, 1988). The therapist's task is to execute a series of interventions aimed at altering the flow of movement in the triangle. When the therapist is able to stay neutral in the face of emotional pressure to participate in a triangle, the therapist facilitates a family's ability to work on their relationships (Bowen, 1978). Bowen remarked that he spent 50% of his effort on conducting the therapy and the other 50% of his effort on staying out of the family's emotional process. To lower emotional reactivity in the system, Bowen would often use humor or reversals to remain in good emotional contact with members while avoiding taking sides. He reasoned that if a therapist can define a self and remain in good contact with both spouses, the couple would pull up their functioning in the presence of the therapist.

Therapy informed by Bowen theory most often takes the form of "family-therapy-with-one-person," in which one member of a family most motivated for change attends sessions with a therapist in a process referring to as 'coaching' (e.g., Bowen, 1978; Brown, 2012; Kerr & Bowen, 1988; Donley, 2003; McGoldrick & Carter, 2001; Titelman, 2008). Typically sessions are scheduled and held less frequently than traditional forms of individual therapy, typically once per month or less frequently in order to give clients time to work on their own in between sessions. Bowen advised starting to work on one's self in the context of less emotionally charged family relationships (i.e., distant aunt or uncle, some cousins), expanding the extent to which one engages in person-to-person relationships (i.e., talking more about self, other, and topics of interest, and less about the weather and other superficial cursory topics), and pushing one's self to maintain engagement in each relationship a bit longer. Many prominent figures in the field of family therapy have continued to refine and advance Bowen's approach in both research and clinical settings; a few examples include Mike Kerr, Daniel Papero, Margaret Donley, Bob Noone, Betty Carter, James Framo, Edwin Friedman, Philip Guerin, Scotty Hargrove, Phil Klever, Monica McGoldrick, and Peter Titleman. Recent decades have seen the vast expansion of the Bowen training network, beyond the Georgetown Family Center to include well-established training centers across the United States and internationally: see www.thebowencenter.org/pages/outsideprograms.html for information).

By contrast, Framo's (1992) family-of-origin approach moved beyond the idea of "coaching" individuals in therapy to achieve improvements in the quality of their interactions with family members outside of the therapy hour. Instead, Framo developed an approach to therapy that involved a few initial sessions with an individual or couple. In these, work would be done in preparation for bringing in other members of the family and following sessions would actually involve multiple generations of family members present, with the chance of working through issues with the help of the therapists. One of the reasons he cites for this is practicality: clients are more likely to terminate if they do not believe that their immediate concerns are being addressed in a timely manner. As the Bowen approach emphasizes "coaching" clients on developing a person-to-person relationship with extended family members, Framo's family-of-origin therapy seeks a similar end point but utilizes face-to-face contact to achieve this (Framo, 1992). The experience of person-to-person contact across generations in the therapist's presence, allows family members to relate to each other as people. In other words, working through issues with multiple members present allows family therapy to take place with the original family, rather than the "family-in-the-head" comprising introjects (Benjamin, 2003; Framo, 1992).

Conclusion

The continuing relevance of multigenerational approaches to the broader field of family therapy can be attributed to their emphasis on the role

of experience across generations of a family in shaping the health and functioning of individual members. Support for taking a multigenerational perspective to promote the health and well-being of family members is being borne out by advances in basic and translational research in the social affective neurosciences that show, for example, that experience in earlier generations can affect subsequent biology in the next (e.g., Champaigne, Francis, Mar, & Meaney, 2003; Fleming, O'Day, & Kraemer, 1999; Meaney, 2001). Although numerous theoretical and clinical case reviews have been published to date, research on the application of multigenerational family approaches to intervention is sorely needed to learn whether multigenerational family therapies are capable of improving functioning and raising differentiation of self levels in individuals and family-wide. Arguably, Bowen theory remains the most comprehensive theory of individual functioning from a systems perspective, however the entire collection of multigenerational approaches to family therapy provide a rich framework for conceptualizing human functioning. For example, randomized trials and effectiveness studies are needed to test Bowen's (1978; Kerr & Bowen, 1988) assertion that therapies informed by Bowen theory can produce moderate increases in differentiation levels in their clients. As both Bowen and Boszormenyi-Nagy have expressed in their writing (Bowen, 1978; Boszormenyi-Nagy, 1974), a multigenerational approach to family therapy is less based on specific therapeutic technique and more on the broader perspective of the family as a part in an ongoing system of relationships. Even those who do not wish to align themselves specifically with these approaches would likely benefit taking into consideration multigenerational context as a way of broadening their scope in approaching families, couples, and individuals.

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10.

POSTMODERN/POSTSTRUCTURAL/SOCIAL CONSTRUCTION THERAPIES

Collaborative, Narrative, and Solution-Focused

Harlene Anderson

We live in a rapidly changing and electronic world in which great numbers of people are instantly aware of social, political, economic, and cultural conditions, variations, and adversities. Most notable in people's responses are their cries for democracy in all areas and levels of life: people increasingly want to have a voice in what affects them. They do not want to have their needs defined by others or be the pawns of rigid insensitive institutions in which they are treated as numbers and categories. They want systems and services that are fair, respectful, and flexible, and responsive to their defined needs.

In step with our changing world and people's responses to it, over the last four decades a growing international community of family therapists have veered from established family therapy practices based in concepts such as universal truths, knowledge and knower as independent, language as representative, and meaning as in the word (Andersen, 1987, 1991; Anderson, 1997b; Anderson & Gehart, 2007; Anderson & Goolishian, 1988, 1992; Anderson, Goolishian, Pulliam, & Winderman, 1986; Berg & de Shazer, 1993; de Shazer, 1985, 1988, 1991; De Jong & Berg, 2002; Freedman & Combs, 1996; Hoffman, 2002, 2007; Katz & Shotter, 2004; Lipchick, 2002; Malinen, Cooper, & Thomas, 2012; McDaniel, 1995; McNamee & Gergen, 1992; Olson & Seikkula, 2003; Penn & Frankfurt, 1994; Riikonen & Smith, 1997; Seikkula et al., 1995; Strong & Pare, 2004; White & Epston, 1990). Such concepts place human systems and behaviors into frameworks of understanding in which hierarchical and dualistic expert–non-expert structures, discourses of pathology and dysfunction, and worlds of knowing and certainty are created. These concepts no longer seemed helpful in accounting for and dealing with the changes and complexities in our world and the impact these have on people's lives. To one degree or another, the therapists referenced above turned to the development of alternative frameworks in the social and natural sciences including those commonly classified as postmodern and poststructural philosophies and social construction theory (Bakhtin, 1981; Bateson, 1972; Berger & Luckmann, 1966; Bruner, 1986, 1990; Derrida, 1978; Foucault, 1980; Gadamer, 1989; Gergen, 1985, 1994, 2009; Heidegger, 1962; Lyotard, 1984; Merleau-Ponty, 1962; Rorty, 1979; Schon, 1984; Shotter, 1993, 2010; Vygotsky, 1986; Wittgenstein, 1953).

Briefly: postmodernism offers an ideological critique or skepticism of the authority and certainty of inherited knowledge such as cultural and political meta-narratives and dominant discourses; poststructualism offers a method of analysis (including deconstruction) of

how meanings and subject matters are constructed in language; and social constructionism focuses on the communal and relational processes through which knowledge is produced and functions. Language and knowledge emerged as central metaphors. Knowledge (e.g., truth, reality) is historically and socially embedded, and is created within these contexts. Knowledge-based institutions and discourses gain power and influence the constitution of human systems and their members' relationships and interactions with each other. Language (e.g., signs, symbols, words, bodily movements), as philosopher Richard Rorty (1979) suggests, does not mirror what is; for instance, it is not an outward description of an internal process and does not describe accurately what actually happened. Instead, language allows a description of what happened and an attribution of meaning to it. Language gains its meaning and its value through its use. Thus, it limits and shapes thoughts and experiences and our expressions of these. What is created in and through language (realities such as truths, values, and meanings) is multi-authored among a community of persons. That is, the reality that we attribute to the events, experiences, and people in our lives does not exist in the thing itself; rather, it is a socially created attribution constructed within a particular culture and is shaped and reshaped in language. What is created, therefore, is only one of multiple perspectives.[1] Combined, these perspectives question the certainty of objective truths, the relevance of universal discourses or meta-narratives, and language as representative of the truth (Lyotard, 1984; Kvale, 1992). As social psychologist Kenneth Gergen (2009) suggests, they explicate the processes through which people develop their descriptions and explanations of the world in which they live and their identities.

Influenced by the aforementioned frameworks, along with therapists' experiences and practice contexts, therapy approaches developed that became variously referred to as conversational, dialogical, discursive, narrative, postmodern, reflecting, solution-focused, and *withness* therapies (Andersen, 1987, 1991; Anderson, 1997b; Anderson & Gehart, 2007; Anderson & Goolishian, 1988, 1992; Anderson, Goolishian, Pulliam, & Winderman, 1986; de Shazer, 1985, 1988, 1991; Berg & de Shazer, 1993; De Jong & Berg, 2002; Freedman & Combs, 1996; Hoffman, 2002, 2007; Katz & Shotter, 2004; Lipchick, 2002; Malinen et al., 2012; McDaniel, 1995; McNamee & Gergen, 1992; Olson & Seikkula, 2003; Penn & Frankfurt, 1994; Riikonen & Smith, 1997; Seikkula et al., 1995; Sermijn, Devlieger, & Loots, 2008; Strong & Pare, 2004; White & Epston, 1990).

This ideological and epistemological shift holds significant implications and challenges for therapists' thoughts and actions. It offers a broad challenge to reexamine and reimagine the cultures, traditions, and practices of the helping professions, including how problems and solutions are conceptualized, client–therapist relationships, the process of therapy, and therapist expertise. A focus away from the family as the limited target of treatment is inherent in this shift as the premises and practices of postmodern/poststructural/social construction approaches are applicable to individuals, couples, families, and groups as well as non-therapeutic assemblies. Family therapy historian Lynn Hoffman (2002) suggests that the shift changed the definition of what needs to be changed: the target moved from the unit of membership to the situation. Problems are not believed to reside within the person, the family, or the larger system. Instead, as Anderson and Goolishian (1988) suggested, problems are considered as linguistic constructions, with various punctuations such as the local dialogical context and process of people's everyday lives and the subjugating and oppressing influence of dominant universal narratives. The aim of a therapist is to set a context and facilitate a dynamic potentially transformative process rather than to change a person or group of people.

Commonalities among Collaborative, Narrative, and Solution-Focused Therapies

Similarities weave through the assumptions on which collaborative, narrative, and

solution-focused therapies are based: a) skepticism regarding inherited knowledge and universal truths, and the authority we give them; b) the value of the local knowledge of a person or any community of persons; c) the risks of generalizing across peoples and problems; d) knowledge and truth as communally constructed; e) polyphony and the richness of multi-verses of reality; f) language constructs the meanings we give to events, and experiences of our lives; g) the person and *self*, including development and human agency, are viewed as interdependent, communal, and dialogic entities and processes rather than as isolated autonomous interior ones; and h) people have multiple identities and these are shaped and reshaped in social interaction that occurs on the backdrop of dominant discourses. Collaborative, narrative, and solution-focused therapists also share similar values to one degree or another. They: a) take a non-pathological, non-judgmental view; b) appreciate, respect, and utilize the client's reality and resources; c) use story and narrative metaphors; d) invite more collaborative and less hierarchical and dualistic structures and processes; e) are public and transparent about their values and biases; and f) believe that most human beings value, want, and strive toward healthy successful relationships and qualities of life. In addition, Tarragona (2008) suggests they also share the following characteristics: transdisciplinary inspiration, social or interpersonal view of knowledge and identity, attention to context, language as a central concept in therapy, therapy as a partnership, valuing multiplicity of voices, valuing local knowledge, interest in what works well, personal agency, and briefer duration of therapy.

These therapists, though they value outcome assessment, also value learning about the effectiveness of therapy during the therapy process, focusing on the client's voice and judgment rather than that of an "outsider" after the fact (Anderson, 1997a, 1997b). This focus on the client's voice spawned a number of qualitative studies that provide in-depth first-person descriptions of the lived experience of therapy processes and the nuances of its effectiveness, or lack of, from both therapists' and clients' perspectives. What is learned from the "insiders" can have relevancy to both current and future practices and can yield a more thorough picture of the nuances of therapy than can be captured in outsider quantitative research. These efforts complement other family therapy approaches whose effectiveness is documented through multiple alternative research methodologies, particularly qualitative ones such as single case studies, ethnographic interviews, and narrative accounts (see Addison, Sandberg, Corby, Robila, & Platt, 2002).

Three postmodern/poststructural/social construction approaches are discussed in this chapter: collaborative therapy of Harlene Anderson and Harry Goolishian (Anderson & Goolishian, 1988, 1992; Anderson, 1997a), narrative therapy of David Epston and Michael White (Freedman & Combs, 2000; White & Epston, 1990; White, 1995, 2007), and solution-focused therapy of Insoo Berg and Steve de Shazer (de Shazer, 1985, 1988, 1991; Berg & de Shazer, 1993; Lipchik, 1993, 2002, 2009). These were selected because they are the approaches most typically found in graduate and postgraduate family therapy curriculums with titles such as postmodern/social construction, advanced systems, and narrative therapies—both within the United States and internationally. Other significant contributors to the emergence of postmodern/poststructural/social construction practices and its studies important to acknowledge include: Tom Andersen in Norway, Lynn Hoffman and Peggy Penn in the United States, and Jaakko Seikkula and his colleagues in Finland (Andersen, 1987, 1991; Hoffman 1981, 1998, 2002; Penn, 1985, 2001; Penn & Frankfurt, 1994; Seikkula, 1993, 2002). Although each of the above approaches is historically or currently influenced by the postmodern/poststructual/social construction perspectives to various extents, they are not necessarily limited to these influences and their originators might make different theoretical and practice application punctuations than this author.[2]

Collaborative Therapy

History and Background

Collaborative therapy evolved from the twenty-year joint work of Harlene Anderson and Harry Goolishian and their colleagues and students,

and has further evolved through Anderson's work beginning in the 1970s at the University of Texas Medical School and later in what is now the Houston Galveston Institute (MacGregor et al., 1964). Its roots, however, can be traced back to the early Multiple Impact Therapy (MIT) family therapy research project at the University of Texas Medical School in Galveston in which Harry Goolishian was a primary investigator (McGregor et al., 1964). Though the team practice and three-day criss-crossing membership sessions were quite innovative at that time, the theory used to describe and understand the MIT practice was limited by the psychodynamic, psychoanalytic, and developmental theories available at that time. Deciding that these theories, and the developing family therapy theories, could not provide adequate descriptions for their and clients' experiences of therapy, Goolishian and his colleagues began a continuous search for new theoretical vocabularies. This set the stage for the important reflexive process of the interaction of practice and theory: new practices led to new theories, and so forth. The team, working mostly with clients commonly called resistant or treatment failures, inquired into the clients' experiences and descriptions of successful and unsuccessful therapy, and continually adjusted their practice based on this learning. Interest in client voices remained an important thread throughout the development of collaborative therapy.

Major Theoretical Constructs

As Anderson and Goolishian (1988) searched for new descriptions and understandings, they were drawn to revolutions in the social and natural sciences, hermeneutic and postmodern philosophies, and dialogue, narrative, and social construction theories (Bakhtin, 1981; Bateson, 1979; Bruner, 1986, 1990; Gergen, 1985, 1994, 2009; Heidegger, 1962; Lyotard, 1984; Maturana, 1978; Rorty, 1979; Schon, 1984; Shotter, 1993; Vygotsky, 1986; and Wittgenstein, 1953). Particularly relevant for Anderson and Goolishian were the concepts of knowledge as a social-communal construction, language[3] as generative and the vehicle for knowledge construction and product of human interchange, and understanding as an interpretive process. More specifically, knowledge is linguistically constructed and therefore fluid not static or discoverable. Authoritative discourses from this perspective give way to knowledge constructed on the local level that has practical relevance for the participants involved.

These concepts and their associated assumptions influenced Anderson and Goolishian's move away from general systems and cybernetic systems theories and toward an interest in language and the notion of human beings as systems in language: language-meaning-making systems (Anderson & Goolishian, 1988). Therapy, hence, was viewed as one kind of language or meaning-making system. Originally, Anderson and Goolishian referred to their work as Collaborative Language Systems. Anderson later simplified it to Collaborative Therapy to highlight a distinction from the meanings inherent in systems or systemic therapies (Anderson, 2000, 2001a, b) and more recently to Collaborative Practices (Anderson, 2012) to emphasize its applicability beyond therapy to across human systems regardless of membership numbers or context.

The assumptions that thread through the contributions of philosophical pioneers and critical thinkers mentioned above were augmented by the writings of Gergen (1985, 1994, 2009) and Shotter (1993, 2010). Specifically for Anderson and Goolishian, these ideas influenced a *perspective-orientation*[4] from which a collaborative therapist attends to, approaches, relates, and responds to their world, others, and themselves. Highlighted are the importance to:

1. Maintain skepticism. Maintains a critical and questioning attitude toward inherited knowledge and dominant discourses as fundamental and definitive. This does not suggest that inherited knowledge or discourses (such as therapeutic or pastoral care or family therapy) should be abandoned. Instead such knowledge is used with thought, care, and reflection: claims to truth are held provisionally, including discourses such as postmodern and social construction ones.
2. Avoid generalization. Dominant discourses, meta-narratives, and universal truths easily risk generalizing across peoples, cultures,

situations, or problems. Such ahead of time knowledge (such as theoretical scripts, predetermined rules) can inadvertently create and place people in categories, types, and classes of problems, and solutions that can inhibit a therapist's ability to learn about the uniqueness, novelty, and particulars of each person or group of people.

3. Privilege local knowledge. Appreciate and trust the local knowledge (e.g., expertise, truths, values, habits, culture, wisdom, and narratives) that is created within a community of ordinary people (e.g., a family) who have first-hand knowledge of themselves and their situation is important, and trust that new knowledge will grow out of the voice of people in conversation. Local knowledge—though it always develops against the backgrounds and conditions of dominant discourses and universal truths—formulated within a community to address their self-defined needs can be more relevant, pragmatic, and sustainable for that community and its members.

The perspective orientation influences a *collaborative relationship* and *dialogic conversation*: the *metaphorical relational space* and *conversational process* of therapy, referring to an open and unguarded relational forum where differing voices can exist side by side and together explore and negotiate a diversity of perspectives in a nonconfrontational or violent manner. Collaborative therapists find engagement in this metaphorical space and polyphonic process invites participants to talk, listen, and hear with themselves and others in new ways that can be expressed in an infinite variety of forms such as enhanced self-agency and liberating self-identities.

Collaborative relationship refers to the way in which therapists orient themselves in relation to the other person(s) that invites an in-there-together process. It is characterized by a sense of participation, belonging, and contributing which leads to a sense of shared responsibility and dynamic sustainable pathways to the future (Anderson, 1997a).

Dialogue is a form of communication (any way we try to communicate, articulate, and express with others and with our selves—including words, signs, symbols, gestures, etc.) in which participants engage "with" each other (out loud) and "with" themselves (silently) in a search for meaning and understanding (Bakhtin, 1984). Dialogic understanding involves a mutual or shared inquiry in which participants engage to try to understand the other person from that person's perspective—it is not a search for facts or details but an orientation. It is an interactive process that requires participation through responding to connect and learn with the other person from them, rather than to pre-know and understand them and their words from a theory or any other prejudiced position, or to search for facts or details.

Process of Collaborative Therapy

The perspective-orienting assumptions inform what are referred to as *action guiding sensitivities*[5] or *ways of being 'with'* that involve a posture, an attitude, and a tone that communicates to the other the special importance that they hold for a therapist, that they are unique, that they are respected and appreciated, and what they have to say is important. The stance is an expression of a value and belief: a way of being "with" people, including ways of thinking, talking, acting, and responding with them, not to, for, at, or about them. Influenced by Shotter (2010) and Hoffman (2007) the stance refers to a "withness" process of orienting and re-orienting oneself to the other person. *Withness* relationships and conversations in which the other is invited and encouraged to participate on a more equitable basis, become more participatory and mutual and less hierarchical and dualistic. A collaborative practitioner's actions are spontaneous and natural, fitting to the person(s), context, and circumstance; they are not actions informed by techniques or formulaic pre-structured steps. In other words, a therapist is poised and ready to fit and respond to what an occasion calls for.

The interconnected features of the action-guiding sensitivities that inform creating and sustaining the *generative conversational partnership* include those listed below.

Mutually Inquiring

The conversational partnership is characterized by a joint activity of shared or mutual inquiry:

an in-there-together, doing-with, back-and-forth process in which two or more people put their heads together to puzzle over and address the situation at hand (Anderson & Goolishian, 1988; Anderson, 1997a). A practitioner invites the other person(s) into this mutual inquiry by taking a curious, inquisitive learning position.[6] This learning position spontaneously engages the client as a co-learner, as if a therapist's curiosity is contagious. In other words, what begins as one-way learning becomes a two-way process of mutual learning as client and therapist co-explore the familiar and co-develop the new, examining, questioning, wondering, and reflecting with each other (Anderson & Gehart, 2006, p. 47).

A therapist's responses (e.g., questions, comments, gestures, etc.) are informed by and come from inside the conversation itself and stay coherent with what the person has just said or done. They are not informed by a therapist's "truths" about them such as what the other should be talking about or doing—truths derived, for instance, from theoretical maps, clinical experience, or personal values. A therapist wants to respond in ways that encourage client engagement in a new curiosity about themselves. Through the inquiry process the client begins to develop meanings for themselves and the people and events in their lives that permit expanded or new agency and actions. In other words, the newness comes from within the relational-dialogic process in contrast to it being created by a person or persons or imported from outside it.

Through this joint activity, the relationship and conversation begin to determine the in-the-moment process or method of inquiry. The method does not define the relationship and the conversation but just the opposite. Together, client and practitioner shape the storytelling, the retelling within the moment-to-moment unfolding of the present relationship and conversation. The storytelling process and direction are not determined from outside or ahead of time.

In family therapy, each family member comes with their unique story and it is not unusual for members to have different and sometimes competing story versions. These are part of the collective narrating. A therapist wants to explore and understand each version, giving each member ample room to speak and listen. Collaborative therapists often immerse themselves in listening and speaking with each member, one at a time. As one family member talks and others listen, all parties begin to experience a difference in the storytellings and re-tellings. When a speaker has the room to fully express him- or herself without interruption and the others have equally full room for listening, they have the opportunity to begin to have a different experience of each other, what is said and how they hear (interpret) it. A therapist does not strive for a consensus story version, as differences and tension are important aspects of dialogue and hold the richness for possibilities to emerge.

Relational Expertise

Both client and practitioner bring expertise to the encounter and create new knowledge through the emergent process of dialogue: the client is expert on themselves and their world; the practitioner is an expert on the conditions critical for collaboration and dialogue. Focus is placed on the client's expertise, a therapist being careful to not value and privilege themselves as a better knower than the client (Anderson, 1997b; Anderson & Goolishian, 1992).

This does not suggest that a therapist denies their knowledge and expertise. Practical, clinical, and book knowledge are resources that are always available but not in a hierarchical or instructive fashion. Their expertise is "know-how" in inviting collaborative relationships and dialogic conversations; it is not in how best another person should reconstruct their narrative or live their life.

A therapist respects and honors the client's story, listens to hear what is important for the client, and takes seriously what the client says and how they say it. A therapist does not expect that a story should unfold in a chronological order or at a certain pace. A therapist does not expect certain answers and does not judge their quality or correctness. Tom Andersen (1991) suggested just how challenging it is to respect the client's expertise, "what I myself found important, but extremely difficult, to do was to try to listen to what clients say instead of making up meaning

about what they say. Just listen to what they say" (p. 132).

Collaborative therapists often work with members of clients' personal or professional systems. As with a family, a therapist appreciates, respects, and values each voice and reality and strives to understand the multiple and unique understandings from each member's perspectives: it is believed that the richness of these differences become the seeds for infinite possibilities.

Not-knowing

Not-knowing[7] refers to: *how a practitioner thinks about the construction of knowledge and the intent and manner with which it is introduced into the consultation*. It refers to a humble attitude about what a therapist thinks they might know, including a belief that they do not have access to privileged information, can never fully understand another person, and always need to learn more about what has been said or not said.

Not-knowing is a "*knowing with*" the other instead of "*knowing about*" the other. Knowing with is crucial to the dialogical process. Also crucial is an ever-awareness that knowing can risk placing a person in a pre-determined problem category or identify them as a type of people. This can interfere with a practitioner's ability to be interested in and learn about the distinctiveness of the person and the nuances of their life. In other words, knowing tempts us to depersonalize the person, fill in the story gaps, and proceed based on our assumptions rather than learning from the person with whom we are talking. This can limit a therapist's and their dialogical possibilities. As Riikonen and Smith (1997) suggest: "Knowing [outsider knowledge] is the prime source of non-participation in dialogue" (p. 141).

The emphasis is on the intent, manner, attitude, tone, and timing with which a therapist's knowing is introduced. It is introduced simply as a way of participating in the conversation, offering food for thought and dialogue, and posing a possible alternative way to continue to talk about what is being addressed. A therapist pays careful attention to the client's response, aiming to remain in sync with it.

Being Public

Being public refers to a therapist's openness about their inner thoughts. A therapist does not operate or try to guide the therapy from private thoughts (e.g., knowing, interpreting). For instance, if a therapist wants to ask a question that is not coherent with the conversational moments or has an idea or opinion, they share it in the spirit of food for thought and dialogue and with forthrightness about the reason. Keeping therapists' thoughts public minimizes the risk of therapist and therapist–client monologue—being occupied by one idea about a person or situation.

Trusting Uncertainty

Dialogic conversation is similar to natural talk in which each person's response is a response to the other's: each response informs and invites the other's. The conversations are not guided by structured maps, pre-formed questions, or other strategies as to how the conversation should look or unfold; for example, the pace or the sequence of what is talked about and how. This kind of spontaneous talk always entails uncertainty.

As conversational partners, walking alongside each other, client and practitioner coordinate their actions as they respond, making their path and destination unpredictable. What the path looks like, the detours along the way, and the final destination will vary from client to client, from practitioner to practitioner, and from situation to situation. In other words, in this kind of conversational engagement, what is created is mutual and different from and more than what could have been created by one without the other. This does not deny or ignore that clients may come in with a pre-defined problem and destination as well as expectations about how you will help them. They often do. It is likely, however, that these will change through the course of the therapy conversations. Trusting uncertainty involves taking the risk to trust in the collaborative and dialogic process and its transformative nature, and to be open to the unforeseen.

Mutually Transforming

In this kind of *withness* relational-dialogic process, each participant is influenced by the other(s)

and hence each, including a therapist, is as much at-risk of change as is the other. It is not a one-sided, unilateral driven process, nor is a therapist passive and receptive. A therapist is actively involved in a complex interactive process of continuous response with the client, as well as with his/her own inner talk and experience. In other words, as conversational partners, all members of the conversation continually coordinate their actions with each other and are partly shaped by the other in the relational process.

Orienting Toward Everyday Ordinary Life

Collaborative therapy resembles the way people interact and talk in everyday life or the "naturally occurring interactional talk . . . through which people live their lives and conduct their everyday business" (Edwards, 2005, p. 257). As in everyday life as Wittgenstein suggests, people search for how to know our "way about" and how to "go on" with their lives. Collaborative therapists find it helpful to: a) have a positive outlook regarding the people who consult them regardless of their histories and circumstances; b) to view discourses of pathology and dysfunction as constraining; c) to trust that people are naturally resourceful, resilient, and desiring of healthy relationships and qualities of life.

Etiology of Clinical Problems

A collaborative therapist takes the position that there is no such thing as an objective problem or a problem that is caused by or resides within a person or group of persons (e.g., family). Problems are viewed as co-evolved, meaning that they exist in ongoing communication among others and self. Through our interpretations we attribute meaning to others, events, actions, and ourselves. Problems cannot be separated from an observer's interpretations and their pre-understandings that inform them. This is not to say that person A did or did not hit person B; instead, the emphasis is on the meaning attributed to the action, the interpretation of the action.

Problems are considered part of everyday living and not the product of pathological individuals or dysfunctional systems. What is problematic to one person or system may not be problematic to another: "Each problem is conceived as a unique set of events or experiences that has meaning only in the context of the social exchange in which it happened" (Anderson, 1997a, p. 74). Problems can be perpetuated and escalated through conversational breakdowns, a failure to maintain generative conversations (Anderson, 1986, 1997a).

Assessment

Traditional notions of diagnosis and assessment are based on the idea of objective reality, commonality across problems, and linear cause and effect. Inherent in the notion of assessment is a determination of *what is*: a problem can be defined, its cause can be located, and it can be solved. From a collaborative perspective each observation, problem description, and understanding is unique to the people involved and their context. In therapy, what is designated as a problem is collaboratively explored and defined through conversation. Because conversation or dialogue is generative, a problem is never fixed; it shifts as its definitions, meanings, and shapes change over time through conversation.

Although collaborative therapists seldom find traditional notions of diagnosis and assessment useful, they acknowledge that they and their clients live and work in systems in which these are relevant. This challenges therapists to respect, be in conversation with, and navigate the multiple realities and expectations of the contextual parameters and stakeholders.

Effectiveness

Collaborative therapy contrasts with therapy approaches in which professional knowledge externally defines problems, solutions, outcomes, and success—creating expert–non-expert dichotomies. Collaborative therapists believe that one must ask the client to determine whether therapy was useful, and if so how. Although therapists' experiences and opinions are valued, every effort is made to privilege clients' perceptions and evaluations of therapy and to pay attention to what therapists can learn from them. Research, so to speak, becomes part of everyday practice, with

therapists and clients as co-researchers during the process of therapy, as well as at its conclusion (Andersen, 1997; Anderson, 1997a). Findings are used during the therapy process to make therapy more useful to the client and, of course, influence the further evolution of ideas and practices (see Andersen, 1997).

The strengths of the approach are in the relationships and conversations that are created between the client and a therapist and in their inherent possibilities. Consequently, therapy becomes less hierarchical and dualistic, less technical and instrumental, and more of an insider rather than an outsider endeavor. Clients report a sense of ownership, belonging, and shared responsibility. Therapists report an increased sense of appreciation for their clients, sense of enthusiasm, and sense of competency, creativity, flexibility, and hopefulness for their work. They also report a reduction in burnout.

Most "evidence" of the effectiveness of collaborative therapy is practice-based qualitative methodology, anecdotal, and privileges the client's voice. Client and therapist narratives about their experiences of therapy and the usefulness of the therapy for them are included, for instance, in articles on child abuse and other types of domestic violence, eating disorders, substance abuse, war trauma (Anderson, 1997a; Anderson & Levin, 1998; Anderson, Burney & Levin, 1999; Anderson & Creson, 2002; Chang, 1999; London, Ruiz, Gargollo, & Gargollo, 1998; St. George & Wulff, 1999; Swim, Helms, Plotkin, & Bettye, 1998); couple-focused inquiry (Anderson, Carleton & Swim, 1998; Sesma, 2011). As in narrative therapy, it is not unusual for therapists to invite clients to participate in writing and professional presentations (London et al., 1998; Swim et al., 1998). Qualitative research includes studies of the effectiveness of collaborative therapy and analysis of therapists' experiences of the approach and whether therapists' behaviors and attitudes were consistent with their therapy philosophy (Gehart-Brooks & Lyle, 1999; Sesma, 2010; Swint, 1995), and the application of the ideas in supervision and education (St. George, 1994a, 1994b).

The history of its development also supports its effectiveness. The collaborative approach evolved in practice settings with a variety of challenging clients. These include chronic treatment failures and patients in outpatient and inpatient psychiatric settings and later with public agency clients such as children's protective services, women's shelters, and adult and juvenile probation who were often mandated for therapy and from various cultures (Anderson & Gehart, 1997; Anderson & Goolishian, 1988, 1992; Anderson & Levin, 1998; Levin, Raser, Niles, & Reese, 1986). Finnish psychologist Jaakko Sekkula and his colleagues have aptly demonstrated effectiveness of the open dialogue approach through a research project with a five-year follow-up with psychotic patients and their families (Seikkula, 1993; Seikkula et al., 1995). Often-asked questions about the effectiveness of the collaborative approach include: 1) "What are its limits?;" and 2) "It sounds so cognitive, how does it work with people who are not so verbal or bright or who are psychotic?" Limits are considered therapist-created: a therapist for instance slips out of a collaborative way of being.

Narrative Therapy

History and Background

Social workers Michael White at the Dulwich Centre in Adelaide, Australia and David Epston in Auckland, New Zealand became interested in each other's work in the early 1980s. Combining Epston's background in anthropology and his interest in storytelling and White's interest in interpretive methods inspired by the writings of Gregory Bateson, they created what became known as narrative therapy (White & Epston, 1990; Epston & White, 1992). Several factors affected the development of narrative therapy. Contextually, it is not surprising that narrative therapy emerged in these geographic and cultural contexts during a period when social and governmental attention and commitment in both countries were drawn to the oppression of their indigenous cultures and efforts of restitution. Given this backdrop, Epston and White were naturally attracted to the relevance of European post-structural theory, particularly Foucault's position on constructed truths and the inseparability of power and knowledge. It is believed by many that

Cheryl White influenced White and Epston's interest in feminist theory and analysis of power. Over the years, there have been numerous important leaders and extenders of the narrative therapy movement: Gene Combs and Jill Freedman (Freedman & Combs, 1996), Victoria Dickerson and Jeffrey Zimmerman (Zimmerman & Dickerson, 1996), Gerald Monk and colleagues (Monk et al., 1997), Sallyann Roth (Roth & Epston, 1996), Craig Smith and David Nyland (1997) and Kathy Weingarten (1998) in the United States as well as in Canada (Madigan & Epston, 1995) and other countries.

Major Theoretical Constructs

Narrative therapy is based on a narrative/story metaphor: people make sense of and give meaning to their lives, including the people and events in it through their narratives, through the stories they tell others and themselves and the stories they are told. That is, narratives or stories about others and self shape our experiences, the meanings we attribute to them, and thus our lives. People's narratives are their realities. We are born into a background of dominant narratives or discourses of our unique cultures that are created by the culture's power brokers. These dominant discourses, or truths, influence local and personal narratives, affect the words we use and the knowledge we have, and become internalized truths. The lived experience of the person becomes lost or subjugated to the dominant narratives. Narrative therapy views problems—their formation and their resolution—from this dominant narrative perspective.

Based on these cultural discourse problem formation perspectives, narrative therapy carries a political and social agenda: to help people deconstruct and liberate themselves from their culture-dominated problem stories and to construct stories about themselves that give more possibilities to their lives. This applies to therapists as well as clients. Therapists are also subject to being captives of cultural privileged truths and imposing them on their clients. To avoid this risk, narrative therapists examine the influence of larger cultural discourses on their own narratives, preferred truths, and actions, and they openly disclose, or are transparent about, their beliefs and biases about problems, therapy, and so forth.

In the development of narrative therapy, this perspective and agenda were strongly influenced by the poststructuralism view of the French social philosopher Michel Foucault (1975), more so than by a postmodern perspective. Foucault's life work was committed to calling attention to and challenging the taken-for-granted and often invisible but pervasively influential social, political and cultural institutional structures and practices in which people live. Foucault, persuaded by his studies of institutions such as justice-penal systems and medical-psychiatric systems, believed that the dominant discourses of these institutions gave power and influence to some people, usually to those deemed to have expert and objectified knowledge of marginalized or victimized others. This consciousness-raising became a guiding principle for narrative therapy in relation to the goal of therapy, the process of therapy, and the position of a therapist. Narrative therapy's commitment to social justice and questioning of power influences outside and inside the therapy room drew many therapists who shared this commitment to it.

The works of French literary deconstructionist Jacques Derrida (1978), North American anthropologist Clifford Geertz (1973) and psychologist Jerome Bruner (1986) have also influenced the narrative approach. Derrida's work focuses on meaning and its relation to the texts. For Derrida, a text has no one true meaning. The reader, through reading and interpreting a text, creates a text and its meaning. It is a linguistic trap to assume that a certain text exists or that one can search for and find it. Narrative therapists have also adopted Derrida's concept of deconstruction: "the critical analysis of texts . . . how a text is given meaning by its author or producers" (Smith, Harre, Langenhove, 1995, p. 52). Specifically, for White and Epston the text analogy "advances the idea that the stories or narratives that persons live through determine their interaction and organization: the evolution of lives and relationships occurs through the performance of such stories or narratives" (White & Epston, 1990, p. 12). In narrative therapy, deconstructing an event, for

instance, through deconstructing questions helps to distinguish it from others, to open pathways for alternative meanings, and to free the person from a subjugating dominant discourse associated with practices of power. Geertz introduced the concept of "context analysis": an interpretive process of looking into the meaning of talk and action in their social and cultural contexts. The analysis gives a local "native" understanding, or a fuller understanding that Geertz referred to as "thick description" (1973). Through these local understandings, access is gained to the human lived experience rather than to normative objective descriptions, labels, and classifications. A common thread through the works of Foucault, Derrida, and Geertz is a strong plea to the human sciences to be aware of and not participate in the entrapping danger of normalization to subjugate and control. Narrative therapists borrowed from Burner's narrative theory, including his ideas about the structure of stories, how people understand and give meaning to their experiences through them, and how they create realities for the writer (teller) and the reader (listener).

Combined, these conceptual frameworks influenced the designation *narrative* therapy: the way that our narratives, our stories about others and our selves shape our experiences, our realities and constitute our identities. Combined, they influence the mission of a narrative therapist: to help people deconstruct the stories that guide their lives, emancipate themselves from limiting or oppressive stories, and live their preferred stories. The influence of these conceptual works on the premises and promises of narrative therapy are apparent in the following sections.

Etiology of Problems

From the narrative perspective, dominant cultural discourses and institutions influence the problem stories that people bring to therapy. Discourses of pathology and causality that exist within our broader social and psychotherapy cultures are large influences and are easily internalized, inviting problem-saturated stories. Problem stories negatively effect people's identities and generate blame and hopeless feelings. Problems persist because problem-saturated stories persist. Thoughts and experiences of others and self become the interpreting and validating lens that fix and perpetuate the problem story. In the words of White and Epston "persons experience problems, for which they frequently seek therapy, when the narratives in which they are 'storying' their experience, and/or in which they are having their experiences 'storied' by others, do not sufficiently represent their lived experience, and that, in these circumstances, there will be significant aspects of their lived experience that contradict these dominant narratives" (1990, p. 14).

A problem is not inside a person, couple or family; it is not found within family structures or interaction patterns. Instead, problems are viewed as external to each person, limiting or oppressing them and other members of their system. People, therefore, are not blamed for problems.

Assessment

Assessment assumes that there is something (e.g., a structure, a pattern, a personality, or a relationship) to evaluate. Usually embedded in that assumption is that the something is static. Traditionally, in psychotherapy, assessment tends to focus on determining the correct diagnosis, which in turn informs the treatment. Narrative therapists do not use standardized assessment instruments or focus on quantifiable diagnoses. Narrative therapists value the local or the native description of the problem. The person consulting a therapist is the best source of description of the problem and the best judge of what they want from therapy and a therapist, and whether the therapy is helpful. Assessment is not seen as a beginning phase of treatment that determines the goal and the strategies for reaching that goal. Rather, assessment, or learning about the problem, is part of the continuous process of telling and re-telling the story. Narrative therapists are interested in mapping the impact and effect of the problem on the individual and the family rather than in finding its cause.

Because narrative therapists hold assumptions about limiting and oppressing dominant discourses, they develop ideas about which discourses these might be as they listen to the client's narrative. Also, they ask clients to identify

where some ideas may come from and how they would name that source or set of beliefs. So, part of the assessment would include determining the discourse in which the client's problem is located and the restraints that it poses on the client's life. Although introducing the taken-for-granted or invisible discourse can be viewed as an intervention, it is also viewed as an opportunity to assess the client's response and negotiate understanding.

Clinical Change Mechanisms and Curative Factors

Narrative therapy is based on the assumption that resolution requires a change in story or narrative. Narrative therapists want to help people "re-author" (White & Epston, 1990) their lives and relationships and to form new identities that liberate them from limiting and oppressing narratives. Re-authoring involves re-envisioning both the past and the future. It also requires making the invisible constraining problem-supporting discourses visible and helping people "confront the discourses that oppress or limit people as they pursue their preferred directions in life" (Freedman & Combs, 2000). The new or alternative story is sometimes called a preferred outcome. The new story becomes the vehicle for a new self-identity. This said, it should be noted that narrative therapists prefer to focus on practice (e.g., actions, not constructs, e.g., meanings).

The focus is not on the more usual techniques and goals of therapy such as improving communication among family members or encouraging people to express their feelings. Instead, the primary therapist activity is deconstructing the problem story and its supporting assumptions, and externalizing the problem. Critical to change is a therapist's attitude of respectful confidence in the client and tenacious hope.

Process of Narrative Therapy

The preferred position for a narrative therapist is one that exemplifies a worldview of a "way of living that supports collaboration, social justice and local, situated, context-specific knowledge rather than normative thinking, diagnostic labeling, and generalized (non-contextualized) 'expert' knowledge" (Freedman and Combs, 2000, p. 345). This de-centered therapist position is critical to achieving the mission of narrative therapy: re-authoring of lives.

Whether narrative therapists describe their work in the language of technique and intervention varies. For example, some speak of "practices" (Freedman & Combs, 2000, p. 350). Narrative therapists take several identifiable structured actions, regardless of what they call them, to help them achieve their mission to deconstruct and liberate people from problem stories and to re-author a preferred story. Questions usually take the lead in this agenda; narrative therapists ask questions to influence the emergence of preferred outcomes and alternative storylines that lead to re-authoring

Deconstructing. A therapist asks questions to deconstruct the problem story—detail it, explore its context—and to reveal the dominant social, cultural, and political practices that have helped create and maintain the problem. Some therapists refer to the deconstructing process as unpacking.

Externalizing. Externalizing conversations "employ practices of objectification of the problem against cultural practices of objectification of people . . . makes it possible for people to experience an identity that is separate from the problem" (White, 2007, p. 9). In practice, a therapist asks questions and makes comments that emphasize the problem as an outside influence on the person rather than as a characteristic or defect inside them or their actions. Externalizing disconnects the person from the problem and disrupts the idea that problems originate within people. To aid in this disconnection and to help people renegotiate their relationship with the problem and exercise control over it, the problem is often given a name or personified. Externalizing the problem challenges not only the location of the problem, but also the idea of it as fixed and as a totalizing entity.

Thickening stories. A therapist asks questions that help create fuller descriptions and understandings of the lived experience of the client and that invite new preferred life narratives. Deconstructing, unpacking, and externalizing are part of the thickening process.

Realizing unique outcomes and creating preferred outcomes. Critical aspects of creating external definitions of problems are what narrative therapists call realizing unique outcomes and creating preferred outcomes. Narrative therapists believe that people have experiences in their lives that are often unrecognized or not valued that can be rich resources for having a voice and for potential action. More specifically, a therapist listens and looks for such experiences and engages the client in conversation about them with the intention that this leads to additional "points of entry for rich story development" (White, 2007, p. 260). For instance, a therapist asks questions that help elicit unique outcomes—instances or "sparkling events" that contradict or open the way for an alternate or preferred story. They identify, highlight, and reinforce these unique outcomes, inviting and supporting the client to have power over the problem and his or her life. In addition to focusing on past and present unique outcomes, a narrative therapist focuses on future unique and unexpected outcomes. Therapists ask questions, using their knowledge of the problem story and their imagination to help the clients construct a preferred or more useful story.

Being transparent. One way for a narrative therapist to minimize the power differential between client and therapist is to offer selected information about themselves and their beliefs (as this relates to the reason for seeking consultation) and to invite clients to ask them questions about these. In the words of Freedman and Combs, "We try to be transparent about our own values, explaining enough about our situation and our life experience that people can understand us as people rather than experts or conduits for professional knowledge" (1996, p. 36).

Reflecting. Using Tom Andersen's notion of reflecting process (Andersen, 1995) a therapist gives a therapy team or observers of the therapy the opportunity to reflect on the conversation while the client and therapist listen. The reflectors are thought of as one kind of community of concern (discussed below).

Letter writing. A therapist or team writes letters as another way of participating in a client's story, externalizing the problem, and creating unique outcomes. Letters are most often written and mailed to a client after a therapy session or at the end of a course of therapy. Letters are used to show therapists' recognition of the client's situation and to help support and sustain change during the course of therapy or at its end. A client will then have the letter to read and re-read long after therapy has concluded. Letters may take any creative form and their content may vary, all depending on the clients and their circumstances and what a therapist hopes to accomplish. Numerous examples of a variety of letters can be found in White and Epston's *Narrative Means to Therapeutic Ends* (1990, pp. 84–187).

Two other techniques, creating communities of concern and designing definitional ceremonies, serve as important aids to acknowledging, solidifying, and sustaining the new story. They create another way of telling and re-telling the story or what Wolfgang Iser (1978) calls a "performance of meaning." They also invite a sense of ownership for the client and a sense of joint responsibility for all participants.

Creating communities of concern. A therapist invites the client to bring into the conversation, literally or figuratively, the voices of significant people in their lives to help counter the influence of the broader culture's restrictive narratives and to support and maintain new narratives and preferred outcomes. These voices are utilized throughout the therapy and at its conclusion. A therapist can also encourage and help the client to bring together or join groups of people with the same kind of problem. Examples include Anti-Anorexia/Anti-Bulimic Leagues (Madigan & Epston, 1995) and Internet websites (Weingarten, 2000).

Designing definitional ceremonies. To focus on the change, including to have others witness it, to celebrate it, and to sustain it, White borrowed from anthropologist Barbara Meyerhoff's (1986) practice of definitional ceremonies. In its original use, therapists invited clients to create a ceremony or ritual in which significant people in their lives can witness the change, thus highlighting it. The event could take any form or shape

that acknowledges the accomplishment such as a certificate, a declaration, an imagined public announcement, a song, and so forth. The options were limitless and only depended on the creativity of the participants. Later, White developed a fairly structured way of working with and preparing the "external witnesses." After the "witnesses" hear the conversation between therapist and client, a therapist asks each of the witnesses four questions along the lines of "expression," "image," "resonance," and "transport". Early on White recruited his witnesses from people's families, and friendship and community networks. He later preferred to recruit from his former clients because he believed, among other reasons, that former clients who had experienced the outsider witness process, had a sense of the usefulness of the process and the deep impact that it could have.

Though all of the above "interventions" remain critical to narrative therapy, White (2007) later focused on the notion of "maps" as a way to "shape a therapeutic inquiry" in which in White's words "people find themselves interested in novel understanding of the events of their lives, curious about aspects of their lives that have been forsaken, fascinated with neglected territories of their identities" (p. 5). To become familiar with White's most current organization and extension of his ideas (e.g., landscape of action, landscape of consciousness, subordinate storylines), the reader is referred to *Maps of Narrative Practice* (White, 2007).

Effectiveness

Most of the dissemination of information on the effectiveness and in support of narrative therapy is found in anecdotal form at conferences, in books and journal articles, and the Dulwich Centre Newsletter. In keeping with the narrative/story metaphor, narrative therapists invite present and former clients, individuals and large groups to tell their stories in writing and in professional presentations. This allows the conference participants and readers to hear the clients' stories and therapy experiences directly from the source rather than through therapists' filters. It also acknowledges the major role of clients in the therapy and the change.

The approach has demonstrated success in various contexts and with different presenting problems. Application in schools is partly demonstrated in a special section on "Narrative Work in Schools" in the *Journal of Systemic Therapies* (Zimmerman, 2001) including success with bullying (Beaudoin, 2001), the effects of terroism (Shalif & Leibler, 2002), and the use of teacher's knowledge to revive commitment and success in teaching (Kecskemeti & Epston, 2001). Application with custody evaluation has demonstrated a favorable outcome of a narrative-collaborative process in which all parties (clients and evaluators) felt more respected and heard and less traumatized and blamed. Furthermore, its application and effectiveness in home-based therapy has been demonstrated (Madison, 1999). The success of narrative therapy is also discussed in Freedman and Combs (2000) and Smith and Nylund (1997). More recent quantitative studies include Gardner and Poole's (2009) study of older adults and addictions and Vroman and Schweitzer's (2011) study of narrative therapy with adults with major depressive disorders.

Solution-Focused Therapy

History and Background

Steve de Shazer is widely acknowledged as the principal originator of solution-focused therapy, although its development emerged from the collective work of de Shazer, his professional partner and wife Insoo Kim Berg, and his colleagues in Milwaukee, Wisconsin in the late 1970s. Well-known others, primarily Eve Lipchik, William O'Hanlan, Jane Peller and John Walter, and Michele Weiner-Davis built on the early foundations and practices of solution-focused therapy, especially its focus on solutions and brevity, and developed their own unique versions and names for it (O'Hanlon & Weiner-Davis, 1989; Lipchick, 1993, 2002; Walter & Peller, 2000). De Shazer was strongly influenced by his early work with the Mental Research Institute (MRI) group in Palo Alto, California and their brief problem-focused therapy.

De Shazer and Berg do not necessarily place solution-focused therapy under a postmodern/poststructural/social construction umbrella, as there are distinct differences between solution-focused and collaborative and narrative

therapies. All three, however, share the centrality of language and its relationship to reality; and de Shazer and Berg also use the narrative metaphor to refer to the ways people talk about and construct their lives. Like the MRI group, they promote the simplicity of their theory and practice; however, solution-focused therapy does have a solid theoretical base.

Major Theoretical Constructs

Solution-focused therapy is historically rooted in a tradition that started with the influence of Milton Erikson, Gregory Bateson, and the MRI associates; and giving credit to Berg, de Shazer supplemented the MRI influence with the premises of Buddhism and Taoism (de Shazer, 1982). De Shazer and Berg basically flipped the problem-focused approach that suggested more of the same ineffective solutions maintain the problem to more of the same effective solutions solve the problem. They continued the MRI group's commitment to a pragmatic, deliberate intervention and brief perspective, including the importance of what rather than why and the importance of the present rather than history, and they added an emphasis on the future. They referred to their early task and goal-directed practice as an ecosystemic approach to brief family therapy (de Shazer, 1982). Later de Shazer and Berg wove philosopher Ludwig Wittgenstein's notions of language and language games into the background of these earlier influences (de Shazer, 1991). Language creates and is reality. Therefore, a problem is a client's reality: to change a problem, one must change the reality by changing the language. In de Shazer's view, a shift from problem talk to solution talk is critical to this change. Solution-talk takes the form of what de Shazer (1991) refers to as progressive narratives, ones that lead toward goals by allowing "clients to elaborate on and 'confirm' their stories, expanding and developing exception and change [problem] themes into solution themes" (pp. 92–93). In addition to the earlier writings of de Shazer and Berg, a later book by De Jong and Berg (2002) clearly explicates the history, the theoretical and practical underpinnings, and the techniques of solution-focused therapy. The reader is referred to Lipchik (2009) for a thoughtful and engaging account of the details of the original team's journey in the theoretical and practice development of the approach.

Solution-focused therapy is a non-pathologizing, positive, and future-oriented approach. Therapists focus on the positive aspects and potential of clients, as well as on empowering them. Solution-focused therapy revolves around the question, "How do we construct solutions?" (Walter & Peller, 1992). The major premise is that information about problems is not necessary; for change, all that is necessary is solution or goal talk (Walter & Peller, 1992). Central assumptions that guide a therapist's thinking and activity include change and cooperation as inevitable, everyone has the resources to change, and clients succeed when their goals drive therapy (Selekman, 2002). Maintaining the early systems notions that a change in one relationship or part of the system will effect change in others and that a small change can lead to a large change, solution-focused therapists believe it is only necessary to work with the complainant and to have modest goals. Therapists are, however, flexible depending on the requests of the referring person(s) or other customer or complainant. Early on, solution-focused therapists placed clients in one of three categories to designate their commitment and level of desire to change: visitors, complaintants, and customers. Interestingly, when clients do not cooperate they interpret this as helping a therapist find a better way to help them.

A later influence for de Shazer was the work of Austrian philosopher Ludwig Wittgenstein (Miller & de Shazer, 1998). As mentioned above, drawing on Wittgenstein's notion of language games and his and other philosophers' notion that realities and meanings are created in language, de Shazer speaks of the construction and action of problem-talk and solution-talk as language games. Solution-focused therapists prefer to play the solution-talk game with its focus on solution consequences.

Etiology of Clinical Problems

Problems from a solution-focused perspective are related to language: the way that people

talk about and attribute meaning to what they call problems. The talk about the events, circumstances, and people in clients' lives defines a problem as a problem. In de Shazer's words, "There are no wet beds, no voices without people, no depressions. There is only *talk* about wet beds, *talk* about voices without people, *talk about depression*" (1993, p. 89). From this perspective, information about the problem such as its root and cause, its patterns, or its frequency are not important. To the contrary, as mentioned earlier, solution-focused therapists want to avoid talking about the problem.

Assessment

Assessment is not a component of solution-focused therapy in the traditional sense. De Shazer challenges the relationship between problem and solution, making assessment of problems irrelevant. In his words, "The problem or complaint is not necessarily related to the solution," and, "The solution is not necessarily related to the problem" (1991, p. xiii). Again, they hold a strong belief that neither therapists nor clients need to know the problem's etiology or to even understand the problem. Looking for causes and grasping for meanings of problems are viewed as little more than problem-talk. And, problem-talk can perpetuate the clients' obsession with and immersion in their problems, risk reifying problems, and obstruct the development of solutions. This is believed to be true for both the therapist and the client.

Solution-focused therapists do want to know or assess the client's goal. They also want to know the exceptions to the problem, for these exceptions hold the seeds for solutions. Although historically they have maintained a strategic stance, some now strive for a collaborative construction of goals and solutions.

Process of Solution-Focused Therapy

The hallmarks of solution-focused therapy is its focus on solutions and brevity. Early in the development of solution-focused therapy, de Shazer used techniques that he called "formula tasks" (de Shazer, 1985) that later included specific kinds of questions to help move people from problem-talk to solution-talk, to discover and create solutions. With the tasks and questions, therapists aim for specific concrete behavioral information and instructions. The approach is manualized in the sense that all questions and tasks are based on the assumption that the solution to client's problems already exist in their lives and are constructed to achieve the desired outcome: solutions. The manualization also contributes to its efficiency. In spite of the manualization, early on solution-focused therapists believed in the value of cooperative relationships with clients. The most popular questions and tasks include those listed below.

Exception questions. Establishing exceptions to the problem is intended and believed to be an important part of orienting people toward solutions. Exception questions search for, identity, and confirm times in the past and present when the problem was not as problematic. This is a way of deconstructing the problem without searching for causes and understandings of it and constructing the solution. Another way to consider this process is to think of a therapist as helping to deconstruct an unsatisfactory reality, and when the problem is no longer a problem, a therapist constructs a satisfactory one.

Miracle questions. Miracle questions are "hypothetical solution questions" (Walter & Peller, 1992, pp. 75–85). They help people set goals by coaching them to imagine what their life would be like if the problem were solved. As with other solution-focused questions, the intent is to focus on the solution and defocus on the problem. The response to the question is often a starting place for helping the client and therapist have a better sense of the client's objective and will often reveal clues to reaching it. The miracle question is typically worded,

> Suppose that one night there is a miracle and while you were sleeping the problem that brought you to therapy is solved: How would you know? What would be different? What will you notice different the next morning that will tell you that there has been a miracle? What will your spouse [for instance] notice?
>
> *(de Shazer, 1991, p. 113)*

Scaling questions. Scaling questions are used by solution-focused therapists much like they are used by other therapists; that is, to help clients be more specific and concrete and be able to quantify and measure problems and successes. The responses can note how and where the client perceives him or herself and give a therapist clues for questions that can reinforce improvement as well as suggest the possibility of or nudge extenuation of the improvement. For instance, a therapist might ask questions such as: "On a scale from one to ten with one being the lowest, where would you place your depression when you first came in? Where are you now? How did you move from a one to a three? What would it take to move from a three to a five?"

Coping questions. DeShazer and Berg also use what they call coping questions. These are questions to help clients who fail to see any exceptions or forward movement. Such a question might be, "I'm curious to know why you're doing as well as you are?" Again, striving for any kind of difference.

Creative misunderstanding. De Shazer suggests that therapist misunderstanding is more likely to occur than understanding, so use misunderstanding to a therapist's advantage (de Shazer, 1991). For example, what might be typically thought of as resistance is viewed as information or a message that a therapist has misunderstood the client or erred in their interpretation. This provides a therapist the opportunity to learn more from the client and get back on the solution track.

Feedback. De Jong and Kim Berg (2002) suggest that it is important to give the client feedback, usually near the end of the session. The feedback focuses on the client's positive improvements, connects with the client's goals, and addresses what is better or suggests doing more of what is making things better.

Effectiveness

Like collaborative and narrative therapies, the effectiveness of solution-focused therapy is mostly found in anecdotal and specific case reports. Solution-focused therapists have been prolific writers and conference presenters. Berg and Dolan (2001) offer a collection of success stories by clients and therapists on a variety of presenting problems. Miller, Hubble, and Duncan (1996) offer a review of relevant outcome research and reports of numerous applications of solution-focused therapy in action. Its usefulness has been demonstrated with specific populations and presenting problems such as alcohol abuse (Berg & Miller, 1992), child abuse (Berg & Kelly, 2000), groups (Metcalf, 1998; Sharry, 1999), adolescents (Seagram, 1977; Selekman, 2002), the elderly (Dahl, Bathel, & Carreon, 2000), marital therapy (Gale & Newfield, 1992), schools (Osenton & Chang, 1999), and client-perspective. Qualitative research supporting its effectiveness is reported by Miller et al. (1996), Gingerich and Eisengart (2000) and Kim (2007).

The most comprehensive research was completed by De Jong and Kim Berg (2002) in which they measured intermediate and final outcomes of solution-focused therapy with 275 clients. They concluded that solution-focused therapy had comparable and possibly superior results to other therapies, with an improvement rate of 74% versus an average 66% improvement rate of other therapies. In addition, the improvement occurred in fewer sessions, with an average of two sessions in their study and an average of six in others.

De Jong and Kim Berg (2002) suggest that the effectiveness of the approach is closely tied with a therapist's adherence to the steps for building solutions as described by De Jong and Kim Berg (2002). These steps include explaining to the clients how a therapist works; describing the problem while emphasizing solutions and expectations; defining goals by finding out and amplifying what the client wants; using the techniques of exceptions, miracle questions, and scales; and formulating and offering feedback to the client.

Distinctions Between the Three Therapies

The distinctions between these therapies are influenced by the preferences and experiences of their originators as well as the social and cultural

contexts in which they developed. Collaborative therapy emerged within medical school and community agency practice contexts in which the primary clients served were those often described as multiproblem, socially and economically disadvantaged, and treatment-resistant failures. Very simply put, the originators had an early interest in the alternative views of language as mentioned above and in the inherent transformative potential of dialogue. Narrative therapy emerged within an era of focus on restitution for indigenous peoples and feminism. In line with this focus, the founders had an interest in story and narrative and in the oppressive potential of dominant discourses. Solution-focused therapy emerged from an interest in shifting from the limiting nature of "problem-talk" and the discovery of causes to talk that implied change and the potential and pragmatics of an achievement-encouragement of what works orientation.

Power. Collaborative and narrative therapies place importance on power. Similarly, they value client–therapist relationships and systems that are more egalitarian and less hierarchical; they are careful to be respective, public, and transparent about their views and biases. Dissimilarly, narrative therapy holds an agenda to liberate people from constraining or oppressive dominant narratives; Collaborative therapists pay attention to these narratives when the client thinks it is important. Solution-focused therapists do not find the issue of power relevant.

Client-therapist relationship. Collaborative and narrative therapies place emphasis on the client–therapist relationship, although perhaps a different emphasis. Solution-focused therapies do not accent the relationship.

Therapist-expertise. Therapist-expertise can be thought of as along a continuum in terms of importance and intent. Collaborative therapists espouse that the clients are the experts on their lives and a therapist is in a not-knowing position regarding it. Narrative therapists are experts in helping clients achieve preferred stories and living them, and solution-focused therapists use their expertise in strategies toward goals.

Therapist-role. Collaborative therapists favor a process of mutual inquiry and are not invested in a content outcome; they view themselves as walking alongside their client toward an unknown destination of new meaning and action. Narrative therapists favor a structured map process that leads to preferred stories and people being able to live these; their role is like a narrative editor. Solution-focused therapists follow prescribed steps to steer clients toward solution-talk and a specified behavioral goal.

Future Developments and Directions of Postmodern/Postructural/Social Construction Therapies

These postmodern/poststructural/social construction therapies represent an ideological shift that has slowly evolved over the last three decades and do not represent a fading trend. To the contrary, enthusiasm and iterations of these therapies continue to grow as therapists find them fitting with our contemporary world.

Do these therapies have limitations, and if so, what are they? Most therapists would respond that there are not across-the-board limitations in respect to particular client populations, presenting problems, or cultures (with the exception of the solution-focused therapists categorization of clients as visitors, complaintants, and customers). To the contrary, most of these therapists report that the postmodern/poststructural/social construction approaches permit them, more so than other approaches, to engage and work with a variety of populations and problems even if they have no or limited experience with the same. This freedom and competence seems to be associated with the collaborative aspect of doing something together and pooling resources, whether a therapist calls it that or not. It also seems to be associated with therapists' ability to be creative when not constrained by diagnosing pathology and being the curing expert. Perhaps therapists limit themselves when they fall into these essentialist modes.

The implications of this shift stretch far beyond the dichotomies inherent in the terms individual, family, and group therapy, and to

disciplines and contexts outside the mental health ones. Common among these therapies is their continuous evolution as they strive to meet the changing demands of our world. The so-called originators and their colleagues and generations of thinkers and practitioners around the world continue to explore and extend the vast possibilities for therapy, education, research, organizational consultation, and medicine, as well as the complex social and cultural circumstances that challenge the earth we inhabit.[8]

Notes

1. Anderson does not suggest that "nothing exists outside linguistic constructions. Whatever exists simply exists, irrespective of linguistic practices" (Gergen, 2001). Rather, the focus is on the meanings of these existences and the actions they inform, once we begin to describe, explain, and interpret them.
2. Other therapies that are sometimes placed under the postmodern umbrella are Constructivist Therapies. The distinction is that they draw from constructivist rather or more than social constructionist theory. These therapies are not discussed in this chapter; for comprehensive reviews see Neimeyer, 1993.
3. Language refers to any means—spoken, unspoken—by which we articulate, express or communicate with ourselves and with others.
4. "Perspective-orienting" refers to a viewpoint and attitude from which we attend, approach, relate, and respond to our world, others, and ourselves in a spontaneous manner (Shotter, 2008) rather than from theoretical assumptions that inform preknowing and planned method, technique, and strategy (see Anderson, 1997a, for an expanded body of assumptions).
5. A term suggested by Shotter.
6. For more detailed discussion of engagement in mutual inquiry and the use of host-guest and storyball metaphors in teaching, see Anderson, 1997a, 1997b, 2012.
7. See www.youtube.com.
8. Presentations by Harlene Anderson, Gene Combs and Jill Freedman and Lipchik at the recent Conversation Fest Conference in Texas highlighted the continuing evolution of these therapies.
9. I thank Margarita Tarragona for these references (Tarragona, 2008).

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Web and Training Sites[9]

Postmodern and Collaborative Therapies

www.harlene.org

Harlene Anderson's website with many articles on postmodern and collaborative therapy.

www.talkhgi.com
Website of the Houston Galveston Institute, where the collaborative approach was developed and is one of the most important training centers for Collaborative Therapy in the world.

www.california.com/~rathbone/pmth.htm
Website on postmodern therapies hosted by Dr. Lois Shawver. Contains many interesting discussions about postmodern thought and therapy in the archives of the postings of the Postmodern Therapies Listserve.

www.grupocamposeliseos.com
Website on postmodern therapies in Spanish. Home of Grupo Campos Elíseos, a training center for postmodern therapies in Mexico City.

Narrative Therapy

www.dulwichcentre.com.au
Home of the Dulwich Centre in Adelaide, South Australia, where Michael White works. Many articles and resources on narrative therapy as well as an international directory of narrative therapists.

www.eftc.org
The Evanston Family Therapy Center. Jill Freedman and Gene Comb founded this institute, which is one of the main training centers for narrative therapy in North America.

www.planet-therapy.com
A narratively informed website with resources for the general public and online training programs for therapists.

www.narrativeapproaches.com
David Epston's website. Articles, resources and information about training opportunities in narrative therapy.

Solution-Focused Therapy

www.brief-therapy.org
Home of the Brief Family Therapy Center in Milwaukee, WI, founded by Steve de Shazer and Insoo Kim Berg, creators of SFT. Many articles and workshop materials and interviews, plus books, audiotapes, and videos for sale.

www.brieftherapy.org.uk
Website of the largest training organization for solution-centered approaches in Europe.

11.

INTEGRATIVE APPROACHES TO COUPLE AND FAMILY THERAPY

Jay Lebow

Writing a chapter on integrative methods in couple and family therapy presents a significant challenge. The practice of family therapy has substantially come to be synonymous with the practice of integrative methods. Just as Alan Gurman has pointed out that family therapy is almost intrinsically short-term therapy (Gurman, 2002), family therapy has emerged as largely integrative practice. Although there continue to be adherents to the first generation schools of family therapy and new models that have emerged over the last decade such as narrative approaches, even the approaches that retain a core of school-based underpinnings often now include a great deal of what is termed assimilative integration (Goldfried & Norcross, 1995); that is, the inclusion of methods drawn from other approaches around the foundation of a host approach. Most of the methods catalogued in this volume are integrative approaches. Sometimes integrative approaches are labeled as empirically supported treatments; sometimes as treatments for specific disorders; sometimes as ways of intervening with clients from specific cultures; and sometimes as integrative and eclectic treatments, but these methods are now everywhere. Both the methods presented by the leaders in the field and the practice of most couple and family therapists are now primarily integrative or eclectic (Lebow, 2014).

History and Background of Integrative Family Therapy

It is ironic that family therapy has only recently emerged as primarily an integrative method of practice because the roots of family therapy were much more in shared understandings about family process than in specific theoretical formulations. The great discovery of the first generation of family therapists was that ongoing family process mattered a great deal in the lives of individuals and that individuals needed to be considered in context (see Carr, Chapter 2 in this volume). Witnessing Salvador Minuchin, Carl Whitaker, Murrey Bowen, Virginia Satir, and their contemporaries discuss families was much more about hearing about common ground than difference.

Nonetheless, as in most endeavors, the evolution of the field led to the development of several distinct and constricted schools of practice. Several reasons can be cited for this sojourn away from integrative practice. First, family therapy began as a challenge to the then prevailing orthodoxy, individual psychoanalytic psychotherapy. In so emphasizing the

family, the predominate discourse moved away from any consideration of the individual. Second, the early charismatic leaders in the field each came to institutionalize a method of practice to distinguish their own brands of treatment. Third, to promote growth the field needed models and training centers around which to create structures. These models and training centers inevitably narrowed the scope of ideas and methods. Another irony in the early development of family therapy lies in how the field came to be structured for a substantial period of time around the creation of postgraduate training centers; the field may have thrown out psychoanalytic ideas but gravitated to structures much like those in the world of psychoanalysis. Finally, the consignment of behavioral approaches to academia, away from the postgraduate centers, meant that there was almost no contact between mainstream family therapy and behavioral family methods over the first 25 years of the field's development. All these factors caused family therapy to come to be primarily practiced in distinct schools for a considerable time.

Integrative approaches to family therapy have returned to ascendance through gradual evolution rather than sudden change. In contrast to the revolutionary way family therapy came into prominence through questioning of fundamental assumptions of what was then current practice, integrative approaches have emerged in a slow evolving process. No one integrative method predominates. Indeed, several integrative methods are often not even typically labeled as "integrative." Sometimes these approaches have arisen through evolutionary changes within approaches such as in Jacobson and Christenson's wrestling with the limits of behavioral couple therapy (see Chapter 18 on Integrative Behavioral Couples Therapy in this volume); sometimes through lenses that focused on entities such as gender and culture (and therefore away from school of practice: see Falicov, Chapter 5 in this volume); and sometimes through efforts to develop empirically supported approaches (see the chapters by Sexton, Liddle, and their colleagues in this volume).

What Constitutes Integration?

The terms "integration" and "eclecticism" are sometimes used interchangeably, yet have come to have distinct meanings. "Integration" and "eclecticism" both involve the application of concepts and interventions that cross scholastic boundaries. The term "eclectic" has been used to describe pragmatic case-based approaches, in which the ingredients of different approaches are employed without trying to build a unifying conceptual theory. The term "integration" suggests a more extensive melding of approaches into a meta-level theory that struggles with and works through the juxtaposition of the meanings of different concepts or intervention strategies entailed.

Nonetheless, the distinction between "integration" and "eclecticism" can easily become murky. Psychotherapy is organized on a number of levels: theory, strategy, and intervention (Goldfried, 1982). An approach may utilize one school's theoretical framework (e.g., behavioral family therapy), but may employ strategies and interventions from other approaches in the context of that theory. Such an approach, labeled assimilative integration (Stricker & Gold, 1996) would involve no integration at the theoretical level, yet would involve considerable crossing of scholastic boundaries at the level of strategy and intervention. One example would be Integrative Behavioral Couples Therapy, described in Chapter 18 in this volume, which clearly remains a behavioral approach, yet extensively integrates ways of working with acceptance that typically lie in more experiential and humanistic approaches.

Most discussions of integrative practice describe three threads of practice. One thread centers on the generation of super-ordinate integrative theories that subsume scholastic theories. Some of these approaches center on stating principles of practice that transcend client characteristics: among these models is Integrative Problem Centered Metaframeworks (Breunlin, Pinsof, & Russell, 2011; Pinsof, Breunlin, Russell, & Lebow,

2011a) as well as Pinsof's (1995) Problem-Centered Therapy and Breunlin, Karrer and Schwartz' Metaframeworks model (Breunlin, Schwartz, & Mac Kune-Karrer, 1997). Other approaches within this thread center specifically on the treatment of specific syndromes and problems; among these models are several methods for treating adolescent substance and delinquency, including Functional Family Therapy (Alexander, Waldon, Newberry, & Liddle, 1990; Sexton, 2010), Multidimensional Family Therapy for adolescent substance abuse (Liddle, 2010; Liddle et al., 2001), Brief Strategic Therapy for adolescent externalizing disorders (Szapocznik & Williams, 2000), and Multi-Systemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998, 2009), all of which are summarized in chapters in this book.

The second thread of integration, technical eclecticism, regards theory as less important and looks to create algorithms at the levels of strategy and intervention. Prominent methods within this thread include, Kaslow's Bio-Psycho-Social Therapy for child and adolescent depression (Kaslow & Racusin, 1994), and Stith and colleagues treatment for spousal abuse (Stith & Rosen, 1990).

The third thread emphasizes building treatment on the common factors that transcend particular orientation to treatment, and aim primarily to promote these factors and increase the shared understanding of their potency. In the family field, this work is best represented by the approaches of Sprenkle and colleagues (Sprenkle, Davis, & Lebow, 2009), who present a moderate common factor model that includes support for specific methods and of Duncan, Hubble, and Miller (1997), who present a view exclusively focused on common factors. Common factors are the aspects of treatment that are shared across treatment models. Common factors shared with individual therapies include therapeutic alliance, handling of alliance ruptures, goal setting, the generation of hope and positive realistic expectations, the provision of feedback about progress in therapy, adapting therapy to the clients' stage of change, therapist empathy, therapist congruence, and therapist genuineness. Common factors unique to couple and family therapy include maintaining a relational frame and multisystemic focus, managing conjoint sessions, maintaining a multi-partial alliance, and engaging positive family process (Lebow, 2014; Sprenkle et al., 2009). Also, client factor and therapist factors as general classes are sometimes included under the heading "common factors" since client factors and therapist factors account for the most variance in research assessing the contribution of different aspects of treatment (Duncan, Miller, Wampold, & Hubble, 2010).

Although there are some ways in which these threads represent competing visions of how to bring methods from different approaches together, they are more appropriately viewed as three overlapping vantage points. Most integrative approaches show some aspect of each thread; that is, include some theoretical integration, some pragmatic efforts to bring together strategies and techniques, and some attention to common factors.

Integration in family therapy also typically extends across session formats: family, couple, parent–child, individual, and, at times, group. It is a basic tenet of most integrative family therapy that session formats are selected in relation to what will be most helpful in relation to family dynamics and improving the presenting problem. Although some integrative therapies utilize only one format (e.g., couple therapy in emotion-focused therapy for couple difficulties (Johnson, 2000), many of these therapies continually move from one session format to another even within a specific case (as in, e.g., Liddle's Multidimensional Family Therapy (Liddle et al., 2001)).

Integration refers both to the process of bridging the concepts and interventions of schools of therapy and to the product that results from this process (Goldfried, 1982; Lebow, 1987b, 2014). The terms are best reserved for methods that cross some clear boundary of treatment philosophy. Simply importing one intervention into an approach in which that concept is not employed (e.g., relaxation training in the context of experiential therapy) is more appropriately labeled "assimilation" (Lebow, 1987b). The blending of approaches that are very similar (e.g., two methods of object relations therapy or two methods of conceptualizing narratives) also does not constitute "integration." In addition, it should be noted that what is regarded as

integrative or eclectic changes over time—for example, cognitive and behavioral therapies—represent two quite different traditions assigning prime importance to thought and behavior, yet principally now are regarded as unified in the cognitive-behavioral approach that few would view today as integrative or eclectic.

The Strengths and Liabilities of Integration

Integrative methods have a number of striking strengths, and number of potential difficulties that need to be addressed (Johnson & Lebow, 2000; Lebow, 1997, 1984).

Strengths of Integrative Approaches

Advantage 1: Integrative approaches draw from a broad theoretical base; as such, they can explain human experience in a more sophisticated manner than can simpler theories and better account for the range of human behavior. Theories are almost always slanted to a single framing of the human condition but human experience is the product of a multiplicity of factors. Considerable evidence points to the importance of biological influences, intrapsychic dynamics, cognitions, behavioral contingencies, and interpersonal influences in the genesis of behavior. Theoretical conceptualizations based in only one dimension of experience are therefore limited conceptions. Integrative family therapists are able to consider a broader range of etiological constructs than their more narrowly trained counterparts and are less likely to fall victim to inappropriately extending a theory to an area or example for which it does not fit.

Advantage 2: Integrative approaches also allow greater flexibility in the treatment of any given individual or family and offer the opportunity for increased efficacy and acceptability of the care. The open-minded stance of integrative and eclectic therapists permits the shaping of conceptualizations of problem formation and resolution to the specific case under consideration and the vast array of techniques these therapists have available allow for the generation of a wide variety of treatment options. The integrative/eclectic clinician can move to alternative interventions and thereby increase the chances of impacting on presenting problems.

Advantage 3: Integrative and eclectic approaches are also applicable to a broader client population than more narrowly focused approaches. Techniques and goals can be adapted to the type of clients presenting, the treatment setting, and the time available for therapy.

Advantage 4: Integrative therapists also are better able to match the treatment they offer to their own personal conception of problem development and change, and to their own personality characteristics. The person of the therapist clearly has a key role in therapy. Integrative approaches allow for the possibility of therapy having a best fit with the therapist who delivers the treatment, enabling the best match between practitioner and practice. As a consequence, therapists are more likely to offer interventions for which they are best suited, promoting therapist skillfulness and increased efficacy. This also is likely to lead to greater belief in the treatment by the therapist and the communication of this belief to the client, common factors that have been demonstrated to be important to treatment efficacy (Frank, 1973).

Advantage 5: Integrative therapists can also combine the major benefits of the specific approaches. Each approach to psychotherapy has specific strengths. Integrative and eclectic therapists can draw freely on these strengths.

Advantage 6: Integrative therapists also can bring greater objectivity to the selection of strategies for change. Because they have less of an investment in the adequacy of a particular method of practice, integrative and eclectic practitioners are freer to experiment and explore the literature relevant to the adequacy of specific techniques.

Advantage 7: An integrative approach can also be readily adapted to include new techniques which have been demonstrated to be efficacious. Psychotherapy is a developing field in which new approaches and techniques are constantly emerging. In integrative approaches, therapy is an evolving art and science.

Advantage 8: Integrative approaches also offer several advantages in training. Training in an integrative approach offers a broader range of experience than school-specific training. Integrative training also promotes an open attitude on the part of the therapist and furthers the development of therapists' critical faculties.

Potential Problems to Be Addressed

Criticism 1: It has been suggested that integrative approaches lack a theoretical basis, a rigor of definition of concepts, and a connection between a conceptualization of the human condition and practice. At times, this is a just criticism; what is presented as integration may not contain much integration either at the theoretical level or practically in the mixing of strategies. However, most integrative therapies are far removed from this caricature, being very carefully constructed either around a theoretical integration or a clear algorithm for intervention.

Criticism 2: It also has been suggested that integrative and eclectic approaches lack the consistency found in the various schools of psychotherapy. Again, this can occur; integrative therapies involve the melding of concepts and so by definition are more complex in their formulations and interventions than simpler school-based therapies. However, present-day integrative therapies typically offer tight frameworks leading to consistency in approach.

Criticism 3: Integrative therapies have been criticized for failing to attend to the changes that occur in the meaning of an intervention when incorporated into a different therapeutic framework. For example, efforts to create new stories have quite different meanings when moved from nondirective narrative therapies to more directive contexts (Dickerson, 2010). However, good integrative therapy carefully considers context and how the part fits into the gestalt of therapy.

Criticism 4: Integrative treatments have been criticized for manifesting utopian views and setting grandiose goals of resolving all levels of difficulty. Given a giant tool kit, it can become easy to have too many goals, and a perfectionistic view of treatment process and outcome. However, most integrative therapies remain straightforward, often accenting the simplest intervention possible toward producing the desired result.

Criticism 5: Integrative approaches have also been criticized for being too complex and too difficult to master. Integrative approaches do involve treatment choices that are more complex than those with a more limited perspective and require a clinician who is comfortable intervening on multiple levels. However, therapists typically not only tolerate the commitment involved in learning more complex approaches and choosing among interventions but also welcome this opportunity. In addition, integrative training programs have begun to create smooth routes to learning and becoming skillful in the practice of these therapies.

Shared Properties of Integrative Approaches

Integrative family therapies vary enormously in content and in the specific theoretical constructs about the nature of families and about strategies for intervention. There is not one integrative family therapy but many integrative and eclectic family therapies. Nonetheless, integrative approaches share a number of core tenets that emerge from the nature of integrative practice and there is an emerging consensus among most integrative approaches about several core understandings. These tenets include:

- *The presence of an underlying template: either a theory of change that is an amalgamation of earlier theories, or an algorithm for which therapeutic strategies should be used under particular conditions.*

Modern integrative and eclectic approaches present a crisp and clear formula for combining the ingredients employed. Those that accentuate theory present bridges between the concepts of the theories represented. For example, Liddle and colleagues in Multidimensional Family Therapy describe how the concepts of individual

development in adolescents are integrated with structural concepts and concepts from traditional substance use treatment (Liddle et al., 2001).

- *Attention to multiple levels of human experience, including behavior, emotion, cognition, intrapsychic process, biology, family, and the larger system.*

Integrative approaches typically assume a bio-psycho-social model of human functioning. Rather than focusing on which aspect of human beings represents *the* crucial determinant of psychological health or difficulty, integrative approaches feature both/and inclusiveness. The crucial question becomes not which is the "right" conceptualization, but which level of explanation is most helpful to the treatment of the individual case. Not all approaches incorporate all of these levels though many do.

- *At least some, and in most cases, considerable attention to the powerful set of common factors that have curative value, including both those that apply to all psychotherapies and those that are unique to couple and family therapies.*

Although the majority of writing and presentations about psychotherapy focus on the special qualities of the unique approach involved, considerable research shows that a set of common factors to be at work in most successful psychotherapy (Norcross & Lambert, 2011; Orlinsky, Grawe, & Parks, 1994). Factors such as the therapeutic alliance, therapist empathy, therapist congruence, and homework have been shown to be crucial to therapy outcomes across therapist orientation. Some research has suggested that technique accounts for as little as 15% of the variance in outcome across clients (Hubble, Duncan, & Miller, 1999). All integrative couple and family therapies incorporate these factors and some exclusively emphasize them.

- *An important role assigned to a systemic understanding of the presenting difficulty and to the family system as a vehicle for enabling change.*

Integrative family therapies share some variant of systems theory as a core set of assumptions. Almost all integrative family therapies extend beyond the more radical version of systems theory prominent early in the history of family therapy which suggested that families are invariably involved in the cause of individual difficulties and inevitably move toward homeostasis that promotes the return of earlier modes of being (Watzlawick, Weakland, & Fisch, 1974). Instead, integrative approaches emphasize such broad systemic principles of the importance of feedback, attending to the context of problems, and circular processes as one important set of considerations in the evolution and maintenance of problems. Invariably, integrative family approaches draw upon family members in the resolution of problems.

- *Integrative therapies typically incorporate psycho-education and skill development as part of treatment.*

Almost all integrative family approaches include some efforts to help families understand the problems they experience better and to build family and individual competencies. Most prominently, the family psycho-educational approaches for treating schizophrenia and bi-polar disorder feature the sharing of information as a crucial intervention (McFarlane et al., 1995; Miklowitz, 2011). Such methods have also become commonplace in other integrative approaches, be they focused on adolescent drug abuse (Liddle et al., 2001), the emotional life of couples (Johnson, 2000) or child sexual abuse (Barrett, Trepper, & Fish, 1990).

- *The utilization of language for describing intervention and the change process that is simple to understand and transcend therapeutic orientation.*

As Hubble, Duncan, and Miller (1999) have emphasized, psychotherapy readily becomes a tower of Babel, in which the same concept can be described by innumerable varieties of jargon. Most integrative approaches find simple language to describe theory and intervention. Such

language readily in turn acts as a bridge across differences in orientation and helps families better understand treatment.

- *The tailoring of intervention strategy in relation to specific populations.*

Integrative and eclectic therapies move beyond the one-size-fits-all philosophy to tailor specific intervention strategies to the kind of problem under consideration and the specific case at hand. Some of these therapies feature general methods adapted to the population in focus, as do Pinsof and colleagues in the couples therapy version of Integrative Problem Centered Metaframeworks Therapy (Breunlin et al., 2011; Pinsof, Breunlin, Russell, & Lebow, 2011b; Pinsof, 1995). Other methods such as Liddlle and colleagues' (Liddle et al., 2001) Multidimensional Family Therapy for adolescent substance are built from the ground up around the treatment of specific disorders.

- *The utilization of research findings as an important determinant of what is included within the model and how interventions are structured, and conducting research to assess and better understand the integrative/eclectic model.*

Although it is not a pre-requisite for integrative approaches to be anchored in research data (some stellar approaches are not; consider for example Goldner's therapy for couple violence (Goldner, 1998)), the vast majority of these approaches assign a powerful role to research. Most engage in a cycle of building the theory involved and intervention strategy employed on the findings of research, then testing the impact of the resultant therapy for its impact followed by drawing from the results of the studies of the treatment in the refining of the treatment. In part, the frequent presence of research in method development is a by-product of the fact that many of the most prominent developers of integrative family approaches are also researchers; in part, this linkage stems from the intrinsic relationship between integrative practice and the evaluation of therapy progress.

- *The tracking of change throughout therapy, often through the use of instruments.*

Empirical data do not only assume importance in integrative therapies at the level of establishing the effectiveness of the treatment; progress data is often an essential ingredient in determining changes in intervention strategy. For example, Pinsof and colleagues' Systemic Therapy Inventory of Change (Pinsof, 1995; Pinsof et al., 2009) is an intrinsic part of Integrative Problem Centered Metaframeworks Therapy utilized in therapist decision making.

- *An ultimate pragmatism, centered on what works, that moves beyond broad insights.*

Although the authors of some integrative approaches can elaborate at length on the theoretical underpinnings of their approaches (see, e.g., Liddle et al., 1992) on the place of developmental psychology in their approach), the content of these approaches tends to build from examining and developing what works with clients rather than from armchair musings. Most integrative approaches, even those that accentuate theory, search for the most practical approach to presenting problems.

- *An ongoing dialectic between theory, strategy, and intervention, in which discoveries about each provide feedback to and interact with what emerges at the other levels.*

Goldfried (Goldfried & Norcross, 1995) has suggested that approaches to psychotherapy include three distinct levels: theory (an understanding of the essential elements of human functioning and the change process), strategy (the overall plan for a treatment), and interventions (the specific techniques utilized). In integrative approaches, theory, strategy, and technique, each reciprocally influence each other.

- *A focus on enabling change through the simplest intervention strategy available.*

Integrative and eclectic therapies intrinsically must wrestle with the problem of complexity. It clearly makes sense to be able to see the process of change from more than one perspective, but how does a therapist hold such a viewpoint while

retaining focus and clarity about the direction of treatment? Most integrative family therapies opt for parsimony in intervention, looking to the simplest path that can produce change. Pinsof (1995), for example, establishes choosing the most direct intervention possible as a basic tenet of his approach.

- *A focus on client strengths.*

Integrative family therapies are substantially strength based. In part a by-product of the substantial roots of modern family therapies in the traditions of seeing people as typically healthy and of seeing strength in connection (F. Walsh, 1996, 1998; W. M. Walsh, 2001), integrative family therapies typically assume an underlying health that can be unleashed by drawing on the powerful healing factors in family process.

- *Building empirically supported therapies.*

Many of the newer integrative and eclectic therapies have developed in the tradition of creating therapies targeted to specific populations, building an armamentarium of empirically supported therapies for specific conditions. Such therapies as Functional Family therapy for adolescent delinquency (Alexander et al., 1990), Multidimensional Family Therapy for adolescent substance abuse (Liddle et al., 2001), and Jacobson and Christenson's Integrative Behavioral Couple Therapy (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) all have followed this model of development.

- *Utilizing relational diagnosis.*

Integrative family approaches assume an important aspect of treatment lies in understanding the relational processes and the generation of strategies of intervention aimed at relational difficulties that impact on the problem. Therefore, relational difficulties often move into the center of attention when present. As examples, Functional Family Therapy accentuates an understanding of the relational value of dysfunctional behaviors in the family system (Alexander et al., 1990; Sexton, 2010)

Prominent Approaches: Broadly Targeted Approaches

There have been several widely disseminated integrative and eclectic approaches in family therapy. Some have been broadly targeted and some have been targeted at specific populations.

Integrative Problem Centered Therapy

Integrative Problem Centered Therapy (IPCT), developed by William Pinsof (1983, 1994, 1995), offers both a generic system for organizing integration across treatment methods and a specific set of principles for intervention. Ultimately, IPCT centers on the resolution of presenting problems, as delineated by the patients' definition of the problems for which they are seeking help, which become the center of the therapeutic contract. Assessment in this approach involves an ongoing process of hypothesizing about what Pinsof calls the "problem maintenance cycle" and intervening based in those hypotheses. Assessment is augmented based on the way clients respond to these interventions. Intervention begins with the simplest and most direct interventions. Behavioral and biological interventions are employed first. If these fail to produce change, the therapy moves to a second level in which cognitive and emotion-based interventions are invoked. If these interventions also fail to produce change, intervention shifts to address issues that remain from family of origin, and ultimately to object relations and self-psychological exploration. Family, couple, and individual treatment formats are all utilized as needed; ideally proceeding from the most inclusive (family) to least inclusive (individual) format. A basic premise is that clients are presumed healthy until found to be otherwise. The problem maintenance structure is likewise assumed to be simple and easy to address until proven otherwise. A major emphasis of the approach centers on the building of a strong therapeutic alliance as the vehicle for enabling change (Pinsof, 1988). Assessing the ongoing progress of treatment through the use of instruments and augmenting or altering the treatment based in this data is also a core aspect of this approach (Pinsof & Wynne, 2000).

Metaframeworks

Metaframeworks, developed by Doug Breunlin, Betty Karrer, and Richard Schwartz (Breunlin et al., 1997), provide more of a general framework to guide intervention than a specific roadmap. Drawing from systems theory, metaframeworks emphasize a theory of constraints: the notion that people do what they do, think what they think, or feel what they feel because they are prevented from doing, thinking, or feeling something else (Breunlin, 1999). Metaframeworks aim to identify and remove those constraints as they appear across a number of levels, ranging from most broad, culture and gender, to most narrow, internal process. Interventions are targeted by the level where constraints are most evident and by sequences which indicate the presence of constraints. Interventions in this model range from ones targeted at the larger system, to others targeted at the family, to yet others targeted inside individuals.

Integrative Problem Centered Metaframeworks

Integrative Problem Centered Metaframeworks (IPCM) are an integration of the two integrations just described: Metaframeworks and Integrative Problem Centered Therapy, along with an emphasis on common factors (Breunlin, Pinsof, Russell, & Lebow, 2011; Pinsof et al., 2011a) (see Chapter 28 in this volume by Russel and colleagues for a more detailed description of this approach). This model centers intervention on a blueprint drawn from hypothesizing metaframeworks about sequences, organization, development, mind, culture, gender, biology, and spirituality. Hypotheses are formed on the basis on what is experienced in the family and on the basis of data from the Systemic Therapy Inventory of Change (STIC), a multidimensional scale assessing aspects of family life and, as a repeated measure, progress in changing those dimensions (Pinsof et al., 2009).

As in IPCT, strategies of intervention are sequenced. First are strategies of action (behavioral or structural strategies). Additional strategies are only employed if earlier strategies fail. Intervention is conducted in the simplest and most systemic way possible, and only ventures into other intervention strategies when necessary. If needed, action strategies are followed by strategies focused on meaning (cognitive and narrative strategies) and emotion (experiential strategies), and then on biology. It is only if all these methods fail that intervention comes to focus on strategies involving the historical metaframeworks such as family of origin, internal representation (as in object relations), and self (as in self psychology). More systemic and direct strategies are always utilized before more individually centered and historical methods. The link with the presenting problem is always kept in focus regardless of the strategy. Hypothesizing, planning, conversing, and feedback are systemically linked throughout treatment. The method also emphasizes the creation and maintenance of common therapeutic factors throughout the treatment including the use of the Systemic Therapy Inventory of Change feedback system to provide feedback about client progress and the alliance throughout to inform and improve treatment.

Client-directed Outcome Informed Clinical Work

The approach developed by Mark Hubble, Scott Miller, and Barry Duncan (Duncan et al., 1997; Hubble et al., 1999; Miller, Duncan, & Hubble, 1997) often is considered a solution-focused approach because of the use of positive framing that is a crucial aspect of this treatment, but this approach extends well beyond more typical solution-focused approaches (Adams, Piercy, & Jurich, 1991; de Shazer, 1986, 1988). Most especially, the heart of this approach lies in maximizing the so-called "common factors" in psychotherapy: especially the generation of hope, positive expectancy, and a strong client–therapist alliance. Central aspects of the approach include emphasizing becoming change-focused, potentiating change that does occur, and tapping the client's world outside of therapy to support change processes. The therapeutic alliance is seen as a crucial ingredient in creating the context for change. Therapists in this approach accommodate to the clients' view of the therapeutic alliance and the client's

level of involvement and work actively to build placebo, hope, and expectancy factors through establishing a focus on possibility and creating healing rituals. In each case, the specific techniques employed are tailored to the individual client. Therapy largely consists of learning the client's theory of change and building on it. Duncan, Miller and Hubble utilize progress data extensively in the course of treatment, both to generate hope and positive expectancy and to shape treatment in relation to client progress.

Internal Systems Therapy

This approach, developed by Richard Schwartz (Nichols & Schwartz, 1998; Schwartz & Blow, 2010), integrates structural family therapy and experiential methods, especially gestalt therapy. The mind is seen as consisting of a number of parts that parallel parts in the family-of-origin family system. Some parts, termed "managers," are viewed as working to prevent the occurrence of unpleasant thoughts and feelings, other parts called "exiles" are viewed as activating bad feelings, and yet others, called "firefighters" are viewed as working to control exiled feelings. Therapy consists of working to establish the nature of self to part feelings, freeing the exiles, and unburdening the powerful feeling of the exiles. Much of this work is internally focused within individuals but is conducted in the context of spouses and/or other family members.

Walsh's Resilience Approach

Froma Walsh (F. Walsh, 1998) has pioneered an approach centered on the power of family resilience. Incorporating aspects of the Bowen approach, feminist approaches, and narrative approaches, Walsh's approach emphasizes the healing potential of families for the resolution of individual and collective difficulties. Overcoming legacies that may result from loss assumes a particularly important place in this approach.

Emotion-Focused Therapy

Emotion-Focused Therapy (EFT) has at its center a focus on emotion, but moves beyond experiential methods to include methods from a number of specific schools of therapy. Developed by Les Greenberg in the context of individual therapy, it has been adapted and elaborated to couple therapy and more recently to family therapy by Sue Johnson and her colleagues (Amato & Booth, 1996; Johnson, 2000; Johnson & Greenberg, 1992, 1994, 1995) and by Greenberg (Greenberg & Goldman, 2008). Two variations of this method have emerged. In the version developed by Johnson and colleagues, emotion-focused therapy primarily merges knowledge about emotion, experiential therapy, and a focus on attachment (Johnson, Maddeaux, & Blouin, 1998; Whiffen, Kallos-Lilly, & MacDonald, 2001) (see Chapter 17 in this volume by Johnson and Brucacher for a more detailed description of this approach). In the version developed by Greenberg and Goldman, emotion and experiential methods are merged with a focus on identity and self-soothing. Both variations also incorporate a strong emphasis on promoting the common factors in therapy, especially the building of the therapeutic relationship. The essence of the work with emotion lies in establishing a collaborative focus, evoking and exploring feelings, and emotion restructuring in which the maladaptive emotional schema is accessed, these schemas are challenged, support is provided for the emergence of a more self-affirming stance, and new meaning is created. In the couple context, partners' feelings are accessed, responded to, and ultimately accepted; working though injuries, resulting in a greater sense of connection. In the family context, the same kind of emotional sharing is encouraged as the bridge to family connection.

Therapeutic Palette

Fraenkel (2009) presented the therapeutic palette as an integrative method of couple therapy, but it has equal applicability in family therapy. Rather than emphasizing a sequential progression of intervention strategies, Fraenkel organizes intervention around the domains of time frame (past, present, future), directiveness (more directive vs. less so), and entry point (behavior, cognition, emotion, etc.) to fit the intervention to the task

at the moment in therapy. Drawing on a broad array of intervention strategies, the therapeutic palette provides an evolving focus for therapy, selecting at any moment the time frame, the level of directiveness and entry point that clients and therapist collaboratively decide is likely to be most useful at that moment.

Prominent Approaches: Approaches Tailored to Specific Problems

Specific therapies for specific difficulties are often presented as simply that. Yet, these often are also sophisticated integrative blending of elements from other approaches. Most of these therapies strongly emphasize the generation of common factors in treatment and involve combinations of the shared ingredients that are the base of the practice of family therapy with specific technologies targeted to the presenting problem (Lebow, 2014).

Multidimensional Family Therapy for Adolescent Substance Abuse

Howard Liddle and colleagues' Multidimensional Family Therapy (MDFT) for adolescent substance use disorders (Liddle, 1999) combines ingredients drawn from structural and strategic family therapy, individual developmental psychology, cognitive-behavior therapy, and traditional education-oriented substance abuse counseling (see Chapter 12 in this volume by Liddle for a more detailed description of this approach). The core assumption in this approach is that adolescent drug abuse is a multidimensional phenomenon and change is multidetermined and multifaceted. Motivation is viewed as a malleable aspect of treatment and the working relationship between therapist and family is seen as crucial in helping build this motivation. Interventions are individualized, presented in stages with a clear plan for each case augmented with options for flexibility. Some of the intervention package is delivered with the individual adolescent alone, helping them to communicate more effectively, solve interpersonal problems, manage their anger and impulses, and enhance their social competence (Liddle, 1994; Liddle et al., 1992). A second set of interventions are focused on parents, aiming to enhance both the connection between parents and children and to improve parenting strategies. Meetings involving both parents and children are utilized to directly aim at changing interaction patterns. Additional interventions are directed to other family members and other relevant social systems outside the family. Special adaptations have been made in the approach in relation to the specific culture of the families involved, most especially African-American inner-city clients (Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001). Several outcome studies have demonstrated the efficacy of MDFT with this population (Liddle et al., 2001)

Functional Family Therapy for Adolescent Delinquency and Substance Abuse

Functional Family Therapy (FFT) is the oldest integrative approach to family therapy developed to impact on a specific population (see Chapter 13 in this volume by Sexton for a more detailed description of this approach). FFT was developed in relation to adolescent delinquency and has been extended to treat adolescent substance abuse (Alexander et al., 1990; Haas, Alexander, & Mas, 1988; Sexton & Turner, 2011; Sexton, 2010). FFT focuses primarily on improving family functioning, but also intervenes with other relevant systems. FFT is structured in terms of phases of treatment. In the engagement and motivation phase, the focus is on creating a positive therapy alliance, reducing negativity and blame, and creating hope. The primary interventions in this phase center on reframing in order to build a positive relational focus for the treatment. During the behavior change phase, individualized positive changes are targeted with direct teaching of skills such as communication, parenting, and problem solving. During the third phase, generalization, the positive change developed within the family is extended to the context of other systems. FFT has been demonstrated to be effective for treating adolescent acting out behavior in a number of studies (Alexander, Holtzworth-Munroe, & Jameson, 1994; Mas, Alexander, & Turner, 1991; Parsons & Alexander, 1973; Sexton & Turner,

2011). Culture and gender also are regarded as important factors in FFT in shaping intervention strategies (Newberry, Alexander, & Turner, 1991).

Multisystemic Therapy

Multisystemic therapy (MST) is another integrative family therapy aimed at adolescent delinquency and substance abuse (Borduin & Henggeler, 1990; Borduin et al., 1990; Brown et al., 1999; Henggeler & Borduin, 1995; Henggeler et al., 1998). This approach integrates a perspective on individual development, with concepts from structural and behavioral family therapy, with a strong emphasis on the importance of the key systems in the lives of the adolescents (Henggeler et al., 2009). MST views family as one of several systems that need to be addressed in treatment. Peers, school, and community also receive considerable attention as does individual skill building in the adolescent. Therapy is intensive; therapists trained in this model have small caseloads, working with each of the relevant systems in which the adolescent is involved and remain available to manage crises as they unfold. MST has acquired a great deal of empirical support for its efficacy (Brunk, Henggeler, & Whelan, 1987; Henggeler & Sheidow, 2012; Lebow & Gurman, 1995).

Brief Strategic Family Therapy for Adolescent Substance Abuse

Jose Szapocznik and colleagues' Brief Strategic Family Therapy (BSFT) is another empirically supported therapy for adolescent delinquency and substance abuse (Achenbach & Weisz, 1976; Szapocznik et al., 1997; J. Szapocznik & Williams, 2000). BSFT is based on three central constructs: system, structure, and strategy. Key interventions include proactive efforts at joining, diagnosis of family interactional patterns, restructuring, working in the present, reframing, and working with boundaries and alliances. Much of the work with substance abusing adolescents is done in the clients' homes. BSFT also has extensive research demonstrating its effectiveness (Henggeler & Sheidow, 2012). Szapocznik and his colleagues developed BSFT in Latino communities and have developed versions of the approach to serve in other cultural contexts (Santisteban, Szapocznik, & Rio, 1993).

Psycho-Educational Family Therapies for Schizophrenia and Bi-Polar Disorder

Psycho-educational treatments for schizophrenia (Falloon, McGill, Boyd, & Pederson, 1987; Falloon, 2001; Liberman et al., 1987; McFarlane et al., 1995) and bi-polar disorder (Kuehner, 2009; Miklowitz, 2011, 2012) number among the integrative family approaches with the strongest empirical support. Although these approaches differ somewhat in the specific interventions chosen, each follows a similar form. Each includes the provision of appropriate psychopharmacology for the specific illness involved, psycho-education for family members to help them understand typical patterns in the illness and typical family reactions to it, skill training for the person with the disorder, crisis intervention when needed, and family sessions to help families share their experiences and learn skills for coping with the illness (in each method, a common goal is reducing expressed emotion in the family). In the treatments directed at schizophrenia, the content focuses on schizophrenia; in bi-polar disorder on that illness. The efficacy of these approaches has been demonstrated in a number of multisite clinical trials with adults and has more recently been extended to adolescents (Chambless, Miklowitz, & Shoham, 2012; Falloon et al., 1987; Lebow & Gurman, 1995).

Bio-Psycho-Social Treatment for Depressed Children and Adolescents

Nadine Kaslow and colleagues have developed a bio-psycho-social treatment for treating depression in children and adolescents (Kaslow, Baskin, & Wyckoff, 2002). This approach divides attention between the biological, psychological, and social factors that affect depression. Treatment is delivered by interdisciplinary teams with a special emphasis on therapists having cultural competence to best help the family involved. Considerable attention is focused on

building therapeutic alliances with both children and their families. The specific interventions employed include psychopharmacology, cognitive-behavioral techniques, interpersonal therapy techniques, multifamily psycho-educational presentations and discussions, and problem-solving family therapy.

Treatments for Child Sexual Abuse

Barrett and Trepper (Barrett, Trepper, & Fish, 1991; Trepper & Barrett, 1986, 1989) and Sheinberg and Fraenkel (Sheinberg & Fraenkel, 2001; Sheinberg, True, & Fraenkel, 1994) offer feminist-informed family systems treatments targeted at families in which there has been child sexual abuse. These approaches each include intensive work with the perpetrator to help them accept responsibility for their behavior, intensive work with the victim to help them cope with their trauma, and ultimately conjoint work with the family to work to alter dysfunctional family sequences. In Barrett and Trepper's approach, group therapies are organized for perpetrators, victims, and non-abusing parents to help process what has occurred and individual sessions are also employed to address specific goals.

Bio-Psycho-Social Therapies for Families Experiencing Health Problems

Several integrative family approaches address families who present with issues surrounding physical health. Wood offers a bio-psycho-social approach to intervening in families with child health problems (Ariel, 1999; Wood, 1993, 1995, 2000, 2001; Wood, Klebba, & Miller, 2000), while Rolland (Rolland, 1988, 1993, 1994a, 1994b, 1998) and McDaniel and colleagues (Botelho, McDaniel, & Jones, 1990; McDaniel, Campbell, Wynne, & Weber, 1988; McDaniel, Campbell, & Seaburn, 1995; McDaniel, Hepworth, & Doherty, 1995) offer approaches primarily directed at adult health issues. Although differing in specifics, each of these approaches includes an emphasis on understanding the biology of the illness involved, involving family in treatment, exploring individual and family belief systems in relation to the illness, attending to the health provider system and its interface with patient and family, and individual intervention with the person with the disorder. The approaches principally vary in greater attention to parent–child attachment in Wood's treatment, to belief systems and family resilience in Rolland's, and to family-provider consultation in McDaniel and her colleague's approach.

Integrative Couple Therapy

Alan Gurman merged behavioral, object relations, and systems theory in Integrative Couple Therapy (Gurman, 1992, 2008). Gurman's approach accentuates the utilization of behavioral action-oriented techniques in intervention, but views these interventions in the context of an understanding of the object relations that occur between the couple. Therapy in Gurman's approach is focused and short term.

Integrative Behavioral Couple Therapy

Jacobson and Christenson developed Integrative Behavioral Couples Therapy (IBCT) in relation to what they perceived as limitations of behavioral couple therapy to produce clinically significant and lasting change in the majority of couples (Christensen & Jacobson, 2000; Christensen, Jacobson, & Babcock, 1995; Jacobson & Christensen, 1996; Jacobson et al., 2000). IBCT adds an emphasis on acceptance derived from humanistic therapies to the typical skill building and contracting of behavioral couple therapy. IBCT builds on a functional analysis of the relationship designed to assess the core themes in the couple's interaction. The therapist utilizes this analysis to understand and alter the polarization process between the couple. The functional analysis is developed through both conjoint and individual sessions with the partners, that leads to a case formulation and feedback session with the couple in which specific goals for the treatment are suggested. Although efforts are directed at helping the couple build couple skills, the most important interventions focus on helping the couple experience a unified detachment in order to help them understand their destructive patterns, to empathically join with each other, to increase tolerance of the aversive problem, and to increase self-care. IBCT

has been demonstrated to be efficacious in two clinical trials (Christensen, Atkins, Baucom, & Yi, 2010; Christensen et al., 1995).

Couple Therapy for Domestic Violence

Goldner and colleagues have developed a feminist family systems approach to treating domestic violence in couples (Goldner, 1998; Goldner, Penn, Sheinberg, & Walker, 1990). This treatment brings together a feminist understanding of domestic violence with work with the couple to understand the origins and meaning of the violence. Although the approach specifically evolved from a feminist stance toward domestic violence, the pragmatic observation that women tend to remain in these relationships regardless of the stance of the therapist prompted intense efforts to find ways to break the cycle of violence. The approach builds on feminist, systemic, psychodynamic, and narrative family therapy models.

Multicouple Group Therapy for Domestic Violence

This therapy developed by Sandra Stith, Eric McCollum, and Karen Rosen (Stith, McCollum, Rosen, & Locke, 2002) utilizes a multicouple group format to deliver treatment. This approach targeted to less severe domestic violence incorporates solution-oriented, narrative, and cognitive-behavioral skill building interventions to reduce the risk of further abuse. Men and women first meet separately then in conjoint meetings. The first stage of therapy centers on building the common factors of alliance and hope and a vision of a violence-free relationship; this is followed at broader efforts to build the violence-free relationship.

Postmodern Sex Therapy

Sex therapy in its present incarnation almost invariably involves an integrative approach. As LoPiccolo (2002, 2006) describes, because of the widespread availability of information about sexuality in our society, the treatment of sexual problems typically require much more than the simple sharing of educational information. Postmodern sex therapy no longer speaks of a dichotomy between physical vs. psychological problems, but of a continuum of physical, psychological, and relational issues that need to be addressed in each case. Thus, therapy in part becomes assessment and intervention with biology, in part individual psychology, and in part relational dynamics. LoPiccolo (2002) describes the typical indicators for physical, psychological, and relational emphases and specific techniques that can help ameliorate each disorder across the range of sexual difficulties.

Other Couple Therapies

There have been several other integrative directed at couples. Sager's Marriage Contracts approach for couples therapy centers on explicating and working with an articulation of the marriage contract that included both behavioral and psychodynamic levels of exchange. Weeks (Weeks & Hof, 1994; Weeks et al., 1995) and colleagues developed the intersystem model, integrating interactional, intergenerational, and individual perspectives. Lusterman (1998), Glass (Glass & Staeheli, 2003) and Baucom, Snyder, and Gordon (2009) each developed similar approaches for dealing with the crisis of infidelity accentuating repair and forgiveness.

Therapies Tailored to Specific Cultures

Boyd-Franklin (1995) and Falicov (1995, 1996, 1998a) offer examples of integrative family therapies tailored to specific cultures. Boyd-Franklin describes understandings and intervention strategies that are particularly helpful in African-American families, while Falicov does the same for Latino families. Falicov also provides an integrative model for approaching the many diversities in the client system (Falicov, 1998b). These approaches offer a different vantage point for specific approaches, being rooted in the culture of the family rather than the area of the presenting problem.

Coda

The above section describes the most widely disseminated integrative couple and family therapies at the time of publication of this volume. However,

there remain many other integrative and eclectic couple and family therapies. Innumerable family therapists have constructed their own personal integrations (Lebow, 2014); many of these have been described in publications and/or workshops and have had at least some influence.

Emerging Directions

Integrative and eclectic couple and family therapies are blossoming. These methods are becoming widely disseminated in practice and considerable evidence is accruing for their effectiveness. Specific integrative and eclectic therapies are being developed for a wider and wider range of difficulties. The great majority of therapists doing couple and family therapy utilize integrative or eclectic methods in their treatments.

With such popular acceptance, what are the most important directions for the future development of integrative and eclectic couple and family therapies?

Common Factors, Technical Eclecticism, or Theoretical Integration?

As noted earlier, there are three major threads of integration: theoretical integration, technical eclecticism, and common factors. Theoretical integration creates super-ordinate integrative theories of practice that subsume scholastic theories. Technical eclecticism regards theory as less important and looks to create algorithms at the levels of strategy and intervention. Common factors approaches stress the exposition and augmentation of the shared factors underlying specific intervention strategies. However, these threads are converging. It is becoming the norm for integrative and eclectic family approaches to maximize common factors, state algorithms for intervention strategy, and build unifying theory.

Many Specific Treatments or Principles of Change?

Much of the recent creative edge in integrative family therapy has been concerned with the development of specific treatments for specific populations. In choosing a smaller band to speak to, these approaches have been extremely helpful and become widely disseminated. The limitation of these approaches, however, also lies in their delimited scope, which easily could lead to a highly segmented view of mental health treatment divided by presenting problem with too many treatments for clinicians to learn. Comorbidity and multiproblem families make this problem even more vexing. Does the "best" treatment for a family consist of receiving five different "treatments" for specific conditions? The resolution of this dilemma lies in work that integrates the various integrative approaches. There is a need for dialogue among those promoting the various delimited models of change, as well as between those who are proponents of such models and those promoting broader models. The dialectic between general principles and specific methods can help identify what is special to a problem area vs. that which represents more global processes. I believe this will eventually lead to a core set of generic strategies for intervention supplemented by a set of specific useful strategies demonstrated to be particularly effective in the presence of specific problems (Lebow, 2014).

How to Combine Family, Couple, and Individual Session Formats

Among the thorniest problems that requires further exploration is how and when to combine different session formats in integrative couple and family therapy. Although it is easy enough to articulate the problems that occur in certain problematic configurations (e.g., therapists dealing with secrets shared in individual sessions in conjoint sessions), neither research or discussions about methods have yet shed much light on the relative merits of different ways of combining session formats. In fact, we as yet have no data about the extent to which combining formats helps or hinders treatment (Lebow & Gurman, 1995). More information and discussion about how and under what circumstances session formats combine would be quite helpful.

When to Do What?

Surprisingly little discussion or research has been devoted to the vital question of when to do what

in treatment. It has probably been inevitable in the developmental process of integrative family therapies that concern would focus first on what to include and only later on how to order intervention strategies. There does seem to be consensus between several integrative approaches that the building of the therapeutic alliance should be the first goal of treatment, but beyond this there is little consensus about how to structure this aspect of therapist decision making. Pinsof's (1995) concept in IPCT of beginning with the most direct intervention first seems to be a good launching point for discussion and examination of questions about how to sequence interventions.

Culture and Gender

Culture and gender have begun to receive more attention as important factors in psychotherapy and, more specifically, in integrative family therapies. The feminist and cultural perspectives have also helped elucidate underlying assumptions about gender and culture within treatment models, leading to more informed discussion of these issues (Falicov, 1995, 1996, 1998a; Goldner, 1989, 1991a, b). Several integrative family therapies models now explicitly evolve from a consideration of gender and culture and are tailored to specific cultural groups. Hopefully, in the future, all models of integrative and eclectic family therapy will attend to these factors.

Toward a List of Generic Elements

Integrative approaches have begun to identify a number of generic concepts, strategies, techniques and dimensions of therapeutic experience that transcend orientation and will eventually lead to a list of the elements of couple and family therapy. Examples of such elements include assessment, therapeutic alliance, enactment, contract, reinforcement, insight, and reframing. Further work to create such a generic list of concepts, strategies, and interventions and enable a common language to describe these concepts, strategies, and interventions will help therapists better recognize commonalities across methods, make treatment planning more efficient, and simplify the task of learning therapy skills (Lebow, 2014).

Recognizing the Importance of the Person of the Therapist

Integrative and eclectic approaches vary considerably in the extent to which the person of the therapist in the treatment is emphasized. While most integrative approaches do pay some attention to the therapist, particularly in creating an alliance, most models relegate the person of the therapist to a secondary position. Hopefully, more attention will focus on the therapist and how methods can be best tuned to the individual provider. Psychotherapies can only be delivered through a person and therapists vary enormously.

Prescriptive vs. Therapist-Centered Models

The role of the therapist within integrative and eclectic models falls along a continuum bounded on one end by work which accents each therapist's building of a personal method (Lebow, 1987a), and on the other end by work that offers a highly prescriptive delineation of a pre-assembled combination of therapeutic ingredients and a specific map for when to do what. Prescriptive manuals stress the need for replicable methods of practice while the notion of therapist's building their personal methods emphasize the unique qualities of each therapist. Both kinds of models are useful. For some, a well-organized set of directives delineating steps to follow is most helpful, while others work best in a more fluid environment in which they have a greater sense of choice about strategies. Often, the former type of model is most helpful early in the career of a therapist when rules governing action are typically experienced with relief, while the latter type is more helpful later when improvisation becomes the norm. We need to see further work developing both of these paradigms, especially the less frequently encountered form that allows for considerable improvisation.

Self-Examination by the Therapist

Much of the clinical decision making in integrative family therapy lies outside the conscious awareness of the practitioner, emanating from a level of clinical "intuition" at a preconscious level.

Integrative practice is greatly enhanced by bringing the principles behind practice into consciousness. As an example, Grunebaum (1988) offered a very instructive example of a clinician working to understand the implicit theories, strategies, and interventions operating in the context of a specific case. Grunebaum deconstructs his own integrative/eclectic method, moving from his plan, to observations about his own behavior, uncovering the theories and precepts that guide him that initially were out of conscious awareness. He then considers the impact of these interventions within the specific treatment and for his broader model of practice. Such self-examination would be helpful for all integrative therapists.

Considering Treatment Setting

Factors such as the setting, the funding of care, and the acceptability of the treatment clearly affect therapeutic decision making. To have an appropriate treatment that is inaccessible, unacceptable, or not affordable is of little use. Integrative and eclectic frameworks provide a range of options for treatment, and offer the distinct possibility of setting goals in a manner consistent with resources available. We need to see more consideration of treatment setting and possible financial constraints for the therapy in our treatment models.

Considering Values and Ethics

Integrative family therapies move concepts and interventions anchored in contextual meanings into new contexts, creating the possibility that aspects of approaches will be incorporated without the values lying at the core of those approaches or even that two conflicting ideologies will be combined (Dickerson, 2010). Not only does this invoke possible confusion about the value system around which the approach is anchored (e.g., in attitudes about gender), but also as Messer (Messer & Winokur, 1986) has emphasized, it creates possibilities for mixed messages about core visions of the human condition. Messer suggests that some approaches to psychotherapy are comedic, highlighting optimism and the creation of happy endings with hard work (e.g., cognitive-behavioral approaches), while others are tragic or ironic in worldview (e.g., psychodynamic approaches). It is crucial for integrative and eclectic family therapists to remain able to articulate their underlying belief systems.

Integrative family therapy also calls for innumerable ethical decisions that do not arise nearly as often in more narrowly focused school-based approaches. For example: if more than one family member is included in the treatment, who is the client? How does the therapist choose among the many intervention goals that can be generated? Should these goals focus most on symptom alleviation, problem resolution, or other kinds of goals? When is a therapist practicing outside of her realm of expertise? How many specific kinds of intervention can therapists competently deliver and what efforts should therapists make to stay current with the state of the art in those methods? When is it appropriate to refer clients? We need more discussion of such ethical dilemmas in integrative family therapists' practice.

How Do We Judge the Success of a Treatment Model?

How do we judge integrative models? Does success lie in having the highest degree of consistency and theoretical integrity, the highest level of acceptability to clients, the strongest empirical support for its efficacy in clinical trial research, the best outcomes in effectiveness studies, the greatest ease of dissemination, or the greatest popularity? We are only beginning to evaluate integrative family therapy. The problem is made particularly complex given that the more personalized the treatment is to therapist and client, the harder it is to evaluate group outcomes of the ever-changing treatment. We need a great deal more testing of various methods, as well as a meta-level consideration of how to evaluate these models.

Toward an All-Encompassing Model?

Integrative family approaches enable therapists to practice most effectively. They provide blueprints to direct efficacious intervention and allow for better tailoring of treatment to specific cases. However, the question remains as to where the

evolution of integrative practice will lead. One possible direction, already noted, is toward many treatments organized around specific problems. In such a world, there would be many alternative treatments combining more or less similar ingredients, but with different emphases, much as there are many similar drugs available for treating depression. A second possible direction is toward the emergence of integrative therapies that feature distinct combinations of ingredients that then become adapted to particular situations. An example of such an evolution is Multisystemic Therapy, which began as a treatment for externalizing adolescent problems but has been adapted to varying youth populations such as depressed, eating disordered, and suicidal adolescents (Huey et al., 2004; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). A third direction is toward meta-level models that provide guidance for a fluid process of case formulation and therapist decision making (Pinsof et al., 2011a) and accentuate the shared base of intervention available to therapists (Lebow, 2014). For the time being, clearly each of these threads will develop further. However, I believe in the long term that the future of integrative practice lies more in the emergence of the second and third threads; that is, to a time when the specific methods for specific disorders will be eclipsed by broader models of therapy that then have specific applications in specific contexts, be those disorders, other types of problems, or cultural and service delivery contexts.

I also believe it is clear is that we will never have one all-encompassing approach emerge that will delimit intervention strategies and be able to direct all treatment choices. Such a model would in its comprehensiveness lose vitality and immediacy for the practitioner, would require a level of certainty about the impact of specific interventions beyond our scope, and would invoke a great deal of therapist reactivity and resistance. It also would ignore the now obvious reality that there are many possible alternative paths to change in families. Models that prescribe therapeutic decision making can never fully replace clinical judgment in the complex art/science of family therapy where therapists must attend to so many simultaneous factors. It is better to set our sights on attainable goals, such as extending our understanding of treatment processes and how interventions fit together, cataloging the shared base of intervention that extends across treatment models, negotiating differences in the language assigned to methods across approaches, and exploring how the integrative methods that emerge work with clients and therapists. Hopefully, such exploration, informed by clinical testing and research, can serve as a springboard for the best practice of couple and family therapy.

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PART III

EVIDENCE-BASED CLINICAL TREATMENT MODELS

12.

MULTIDIMENSIONAL FAMILY THERAPY

Howard A. Liddle

> There is little question that drug abuse results from both intraindividual and environmental factors. For this reason, unidimensional models of drug abuse are invariably inadequate and multidimensional research and intervention approaches are necessary.
> *(Glantz & Leshner, 2000, p. 796)*

Introduction: Half Full or Half Empty?

Adolescents occupy a noticeable place in history. Throughout the ages, teenagers have stimulated curiosity, even confusion. At one time or another, scholars, opinion leaders, politicians, policy makers, interventionists, the public at large, and surely parents themselves have taken wrong turns in attempts to make sense of adolescents. Therapists across professions and clinical orientations may squabble about many things, but generally they concur about the challenges of adolescent treatment. Working with youth is difficult and demanding in several ways. Typically youth drug use is secretive or at least hidden from family and other adults. Clinically referred adolescents are often involved in illegal and criminal activities, and can spend considerable time with drug-using peers. Other aspects, low motivation to change, compromises in functioning spanning several life domains, involvement in multiple systems of care, and treatment system factors that too often fail the youth as much as (per the literature's characterization) the youth "fails" treatment can combine to make youth drug abuse treatment an indisputably and enormously tough job.

At the same time, advances worldwide in the substance abuse and delinquency specialties offer tangible guidance and hope (Catalano et al., 2012; Henggeler & Sheidow, 2012; Rowe, 2012). We have witnessed unprecedented amounts of high-quality treatment research, at least bursts of increased funding for specialized youth services, and a continuing interest from basic research and applied prevention and treatment scientists, policy makers, clinicians and prevention programmers, professional and scientific societies, mass media and the arts, and the public at large in the health issues and problems of youth. Developmental and developmental psychopathology research adds to our understanding about factors and forces contributing to adolescent drug experimentation and abuse. The family therapy evidence-based treatment specialty has grown rapidly, if unglamorously, compared to the vibe that characterized family therapy in its glory days (Fraenkel, 2005). In the last decade,

for example, more and improved quality intervention studies have been published than ever before (Boustani, Henderson, & Liddle, 2015; White, Dennis, & Tims, 2002). At the same time, controversy and conflict have surfaced about realistic practice-level conclusions that can be drawn about research-supported treatments (Drug and Alcohol Findings, 2014; Kazdin, 2013; Henggeler et al., 2006; Lindstrom et al., 2013; Littell, 2008; Ogden & Hagen, 2008). Using, among other influence strategies, credible evidence, decision makers in public sector clinical services consistently include family-centered care in their service reform efforts (President's New Freedom Commission on Mental Health, 2003; Stroul, Blau, & Friedman, 2010).

Background and Foundations

This chapter describes Multidimensional Family Therapy (MDFT), a comprehensive, developmentally oriented treatment for youth substance abuse and delinquent behaviors (Liddle, 1991; Liddle, Dakof, & Diamond, 1991).[1] Systematic treatment development, rigorous evaluation, and dissemination to diverse real world clinical settings are the principal objectives of MDFT (Liddle & Hogue, 2001). MDFT is identified as an evidence-based treatment in scientific reviews (Akram & Copello, 2013; Austin, Macgowan, & Wagner, 2005; Becker & Curry, 2008; Hawkins, 2009; Perepletchikova, Krystal, & Kaufman, 2008; Vaughn & Howard, 2004; Waldron & Turner, 2008), independent registries that evaluate interventions (Clark, 2011); Clearinghouse for Military Family Readiness, 2013; European Monitoring Centre on Drugs and Drug Addiction, 2014; Drug Strategies, 2003, 2006; NREPP, 2012), and government and non-government organizations in the U.S. and abroad (NIDA, 2014; NREPP, 2012; CrimeSolutions.gov, 2014; Sherman, 2010; United Nations Office on Drugs and Crime (UNODC), 2014; Compilation of Evidence-Based Family Skills Training Programmes, 2014). *Evidence* in evidence-based refers to the model's research program, as well as to how it uses the empirical knowledge base about positive youth, parent, family development and studies on problem development (Liddle & Rigter, 2013). As detailed in influential blueprints recommending a new kind of science and service connection (Institute of Medicine, 2001; National Research Council and Institute of Medicine, 2009), recommendations to translate existing basic science for intervention design (National Research Council, 2009), and guideline development (Brown et al., 2008; Holmbeck, Devine, & Bruno, 2010), MDFT brings research-derived content directly into treatment (Liddle et al., 2000; Liddle, Rowe, Dakof, & Lyke, 1998).

Several empirically derived frameworks can organize diverse basic science knowledge bases. They provide an overall orientation and inform clinical work directly (Liddle & Saba, 1983). The *risk and protective factor* framework teaches clinicians about the known determinants and buffers to dysfunction. It facilitates identification of factors from different domains of functioning (psychological, social, biological, neighborhood/community) that create problems and the forces that might help to solve them. It also helps therapists to think in interactional or process terms about the many clinically relevant dimensions of the adolescent's and family's current life circumstances (Hawkins, Catalano, & Miller, 1992). The *developmental perspective*, including the developmental psychology and developmental psychopathology research areas, is another useful framework. This knowledge base teaches therapists about the course of individual adaptation and dysfunction through a lens of normative development. Developmental psychopathology moves beyond considerations of symptoms only to understand a youth's capacity to cope with the developmental tasks at hand and considers the implications of stressful experiences and developmental failures in one developmental period for (mal)adaptation in future periods (Rohde et al., 2007). Because multiple pathways of adjustment and deviation may unfold from any given point, emphasis is placed equally on understanding competence and resilience in the face of significant risk. Conceptualized as a problem of development (Newcomb, Scheier, & Bentler, 1993), adolescent substance abuse is a departure

from a range of adaptive developmental pathways (Zucker et al., 2008), and represents difficulties in meeting developmental challenges (Brook, Kessler, & Cohen, 1999a). A third framework, the *ecological perspective* articulates the intersecting web of social influences that form the context of human development (Bronfenbrenner & Morris, 2006). Ecological theory regards the family as a principal developmental arena, and includes details on how both intrapersonal and intrafamilial processes are affected by and affect extrafamilial systems (i.e., significant others involved with the youth and family, such as the youth's peers, school, job or juvenile justice personnel). This theory is compatible with ideas about reciprocal effects in human relationships, underscores how problems nest at different levels, and how circumstances in one domain can reverberate in other areas. And finally, the *dynamic systems perspective* (Granic, 2005) emphasizes the importance of real-time, moment-to-moment processes as the raw material that *grows* developmental outcomes. Abstractions that summarize behavior in terms such as adolescent substance abuse disorder or conduct disorder provide insufficient detail to explain the individual and family developmental outcomes, and leave out important aspects such as the range of emotional tendencies and the multiple relationships and context factors in which individual tendencies are expressed.

Primus inter pares *(First Among Equals)*

Contextual and developmental in philosophy and clinical methodology, the family's central role in understanding and treating youth problems is well established. A thorough assessment of family functioning includes each individual's mental state, emotional functioning, history, and life activities in addition to their role as a family member. Coordinated individual and multi-person subsystem interventions are basic to MDFT (Liddle & Rigter, 2013).

Working with the inner or private world of the adolescent and the parent are essential on theory-based (developmental *and* clinical change theory), empirical (e.g., positive multiple alliances predict MDFT outcomes), strategic, and practical grounds (the value of multiple perspectives). Dichotomous, either/or thinking—about the primacy of individuals vs. systems, emotions vs. cognitions, behavior change vs. individual reflection and personal examination, as examples—is avoided. It is not that these concepts and phenomena are incapable of definition, measurement, conceptualization, and clinical use. Individuals exist as both a *whole* and as a *part.* The foci of assessment and intervention—the adolescent, parent, family, and community or extrafamilial—are understood as *holons* (Koestler, 1978) as *both* wholes and parts. Each is a realm of life activity, offers clinical relevance, and intervention potential in and of itself, but each is also understood in relation to and in dynamic, real-time interaction with the others.

MDFT Guiding Principles

- *Adolescent problems are multidimensional phenomena*. Individual biological, social, cognitive, personality, interpersonal, familial, developmental, and social ecological aspects can all contribute to the development, continuation, worsening and chronicity of drug problems.
- *Family functioning is instrumental in creating developmentally healthy lifestyle alternatives for adolescents*. The teen's relationships with parents, siblings, and other family members are fundamental areas of assessment and change. The adolescent's day-to-day family environment offers numerous and concrete opportunities to re-track the developmental problems of youth.
- *Problem situations provide essential information and opportunity*. Symptoms provide assessment information about individual and family functioning and present essential intervention opportunities.
- *Change is multifaceted, multidetermined, and stage-oriented*. Behavioral change emerges from interaction among systems, levels of systems and people, and domains of functioning that include intrapersonal and interpersonal processes. A multivariate conception of change commits the clinician to a coordinated, sequential use of multiple

change methods and working multiple change pathways.

- *Motivation is not assumed, but it is malleable.* Motivation to enter treatment or to change will not always be present with adolescents or their parents. Treatment receptivity and motivation vary in individual family members and extrafamilial others. Treatment reluctance is not pathologized. Motivating teens and family members about treatment participation and change is a fundamental therapeutic task.
- *Multiple therapeutic alliances are required, and they create a foundation for change.* Therapists create individual working relationships with the adolescent, the subsystem of individual parent(s) or caregiver(s), and individuals outside of the family who are or should be involved with the youth.
- *Individualized interventions foster developmental competencies.* Interventions have generic or universal aspects. For instance, creating opportunities to build teen and parental competence during and between sessions is generic—applicable to all cases. But development- or competence-enhancing interventions must be personalized—tailored or individualized to each person and situation. The family's background, history, interactional style, culture, language and experiences are dimensions on which interventions are customized. Structure and flexibility are two sides of the same therapeutic coin.
- *Treatment occurs in stages; continuity is stressed.* Particular standard operations (e.g., adolescent or parent treatment engagement and theme formation), the parts of a session, whole sessions, stages of therapy, and therapy overall are conceived and organized in stages.
- *Continuity*—linking pieces of therapeutic work together—*is critical.* Each session is one piece that combines with others as thematic work proceeds over time (again, wholes and parts). Similarly, the parts of treatment are woven together in an active attempt by the therapist to maintain continuity and build linkages between sessions to deepen and solidify the change that starts small but is nurtured over the weeks.
- *Therapist responsibility is emphasized.* Therapists are responsible for: a) promoting participation and enhancing motivation of all relevant persons; b) creating a workable agenda and clinical focus; c) providing thematic focus and consistency throughout treatment; d) prompting behavior change; e) evaluating, with the family and extrafamilial others, the ongoing success of interventions; and on this basis; f) collaboratively revising focus and interventions as necessary.
- *Therapist attitude is fundamental to success.* Therapists advocate for adolescents *and* parents. They are neither "child savers" nor unidimensional "tough love" proponents. Therapists are optimistic but not naive or Pollyannaish about change. Their sensitivity to environmental or societal influences stimulates ideas about interventions rather than reasons for how problems began or excuses for why change is not occurring. As instruments of change their personal functioning facilitates or handicaps their work.

Clinical Theory

Clinicians and trainers report that using MDFT offers repertoire-expanding opportunities for creativity (Godley, White, Diamond, Passetti, & Titus, 2001). Individual sessions with the youth, for instance, focus on current pressures, complaints, drug-taking motivation and settings, as well as big picture issues of developing identity, and the youth's hopes and dreams. Sessions also focus on thoughts, feelings and behaviors that have next-day or next-session relevance for the parents, and for the youth's environment in any number of ways. A full session or a brief phone conversation with a parent that follows the youth's session can yield details from the parent about her response to the youth's day-to-day behavior around the house. Parents are advised or coached about a revised response to what has just been learned or experienced. An individual parent session may focus on parenting practices such as the details of monitoring or other house rules, or the parent–youth relationship per se,

but it may also include a deep discussion of the mother's despair about parenting. Treatment can stimulate feelings about a parent's family of origin—experiences a parent believes is handicapping her capacity to feel compassion for or even love her child. MDFT is not a traditional family therapy according to the early incarnations of the term. MDFT could be described as a family-based subsystem therapy, a treatment that works not only with and inside the various "constituent parts" of individuals (i.e., reflecting, deliberating, coaching) and broader systems but also at their intersections in shaping interactions and creating growth oriented individual experiences directly in sessions.

A first task is to understand fully and concretely the current life events of each family member. Clinicians think about how they receive and interpret the clinical presentation that includes diagnoses, previous history, individual functioning, and the present circumstances in the family's and youth's multiple environments. These activities preempt a therapist's becoming preoccupied with or moving to problem-solving interventions prematurely. Clinicians see and speak to the family with a developmentalist's orientation. Family members are quite able to indicate what's important, what's urgent, and what the priorities should be. A launching pad for all interventions, the developmental orientation has attitudinal and belief system aspects, and, of course, a factual basis as well (Offer & Schonert-Reichl, 1992). Accurate knowledge about adolescent development, a parent's development, family development, all from a dynamic systems, or a developmental-contextual frame, infuses therapist training and ongoing supervision. Problem-solving activities are attempts to offer, through an instrumental and close partnership with the youth and parents, as well as outsiders who are involved with the youth in one way or another, a time-bounded relationship with unique features. This relationship and activities—in essence multiple conversations (usually called sessions)—take into account many perspectives and agendas. Shaped and accentuated in several individual and multiperson conversations, therapeutic attention and participation coheres around a central objective—significant and demonstrated improvement of the health and well-being of the youth and family. Skills and communication training are needed frequently and included flexibly, and we aim to sponsor a more profound promotive process within the youth and family. Treatment participation yields an increased caring about and investment in family members' own and each other's lives. Adolescents and parents find enhanced reasons to go on, try again, and develop alternatives to present circumstances.

Logic Model

These processes include renewed day-to-day motivation. But they also include articulating and discussing a *Big Picture* that encompasses individual and family plans. Focusing on and using emotion is one means of materializing the desired processes. For instance, we watch a film, read a novel, view a work of art—each of these can stimulate emotion, create certain experiences, and surely work on humans in various ways or at different levels. Therapy—conversations about important things and with significant others—can evidence multiplicity in terms of its experience and impact. MDFT develops and uses what individuals consider larger life themes (Markus & Nurius, 1986), braiding these with behaviorally oriented detailed work in skills training and problem solving. The youth, parents, and even outsiders become engaged at both broader, thematic levels (i.e., join together to stop the youth's slide into deeper drug use and delinquent behavior, or listen to the youth's experiences and reflections on his life). The therapist's collaboration in theme articulation has generic and idiosyncratic elements—the "culture of the streets" or "culture of drug use," "having the kind of family I always wanted to have," "doing better with my children than my parents were able to do with me." Themes come to life through the real-life stories of family members. While serving motivational purposes, this kind of work also creates continuity in the treatment. Meaningful conversations offer participants personally relevant and practically useful touchstones as all move through the multiple discussions of treatment.

Overview of Core Aspects—Alliances and Engagement

Since adolescents frequently enter treatment under coercion, our aim is create an environment of respect, curiosity, and potential for the youth to, as we say, "get something out of this for yourself." We do not expect the adolescent to have enthusiasm or motivation about starting therapy. Shame, stigma, overwhelming legal troubles, and no experience in understanding what treatment can do, or even negative therapy experiences, are among the many issues that may be at play. We reach out directly to the youth and to the parents as well to build motivation and establish a practically oriented definition for what treatment might accomplish. While therapy resistance is a recurring topic in the adolescent literature, we find most adolescents respond well to the aforementioned strategies. An interaction seems to operate. In a punitive, moralistic, system-mandated, parent-centered therapy that presents no or insufficient opportunity for the youth's voice be cultivated and responded to, resistance is understandable. Treatment with adolescents can attend to individual youth, parent and family, and others' demands and needs. And, when treatment of this nature is offered skillfully, adolescents do more than comply, they participate.

Effective therapy creates positive feedback spirals. When adolescents show themselves to be reasonable responders to therapy's demands, adults experience new aspects of their teenager. The issues, stresses, unhappiness, gripes, and the pressures as felt by a youth are all topics for exploration and expression in MDFT. Developmentally framed and discussed individual developmental milestones, identity, sexuality, changing family relations at this developmental stage, desire for more freedom and a say in how their everyday life goes are included. The youth's sincerely felt life experiences are elaborated in individual sessions. Therapist and youth also discuss what to discuss in family sessions and what to hold on to.

Parents themselves need individual attention, per previous remarks. A parent's functioning as an adult, outside of their caregiving roles and responsibilities, must be covered. Relationship difficulties, health concerns, money problems and stresses, and individual developmental challenges are grist for the mill of the individual work with a parent. The multiple therapeutic alliances, where each person buys into treatment in their own way, as well as in a collective way, are foundational structures and processes that begin behavioral change.

Program Features

Multidimensional Assessment

Assessment yields a therapeutic blueprint. The blueprint directs therapists about where to intervene across multiple domains and settings of the teen's life. A comprehensive, multidimensional assessment process identifies risk and protective factors in relevant areas, and prioritizes and points to specific areas for change. Information about functioning in each target area comes from referral source information, circumstances, and dynamics, individual and family interviews, observations of both spontaneous and instigated family interactions, and observation of family member interactions with influential others outside of the family as well. Four interdependent domains are covered with every case: 1) adolescent, 2) parent(s), 3) family interaction, and 4) extrafamilial social systems. Attending to deficits and hidden areas of strength, we obtain a picture of the unique combination of assets and weaknesses in the adolescent, family, and ecosystem. This portrait includes a multiple systems formulation of how the current situation and behaviors are adaptations, understandable and "make sense," given the adolescent's and family's developmental history and current risk and protection profile. Interventions decrease risk processes known to be related to dysfunction development or progression (parenting problems, affiliation with drug-using peers, disengagement from and poor outcomes in school), and enhance protection, first within areas of urgent need, and in consideration of the most accessible and malleable domains. An ongoing process rather than a single event, assessment continues throughout therapy as new information emerges. In this sense, assessments, and therapeutic planning overall, are

never disconnected from change plans, and they are modified according to ongoing events and feedback from interventions.

A home-based or clinic-based *family session* generally starts treatment. Therapists stimulate family interaction on important topics, noting to themselves how individuals contribute differentially to the adolescent's life and current circumstances. We also meet alone with the adolescent, the parent(s), and other members of the family within the first session or two. Individual meetings reveal the unique perspective of each family member, how events have transpired (e.g., legal and drug problems, neighborhood and peer influences, school and family relationship difficulties), what they have done to address the problems, what they believe needs to change with the youth and family, as well a parent's own concerns and problems, perhaps only indirectly related to the youth.

Therapists elicit the adolescent's life story during early individual sessions. Sharing life experiences contributes to the teen's engagement. It provides a detailed picture of the severity and nature of the youth's drug use and circumstances, individual beliefs and attitude about drugs, trajectory of drug use over time, family history, peer relationships, school and legal problems, any other social context factors and important life events. A therapist must get to know, in practical terms, what is important to the youth—what are the things that he or she values. Therapeutic conversations sketch out an eco-map—the adolescent's current life space. This includes the neighborhood, indicating where the teen hangs or buys or uses drugs, where friends live, school or work location, and, in general, where the action is in the youth's environment. Therapists inquire about health and lifestyle issues, including sexual behavior. Comorbid mental health problems are assessed through the review of previous records and reports, the clinical interview process, and psychiatric evaluations. Adolescent substance abuse screening devices, including urine drug screens which we use extensively in therapy, are invaluable in obtaining a full, dynamic picture of the teen's and family's circumstances.

Assessment with the parent(s) includes functioning as parents and as adults, apart from the parenting role, with individual, unique history and concerns. We assess the parents' strengths and weaknesses in terms of parenting knowledge, skills and parenting style, parenting beliefs, and emotional connection to their child. We inquire in detail about parenting practices, house rules, curfew, and expectations about family issues in individual sessions with the parent(s) as well as with the youth. In family sessions, clinicians observe and take part in parent–youth discussions, listening for point of view, critical incidents, references to significant past events, problem solving, and relationship indicators such as supportive or critical expressions. In discussing parenting style and beliefs, therapists ask parents about their own experiences, including family life when they were growing up. A parent's mental health status and substance use are also evaluated as potential challenges to improved parenting. On occasion we make referrals for individual adjunctive treatment of drug or alcohol abuse or serious mental health problems, but these are rare.

Information on extrafamilial influences is combined with the adolescent's and family's reports to compile the fullest possible picture of individual and family functioning relative to external systems. One component of this focus on-site includes educational academic tutoring that integrates with core MDFT work. We assess school- and job-related issues thoroughly. Therapists build relationships and work closely and collaboratively with juvenile court and probation officers regarding the youth's legal charges and supervision requirements. Clinicians help parents understand the potential harm of continued negative or deepening legal outcomes. Using a non-punitive tone, we help teens face and deal with their legal predicament. Friendship network assessment involves encouraging teens to talk about peers, school, and neighborhood contexts in a detailed and forthright manner. Friends may be asked to join a session, may be phoned during a session with the youth, and can be met during sessions in the family's home. The creation of concrete alternatives that provide prosocial, development-enhancing day-to-day activities using family, community or other resources is a driving force in MDFT.

Adolescent Module

Establishing therapeutic alliances and creating a therapeutic foundation are two sides of the same coin. The therapeutic alliance with the teenager is a working relationship that is distinct from but related to parallel efforts with the parent. We present therapy as a collaborative process, following through on this proposition by collaboratively defining therapeutic goals that are personally meaningful to the adolescent. Goals become apparent as the teen expresses his or her experience and discusses his or her life so far. Treatment aims to attend to these *Big Picture* dimensions. Problem solving, creating practical and reachable alternatives to a drug using and delinquent lifestyle, all of these remediation efforts exist within work that connects to a teen's conception of his or her own life, values, and life's direction and meaning.

Success in one's alliance with the teenager does not go unnoticed to parents. Although it can cut both ways, we find that parents both expect and appreciate a therapist's reaching out to form a distinct relationship and therapeutic focus with the teen. Individual sessions are indispensable; their purpose is defined in "both/and" terms. These conversations allow access and therapeutic focus on individual and parent–teen and other relationship issues through the methods that are available to an individual therapist. Additionally, individual parent and teen meetings prepare (motivate, rehearse, coach) each to come together to discuss matters needing improvement.

Parent Module

We focus on reaching the caregiver(s) as an adult with individual issues and needs, and as a parent who may have declining motivation or faith in her or his ability to influence their child. Interventions include enhancing feelings of parental love and emotional connection, underscoring parents' past efforts, acknowledging difficult past and present circumstances, and generating hope. When parents enter into, think, talk about, and experience these processes, their emotional and behavioral investment in their adolescent grows. This process, the expansion of a parent's commitment and investment to their child's welfare, is basic to the MDFT change model. Achieving these therapeutic tasks sets the stage for later changes. Taking the first step toward change with the parent, these interventions grow parents' motivation and, gradually, their willingness to address relationship improvement and parenting strategies. Increasing parental involvement with one's adolescent (e.g., showing an interest, initiating conversations, creating a new interpersonal environment in day-to-day transactions), provides a new foundation for attitudinal shifts and behavioral change in parenting. Parental competence is fostered by teaching and coaching about normative characteristics of parent–adolescent relationships, consistent and age-appropriate limit setting, monitoring, and emotional support—all research-established parental behaviors that enhance relationships, individual and family development.

Cooperation is achieved and motivation is grown by underscoring the serious, often life-threatening circumstances of the youth's life, and establishing an overt, discussable connection (i.e., a logic model) between that caregiver's involvement and creating behavioral and relational alternatives for the adolescent. This follows the general procedure used with the parents—the attempt to promote caring and connection through several means, first through an intense focusing and detailing of the youth's difficult and sometimes dire circumstances and the need for his or her family to help.

Parent–Adolescent Interaction Module

MDFT interventions also change development-impeding interaction directly. Shaping changes in parent–adolescent interaction are made in sessions through variations in the structural family therapy method of enactment. A clinical method *and* a mini-change theory (Liddle, 1999), enactment elicits topics, relationship events, and themes that are important in the everyday life of the family. Upon discussion relationship strengths and problems become apparent. Therapists then assist family members to discuss and to solve problems in new ways. The method expands behavioral alternatives as the therapist

actively guides, coaches, and shapes increasingly positive and constructive family interactions. In order for discussions between parent and adolescent to involve problem solving and relationship healing, parents and adolescents must be able to experience a daily back and forth without excessive blame, defensiveness, or recrimination. Treatment helps teens and parents to pull back from extreme, inflexible stances as these actions create poor problem solving, hurt feelings, and erode motivation and hope for change. This work may be done in individual sessions that gently cover important issues and prepare family members for family sessions where the issues will be discussed forthrightly and better ways of relating are tried. Skilled therapists direct, with respect, in-session conversations on touchy topics in a patient, sensitive way.

Module on Interactions and Outcomes with Social Systems External to the Family

MDFT also facilitates change in how the family and adolescent interact with involved extrafamilial systems (Liddle, 2014). The teen and their family may be involved in multiple social systems. Success or failure in negotiating these systems has considerable impact on short-term, and in some cases longer-term, life course. Close collaboration with the school, legal, employment, mental health, and health systems influencing the youth's life is critical for initial and durable change. For an overwhelmed parent, aid in dealing with complex bureaucracies or in obtaining needed adjunctive services not only increases engagement, but also improves his or her ability to parent effectively by reducing stress and burden. Therapists help to set up meetings at school or with juvenile probation officers, and these relationships play an integral role in creating positive youth change (Liddle, Dakof, Henderson, & Rowe, 2011). They regularly prepare the family for and attend youth's juvenile justice disposition hearings, understanding that successful compliance with the supervision requirements is a core therapeutic focus and task (Liddle, 2014). School or job skills are also basic aspects of the therapeutic program since they represent real-world settings in which youth develop competence, succeed, and build pathways away from drug using peers and antisocial behavior. In some cases, legal, medical, housing, social service agency, immigration issues, or financial problems may be urgent areas of need. Therapists think through the interconnection of these life circumstances in specifying a flexible and dynamic case conceptualization, and they know that these arenas of everyday life are influential in improving family life, parenting, and a teen's reclaiming of his or her life from the perils of the streets. Not all multisystem problems can be solved, but in every case our rule of thumb is to assess all of them, establish priorities collaboratively and overtly, and, as much as possible, work actively to help the family achieve better day-to-day outcomes relative to the most malleable and consequential areas.

Decision Rules about Individual, Family or Extrafamilial Sessions

As a therapy of subsystems, MDFT consists of working with parts (subsystems) to larger wholes (systems) and then from wholes (family unit) back down to smaller units (individuals). Any given session's composition depends on the stage of treatment and session goals. The interview's goals can exist in one or more categories. For example, there may be strategic goals that suggest who should be present for all or part of an interview. For example, the first interview, given its strategic, information-gathering, and foundation-building objectives, suggests that all family members are present for at least a large part of the session. Later in the treatment, individual meetings with parents and the teen may be needed because of estrangement or high conflict. Individual sessions build relationships, acquire information, and also prepare for joint sessions (working parts to a larger whole). Session composition may be dictated by therapeutic needs pertaining to certain kinds of therapeutically essential information. Individual sessions are often required to uncover aspects of relationships or circumstances that may be impossible to learn about in joint interviews. Therapeutic goals about working a particular relationship theme in vivo, via enactment for instance, may

be another rationale for decisions about session composition.

MDFT works in four interdependent and mutually influencing subsystems with each case. The rationale for this multiperson focus is theory based and practical. While other family-based interventions might address parenting practices by working alone with the parent for much of the therapy, MDFT is unique in its way of not only working with the parents alone but also focusing significantly on the teen alone, apart from the parent sessions, and apart from the family sessions. These individual sessions have enormous strategic, substantive, and relationship-building value. They provide point of view information and reveal feeling states and historical events, not always forthcoming in family sessions. The individual meetings establish one-on-one relationships. Family-based treatment means establishing multiple therapeutic relationships rather than single therapeutic alliances as is the case in individual treatment. If individual therapeutic alliances are basic to individual therapy's success, multiple therapeutic alliances, and success in those relationships, seem equally fundamental to success in our version of family-based therapy. They actualize the kinds of therapeutic processes from which positive clinical outcomes emerge. A therapist's relationships with different people in the mosaic that forms the teen's and family's lives are the starting place for inviting and instigating change attempts. The strategic aspects of these actions are probably obvious by now. There is a leveraging, a shuttle diplomacy that occurs in the individual sessions as they are worked to create content, motivation, and readiness to address other family members in joint sessions.

Training: *It's Impossible to Learn to Plow by Reading Books* (Linklater, 1988)

As the film title above suggests, MDFT training is about *learning by doing.* The training framework (Breunlin, Liddle, & Schwartz, 1988; Liddle & Saba, 1983; Liddle, 1988), clinical training methods, including live supervision (Liddle & Schwartz, 1983; Liddle, Davidson, & Barrett, 1988) and videotape review (e.g., Liddle, Breunlin, Schwartz, & Constantine, 1984) remain relevant. At the same time, they have been revised over the years to reflect current training goals and settings (e.g., creating an MDFT team of clinicians and supervisors in community clinics and residential treatment settings). The manual used in one of the MDFT multisite studies is available online (Liddle, 2002), and the current MDFT manual with core sessions, clinical and supervision protocols is forthcoming (Liddle, in press). A competency-based training-to-certification procedure includes clinical site readiness preparation, step-by-step clinical and supervision training procedures including training of supervisors/trainers protocols. Teams of MDFT therapists are trained through the MDFT dissemination organization. The several day introduction phase of training consists of presentations by a senior MDFT trainer, discussion of readings, manual and protocol mastery, role plays, and video examples.[2] But the majority of the training period, approximately six months, is the application of MDFT ideas and methods with regular program cases. DVD review, case conceptualization practice, weekly planning sheets for each case, and feedback from MDFT experts according to MDFT fidelity and clinical skill enhancement feedback predominate. Training evaluations demonstrate its acceptability and feasibility with practicing clinicians (Godley et al., 2001; Rowe et al., 2013).

Research Evidence

The MDFT research program has accumulated evidence supporting the intervention's effectiveness for adolescent substance abuse and delinquent behaviors. Studies included efficacy/effectiveness RCTs, studies on therapeutic processes or mechanisms of action, economic analyses, and implementation/dissemination. The projects have been conducted at community clinics across the United States, among diverse samples of adolescents (African American, Hispanic/Latino, and Caucasian youth between the ages of 11 and 18) of varying socioeconomic backgrounds. A five-country, multisite, MDFT-controlled trial, funded by the health ministries of Germany, France, Switzerland, Belgium, and

The Netherlands, demonstrated consistent clinical outcomes in substance abuse (Rigter et al., 2012) and behavior problems (Schaub et al., 2014). This same study also speaks to the dissemination potential of the approach, since the treatment was implemented in real world treatment settings with fidelity, clinical skill, and cross-cultural competence (Rowe et al., 2013). Study participants across MDFT-controlled trials met diagnostic criteria for adolescent substance abuse disorder and included teens with serious drug abuse and delinquency. MDFT has demonstrated efficacy in direct comparisons with state-of-the-art, active treatments, including a psychoeducational multifamily group intervention, peer group treatment, individual cognitive-behavioral therapy (CBT), and residential treatment.

Clinical Outcomes. When referred to MDFT, youth and families engage and complete the program between 80% and 97% of the time. *Substance use* is significantly reduced and more youths achieve abstinence from illicit drugs in MDFT to a greater extent than comparison treatments (examples include 41% to 82% reduction from intake to end of treatment) (Liddle & Dakof, 2002; Liddle et al., 2001; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). After treatment and at one-year follow-up, MDFT participants had higher drug abstinence rates than comparison youths (64% for MDFT vs. 44% for CBT, and 93% for MDFT vs. 67% for group treatment) (Liddle et al., 2008; also see Dennis et al., 2004). Additionally, *substance-abuse-related problems*, including antisocial, delinquent, and externalizing behaviors, are significantly reduced in MDFT to a greater extent than comparison interventions, including manual-guided, active treatments. In controlled trials that integrated MDFT with juvenile detention and juvenile drug court programs, MDFT showed added and stable benefits, with significant decreases in substance use problems, and arrest records for outcomes such as felony arrests (Liddle et al, 2011; Dakof et al., 2015). *School functioning* improves more in MDFT than comparison treatments (MDFT clients return to school and receive passing grades at higher rates) (Liddle et al., 2001). *Family functioning* improves (reduces family conflict, increases in family cohesion) to a greater extent in MDFT than family group therapy or peer group therapy (observational measures), and these gains retain at one-year follow-up (Liddle et al., 2001). MDFT has performed effectively as a community-based drug prevention program and has successfully treated younger adolescents who recently initiated drug use (Hogue, Liddle, Becker, & Johnson-Leckrone, 2002). *Psychiatric symptoms* show greater reductions during treatment in MDFT than comparison treatments (30% to 85% within-treatment reductions in behavior problems, including delinquent acts and other mental health problems such as anxiety and depression). Compared with individual CBT, MDFT had better drug abuse outcomes for teens with *co-occurring problems*, decreased externalizing and internalizing symptoms, and demonstrated superior and stable outcomes with the more difficult cases (Liddle et al., 2008; Rowe, 2010). *Delinquent behavior and association with delinquent peers* decreases with MDFT youth, whereas youth receiving peer group treatment reported increases in delinquent behavior and affiliation with delinquent peers; these changes maintain at one-year follow-up (Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004; Liddle et al., 2009). Juvenile justice records indicate that MDFT participants are less likely to be *arrested or placed on probation*, and had fewer findings of wrongdoing during the study period. MDFT transportation studies show that association with delinquent peers decreases more rapidly after therapists have received MDFT training (Liddle et al., 2006). MDFT has demonstrated reductions in *youths' high-risk sexual behavior*, HIV and STD risk reductions (laboratory-confirmed STDs) (Liddle, Dakof, Henderson, & Rowe, 2011; also see Marvel, Rowe, Colon, DiClemente, & Liddle, 2009). MDFT outcome studies have been evaluated in comparative reviews, independent scientific appraisals, reports by private foundations, and government entities.[3] Outcomes are consistent with heterogeneous (Greenbaum et al., 2015), comorbid samples (Henderson et al., 2010), stable at 18-month and longer follow-up assessments.

Studies on therapeutic process and change mechanisms. Two overarching organizers of the MDFT

approach are stages of treatment and the four domains, in which a therapist seeks to foster competence and change. MDFT studies have demonstrated how to *improve family interactions* by targeting family interaction (Diamond & Liddle, 1996) and how therapists build successful *therapeutic alliances* with teens and parents (Diamond, Liddle, Hogue, & Dakof, 1999). Adolescents are more likely to complete treatment and decrease their drug use when therapists have solid relationships with their parents (Hogue et al., 2005) and with the teens (Robbins et al., 2006). Stronger therapeutic alliances with adolescents predict greater decreases in their drug use (Shelef, Diamond, Diamond, & Liddle, 2005). Another process study found a linear adherence-outcome relation for drug use and externalizing symptoms (Hogue, Dauber, Samuolis, & Liddle, 2006). MDFT process studies found that parents' skills are improved during therapy (Henderson, Rowe, Dakof, Hawes, & Liddle, 2009), parent changes predict teen symptom reduction (Schmidt, Liddle, & Dakof, 1996), and that a connection exists between systematically addressing cultural and racial/ethnic themes and increases in adolescent treatment participation (Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001). Finally, MDFT interventions that targeted family interactions related to changes in drug use and emotional and behavioral problems (Hogue, Liddle, Dauber, & Samuolis, 2004).

Economic analyses. The average weekly costs of treatment are significantly less for MDFT ($164) than standard treatment ($365). An intensive version of MDFT designed as an alternative to residential treatment provides superior clinical outcomes at significantly less cost (average weekly costs of $384 versus $1,068) (French et al., 2003).

Implementation outcomes. MDFT moved successfully into a representative day treatment program for adolescent drug abusers (Liddle et al., 2006). There were several important outcomes. Therapists delivered the MDFT according to protocol following training (e.g., broadened treatment focus post-training, addressed more MDFT content themes, focused more on adolescents' thoughts and feelings about themselves and extrafamilial systems) and these changes were retained over time. Clients' outcomes were significantly better, and these gains maintain at follow-up. After staff training in MDFT, youth decreased drug use by 25% before MDFT compared to a reduction of 50% after MDFT training and organizational intervention. And, program or system-level factors improved dramatically, according to dimensions such as adolescents' perceptions of increased program organization and clarity of program expectations. MDFT clinicians collaborate effectively with other professionals in working with the youth and family (Liddle et al., 2011), MDFT training methods have been endorsed by clinicians (Godley et al., 2001), and therapists from diverse cultural contexts evidence benefit from MDFT training by showing outstanding mastery of the approach in regular community settings (Rowe et al., 2013).

Summary

MDFT development and research began three decades ago. In those days, family therapy's funded research potential was unclear. But the pioneers work of researchers such as Michael Newcomb (Newcomb & Bentler, 1988) established a developmental and contextual understanding of youth drug taking and its consequences. The scientific and popular acceptance (Blakeslee, 1988) of this work did much to influence NIDA of the worthwhileness and need to expand this research area. Other highly influential researchers, including Baumrind (Baumrind & Moselle, 1985), Brook and colleagues (Brook et al., 1999), and Kandel (Kandell, Kessler, & Margulies, 1978) conducted seminal studies that established a developmental and family-oriented perspective on youth substance misuse. Some believed that family therapy would have "little direct influence" on adolescent drug use (Oetting & Beauvais, 1987, p. 215). The first family therapy *Request for Applications* led to the funding of three research projects (NIDA, 1983). In discussing a study on peer cluster theory, Oetting and Beauvais (1987) said that these family therapy studies "may fail because the drug-using youth will have already established

peer clusters that encourage and maintain drug use and, unless family therapy can also change those peer associations, it is not likely to influence drug use" (p. 210). But these projects did not fail, and together, they established the feasibility, potential for future, and what would become programmatic work on family therapy with clinically referred youth substance abusers (Joanning, Quinn, Thomas, & Mullen, 1992: Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle, et al., 2001; also see reviews by Williams & Chang, 2000; Weinberg, Rahdert, Colliver, & Glantz, 1998).

MDFT has involved hundreds of collaborators, including researchers, research assistants, students, clinicians, state and community agency administrators, federal agency representatives, private foundation board members, and by now thousands of youths and family members. In one or more ways, all of these individuals have participated in the scientific testing, dissemination, and implementation of the approach in the United States and abroad. This mighty team has contributed to the creation of a treatment with demonstrated strengths as identified in independent evaluations. The treatment is well defined, teachable to clinicians in regular care settings, capable of being sustained in these settings, and able to achieve clinically meaningful outcomes with the most complex clinically-referred youths in the various care sectors. MDFT is seen as culturally responsive, and therapeutic process studies have continued to evaluate and tailor the treatment not just according to diverse adolescent and family backgrounds, but also to the requirements of substance abuse, mental health, juvenile justice, and child welfare clinical settings. The clinical outcomes have been described as noteworthy for their variety, practical relevance (improvements in practical, day-to-day outcomes), stability at follow up (1–4 year follow-ups), and consistency across studies.

Pressing future issues for MDFT, or any of the evidence-supported therapies, concern dissemination and use of effective treatments in routine care environments. The prevailing dissemination approach, where a full version of a standalone evidence-based treatment is brought to a non-research setting, is effective but inefficient (Hogue, Henderson, Ozechowski, & Robbins, 2014). Progress in applying alternative influence models, such as module-based approaches (e.g., MDFT, Rowe et al., 2012; MATCH, Weisz et al., 2012) is promising, but it is too early to ascertain widespread dissemination and uptake outcomes (Barth et al., 2011). The relevance of evidence-supported therapies for training programs deserves more attention (Patterson et al., 2004), given the minor contributions these therapies make to MFT training at present, or professional preparation in other specialties for that matter (Weissman et al., 2006). Another pressing issue, probably more fundamental than dissemination, concerns how the family therapy field will deal with the evidence-based therapies. New ways of evaluating treatments have been offered (Sexton et al., 2008), and some in psychotherapy suggest that a focus on fundamental or cross-cutting change dynamics and principles (vs. models or schools) is preferred (Rosen & Davison, 2003). But in family therapy circles, at least, the reception so far has been mixed. Some express a qualified optimism (Datillio, Piercy, & Davis, 2014; Sprenkle, 2012), others wonder about the meaning, usefulness, or even the validity of evidence-based therapies (Bean, 2012; Eisler, 2007; Gateley, 2014; Imber-Black, 2014). Perhaps these frank appraisals represent progress—better to specify and discuss perceived conclusions than not (Lebow, 2014). Advances in any field are routinely ignored, found impractical, or take decades to incorporate (Gawande, 2013). Conclusions about family therapy's evidence-based approaches depend on where you look, what you believe and know, and who you ask. In its inclusiveness and scope, the current edition of the *Handbook of Family Therapy* surely offers readers a chance to assess these matters for themselves.

Acknowledgments

MDFT development and evaluation has been supported by funding from the National Institute on Drug Abuse and other federal agencies since 1985. Over the years, many NIH Project officials, including Liz Rahdert, Jerry Flanzer, Redonna Chandler, Bennett Fletcher, Lisa Onken, Meyer Glantz, and Wilson Compton, have supported research in the area of family-centered treatment

of adolescent substance abuse, and this support is gratefully acknowledged. Finally, I thank my special collaborators, Gayle Dakof, Cindy Rowe, and Craig Henderson for many years of good ideas and heavy lifting.

Notes

1. MDFT publications and resources are available at www.mdft.org.
2. *Multidimensional Family Therapy* (American Psychological Association DVD, 2008), *Adolescent Drug Abuse: A Multidimensional Approach* (Hazelden Publishing, Center City MN, 2009), *Multidimensional Family Therapy: A Research Proven Approach for Adolescent Substance Abuse and Delinquency* (Alexander Street Press, 2014).
3. Reviews, reports, and evidence-based therapy registry evaluations are available at www.mdft.org/Proven-Success/Awards-and-recognition and www.mdft.org/Proven-Success/Independent-scientific-and-scholarly-reviews.

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13.

FUNCTIONAL FAMILY THERAPY

Evidence-based and Clinically Creative

Thomas L. Sexton

Functional Family Therapy (FFT) is a systematic, evidenced-based, manual driven, family-based treatment program which is successful in treating a wide range of problems affecting youth (including drug use and abuse, conduct disorder, mental health concerns, truancy, and related family problems) and their families in a wide range of multi-ethnic, multicultural, and geographic contexts (Alexander & Sexton, 2002). Among family therapy models FFT is unique. Like many models, FFT is built on the principles of good clinical practice (create a therapeutic relationship, be client-centered, etc.) and contains all of what we would today call the "common factors" of all successful therapies. However, FFT uniquely takes a comprehensive family-based and relationally focused approach that makes it a model that is far more than a series of "intervention techniques." Instead FFT is a systematic, theoretically based, clinical change process with specific clinical and theoretical principles and a systematic clinical protocol ("map") that guides therapeutic case and session planning. As a treatment program, FFT has attended to culture, the changing nature of the family, and the almost magical relational process that unfolds "in the room" during the therapy process. Over its three decades of evolution and development, FFT has matured to include a comprehensive theoretical "lens," a systemically relationally based change process ("map"), and an appreciation and reliance on the clinical creativity of the therapist who translates the model from an idea into practice in the relational interactions with the client and family.

FFT has been written about extensively in published chapters in major handbooks, peer-reviewed articles, research findings, and specific treatment manuals (Alexander, Pugh, Parsons, & Sexton, 2000; Sexton & Alexander, 2003, 2004, 2006). Two recent books (Sexton, 2010; Alexander, Waldron, Robbins, & Neeb, 2013) also describe the model in significant detail. It is clear from looking across the published sources that the core principles of FFT have remained the same for more than three decades. Yet, different articulations of the model have been proposed over those decades in response to the context around FFT. Regardless of the articulation there is a singular core model that has moved from a focus on phases of change, to one emphasizing change mechanisms, to an emphasis on developing methods to enhance the critical thinking, flexibility, and case planning of those implementing FFT (Sexton, 2010).

In practice, FFT is a dynamic, highly interpersonal, relationally focused, and emotional therapeutic experience. As a result, it is not easy to capture the essence of the approach in a more written format. What is lost in description is what might be the most important part of any good treatment mode: the interactive and relational nature of the interaction between client, family, and therapist. Even with its strong evidence base, FFT depends on the therapist to successfully translate the model from ideas to actual practice. Much of what happens in FFT takes place in the interaction between the therapist and the family. It is in that interaction that the therapist follows a model (or a map), is guided by core principles (or a lens), yet is dependent on their own creativity in matching to the unique structure, functioning, and interaction style of the family (or the art). This is why so much of the recent attention has been focused on helping clinician's implementing FFT make model-focused and client-centered clinical decision making. In the end, despite all the theory and change mechanisms, research, and tools for decision making, it is the creativity which occurs within the structure of FFT that results in good outcomes for some of the most difficult clinical cases. Thus, over time FFT has evolved to a treatment model that blends both structure and creativity into a systematic approach to working with some of the most difficult types of clinical cases.

This chapter builds upon ones in previous editions of this handbook (Sexton & Alexander, 2003) and is focused on five areas: the evolutional path in the development of the FFT clinical model, the research foundations of the model, the theoretical foundations, the clinical protocol and the critical role of the therapist, and the specific methods of evaluation, measurement and community-based implementation. Each of these elements is important in successful implementation of Functional Family Therapy in a community-based setting. The chapter also illustrates some of the many tools that have been developed to help clinicians follow the FFT clinical model and at the same time to match and fit families with whom they work.

Dynamic Evolution of FFT: Structure, Specificity, and Creativity

FFT grew out of a need in communities, schools, and community-based treatment centers to serve a population of at-risk adolescents and families who were underserved, had few resources, and were perceived to be difficult to treat. Traditional treatment providers often required individuals and families to be "motivated" as a prerequisite for change, were non-specific, and not based on the emerging evidence of change and adolescent risk and protective factors. FFT took a different approach and focused on understanding why the resistance occurred and on providing the type of intervention that would match to the family members, reduce their negativity, give them hope, and thus motivate them to change. Early articulations of FFT relied on the use of specific and relatively simplistic behavioral technologies such as communication training (Parsons & Alexander, 1973). This led to the classification of FFT as a behavioral approach (Gurman & Knistren, 1981) whereas others characterized FFT as a systems-behavioral approach because of it focus on relational sequences and patterns (Barton & Alexander, 1981). As the model evolved, cognitive theory, particularly attribution and information-processing theories, helped explain some of the mechanisms of meaning and emotion often manifested as blaming and negativity in family interactional patterns. More recently, social constructionists have informed FFT through a focus on meaning and its role in the constructed nature of problems, in interrupting family negativity, and in organizing therapeutic themes and the risk and protective factor models that provide guidance in assessing within and larger system influences on families (Alexander & Sexton, 2003, 2006; Sexton, 2010).

The most current clinical model has three distinct therapeutic phases, with intervention and assessment activities as major threads through each specific phase of therapy (Sexton & Alexander, 1999, 2006; Alexander et al., 2000; Sexton, 2010). The principle behind this model is that rather than stages, assessment and intervention are actually ongoing and intertwined. As such, this model captures the realistic interchange

among family members and the therapist. The model illustrates the inherent circular, systemic, relational, and individualized clinical process visible in intense "in the room" as treatment moves through specific and predictable phases where treatment outcomes built on one another, ultimately resulting in positive behavior change. This was an important development of the model in that it helped FFT move from a traditional linear stage-based model (assessment, treatment) like that used in the medical model approaches to psychotherapy, to a dynamic and more clinically focused approach in which the "around and around" interactions of the therapist and family were the therapeutic "opportunities" through which to pursue the change mechanisms. This addition helped FFT practice become more realistic and consistent with real-world practice.

In the late 1990s, FFT started to be widely implemented in community-based contexts. Bolstered by early evidence-based research, FFT became a model that community providers wanted to use to solve some of the problems they experienced with youth in schools, juvenile justice, and mental-health settings. Large-scale dissemination and implementation brought an opportunity to test the clinical model in a real-life setting, finally moving it from the lab to the community. Yet, early findings regarding evidence-based models suggested that the strong results of efficacy trials found as the model was being established significantly diminished when applied in the community. A recent study by Sexton and Turner (2010) lent support to this finding, suggesting that in community settings the outcomes of FFT were the result of an interaction between the model and the fidelity of the model as implemented by an individual therapist. Thus began an effort to understand what it takes to implement an evidence-based model like FFT in a community setting. These efforts in real-life community settings have resulted in a manual-driven approach to clinical supervision (Sexton, Alexander, & Gilman, 2004), a computer-based quality improvement system that serves as a measurement feedback tool to guide clinicians in following the model and matching to clients (Sexton, 2010; Sexton & Fisher, in press), and a systematic approach to training and implementation (Sexton & Alexander, 2004; Sexton, 2010). Thus, over time FFT has become what Alexander and Sexton (2006) have called a comprehensive service delivery model including a comprehensive theory, a specific clinical protocol, a reliable and valid measurement system, and decision-making tools to help improve outcomes (Sexton, 2010).

Scientific Foundations

Measurement and evaluation have always played a central role in the development of the current FFT model. The cumulative level of evidence spanning over 30 years demonstrates that FFT can, when implemented correctly, result in positive outcomes in many settings and with thousands of diverse clients (Alexander et al., 2000; Sexton, 2010). The research supporting FFT is community based, of high methodological quality, and with "real" youth (e.g., multiproblem, ethnically diverse, wide socioeconomic status) in "real" settings (e.g., home, community) implemented by community-based professionals with diverse training backgrounds. These studies led the Center for Substance Abuse Prevention (CSAP) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to identify FFT as a model program for both substance abuse and delinquency prevention (Sexton & Alexander, 1999; Alvarado, Kendall, Beesley, & Lee-Cavaness, 2000). Similarly, the Center for the Study and Prevention of Violence (CSPV) designated FFT as one of the eleven (out of over 1,000 reviewed) "Blueprint" programs (Elliott, 1998). Such designations are based on the fact that FFT has demonstrated outcomes in many settings and with many and diverse clients.

The initial study of FFT was conducted by Alexander and Parsons (1973) and Parsons and Alexander (1973). At 6–18 month follow-up, the youth treated with FFT re-offense rate of 50% lower than the other treatment groups (26%, compared to 50% for no-treatment controls, 47% for client-centered family group therapy controls and 73% for eclectic psychodynamic family therapy). The study also established that FFT had an impact on communication patterns, frequency of interaction, and on more positive interruptions

of communication for clarification and feedback rather than negativity and blaming interactions. Klein, Alexander, and Parsons (1977) published a two-to-three-year follow-up study and found that siblings in the families that received FFT (in Parsons & Alexander, 1973) had only a 20% post-FFT court referral rate. Siblings of adolescents in the other treatment groups had significantly higher recidivism: no treatment 40%; client-centered family therapy 59%; eclectic-dynamic family therapy 63%. These findings suggest that FFT had not only a significantly greater impact on relatives (as compared to a reasonable alternative treatment) but also an absolute effectiveness (as compared to no treatment) on siblings who were not even the primary focus of attention in treatment.

Barton, Alexander, Waldron, Turner, and Warburton (1985) conducted a series of three small studies of different severity of youth delinquency. FFT conducted by undergraduate students resulted in significant reduction of one-year recidivism rates of 26% for youth in the FFT group as compared to 51% base rated on the juvenile justice jurisdiction. The second study (Barton et al., 1985) studied reductions in out of home placements. Comparison rates of placement for workers trained in FFT skills found a significant decrease in out of home placement rates (48% vs. 11%). The final study in this series investigated the effectiveness of FFT with "hard core," seriously offending youth (Barton et al., 1985). Averaging 30 hours of therapy, the FFT group had a 60% recidivism rate at the 16-month follow-up compared to 93% of comparison youth released to alternative "reentry" programs (primarily group homes) and an 89% average annual institutional base rate.

Gordon and colleagues were the first independent group to study the outcomes of FFT. In two studies, Gordon, Arbuthnot, Gustafson, and McGreen (1988) and Gordon, Graves, and Arbuthnot (1995) established that FFT could be replicated outside the Utah setting. Using a model of FFT that emphasized problem solving and specific behavior change skills, they found FFT to have much lower rearrests rates at both 24 months and 5 years post-treatment. Compared to juveniles who received regular probation services (n=27, 67% recidivism rate), clients in the FFT group had an 11% recidivism rate at a 2-year follow-up. At a 5-year follow-up, the group that received FFT had a 9% recidivism rate as (as compared to 41% recidivism rate for the comparison group).

Waldron and colleagues (Waldron, Slesnick, Turner, Brody, & Peterson, 2001) studied the impact of FFT with drug-using youth. Combined treatments showed significant reductions in percent of days using marijuana from pretreatment to 4 months following initiation of treatment. These results provide support for the immediate benefit of family therapy for substance-abusing youth and are generally consistent with the family therapy outcome literature for adolescent substance abuse.

The largest FFT was conducted in Washington State and is the first to study FFT in a true community-based setting. The project results have been reported by Barnowski (2002), Sexton and Alexander (2004), and Sexton and Turner (2010) in varying forms and with different subsets of participants. Youth in the study were high risk, including: 85.4% that drug involved (high drug risk), high rates of reported alcohol use/abuse (80.47%), a range of other mental health or behavioral problems (27%), most had committed felony crimes (56.2%), 10.4% had adjudicated weapons crimes, gang involvement (16.1%), out of home placements (10.5%), running away from home (14.1%), and school dropout (46.39%). When compared to a no-treatment control, FFT had a 31% reduction in criminal behavior, and a 43% reduction in violent recidivism. However, the positive effect of FFT was not universal. In fact, those therapists who delivered FFT with high fidelity (i.e., how it was designed) had the outcomes noted above. However, those who did not deliver the model with high fidelity had outcomes that were worse than that with youth who received no therapy at all but instead were merely supervised by their probation officer. This finding would suggest that quality assurance and implementation plans are a critical feature in successful community implementation.

The most recent published studies of FFT were conducted in Ireland. The first was a retrospective study of FFT's effectiveness suggesting

that adolescent behavior problems improved in cases treated with FFT and the greatest improvement occurred in cases treated by therapists who adhered to the FFT model and implemented FFT with a high degree of fidelity. For the 98 treatment completers, there was significant improvement in conduct problems, hyperactivity, emotional symptoms, and prosocial behavior scales. After an average of 17 weeks of FFT, approximately 40% of all 98 cases were clinically recovered and scored below the clinical cut-off on the SDQ total difficulties scale (compared with a dropout control) and various areas of mental health and the best outcomes occurred when receiving treatment from therapists who conducted FFT with a high degree of fidelity (Graham, Carr, Rooney, Sexton, & Satterfield, 2013). In a second randomized trial (Hartnett, Carr, & Sexton, in press), the dropout rate was only 7%, compared to the comparison group. Those families who participated in FFT reported significantly greater improvement in adolescent conduct problems and family adjustment, and improvements shown immediately after treatment were sustained at a 3-month follow-up. Clinical recovery rates were significantly higher in the FFT group than in the control group. Some 50% of FFT cases were classified as clinically recovered after treatment, compared with 18.2% of cases from the waiting-list control group. Clinical recovery was defined as obtaining a score below the clinical cut-off on the parent-completed SDQ total difficulties scale post-treatment. Compared with teenagers, parents perceived a greater degree of improvement in a greater number of domains of adolescent behavioral problems.

The cost saving of FFT in community-based systems has also been studied. These comparisons of cost support the cost findings of the Washington Study. Using the algorithm developed by Aos and Barnowski (Barnowski, 1997), FFT saved the Washington State system $16,250 per youth in court costs and crime victim costs, not to mention the incalculable emotional pain suffered by family members. In addition, for this project $1,121,250 was saved in the first year. This same algorithm suggests that for every $1 invested in delivering FFT more than $14.67 is saved.

The FFT Clinical Model

The FFT clinical model has three core elements: the core theoretical principles (the model "lens"), the clinical protocol (the model "map") and the specific principles used by therapists to match the treatment model to the unique characteristics of the family (the artful implementation of the model). In the following sections we consider these core components of FFT.

Core Principles: The Lens of FFT

A "lens" is a useful metaphor for understanding the role of the core principles of FFT. A lens helps bring objects into focus in a way that pulls out certain details to define particular characteristics. Looking through a lens helps focus extensive information in an understandable way. The "lenses" through which the clinician looks to view the client and the situation are the core foundation of their subsequent clinical decision making. There are six core theoretical principles of FFT that shape the assessment and intervention. These core principles have been presented in a number of previous publications about FFT (Sexton & Alexander, 2003, 2006; Sexton, 2010). Each of these principles is described in the following sections.

1 Risk and Protective Factors in a Multisystemic Context

FFT is based on the principle that all behavior is part of a multisystemic relational system with multiple, mutually interactive components including the youth, parents, family system, and community and extended family, among others. From this perspective, problem behavior is a complex interaction between the specific behavior that is embedded with a relational pattern, and is influenced by many systems within a multisystemic context. The family is the primary entry and assessment point for the initial work in FFT. Working from the inside of the family, FFT addresses initial within-family barriers to change, and helps identify specific new prosocial behaviors to be built. Across the phases of FFT, the emphasis moves from inside the family to the

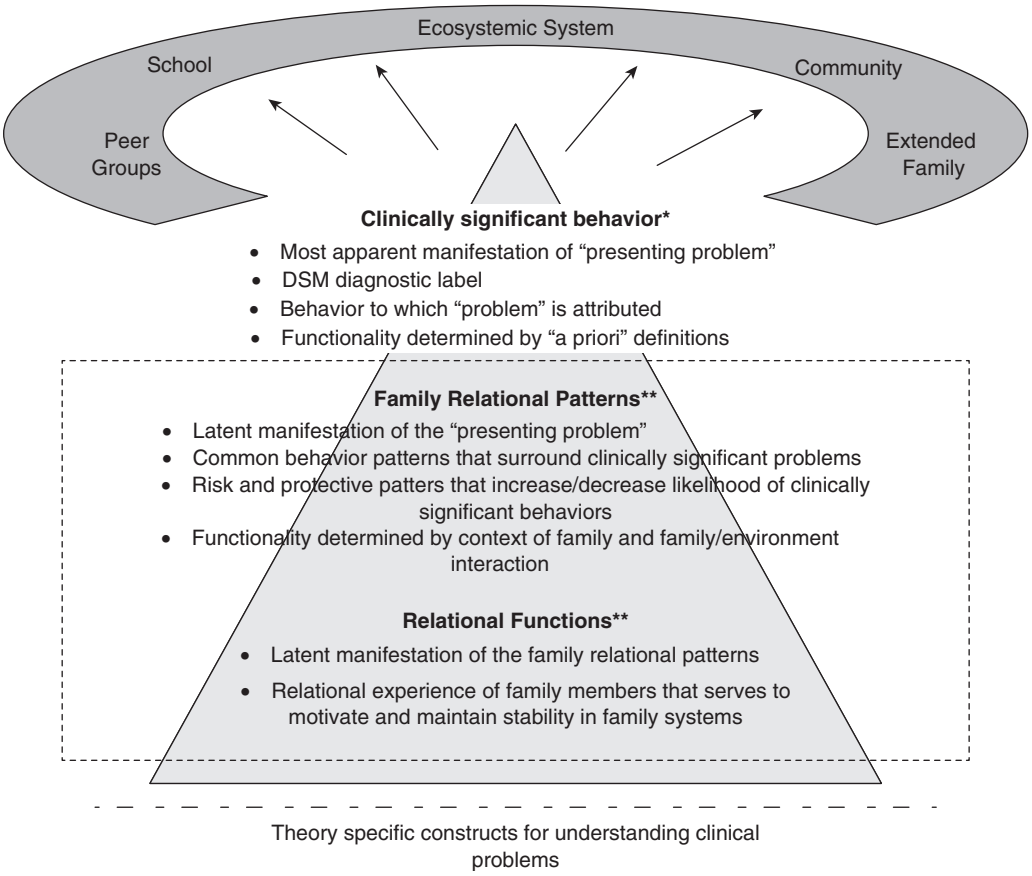

Figure 13.1 Multisystemic view of clinical problems: specific problematic behavior, family behavior patterns, and relational functions (Sexton & Alexander, 2003)

outside system that impacts relapse and maintenance of change over time. It is important to note that FFT's primary goal is to reduce the negative and problematic behavior of the youth so that they stay in school and out of the juvenile justice system and work together with their family to solve future problems. Figure 13.1 illustrates the multisystemic context of FFT.

The concept of risk and protective factors provides a comprehensive, clinically specific way to identify the potential strengths and weaknesses of youth and families within the multilayered, multisystemic system described in the section above. Risk and protective factors are those elements within the broader system that increase the likelihood of problem behavior while protective factors are elements of family to retrain and build upon. Risk and protective factors first became part of FFT in the 2000 Blueprint Manual (Alexander et al., 2000). FFT's risk and protective factors approach to understanding "clinical" problems is useful because it puts risk and protective factors into a family relational model to *describe* patterns of behavior that can be changed rather than applying labels that are permanent, both following and preceding the youth and family as they pass through community systems. The presence of single risk factors does not cause antisocial behavior; instead, multiple risk factors combine to contribute to and shape behavior over the course of development. It is the confluence of risk factors and protective factors that determines the likelihood of risk-taking behavior not any single characteristic of family structure or youth or caregiver behavior. When one takes a multisystemic perspective, it becomes clear that

the source of the family's difficulty is not one individual's "problem" behavior, but the way it is managed within the family system.

2 Families First

In FFT the family system is the primary focal point for understanding and intervening. Families are the earliest and possibly the dominant context for childhood learning, especially for what relationships mean and how to develop and maintain them. Thus, families play a role in how the youth develops, but even more importantly, in the direct functioning of the family and the youth every day. Families also play a role in the struggles and problems of youth. It is not that families are the cause of problems, but that the primary clinical problem is, by the time it reaches the FFT therapist, embedded in the relational process of the families. As such, the youth's "problems" and the manner in which the family tries to understand and change those problems have been stagnant and stuck. FFT focuses on three elements of family functioning that help explain how the problem "works" in the family and which relational process to target for change: core relational patterns, problem definitions, and relational functions.

- *Relational patterns*. Family relational patterns are the unspoken connections that organize, structure, promote, support, and thus also encourage and maintain the behaviors and emotions we notice in our observation. The patterns are a bit like a spider's web where any single element in the web is connected by innumerable smaller, subtle strands to other elements. While hard to see, multiple strands of connection link each member to the others in the immediate and extended family. These strands define the relationships, and, in a sense *are* the relationship, and certain strands, like those of the spider's web, hold the relationships together. The implication is that moving any one part moves all the others. Pulling one part out results in a resistance or "pull back" from other parts, and to understand any part, the whole relationship must be considered (Sexton, 2010). From an FFT "lens," individual problems are embedded within a core family relational pattern, which represents the "way" the family interacts around the problem behavior. In accordance with the concepts of the systemic relational process, these patterns become very stable and, once established, they perpetuate the problem behavior. Relational patterns can be a source from which to identify critical risk/protective patterns as maintained and supported by the ways in which relationships "function" within the family and for individuals.
- *Problem definitions*. These are the descriptions given to the therapist by family members when asked, "What is the problem?" The resulting descriptions from each family member represent each person's natural and normal attempts to understand what is causing the pain and struggle in the family and form what we term "problem definitions." The construct of problem definitions is based on the lessons of the attribution literature and some of the most current research on the therapeutic alliance. Like anyone, youth and family members attribute causes for the problem to what they can see. Thus, if the family representation is that the adolescent is the problem, the parents likely view both the cause and the source of change on the one to which the problem is attributed. It is not as if the "belief" or attribution of the problem held by the youth or their parents is wrong. It is more that a problem definition binds the youth and caregiver to a perspective that organizes (or not) their response to the problem.
- *Relational functions*. Developed by Barton and Alexander (1981), the concept of relational functions represents a way to understand why, despite their painful processes, problems endure in a family relational system. In fact, from a FFT perspective, relational functions are the "glue" that holds seemingly dysfunctional and painful patterns of behavior together over time. Regardless of their form, the common, repetitive, and highly entrenched behavioral sequences apparent in families lead to consistent

relational outcomes (functions) that can be understood only from an ideographic perspective. In other words, so-called maladaptive behavioral patterns represent people meeting their relational functions in ways that make sense given their unique learning histories, capacities, and environments, yet have a negative impact and stand in the way of successful current functioning (Sexton & Alexander, 2003). In FFT there are two main dimensions of relational functions within the family: relational connection (or "interdependency") and relationship hierarchy (Alexander & Parsons, 1982; Sexton & Alexander, 2003).

Relational connection (*or "interdependency"*) refers to the characteristic pattern that describes a relationship in terms of the degree to which high rates of mutual and emotionally vulnerable contact are necessary to maintain the relationship (Sexton & Alexander, 2004). High degrees of relatedness (relational interdependency) are experienced not only as a sense of interconnectedness, but also as psychological intensity in regards to frequency of contact in the relationship, emotional contact, and/or enmeshment. Feelings of autonomy, distance, independence, low degree of psychological intensity, and prolonged contact characterize low degrees of relatedness. Note that low degrees of relatedness are not necessarily associated with "not loving" someone: one can "love" someone very much without a high rate of contact to maintain the relationship. Thus, high and low degrees of relatedness are not different ends of a continuum but instead represent two dimensions both of which are evident to some degree in the experience of a relationship (Sexton & Alexander, 2004). Midpointing is an experience of a relationship represented by both high connectedness (interconnectedness) and distance (independence). This balance can be one, which manifests itself as an acceptable relational pattern, or can be maladaptive (as we see often in such phenomena as "borderline" or "ambivalent" parenting patterns). Figure 13.2 is an illustration of these constructs.

Relational hierarchy is a different dimension of relational functions (Figure 13.3). This dimension is a measure of relational control and influence based on structure and resources (Sexton & Alexander, 2004). Hierarchical influence ranges from high to low, with relational symmetry being an experience of balanced structure and shared resources in the relationship. So-called "one-up" and "one-down" relationships "complementary" are ones in which one member of a relationship has influence through resources (economic,

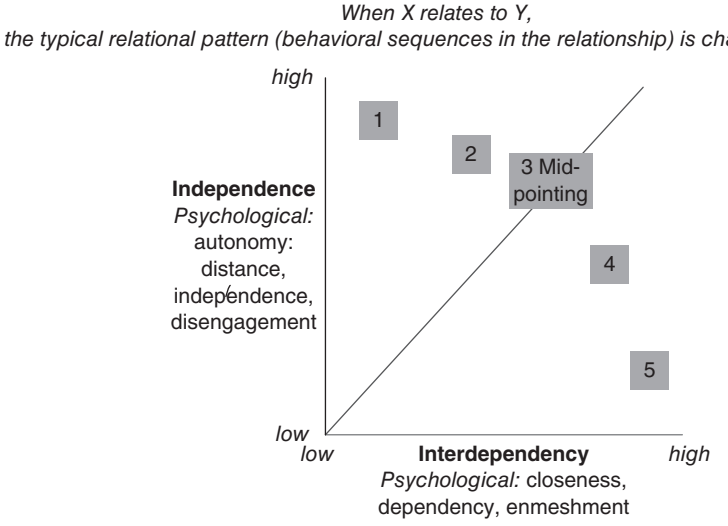

Figure 13.2 Relatedness (Sexton, 2010; Sexton & Alexander, 2004)

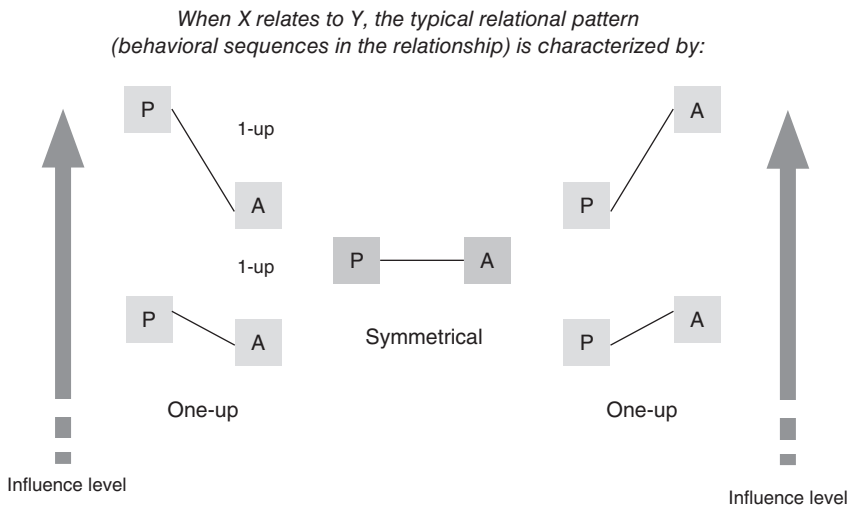

Figure 13.3 Relational hierarchy (Sexton, 2010; Sexton & Alexander, 2004)

physical power, positional or role power supported by external systems) that are less available to the other member(s) in the relationship.

It is important to note that very different family relational patterns (e.g., constant bickering vs. warmth and cooperation) could produce the same relational experience (e.g., a high degree of interconnectedness) (Sexton & Alexander, 2003). In contrast, very similar interactional sequences (warm communication and intimacy behaviors) can produce entirely different relational outcomes (e.g., they will enhance contact in one relationship, and can increase distance in another relationship). From the FFT perspective, there is nothing wrong (or to be changed) with respect to any of these "experiences" (e.g., having a sense of control, receiving attention, or having a sense of belonging). Each has its strengths and its weaknesses. FFT therapists do not change the core relational functions of the family members. In fact, FFT argues that different cultures, family configurations, and learning histories produce and value a wide range of relational patterns, and each of these patterns can produce both positive and negative behavioral expressions.

3 Alliance-based Motivation

From an FFT perspective, alliance is a core part of the clinical change process. Yet, alliance is not just a platform on which other interventions are conducted, but is, instead, a core mechanism of change. Early on in its evolution FFT saw that both the alliance between family members and the alliance between each member and the therapist were the foundation for engagement, the motivation to engage in treatment, and motivation for behavior change and maintenance. The earliest FFT ideas of alliance were rather simplistic, suggesting that alliance was built on a combination of therapist structure and support (Alexander & Parsons, 1973). More recent work on the alliance (Friedlander et al., Chapter 23 this volume) has helped expand the range of alliance to include not only empathy and support but also a process of developing shared problem definitions—or shared belief about each person's part of a common solution to the presenting problem. It is also increasingly clear from process research that alliance is critical and needs to be balanced and that balance occurs when the therapist has the same level of working alliance with the parents and the youth, regardless of the overall level (Robbins, Jimenez, Alexander, & Turner, 2001; Sexton & Alexander, 2003).

The dictionary definition of motivation is an "incentive to action." In the context of therapy, motivation is often viewed as a static construct—that is, a condition (incentive) that exists within that client that moves him or her to change. Yet, the majority of families that come to FFT have

one or more members who are not motivated to change. As a result, FFT has developed strategies and techniques to create the motivation to change, leading to high success rates even in populations characterized as "unmotivated to change." Motivation is an outcome of the type of therapeutic alliance described above in which a successful change process is built on an atmosphere, which is shared by the family, of hope, expectation of change, a sense of responsibility (internal locus of control), and a positive sense of alliance. Thus, therapeutic motivation (an incentive to change or to act) is a relational process (alliance) that has an early therapeutic goal based on the alliance (a relational process).

4 Meaning Change Through Reframing

In family therapy one of the biggest therapeutic challenges is that there are as many definitions and meanings of what the problem is as there are family members. In fact, much of the negativity and blame that fuels the troubled interactions between family members comes from each member feeling the conflicting clash of different experiences of the source of the problems and therefore the solutions that seem to have the most potential to produce the changes that will eliminate the anger and the pain

The individual meaning that each family member carries regarding the problems and functions in their family is a critical point to be addressed in the change process. When a family first begins therapy, they come with a history of having struggled with the behavior problems of their adolescent and/or parent for some time. It is only natural, and maybe quite uniquely human, that we all try to make sense of what has and is happening to us. From our perspective, that is part of the inherently self-reflective part of what it means to be human. Thus, it is only natural that each family member comes to therapy with well-defined explanations for the problems they experience. These definitions may exist in emotional ("It hurts and I am angry"), behavioral ("Stay away from me," "You don't deserve a break") or cognitive terms ("You are just trying to hurt me," "Why does he/she intentionally do this?"). The cognitive sets, or problem definitions, that family members possess represent the *meanings* that contribute to the emotional intensity that is often behind the anger, blaming, and negativity seen in the interpersonal interactions between family members. A family-focused problem definition is one in which everyone in the family has some responsibility and, thus, some part in the problem. However, no family member has blame for the state of affairs in the family. The difficult goal is the reduction of blame while retaining a sense of responsibility for one's own actions.

Reframing, a central technique in FFT, was initially made popular by the early communication theorists (Watzlawick, Weakland, & Fisch, 1974) and strategic therapies (Selvini-Palazzoli, Boscozo, & Prata, 1978) and has become one of the most universal therapeutic techniques across all family therapies. In FFT, reframing is a family-focused method to create alternative cognitive and attributional perspectives that help redefine meaning events and thus reduce the negativity and redirect the emotionality surrounding the events, reframe, and then challenge clients (implicitly at first, then explicitly later in therapy) to identify new directions for future change, and to link family members to one another, such that each shares in the responsibility for the family struggles. This view of reframing is rooted in attributional and information-processing constructs of cognitive psychology (Jones & Nisbett, 1972; Kelley, 1973; Taylor & Fiske, 1978), social influence process of social psychology (Heppner & Claiborn, 1988), and the more recent systemic (Claiborn & Lichtenberg, 1989) and social constructionist ideas regarding the meaning basis of problem definitions (Friedlander & Heatherington, 1998; Gergen, 1985; Sexton & Griffin, 1997).

5 Obtainable Change Goals

For the multiproblem families for which FFT is intended, it is critical to find ways to make changes that become meaningful, relevant, practical, and lasting. Thus a core principle of FFT is that any change goals need to be significant yet obtainable behavioral changes that will have a lasting impact on the family. To do so, the FFT model seeks to pursue obtainable outcomes that "fit" the values, capability, and style of the family,

rather than to mold families into someone's version of "healthy" or to reconstruct the "personality" of the family or individuals therein. The goal is to focus on obtainable behavioral changes that are individualized and tailored for each family: with the resources family members have, with the values that they hold, and in the circumstances in which they live (Sexton & Alexander, 2003).

Specific and obtainable behavior changes have a major impact on family function because they are targeted to alter the underlying risk and protective patterns that support and maintain other problematic behaviors. Thus, what might look to be small behavior changes in family process (positive parental monitoring; reduction of between family member blame, etc.) are ones that are lasting because they enhance the relevant protective factors and decrease the important risk factors in the individual family in treatment. By pursuing obtainable changes that occur in these families, FFT not only has an immediate effect of changing a specific "problem" but also has an additional impact of actually changing the *way* in which families function thus, empowering a family to continue applying changes to future circumstances. Thus, what might seem like a small change becomes, over time, a significant and lasting alteration in the functioning of the family that is reflected in major changes in the behavioral outcomes, such as cessation of drug use and within-family violence.

6 Evidence-based Clinical Decision Making Results in Better Community-based Outcomes

In real-life clinical settings, clinicians must make decisions adapting treatment to the needs of clients they serve. To do so, FFT has a relational theory at its foundation, a clinical map to follow, and evidence based markers and feedback through out treatment allowing for FFT to be evidence based in its foundation and evidence based in its everyday practice.

The FFT Clinical Protocol: Following the "Map"

While a lens was a useful metaphor for describing core principles, a *map* is a useful metaphor to describe the clinical protocol of FFT. The FFT change "map" or clinical protocol is a systematic and temporally organized set of core mechanisms, specific goals, and relational outcomes that result from doing FFT as a clinical process. FFT has three phases of clinical intervention. Each phase has specific goals and intervention strategies specifically designed to address these goals. FFT phase goals are "proximal goals" or intermediate steps to lasting family change. When used by the therapist, the protocol becomes somewhat like a "map" of change (engagement/motivation, behavior change, and generalization). When followed by the family it is experienced as a seamless process and conversation that is highly personal, specific, and relevant to the issues of most concern, while engaging of all family members. Together, this change model provides a "map" to guide the therapist through intense, emotional, and conflicted interactions presented by the family (Sexton & Alexander, 2004). Each of the three phases of FFT sets distinct goals and therapist skills that, when used competently, maximize the likelihood of successful accomplishment of these goals. Each phase also has specific focused interventions and desired "proximal" outcomes that form the building blocks of change. Figure 13.4 illustrates the three phase of FFT.

Engagement and Motivation Phase

Engagement and motivation begins with the first contact between the therapist and family. This phase has three primary objectives: build balanced alliance (between the family members and between each family member and the therapist), reduce between-family blame and negativity, and create a shared family-focused problem definition in order to build engagement in therapy and motivation. The desired outcome of these early interactions is that the family develops motivation by experiencing a sense of support in their position, emotions, and concerns, a sense of hope for change, and beliefs that the family psychologist and therapy can help promote those changes. When negativity and blaming is reduced, more positive interactions among family members foster hope. This allows the family psychologist to demonstrate that she is a competent force,

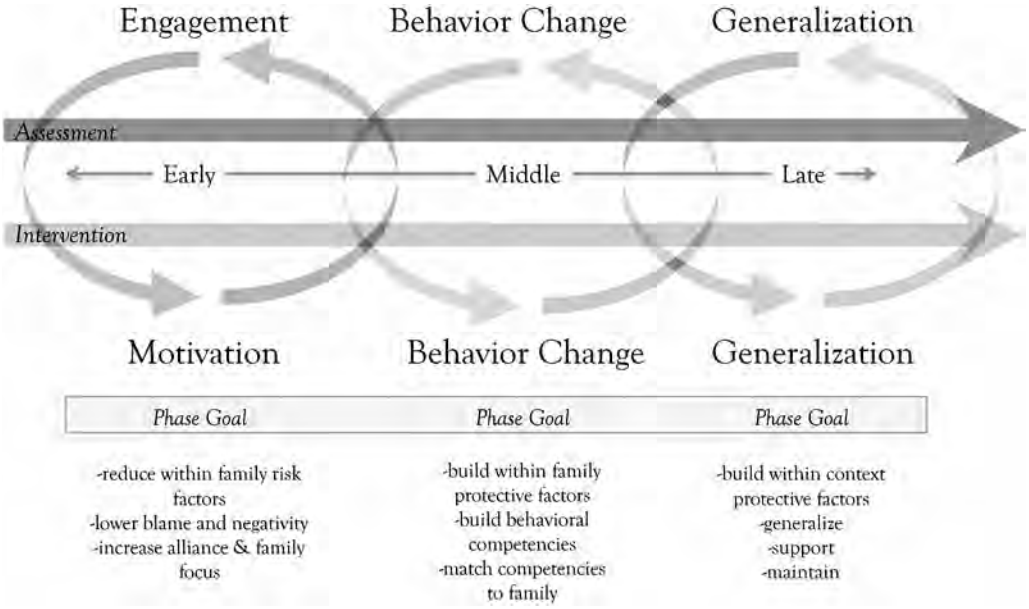

Figure 13.4 Clinical phases of FFT (Sexton & Alexander, 2003)

capable of guiding the family toward change. An alliance develops where each family member believes that the family psychologist supports and understands his or her position, beliefs, and values.

The engagement and motivation phase is successful when the family members begin to believe that although everyone in the family has a different and unique contribution to the primary concerns, everyone shares in the ongoing emotional struggle. The family comes to trust the therapist; its members believe that the therapist has an understanding of their unique position, albeit they may not agree, and the therapist has the ability to help. They come to know that regardless of what they may have done, the therapist will protect and help them as much as anyone else. They become engaged in the process and come to believe that it will benefit them personally and the family as a whole, and that the solution will require changes from each of them. In a sense they will each be more hopeful that a solution is possible and will feel motivated to take the responsibility to try new behaviors and techniques in search of this solution (see Figure 13.4).

It takes far more than just positive statements to accomplish these goals. In each of the three primary ways to accomplish the goals of the engagement and motivation phase, the therapist is active, direct, and collaborative. First, negativity and blame are reduced if conversation, and thus the relational pattern, that procures it is interrupted or diverted away from the negative, blaming, and dead-end curricular patterns around the "problem" behavior. Within the discussion, the FFT therapist makes ongoing assessments of negativity, blame, and the attributional focus of the problem definition of each family member. When negativity or blame occurs, the therapist refocuses the discussion on the noble intentions of the family, family strengths, and understanding the perspectives of the other family members.

Reframing is a second and far more elegant intervention, resulting in the reduction of blame and negativity and the enhancement of a motivation frame reference that can serve as the future behavior changes. Reframing is one of the most common interventions in psychotherapy (Sexton, 2010); yet, FFT has a somewhat unique perspective on reframing as a relational activity between therapist and family member. Unlike broad and general statements of positive intention and family strength, reframing gives the FFT therapist a way to acknowledge the importance

of what each family members feels and believes while at the at the same time creating within-family alliance and therapeutic motivation. The circular nature of the FFT reframing process makes adjustment and "fit" to the family more likely. Figure 13.5 illustrates the multistage ongoing of what FFT describes as the "relational process of reframing." Reframing has three elements: 1) acknowledgment of the client-presented perspective, 2) a reattribution of the meaning of that event, and 3) a reformation of the next reframing response that incorporates client feedback. The process of reframing begins when a family member discusses some aspect of the presenting concern (content) that is negative and that usually contains blaming. This "content" presentation has an attributional component (who/what did it), an emotional reaction to the attribution (anger, fear, hurt), and related, usually negative, behavioral interchanges that have become common. These client statements offer the therapist a reframing opportunity because they generally set off a process of defensive responding and "counterblaming" into which the therapist contingently intrudes.

The first step of relational reframing is one in which the therapist acknowledge the issues raised by the client. The acknowledgment demonstrates support, understanding, and respect for the client. To be successful, the acknowledgment avoids broad generalizations ("all parents feel this way") and instead focuses on personal, individual, and insightful statements, such that the client believes the therapist to be working

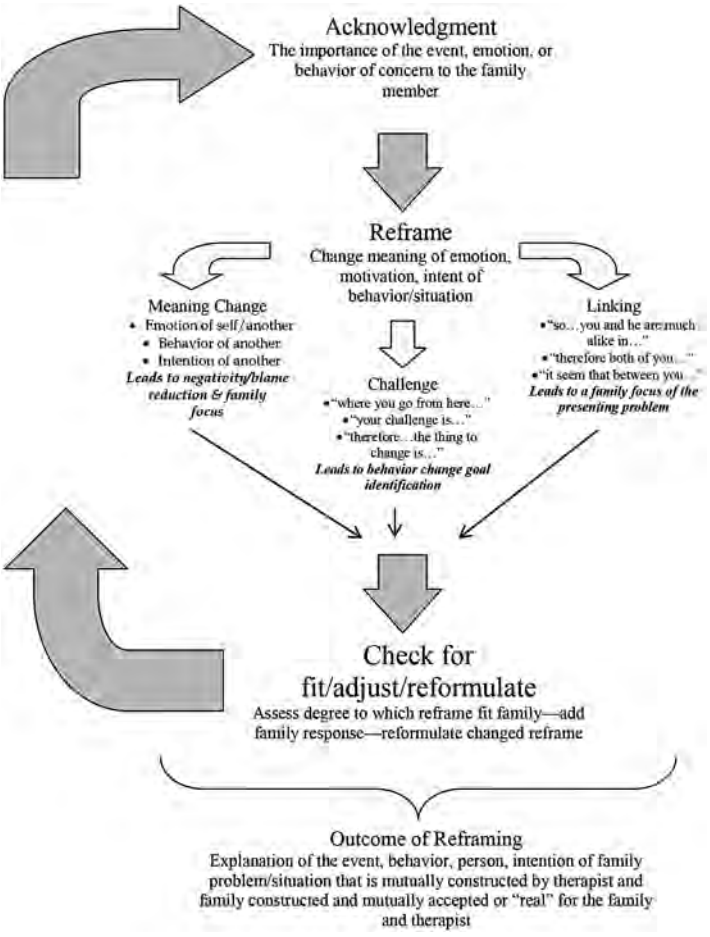

Figure 13.5 Reframing as a relational therapeutic process (Sexton & Alexander, 2003)

hard to understand his or her unique perspective. Acknowledgment is followed by a reattribution statement, which presents an alternative theme that targets the attributional scheme embedded in the client presentation (see Figure 13.5). The reattribution statement can take many forms; including offering an alternative explanation for the "cause" of the problem behavior such that it fits him or her. The alternative meaning or theme intent of another to a more benign attribution must be plausible and believable to the client. As described by Sexton and Alexander (2003), it is possible to reframe anger as the hurt that the individual feels in response to the trouble in the family, with the angry person being "willing to be the emotional barometer for the sake of the whole family." The reattribution is helpful because it changes the focus of the behavior from being directed to another person to inside the speaker. Thus, the blame inherent in anger is now redefined as hurt and even sacrifice, which removes negative emotions, while retaining behavioral responsibility. The cognitive sets, or problem definitions, are the meanings that contribute to the emotional intensity that is often behind the anger, blaming, and negativity seen in the interpersonal interactions between family members. Focusing on meaning change often achieves the goal of negativity reduction.

During the second and third phases of therapy (behavior change, generalization), it can be useful to expand reframing by challenging the client/family to move toward a new solution attempt. For example, it is possible to reframe the anger and frustration of parents to the challenge of needing to manage one's own emotions so that parents can help teach their child new ways of negotiating alternative behaviors. In this way the reframe moves the focus of attention from the child (being irresponsible) to the parents (managing emotions and teaching), in a way that builds individual responsibility and leads toward behavior change.

Reframing can also link family members together and develop a joint family definition of the struggles experienced. A joint or family-focused definition of the "presenting problem" is essential in the early phases of FFT. It is only natural that all family members come to therapy with well-defined explanations for the problems they experience. These definitions may exist in emotional ("It hurts and I am angry"), behavioral ("I need to force you to think different") or cognitive terms ("Why does he (or she) intentionally do this?").

Note in Figure 13.5 that reframing does not end with a therapist intervention. Instead, the acknowledgment and reframing statements of the therapist are followed by an assessment of the "fit," by listening to the client response and incorporating changes or alternative ideas into the next validation and reframing statement by the therapist. In this way, reframing is a constant feedback loop between therapist and client interactions that builds toward the therapeutic goal. As a process, the therapist and the client are actually constructing a mutually agreed-upon and jointly acceptable alternative explanation for an emotional set of events or series of behaviors. Because it is jointly constructed, it is "real" and relevant to both client and therapist. Over time, the small individual "reframes" become thematic, involving many family members, a series of events, and a complex alternative explanation for the "problem." In this way, the reframing process helps organize and provide a therapeutic thread to the engagement and motivation phase. In fact, the constructed, family-focused problem definition helps organize therapy and becomes the major theme that explains the problems of the family and thus organizes behavior change efforts. Without this redefinition to include all family members, it is almost impossible to get everyone in the family involved in the behavior change phase.

Behavior Change Phase

The primary goal of the behavior change phase is to target and change specific risk behaviors of individuals and families by building specific protective skills within the family. Changing risk behaviors involves targeting the behavioral skills of family members in order to increase their ability to competently perform the myriad of tasks (e.g., communication, parenting, supervision, problem-solving, conflict management) that contribute to successful family functioning. Risk

factors are reduced as family members develop more protective behaviors for use in these common family tasks. This phase is not curriculum based (like many other approaches) but instead conducted in a manner in which the goals are accomplished from within the family by applying new skills to salient issues presented by the family. The behavior change phase has three primary goals: 1) changing individual and family risk patterns, 2) in a way that matches the unique relational functions of the family and, 3) in a way that is consistent with the obtainable change of this family, in this context, with these values.

The targets of a behavior change plan is the risk factors common in many families (see earlier discussion of risk and protective factors) in the population of at-risk adolescents. These targets frequently include changes in communication, problems solving, conflict management, and parenting. However, it is the manner in which these concrete behavioral skills are implemented with a family that makes the FFT work. Each of the relatively simple targets of change need be uniquely crafted to fit the relational functioning of the individual family in treatment. This might mean that in one family the implementation of communication change might take the form of close and connected negotiation of changes so that both parents feel connected and part of a collaborative relationship with one another. In another family, with a different relational profile, the same communication changes would look more disconnected and distanced, with information exchanged via notes instead of conversation. Therefore, the goal of our behavioral intervention is not to change the relational functions of behaviors but instead to change the manifestation of these functions. By focusing on the expression of functional outcomes, not on the outcomes themselves, FFT individualizes the changes of behavior to fit the existing relational functioning of the family. Making behavioral technologies "fit" the family relational system allows the family therapist to take the path of least resistance.

Generalization Phase

In the generalization phase the focus of attention turns from changing family behaviors to extending the application of these changes to other areas of family relationships. In this phase the primary attention is on the family's interface with the external world. Once again, the therapist accomplishes the phase goals by engaging in discussion of salient issues of the family rather than in predetermined curricular-based ways. There are *three primary goals* in this phase: *generalize* the changes made in the behavior change phase to other areas of the family relational system; *maintain* changes made in the generalization phase through focused and specific relapse prevention strategies; and *support* and extend the changes made by the family by incorporating relevant community resources into treatment. The desired outcomes of the generalization stage are to stabilize emotional and cognitive shifts made by the family in engagement and motivation and the specific behavior changes made to alter risk and enhance protective factors. This is done by having the family develop a sense of mastery around its ability to address future and different situations.

The Role of the Therapist: Creativity Within the Structure

The task facing a therapist working with youth with problem behavior is daunting. As the family tells "their story," the therapist must respond in a personal, yet therapeutic way, taking every opportunity to purposefully respond, meeting the phase-based relational goals of the model and moving therapy forward. For any intervention, including FFT, to be successful, it must be conducted in a relational way that is artful, personal, and at the same time systematic and model-focused. Paradoxically, it is as if the structured FFT model has to be implemented in a new way with each different and unique family.

If you were to watch from the outside, FFT is a conversation, an ongoing discussion in which clients describe their struggle and experience their related emotion, and that helps change their own situation. Thus, they present to the therapist their "problem definition"—the way they have come to understand, behave, and feel about the behavior(s) of other family members. This is particularly heightened and more emotional with

clients involved in the juvenile justice, mental health and/or child welfare systems. For the therapist, the assignment is to stay on task and maintain a personal level of involvement in the "in the room" process while at the same time retaining a clear view of the steps and direction of this particular change process. This is no small task given the difficultly in engaging simultaneously in thinking and planning and being respectfully present and systemically involved. It is the job of the therapist to turn this discussion into a mechanism for positive change. It is the creativity of the therapist that helps translate the presented concerns of the problem by the family in a specific and relevant way into the FFT change process. Creative therapists are ones that can take the immediate, unexpected, yet important relational events that happen between family members and respond in a way that is both client centered and purposefully focused on the relevant change process of the stage of treatment. To be creative, the FFT therapist must see the highly emotional, personal, and problematic discussion between family members as the very opportunities that, when dealt with in systematic and appropriate ways, make therapy more relevant and thus more engaging for clients so that therapy goes more quickly, is more relevant, and has better outcomes. Therein lies one of the paradoxes of good therapy—it balances clinical relevance with structure and flexibility, all at the same time.

Creativity in FFT takes more than clinical expertise alone. It is the structure of the model that provides a set of principles, a specific knowledge base to back up those principles, research-informed evidence on the validity and reliability of the method, client, therapist, and contextual variables to know/address/include for successful treatment to work in clinical settings. FFT is the structure within which the expert develops systematic and complex case conceptualizations by providing a reliable and clinically relevant way to understand clients, problems, and context. The FFT model is both the knowledge and the procedural structure that forms the scaffolding of a therapist's expert judgment. It is this scaffolding that forms the structure within which cases are conceptualized that form the foundation of how "in the room" decisions are made, and provide a road map of the steps to take to promote successful change process. The model provides a way to integrate case conceptualizations, core skills, and contingent, yet model-specific, clinical decisions. It organizes the vast array of information we each gain from our clinical experience into meaningful and usable principles that have clinical utility. It brings to the therapist the ability to know what their goal is, the most reliable and valid ways of accomplishing that goal, and a way to judge whether adaptation or variation need to occur.

The balance between structure and creativity is part of any complex activity. Playing music involves both music theory and the creative application of theory to the mood and context of the moment. Like the musician, the FFT expert is able to bring two unique, yet overlapping elements to the FFT model. First, they bring model adherence. The term "adherence" means to "stick to." In psychotherapy, this term is often called "model fidelity." In FFT, adherence means that the therapist conceptualizes cases within the knowledge domains of the model and its theoretical principles and can perform the procedural elements of the model. Second, they bring competence in delivering the model to family. The FFT expert applies the model in unique ways to the unique variations in the family. It requires the therapist to remain model adherent and at the same time adapt and apply the model in meaningful ways that are helpful for this family.

Implementing FFT in the "Real World": Practicing FFT in an Evidence-based Way

It seems increasingly clear that without model fidelity the demonstrated outcomes of evidenced-based approaches like FFT cannot be replicated in community settings without good implementation, model adherence, and clinical work that matches the client (Sexton & Turner, 2010). This may occur because treatment complexity and diversity of community settings requires adaptations of Evidence-Based Treatment (Bickman, 2010), and/or that the approaches are not implemented with sufficient fidelity or adapted to the individual needs of clients. Thus one of the most pressing questions is how to equip the community

agency and community-based therapist with the knowledge, tools, and skills necessary to form scaffolding to successfully implement FFT. Like other systematic programs, FFT has a training manual (Alexander et al., 2000; Sexton & Alexander, 2003) and a systematic implementation, and training programs includes training, ongoing case consultation, and supervised practice (Alexander et al., 2000).

Over the last decade a systematic measurement system of model fidelity and treatment adherence has been developed (FFT Clinical Measurement System: Sexton, 2010; Sexton & Fischer, in press). In fact, measurement has become a critical element in the successful community implementation of FFT and is discussed in more detail in the final section of this chapter. In real-life clinical settings, clinicians must make decisions adapting treatment to the needs of clients they serve. To do so, clinicians must be able to evaluate whether a client is improving, remaining stable, or deteriorating. To do so successfully, clinicians require sources other than clinical observation to understand the therapeutic process and progress of their clients. FFT is unique in that it also developed a model-specific measurement feedback system (FFT-Clinical Measurement Inventory; Sexton, 2010) that allows for reliable session-by-session measurement of symptoms, model impact, progress that is part of a web-based feedback tool that provides specific evidence from which to make clinical decision and session plans. The combination of case planning tools, proximally measure of session impact and progress, and longer-term measure of outcome allow for a way to practice FFT in an evidence-based way and accomplish what Strikler (2007) called becoming a local clinical scientist. The goal of all of the implementation tools is to help equip the therapist with all the necessary tools to be both model specific and client centered in their implementation and delivery of FFT. FFT treatment manuals and supervision process have been covered at length in other descriptions of FFT (Sexton, 2010).

FFT-Care4 is a FFT-specific Measurement Feedback System that integrates an existing battery of process, progress, and case planning measures (of youth symptoms, family functioning, session impact and progress). The FFT-Care4 is composed of two components: 1) clinically sensitive measures that are administered regularly throughout treatment to collect ongoing information concerning the process; and 2) progress of treatment and timely and clinically useful feedback about the progress and process of treatment to aid in clinical decision making. In actual practice assessment, treatment planning and individualization of treatment is difficult. The goal of the FFT-CFS is to *provide information that helps clinical decision making by*: prioritizing and therefore individualizing the process more quickly and effectively; giving youth and families a voice in treatment where they are safe to express it if necessary; using a multisystematic perspective to consider multiple points of view; and providing a way to monitor the therapeutic process and progress in real time. The FFT-Care4 allows the clinician to become a scientist in his or her own work, noticing trends, areas of strength, and areas of marginal outcomes and thus integration of two equally important aspects of psychotherapy: its art and its science. Figure 13.6 illustrates the core domains of FFT-Care 4.

Each week the family members complete short and relevant measures of youth symptoms, session impact, and progress, which in turn provides "feedback" to the clinicians through the secure web-based application. Clients can enter data on paper (and it can be transferred to the system) or directly into the system via tabled computer input. The clinician feedback system is based on a "quickly look" philosophy—clinicians can look at the graphic representation of client progress over time and compare it with other members of the family to determine how things are going and what to do next rather than read extensive reports and text. Feedback is presented through status indicators (where does the youth symptoms level, session progress, family functioning), clinical alerts (indicators of immediate need, e.g., runaway), and comprehensive feedback reports showing change in symptoms, impact of FFT, and progress over time by each family member. This comprehensive and real-time feedback becomes the basis of the next session plan.

The FFT Clinical Measurement Inventory (FFT-CMI) is the measurement core and is

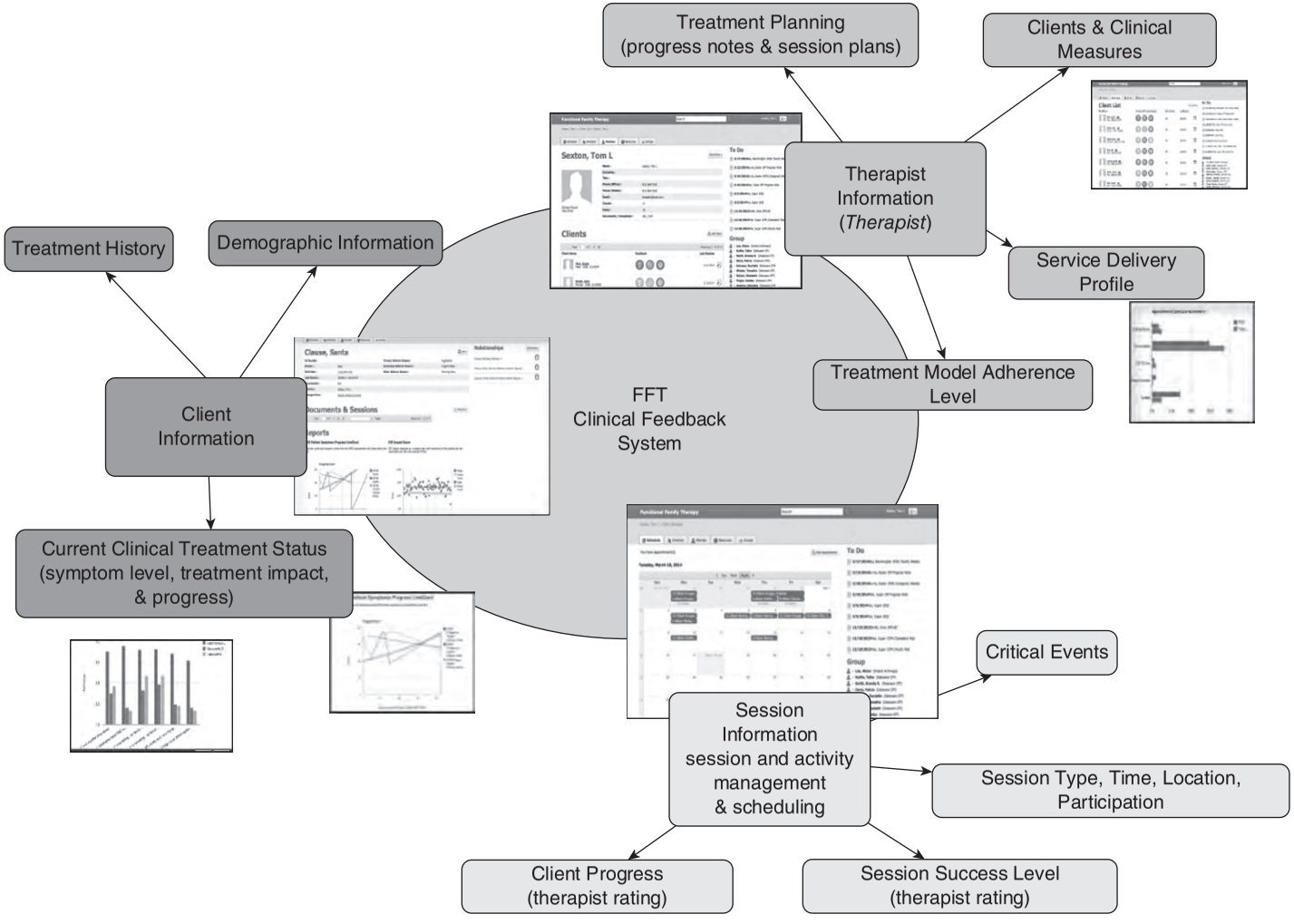

Figure 13.6 FFT Care4 (Sexton & Fischer, 2015)

built on the assumption that continuously measuring the major domains of clinical practice will improve the quality of FFT if it is done in a relevant way (Sexton, 2010). The FFT-CMI consists of brief and psychometrically sound measures to be completed by clients, therapists, and supervisors. These measures can be taken electronically or on paper (to be put in the system manually) and inform four central domains of clinical decision making: *Treatment Planning* (service delivery, case conceptualization, and session planning), Treatment *Progress and Process* (family relational factors, alliance, phase-specific progress, general improvement, and symptom level), *Model Fidelity* (therapist model fidelity from supervisor-client perspective), and *Client Outcomes* (family and symptom changes).

Sexton and Fisher (in press) have described the manner in which the real-time clinical feedback can be part of the ongoing clinical decision making of the therapist by providing information that leads to actionable model-specific adaptations in a way that incorporates an understanding of how cognitive processes influence responses to feedback.

Status feedback is where the client/family are in the present with regard to how they view progress, the impact of the treatment, and the symptom level of their youth. Status feedback is designed in a way that it can be interpreted and useful by merely glancing at the feedback report. This is intended to alert the clinician to areas that need immediate attention. Trends are a type of feedback that allows the clinician to view changes in symptoms, impact, and progress over time from the perspective of each family member. Comprehensive feedback details each measure, subscale, and question answer for detailed case planning. Over time that process continues, resulting in a focused and tailored approach to matching the treatment intervention with the specific client.

Conclusions

FFT is one of the few family-based treatment models that have successfully evolved from broad theory to specific treatment protocol in the field of family psychology over the last decade. A traditional family therapy model, FFT also is dynamic and, as a consequence, has grown and developed as new knowledge and information about therapy and change. Alexander and Sexton, (2003) suggested that this ability to assimilate and accommodate new findings and ideas while retaining the core principles and approach is the sign of a mature clinical model. As a result, FFT has evolved from a simple set of ideas about engaging youth in the early 1970s, to a systematic evidence-based model ready for community implementation in 2014. The core principles have been enhanced with the notions of risk and protective factors and adopted a dynamic and circular model of change through three phases. With the need to do large-scale implementation and the current findings regarding replication of EBT in community settings, attention turned to the development of tools to help improve model adherence and competence. These tools include a systematic measurement system (FFT-CMI) and a web-based quality improvement, measurement feedback system (FFT-Care4) to accompany the treatment manual (Alexander, 2000; Sexton & Alexander, 2003) and supervision protocol (Sexton, Alexander, & Gilman, 2004). Yet at the end of the day, FFT, like any good treatment model, is only as good as it is implemented and translated by the clinician to the client. Despite its strong evidence base and systemic model and approach, FFT still requests a creative therapist who can work within and around the structure to match the FFT clinical model to the unique client with whom they are working. It is the structure that provides the foundation for creative application of FFT.

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14.

MULTISYSTEMIC THERAPY[1]

Sonja K. Schoenwald, Scott W. Henggeler, and Melisa D. Rowland

Introduction

A decade ago, the editor of the current volume observed that theory and research in family therapy had matured from "universal theories of how families operate" (Lebow, 2005, p. xv) articulated within "schools" of family therapy to identification of family processes associated with specific clinical problems and core tenets and interventions to address those processes and problems. A parallel process is underway in psychotherapy effectiveness research, although it began at the opposite end of the universality–uniqueness continuum. Having focused for three decades on the development and testing of diagnosis-specific treatment protocols, psychotherapy research is increasingly designed to identify therapeutic techniques commonly used across distinct treatments for a particular disorder and across treatments for disorders evidencing overlap in some clinical features and etiological mechanisms (e.g., anxiety and depression). Emerging from these efforts are transdiagnostic, modular, and principle-based approaches to treatment. Each approach aims to embed specific empirically tested clinical procedures within a cogent case conceptualization process that allows for individualization of treatment (McHugh, Murray, & Barlow, 2009).

The shift in theory and research on family and individual therapies toward mapping the empirically supported middle ground between universal and diagnosis-specific treatments holds promise for extending the reach of effective treatment to the public (Rotheram-Borus, Swenden, & Chorpita, 2012). Multisystemic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009b) has long occupied this middle ground. This chapter describes the major theoretical and research-based constructs underlying standard MST, the development and evaluation of adaptations of MST for different target populations, and research supporting the effectiveness and mechanisms of action of standard MST and its adaptations. The quality assurance/quality improvement system used to support the community-based implementation of MST is described, as is research on quality assurance elements, strategies, and youth outcomes.

History and Background

MST was developed initially to address the clinical needs of juvenile offenders and their families (see, e.g., Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986). Development of the model began in the late 1970s, a time when government reviews concluded that programs to prevent or attenuate criminal offending were largely ineffective; public policies supported the incarceration of delinquent youth; and, outpatient mental health treatment was typically delivered once weekly in clinics or community mental health centers. In this policy and treatment context, Scott Henggeler began to translate the tenets of Bronfenbrenner's (1979) theory of social ecology into a family- and community-based treatment for delinquent youth. The treatment approach took into account empirical evidence then available regarding the correlates of delinquency, family systems theories and the clinical techniques used in pragmatic family therapies, and practical barriers faced by families seeking treatment (e.g., lack of transportation, work and school obligations that precluded attending daytime appointments at a clinic, need for childcare, and, in some cases, want for basic necessities such as running water and electricity).

The first volume describing MST was published in 1990 (Henggeler & Borduin, 1990) and presented a unified, if not universal, approach to treating different types of clinical problems via extensive case examples. Prior to its publication, quasi-experimental and experimental studies with samples of youths and families treated by doctoral students supervised by the authors had produced results favoring MST (Brunk, Henggeler, & Whelan, 1987; Henggeler et al., 1986). Early studies also evaluated postulates of family systems theories such as the role of cross-generational coalitions in symptom maintenance and of strong parental dyads in symptom improvement (Mann, Borduin, Henggeler, & Blaske, 1990). Specification followed of nine treatment principles and of the implementation of MST for youth with serious antisocial behavior (Henggeler et al., 2009b).

The publication in the 1990s of favorable results of three community-based effectiveness trials with chronic and/or violent juvenile offenders resulted in the identification of MST as an effective community-based alternative to incarceration for such youth and their families. Service system and provider organization demand for MST catalyzed the transport and evaluation of the implementation and outcomes of MST nationally and internationally. Within the last decade, specification and testing has progressed of MST adaptations for other challenging populations.

Social Ecological Theory

The fundamental tenet of the social ecological framework for human behavior articulated by Urie Bronfenbrenner (1979) is that individuals are embedded in multiple systems that have direct and indirect influences on behavior and one another. In addition, as emphasized by Bell (1968), these influences are reciprocal in nature: the parent influences child, and the child influences parent. This reciprocity of influence is evident among subsystems within the family (marital interaction affects parent–child interaction and vice versa) and in other systems in the youth's social ecology (teacher–classroom interactions influence, and are influenced by, student problem behavior).

Pragmatic Therapies for Families

The development of MST was also informed by the work of strategic (Haley, 1976) and structural (Minuchin, 1974) family therapy theorists. Several aspects of MST are based on commonalities of these approaches. The models (a) are problem-focused and change-oriented, (b) recognize the principle of equifinality (i.e., different paths can lead to the same outcomes), (c) assume that the therapist should take an active role in treatment, (d) develop interventions within the context of the presenting problem, and (e) view changing interpersonal transactions as essential to long-term behavior change. Also influential in the development of MST was social learning theory and its application to research on the etiology and treatment, via parent-mediated intervention, of aggressive behavior in children (see, e.g., Chamberlain, 2003).

The integration of core tenets of distinct theories of human behavior (social ecological, family systems, and social learning) that characterized the development of MST has become

more common in the field of family therapy. As noted by Lebow, there is "a far better grasp of patterns of learning and social exchange that occur in families, and how they impact on family process. Classical conditioning, operant conditioning, modeling, covert processes of learning, and psychological principles of exchange have all clearly emerged as central processes shaping the lives of family members" (Lebow, 2005, p. 3).

Research Supporting Social Ecological Risk Factors for Delinquency

The results of correlational and prospective studies conducted by sociologists, criminologists, and developmental psychologists in the 1970s and 1980s laid early empirical groundwork supporting a social ecological approach to the treatment of delinquency. These studies illuminated the role of deviant peers in predicting delinquent behavior, and the interplay of distinct family, school, and neighborhood factors in predicting youth association with deviant peers and delinquent behavior (Henggeler, 1989). Findings from large-scale, longitudinal studies published subsequently (see, e.g., Elliott, 1998; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Thornberry & Krohn, 2003) continue to show delinquency is predicted by a combination of risk factors within and between the key systems in which children are embedded: family (monitoring and supervision, discipline strategies, consistency of parenting, parental support, affective relations, conflict), peer (association with deviant peers), school (poor performance, poor family–school linkage), and neighborhood (transience, high crime). Differences in some risk factors for different populations (e.g., males vs. females, Whites vs. African Americans, early vs. late adolescence) have emerged; yet, the consistency is remarkable of the interplay of these factors in predicting serious antisocial behavior in youth (Biglan, Brennan, Foster, & Holder; 2004; Hoge, Guerra, & Boxer, 2008).

Research-Based Treatment Protocol

Specification Via Principles

Because MST focuses on the interaction of a comprehensive array of risk factors in the social ecology and is individualized to each youth and family, it is not conducive to specification in step-by-step or session-by-session format. Following the example Dr. Fred Piercy (1986) set of using principles to describe brief family therapy for research, nine MST principles were developed to balance specification of key aspects of the model with responsiveness to the needs and strengths of each youth and family. The principles, below, inform case conceptualization and the development and implementation of intervention strategies.

- Principle 1: The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context.
- Principle 2: Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
- Principle 3: Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
- Principle 4: Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
- Principle 5: Interventions should target sequences of behavior within and between multiple systems that maintain the identified problems.
- Principle 6: Interventions should be developmentally appropriate and fit the developmental needs of the youth.
- Principle 7: Interventions should be designed to require daily or weekly effort by family members.
- Principle 8: Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
- Principle 9: Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering care givers to address family members' needs across multiple systemic contexts.

The MST principles establish the social ecology of the youth and family as the target of assessment

and intervention. The principles embody the specificity of problem definition and present-focused, action-oriented emphases of behavioral and cognitive-behavioral treatment techniques, as well as the necessity to comprehend and address interaction patterns involving multiple individuals emphasized in pragmatic family therapies. They reflect the imperatives of client–clinician collaboration and generalization of treatment in the activities of everyday living emphasized in the values of consumer empowerment and recovery. Using the MST principles, therapists select and integrate interventions in ways hypothesized to maximize their synergistic interaction and impact in the social ecology of a particular youth and family. MST thus differs from "combined" treatments (Kazdin, 1996) that deploy two or more intervention protocols simultaneously or sequentially.

Analytic Process (aka Do Loop)

In addition to the MST principles, a scientific method of hypothesis testing referred to as the MST Analytic Process (aka "Do Loop," Figure 14.1) is used to guide therapists through the interrelated steps of case conceptualization, planning, implementing, and evaluating the impact of interventions. Note the background of the figure is highlighted to indicate alignment of treatment goals among treatment participants and stakeholders and sustained engagement in the ongoing assessment and treatment process. Within this context of alignment and engagement are interrelated steps that connect the ongoing assessment of the "fit" of referral problems (e.g., criminal activity, fighting with peers, chronic truancy) with the development, implementation, and evaluation of interventions. The Do Loop provides the structure for the case summary form therapists complete weekly, prior to group supervision.

The steps identified with labels on the Do Loop figure are briefly elaborated below, beginning at the top of the figure and moving clockwise around the loop. Throughout the process, therapists obtain information via observation, interaction, interview, and official records where applicable (e.g., school attendance records, probation violations).

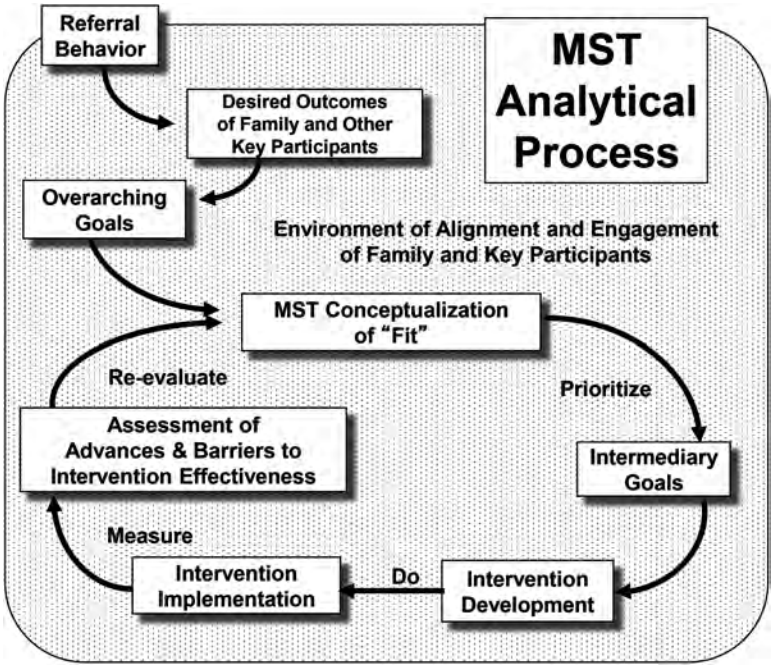

Figure 14.1 MST Analytic Process (aka Do Loop)

- Initially, the therapist gathers the desired treatment outcomes of each family member and stakeholder, and then helps the participants develop consensus on the overarching goals of treatment and how these can be measured in tangible ways.
- Next, the therapist assesses the family and other systems to develop an understanding or "fit" of the referral behaviors and how these behaviors make sense in the context of the systems (i.e., home, school, peer, community) in which the youth and family live.
- Then, family members and clinical team prioritize the hypothesized drivers of the clinical problems and develop interventions targeting these drivers.
- These interventions are subsequently implemented, their implementation is monitored, and barriers to their implementation as intended are identified.
- Finally, the therapist gathers multiple perspectives on the effectiveness of the intervention. If the information gathered suggests the intervention was not successful, the therapist and team start back at the top of the Do Loop and work with the family and other participants to re-conceptualize the "fit" of the behavior and generate new hypotheses about potential drivers of the problem and subsequently new interventions.

This reiterative process reinforces among MST team members that treatment failures provide learning opportunities that can be used to "fail forward" (Henggeler et al., 2009b); and, that there is hope for the family and team as long as the latter takes responsibility for understanding and addressing the failures. For example, a therapist may have truncated a couple's practice implementing consequences in the face of their teenage son's protests prior to their attempting the implementation because the couple's verbal conflict escalated. The therapist's supervisor, in turn, may not have ensured the therapist was adequately skilled in techniques to predict and resolve such conflict. Thus, the MST treatment process is self-reflexive for therapists, supervisors, and MST consultants, who continuously consider how their own behaviors contribute to intervention success and failure.

Service Delivery Model

MST interventions are delivered where problems and their solutions are found: at home, at school, and in the neighborhood and community. MST uses a short-term (three to five months) intensive home- and community-based model of service delivery to implement within the social ecology comprehensive treatment that specifically targets factors in that ecology (family, peers, school, neighborhood, and community). Therapists are available to families at home and in the community twenty-four hours a day, seven days a week, and routinely have sixty or more hours of face-to-face contact with family members. The frequency and duration of treatment contacts varies throughout treatment in accordance with the circumstances, progress, needs, and strengths of each family. Early in treatment, a therapist may arrive at the family's apartment at 6:30 am to support a grandmother's effort to wake her grandson and get him to school, meet with a teacher for ten minutes at the end of the school day, and return to the home for a family session in the evening after the mother has returned from work.

Therapists are organized into teams of three to four therapists and an MST supervisor who may also carry a partial caseload. The team configuration is designed to enhance the case conceptualization, intervention, and problem-solving capacities of each team member; ensure therapists have sufficient familiarity with the families for cross coverage; engender practical and emotional support; and reinforce accountability for outcomes. Therapists and supervisors typically have a master's degree in social work, counseling, marriage and family counseling, or psychology.

MST Adaptations

The documented effectiveness and larger-scale implementation of MST for juvenile offenders generated interest among researchers and service systems in using standard MST as a platform for the development of adaptations to treat other serious problems. MST adaptations have been specified and tested for youth whose psychiatric problems place them at high risk

for hospitalization (MST-Psychiatric; Henggeler, Schoenwald, Rowland, & Cunningham, 2002); families in which physical abuse and neglect has occurred (MST-Child Abuse and Neglect; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010); and for youth with chronic health conditions such as type 1 diabetes, asthma, and obesity (MST Healthcare; Ellis et al. 2004; Ellis et al. 2005; Ellis et al. 2012). In addition, a formal adaptation has been developed for juvenile sex offending, which had been treated with standard MST in an early efficacy trial (Borduin, Henggeler, Blaske, & Stein, 1990); and for substance abuse and dependence in delinquent youth, also originally treated with standard MST (Henggeler, Pickrel, & Brondino, 1999a).

The logic underlying the development and testing of MST adaptations can be characterized as follows. First, evidence is lacking for clinically effective and cost-effective treatment of a target problem with grave consequences to the health and safety of the youth and family (placement, incarceration, hospitalization). Second, evidence exists of overlap in predictors of the target problem and problems for which standard MST has proven effective (e.g., adolescent substance abuse, or adolescent sex offending, and delinquency). Third, evidence exists for some distinctive risk factors. For example, research indicates youths experiencing psychiatric crises can be expected to differ from those referred primarily for delinquency with respect to: prevalence of bipolar affective disorder, thought disorder, serious depression, anxiety, and other internalizing problems; number of females and younger children; and prevalence of psychiatric disorders among parents and relatives (Henggeler et al., 2002). Fourth, if risk factors for a target problem and youth previously treated with MST are largely distinctive, then there is evidence of overlap across the populations in the predictors of deleterious outcomes. For example, risk factors are not shared for the development in youth of type 1 diabetes and serious antisocial behavior; however, poorly controlled type 1 diabetes and the health crises it precipitates do share several social ecological risk factors with delinquency (Ellis et al., 2005).

Guidelines for the adaptation process include specification of additional clinical protocols, additions to training and quality assurance, and the conduct of validation research (http://mstservices.com/MSTadaptations.pdf). The clinical, training, and administrative changes embodied in these adaptations can be conceptualized in terms of a continuum of the extensiveness of change. For example, programs primarily targeting substance-abusing or dependent juvenile offenders might implement the adaptation known as MST Substance Abuse (MST-SA), which incorporates Contingency Management techniques including routine drug testing and requires additional training but no personnel changes. MST-Psychiatric and MST-CAN require additional training and integrate additional personnel—a part-time psychiatrist and crisis caseworkers.

The development and testing of MST adaptations has yielded some synergies and efficiencies. As examples, the safety planning process specified in the first randomized trial testing MST-Psychiatric were incorporated into MST-CAN and MST for juvenile sex offenders; and the process of clarification and ownership of responsibility for instances of child abuse specified for MST-CAN is applied for instances of juvenile sex offending.

Research Evidence Supporting MST Effectiveness

Over the past thirty-five years, MST outcome research has transitioned from small efficacy trials conducted in university settings with graduate students as therapists to large-scale multisite effectiveness studies conducted with community-based provider organizations and therapists. Many of these studies were conducted independent of the MST developers. Altogether, findings from twenty-four controlled evaluations (i.e., twenty-two randomized clinical trials [RCT] and two quasi-experimental studies) have been published, and several other rigorous evaluations are currently in progress. Relatively extensive descriptions of the methodologies and findings of these studies were provided in Henggeler (2011) and Henggeler and Sheidow (2012), and a complete listing of MST outcome research is available at http://mstservices.com/outcomestudies.pdf. For present purposes, this body of MST outcome

research through 2012 is summarized here with an emphasis on the conceptual aims and primary outcomes targeted in a particular study (e.g., reductions in re-arrest and incarceration in studies with serious juvenile offenders, reductions in mental health symptoms and psychiatric hospitalization in studies of youth with serious emotional disturbance).

Juvenile Offenders

With fourteen RCTs (six of which were independent) and one quasi-experimental study published, the model has been validated most extensively with this population. Table 14.1 summarizes the reductions in recidivism and out-of-home placements for all MST studies with juvenile offenders that examined either of these variables as well as for two studies that focused on youth with serious emotional disturbance and one that focused on youth with type 1 diabetes. Across all studies, the median reduction in rearrest was 39%, and the median reduction in out-of-home placements was 53%. When only studies with juvenile offenders are considered, the median reductions in recidivism and out-of-home placement were virtually the same.

Serious Juvenile Offenders

In a community-based effectiveness study with serious juvenile offenders at imminent risk of incarceration, Henggeler et al. (1992) showed that MST improved family relations and peer interactions, both of which are mediating variables for MST, while decreasing recidivism and incarceration for this challenging population. These findings were replicated in a subsequent efficacy study conducted by Borduin et al. (1995) and extended in a 21.9-year follow-up (Sawyer & Borduin, 2011), which showed that former MST participants, now in their mid-thirties, had 36% fewer felony arrests and 33% fewer days in adult confinement than did counterparts who had received individual therapy. The third study was a two-site, community-based trial that examined the effects of eliminating a key component (i.e., weekly consultation from an MST expert) of the MST quality improvement system (Henggeler et al., 1997). Although favorable reductions in

Table 14.1 MST effects on recidivism and out-of-home placement

Study	*Reduction in Recidivism*	*Reduction in Placements*
Borduin et al. (1990)	72%	not assessed
Henggeler, Melton, & Smith (1992)	43%	64%
Borduin et al. (1995)	63%	57%
Henggeler, Melton, Brondino, Scherer, & Hanley (1997)	26%	53%
Henggeler, Pickrel, & Brondino (1999a)	19%	50%
Henggeler et al. (1999b)	not assessed	49%
Ogden & Halliday-Boykins (2004)	no juvenile justice system	78%
Rowland et al. (2005)	34%	68%
Timmons-Mitchell, Bender, Kishna, & Mitchell (2006)	37%	not assessed
Stamburgh et al. (2007)	not assessed	54%
Ellis, Naar-King et al. (2008)	not appropriate	47%
Sundell et al. (2008)	0%	0%
Letourneau et al. (2009)	not assessed	59%
Borduin et al. (2009)	50%	80%
Glisson et al. (2010)	not assessed	53%
Butler, Baruch, Hickley, & Fonagy (2011)	41%	41%

incarceration were observed, MST effects on re-arrest were dampened. Additional analyses showed that youth recidivism was more likely when therapist adherence to the MST intervention protocols was low.

The findings from these MST studies with serious juvenile offenders informed subsequent research aimed at testing the boundaries of MST effectiveness through independent replication, multisite community-based evaluations, and further consideration of the role of therapist fidelity in achieving favorable outcomes. In a four-site RCT conducted in Norway, Ogden and colleagues (Ogden & Hagen, 2006; Ogden & Halliday-Boykins, 2004) demonstrated MST effects on youth mental health symptoms as well as decreased out-of-home placements through a twenty-four-month follow-up. Timmons-Mitchell et al. (2006) found MST decreased re-arrests and improved the functioning of juvenile felons. Similarly favorable MST outcomes from RCTs with juvenile offenders have been reported in England (Butler et al., 2011) and the Netherlands (Dekovic, Asscher, Manders, Prins, & van der Laan, 2012). In a multisite study conducted in Appalachia, Glisson et al. (2010) reported favorable MST outcomes for problem behavior and out-of-home placement. In Sweden, a study conducted by Sundell et al. (2008) represents the only substantive exception to the generally favorable findings of the MST RCTs. In a context of low treatment fidelity, no favorable outcomes were achieved. Together, this body of outcome research provides relatively strong support for the effectiveness of MST with juvenile offenders and their families as long as the fidelity of treatment implementation is strong.

Juvenile Offenders with Substance Use Disorders

Two RCTs have focused on the use of standard MST with substance abusing or dependent delinquents. In the first (Henggeler et al., 1999a), MST was effective at decreasing youth substance use and out-of-home placements. A four-year follow-up to this study showed that MST decreased violent crime and increased marijuana abstinence (Henggeler, Clingempeel, Brondino, & Pickrel, 2002). The second study (Henggeler et al., 2006b) showed MST enhanced substance use outcomes for youth in juvenile drug court.

Juvenile Sex Offenders

The effectiveness of standard MST with juvenile sex offenders has been supported in two RCTs. A small efficacy study with a three-year follow-up (Borduin et al., 1990) demonstrated the potential of MST to greatly reduce reoffending, and these results have been replicated in a larger efficacy study. Borduin et al. (2009) found large decreases in recidivism and incarceration across a nine-year follow-up as well as a broad array of other favorable outcomes (e.g., improved family relations, peer relations, and school performance; decreased youth mental health symptoms). A third effectiveness trial in which adaptations to standard MST were more formally incorporated (Letourneau et al., 2009) demonstrated decreased sexual behavior problems, delinquency, substance use, externalizing symptoms, and out-of-home placements for juvenile sex offenders in the MST condition when compared with counterparts receiving usual sex offender-specific treatment.

Research Supporting the Effectiveness of Clinical Adaptations of MST

Youth with Serious Emotional Disturbance

MST-Psychiatric was first tested in an RCT as an alternative to the psychiatric hospitalization of youth presenting mental health emergencies (i.e., suicidal, homicidal, psychotic). It was more effective than inpatient care in improving family relations and decreasing youth symptoms (Henggeler et al., 1999b) and out-of-home placements (Schoenwald, Ward, Henggeler, & Rowland, 2000) at post-treatment, although favorable effects generally dissipated at sixteen-month follow-up (Henggeler et al., 2003). Positive outcomes (e.g., reduced symptoms and out-of-home placements) have also been observed in a community-based RCT (Rowland

et al., 2005) and independent quasi-experimental trial (Stambaugh et al., 2007).

Youth with Chronic Health Conditions

Ellis and Naar-King have led efforts to adapt MST (i.e., MST-Health Care) for youths with chronic health care challenges and their families. These independent investigators have completed three RCTs of MST-Health Care for youth with chronically poorly controlled type 1 diabetes (Ellis et al., 2004; Ellis et al., 2005; Ellis et al., 2012). Across studies, findings showed that MST-Health Care improved diabetes treatment adherence and metabolic control, and decreased hospital admissions. In an RCT with adolescents with primary obesity, Naar-King et al. (2009) found that MST-Health Care produced decreased percent overweight, body fat, and body mass index.

Maltreating Families

The first MST RCT was an efficacy trial conducted with maltreating families (Brunk et al., 1987), and results were promising in that parent–child interactions were improved. The subsequently formalized adaptation of MST for treating child abuse and neglect, MST-CAN, was tested in an effectiveness trial. Results showed decreased symptoms for youth and caregiver, improved parenting behaviors, increased social support, and decreased out-of-home placements (Swenson et al., 2010).

Mediation Studies

Consistent with the MST theory of change (Henggeler et al., 2009b), mediation and qualitative studies have demonstrated the importance of improving family relations as the mechanism to reduce youth antisocial behavior. Huey, Henggeler, Brondino, and Pickrel (2000) found that high therapist treatment fidelity improved family relations and decreased association with deviant peers, which reduced subsequent delinquent behavior. Findings from Henggeler et al. (2009a) and Dekovic et al. (2012) also supported the pivotal role that improved family relations play in decreasing youth antisocial behavior. Qualitative research (Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012) has highlighted the importance of enhanced parenting skills and improved family relations in obtaining favorable outcomes for MST.

Community Implementation and Evaluation

Developing and executing interventions that work across, within and between the systems in the social ecology can be challenging even for highly skilled therapists, particularly when the stakes of treatment failure are high (i.e., incarceration, hospitalization). The workforce implementing MST nationally and internationally is characterized by diverse educational, professional, cultural, local, and personal experiences. In addition, the organizations and service systems in which MST programs operate can influence the implementation and outcomes of treatment. These organizations operate a variety of service programs, only one of which is MST.

The MST Quality Assurance/Quality Improvement (QA/QI) System

The MST quality assurance and improvement (QA/QI) system, depicted in Figure 14.2, is designed to support the sustainable implementation with fidelity of MST at multiple levels of the practice context. The development and refinement of this system was informed by procedures used to support therapist implementation of MST in randomized effectiveness trials; then-available theory and research on the diffusion of innovation and technology transfer in behavioral health; and early experiences attempting the transport of MST. The three major components of the MST QA/QI system are: (1) clinician training and ongoing support; (2) organizational support; and (3) implementation measurement and reporting. Each component is composed of several elements that are described in the next section. The QA/QI system is deployed through MST Services, LLC (MST Services), and by Network Partners. Network Partners are organizations that have developed the capability to implement and transport all aspects of MST. These

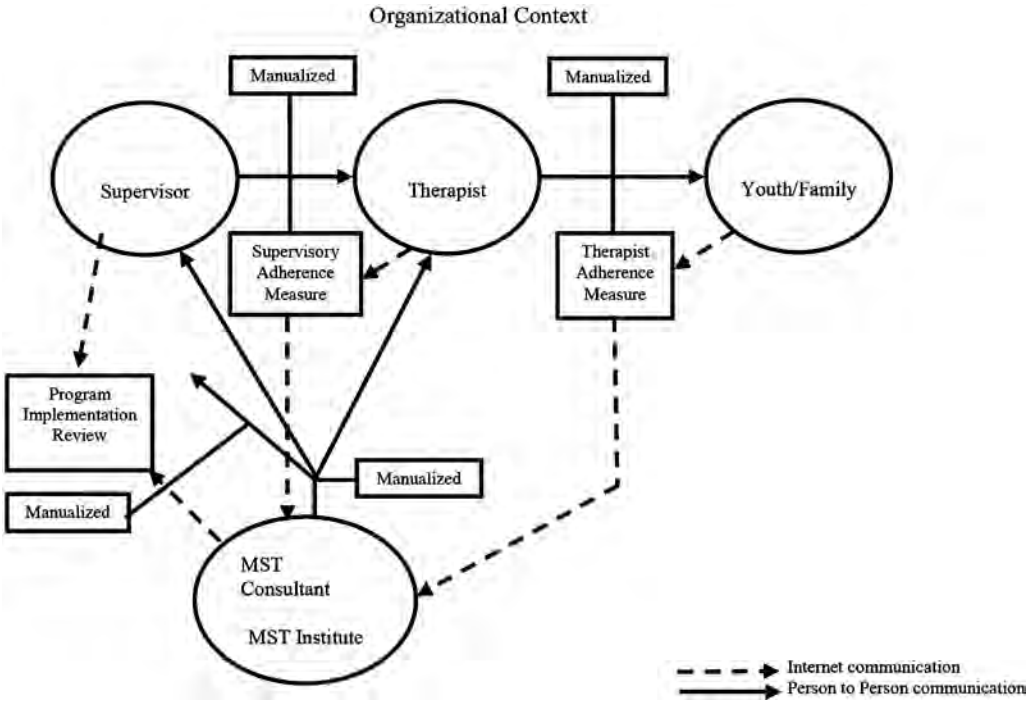

Figure 14.2 MST Quality Assurance/Quality Improvement System

organizations currently provide implementation support to the majority of MST teams nationally and internationally.

Clinical training and support. Training and support for MST teams includes the following: (1) initial five-day orientation training; (2) quarterly booster training; (3) weekly on-site supervision, and (4) weekly consultation with an MST expert (originally, the MST model developers and researchers).

Initial five-day orientation training. MST therapists, on-site supervisors, and other clinicians within the organization likely to participate in some aspect of treatment for youth receiving MST (e.g., a staff psychiatrist who might evaluate and prescribe medication for a youth or caregiver) participate in five days of initial orientation training. The first morning brings together the new MST team, interested members in the management and leadership of the organization hosting the MST program, and key community stakeholders. The remainder of the week focuses on the therapists and MST supervisor. The trainers are MST consultants, one of whom will provide ongoing training and consultation to the team. They use didactic approaches to lay out the rationale for MST assessment and intervention strategies and experiential approaches to enable participants to observe and practice using the strategies in role-play situations.

Quarterly booster training. As therapists gain field experience with MST, the expert consultant working with the team conducts quarterly 1.5-day booster training sessions on site. The booster sessions are designed to enhance the knowledge and skills of team members to more effectively address clinical challenges they face over time (e.g., marital interventions, treatment of caregiver depression). The consultant and team use audio or video review and enactment (via role play) of particularly difficult cases to identify and problem-solve barriers to progress and practice implementing needed intervention strategies. Between boosters, the MST supervisor and consultant monitor therapist implementation

of the skills and strategies emphasized during the booster and identify and address barriers to such implementation (e.g., booster provided too few practice opportunities, use of strategies was poorly monitored).

Weekly clinical supervision. The main objective of MST supervision is to help therapists use the clinical skills—conceptual and behavioral—needed to effectively implement MST in the field with each and every youth and family served. The MST team and supervisor meet as a group weekly. The supervisor follows the Do Loop in reviewing and addressing the issues in each case with the team. Additional group or individual supervision meetings can be convened to address a case crisis, when the need for field supervision emerges (i.e., supervisor accompanies the therapist), and to address the professional developmental needs of a therapist. MST supervisors, like MST clinicians, are available twenty-four hours a day, seven days a week, and many MST supervisors are recruited from the ranks of effective MST therapists. Supervisors of one team may also carry a reduced caseload of families, whereas supervisors of two teams typically do not. Training and support of MST supervisors occurs via several venues, which include: review of the MST supervisory manual (Henggeler & Schoenwald, 1998); initial supervisor orientation training prior to or during the initial five-day orientation training; and, periodic conjoint review of supervisor work samples, including at least one audio tape of group supervision monthly. Booster sessions for MST supervisors are tailored to the opportunities and challenges awaiting supervisors with different levels of MST experience.

Expert consultation. The role of the MST expert consultant is to facilitate, within each MST team, the rapid development of the knowledge, skills, and competencies therapists and supervisors need to effectively implement MST with the diverse array of families they serve; and of the skills and processes needed to anticipate, identify, and address clinical, team-level, organizational, and systemic barriers to effective clinical implementation. The consultant provides the initial orientation training, weekly telephone consultation, and quarterly booster training to MST therapists and supervisors and supervisor orientation training and support to MST supervisors. The MST consultation manual (Schoenwald, 1998a) outlines the knowledge base and skills individuals need to effectively execute their responsibilities. The majority of MST experts are individuals who were successful MST supervisors in communities that sustained successful MST programs. Initial training for consultants is codified in an on-the-job training manual, and seasoned consultants serve as coaches in the training process.

Organizational Support

A multistep, multistakeholder program development process is undertaken prior to the establishment of an MST program in any community. The MST purveyor convenes representatives of the service systems (including referral and funding sources) and provider organization that will operate the program assess together the appropriateness, feasibility, and sustainability of MST to treat a specific target population in the context of a specific community and service system. Upon completion of this process, a Goals and Guidelines document for the new MST program is completed, staff hiring is accomplished, and initial MST training begins.

Ongoing support at the organizational level comes in the form of an organizational manual, semi-annual Program Implementation Review (PIR), and consultation with the MST expert on organizational issues affecting clinical implementation. The PIR enables the MST team, provider organization, MST purveyor, and stakeholders to jointly examine the team's performance on program indicators derived from the Goals and Guidelines document. Additionally, MST program directors participate in conference calls and webinars to share experiences and expertise with one another. Typical foci of discussion include organizational, operational, and service system developments affecting program sustainability; expansion requested by service systems; and the interface of the MST program with other evidence-based treatments implemented by the same organization or other organizations in the service system.

Implementation Monitoring, Measurement, and Reporting

Adherence to MST treatment principles and processes is assessed at the therapist, supervisor, and expert consultant level using instruments supported by evidence of reliability and validity obtained in randomized trials and multisite studies on the implementation of MST in diverse communities. Caregiver ratings of therapist adherence to the Therapist Adherence Measure-Revised (TAM-R; Henggeler, Borduin, Schoenwald, Huey, & Chapman, 2006) are obtained monthly. Therapist ratings of supervisor adherence are obtained every other month using the Supervisor Adherence Measure (SAM; Schoenwald, Henggeler, & Edwards, 1998), as are therapist and supervisor ratings of consultant adherence on the Consultant Adherence Measure (CAM; Schoenwald, 1998b). A web-based platform available via the MST Institute (www.mstinstitute.org) supports the collection, scoring, reporting, and interpretation of these adherence ratings, and of therapist-reported youth outcomes. The scores are reviewed by the MST team and consultant at least quarterly and are elements of the semi-annual program review. Details of the development, contents, and psychometric evaluations of the therapist, supervisor, and consultant adherence measurement instruments have been published in peer-reviewed journals and summarized in several chapters.

Empirical Evaluation of Community-Based Implementation

In addition to the research represented in Table 14.1, independent evaluations of the implementation and outcomes of MST have been conducted by state and local governments and independent evaluators, using a range of designs including randomized trials, quasi experimental studies, benchmarking studies, and single group, pre-post and follow-up studies. Too numerous to review here, the results of these investigations are summarized elsewhere (Henggeler, 2011). With a few exceptions (an unpublished Canadian study evidencing site effects and its contribution to an early meta-analysis) results have been favorable.

Adherence and outcomes in community practice. Findings from randomized trials supporting linkages between therapist adherence and youth outcomes were replicated in a forty-five-site study of the transportability and implementation of MST that involved 1979 youth and families treated by 429 therapists. Moreover, findings from this study showed relations among adherence at each level of the practice context—therapist, supervisor, and expert consultant—and youth outcomes. Specifically, caregiver ratings of therapist adherence predicted youth behavior problem reduction through a one-year post-treatment follow-up; and criminal charges through four years post-treatment (Schoenwald, Carter, Chapman, & Sheidow, 2008; Schoenwald, Chapman, Carter, & Sheidow, 2009). Supervisor focus during group supervision on adherence to treatment principles predicted greater therapist adherence; and supervisor adherence to the structure and process of supervision predicted changes in youth behavior problems through one-year post treatment (Schoenwald, Sheidow, & Chapman, 2009). With respect to expert consultation, linkages were found among the competence of consultants, their focus on MST procedures, therapist adherence, and reductions in youth behavior problems (Schoenwald, Sheidow, & Letourneau, 2004).

Conclusion

The clinical and scientific journey of MST has encompassed and contributed to several substantive transitions in the field of mental health services for youth. On a clinical level, these include an emphasis on family empowerment, ecological validity of interventions, and the use of structured decision-making and outcome-monitoring procedures to guide treatment. MST was one of the first evidence-based treatments to build and evaluate mechanisms to transport and implement with fidelity treatment in distal organizational and community contexts. Scientifically, MST effectiveness has been examined in numerous state-of-the-art clinical trials and findings from meditational research support the MST theory of change

and groundbreaking implementation research has examined linkages among key components of the MST quality assurance process. With only 5% of serious juvenile offenders receiving an evidence-based treatment in the US (Henggeler & Schoenwald, 2011), however, our next challenge, and one facing the broader field of evidence-based practices, is to develop and evaluate proactive strategies for expanding the reach of effective services.

Note

1. Multisystemic Therapy is a registered trademark of MST Group, LLC

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15.

BRIEF STRATEGIC FAMILY THERAPY TREATMENT FOR BEHAVIOR PROBLEM YOUTH

Theory, Intervention, Research, and Implementation[1]

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In this chapter, we review the nearly forty-year history of the Brief Strategic Family Therapy (BSFT) approach to treating adolescent problem behaviors. This research program has occurred in many phases, and we have organized the chapter to reflect the development of the BSFT approach. The chapter is organized into two major sections. Part I focuses on "The Brief Strategic Family Therapy Approach" and includes a) History and Background of the BSFT Approach, b) Key Concepts Underlying the BSFT Approach, c) BSFT Treatment Protocol, d) BSFT Research, and e) BSFT Therapist Behaviors, Therapy Processes, and their Relationship to Outcomes. Part II focuses on the BSFT Implementation and includes a) What is BSFT Implementation and Why is it Needed?, and b) the Nuts and Bolts of BSFT Implementation.

The Brief Strategic Family Therapy Approach

History and Background of the BSFT Approach

Brief Strategic Family Therapy (BSFT) was developed in the mid 1970s as a response to the increased number of Cuban immigrant adolescents in Miami who were involved with drugs. This problem was particularly alarming because Cuban immigrant youth were not utilizing existing drug treatment services. To address this problem, the Spanish Family Guidance Center (later known as the Center for Family Studies) was established at the University of Miami. The first goal of this program of clinical research was to identify or develop a culturally appropriate treatment intervention for drug using/behavior problem Cuban youths. Our early formative research (Szapocznik, Scopetta, & King, 1978b; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978a) indicated that Cuban families in Miami, for whom the BSFT approach was initially developed, tended to value hierarchy and family connectedness over individual autonomy, and tended to focus on the present rather than on the past. Indeed, family connectedness represents an integral value within most Hispanic cultural streams (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987). As a result, we sought to develop a treatment model that would align with the importance of family connection and hierarchy. The present orientation required that we quickly address the family's presenting concerns and develop a treatment that worked primarily in the present and created a sense of immediacy.

The BSFT intervention was formulated as an integrative model that combined structural and strategic family therapy concepts and techniques to address systemic/relational (primarily family) repetitive patterns of interactions that are associated with the adolescent's presenting problem behaviors. The structural component of the BSFT treatment draws on Minuchin's (1974; Minuchin & Fishman, 1981) structural family therapy. This therapy model, in which hierarchy plays an important role, has provided the foundation for the Center's clinical developments and innovations (Szapocznik et al., 1978b; Szapocznik & Williams, 2000).

The need to focus on the present in treatment led us to modify the model to include treatment methods that are both strategic (i.e., problem focused and pragmatic, limited number of sessions) as well as structural. The strategic aspect of the BSFT approach was influenced by Haley (1976) and Madanes (1981). The integration of structural and strategic family therapy approaches led us to develop a problem-focused, planful, and practical model—focusing primarily on those family patterns of interactions linked to the adolescent's problem behaviors (e.g., delinquency, drug use, risky sexual behaviors). Other family issues, such as problems between the parent figures, are typically not addressed in our brief therapy unless they are directly related to the adolescent's problems. Through a series of clinical research studies, the structural and strategic approaches were blended and refined to meet the needs of Miami's increasingly diverse Hispanic community.

Not surprisingly, the BSFT approach shares a number of characteristics, such as a systems orientation, in common with other family-based therapies, such as Multidimensional Family Therapy (Liddle & Hogue, 2001), Functional Family Therapy (Alexander & Robbins, 2010), and Multisystemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). However, the BSFT approach is unique in that it focuses on diagnosing repetitive patterns of family interactions and restructuring (i.e., changing) the family interactions associated with the adolescent's problem behaviors. One of the major innovations of the BSFT approach has been the principle that challenges in engaging families into treatment are derived from the same interactional problems that maintain the adolescent's symptoms. The specialized engagement procedures developed to address these challenges (Szapocznik & Kurtines, 1989; Szapocznik et al., 1989) have revolutionized the field of family therapy.

Although the BSFT approach was originally designed for use with Hispanic families, subsequent research (e.g., Robbins et al., 2011a, 2011b; Santisteban et al., 1997) has indicated that the model is efficacious and effective with other ethnic groups as well. Indeed, although the Cuban population in Miami during the 1970s tended to prefer family-based intervention strategies, many studies have indicated that family-based modalities appear to be most appropriate for preventing and treating substance abuse and related problems in adolescents regardless of ethnicity (Szapocznik, Prado, Burlew, Williams, & Santisteban, 2007; Tanner-Smith, Wilson, & Lipsey, 2013; Waldron, Turner, & Ozechowski, 2009). Following the initial efficacy research, work on the BSFT model moved to evaluating effectiveness, investigating effects of therapist behaviors on family and adolescent outcomes, and implementing the model in community settings. We cover these developments later in the chapter, following a review of the key concepts that underlie the BSFT approach.

Key Concepts Underlying the BSFT Approach

The BSFT model is organized around three central constructs: system, structure (i.e., repetitive patterns of interactions), and strategy (Szapocznik & Kurtines, 1989), described below.

System

A *system* is an organized whole comprising interdependent or interrelated parts. A family is a system comprising individuals whose behaviors affect each other. Because such behaviors have occurred thousands of times over the years, family members become habituated to the family's repetitive patterns of behaviors. These patterns

of behavior synergistically work together to characterize the family system. Accordingly, family systems theory (Rolland & Walsh, 1996, 2009) posits that a family system represents more than the sum of the individual family members. In our case, we might say that the family system comprises its individual members and their patterns of interactions. Given the influence that family systems have on their younger members, it has been suggested that individually based therapeutic approaches are less likely to be efficacious in treating adolescent drug abuse compared to family-based approaches (e.g., Henderson, Dakof, Greenbaum, & Liddle, 2010; Santisteban et al., 2003).

Structure

A central characteristic of a family system is that comprises parts that interact with each other. These repetitive patterns of interactions that are idiosyncratic to a particular family are called the family's *structure*. A maladaptive family structure is characterized by repetitive family interactions that persist despite the failure of these interactions to meet the needs or goals of the family or its individual members. A maladaptive family structure is viewed as an important contributor to the occurrence and maintenance of behavior problems, such as conduct problems and drug abuse. BSFT specifically targets those family patterns of interaction that have been shown in the research literature to be predictors of drug abuse and related antisocial behaviors (e.g., negative and conflictive interactions, intergenerational alliances, vague or indirect communication; cf. Szapocznik & Kurtines, 1989). At the same time, some interactional patterns may be highly adaptive and supportive of family members and should be maintained. In the BSFT approach, we identify both the adaptive and the maladaptive repetitive patterns of interactions, intervening to correct those that are maladaptive while supporting and strengthening those that are adaptive.

Strategy

The third fundamental concept of BSFT, *strategy*, is defined by interventions that are practical, problem-focused, and deliberate. Practical interventions are selected for their likelihood to move the family toward desired objectives. For example, a therapist can choose to emphasize one aspect of a family's reality (e.g., that a drug-abusing youth is in pain) as a way to foster a parent–child connection, or another aspect (e.g., "this youth could get into serious trouble, get killed, or overdose at any time") as a way to heighten the parent(s)' sense of urgency. This pragmatically constructed framing is done in lieu of portraying the entire reality of a situation. Such a practical selective focus is used, in part, in an effort to create a motivational context for change which will encourage family members to move outside or beyond their habitual and maladaptive patterns of interaction.

The problem-focused aspect of BSFT refers to targeting family interactional patterns that are most directly relevant to the adolescent's presenting problem(s). Although families with behavior problem youth usually have multiple problems, targeting only those patterns of interactions linked to the development and maintenance of the symptomatic behavior contributes to the brevity of the intervention. For example, a couple's ability to parent is likely to be targeted because of its direct link to problem behaviors. However, the couple's sexual problems might not be targeted in this brief therapy model. As such, intervention strategies are very deliberate, and are specifically intended to help the family shift from one set of interactions that maintain symptomatic behaviors in the youth (e.g., conflicted parent–child relationships) to another set of interactions that will reduce symptomatic behaviors (e.g., more nurturing, yet effective parenting). These same intervention strategies are also used to capitalize on adaptive interactional patterns (e.g., anger between a parent and a child reflects the strong connection between parent and youth—a connection that needs to be validated, highlighted, and supported, but also transformed into a positive connection).

BSFT Treatment Protocol

The BSFT intervention is a flexible approach that can be utilized with a broad range of family

situations (e.g., two-parent families, single-parent families, stepfamilies, multigenerational families). It can be utilized in a variety of service settings (e.g., mental health clinics, drug abuse treatment programs, and other social service settings), or it can be (and often is) provided in the family's home. Furthermore, the BSFT model can be adapted to fit a variety of treatment modalities (e.g., as a primary outpatient intervention, in combination with residential or day treatment, as an aftercare/continuing-care service to residential treatment, and for family preservation or reunification). Moreover, the BSFT approach is applicable across a range of racial/ethnic groups (Robbins et al., 2011b).

In the BSFT approach, whenever possible, preserving the family is desirable. That is, wherever possible, the focus should be on improving family functioning rather than removing the adolescent from the family or prompting family members to leave the home. Within this approach to family preservation, two goals must be set: a) "strategic or symptom focus," that is, to eliminate or reduce the adolescent's problem behaviors such as drug use and sexual risk taking; and b) "systemic and structural focus," that is, to change the family interactions that are associated with the adolescent's problem behaviors. It should be noted, however, that there are times when family preservation may not be in the best interest of the adolescent, such as when another family member is using drugs. To eliminate the adolescent's drug use, the other drug-using family member must either go into treatment or possibly leave the household.

It is useful to view the BSFT approach as organized into five steps along the "BRIEF" acronym:

1. Bring together a family-therapist team.
2. Recognize the presenting problem.
3. Identify the interactional patterns that need to be changed or supported, and create a plan for change.
4. Establish a motivational context for change.
5. Facilitate new family interactional patterns by utilizing BSFT strategies to restructure maladaptive patterns, while also strengthening adaptive interactions.

After creating the family-therapist team, the therapist identifies the interactional patterns that are linked to the adolescent's presenting problem. An example of a structural, systemic focus occurs when a parent directs his anger toward the youth who is exhibiting the problematic behavior. The parents' negativity toward the adolescent serves only to increase the youth's problematic behaviors, and the adolescent's problematic behaviors further increase the parents' negativity (Koh & Rueter, 2011). At the family systems level, the therapist may, for example, transform the cycle of family interactions that fuels negativity and reinforces the adolescent's problem behavior. This is done by changing the meaning of negative interactions through reframing (e.g., "I know you are angry, and your anger is a measure of your concern for your son"). This will typically prompt family members to speak and act in ways that promote more supportive family interactions, which, in turn, is likely to result in reductions in the adolescent's problem behaviors.

The BSFT approach employs four specific theoretically and empirically supported techniques for working with families. These include joining, tracking and eliciting, reframing, and restructuring.

Step 1. In BSFT this is to bring together, or create, the therapist–family team. This is done through *joining* interventions. Joining interventions, intended to establish a therapeutic alliance with each family member and with the family as a whole, are essential to establishing the bond between the therapist, the family, and its members. Joining requires that the therapist demonstrates acceptance of and respect toward each individual family member, as well as toward the way in which the family as a whole is organized. A commonly used joining intervention involves the therapist initially accepting the family's repetitive pattern of interactions as a way of gaining access to the family. Once the therapist has been accepted into the family, s/he will work to change those repetitive patterns of interactions that are maladaptive.

Joining is also accomplished through validating statements that convey empathy for each family member, and by demonstrating to each

family member how participating in BSFT sessions can help her/him to reach a goal that s/he considers important. For example, an adolescent may say that he wants to "get my mother off my back," whereas the mother may say that she wants to "get my son off drugs." The therapist can offer each family member the opportunity to achieve her or his objectives by attending BSFT sessions.

Step 2. This step recognizes and identifies the adolescent's presenting problems. These can generally be determined during the first meeting between the therapist and the family, or it may be a reason for the referral.

Step 3. This induces the family to behave in its usual ways to identify and diagnose the family's repetitive patterns of interactions, and to determine which specific interactional patterns are linked to the adolescent's problem behaviors. We refer to this stage of the treatment model as *tracking and diagnostic enactment*. The first task in tracking and diagnostic enactment is for the therapist to encourage the family members to behave as they would if the therapist was not present. For example, if the mother complaints about her husband not helping, the therapist encourages the mother to tell her husband directly. As mother speaks to her husband, her daughter attracts attention to herself and the father reacts to the daughter rather than responding to the mother. Observing this interactional sequence allows the therapist to identify the family's routine patterns of interactions, those that are maladaptive such as the kind of triangle described above, and those that are adaptive because they create positive experiences among family members. Having identified the family's interactional patterns, the therapist might track and highlight the pattern of interactions by asking, "Is it always the case that when mother speaks to father, Lisa interrupts?" Based on identifying the family's repetitive patterns of interactions, the therapist can formulate a treatment plan that will transform maladaptive interactions, and capitalize and strengthen the adaptive family patterns of interactions. The therapist here thus induces typical family patterns of interacting, and then diagnoses the interactional patterns and creates a plan for change.

Over the course of treatment, therapists are expected to maintain an effective working relationship with each family member (joining), to facilitate within-family interactions (tracking and diagnostic enactment), and create a motivational context for change by transforming negative affects (often reflective of overly strong family bonds) into constructive interactions.

Step 4. This is to establish such a motivational context for change, for which reframing is the most useful and powerful technique. *Reframing* interventions are utilized to reduce negative affects in family interactions while changing the meaning of interactions in ways that create hope and prepare the family for change.

Reducing negative affect is essential for a productive session, and it is critical during the initial therapy sessions. Research demonstrates that a liberal use of reframing increases the likelihood that families will remain in treatment after the first session. Conversely, the inability to reduce negativity in the first session is predictive of dropout from treatment (Robbins, Alexander, & Turner, 2000). For example, consider a case in which a father is angry at his son for getting arrested for dealing marijuana. The son withdraws emotionally as his father vents his anger at him. The therapist reframes the father's anger into caring by stating, "I can see how concerned you are for your son's future. You had so many dreams for him and you are worried that if he continues down this path, they will not be possible. You must have a great deal of love for your son for his missteps to make you so angry." The father might then respond sadly, "You are damned right. He is ruining his future. He is too young to have a criminal record. If he continues to do this, he could end up in jail or worse." The therapist would then turn to the son and say, "Did you know that your dad is worried about you?" The therapist thus reframes/changes the meaning of the father's anger into concern, thereby reducing negativity and creating a motivational context within which new interactions can occur.

Because reframing is used to transform negativity into positive connection, it serves as a natural springboard for *restructuring* interventions

that transform family relations from problematic to effective and mutually supportive.

Step 5. This brings about changes in the maladaptive patterns of family interactions that are linked to the adolescent's presenting problems through restructuring interventions. Such restructuring interventions include: a) directing, redirecting, or blocking communication, b) changing family alliances, c) helping families to develop conflict resolution skills, d) developing effective behavior management and conflict resolution skills, and e) fostering positive parenting and parental leadership skills. All of these interventions involve assigning in-session tasks, followed by out-of-session "homework" tasks once the in-session tasks are proceeding well. For example, in a family in which a troubled adolescent is triangulated with her parents' relationship, parent figures might be asked to engage in a conversation about managing the adolescent's behavior. Initially, the therapist will block the adolescent from interfering with the conversation. Then, at a subsequent session, the therapist will ask the parents to block the adolescent from interfering with their conversation and will discuss with them how they might accomplish this. As they engage in the conversation about behavior management, the adolescent will, as usual, try to interfere and distract her parents from their conversation. The parents' initial reaction will likely be to fall back into their overlearned pattern of behavior in which they allow the adolescent to triangulate herself into their discussion. The result is likely to involve the parents redirecting their anger (which had been directed toward one another) toward the adolescent, who has now successfully interrupted the parents' conversation. The therapist would now softly remind the parents that their task is to "gently" block the adolescent and to return to their conversation. With coaching, the parents are eventually able to achieve this in the session despite repeated attempts by the daughter to disrupt them (and after repeated efforts by the therapist to keep the parents on track). Once they have learned this set of skills and become successful in carrying them out in the office, the therapist assigns a homework task for the parents to have a conversation with each other in the house and use the skills they have learned in the office to ensure that the conversation stays between them, gently blocking the adolescent from interfering. In this way, parents acquire the skills to address one important aspect of their triangulated relationship with their daughter. The skill continues to be observed in session by the therapist, who will remind/coach parents whenever necessary. At the same time, during sessions, the therapist will help the adolescent to cope with the new situation. At first, the therapist will move next to the adolescent and, after the parents have blocked her from their conversation, the therapist will distract her by talking with her. The therapist will use joining and validating interventions with both the adolescent and the parents to reward their new behaviors and to encourage them for engaging in a very challenging new set of behaviors. Slowly, the therapist will move out of this role and allow the parents to block the adolescent's triangulation on their own, so that the BSFT sessions can resemble what might occur when the therapist is not present.

BSFT Engagement (Szapocznik & Kurtines, 1989)

When families are not able to agree on (or even successfully discuss) ways to manage an adolescent's undesirable behavior, it is unlikely that they will be able to negotiate coming to therapy together. Further, if family members believe that the adolescent is "the problem," they may think that only the youth needs to be in therapy. Indeed, the same interactional problems that maintain the adolescent's symptoms are also associated with the family's inability to coming to treatment. Within the BSFT model, specialized engagement techniques were developed to overcome these impediments to engagement of full families into treatment. These techniques have been developed and evaluated in four randomized clinical trials (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Robbins et al., 2011b; Santisteban et al., 1996; Szapocznik et al., 1988). The same intervention domains used in BSFT treatment—joining, tracking and diagnostic enactment, and reframing—are also utilized to engage families into therapy.

Often, one essential family member, a powerful problem youth (i.e., an adolescent whose parents have lost their parental authority) or an alienated father figure, may not want to come to treatment. With the approval of the person who called the therapist for help—usually the mother—the therapist will reach out to, and join with, the family member who is unwilling to attend therapy. This joining effort represents an effort to persuade the unwilling family member that she or he has something to gain from coming to treatment, while also alleviating any concern she or he may have. From speaking with the family member who called for help, it is often possible for a therapist to formulate an initial diagnosis of the interactional challenges that prevent a family from coming into treatment. The therapist begins to explore the family interactions in the first call by giving the caller a task—"Could I ask you to bring all the members of your family into the first session?" The organization of the family will become apparent when the caller either responds that "my son won't come to treatment," or "my husband won't come to treatment," or "it is best if just my son and I come—it is not necessary to bring my husband" (or, "my husband is too busy to come"). In the first and second cases, the caller believes that she lacks the influence needed to bring that family member into treatment. In the third case, the caller either prefers not to bring her spouse, or is at best ambivalent about bringing him. In each case, and with the caller's approval, the therapist will insert herself into the family process by reaching directly to the family member who the caller believes will not come to treatment or whom the caller is not eager to bring to treatment. This direct action on the part of the therapist represents a way of getting around the interactional patterns that interfere with bringing all family members into treatment.

BSFT Research

The BSFT approach has been found to be efficacious in treating adolescent drug abuse, delinquency, conduct problems, associations with antisocial peers, and impaired family functioning. All of these outcomes are important risk factors for unsafe sexual behavior (e.g., Bersamin et al., 2008; Guo et al., 2005). The BSFT model has been evaluated in a number of randomized clinical trials evaluating the efficacy and effectiveness of the model. In addition, research has identified specific therapist behaviors that are associated with the most favorable adolescent and family outcomes. These studies have led the US Department of Health and Human Services to label the BSFT approach as one of its "model programs" and to be included in the National Registry of Evidence-based Programs and Practices (NREPP; http://nrepp.samhsa.gov/ViewIntervention.aspx?id=151). Given that the model was developed to address problem behaviors in Cuban immigrant adolescents in Miami, it should not be surprising that the early studies on BSFT were conducted with Hispanic families (Coatsworth et al., 2001; Santisteban et al., 1996, 2003; Szapocznik et al., 1988, 1989). However, BSFT effectiveness research has suggested that the model is equally applicable to African American, Hispanic American, and white American families (Robbins et al., 2011b)—and the model is currently being implemented with a variety of populations in the Unites States and Europe.

BSFT Treatment Efficacy

The efficacy of the BSFT model in reducing behavior problems and drug abuse has been tested in two randomized, controlled clinical trials. In the first trial, Szapocznik and colleagues (1989) randomized behavior-problem and emotional-problem 6–11-year-old Cuban boys to BSFT, individual psychodynamic child therapy, or a recreational placebo control condition. The two treatment conditions, implemented by highly experienced therapists who were regarded by their peers as experts in their respective modalities, were found to be equally efficacious, and more efficacious than recreational control, in reducing children's behavioral and emotional problems and in maintaining these reductions at one-year post-termination. However, at one-year follow-up, the BSFT condition was associated with a significant improvement in independent, blind to condition, observer ratings of family functioning across time, whereas individual psychodynamic child therapy was associated with

a significant deterioration in family functioning across time.

In a second study, Santisteban and colleagues (2003) randomly assigned Hispanic (half Cuban and half from other Hispanic countries) behavior-problem and drug-abusing adolescents to receive either BSFT or adolescent group counseling. The adolescent group counseling condition was modeled after a widely used program in our community. The BSFT condition was significantly more efficacious than group counseling in reducing conduct problems, associations with antisocial peers, and marijuana use, and in improving independent, blind to condition, observer ratings of family functioning. Baseline family functioning emerged as a moderator of treatment effects. For families entering the study with comparatively good family functioning, family functioning remained high in the BSFT condition, whereas it deteriorated in the families of adolescents in group therapy. For families entering the study with comparatively poor family functioning, the BSFT condition significantly improved family functioning, whereas family functioning remained poor in families assigned to adolescent group counseling. Moreover, adolescent group counseling was associated with clinically significant increases in marijuana use.

We have also explored the extent to which the BSFT model can be used with African American as well as Hispanic adolescents with behavior problems. In an uncontrolled study, Santisteban et al. (1997) examined the suitability of the BSFT approach for both Hispanic and African-American adolescents. Outcome variables included association with antisocial peers and observer-rated family functioning, measured before and after BSFT treatment. Although BSFT treatment significantly reduced association with antisocial peers and improved family functioning for both Hispanics and African Americans, BSFT treatment was significantly more efficacious in reducing association with antisocial peers among African Americans than among Hispanics. Conversely, BSFT treatment was significantly more efficacious in improving family functioning among Hispanics than among African Americans. These early findings suggested that BSFT may benefit different racial/ethnic groups through different mediational pathways.

BSFT Engagement Efficacy

The efficacy of BSFT Engagement was tested in three separate randomized clinical trials with Hispanic behavior-problem adolescents and their families. In the first study (Szapocznik et al., 1988), Hispanic (mostly Cuban) families with drug-abusing adolescents were randomly assigned to BSFT + Engagement as Usual (the control condition) or to BSFT + BSFT Engagement (the experimental condition). The Engagement as Usual condition was modeled after community-based adolescent outpatient programs' approaches to engagement in the South Florida area. Results indicated that 93% of the families in the BSFT Engagement condition, compared with only 42% of the families in the Engagement as Usual condition, were engaged into treatment (defined as all family members in the household attending an admission session). Moreover, 75% of families in the BSFT Engagement condition completed treatment (defined as reaching a mutual decision with the therapist that treatment should be terminated), compared with only 25% of families in the Treatment as Usual condition.

In the second study (Santisteban et al., 1996), families were randomly assigned to either BSFT Engagement or Engagement Control (no specialized engagement) conditions. In the BSFT Engagement condition, 81% of families were successfully engaged (defined as attending an intake and a first family therapy session), compared to 60% of the families in the Engagement Control condition (defined as attending the admission session plus a first therapy session). A major finding of this study was that the effectiveness of BSFT Engagement procedures was moderated by Hispanic nationality. Among the non-Cuban Hispanics (composed primarily of Nicaraguan, Colombian, and Puerto Rican families) assigned to the BSFT Engagement condition, the rate of engagement was high (93%) compared to the lower rate for Cubans assigned to this same condition (64%). Most of the Cuban families had US-born adolescents, whereas the majority of

adolescents from other national backgrounds were foreign-born. Hence, the families of US-born Cuban adolescents had spent more time in the Unites States than the families of non-Cuban, foreign-born adolescents. Evidence suggests that US-born Hispanic adolescents tend to be more Americanized compared to adolescents born outside the United States (Schwartz, Pantin, Sullivan, Prado, & Szapocznik, 2006). There is evidence that, in Hispanic families, acculturation to American values and behaviors is associated with decreased orientation toward family (Sabogal et al., 1987). As a result, it is possible that the lower engagement rate found for Cubans was due to higher rates of Americanization in the Cuban families. It is possible that more Americanized families perceive less need for family involvement in adolescent drug abuse treatment. Given this finding, specific family reconnection strategies, focusing on reorientation toward the importance of family, have been incorporated into the current version of BSFT Engagement.

A third study (Coatsworth et al., 2001) tested the ability of BSFT + BSFT Engagement to engage and retain adolescents and their families in comparison to a *community* control condition. An important aspect of this study was that the control condition was implemented by a community treatment agency and, as such, was less subject to the influence of the investigators. The Hispanic adolescents and families in this study were primarily Cuban or Nicaraguan. Findings in this study indicated that BSFT Engagement successfully engaged 81% of families into family therapy treatment, whereas the community control condition engaged 61% into treatment. Likewise, among families who were successfully engaged, 71% of BSFT cases, compared to 42% in the community control condition, were retained to treatment completion. In terms of retention, 58% of BSFT cases, compared to 25% of control cases, completed treatment. It should be noted that in the last two studies, the control conditions could be family therapy but did not have to be family therapy. Consequently, engagement was defined as family engagement in the BSFT Engagement conditions, and family or individual engagement in the control conditions.

BSFT Effectiveness

An effectiveness trial (Robbins et al., 2011b) of the BSFT approach was conducted in the context of the National Institute on Drug Abuse's National Drug Abuse Treatment Clinical Trials Network. In this study, both therapists and families were randomized within clinics. The study compared BSFT versus Treatment as Usual (which was allowed to vary based on whatever treatment the agency typically provided for drug-using adolescents) by randomizing 480 families of adolescents (213 Hispanic, 148 white, and 110 black; 377 male, 103 female) referred to drug abuse treatment at eight community treatment agencies located around the United States. Seventy-two percent of these adolescents were referred for treatment by the juvenile justice system, and most of the remaining cases were referred from residential treatment. Services in both conditions were delivered by therapists in community agencies. An unselected group of therapists (provided by the agency, rather than selected by the study team) were randomized within agency to deliver either the BSFT or treatment as usual (TAU) modalities.

Engagement and Retention

Families in TAU were 2.33 times (11.4% BSFT; 26.8% TAU) more likely to fail to engage (defined as not completing at least two treatment sessions) compared to families in the BSFT condition. Families in TAU were 1.41 times (40.0% BSFT; 56.6% TAU) more likely to fail to retain (defined in this study as completing fewer than eight sessions) compared to families in BSFT. These differences were statistically significant and were consistent across the three racial/ethnic groups in the study: African Americans, Hispanic Americans, and white Americans.

Treatment duration

Therapy took much longer to administer than expected. The usual expectation is that BSFT therapy should last approximately four months, which is consistent with our implementation experience. However, the median length

of treatment for those participants who were retained in treatment was approximately eight months for both conditions. As discussed later, this difference between the effectiveness study and our implementation experience in delivering the BSFT intervention may have occurred because in the effectiveness study, the BSFT condition was implemented by therapists who were not solely focused on BSFT implementation. These therapists had additional caseloads, often involving other treatment approaches, in addition to their BSFT caseload for the study.

Effects on Adolescent Drug Use

Drug use was operationalized as the number of self-reported drug using days within each twenty-eight-day period. There were no significant differences by treatment condition in terms of trajectories of drug using days per twenty-eight-day period or the mean number of drug using days per twenty-eight-day period at one-year post-randomization. However, using non-parametric analyses, the median number of self-reported drug use days per month at the twelve-month follow-up was significantly higher in the treatment as usual condition (3.5 days) than in the BSFT condition (two days). It should be noted that the mean and median number of drug use days was low and restricted, with an interquartile range between one and three days of self-reported use per month. Such a restricted range made it difficult to detect statistically significant or clinically meaningful differences in drug use trajectories. The overwhelming majority of adolescents in the study were referred from residential treatment or from juvenile justice, both of which involved surveillance (and limited opportunities to engage in drug use). These referral sources may have been responsible for the relatively low baseline rates of drug use, and in the case of the juvenile justice referrals, continued surveillance may have been responsible for the low levels of drug use over time.

Family Functioning

Patterns of findings for family functioning differed between adolescent and parent reports. The BSFT condition produced significantly greater improvements in parent-reported family functioning (defined as positive parenting, parental monitoring, effectiveness of parental discipline, parental willingness to discipline adolescents when necessary, family cohesion, and absence of family conflict) compared to the treatment as usual (TAU) condition. Adolescent in both conditions, however, reported significant improvements in family functioning, with no statistically significant differences by treatment condition.

Parental Functioning

Post-hoc analyses demonstrated that the BSFT intervention was more effective than TAU in reducing alcohol use in parents, and that this effect was mediated by parental reports of family functioning. In addition, BSFT, as compared to TAU, had its strongest effect in reducing adolescent drug use among youth whose parents used drugs at baseline (Horigian, Feaster, Brincks, Robbins, & Szapocznik, 2014).

BSFT Therapist Behaviors, Therapy Process, and Their Relationship to Outcomes

Research has demonstrated that negativity in family interactions in the first session leads to failure to retain families in treatment past the first session (Fernandez & Eyberg, 2009); that families are more likely to engage into treatment if negativity is reduced during the first session (Robbins et al., 2000); that reframing is an effective method of reducing negativity (Moran, Diamond, & Diamond, 2005); and that reframing is the technique that is least likely to damage therapists' rapport (alliance, bond) with family members (Robbins et al., 2006). Research also shows that early engagement requires therapists to maintain a balanced bond with the parent (often the father figure) and the problem youth. Research on the BSFT intervention has shown that if, in the first session, the therapist does not develop a balanced set of bonds with the parent and the youth, this imbalance leads to early dropout from treatment (Robbins et al., 2008). These findings have been incorporated into BSFT treatment as conducted today.

Effects of BSFT Therapist Adherence and Behaviors on Outcomes

Using data from the effectiveness study, Robbins et al. (2011a) examined the extent to which BSFT therapists implemented the treatment protocol properly. To do this, adherence items were rated in terms of the four theoretically and clinically relevant expected/prescribed therapist behaviors: joining, tracking and eliciting enactments, reframing, and restructuring. These items were completed by trained independent raters who watched videos of therapy sessions. The four therapist behaviors—joining, tracking and eliciting, reframing, and restructuring—demonstrated adequate factorial validity and converged well with clinical supervisor ratings. Mean levels of adherence varied over time in theoretically and clinical relevant ways. Therapist adherence to the BSFT model was associated with:

1. *Engagement*. Using adherence ratings for the first session, with engagement defined as whether or not the family attended a second treatment session. Results revealed that higher levels of restructuring and reframing (reducing negativity) significantly increased the likelihood of families being engaged into treatment. Because joining, and tracking and diagnosis were high across most cases, what distinguished cases that came to a second session from those that did not were higher levels of reframing and restructuring, the technique domains that therapists found most challenging.
2. *Retention*. The impact of adherence on retention was evaluated using adherence ratings for sessions two to seven, with retention defined as a family attending at least eight sessions. Results indicated that higher levels of all four technique domains—therapist joining, tracking and enactment, reframing, and restructuring—predicted significantly higher rates of retention. A one standard-deviation increase in reframing predicted a 19% increase in the likelihood of retention; a one standard-deviation increase in joining predicted a 22% increase in the likelihood of retention; a one standard-deviation increase in restructuring predicted a 59% increase in the likelihood of retention; and a one standard-deviation increase in tracking and eliciting enactment predicted a 62% increase in the likelihood of retention.
3. *Family functioning*. Overall joining levels predicted improvements in observer-reported family functioning.
4. *Adolescent drug use*. The effect of prescribed therapist behaviors on adolescent drug use was complex. Across time, as would be expected, joining decreased, and restructuring increased. Smaller declines in therapists use of joining interventions and larger increases in therapists use of restructuring interventions predicted significantly less adolescent drug use at the twelve-month follow-up. That is, therapists who were high in joining in early sessions and remained so throughout treatment were associated with "better" adolescent drug use outcomes. Therapists whose attempts to restructure maladaptive family interactions increased most during the course of treatment were also associated with "better" adolescent drug use outcomes. Thus, therapists who failed to implement sufficient numbers of restructuring interventions were less able to affect the youths' drug use. Although the range of drug use days was restricted to an interquartile range between one and three days of self-reported use per month, the impact of therapist behaviors on drug use was sufficiently strong to detect significant differences even with a relatively restricted drug use range.

These results indicate that, within a sample of unselected therapists from community agencies, therapists' clinical interventions follow a pattern that is consistent with the theory behind the BSFT model. Indeed, the specific therapist behaviors prescribed by the BSFT approach are needed to engage families into treatment, retain them, improve family functioning, and reduce adolescent drug use. However, when therapists did not engage sufficiently in these behaviors, adolescent and family outcomes suffered. Robbins et al. (2011a) concluded that adherence ratings were

affected by a number of host agency systemic factors, including over-burdened therapists and therapists' lack of embeddedness within dedicated BSFT units. This experience in real-world community settings presented challenges that we have strived to address by developing a BSFT Implementation intervention model to complement the dissemination of the BSFT treatment approach when applied in community settings.

BSFT Implementation: Implementing the BSFT Approach in Community-Based Practice

What Is BSFT Implementation and Why Is It Needed?

Although treatment researchers know how to successfully treat problem behaviors such as drug abuse, delinquency, and sexual risk behaviors, they have for the most part not been successful in achieving widespread adoption of evidence-based treatments or preventive interventions in the front lines of practice (Institute of Medicine, 1998, 2007, 2009). The purpose of this section on BSFT Implementation is to present an approach to bridge the research-to-practice gap based on our early failures and more recent successes in implementing the BSFT model in community settings. We also discuss in this section three types of "interventions" that need to come together for successful implementation in a multilevel framework (see Figure 15.1). One is the evidence-based intervention, in our case the BSFT clinical intervention that is provided to the family. The two other "interventions" needed are outside the treatment model itself—and we refer to these as "BSFT Implementation" interventions. One of these, the training intervention, involves the process of training, monitoring, coaching, and providing feedback to therapists, to achieve BSFT fidelity. The other strategy, the BSFT Implementation Intervention, involves the creation and maintenance of a broad systemic organizational and community-focused system to support BSFT Implementation across three stages from adoption, reaching and maintaining fidelity, and sustainability of the model in the agency (Aarons, Hulbert, & Horwitz, 2011; Brown et al., 2013; Landsverk et al., 2012).

The experience in BSFT Implementation has taught us that organizational work with the agency is essential to establish the context for successful adoption, fidelity, and sustainability. Similarly, agencies must receive sufficient support from their funders, referral sources, and other stakeholders to ensure that agencies have the flexibility to adopt (e.g., funding by case rather than by session), reach acceptable levels of fidelity (e.g., have time set aside for therapists to be trained, supervised, and review their own work) and achieve sustainability (e.g., sustainable funding based on excellent clinical outcomes; demonstrated cost savings to the funder and/or society; availability of a trained and certified BSFT on-site supervisor to ensure ongoing supervision to fidelity over time; and having an advocate for the model within the agency).

Just as systems theory was used to develop the BSFT clinical intervention, we use a systems orientation to conceptualize parallel systemic processes across the multiple systems (see Figure 15.1) that influence our ability to help families. Research on the BSFT approach (Robbins et al., 2011a) and other models (e.g., Multisystemic therapy; Schoenwald, Sheidow, & Letourneau, 2004) demonstrate that fidelity is essential to achieve the desired outcomes. As a result, ensuring fidelity of the model is a core principle of moving intervention research into practice.

From a systems perspective, we believe that there is an inevitable relationship between changes in the behavior of the system and changes desired in a target unit. In the BSFT clinical intervention model the target system is the family and the target unit is the adolescent—and repetitive patterns of interactions among family members permit or prevent specific adolescent behaviors.

Similar principles may be applied to implementation science, where much more complex sets of interlocking systems are involved (Fixsen, Blase, Naoom, & Wallace, 2009). For agencies to adopt, sustain, and deliver an evidence-based model with fidelity, multiple actors and social processes are involved in complex and interlocking interactions. For example, the BSFT clinical intervention would be part of an agency's subsystem of service delivery. Another relevant subsystem would be an agency's supervisory and

evaluation system. If clinicians are to be effective in delivering the BSFT intervention, then their performance in achieving change in family and adolescent outcomes should be a major part of their evaluation within the agency (rather than number of service hours provided). Thus, a system-level change in evaluation at the agency would be required to adopt and sustain the BSFT clinical intervention.

In implementation science, individual actors and organizations are studied as they interact across multiple levels. This perspective requires us to identify ways to represent the types of changes that should be brought about through the BSFT clinical intervention and BSFT Implementation intervention, and which group is responsible for these changes. These changes can be represented by a series of "directed action" steps. We have adopted a neutral term, *Directed Action*, that was borrowed from neuroscience, agent-based models (Grimm et al., 2005; Heath, Hill, & Ciarallo, 2009; Miller & Page, 2007; Ormerod & Rosewell, 2009), social network analysis (Valente & Davis, 2009), and mediation analysis (MacKinnon, 2008) to represent and describe the processes underlying the complex multilevel interventions involved in implementation. The key concept of Directed Action is that is "goal-oriented," which in the neurosciences has been defined to be those "actions that are mediated by: 1) instrumental knowledge of the causal relationship between the action and the outcome or goal; and 2) the current goal or incentive value of the outcome" (Dickinson & Balleine, 1994; Shea & Krug, 2008).

Each directed action can be represented as a four-element Director–Action–Target–Intended Goal (D–A–T–I) implementation component that can encompass all of the different types of interventions. In this model, the Director acts (Action) on the Target to obtain the Intended Goal. In the case of the BSFT Implementation intervention, at the most proximal level, the family system acts on the youth to achieve reductions in the youth's problem behaviors (Figure 15.1, row A). At a level immediately upstream, the therapist acts on a family to achieve changes in family interactions that are directly linked to the youth's problem behaviors (Figure 15.1, row B). At a third level, the BSFT Model Manager acts on therapists through training, coaching and feedback so that therapists implement the BSFT Clinical intervention with fidelity (Figure 15.1, row C). At a fourth level, the BSFT Consultant acts on the Agency Leadership to achieve both the agency conditions that will support fidelity as well as goals desired by the Funder (Figure 15.1, row D) and other important stakeholders, such as better outcomes with lower costs. And at a fifth level, the Agency Leadership acts on Funders and other stakeholders to achieve their support for adoption and sustainability of the BSFT clinical intervention (funding approach (sessions vs. cases), referrals, etc.) (Figure 15.1, row E). As with any other system, the actual interactions across levels and across director, target, and intended goal are much more complex than can be depicted in a two-dimensional figure because all elements in a system have the potential to interact and influence each other. The two-dimensional Figure 15.1 attempts to represent some of the complex systemic processes inherent in achieving adoption, fidelity and sustainability of an evidence based intervention needed to ultimately affect youth behavior.

The Nuts and Bolts of BSFT Implementation

In this section, we describe the two implementation interventions: the training-to-fidelity intervention conducted with individual therapists, and the systemic intervention that targets the agency as well as funders and other stakeholders who may be critical to the long-term sustainability of the model. Both implementation interventions—the training of therapists to adhere to the BSFT model and the systemic intervention to ensure adoption and sustainability—are conducted by the Brief Strategic Family Therapy Institute (http://bsft.org/).

The BSFT Institute trains therapists to BSFT fidelity in their interactions with the family system (Figure 15.1, row C) and intervenes with the agency and its leadership to ensure not only that the conditions are appropriate for therapists to be trained properly and conduct BSFT consistent with its clinical manual, but also to ensure that the agency produces treatment outcomes that will

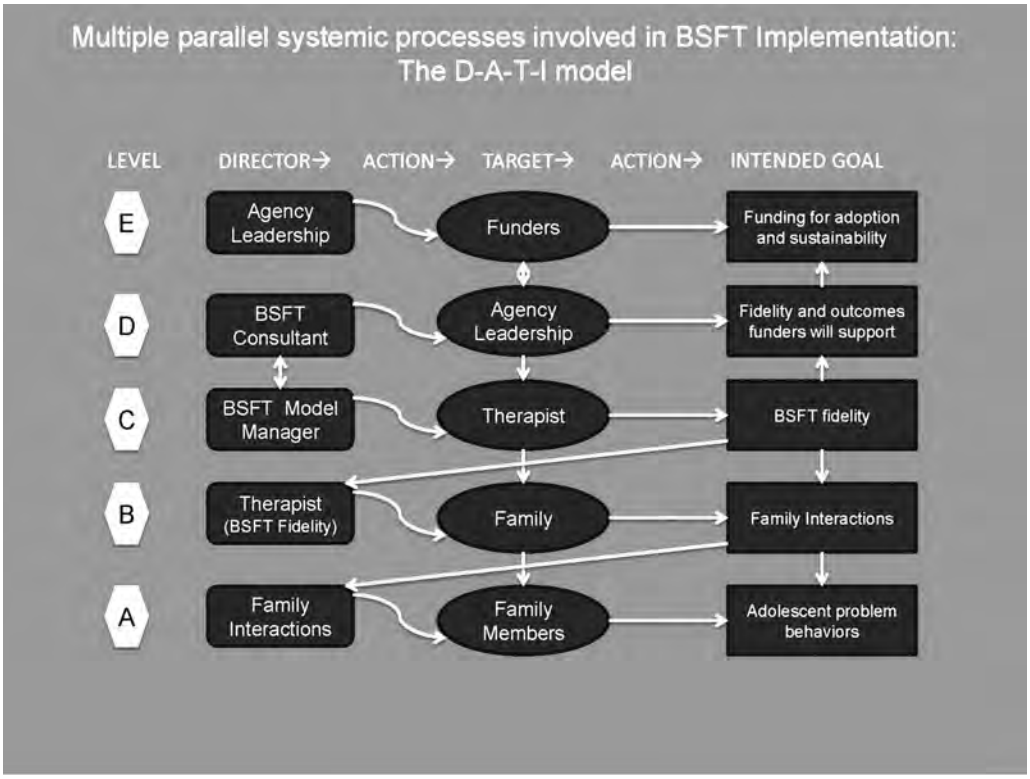

Figure 15.1 BSFT Implementation: explaining multiple parallel systemic processes involved in BSFT Implementation through the Directed–Action–Target–Intended Goal (D–A–T–I) model

convince funders and other stakeholders (e.g., judges, legislators, referral sources) to support adoption and sustainability (Figure 15.1, row D). The BSFT Institute consultants also interact with funders and other stakeholders, in support of the agency, to present the model, research findings, and the BSFT Implementation approach. BSFT Institute consultants also join with funders and other major stakeholders by stressing the important role they play as partners in attaining not only adoption and sustainability, but also fidelity—explaining that their support is essential for the provision of training and monitoring that is required to facilitate the level of agency and therapist fidelity needed to produce clinically meaningful and lasting treatment outcomes.

A team of four therapists is the standard unit for administering the BSFT program, and multiple BSFT teams can operate within one agency. BSFT Implementation begins with a site readiness assessment. Site readiness is the process of engaging organizational leaders and staff of the community agency and preparing them to adopt the BSFT program. The goal of the site readiness process is for agency staff to obtain a full understanding of the requirements for implementing the BSFT program, and of the organizational changes necessary to achieve successful clinical outcomes. Site readiness activities include establishing parameters for therapist eligibility, selecting the BSFT team, explaining and discussing the training and supervision process, and identifying specific organizational changes that must be enacted for the agency to successfully implement the BSFT clinical intervention. The goal of the site readiness process is to prepare the agency for the changes needed to implement the BSFT model successfully. This is accomplished by sharing information about the BSFT program and its potential impact on clients, and

by engaging the agency leadership in supporting the organizational changes that will be required. Because many agencies implementing the BSFT clinical intervention are adopting an evidence-based program for the first time, changes in their standard practices are required to adopt the BSFT intervention and successfully implement the BSFT clinical intervention with fidelity.

The next phase of BSFT implementation is the training phase, which includes three three-day workshops and two hours of weekly group supervision of videotaped sessions for approximately one year. To engender a willingness to change among therapists, workshops cover the research evidence supporting the BSFT model, the philosophy of the model, key theoretical principles underlying the BSFT approach, and the four key types of BSFT interventions and the skills required to carry them out. Therapists are also trained to implement BSFT's specialized engagement techniques for engaging and retaining drug-abusing youth and their families in treatment. Discussion of findings on treatment outcomes, and on the effects of therapist behaviors on these outcomes is critical to encouraging and motivating therapists to adopt and adhere to the BSFT model. Weekly supervision helps therapists to conceptually integrate the model into their interactions with client families, to develop the skills needed to implement the BSFT model, and thereby to gradually move therapists toward BSFT fidelity. After the initial training phase, and once the agency-based BSFT team has demonstrated adequate fidelity to the model, a critical step toward sustainability is the selection of the BSFT On-Site Supervisor. In weekly supervision during the first year, a particularly competent BSFT therapist will emerge and will be nominated as a BSFT On-Site clinical supervisor whose role is to lead weekly group supervision sessions. The actual appointment of the BSFT On-Site Supervisor is done by the agency in collaboration with the BSFT Model Manager. The On-Site Supervisor is trained in BSFT supervision during the second year of BSFT implementation. The primary responsibility of the BSFT On-Site Supervisor is to ensure fidelity to the model. This function is crucial given our research linking BSFT adherence/fidelity to good clinical outcomes. The BSFT On-Site Supervisor is guided and supported through weekly supervision meetings with the BSFT Model Manager. During these weekly meetings, the BSFT Model Manager provides guidance and coaching on how to supervise and maintain fidelity to the BSFT intervention, suggests techniques to use when therapists "drift away" from the model, presents guidelines for successful case closures, and supports the BSFT On-Site Supervisor in monthly meetings with agency leaders.

The next step in the BSFT sustainability plan is licensing the agency's BSFT unit. Agencies are granted a license to practice the BSFT clinical intervention once agency personnel have been trained and have demonstrated that they possess the necessary resources to implement the model. With this license comes the responsibility of adhering fully to the BSFT manual, program, and sustainability requirements. These requirements include full participation in the training program for the first year and ensuring that the team of BSFT therapists reaches or exceeds the minimum level of competency. In the second year and beyond, agencies are required to participate in an annual two-day booster workshop and an annual two-day live-case consultation visit. Booster workshops address areas in which the therapists may have drifted away from the model. The live-case consultation visit allows for therapists to invite the BSFT Model Manager to their sessions and receive live consultation. Live consultation consists of BSFT experts demonstrating effective delivery of the BSFT program with the therapists' own BSFT cases.

As noted above, throughout the entire process beginning with the site preparation visit, and continuing with training and licensing, the BSFT Consultant works with agency leadership to create conditions that support the BSFT clinical intervention within the agency, maximizes the likelihood of outcomes that funders and other stakeholders will desire, and support the agency leadership with funders and other stakeholders by presenting the model and the research evidence. As stated above, joining with funders and stakeholders is essential because their support is needed to permit restructuring the time of BSFT therapists, creating BSFT units, establishing new

reimbursement approaches, and ensuring long-term funding for BSFT Implementation.

Conclusions

Nearly four decades of research has shaped the BSFT clinical intervention as it is delivered today. The BSFT model was originally developed to address conflicted parent–adolescent relationships in immigrant families and has evolved into a broadly applicable treatment approach. Indeed, the model has evolved in response to specific needs—engagement interventions were added to bring reluctant family members into treatment; reframing became increasingly prominent as a way to reduce negativity in family interactions to increase retention and to create a motivational context that prepares families to change their interactional patterns. In response to the frustration of being unable to sustain programs in community agencies, we established the BSFT Implementation program and a BSFT Institute to carry it out. Delivering the BSFT clinical intervention in community settings involves a great deal more than just training, coaching, and providing feedback to therapists; it includes developing the agency and community supports required to adopt, implement with fidelity, and sustain the program over time.

Experience in BSFT implementation across multiple sites has taught us that parallel organizational work with the agency is essential to establish the context for successful adoption, fidelity and sustainability. Having BSFT units in which therapist reinforce each other's adherence to the clinical model, as well as agencies that evaluate therapists based on their adherence to the BSFT model, are two avenues to improve adherence and, consequently, adolescent outcomes. Similarly, agencies must receive support from their funders and referral sources to ensure that the agencies: a) have the flexibility to adopt (e.g., funding by case rather than by contact); b) reach acceptable levels of fidelity (e.g., establish BSFT clinical units, have time set aside for therapists and supervisors to train, be supervised, and review their own work); and c) can sustain the program (e.g., sustainable funding based on excellent clinical outcomes, cost savings to the funder or society, on-site supervisor to ensure adequate fidelity, and continued flow of referrals).

Unlike the rigorous testing for efficacy and effectiveness that we have done on the BSFT treatment model, our work so far on implementation has been guided by the experience in practice. We, as well as others (Henggeler, 2012; Glisson et al., 2010), are searching for a more comprehensive understanding of the contextual factors that enhance or impede effective and efficient implementation. We are also developing representations, such as Directed Actions, that will ultimately lead to characterizing implementation strategies so that they themselves can be monitored, compared, and improved over time. The next stage in our program of research is to investigate the efficacy of the BSFT Implementation interventions, and determine mediators and moderators of implementation success. Moving the BSFT intervention into standard clinical practice is the next frontier in this nearly forty-year research program.

Note

1. The University of Miami holds the copyright and trademark for the Brief Strategic Family Therapy. Dr. Szapocznik is the developer of this method. The University and Dr. Szapocznik have the potential for financial benefit from the future commercialization of the method.

Preparation of this article was supported by Clinical Translational Science Institute Grant 1UL1TR000460 from the National Center for Clinical and Translational Science and the National Institute on Minority Health and Health Disparities, U10 DA013720 from the National Institute on Drug Abuse to José Szapocznik, P30 DA02782 to C. Hendricks Brown, and DA025694 and AA021888 to Seth Schwartz.

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16.

FAMILY PSYCHOEDUCATION FOR SEVERE MENTAL ILLNESS

William McFarlane

History and Background of Family Psychoeducation

Family intervention for the severe psychiatric syndromes—psychotic and severe mood disorders—has been established as one of the most effective treatments available. Often subsumed under the term "family psychoeducation," it is a method for incorporating a patient's family members, other caregivers, and friends into the acute and ongoing treatment and the rehabilitation process. The descriptor "psychoeducation" can be misleading: family psychoeducation includes cognitive, behavioral, and supportive therapeutic elements, often utilizes a consultative framework, and shares characteristics with some models of family therapy. Based on a family–patient–professional partnership, the most effective models are essentially cognitive-behavioral therapy with consistent inclusion of family members as collaborators. As a substitute for a family member, it can include any friend or para-professional person who is providing support to persons with a severe mental illness. It combines providing clear, understandable, and accurate education for family members about the psychobiology of the major disorders with training and ongoing guidance in problem-solving, communication skills, and coping skills, while providing and developing social support. The goals are to improve clinical and functional outcomes and quality of life for the patient *and* to reduce family stress and strain as an indispensable means of achieving those outcomes. It combines the complementary expertise and experience of family members, patients, and professionals.

Family psychoeducation has been empirically demonstrated in a large number of research studies to improve outcomes in schizophrenia and bipolar disorder to the same or greater degree as medication, complementing but nearly doubling its treatment effects. Family intervention is particularly beneficial in the early years of the course of a mental illness, when improvements can have a dramatic and long-term effect and while family members are still involved and open to participation, change in attitude, and interaction with the patient. Patients who experience frequent hospitalizations or prolonged unemployment benefit substantially and often dramatically, as do families who are especially exasperated or confused about the illness or even hostile toward the patient. When there is a family member available, it should be applied as widely and as routinely as medication.

Family psychoeducation originated from several sources in the late 1970s. Perhaps the leading influence was the growing realization that conventional family therapy, in which family dysfunction is assumed and becomes the target of intervention for the alleviation of symptoms, proved to be, at least, ineffective and perhaps damaging to patient and family well-being. Awareness also grew, especially among family members themselves and their rapidly growing advocacy organizations, that living with an illness such as schizophrenia is demoralizing, frustrating, and confusing for patients and families alike. In a reciprocal process, the resulting stresses on families often lead to interactions and persisting patterns of interaction that can have equally devastating effects on the patient and the course of the disorder over time. It became increasingly clear that to adapt under these circumstances, the family has to possess the available knowledge about the illness itself and coping skills specific to a particular disorder, skills that are counter-intuitive to most families and many clinicians. It became clear that it was unrealistic to expect families to understand such mystifying disorders and to know what to do about them, independent of professional guidance. The most adaptive family was increasingly seen to be the one that has access to information, with the implication that clinicians are a crucial source of that information.

As to coping skills, families develop methods of dealing with positive, negative, and mood symptoms, cognitive deficits, functional disabilities, and the desperation of their ill relative through painful trial and error. These successes, however, are rare. Another critical need is that families have access to each other to learn of other families' successes and failures and to establish a repertoire of clinically effective coping strategies that are closely tailored to the disorder, to the specific family, and to the individual person. Further, family members and significant others often provide emotional and instrumental support, case management functions, financial assistance, advocacy, and housing to their relative with mental illness. Doing so can be rewarding but poses considerable burdens. Family members often find that access to needed resources and information is lacking. Too often, the end result is a family that is so anxious, confused or even hostile that their interactions with the patient become risk factors for relapse, functional deficits, and eventually deterioration. Given that perspective, clinical investigators began to recognize the crucial supportive role families played in outcomes after an acute episode of schizophrenia and endeavored to engage families collaboratively, sharing illness information, suggesting cognitively sophisticated behaviors that promote recuperation, and teaching coping strategies that reduce their sense of burden. The group of interventions that emerged became known as family psychoeducation.

These approaches recognize that schizophrenic and mood disorders are brain disorders that are only partially remediable by medication, and that families can have a significant effect on their relative's recovery. Functional deficits and behavioral changes induced by these disorders are stress-induced. Nevertheless, they are often the most confusing and burdensome for family members, because they usually do not identify them as part of the disorder, while also finding themselves trying to support the affected member and compensate for those deficits. The psychoeducational approach shifted away from attempting to get families to change their "disturbed" communication patterns toward educating and persuading families that their interactions with the patient can facilitate recovery by compensating for deficits and sensitivities specific to the various disorders. For example, a family might interfere with recuperation if in their natural enthusiasm to promote and support progress they create unreasonable demands and expectations, but the same family could have a dramatically positive effect on recovery by gradually increasing expectations and supporting an incremental return of functioning. This strategy is much like that recommended after a heart attack.

Research conducted over the last three decades has supported evidence-based practice guidelines for addressing family members' needs for information, clinical guidance, and ongoing support. This research has demonstrated that altering key types of negative interaction, while meeting the needs of family members,

dramatically improves patient outcomes while improving family well-being. Several models have evolved to address the needs of family members. They include:

1. Individual family consultation (Wynne, 1994).
2. Family psychoeducation (Anderson, Reiss, & Hogarty, 1986; Falloon, 1984), in single-family format.
3. Professionally led psychoeducational multifamily group (Kopelowicz et al., 2012; McFarlane, 2002).
4. Modified forms of more traditional family therapies (Marsh, 2001).
5. A range of professionally led models of short-term family education (sometimes referred to as therapeutic education) (Amenson, 1998).
6. Family-led information and support classes or groups such as those of the National Alliance for the Mentally Ill (NAMI) (Pickett-Schenk, Cook, & Laris, 2000).

Of these models, professionally led family psychoeducation has a deep enough research and dissemination base to be considered an evidenced-based clinical practice, especially in first-episode psychosis (Dixon et al., 2001; Lehman, Carpenter, Goldman, & Steinwachs, 1995; Lucksted, McFarlane, Downing, & Dixon, 2012; McFarlane, Dixon, Lukens, & Lucksted, 2002).

Psychoeducational treatment, when professionally led, is offered as part of a treatment plan for the patient, and is usually diagnosis-specific. The models differ in format (multiple-family, single-family, relatives only, combined), structure (involvement/exclusion of patient), duration and intensity of treatment, and setting (hospital, clinic, home). They place variable emphasis on didactic, emotional, cognitive-behavioral, clinical, rehabilitative, and systemic techniques. Most have aimed to achieve clinical and functional patient outcomes, although family understanding and well-being are assumed to be necessary to achieve those outcomes. All focus on family resiliency and strengths. Described here are the theoretical background for this treatment model, evidence of its effectiveness and its major components and technical methods.

Major Theoretical and Research-Based Constructs

While the scientific evidence is increasingly strong that the major psychotic disorders are based in genetic or neurodevelopmental defects involving brain function and structure, there is also abundant evidence that the final development and relapse of psychotic or severe mood symptoms are the result of psychosocial stress. The stress-diathesis or stress-vulnerability model provides a widely accepted, empirically supported and useful framework for describing the relationships among provoking agents (stressors), vulnerability and symptom formation (diathesis), and outcome (Zubin, Steinhauer, & Condray, 1992). Thus, a genetically or developmentally vulnerable person, whose inborn tolerance for stress is incompatible with exposure to either excessive internally or externally generated stimulation, may experience an episode of psychotic illness. This principle underlies the Biosocial Theory, which states that major psychotic and mood disorders are the result of the continual interaction of specific biologic disorders of the brain with specific psychosocial and other environmental factors (McFarlane, 2002). These psychosocial factors are the proximal causes of relapse in established cases and of the initial psychotic episode. Specifically, episodes are induced in biologically vulnerable individuals by major stresses imposed by role transitions and other life events, social isolation, family expressed emotion, conflict and exasperation, separation from family of origin and experienced stigma, among many others (see Box 16.1). This causal biosocial theory yields an interactive, feedback-based model for the final stages of onset and relapse, as compared to a simpler linear-causal model. In this conceptual framework, subtle symptoms and behavioral changes induce anxiety, anger, social rejection, confusion, and other reactions in family members, which in turn exacerbate those very same symptoms by inducing psychological and ultimately physiological stress reactions in the vulnerable person. The end result is a positive feedback process that leads to deterioration of both the patient and the family.

Box 16.1 Biologically Based, Empirically Derived Stressors in Major Psychotic Disorders

- Sensory stimulation
- Prolonged stress
- Strenuous demands
- Rapid change
- Excessive complexity
- Social disruption
- Stimulant drugs and alcohol
- Negative emotional experience

Prospective Studies of Family Interaction Prior to Onset

Tienari and his colleagues recently, and Goldstein and his colleagues earlier, have shown in two landmark prospective studies that family expressed emotion (EE) and communication deviance (CD), especially negativity directed toward the at-risk young person, predict onset of psychosis, interacting with genetic risk (having a biological mother with schizophrenia) or psychiatric (already having non-psychotic symptoms and behavioral difficulties) (Goldstein, 1985; Tienari et al., 2004). In support of the stress (environmental risk) part of the biosocial theory, Goldstein demonstrated that onset of psychosis in disturbed adolescents seeking psychological treatment could be predicted by in-vivo assessment of negative family Affective Style (AS, a directly observed form of EE) and deficiencies in clarity and structure of communication (CD). The Finnish Adoption Study rigorously combined and tested both psychosocial and genetic risk factors and their interaction in a developmentally sensitive design. This study provided the first compelling evidence for a gene-environment interaction for schizophrenia spectrum disorders. The results indicated that risk for development of schizophrenia spectrum disorders was much higher—37% vs. 6%—among genetically at-risk adoptees reared in families in which there were higher levels of negativity, family constrictedness (flat affect, lack of humor), and family boundary problems (e.g., generational enmeshment, chaotic family structure, unusual communication). There was no increase in the incidence of schizophrenia spectrum disorders among genetically at-risk adoptees reared in less distressed families. Thus, not only were certain types of common family dynamics implicated in triggering the onset of schizophrenia in genetically vulnerable children, healthier family dynamics also played a protective role; that is, preventing an illness in genetically predisposed individuals.

These studies lead to a more complex model of etiology, but one that is far more precise and therefore more clinically useful. In essence, negative family interactional patterns are as potent and indispensable factors in onset as are genetic and neurodevelopmental factors, but only when those predisposing biological factors are themselves present. This model joins a now large literature that documents gene-family interaction as a mutually causal process in both mental and physical health disorders (Felitti et al., 1998; Reiss, Neiderhiser, Heatherington, & Plomin, 2000; Repetti, Taylor, & Seeman, 2002). The current conclusion based on empirical—rather than ideological or theoretical—foundations is that severe psychiatric and medical disorders are the result of (negative family) nurture acting on (genetically or developmentally abnormal) nature, specifically defined in each disorder but heavily and equally dependent on both sets of influences. For the severe mental disorders, most of the negative family interaction is reactive to the developing or continuing illness itself. In that empirical context, family intervention targets one of the two fundamental etiological domains in major psychiatric disorders.

Expressed Emotion (EE)

High levels of criticism and emotional overinvolvement are strongly predictive of exacerbation

or relapse of symptoms (Brown, Birley, & Wing, 1972). In an extensive meta-analysis, Bebbington and Kuipers (1994) cite the overwhelming evidence from twenty-five studies representing 1,346 patients in twelve different countries for a predictive relationship between high levels of expressed emotion and relapse of schizophrenia and bipolar disorder. Inclusive reciprocal models have been proposed to increase the accuracy of the construct. For example, Cook (Cook, Strachan, Goldstein, & Miklowitz, 1989), Strachan (Strachan, Feingold, Goldstein, Miklowitz, & Nuechterlein, 1989) and Goldstein (Goldstein, Rosenfarb, Woo, & Nuechterlein, 1994) found that expressed emotion among key relatives is a reflection of transactional processes between the patient and family, supporting the conclusion that family functioning is strongly and negatively affected by aspects of the illness in the patient–relative, as well as the converse.

Recent studies have provided support for an ongoing interaction between symptoms and family responses, reflected in data on EE at different phases. Several studies suggest that EE is less pronounced in the earliest phases of psychosis, and increases over time. Hooley and Richters (1995) found that criticism and hostility rates rose rapidly in the first few years of the course of illness: in 14% of families with less than one year of illness, 35% within one to three years of onset and peaking at 50% of the sample after five years. Components of EE (rejection, warmth, protectiveness, and fusion) differ widely across prodromal and chronic patient samples. Parental scores for rejecting attitudes and emotional over-involvement were all but identical in established-disorder samples but were markedly higher than scores in a prodromal sample (McFarlane, 2006). These studies strongly suggest that expressed emotion is largely reactive to cognitive deterioration, disabilities, and emerging negative behavior manifested by the young person developing a psychotic disorder.

Attribution—the relatives' beliefs about the causes of illness-related behavior—has also been associated with expressed emotion. Relatives described as critical or hostile misperceive the patient as somehow responsible for unpleasant, symptomatic behavior, whereas more accepting relatives saw identical behaviors as characteristic of the illness itself (Brewin, MacCarthy, Duda, & Vaughn, 1991). Relatives have special difficulty in distinguishing negative symptoms, especially amotivation and anergia, from simple laziness, personality disorder or outright oppositional or manipulative behavior. For that reason, they often do not express the kind of empathy that might protect against exasperation, resentment, or hostility. This is an especially acute risk in the prodromal phase and in the first episode, during which symptoms and deficits often develop gradually, sometimes imperceptibly, appearing to reflect emerging personality or behavioral faults. A youth who slowly becomes cognitively impaired, while denying illness and becoming increasingly paranoid, hostile, affectively labile, socially withdrawn, or anhedonic, will be much less likely to receive the support needed to function at an optimal level (McFarlane & Lukens, 1998). If family members confronted by such symptoms in a loved one have little formal knowledge of the illness, they are likely to respond with increased involvement, emotional intensity, criticism, or even hostility.

Stigma

Stigma is often associated with a withdrawal of social support, demoralization, and loss of self-esteem, and can have far-reaching effects on daily functioning, particularly in the workplace. As Link and colleagues (Link, Mirotznik, & Cullen, 1991) observed, stigma has a strong continuing negative impact on well-being, even though proper diagnoses and treatment improve symptoms and levels of functioning over time. Stigma affects the family as well. Effects include withdrawal and isolation on the part of family members, which in turn are associated with a decrease in social network size and emotional support, increased burden, diminished quality of life, and exacerbations of medical disorders (Wong et al., 2009). Self-imposed stigma tends to reduce the likelihood that early signs will be addressed and treatment sought and accepted, especially during the first episode (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001).

Communication Deviance

Communication deviance, a measure of distracted or vague conversational style, has been

consistently associated with schizophrenia. It was the other factor in the prospective long-term outcome study that predicted the onset of schizophrenic psychosis in families of disturbed, but non-psychotic, adolescents (Goldstein, 1985). Studies have demonstrated that it is correlated with cognitive dysfunction in the relatives, which is of the same type, but of lower severity, as is seen in patients with schizophrenia (Wagener, Hogarty, Goldstein, Asarnow, & Browne, 1986). This suggests that some family members have an inherent—probably genetically derived—difficulty holding a focus of attention, with important implications for treatment design. The result is that a child with subtle cognitive deficiencies may learn to converse in a communication milieu that is less able to compensate and correct.

Social Isolation

The available evidence across several severe and chronic illnesses indicates that ongoing access to social contact and support prevents the deterioration of such conditions and improves their course (Penninx, Kriegsman, van Eijk, Boeke, & Deeg, 1996). Family members of the most severely ill patients seemed to be isolated, preoccupied with, and burdened by the patient. Brown et al. (1972) showed that 90% of the families with high expressed emotion were small in size and socially isolated. In addition, social support buffers the impact of adverse life events (Lin & Ensel, 1984) and is one of the key factors predicting medication compliance (Fenton, Blyler, & Heinssen, 1997), behavior toward treatment in general, schizophrenic relapse, quality of life (Becker et al., 1998) and subjective burden experienced by relatives (Solomon & Draine, 1995). Social network size decreases with number of episodes, is lower than normal prior to onset, and decreases during the first episode (Anderson, Hogarty, Bayer, & Needleman, 1984).

Effects of Psychosis on the Family

Because there is so much evidence that some family members of patients share sub-clinical forms of similar deficits and abnormalities, treatment for psychotic and severe mood disorders must be designed to compensate for some of those difficulties. Those deficits lead to diminished coping ability in some family members, which is required in abundance in order to provide a stabilizing, let alone therapeutic, influence on the affected family member. Further, the psychotic disorders exact an enormous toll on family members, in anxiety, anger, confusion, received stigma, rejection, and exacerbation of medical disorders (Johnson, 1990). The organization of most families undergoes a variety of changes, including alienation of siblings, exacerbation, or even initiation of, marital conflict, severe disagreement regarding support versus behavior control, even divorce. Almost every family undergoes a degree of demoralization and self-blame, which may be inadvertently reinforced by some clinicians.

A Model of Reciprocal Causation

These critical family and psychosocial factors lead to onset and relapse of psychosis via a) a general and biologically based sensitivity to external stimulation and b) a major discrepancy between stimulus complexity and intensity and cognitive capacity. Cognitive deficits, behavioral changes in the patient, effects of the psychosis on the family and characteristic family coping styles converge, generating external stresses that induce a spiraling and deteriorating process that ends in a major psychosis or onset of a major mood episode.

These are the factors that are potential targets for family psychoeducation and multifamily groups. Family intervention alters critical environmental influences by:

- reducing ambient social and psychological stresses
- reducing stressors from negative and intense family interaction
- building barriers to excess stimulation
- buffering the effects of negative life events
- promoting patient- and family-specific coping skills.

The family psychoeducational model defines schizophrenia and other psychotic and mood disorders as disorders of brain function that leaves the patient highly and unusually sensitive to the social environment. Thus, this form of treatment is seen as bimodal, influencing both the disease, through medication, and the social environment,

through techniques which deliberately reduce stimulation, negativity in interpersonal interaction, rate of change, and environmental and interactional complexity. The approach achieves that goal by providing relevant education, training and support to family members, friends and other caretakers—those who provide support, protection, and guidance to the patient.

Research Evidence That Supports the Model

The cumulative record of efficacy for family intervention, variously termed "family psychoeducation," "family behavioral management," or "family work" (but not "family therapy") is remarkable. Over forty controlled clinical trials have demonstrated markedly decreased relapse and rehospitalization rates among patients whose families received psychoeducation compared to those who received standard individual services; the larger effects have been observed in studies in which the treatment was continued for twelve months or more. Several literature reviews have been published in the past decade, all finding a large and significant effect for this model of intervention (Dixon, Adams, & Lucksted, 2000; Lucksted, McFarlane, Downing, & Dixon, 2012; McFarlane, Dixon, Lukens, & Lucksted, 2003). Since 1978, there has been a steady stream of rigorous validations of the positive effects of this approach on relapse in schizophrenic disorders. Overall, the relapse rate for patients provided family psychoeducation has hovered around 15% per year, compared to a consistent 30–40% for individual therapy and medication or medication alone (Baucom et al., 1998). In a recent Cochrane review, relapse was lower in psychoeducation group (n = 1214, RR 0.70, CI 0.61 to 0.81, NNT 9, CI 7 to 14), as was hospital readmission (n = 206, RR 0.71, CI 0.56 to 0.89, NNT 5, CI 4 to 13). Psychoeducation also promoted better social and global functioning. Treating four people with schizophrenia with psychoeducation instead of standard care resulted in one additional person showing a clinical improvement. Evidence suggested that participants receiving psychoeducation were more likely to be satisfied with mental health services (n = 236, RR 0.24, CI 0.12 to 0.50, NNT 5, CI 5 to 8) and have improved quality of life (Xia, Merinder, & Belgamwar, 2011). This effect size equals or exceeds the reduction in relapse in medicated vs. unmedicated patients in most drug maintenance studies and is universally consistent across well-conducted studies.

McFarlane and colleagues have shown that when rigorously compared, psychoeducational multifamily groups lead to even lower relapse rates and better employment outcomes than the same intervention in single-family sessions (McFarlane, Link, Dushay, Marchal, & Crilly, 1995a; McFarlane et al., 1995b). The simplest explanation is that enhanced social support, inherent in the multifamily format, reduces vulnerability to relapse by further reducing anxiety and general distress (Dyck et al., 2002). In a study of differential effects in schizophrenia of single- (SFT) and multifamily group (MFG) forms of the same psychoeducational treatment method, better outcomes were observed for multifamily groups among those having their first hospitalization (McFarlane, Dushay, Stastny, Deakins, & Link, 1996; McFarlane et al., 1995b), including very low relapse rates over four years (12.5% per year). For those cases fully remitted after an index admission (BPRS mean item score ≤ 2), there was no difference in relapse rate between treatment modalities (32.7% in PMFGs, vs. 31.8% in SFT). However, for those who were symptomatic at discharge (BPRS > 2), 19% of the MFG cases relapsed, while 51% of the cases assigned to SFT relapsed, a risk of relapse only 28% of that of SFT, a highly significant difference. That is, in the highest risk sub-sample, the MFG relapse rates were actually lower than in more well-stabilized patients, while the opposite effect was observed in single-family treatment. These empirical results strongly suggest a multidimensional effect for the multifamily group format as the explanation for improved clinical outcomes. Recent reports have only added to the strong validation of the effects on relapse, particularly because these later studies have been conducted in a variety of international and cultural contexts. Reductions in relapse for family intervention, compared to the control conditions, have been demonstrated in China (Zhao et al., 2000), Spain (Muela Martinez & Godoy Garcia, 2001), Scandinavia (Rund et al., 1994) and England (Barrowclough et al., 2001). In particular, psychoeducational multifamily group

treatment is the only psychosocial intervention for first-episode psychosis that has achieved both Evidence Level A and the highest level of international consensus for efficacy (Addington, McKenzie, Norman, Wang, & Bond, 2013).

These and other studies have demonstrated significant effects on other areas of functioning, going beyond relapse as the main dimension of outcome. In particular, family intervention, especially in the multifamily group format, has demonstrated clinically significant reductions in negative symptoms, something not achieved by antipsychotic or any other group of medications. This reflects observation from the earliest reports of multifamily groups—patients seemed to gradually re-emerge from their anergia and social withdrawal and begin to relate more positively to their families and peers in these groups, compared to other forms of therapy and medication. Many patients and their family members are more concerned about the functional aspects of the illness, especially housing, employment, social relationships, dating and marriage, and general morale, than about preventing relapse, which tends to be somewhat abstract as a goal. Several of the previously mentioned models, particularly the American versions—those of Falloon, Anderson, and McFarlane, have used remission (the absence of relapse) both as a primary target of intervention and as necessary first step toward rehabilitative goals and recovery. In addition, these models all include major components designed to achieve functional recovery, and the studies have documented major progress in those same domains. Several investigators, including our research team, have extended the aims beyond the clinical to include targeting these more human aspects of illness and life. Other effects have been shown for:

- improved family member well-being (Cuijpers, 1999; Falloon & Pederson, 1985)
- increased patient participation in vocational rehabilitation (Falloon et al., 1985)
- substantially increased employment rates (McFarlane et al., 1996; McFarlane et al., 2000)
- decreased psychiatric symptoms, including negative symptoms (Dyck et al., 2000; Zhao, et al., 2000)
- improved social functioning (Montero et al., 2001)
- decreased family distress (Dyck et al., 2002)
- reduced costs of care (McFarlane et al., 1995b; Rund et al., 1994).

As a result of the compelling evidence, the Schizophrenia Patient Outcomes Research Team (PORT) project included family psychoeducation in its set of treatment recommendations. The PORT recommended that all families in contact with their relative who has mental illness be offered a family psychosocial intervention spanning at least nine months and including education about mental illness, family support, crisis intervention, and problem-solving skills training (Lehman et al., 1998). Other best practice standards (American Psychiatric Association, 1997; Frances, Docherty, & Kahn, 1996) have also recommended that families receive education and support programs. An expert panel that included clinicians from various disciplines, families, patients, and researchers emphasized the importance of engaging families in the treatment and rehabilitation process (Coursey, Curtis, & Marsh, 2000).

It is important to note that most studies evaluated family psychoeducation for schizophrenia or schizoaffective disorder only. However, several controlled studies do support the effects of family intervention for other psychiatric disorders, including dual diagnosis of schizophrenia and substance abuse (Barrowclough et al., 2001; McFarlane et al., 1995b), bipolar disorder (Miklowitz, George, Richards, Simoneau, & Suddath, 2003; Tompson, Rea, Goldstein, Miklowitz, & Weisman, 2000), major depression (Emanuels-Zuurveen, 1997; Leff et al., 2000), depression in mothers with disruptive children (Sanders & McFarland, 2000), mood disorders in children (Fristad, Gavazzi, & Soldano, 1998), obsessive-compulsive disorder (Van Noppen, 1999), anorexia (Geist, Heinmaa, Stephens, Davis, & Katzman, 2000), alcohol abuse (Loveland-Cherry, Ross, & Kaufman, 1999), Alzheimer's disease (Marriott, Donaldson, Tarrier, & Burns, 2000), suicidal children (Harrington et al., 1998), intellectual impairment (Russell, John, & Lakshmanan, 1999), child molesters (Walker,

2000) and borderline personality disorder (Gunderson, Berkowitz, & Ruizsancho, 1997), including single- and multifamily approaches. Gonzalez and Steinglass have extended this work to deal with the secondary effects of chronic medical illness (Steinglass, 1998).

Research-Based Treatment Protocol: Psychoeducational Multifamily Group Treatment

The psychoeducation multifamily group treatment model described here is designed to assist families in coping with the major burdens and stresses of the psychotic and severe mood disorders. Thus, this approach:

- allays anxiety and exasperation;
- replaces confusion with knowledge, direct guidance, problem-solving and coping skill training;
- reverses social withdrawal and rejection by participation in a multifamily group that counteracts stigma and demoralization;
- reduces anger by providing a more scientific and socially acceptable explanation for symptoms and functional disability.

In short, it relieves the burdens of coping while more fully engaging the family in the treatment and rehabilitation process. It also compensates for the expected subclinical cognitive or mood symptoms that many relatives can be expected to manifest. Optimally, family intervention should occur as early as possible for those who are experiencing a first episode of psychosis or major mood disorder or during the early, prodromal phase of the disorder. The multifamily group intervention, which incorporates elements of family psychoeducation and family behavioral management, is described briefly here and in detail elsewhere (McFarlane, 2002). The intervention model consists of four treatment stages that roughly correspond to the phases of an episode of schizophrenia or mania, from the acute phase through the recuperative and rehabilitation phases. These stages are: 1) Engagement; 2) Education; 3) Re-entry; and 4) Social/Vocational Rehabilitation (Anderson, Hogarty, & Reiss, 1986).

Engagement

The families and the newly admitted individuals are contacted within forty-eight hours after a hospital admission, onset of psychosis, or a mood episode or referral for imminent risk of an episode. Initial contacts with the patient are deliberately brief and non-stressful. The young person is included in at least one of the joining sessions, and the caretaking relatives meet alone with the clinician for at least one session. If the patients are actively psychotic, they are not included in these sessions, but only engaged in a patient–clinician format. The aim is to establish rapport and to gain consent to include the family in the ongoing treatment process. The clinician emphasizes that the goal is to collaborate with the family in helping their relative recover and avoid further deterioration or relapse. The family is asked to join with the clinician in establishing a working alliance or partnership. This phase typically includes three to seven single-family sessions for either the single- or multiple-family group format, but in the group approach more sessions may be required until a sufficient number of families is engaged.

Education

Once the family is engaged and while the patient is still being stabilized, the family is invited to a workshop conducted by the clinicians who will lead the multifamily group. These six-hour sessions are conducted in a formal, classroom-like atmosphere, involving five or six families. Biological, psychological, and social information about psychotic or mood disorders and their management are presented through a variety of formats, such as videotapes, slide presentations, lectures, discussion, and question and answer periods. Information about the way in which the clinicians, patient, and family will continue to work together is presented. The families are also introduced to guidelines for management of the disorder. The framework throughout the education is to have everyone understand that overcoming the illness involves understanding and addressing the underlying vulnerability to stress and information overload (see Box 16.2). Patients attend these workshops if they are clinically stable, willing, interested, and seemingly able to tolerate the social and informational stress.

Box 16.2 Guidelines for Families: Ways to Hasten Recovery and to Prevent a Recurrence

- Believe in your power to affect the outcome: you can.
- Make forward steps cautiously, one at a time.
  Go slow. Allow time for recovery. Recovery takes time. Rest is important. Things will get better in their own time. Build yourself up for the next-life steps. Anticipate life stresses.
- Consider using medication to protect your future.
  A little goes a long way. The medication is working and is necessary even if you feel fine. Work with your doctor to find the right medication and the right dose. Have patience, it takes time. Take medications as they are prescribed. Take only medications that are prescribed.
- Try to reduce your responsibilities and stresses, at least for the next six months or so.
  Take it easy. Use a personal yardstick. Compare this month to last month rather than last year or next year.
- Use the symptoms as indicators.
  If they re-appear, slow down, simplify and look for support and help, quickly. Learn and use your early warning signs and changes in symptoms. Consult with your family clinician or psychiatrist.
- Create a protective environment:
  - Keep it cool.
    Enthusiasm is normal. Tone it down. Disagreement is normal. Tone it down too.
  - Give each other space.
    Time out is important for everyone. It's okay to reach out. It's okay to say "no."
  - Set limits.
    Everyone needs to know what the rules are. A few good rules keep things clear.
  - Ignore what you can't change.
    Let some things slide. Don't ignore violence or concerns about suicide.
  - Keep it simple.
    Say what you have to say clearly, calmly, and positively.
  - Carry on business as usual.
    Re-establish family routines as quickly as possible. Stay in touch with family and friends.
  - Solve problems step by step.

(Anderson, Reiss, & Hogarty, 1986; McFarlane, 2001)

To the extent possible, the clinicians build education and information-sharing on each patient and family's unique and evolving experience, as assessed during the engagement process. Psychosis is defined as a reversible, treatable condition, like diabetes. The core problem is presented as an unusual sensitivity to sensory stimulation, prolonged stress and strenuous demands, rapid change, complexity, social disruption, illicit drugs and alcohol, and negative emotional experience. As for blame and assigning fault, the clinicians take an important position: neither the patient nor the family caused that sensitivity. Whatever the underlying biological cause might be, it is part of the person's physical personhood, with both advantages and disadvantages. Families are explicitly urged not to blame themselves for this vulnerability.

Re-entry

Following the workshop, the clinicians begin meeting twice monthly with the families and patients in the multiple family group format. The

goal of this stage of the treatment is to plan and implement strategies to cope with the vicissitudes of a person recovering from an acute episode of psychosis or to facilitate recovery from the prodromal state. Major content areas include treatment compliance, stress reduction, buffering and avoiding life events, avoiding street drugs and/or alcohol, lowering of expectations during the period of negative symptoms and a temporary increase in tolerance for these symptoms. Two special techniques are introduced to participating members as supports to the efforts to follow family guidelines: formal problem solving and communications skills training (Falloon, Boyd, & McGill, 1984). To facilitate community re-entry, the approach strives to maintain stability by systematically applying the group problem-solving method, case by case, to difficulties in implementing the family guidelines and fostering recovery.

Social and Vocational Rehabilitation

The family intervention approaches as a group are designed to accommodate and exploit the natural course of recovery from an acute episode. That is, because the time course of recovery from negative symptoms can be measured in months to years, rather than days to weeks as in the response of positive symptoms to medication, the family is coached, having initially tempered expectations and demands after the acute episode, to carefully and gradually increase expectations and demands toward the end of the first post-episode year. This strategy, derived from empirical analysis of time-courses optimal for recovery (Hogarty & Ulrich, 1977), is crucial to the success that family intervention has demonstrated in the functional domain (see Figure 16.1). It is entirely analogous to the strategy currently used to successfully recover from myocardial infarction—initial recuperation followed several months later by a careful increase in exercise and cardiac stress. Thus, approximately one year following initiation of treatment or an acute episode, most patients begin to see signs of a return to spontaneity and active engagement with those around them. This is usually a sign that the negative symptoms are diminishing and the patient can now be challenged more intensively.

The focus of this later phase deals more specifically with his/her rehabilitative needs, addressing the three areas of functioning in which there are the most common deficits: social skills, academic challenges and the ability to get and maintain employment. The rehabilitation phase should be initiated by patients who have achieved clinical stability by successfully completing the community re-entry phase. The central emphasis during this phase is the involvement of family (and multifamily group) members in helping each patient to begin a gradual, step-by-step resumption of responsibility and socializing. The clinicians continue to use problem solving and brainstorming in the PMFG to identify and find

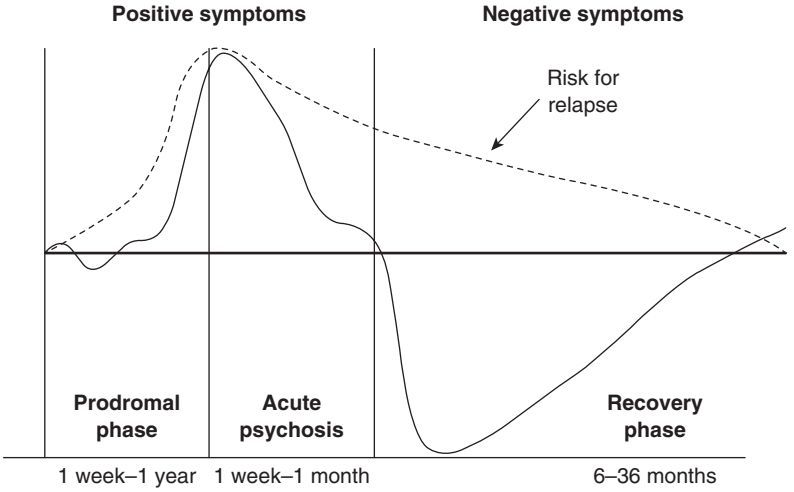

Figure 16.1 Risk for relapse over time in relation to positive and negative symptoms of schizophrenia

jobs and social contacts with the patients, and to find new ways to enrich their social lives. As stability increases, the multifamily group version of the approach functions in a role unique among psychosocial rehabilitation models: it operates as an auxiliary to the in-vivo social and vocational rehabilitation effort being conducted by the clinical team.

Multifamily Group Methods

These groups address elements of expressed emotion, social isolation, stigmatization, and burden directly by education, training, and modeling. Some of this effort focuses on modulating emotional expression and clarifying and simplifying communication. However, much of the effectiveness of the approach results from increasing the size and density of the social network, by reducing the experience of being stigmatized, by providing a forum for mutual aid, and by providing an opportunity to hear similar experiences and mutually to find workable solutions.

A stable membership of from five to seven families meets with two clinicians on a bi-weekly basis usually for one to three years following the onset of an episode of psychosis; all family members would have participated in an educational workshop. Unless psychotic, the patients also attend the group, although the decision to do so is based upon the patient's mental status and susceptibility to the amount of stimulation such a group occasionally engenders. Each session lasts for 1.5 hours.

Initial Sessions

The first meeting of the ongoing psychoeducational multifamily group follows the workshop by one or two weeks; it is co-led by the clinicians (usually two) who have engaged the participating families. The format of the sessions is controlled by the clinician, following a standard paradigm. From this point forward, patients are strongly encouraged to attend and actively participate. The task of the clinicians, particularly at the beginning, is to adopt a warm, but business-like tone and approach that promotes a calm, supportive, and accepting group climate, oriented toward learning new coping skills and engendering hope.

During the first two multifamily group sessions, the goal is to quickly establish a partnership among all participants. The initial sessions are intended to build group identity and a sense of mutual shared interest before going on to discuss clinical and rehabilitation issues. This approach promotes interfamily and interpersonal social support, and does *not* promote expressing feelings and usually suppresses negative emotional interactions among group members. Solving problems in the group depends on ideas being shared and accepted across family boundaries, so it is best to proceed slowly and take the time to develop trust and empathy.

People need an opportunity to get to know one another apart from the illness. The first and second group sessions are designed to help the participants and co-facilitators learn about each other and bond as a group. PMFG members are encouraged to also talk about topics unrelated to the illness, such as their personal likes, dislikes, and daily activities. The first two sessions are especially important in this regard. To succeed, the co-leaders act as a good host or hostess, one who makes introductions, points out common interests, and guides conversations to more personal subjects, such as personal histories, leisure activities, work, and hobbies. As well, the leaders act as role models; they should be prepared to share a personal story of their own. The guiding principles for this session are validation and positive reinforcement.

The second group session focuses more on how the mental illness has changed the lives of the people in the group and is intended to quickly develop a sense of a common experience of having or having a relative with a major mental illness. The mood of this session is usually less lighthearted than the previous session, but it is the basis for the emergence of a strong group identity and sense of relief. The leaders begin with socializing, encouraging participation by modeling, pointing out connections between people and topics, and asking questions. After socializing, the clinicians proceed to the topic for this meeting. The leaders share as much as possible about their own professional and personal

experiences, sharing a story about a friend or family member with mental illness, or talking about how they became interested in their work. Some individuals may find it difficult to talk about their experiences, so the leaders strive to point out any similarities among group member's experiences. Compared to the first meeting, the mood of this meeting is often sad, and there may be anger and frustration expressed as well. In closing, the leaders also remind group members that during future meetings everyone will be working on solving problems like the ones expressed in this meeting and that similar issues have been successfully dealt with in previous groups. It is important to be optimistic and send people home with the sense that the group can help them. There should be ten minutes or so to socialize before concluding the group.

Problem-Solving Procedures

Problem-solving within the context of the psychoeducational multifamily group is the essence of the process and its most potent therapeutic element. It is in this portion of the group that patients, families, and clinicians begin to make clear gains against the illness in a planned and methodical manner. The goal of the multifamily group is not just to have the group's help to solve problems. Rather, it is to provide individuals and families with an ongoing means to manage the symptoms of the illness beyond the group itself.

The multifamily group's primary working method is to help each family and patient to apply the family guidelines to their specific problems and circumstances. This work proceeds in phases whose timing is linked to the clinical condition of the patients. The actual procedure uses a multifamily group-based problem-solving method adapted from a single-family version by Falloon and Liberman (1983). It is the core of the multifamily group approach, one that is acceptable to families, remarkably effective and nicely tuned to the low-intensity and deliberate style, that is essential to working with the specific sensitivities of people with psychotic disorders.

Each session of the PMFG begins and ends with a period of social interchange, facilitated by the leaders (see Table 16.1). The purpose is to give the patients and even some families the opportunity to re-capture and practice any social skills they may have lost due to their long isolation and exposure to high levels of stress. Following the socializing, the clinicians specifically inquire as to the status of each family, offering advice based on the family guidelines or direct assistance, when it can be done readily. A single problem that has been identified by any one family is then selected and the group as a whole participates in problem solving. This problem is the focus of an entire

Table 16.1 Session program for ongoing family psychoeducation meetings

	Multifamily group	*Single family*
1. Socializing with families and consumers	15 m.	10 m.
2. A go-around, reviewing:	20 m.	15 m.
a. The week's events		
b. Relevant biosocial information		
c. Applicable guidelines		
3. Selection of a single problem	5 m.	5 m.
4. Formal problem solving	45 m.	25 m.
a. Problem definition		
b. Generation of possible solutions		
c. Weighing pros and cons of each		
d. Selection of preferred solution		
e. Delineation of tasks and implementation		
5. Socializing with families and consumers	5 m.	5 m.
Total:	90 m.	60 m.

session, during which all members of the group contribute suggestions and ideas.

The affected family then reviews their relative advantages and disadvantages, with some input from other families and clinicians. Typically, the most attractive of the proposed solutions is reformulated as an appropriate task for trying at home and assigned to the family. This step is then followed by another final period of socializing. This group format continues for most of the duration of the work, but is sometimes interspersed with visiting speakers, problem solving focused on generic issues facing several families and/or patients, and celebrations of steps toward recovery, holidays, and birthdays.

This five-step approach helps breaks down problems into a manageable form, so that a solution can be implemented in stages. One of the clinicians leads the group through the five steps. The other ensures group participation, monitors the overall process, and suggests additional solutions.

Defining the problem. While sometimes viewed as a rather simple process, this is often the most difficult step in the PMFG process. If the problem is not properly defined, individuals, families, and clinicians become frustrated and may be convinced that the problem cannot be solved. Common difficulties that groups experience in this aspect of the process are choosing a problem that is too large or too general, defining the problem in an unacceptable way for a participant, and defining the problem as the person with the problem.

The problem-solving process begins in the "go-around." The leaders address each issue presented individually, avoiding the temptation to combine similar concerns of group members. After each person has had an opportunity to report their perceptions of difficulties with the illness, the facilitators review the issues presented to determine which will be the focus of the group's efforts. Once a problem has been defined in a way that is acceptable to each member of the family, the clinician asks the recorder to write it down and read it back to the group. The clinicians need to consider carefully any report of actual or potential exacerbation of symptoms. Areas of particular significance are safety, incorporating the family guidelines, issues concerning medications and substance use, life events, and disagreement among family members as to how to assist the ill member. In order to decide which problem to work on, the clinicians ask detailed questions to clarify the problem, focusing on behavioral aspects as much as possible. Check in with the individual who raised this issue to be sure that the group truly understands their perception of the issue. The scale of problems, at least in the first few months of the group, is also a factor in selecting the problem. For instance, long-standing or previously intractable problems should only be addressed if they can be broken down into more solvable sub-problems. Leaders may choose to select simpler problems early in the group, so that the members learn the method, gain trust in each other, and achieve a few successes.

Generating possible solutions. The group members are then asked to offer whatever solutions they think may be helpful. The leaders should stress that it is important to resist evaluating or discussing solutions, since doing so dramatically reduces the number of solutions presented. After all solutions have been presented, facilitators invite group members to share their thoughts on the efficacy of each solution. Each solution is addressed individually, marking the "pros" and "cons" after each solution. This allows the group to become active in thinking about possible solutions, even when there are multiple solutions available.

Choosing the best solution. When all solutions have been evaluated, facilitators review the list, stressing those with the most positive and fewest negative responses. The whole solution list is then presented to the individuals who provided the issue originally. They are asked which of the solutions they would like to test out over the next two weeks. It is important to stress that testing solutions is for the benefit of both the individual and the group, as everyone is looking for things that work.

Implementing the chosen solution. Once a solution has been selected, a very detailed, behaviorally

oriented plan is developed. Each step is discussed and a person assigned responsibility for completion of each step. The greater the detail provided, the better. Some groups offer the solutions to all group members to try, asking that the group be informed of their efforts, successes or lack of success, thus increasing the repertoire of knowledge of the group.

Reviewing implementation. The individual is reminded that the facilitators may call during the coming week to check on their progress and to offer assistance. The individual is also asked to report at the next group meeting how successful they were and any obstacles that they encountered.

Single-Family Psychoeducation

The model described for the multifamily group can be readily adapted to work in single family sessions. Details of the single-family clinical models are to be found in Anderson's and Falloon's books and are summarized here. Both the single- and multifamily approaches described here are based on these works and the outcome research conducted by their groups. Another key source is *Bipolar Disorder: A Family-focused Treatment Approach*, by David Miklowitz and Michael Goldstein (1997), which describes the family behavioral management approach for that disorder. Table 16.1 details the structure that frames work in both formats; single-family sessions are usually an hour in length, but the sections of the session are all but identical.

Clinical Methods

As in the PMFG format, the basic psychoeducational model consists of four stages that roughly correspond to the phases of an episode of schizophrenia, from the acute phase through the slow recuperative and rehabilitation phases.

Engagement

This stage refers to a way of working with families that is characterized by collaboration in attempting to understand and relate to the family. The joining phase is typically three to five sessions and is the same in both single- and multifamily formats. The goals of this phase are to: a) establish a working alliance with both the family members and the consumer; b) acquaint oneself with any family issues and problems which might contribute to stress either for the consumer or for the family; c) assess and validate the family's strengths and resources in dealing with the illness; d) instill hope and an orientation toward recovery; and e) create a contract with mutual and attainable goals. Engagement, in its most general sense, continues throughout the treatment, since it is always the responsibility of the clinician to remain an available resource for information and guidance for the family as well as their advocate in dealing with any other clinical or rehabilitation services necessitated by the illness of their relative. To foster this relationship, the clinician acknowledges the family's loss and grants them sufficient time to mourn, is available to the family and consumer outside of the formal sessions, helps to focus on the present crisis, and serves as a source of information specifically geared to their needs and questions about the illness.

Educational and Training Workshop

The family is invited to attend workshop sessions conducted in a formal, classroom-like atmosphere. If a multifamily workshop is not feasible, information is provided to a single family, tailored to their specific situation and the diagnosis and phase of illness of the patient. Biological, psychological, and social information about schizophrenia (or other disorders, as the case may be) and its management are presented through a variety of formats, such as videotapes, slide presentations, lectures, discussion, and answering their specific question. An advantage of single-family education is that the education can be done in the family's home. Information about the way in which the practitioner and the family will continue to work together is also presented. A multifamily educational workshop is typically six to eight hours in length, but single-family education can be set up as a series of shorter sessions on a weekly basis. The family is also introduced to the "guidelines" for management of the illness.

These consist of a set of behavioral instructions for family members that integrate the biological, psychological, and social aspects of the disorder with recommended responses, those that help maintain an optimal home environment that minimizes stress (see Box 16.2).

Community Re-entry

Regularly scheduled, bi-weekly, single-family meetings focus on planning and implementing strategies to cope with the vicissitudes of a person recovering from an acute episode. These working sessions are similar in structure to that described in the multifamily group format. Major content areas include the effects and side effects of medication, common issues about taking medication as prescribed, helping the consumer avoid the use of street drugs and/or alcohol, the general lowering of expectations during the period of negative symptoms, and an increase in tolerance for these symptoms. Two special techniques are introduced to participating members as supports to the efforts to follow family guidelines (Falloon et al. 1984): 1) formal problem solving and 2) communications skills training. The application of either one of these techniques characterizes each session. Further, each session follows a prescribed, task-oriented format or paradigm, designed to enhance family coping effectiveness and to strengthen the alliance among family members, consumer, and the clinician. The re-entry and rehabilitation phases are addressed using formal problem-solving methods and communication skills training. The problem-solving method is described more fully in the section on multifamily groups. The principal difference is that in single-family sessions, the participants and the recipients of ideas are the same, so that family members most commonly develop new approaches to their problems by brainstorming among themselves.

In the single-family approach, communications skills training is particularly important, whereas in the multifamily group format, the influence of other families tends to improve communication within and among families; in a PMFG, explicit communication skills training is usually not required. Communication skills training is a set of skills developed to address the cognitive difficulties often experienced by consumers with the severe mental illnesses, especially those with a psychotic phase. The core goal is to teach family members and the patient new methods of interacting that acknowledge and hopefully counteract the effects of mental illness on the patient's information-processing abilities and marked sensitivity to negative emotion and stimulation. The key skills include: a) communication of positive feelings for specific positive behavior; b) communication of negative feelings for specific negative behavior; and c) attentive listening behavior when discussing problems of other important family issues. The approach involves rehearsing communication skills in the session, often modeled by the clinician, followed by repeated rehearsal, often at home, and then homework to assist generalizing the skills learned to other contexts, with social reinforcement used throughout the process of training. These skills are especially useful for families whose members are markedly exasperated and manifesting criticism or hostility toward the consumer and/or severe anxiety, preoccupation, and intrusiveness as a consequence of disability and symptoms caused by the illness. Often, such reactions by family members are because of poor treatment response, substance abuse, medication refusal, or expectations that are beyond what the consumer is able to achieve at the present time given the severity of illness.

This process is repeated throughout the community re-entry phase and continued as needed through the rehabilitation phase. The focus of this later phase deals specifically with the rehabilitative needs of the patient, addressing the two areas of functioning in which there are the most common deficits: social skills, and the ability to get and maintain employment. The sessions are used to role-play situations that are likely to cause stress for the consumer if entered into unprepared. Family members are actively used to assist in various aspects of this training endeavor. Additionally, the family is assisted in rebuilding its own network of family and friends, which has usually been weakened as a consequence of the illness. Regular sessions are conducted on a once- or twice-monthly basis, although more contact may be necessary at particularly stressful times.

Conclusion

Family psychoeducation and multifamily groups have shown remarkable outcomes in more than a score of studies, and multifamily groups appear to have a specific efficacy in earlier phases and in more distressed families. Clinical trials and extensive clinical experience have demonstrated that family-oriented, supportive, psychoeducational treatment is acceptable to families and meets many of their needs. There is theoretical support for the efficacy of these methods, with their strategy of stress-avoidance, -protection and -buffering, while the multifamily group format adds an inherent element of social support and network expansion.

Key Points

- Family psychoeducation and multifamily groups have shown remarkable outcomes in more than a score of studies, achieving a minimum of 50% reduction in relapse rates beyond medication effects, and marked improvements in social and vocational functioning.
- Multifamily groups appear to have a specific efficacy in earlier phases and in more distressed or negative families and are markedly more cost effective.
- Clinical trials and extensive clinical experience have demonstrated that family-oriented, supportive, psychoeducational treatment is acceptable to families and meets many of their needs.
- There is theoretical support for the efficacy of these methods, with their strategy of stress-avoidance, -protection and -buffering, while the multifamily group format adds an inherent element of social support and network expansion.
- The core elements are:
    - Joining with families and patients to engage them in a mutual partnership to treat and overcome the impairments of severe mental disorders.
    - Educating families and patients about the psychobiology of those disorders, their effective treatments, and the strategies that families and patients can use to overcome and cope with those symptoms and impairments.
    - Problem-solving specific clinical and functional barriers to recovery, using the perspectives of each family member, the clinician and—in the multifamily group format—the perspectives and experience of other families.
    - Communication skills training to reduce negativity and maximize warmth and clarity.
    - Setting limits on self-destructive, threatening or annoying behavior secondary to the illness.
    - Building or providing—in the multifamily group format—social support and validation.

The outcomes consistently observed, such as a 50–85% reduction in rehospitalization rates, can only be achieved by adhering to well-tested practice guidelines and protocols.

Recommenced Readings and Sources

Several reviews, websites, and textbooks have proven useful to clinicians who are embarking on understanding and becoming proficient in family psychoeducation. The books by Anderson, Falloon, Leff, Miklowitz, this chapter's author and their colleagues are particularly useful as clinical guides; several of them are the treatment manuals for their respective outcome research studies. The website at SAMHSA includes a workbook that gives a brief overview of the clinical intervention as a practice model.

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Websites

Evidence-based practices: family psychoeducation:

- http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/default.asp

Families and early detection of psychosis:

- www.stopmentalillness.org
- www.rwjf.org
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17.

EMOTIONALLY FOCUSED COUPLE THERAPY

Empiricism and Art

Susan M. Johnson and Lorrie L. Brubacher

Introduction

Emotionally focused couple therapy (EFT) (Johnson, 2004) is a brief, integrative approach that focuses on helping partners in close relationships create secure attachment bonds. In practice, EFT integrates an experiential humanistic perspective that values emotion as an agent of change combined with a systems view of reciprocally reinforcing patterns of interaction, all grounded in an attachment orientation to intimate adult relationships. The EFT therapist is a process consultant, helping partners expand constricted and constricting inner emotional realities and interactional responses, thereby shifting rigid interactions into responses that foster resiliency and secure connection (Lebow, Chambers, Christensen, & Johnson, 2012).

The EFT model, first tested in the early 1980s (Johnson & Greenberg, 1985), has many strengths which have been validated and are being expanded upon as we have moved into the 21st century. They may be listed as the following:

- The EFT model fits very well with research on the nature of couple distress and satisfaction, which focuses on the quality of emotional engagement, the power of negative interaction patterns, and the need for soothing responsiveness in close relationships. At the end of the last century, EFT was found to achieve the most positive outcomes of any approach to couple therapy, in terms of both helping clients reach recovery from distress and maintaining these results over time (Johnson, Hunsley, Greenberg, & Schindler, 1999; Lebow et al., 2012). No other empirically validated approach has yet exceeded its effect size of 1.3 and been found to be stable over time (Clothier, Manion, Gordon-Walker, & Johnson, 2002; Halchuk, Makinen, & Johnson, 2010). Added to this is the encouraging finding that couples treated with EFT have shown increased improvement after therapy ends (Johnson & Talitman, 1997).
- EFT is based on a clear and empirically validated theory of adult love relationships in the form of attachment theory (Johnson & Whiffen, 2003). There is nothing so practical as a good theory. Attachment theory which has, in the last two decades, generated a plethora of creative research (Mikulincer & Shaver, 2007; Cassidy & Shaver, 2008; Simpson & Rholes, 2015) guides the EFT therapist moment to moment in the choice of interventions and the creation of change events. New attachment neuroscience (Coan, 2008) provides support for the emotion regulating function of secure attachment bonds in adult relationships that EFT interventions foster.

- EFT has taken a lead in addressing a concern identified by Lebow (Lebow et al., 2012): the undeveloped area of couple therapy process research that studies *how* change is created. EFT has a substantial body of process research (Greenman & Johnson, 2013), a detailed examination of therapist and client in-session actions and responses that leads to continual refinement of the model. These studies, which examine client change processes and therapist interventions that shape successful change events provide an empirical basis to the belief that EFT interventions are "on target" and also aid the therapist in the construction of key change events (Bradley & Furrow, 2004; Zuccarini, Johnson, Dalgleish, & Makinen, 2013). This is described in more detail in the section below on research on EFT.
- EFT has expanded to community and psychoeducational settings. The book *Hold me Tight* (Johnson, 2008b), now available in over twenty languages, has made attachment theory and the Steps of EFT available to the general public, many of whom may never step foot inside a therapist's office. Community-based education and enrichment programs have been developed for the public (Johnson, 2010) and specifically for military post-deployment couples (Johnson & Rheem, 2006). EFT is increasingly embraced around the globe, suggesting that its foundation in attachment theory has relevance and is effective across cultures.
- EFT has expanded considerably in the last decade in its application to many specific treatment populations and different clinical issues. Consonant with important recent developments in the field of couple and family therapy (Lebow et al., 2012), EFT is expanding its validation as an effective treatment for many previously identified individual disorders (Furrow, Johnson, & Bradley, 2011). It has been found to be particularly applicable to couples where partners suffer from depression and post-traumatic stress disorder. EFT has addressed the areas of sexuality (Johnson & Zuccarini, 2010, 2011) and cultural diversity and differences (Greenman, Young, & Johnson, 2009). Additionally in clinical practice, EFT is routinely used with same-sex couples, in family therapy (EFFT; Johnson, Maddeaux, & Blouin, 1998) and in work with blended families (Furrow & Palmer, 2011).
- EFT is integrative, combining an experiential focus on self with a systemic focus on interaction. It is an integration of empiricism and art: following the path laid out in empirical research on the elements that constitute emotional experience, the over-riding power of attachment, and the imperatives of separation distress, EFT also relies upon the art of the therapist's imagination and creativity to empathize, attune, and resonate with each individual client and with the distressingly painful attachment drama in which the couple is caught. It is collaborative and respectful of clients, as are all humanistic interventions, focusing as they do on growth, rather than on pathology, and with its grounding in attachment theory is congruous with feminist approaches.

Historical Development of EFT

Much has happened in the field of couples' therapy since the early 1980s, when EFT was first formulated. At that time, behavioral interventions, based on social exchange theory—a focus on profit and loss in close relationships—offered the only clearly structured and tested treatment for relationship distress. Emotion was seen as part of the problem of distress, rather than as part of the solution. Interventions tended to focus on skill acquisition, negotiated behavior change, or, in more psychodynamic models, insight into past relationships. The application of attachment theory was limited to the relationship between parent and child, and emotion, if discussed at all, was seen mostly in terms of ventilation and catharsis and was generally avoided in couple therapy sessions (Mahoney, 1991). Unless the therapist adopted a behavioral perspective, there was very little specific guidance in the literature on how to conduct couples' therapy. Even though clinicians such as Satir (Satir & Baldwin, 1983) had formulated a number of interventions, there was no articulated model of couple therapy that combined a focus on inner realities and outer

systemic interaction patterns. The detailed observation and tracking of numerous couples as they struggled to repair their relationships in therapy lead to the first EFT manual and the first outcome study (Johnson & Greenberg, 1985). This observation, however, was guided by a particular theoretical framework.

The guiding perspective was the humanistic experiential approach put forward by Carl Rogers and Fritz Perls (Cain & Seeman, 2002), which focuses on the proactive processing of experience as it occurs and on how meaning is constructed (Neimeyer, 1993). Rogers, in particular, modeled active empathic collaboration with the client in the processing of experience and emphasized the power of emotion to organize meaning making and behavior (Rogers, 1951). However, as Bateson pointed out (1972, p. 493), "When you separate mind from the structure in which it is immanent, such as human relationships . . . you embark on a fundamental error," so to this general experiential perspective, it was necessary to add a systemic orientation, epitomized by Minuchin and other structural family therapists (Minuchin & Fishman, 1981). In both systems theory and experiential approaches problems are seen in terms of process, rather than being inherent in the person; that is, it is how the inner processing of experience or how key interactions in key relationships are organized that triggers and maintains dysfunction or distress.

It was also not very long before clinical observation began to evoke Bowlby's attachment theory as a natural explanatory framework for how relationships became troubled and how they could be repaired (Johnson, 1986). Partners spoke of disconnection and isolation as traumatizing, and the power of safe emotional engagement became obvious as partners repaired their relationship. Attachment theory which has been extensively applied to adult relationships in the last twenty-five years offers the EFT couple and family therapist a clearly articulated theory of adult love and close relationships to guide goal setting and intervention (Johnson, 2008a). It is important to note that attachment theory integrates a focus on self and system and views individuals' construction of self in the context of their closest relationships. It is then easily integrated with systems perspectives (Johnson & Best, 2002).

Since the 1980s, there has also been an appreciation of the role emotion plays in individual mental and physical health (Coan, 2008; Robles & Kiecolt-Glaser, 2003) and relationship functioning. As Zajonc notes (1980, p. 152), "Affect dominates social interaction and it is the major currency in which social interaction is transacted." The role of emotion in creating change in therapy has gradually become more explicit and refined (Fosha, Siegel, & Solomon, 2009). Core emotions identified as present across all cultures are anger, fear, sadness/agony, disgust, contempt, surprise, and joy, and emotion is defined as an *active process* beginning with a rapid limbic appraisal to an environmental cue, moving to physiological, behavioral, and meaning-making cognitive components (Ekman, 2003/2007). Therapists have also identified different kinds of emotion, such as secondary reactive emotion and more primary emotion that is often avoided or left unarticulated, but that can be used to create change in therapy. This literature focuses on how emotion, which comes from the Latin word "to move," can move people toward change, and how emotional communication defines the nature of relationships (Johnson & Greenberg, 1994). As a new technology of working with emotion emerges, systemic therapists are incorporating a focus on emotion in their work (Johnson, 2009; Schwartz & Johnson, 2000).

The Theoretical Perspective of EFT on Relationship Distress and Adult Intimacy

The theoretical perspective of EFT combines the research on the nature of relationship distress with the research on the attachment perspective of adult love and relatedness. Attachment theory, as will be shown below, makes the findings on relationship distress more pertinent and practical for the couple therapist. The later section "Interventions in EFT" illustrates further how attachment theory guides the EFT clinician's moment-to-moment choice of interventions and creation of key transformative change events toward alleviating the factors identified in the relationship distress research. The study of emotion and the growing body of research

on affective neuroscience (Cozolino, 2006; Coan, 2008) are both endemic to and expansive of EFT's theoretical underpinnings. The most recent research shows that EFT outcomes extend beyond increasing relationship satisfaction into the realm of altering capacities to regulate emotion, reducing anxiety and avoidance, and creating more secure attachment bonds (Burgess Moser et al., in press). This is the first time that a couple intervention has been shown to significantly impact the quality of an attachment bond, identified in the extensively studied and rich explanatory theory of adult love as the core feature of love relationships.

What Is the Essential Nature of Couple Distress?

The primary issue in couple distress are repeating and escalating negative cycles that maintain disconnection and limit responding to needs for comfort and support. The EFT perspective focuses on the power of absorbing states of negative affect and negative interaction patterns, such as criticize/demand followed by defend/distance, and how they generate and maintain each other. Negative affect, in this model, is potentiated by the fact that this affect is attachment related and is thus associated with primal needs for comfort and closeness in the face of threat, danger, and uncertainty. This focus on the power of negative affect and interaction patterns echoes empirical findings on the nature of relationship distress and satisfaction (Gottman, Coan, Carrere, & Swanson, 1998; Huston, Caughlin, Houts, Smith, & George, 2001). Researchers such as Gottman view EFT as consonant with these findings. Some of the specific commonalities between these findings and the EFT approach can be summarized as follows:

- Both emphasize the power of negative affect, as expressed in facial expression, for example, to predict relational distress and dissatisfaction.
- Both focus on the importance of emotional engagement and how partners communicate, rather than on the content or the frequency of arguments.
- Both view cycles such as demand-withdraw as potentially fatal for close relationships.
- Both look beyond conflict resolution or the use of communication skills to the necessity for soothing, comforting interactional cycles and stress the importance of such soothing in relationship satisfaction and stability.
- Both stress the power of positive affect to define relationships, whether this is called, as in the behavioral literature, positive sentiment override or, as in the EFT literature, secure attachment.

There is, however, also a key difference between the EFT perspective and the research noted previously. Theory is the explanation of pattern, and the EFT therapist places the data on distress in an attachment framework. Four examples of how the attachment frame refines and elucidates such findings follow. First, there is some controversy (Stanley, Bradbury, & Markman, 2000) as to how to label the response of husbands in satisfying relationships to their wives' complaints. Gottman (1994) reports that wives in happier relationships start their complaints in a softer, less confrontational manner and husbands "accept their influence." Others have questioned this interpretation and suggest that a more accurate description is that these husbands are able to tolerate their spouses' negative emotion and stay engaged. An attachment view of such data would support this latter conclusion and would refine the meaning of this behavior, seeing this as an example of a more securely attached husband remaining accessible and responsive to the attachment "protest" behavior of his spouse and perceiving the implicit bid for contact in such behavior.

Second, attachment theory also offers an explanation of how the "stonewalling" response has been found to be so corrosive in close relationships. In attachment relationships such a response, much like the still face experiments (Tronick, 1989) where mothers show no response to children's attempts at connection, shatters assumptions of responsiveness and induces overwhelming distress. Third, the research data on distress found that to have a satisfying relationship, it is necessary to have five times more positive than negative affect. As a clinician, it

is difficult to grasp the meaning of this kind of ratio. Attachment theory suggests, more specifically, that when one partner fails to respond at times when the other partner's attachment needs become urgent, these events will have a momentous and disproportional negative impact on the affective tone of the relationship and its level of satisfaction (Simpson & Rholes, 1994). Conversely, when partners are able to respond at such times, this will potentiate the connection between them. Fourth, the previously mentioned research findings also tend to view couple relationships as friendships, which does not seem to account for the intensity of affect and the impact of distressed couple relationships in people's lives. From the EFT viewpoint, then, the attachment perspective on adult love can elucidate and refine the research findings on couple distress, thus making them more pertinent for the clinician.

What Is the Essential Nature of Adult Love?

Attachment theory, based on the work of John Bowlby (1969/1982, 1973, 1980, 1988), has become "one of the broadest, more profound, and most creative lines of research in 20th (and now 21st century) psychology" (Cassidy & Shaver, 2008, p. xi). This theory offers the couple therapist a coherent conceptualization of adult love and relatedness to specify treatment goals and guide intervention. The main principles of attachment theory, examined below, form the foundation for the EFT position that emotion is both a target and an agent of change (Johnson, 2009):

1. Dependency is de-pathologized. The need for a predictable emotional connection or a tie with a few significant others is an innate, primary motivating principle in human beings. More specifically, this connection is our "primary protection against helplessness and meaninglessness" (McFarlane & van der Kolk, 1996, p. 24). "Felt security" with a loved one offers us a safe haven in a dangerous world. The need for this emotional connection with one's attachment figures, and for most adults their key attachment figure is their spouse, is compelling and becomes particularly poignant during times of transition, stress, uncertainty, or danger.
2. A sense of "felt security," that we can turn to and depend on another, fosters autonomy (Feeney, 2007) and self-confidence. A secure interdependence in an adult relationship allows partners to be separate and different without anxiety and encourages them to explore their world. In contrast to the pathologization of dependency that has been common in Western cultures, this perspective views a secure emotional tie as offering a secure base that provides people with the optimal environment in which to learn and grow. Sensitive caring connections with others enable autonomy. There is no such thing as self-sufficiency or over-dependence; there is only effective or ineffective dependency.
3. Emotion is central to attachment and to relationship distress (Bowlby, 1979). Cassidy and Shaver (2008) note the salience of emotion in the titles of Bowlby's second and third volumes on attachment: *Separation: Anxiety and Anger* (1973) and *Loss: Sadness and Depression* (1980). Emotional accessibility and responsiveness are the essential ingredients that define the security of a bond and predict the quality of a couple relationship. Emotional engagement with a loved one is a primary source of emotion regulation (Mikulincer & Shaver, 2008). Recent studies confirm that partners serve as "hidden regulators" of one another's emotional and physiological reactions (Coan, Schaefer, & Davidson, 2006). From this perspective any response, even an angry one, is better than none. If there is no emotional engagement, the message is read as, "Your signals do not impact me. They do not matter and there is no connection between us." The frustration of this innate need for accessibility and responsiveness sparks and maintains significant conflict in an attachment relationship.
4. Adult attachment integrates caregiving (which is associated with parenting in adult–child attachment), attachment needs, and sexuality. Elements of sexuality, such as

touching, emotional connection, and soothing, rather than sexual release, are highlighted here (Gillath & Schachner, 2006). Erotic pleasure is heightened when the emotional openness, responsiveness, and trust of a secure bond combine with tender touch. Adult attachment, in contrast to parent–child attachment, is mutual and reciprocal. It is worth noting that relationships characterized by mutuality, intimacy, reciprocity, and interdependence are similar to the kinds of relationships promoted by gender-sensitive therapists (Haddock, Schindler-Zimmerman, & MacPhee, 2000). This attachment is also representational, so that adults do not always need the concrete presence of an attachment figure. It is part of secure attachment that we experience attachment figures as keeping and holding us in their minds (Fonagy, Gergely, & Target, 2008).

5. If an attachment figure is not perceived as accessible and responsive, then a predictable drama of separation distress ensues. This involves angry protest, clinging and seeking, depression and despair, and finally detachment. Bowlby distinguishes between the anger of hope and the anger of despair. It is the latter that most often leads to the destructive coercive patterns that couple therapists are only too familiar with. Bowlby saw emotion as conveying to the self and to others crucial information about the motives and needs of the individual. In separation distress, intense emotions such as fear, anger, and sadness will arise and take control over all other cues (Tronick, 1989). Emotion may be considered the music of the attachment dance.
6. An attachment bond involves a set of behaviors that elicits contact with the loved one. In secure attachment these involve the sending of clear, congruent messages that pull the loved one closer. Secure attachment is associated with the ability to self-disclose, with assertiveness and with openness (Kobak, Ruckdeschel, & Hazan, 1994; Kobak & Madsen, 2008). In less secure relationships, people rely on forms of engagement with their partner that tend to maintain or exacerbate the lack of safe emotional connection. That is, they send the message that the partner is unreliable or that he or she is inaccessible and unresponsive, or any combination of these. There appear to be two basic strategies for dealing with lack of safe emotional engagement. The first strategy involves an over-activation of the attachment system and is characterized by clinging, anxious pursuits and even aggressive attempts to get a loved one to respond (Bartholomew & Allison, 2006). Attachment needs are focused on and their expression maximized. People are fearful of losing their loved ones and are vigilant for any sign of distance. The second strategy involves a de-activation of the attachment system. People are inhibited emotionally and are avoidant. In this way, attachment needs are minimized. Engagement is limited, especially when vulnerability is expressed by the other partner, and there is a strong focus on activities and tasks, avoiding the stress of engaging emotionally with the partner (Mikuliner & Shaver, 2008). Secure adults can better acknowledge their needs, can give and ask for support, and are less likely to be verbally aggressive or withdrawn during problem solving (Simpson, Rholes, & Phillips, 1996). These patterns were first formulated from observing mothers and children in separation and reunion events (Ainsworth, Blehar, Waters, & Wall, 1978). In the child literature, different habitual forms of engagement have often been viewed as styles that characterize the individual and may be brought forward into adulthood. In the adult attachment literature, however, individual differences are viewed more as strategies or habitual forms of engagement that can be described in terms of two main dimensions: anxiety and avoidance. These habitual forms of engagement characterize a particular relationship, and are formed in response to and confirmed by the partner's response to the basic question, "Can I count on you when I need you?" They are

seen as more fluid and transactional (Kobak & Madsen, 2008). The insecure strategies mentioned previously are not problematic in themselves. They become so when they become so habitual and self-reinforcing that they are difficult to modify, refine, or update in response to new situations. Such inflexibility constrains interactions in close relationships.

7. Attachment theory is systemic in its understanding of how constrained patterns of interaction tend to narrow down the construction of inner realities (Johnson & Best, 2002). Bowlby believed that working models of self and other were constructed by interactions with key attachment figures (Mikulincer & Shaver, 2008; Bretherton & Munholland, 2008). This is consonant with recent perspectives on the relational construction of the self (Fishbane, 2001). Specifically, Bowlby stressed that models concerning the dependability of others and the worthiness of the self are formed and maintained in the emotional communication with attachment figures. More secure attachment has been found to be associated with a sense of self-efficacy and a more coherent and positive sense of self. These working models may change in new relationships and to be useful they must be open to revision and adjustment in different contexts (Mikulincer & Shaver, 2007).

Without such a theory, how do we know which differences or changes will really make a difference in adult love relationships? Individual therapists need a model of individual personality and growth, and couple therapists need a model or map to the territory of love and close relationships (Roberts, 1992). There is now a large and growing body of literature addressing adult love from an attachment perspective (Bartholomew & Perlman, 1994; Cassidy & Shaver, 2008; Mikuliner & Shaver, 2007; Simpson & Rholes, 2015), and information on this perspective is beginning to reach the general public (Johnson 2008b, 2013). Secure attachment has been found to be associated with effective affect regulation, information processing, communication, relationship satisfaction (Johnson & Whiffen, 1999; Mikulincer & Shaver, 2008) and attenuating neural response to threat (Coan et al., 2006). Based on these empirical and theoretical viewpoints, the goals of EFT are to help couples restructure both their emotional experience and their interactions in the direction of increased attachment security.

Treatment Protocol: The Practice of EFT

If we were able to take a snapshot of EFT, what would we see the therapist doing? At any given moment we might see the therapist reflecting the pattern of interactions occurring between the partners in a couple, then systematically unfolding one partner's key emotional response and helping this partner access marginalized emotion or piece his or her experience together in a new or more complete way. The therapist would then help the partner to express and enact this newly formulated experience and support the other partner to hear and respond, thus creating a new level and kind of dialogue. The goals of the EFT therapist are to restructure the key attachment emotions that organize interactions and thereby shift and restructure interactional cycles. This shift is specifically toward key prototypical bonding interactions that are a natural antidote to the negative patterns that characterize couple distress.

EFT is a relatively brief intervention that is implemented in three phases. These phases are the de-escalation of negative interaction patterns, the structuring of new interactions that shape attachment security, and, finally, integration and consolidation. The creation and maintenance of a positive alliance with the therapist, to offer a safe haven and a secure base for exploration, is considered essential. Characterological aggression or violence on the part of one or both partners is a contraindication for EFT, however, in cases with low levels of intimidation, remorse from an offending partner and a lack of significant fear on the part of the victimized partner, EFT is feasible. The process of change, outlined in nine steps, which are delineated in the manual for EFT (Johnson, 2004) and EFT workbook (Johnson et al., 2005) are described below.

Stage One: Cycle De-Escalation

Step 1: Assessment. Creating an alliance and clarifying the core issues in the couple's conflict using an attachment perspective.
Step 2: Identifying the problematic interactional cycle that maintains attachment insecurity and relationship distress.
Step 3: Accessing the unacknowledged emotions underlying interactional positions.
Step 4: Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

The goal, by the end of Step 4, is for the partners to have a meta-perspective on their interactions. De-escalation, the first change event, is complete when partners recognize how they are unwittingly creating, but also being victimized by, the narrow patterns of interaction that characterize their relationship. They recognize their automatic pattern of self-protection: unexpressed attachment fears and needs trigger one partner to behave in ways that trigger the other partner's fears and reactive behaviors, which in turn trigger the first partner's reactive moves in a self-reinforcing cycle. At this point, partners have achieved level one change in that responses tend to be less reactive and more flexible, but the organization of the dance between them has not changed and their core underlying vulnerabilities have not shifted. As a client remarked, "We are nicer to each other and things are easier, but nothing has really changed. I still chase and he still dodges me." If therapy stops here, the couple will likely relapse.

De-escalation marks level one change, and a clear sense of hope that it will be possible to take control of the relationship back from the negative cycle. From there it is possible to move forward into the level two change events of Stage Two: restructuring the attachment bond into a safe haven and secure base.

Stage Two: Restructuring Interactional Positions/Patterns

Step 5: Promoting identification with disowned attachment needs and fears (such as the need for reassurance and comfort) and aspects of the self (such as a sense of shame and unworthiness) and expressing them to the other partner.
Step 6: Promoting acceptance in the observing partner of the actively exploring partner's construction of experience and new emotional expressions.
Step 7: Facilitating the expression of specific needs and wants and creating emotional engagement between partners.

Steps 5 to 7 are done twice: once for each partner.

Partners usually move through the steps of Stage One together. Stage Two is more intense, and, unless the couple is experiencing relatively low distress, the therapist invites one spouse to precede the other. Because a more critical distressed spouse will not take risks with a partner who remains withdrawn, the more withdrawn partner is invited to navigate Steps 5–7 before the more blaming, critical spouse actively engages in Step 5. The goal here is to have withdrawn partners first engage with their newly accessed emotional experience and attachment fears, and then to reengage in the relationship and actively state the terms of this reengagement. For example, a spouse might initially acknowledge and explore how lonely and painful it is to tip-toe gingerly in fear that he is not important to his partner, and how he needs to sense that she actually wants and needs him. He may expand on his needs and state, "I am opening up. I can do that. But I want some respect from you. You don't have to be so sharp. You are all edges sometimes. I want to learn to be close and I want you to make it a little easier for me to get there." Once this partner is more accessible and responsive, the goal is then to have the more blaming partner complete Steps 5–7 and "soften," that is, to ask from a position of vulnerability for his or her attachment needs to be met. A position of vulnerability pulls for responsiveness from the partner. This latter event has been found to be associated with recovery from relationship distress in EFT, and linked to strengthening the attachment bond (Bradley & Furrow, 2004; Burgess Moser, Johnson, Dalgleish, Tasca, & Wiebe, 2014). When both partners have completed Step 7, a new form of safe emotional engagement is possible and prototypical bonding events of reciprocal confiding, connection, and comforting can occur. These events are carefully

shaped by the therapist in the session, but also occur at home. Transcripts of both key change events, withdrawer reengagement and blamer softening, can be found in texts and other chapters on EFT (Johnson, 1998a, 1998b, 2000, 2002, 2004, 2009; Furrow et al., 2011), and snapshots of the process can be found later in this chapter.

Stage Three: Integration and Consolidation

Step 8: Integrating the new cycle with the old problems. Facilitating the emergence of new solutions to old problematic relationship issues.

Step 9: Consolidating new more responsive positions and cycles of attachment behavior. Enacting new stories of problems and repair.

The therapist supports the couple to solve concrete problems that have been destructive to the relationship. This is now relatively easy because dialogues about these problems are no longer infused with overwhelming negative affect and issues of relationship definition. The discussions are no longer implicit fights about attachment fears and needs ("Can I count on you?" "Do you really want me?"). The partners are supported to actively plan how to retain the connection that they have forged in therapy. The goal here is to consolidate new responses and cycles of interaction by, for example, reviewing the accomplishments of the partners in therapy, helping the couple to create bonding rituals and a coherent narrative of their journey into and out of distress. This narrative, called "Creating a Resiliency Story" in *Hold me Tight* (Johnson, 2008b), is an example of how EFT interventions have evolved through observation, through input from narrative models of therapy, and from the influence of attachment theory, which stresses the association of the ability to form coherent attachment narratives and secure attachment (Slade, 2008).

Interventions in EFT

The new science of love and attachment is generating a revolution in the field of couple therapy (Johnson, 2003b, 2013), offering a map of the normative needs, emotions, and ideal processes of adult love relationships and of the specific interventions that can transform relationship distress into secure attachment bonds. EFT interventions have been tested and found to be related to positive outcome (discussed in more detail in the Research section). They are described in detail in the literature (Johnson, 2004, 2015) and delineated operationally in the EFT Therapist Fidelity Scale (Denton, Johnson, & Burleson, 2009) developed to measure therapist adherence to the EFT interventions.

The unique contributions of attachment theory and the theory of emotion as the organizing element in couple interactions mark a significant departure from the traditions of couple and family therapy. There are distinct differences between EFT and other approaches to couple therapy that remain unacknowledged in the common factors literature (Sprenkle, Davis, & Lebow, 2009). For example, EFT has explicit empirically validated interventions that heighten emotional experiencing and create in-session corrective emotional experiences (Johnson, 2015) that are not a part of other couple therapies. EFT has interventions to access disowned vulnerable emotions as the pathway to previously unexpressed needs and to structure and intentionally process enactments where partners risk sharing previously unexpressed fears and needs in a way that moves the loved one to respond. The interventions create corrective emotional bonding experiences that foster lasting change. Tilley and Palmer (2012) explicate how these choreographed interactions in EFT are different than enactments in other approaches.

The therapist moves recursively between three tasks: monitoring and actively fostering a positive alliance, expanding and restructuring key emotional experiences, and structuring enactments that either clarify present patterns of interaction or, step by step, shape new, more positive patterns. EFT interventions are identified as follows. The EFT therapist is always *tracking* and *reflecting* the process by which both inner emotional realities and interactions are created. The therapist also *validates* each partner's realities and habitual responses so that partners feel safe

to explore and own these. Internal experience is expanded by *evocative questions* that develop the outline of such experience into a sharply focused and detailed portrait. *Heightening of emotion* may be done with images or repetition, or the therapist may go one step beyond how clients construct their experience with an *empathic conjecture* by adding an element, such as asking if someone is not, as they say, only "uncomfortable" but even a little anxious. The therapist also *reframes* interactional responses in terms of underlying emotions and attachment needs and fears and *choreographs enactments*.

The level of client emotional engagement during enactments is significant and at the heart of the change process in EFT (Burgess Moser et al., in press). The therapist finely tunes levels of enactment by moving to the level a client can tolerate at any given moment. That is, if a client cannot turn and state an emotional response, clarified in the dialogue with the therapist, to his or her spouse, the therapist will ask the client to express how hard it is to share this and explore this reluctance to engage the partner. If this is not possible, the therapist will help the clients share their blocks and even their refusal to share. The EFT therapist, however, even when caught up in the multileveled drama of a distressed relationship, always returns to the core attachment emotions of fear, anger, sadness, and shame, the attachment meanings partners are making, and the structuring of new enactments with the partner. The focus of EFT is always on the couple's habitual ways of regulating and expressing affect and how these constitute habitual forms of engagement with attachment figures.

In the task of expanding how key relational experiences are processed when attachment insecurity and defensiveness constrict such processing, the therapist moves between all the interventions mentioned previously in a manner that fosters the unfolding of key emotional experiences and defining relational moments. The developmental concept of scaffolding is useful here. A scaffold is an external structure that allows children to acquire abilities just beyond their reach (Wood, Bruner, & Ross, 1976), in their zone of "proximal development" (Vygotsky, 1978). The therapist then goes to the edge of a client's formulated experience and focuses on "bottom up" details to give this experience shape, form, and color, integrating all the interventions listed previously. For example, a therapist might say the following:

So, what happened when he turned away from you in that moment, in the moment before you ran from the house, before, as you put it, you "shut down for good"? (Reflection, evocative responding focused on a key moment, image of relational stance)

So, you felt sick?—"Nauseated," as you put it—and said to yourself, "I am invisible to him, he isn't there for me"— is that it? It was like you didn't matter, your pain didn't matter to him? And that moved you into "I must protect myself? I must shut down—not let myself need?" Is that it? (Evocative responding, heightening, inference of meaning of incident for attachment security)

How do you feel as you talk about this now? (Evocative question). You say you are angry, but I notice that you also weep. There is grief as well? You felt like you lost him that day—your trust—your sense of being able to count on him? (Heightening, conjecture, reflection).

Can you tell him right now—"In that moment I lost my faith in you—in us—so I shut down-shut you out"? (Structuring of enactment)

The number of evocative questions here is significant, in that the unfolding of this experience is done in partnership with the client, who constantly corrects and refines the therapist's empathic construction of a response, an event, and its interactional consequences. The therapist acts as a surrogate processor of experience and structures engagement tasks for the couple. In change events, such as blamer softenings, EFT therapists particularly use evocative questions, heightening, and reframing in terms of attachment significance (Bradley & Furrow, 2004). This research, however, also found interventions that were not formally written up in the initial EFT manual (Johnson, 1996). In successful softenings, therapists offered images of "just out of reach" attachment responses that would constitute a step toward more secure attachment for a partner. The therapist might say:

So you could never turn to him and say, "How could you stay so cool and separate, when I needed you? And now, I am so far away—I can't listen to my longings—can't ask you to comfort me." You could never say "I need your reassurance—your closeness, to know you see me and that I am not invisible to you"?

This, then, offers the client a model of what a disclosing interaction that makes a bid for responsiveness from the partner might look like, invites the client to struggle with this possibility, and addresses blocks to this kind of risk taking. This intervention that became known as "seeding attachment" is an example of how empirical research that allows us to know what we do and when it works spurs on innovation and the refinement of the art of therapy.

The person of the therapist and how the interventions above are operationalized and shaped to meet client needs are crucial. Thus, EFT therapists need to seek professional and personal growth throughout their lives (Palmer & Johnson, 2002; Palmer-Olsen, Gold, & Woolley, 2011). EFT requires that the therapist be, as Rogers articulated, genuine and transparent. Sometimes this involves being willing to be confused and lost and actively learning with one's clients how a relationship drama or an inner dilemma evolves. EFT therapists need to be comfortable with experiencing powerful emotions—within themselves and others—in order to offer a fully engaged emotional presence to their clients (Furrow, Edwards, Choi & Bradley, 2012). This is a prerequisite to effectively helping clients to deepen their emotional experience and to remain emotionally engaged while sharing with their partner. Emotions come into focus when the therapist is using a low evocative voice, when images are used to capture the experience and when the pace of dialogue is slow and somewhat repetitious. (Emotion takes more time to process.) There is empirical evidence that imagery elicits physiological responses that abstract words do not (Borkovec, Roemer, & Kinyon, 1995). In addition to using imagery and repetition to facilitate emotional engagement, the EFT therapist has a simple mantra: "Stay slow, simple, soft, specific, vivid, explicit and in the present moment."

Snapshots of Client's Change Process in EFT

The case of "Now you see me-now you don't."

If we were to take snapshots of key moments in change events of de-escalation, a withdrawer's reengagement and a blamer's softening, what would they look like? Mark and Cora, a successful professional couple with two children who had been married for twenty years, had come to the end of the line. Cora's whole body radiated rage. She described the relationship as a "charade." She was critical but from a detached standpoint. She had already given up pursuing Mark, stating that she had "no hope" and that "It was too late to save this marriage." Mark was on the defensive. "She explodes, she blames," he said. "So what can I do? I try to stay calm and use logic."

Cora described Mark as a loving father and as doing chores in the house but as offering no closeness. However, they were not a typical extremely distressed couple, in that they described brief periods of close connection and sexuality all through their marriage. This had now become part of the problem, however. Cora described Mark as "Jekyll and Hyde," by which she meant close and available and then gone for weeks. As she stated it, "He can pick me up and then put me down—so now I don't initiate. I'd rather be alone than this now you see me, now you don't."

Stage One: Key Statements Made in Mark and Cora's De-escalation

Mark and Cora identified that they were rigidly stuck in a negative dance of Cora demanding and raging and Mark defending and ducking the line of fire, and how this dance had gradually taken control of the relationship, until Cora gave up and filed for divorce.

Mark: "The more she comes at me the more I go away."

Cora: "The more he went away, the more I used to go after him, but now I've just given up the entire chase!"

In identifying this negative dance, they also described the attachment meanings they had automatically created to make sense out of their

partner's behaviors. Cora said in response to Mark's distancing, "You hide from me and obviously don't care." "I don't matter. I am unlovable."

Mark in turn shrugged, "What's the point in trying anymore! You think I am a bad dad, bad husband. That plays like a chainsaw in my mind all the time: 'bad dad, bad husband.' I am a just one big disappointment to you!" (These attachment meanings convey the working models of self and other in their negative cycle and are segues into the vulnerable underlying attachment emotions and unmet needs). In Step 3 the therapist worked with them to discover the previously unacknowledged emotions and attachment meanings underlying their positions of pursuing and distancing.

Cora accessed feelings of loneliness and fears of abandonment, while Mark said he felt empty. The emptiness, with the therapist's reflection and validation, expanded to sadness and shame about failing to be the dad and husband he wanted to be and fearing total rejection from Cora. Cora's detached attitude voiced as "I don't even care anymore!" began to shift into the old rage at the distance she felt between them and her desperate need to have him on her team.

They began to notice times outside therapy when, "We get sucked into the old dance." Cora noticed that the more she complained, demanded or wept in despair, the more Mark seemed to feel he was failing her, and would disappear or defend himself. Mark experienced that the more he defended himself with logic and explanations or withdrew and worked harder to please her, the more she sensed she was not important, and blew up in rage at his distance. The couple experienced relief at being able to frame their problem as a negative cycle or dance. Together the therapist helped them frame the real enemy as repetitive moves in a dance to the music of these very real fears, loneliness, sadness, and shame. Once this couple's cycle had been clarified and the partners began to see the cycle, rather than each other, as the enemy, they began to spend more time together. Cora became less enraged and acknowledged that she and Mark were "friends," and Mark began to describe his "guilt" about failing as a husband and how he froze in the face of Cora's rage and "unpredictability."

De-escalation, the first change event in EFT was complete when Mark and Cora were able to see that the real problem was the negative automatic cycle they got pulled into when they did not see or share their vulnerable underlying fears and needs. New parts of self and the underlying core emotions were recognized as pulling them into their negative cycle. Greater compassion and an expanded view of the partner was accessed: Cora felt relief to see Mark was not indifferent or uncaring, but was hiding to protect himself from the enormity of her complaints and unhappiness; Mark began to see that Cora's complaints and anger were not "failure messages" of being a bad dad and a bad husband, but desperate attempts to pull him close—that she very much wants him and is making a desperate response to his position of hiding and silence.

Let us now look at snapshots of this couple's journey thorough Stage Two of EFT. These comments, distilled from the ongoing dialogue and heightened by the therapist, would also be used to create enactments (where a partner discloses directly to the other partner) to generate new forms of engagement between Mark and Cora.

Stage Two: Key Statements in Mark's Journey to Reengagement

> I am a mathematician—I like logic. When she gets hysterical, I am so lost—so I withdraw. I stay out of the way. I feel so helpless—totally out of my depth. It's not safe enough to initiate any connection.
>
> I get terrified—I was alone in my family—she is the only one I have ever felt connected to—if she disappears—I'd be lost! So I just go oblivious—frozen in despair.
>
> To Cora: "I get overwhelmed—the message that I disappoint you stops me dead. I can't meet your expectations. I want more safety—maybe then I can show you my emotions. I do need you—I do want to be close."
>
> I disappear when her rage gets too much.
>
> [To Cora:] I want you to stop the bombardment—then I can come out of the

foxhole—no more name calling. You go too far. No more defining me.

[To Cora:] I do long for closeness—I think of it every day, but then—it's like pressure—I've done my repertoire—nothing to give then—can't please you—can't pass the test. But I don't want to go paralyzed any more. I want your reassurance—no more "on test" stuff.

[To Cora:] I can tell you now when I go paralyzed. Can I ask to be comforted? It feels strange. I think we can make it. Put your armor away now. I want you to hope with me. Risk it.

Stage Two: Key Statements in Cora's Journey to Softening and Bonding

We make love—get close—and then—the big disconnect. I can't rely on the closeness—so I wait and hope he will come back. I feel this deep disappointment—better to be alone. I get so absorbed in my feelings. I can't even see him.

I guess I am more sad than anything—hurt that he can just put me down. Can't bear the uncertainty—even when we are close—I can't count on it. It hurts too much to need this.

I see him risking—but. What do I want? Too scared to count on him—I'll risk it and then suddenly be alone—betrayed. So I rebuff him—even now when he does risk.

[To Mark:] I have a huge barrier—a wall. I won't let you hurt—abandon me anymore.

I am too scared to respond—see you reaching—and I go on guard. I make you walk through fire—keep my armor on. Don't know how to let you in. It's too hard.

[To Mark:] Do I really matter so much to you? Maybe . . . It's scary to let those barriers down. I think I need to cry for a long time—but you can help me take them down—will you hold me now?

The bonding interactions that occur at this point in EFT redefine the nature of the relationship and create new patterns of safe emotional engagement.

Research Evidence Supporting EFT

Since having met the gold standard for being an empirically validated model for reducing relationship distress (Johnson et al., 1999), EFT research has continued to grow, to include sixteen outcome studies, and nine process research studies that validate *how* change is created in this model. In addition the empirical bases of EFT are substantial and are continuing to grow: 1) research on attachment as a model of intimate relationships is expanding (Cassidy and Shaver, 2008; Simpson and Rholes, 2015); and 2) research on emotion is expanding the empirical base for placing emotion in the forefront as both target and agent of change. The powerful physiological and emotional impact that attachment figures have on each other is supported by studies in affective neuroscience (Coan, 2008; Coan et al., 2006).

There have been several new dimensions of EFT research in the past decade: numerous exploratory studies validate the generalizability of EFT across different kinds of clients and couples facing co-morbidities. Process research continues to delineate more specifically how the moment-to-moment interventions in therapy impact the change process. Beyond being an evidence-based treatment for creating relationship satisfaction, recent research (Burgess Moser et al., in press; Burgess Moser et al., 2014) is demonstrating that EFT also increases relationship-specific attachment security—a clear contributor to mental and physical health.

The newest development in EFT research is a study on the effects of EFT with an fMRI component. The study examined the effectiveness of EFT to create secure attachment bonds, looking at how these bonds function to modify the perception of threat, thereby creating a safe haven and secure base for partners. It focused on how partners use their bond to regulate affect and to carry out tasks of attachment relationships such as reaching to the other when in distress. Self-report and fMRI images were used to study the impact of contact with a loved one when under threat of electric shock (Johnson

et al., 2013). The study found that prior to therapy holding a partner's hand did nothing to ameliorate the encoding of threat, but after therapy this contact seemed to have an antidote effect. It was associated with non-activation of the threatened partner's brain, even in the pre-frontal cortex area that is responsible for affect regulation, and with the reduction of reported pain from shock. Attachment theory postulates that a more secure bond mediates the encoding of threat and indeed this appeared to be the case in this study.

Completed and ongoing EFT research consistently supports the efficacy of the model. The outcome research and meta-analyses of rigorous clinical trials (Johnson et al., 1999; Wood, Crane, Schaalje, & Law, 2005) have shown EFT to be effective when tested against control groups and alternate treatments. The introduction highlighted the meta-analysis of the four most rigorous outcome studies, conducted before 2000, which showed a larger effect size than any other couple intervention has achieved to date. The impressive effect size of 1.3 translates into a 70 to 73% recovery rate from relationship distress and 86% reported significant improvement over controls. This is significant compared to Dunn & Schwebel's (1995) average effect size of 0.9 for behavioral interventions in couple therapy. EFT has systematically met all the standards set by bodies such as the APA for optimal models of psychotherapy research. Studies consistently show excellent follow-up results even with couples at high risk for relapse (Clothier et al., 2002) and often significant progress continues after therapy ended (Johnson & Talitman, 1997). Results of a randomized clinical trial (Dandeneau & Johnson, 1994) showed higher levels of empathy and self-disclosure at post-test, higher self-reported intimacy at follow-up, and greater stability of results than the cognitive marital therapy group whose treatment results receded at follow-up. This may reflect the power of the bonding interactions that constitute change events in EFT and continue after termination. A three-year follow-up study on the Attachment Injury Resolution Model (Halchuk et al., 2010) found that improvements in trust, forgiveness and in relationship adjustment were stable over time. All EFT outcome studies have included treatment integrity checks and have shown a very low attrition rate, except for one study where extremely novice therapists were used (Denton, Burleson, Clark, Roderiguez, & Hobbs, 2000).

A process study examining predictors of success in EFT (Johnson & Talitman, 1997) found that while in BMT the initial distress level was found to account for 46% of the variance in outcome, this factor was found to account for only 4% of the outcome variance in couples treated with EFT. This finding is consonant with clinical experience, in that EFT therapists report that it is client engagement in the therapy process in sessions that seems to determine clinical outcome. The theory of EFT suggests that, if key bonding events that constitute corrective emotional experiences can occur in therapy sessions, these events have the power to create significant shifts even in exceedingly distressed relationships. Also, in this study, EFT was found to work better with partners over thirty-five and with husbands described as "inexpressive" by their spouses. Traditionality (male orientation toward independence and female orientation toward affiliation) did not seem to affect outcome. Denton et al. (2000) also found EFT to be particularly effective with low socioeconomic status partners. The most powerful predictors of outcome were, first, a particular aspect of the therapeutic alliance that reflects how relevant partners found the tasks of therapy, and by implication, their level of engagement in them and, second, the faith of the female partner—that is, her level of trust that her spouse still cared for her. Presumably, once this faith has been lost, the emotional investment necessary for change is difficult to come by. These results appear to fit with the general conclusion that "the quality of the client's participation in therapy stands out as the most important determinant of outcome" (Orlinsky, Grawe, & Parks, 1994).

Process research studies have validated that the key ingredients of change in EFT are the depth of emotional experiencing and the shaping of interactions in-session where partners are able to clearly express fears and needs and be moved to respond congruently to each other's needs (Bradley & Johnson, 2005; Greenman & Johnson, 2013). The bottom-up, discovery-oriented

direction of process research, known as task analysis, carefully examines the actual change processes in therapy, thereby making EFT accessible for therapists to learn and relevant to daily clinical practice. EFT has been described as an "example par excellence of an empirically validated model that has a large impact on day-to-day office practice" (Sprenkle, 2012, p.18). The large amount of process research done with EFT is one of the ways this model of couple therapy has significantly contributed to narrowing the research-practice gap, addressed as an ongoing concern in the field of couple and family therapy (Sprenkle, 2003).

Process of change research which began with the Blamer Softening change event (Bradley & Furrow, 2004) has also been done with the Attachment Injury Resolution Model (Zuccarini et al., 2013). Process of change research offers clinicians very specific guidance through the specific moves of the change event processes (Bradley & Johnson, 2005; Zuccarini et al., 2013) explicating both the client processes and the therapist interventions used most effectively moment to moment in-session. Greenman and Johnson (2013) outline the nine studies of the process of change in EFT, all of which find consistent results: two key elements which predict positive change and are associated with the change events of Stage Two are deepening emotional experience and turning affiliatively toward one's partner to disclose attachment fears and needs.

These studies have validated that change does indeed happen as theorized. The EFT interventions and steps of specific change events of EFT have been validated (Johnson, 2003a). Therapist interventions of emotionally evocative questioning, heightening awareness of process patterns and emotions, structuring enactments and facilitating the expression of soft, primary emotions are associated with change (Greenman & Johnson, 2013; Lebow et al., 2012; Zuccarini et al., 2013). Two client change events fostered in Stage Two of EFT are the reengagement of the more withdrawn partner and the "softening" of the more critical or pursuing partner. The latter event has been empirically linked to increases in relationship satisfaction and more recently to enhancing the security of the attachment bond (Burgess Moser et al., 2014).

Generalizability Across Different Clinical Populations and Clinical Issues

In the last decade, research of the application of EFT to various clinical contexts and to couple distress co-occurring with other physical and psychological problems has grown tremendously. EFT has been validated as an effective treatment for a variety of conditions co-occurring with couple distress, including relationships impacted by traumatic stress, depression, infidelity, and other relationship injuries, all of which will be reviewed below. Client populations receiving increased attention in terms of the applicability of EFT include families, couples with sexual difficulties, culturally diverse couples, and gay and lesbian couples.

Traumatic Stress

Building on the salience in EFT of affect regulation and the fostering of resilience through creating secure connection, four studies have focused on couples dealing with trauma. Given the high prevalence of relationship distress in couples where female partners have a history of childhood abuse, there is a need for couple-based treatment models that target co-morbid relationship distress and trauma symptoms. Dalton, Greenman, Classen, and Johnson, (2013) conducted a randomized controlled trial to examine the efficacy of treating couples with EFT where the female partners were survivors of childhood abuse. Twenty-four couples experiencing marital distress and in which the women had childhood abuse histories were randomly assigned either to twenty sessions of EFT or to a waitlist control group. In the treatment group, 70% of the couples scored as non-distressed on the DAS (Dyadic Adjustment Scale: Spanier, 1976) at the end of treatment and the women reported a reduction in trauma symptoms, such as phobic avoidance, interpersonal sensitivity and dissociation. As predicted, a clinically and statistically significant reduction in relationship distress was found in couples in the treatment group.

A second study (MacIntosh & Johnson, 2008) examined the effectiveness of nineteen sessions of EFT for couples with a small group (N=10) of couples where one partner was a survivor of severe chronic childhood sexual abuse. Survivor partners reached criteria for complex PTSD and some couples presented with dual trauma. Levels of distress were high and emotional flooding and numbing and the difficulty of risking relying on others stood out in a thematic analysis of treatment issues. Typical of such survivors is a fearful/avoidant style of attachment which is particularly detrimental to the creation of trust and satisfaction in close relationships (Simpson & Rholes, 1998). Half of the couples in this study showed clinically significant improvements on the DAS (Spanier, 1976) and significant reduction in trauma symptoms (measured by the Trauma Symptom Inventory; Briere, Elliott, Harris, & Cotman, 1995) and a structured interview, the CAPS (Blake et al., 1990). Given the very high level of symptomatology and relationship distress, these results are considered very encouraging and basically support the specific adaptations to the EFT model offered in the literature to promote positive change with traumatized clients (Johnson, 2002).

Critical illness of a spouse or a child is also traumatic. A third study of EFT's effectiveness in treating trauma was a small study (N=12), conducted with maritally distressed breast cancer survivors. Approximately 40% of breast cancer survivors experience anxiety and depression of PTSD proportions (Kissane, Clarke, & Ikin, 1998). A multiple baseline design was used so that clients acted as their own controls. Couples were randomly assigned to twenty sessions of psychoeducation (three) or to EFT (nine couples) and tested at pre-treatment intervals, mid-treatment, termination, and follow-up (Naaman, Radwan, & Johnson, 2009). Fifty per cent of the couples who received EFT showed significant improvement on the DAS measure of marital adjustment, quality of life, mood disturbance, and trauma symptoms. Marital adjustment and quality of life continued to improve at follow-up with no evidence of relapse. The educational group reported no improvements on any variables. A fourth trauma study examined the effects of EFT treatment for couple distress where couples were raising chronically ill children (Gordon-Walker, Johnson, Manion, & Cloutier, 1996). They found considerable stress reduction in the group treated with EFT compared to a control group and a two-year follow-up study showed an improvement in treatment results (Clothier et al, 2002). Finally, a trauma study at the Baltimore VA showed statistically significant reductions of PTSD symptoms in war veterans after participating in an average of thirty sessions of EFT therapy with their wives (Weissman et al., 2011; see also Greenman & Johnson, 2012).

Depression

It has been established that EFT is appropriate and effective for treating couples in relational discord where one or both partners are suffering from depression. The focus on strengthening the attachment bond, which is the core of EFT, explicitly addresses issues associated with depression, namely a sense of isolation, of not being valued, and of impending abandonment and rejection (Denton & Coffey, 2011). A 1994 study of the impact of EFT upon depression in distressed partners showed that EFT reduced distress and increased intimacy (Dandeneau & Johnson, 1994). More recently two randomized clinical trials were conducted to examine the impact of EFT on the treatment of couples where the woman was diagnosed with major affective disorder. In the first study (Dessaulles, Johnson, & Denton 2003), couples were randomly assigned to either treatment with EFT alone or to antidepressant medication for the depressed partner. In the second (Denton, Wittenborn, & Golden, 2012), couples were randomly assigned to treatment of medication alone or to antidepressant medication in combination with EFT. The first study found that after sixteen weeks of treatment both groups showed a decrease in depressive symptoms. EFT was as effective as antidepressant medication alone. The group treated with EFT alone, however, had significant improvement in depressive symptoms in the post-therapy period at six months follow-up. The benefits of EFT treatment continued to expand after therapy ended! In the second study, both groups again made significant reductions in depressive

symptoms, however, women receiving EFT experienced a significantly greater improvement in relationship quality. Given that relationship distress and depression are frequently linked, this could indicate EFT's usefulness for relapse prevention.

Infidelity and Relationship Injuries

EFT research explored an impasse in the change process where a past injury arose that blocked the creation of trust and connection in Stage Two of EFT (Johnson, Makinen, & Millikin, 2001). An Attachment Injury Resolution Model (AIRM) has been developed to successfully address such impasses. These injuries, conceptualized as abandonments and betrayals at key moments of need, trigger attachment panic and general insecurity. Steps in the process of forgiving these injuries were outlined and one outcome study (Makinen & Johnson, 2006) found that in a brief EFT intervention 63% of all distressed injured couples moved out of distress and were able to forgive the injury and complete key bonding events that predict success in EFT. A three-year follow-up (Halchuk et al., 2010) found results were stable. It appears that once a couple can resolve the relationship injury or betrayal and have mutual accessibility and responsiveness, the attachment bond becomes increasingly secure. The couples who found the intervention less effective reported that the thirteen-session treatment was too brief. These couples also had multiple injuries and lower levels of initial trust. The recent process study (Zuccarini et al., 2013) validated the EFT model of forgiveness, finding that steps as outlined were indeed reflected by scores on process measures such as the Depth of Experiencing Scale (ES; Klein, Mathieu-Coughlan, & Kiesler, 1986) and Levels of Client Perceptual Processing (Toukmanian & Gordon, 2004) and indeed differed for resolved and non-resolved couples. This study of the process of change found that most frequent therapist interventions in key sessions with resolving partners who reached high levels of forgiveness were evocative questioning, heightening emotional engagement, and shaping enactments. Client responses noted in partners who were able to resolve their injury and move out of distress were that of processing their primary attachment emotions in a clear, reflective, and integrated manner and becoming more responsive to and trusting of their partner.

EFT for Sexual Issues

Bowlby (1969/1982) stated that there are three aspects to adult love: attachment, sexuality, and caregiving, with attachment being the core element that in turn shapes sexuality and caregiving. While the effect of EFT on sexuality has only begun to be studied (MacPhee, Johnson, & van der Veer, 1995), the literature on attachment and sexuality is expanding (Johnson & Zuccarini, 2010). EFT offers a compelling alternative to the individually oriented and problem-focused interventions that pervade the sex therapy field. The EFT solution to sexual difficulties turns away from sexual techniques and novelty and toward de-escalating negative cycles of anxious critical pursuits for closeness and avoidant emotional distancing that focuses on sensation and performance. After de-escalating these negative cycles, the EFT therapist structures moments of secure bonding. The nine steps of EFT in treating sexual problems of arousal, desire, and orgasm have been delineated (Johnson & Zuccarini, 2011). Snapshots of key EFT moments of creating secure attachment bonds with couples facing sexual problems can be seen in the literature, and illustrate helping partners co-construct bonds that meet their attachment, caregiving, and sexual needs (Johnson & Zuccarini, 2010, 2011). More and more studies are showing the significant impact of attachment security on sexual engagement and satisfaction (Johnson & Zuccarini, 2010). Secure loving bonds foster engaged sexual satisfaction and engagement whereas high levels of anxiety and avoidance are associated with lower sexual satisfaction. Different strategies for regulating emotion play a key role in levels of desire, arousal, and sexual satisfaction. Hence creating emotional safety and attunement is the essence of the EFT approach to restoring sexual satisfaction and intimacy.

Training in EFT

Finally, research on how to train therapists to learn EFT is expanding (Palmer-Olsen et al., 2000; Montagno, Svatovic, & Levenson, 2011; Sandberg, Knestel, & Schade, 2013). Recent studies are

expanding our knowledge of the application of EFT for different populations and therapists (Johnson & Wittenborn, 2012). Two studies, focused on the person of the therapist (Furrow et al., 2012; Wittenborn, 2012), underscore the impact of the therapist's own emotional experiencing and attachment states of mind to the effective delivery of EFT. The research-based EFT supervision model (Palmer-Olsen et al., 2011) supports the implications of these findings, by giving prominence to enhancing the therapist's capacity to be emotionally present to emotional experiencing and attachment processes within self and the clients.

Implementation of the Model in Community Practice Settings

EFT has an admirable record for meeting the challenge of transporting an empirically based model beyond academic and research-controlled contexts into community and private practice settings. Sprenkle (2012) underscores three ways this has occurred:

> It's developers (a) [have] made training manuals, workbooks and other training materials very accessible, (b) offer frequently geographically dispersed workshops that most clinicians can qualify to attend, and (c) provide an online support community and many opportunities for continuing education.
>
> *(p. 11)*

Specific illustrations of these activities follow.

- Accessible EFT training materials include over ten training DVDs and a triad of written references for clinicians: *The Practice of Emotionally Focused Couple Therapy: Creating Connection* (Johnson, 2004) together with *Becoming an Emotionally Focused Couple Therapist: The Workbook* (Johnson et al., 2005) and the most recent resource, *The Emotionally Focused Casebook: New Directions in Treating Couples* (Furrow et al., 2011). The basic treatment manual (Johnson, 2004), is currently available in eleven languages. The casebook illustrates the applicability of EFT to a variety of clinical issues and populations, including couples living with depression, aphasia, chronic medical illness such as breast cancer, trauma, infidelity, and sexual issues as well as specific populations, including remarried couples and blended families, culturally diverse couples, same sex couples, and couples who value spiritual practices or religious beliefs.
- Training opportunities around the globe have made it possible for therapists from over forty countries to be trained in EFT. There are 39 communities and centers formed worldwide of trainers, supervisors, and EFT-certified therapists committed to supporting one another in developing excellence in the model and providing their communities with the most effective couple and family therapy available.
- The International Centre for Excellence in EFT (ICEEFT) continues to expand its commitment to excellence, integrity and inclusivity in service to its over 4,000 members and to couples and families. Online support is provided for professional development with a quarterly newsletter, an active listserv, and various online training opportunities. The website www.iceeft.com/ provides a breadth of accessible resources.
- Beyond this, EFT has expanded to community-based psycho-educational settings and enrichment programs (Johnson, 2010; Johnson & Rheem, 2006). The self-help books *Hold Me Tight* (Johnson, 2008b), now translated into over twenty languages, and *Love Sense: The Revolutionary New Science of Love Relationships* (Johnson, 2013) are making the science and logic of love relationships accessible to the general public. Expansion in professional memberships of ICEEFT, international translations of training materials, and ongoing research combine to contribute to growing relevance and implementation of EFT in community settings worldwide.

Conclusion

EFT research has, in three decades, successfully responded to the critical goals identified for the

field of couple therapy (Sprenkle, 2003; Johnson & Lebow, 2000). These are, first, that the field become more empirically based; second, that research into the process of change increase and so be used to bridge the gap between research and practice and refine the art of intervention; and third, that we strive toward conceptual coherence, where there are clear links between models of adult love and relatedness and pragmatic "if this . . . then that" interventions.

First, the empirical base of the field of couple therapy has been significantly strengthened by EFT. EFT meets the criteria of the APA Division 43 Task Force's highest level of validation for an empirically validated intervention. EFT's thirty-year research program has systematically covered all the factors set out in optimal models of psychotherapy research. We know EFT is an effective approach for repairing distressed couple relationships, enhancing relationship satisfaction and fostering secure bonds, and we know the therapist and client processes that make it possible. Second, EFT has moved beyond validating that the approach is effective, into the relatively unexplored arena (Halford & Snyder, 2012) of knowing *how* a couple therapy approach works. EFT has and continues to use process research to refine interventions and, as an experiential model, to return to and learn from the clinical reality of sessions where partners fight to define their relationships and themselves. Lastly, EFT has created conceptual coherence in the field of couple therapy. It is the only couple intervention based on the most articulated, comprehensive, and extremely well-researched understanding of adult love as the clear target for the end point of therapy: a secure and lasting emotional bond. This coherence offers a map of the terrain of distress that can help the couple therapist to chart what is universal and common in distressed couples and in their change process and also to recognize and respect what is unique and particular to each individual couple.

Many years ago, a study of health in families (Lewis, Beavers, Gossett, & Phillips, 1976) suggested that couple relationships are the primary context for individual health and well-being and the basis of healthy families. Intervention with couples then offered the therapist a uniquely powerful way into self and system that could maximize therapeutic impact and promote health on many different levels and in many different ways. Beyond being an evidence-based treatment for creating relationship satisfaction, recent research (Burgess Moser et al., in press) is demonstrating that EFT also increases relationship-specific attachment security—a clear contributor to mental and physical health (Zeifman & Hazan, 2008). The initial version of this chapter concluded with a hope that EFT would continue to contribute to the growth of the couple therapy field and that EFT therapists will continue to learn from the moment-to-moment magic that is the redefinition and growth of that most precious of gifts, an intimate partnership. With its expansion in the past twelve years this growth has and is continuing to exceed those dreams.

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18.

TRADITIONAL AND INTEGRATIVE BEHAVIORAL COUPLE THERAPY

Lisa A. Benson and Andrew Christensen

This chapter briefly reviews the history, methods, and empirical support for the behavioral family of couple therapies: specifically, its "first wave," traditional form, and its "third-wave," integrative successor, which adds an emphasis on acceptance. The "second wave" of cognitive-behavioral couple therapy is addressed in Chapter 6, "Cognitive-Behavioral Couple and Family Therapy," and Chapter 19, "Cognitive-Behavior Couple Therapy," in this volume.

Traditional Behavioral Couple Therapy

History and Background of the Approach

It was in the late 1960s and 1970s that the growing body of research on behavioral intervention technologies for individuals was first applied to interventions with couples. The possible efficacy of this approach for improving relationship satisfaction was suggested by basic research demonstrating that distressed couples had fewer positive and more negative behaviors toward each other than non-distressed couples (Birchler, Weiss, & Vincent, 1975). Many researchers also noted the possible importance of training couples in new communication behaviors, due to the frequency with which distressed couples reported having difficulty communicating with one another (Jacobson & Martin, 1976). In 1979, Neil Jacobson and Gayla Margolin published the first treatment manual for Traditional Behavioral Couple Therapy[1] (TBCT) (drawing on earlier work by Robert Weiss, Gerald Patterson, and Richard Stuart).

Major Theoretical and Research-Based Constructs

Reinforcement

Behavioral couple therapy is an application of the broader principles of behaviorism, particularly the concept of reinforcement. When a stimulus that follows a behavior increases the frequency, duration, or magnitude of that behavior, the behavior is said to have been reinforced by the stimulus (Skinner, 1970). Reinforcement is defined in terms of the effect on behavior, not the organism's state of mind concerning the stimulus. However, stimuli themselves can be appetitive (if they are expected to be pleasurable) or aversive (if they are

expected to be unpleasant). Reinforcement is "positive" when it involves the delivery of an appetitive stimulus and "negative" when it involves the removal of an aversive stimulus. In couple therapy, for example, one partner's self-disclosure of sad feelings may be positively reinforced if the other partner shows increased interest in response to that disclosure. The same behavior may be negatively reinforced if the other partner had been loudly complaining and became quiet after the self-disclosure.

Good Faith Versus Quid-Pro-Quo Agreements

Early TBCT therapists often helped couples set up "quid-pro-quo" contracts, where one partner agreed to change a behavior that would please the other partner only when the other partner had first changed a behavior of his or hers. This model has the advantage of having the reinforcers for each behavior built in to the model; however, unfortunately, it requires one partner to take the leap of faith of making the first change (Jacobson & Martin, 1976). Jacobson and Margolin (1979) suggested instead that couples make "good faith" agreements, where each one agrees to make behavioral changes regardless of the other partner's behavior.

Research-Based Treatment Protocol

The behavioral intervention strategy outlined by Jacobson and Margolin (1979) has four primary components: assessment, behavior exchange (BE), problem solving (PS), and communication training (CT). Following a thorough assessment of the couple's presenting problem, these interventions can be used in any combination, although therapists typically begin with BE and proceed to the other two.

Behavioral exchange involves identifying behaviors that would be pleasing to the other partner, engaging in those behaviors during the week, and discussing their impact in the following session (Jacobson and Margolin, 1979). When therapists ask both partners to generate possible lists of pleasing behaviors, they note that the behaviors should be specific and feasible (e.g., "buy more presents" is unlikely to be feasible on a regular basis). Each partner should ask the other's advice in revising the list. The therapist may ask the couple to engage in the behaviors at any time during the week, or may specify they should do so on pre-assigned "caring days." In the next session, the therapist follows up on these assignments, debriefs the experience, and provides positive reinforcement for successes, while encouraging the other partner to reinforce improvement as well (Jacobson and Follette, 1985).

Both PS and CT focus on training the couple in new, more effective behaviors, providing the couple with constructive feedback, and asking them to practice these behaviors together outside the session. Communication training focuses on improving dyadic communication by expressing one's subjective views rather than making seemingly objective, blaming statements. The therapist teaches the couple that listening and speaking are separate roles that should be alternated during a conversation. When in the speaker role, partners are permitted to express their views about the topic of conflict, but must use phrasing that is clear and behaviorally specific. In a procedure sometimes called an "I statement," speakers state the specific situation or behavior troubling them ("When you didn't take out the trash even though you said you would") and describe their emotional reaction to that situation ("I felt irritated and resentful"; Dimidjian, Martell, & Christensen, 2008). The listener's role is to listen actively, without interrupting, so they can then paraphrase how they understood the other person's message without adding their own content (Lester, Beckham, & Baucom, 1980). If the speaker disagrees with the listener's restatement, the listener must try again. These roles remain fixed until the speaker has communicated his or her thought and it is clear that the listener understands; the couple may then change roles.

Problem solving has a similar goal of providing couples with an effective structure for handling disagreement (Lester et al., 1980). Therapists teach couples to agree on a clear and behavioral definition of the problem in a way

that acknowledges the roles of both partners. The couple should then generate ("brainstorm") a list of possible solutions without evaluating them. After completing the list, the couple identifies the advantages and disadvantages of each option and selects one or more to try, without necessarily ruling out the others for the future. They make a "good faith" agreement to carry out their separate activities in this agreement. They decide on a length of time for which they will try this solution, planning to meet again at the end of this period to evaluate the effectiveness of this solution and decide whether to try another (Baucom, Epstein, LaTaillade, & Kirby, 2008).

Methods of Model Evaluation

TBCT is classified as "well-established" according to the American Psychological Association Division 12 Task Force criteria (Chambless & Hollon, 1998), due to the large number of randomized clinical trials that have been conducted to show its efficacy. Multiple process studies have also been conducted to identify mechanisms of change in TBCT and the predictors of response to this treatment.

Research Evidence That Supports the Model

A meta-analysis of thirty randomized clinical trials has found TBCT to be significantly more effective than no treatment, with an effect size of $d = 0.59$ (Shadish and Baldwin, 2005). Some earlier meta-analyses (such as Hahlweg & Markman, 1988) have found larger effect sizes for TBCT, but this seems to be due to four outlier studies with small samples (Jacobson, 1977, 1978; Bogner & Zielenbach-Coenen, 1984; Beach & O'Leary, 1986). In some studies, not all three major components of TBCT were included; these studies using only one component tended to have smaller effect sizes than those in which the full TBCT protocol was used (Jacobson, 1984). Comparisons of the three components indicate that studies in which communication training or problem solving was used had larger effect sizes than those in which it was not; inclusion of behavior exchange did not have a significant influence on effect size (Shadish and Baldwin, 2005).

It is also useful to describe what percentage of couples in these studies experienced statistically and clinically reliable improvement in relationship satisfaction. Across four studies (with a total of 148 couples; Margolin & Weiss, 1978; Baucom, 1982; Hahlweg, Revenstorf, & Schindler, 1982; Jacobson, 1984), 54.7% of participating individuals reported statistically reliable improvement. However, in only 35.4% of couples did both partners report reliable improvement. Moreover, only 35.1% of couples had reliable improvement in satisfaction to a clinically non-distressed level. Jacobson, Schmaling, and Holtzworth-Munroe (1987) found that 25% of TBCT couples experienced deteriorating marital satisfaction, and 9% divorced by the two-year follow-up, while Snyder, Wills, and Grady-Fletcher (1991) found that 38% of couples treated with TBCT divorced after four years. These results suggest that although TBCT can be helpful to couples, the changes are often short-lived or insufficient for true recovery from distress.

Several pre-treatment characteristics have been found to predict response to treatment in a sample of sixty couples (Jacobson, Follette, & Pagel, 1986). Some are perhaps unsurprising: having taken more steps toward divorce, having lower commitment to the relationship, and having less sexual intimacy (Jacobson et al. 1986; Jacobson & Christensen, 1996). However, other important predictors of reduced response to treatment are older age, a tendency to withdraw during discussions of the relationship, wives scoring higher on measures of femininity, husbands reporting greater independence, and wives reporting greater affiliation needs (Jacobson et al., 1986; Jacobson & Christensen, 1996). As Jacobson and Christensen (1996) note, what these types of couples have in common seems to be a rigidity or lack of flexibility about relationship roles.

From among a set of possible mechanisms of change in TBCT, those that have been found to significantly predict improvements in marital satisfaction are therapists' self-reported ability to induce collaboration in the couple, husbands' reports of therapist nurturance, husbands' reports

of therapist competence, husbands' reports of client collaborative behaviors, and wives' reports of client collaborative behaviors (Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989). These findings suggest that collaboration in the couple is essential to success in TBCT.

Implementation of the Model in Community/Practice Settings

The implementation of TBCT has occurred primarily through graduate training and continuing education workshops. Few data are available concerning therapists' use of TBCT as versus other methods. However, TBCT has been highly influential in its applications to specific clinical needs such as relationship education and conjoint treatment for alcoholism. Behavioral Couples Therapy for Alcoholism and Drug Abuse (O'Farrell and Schein, 2000) is an empirically supported treatment that is currently being promoted by the US Department of Veterans Affairs (VA) for use by its clinicians (for more information about VA trainings, see the section on implementation of IBCT, page 357).

Two empirically supported relationship education programs, Prevention and Relationship Enhancement Program (PREP; Markman, Stanley, & Blumberg, 2010) and Couple Commitment And Relationship Enhancement (Couple CARE; Halford et al., 2006), are based on the same behavioral and communication training principles as TBCT (Halford & Bodenmann, 2013). Many clergy and lay community leaders have been trained in these relationship education techniques through these studies; for example, Stanley and colleagues (2001) trained leaders from forty-five religious organizations in the Denver area to administer PREP and found they were as successful as university-based therapists in doing so.

Integrative Behavioral Couple Therapy

History and Background of the Approach

As the previous section on the efficacy of Traditional Behavioral Couple Therapy states, research throughout the 1980s revealed that it was able to bring only about one-third of treated couples into a clinically non-distressed range. The findings that TBCT is less efficacious with couples who are more traditional or in other ways less flexible in their relationship roles, as well as couples who are less collaboratively minded, may in part explain the results of these outcome studies. In TBCT, if a couple does not enter therapy willing to compromise and alter their own behavior in order to resolve their difficulties (as is often the case), the therapist must simply ask them to commit to trying collaborative techniques despite their feelings (Jacobson & Christensen, 1996). Unfortunately, even if a couple does attempt to simulate this mindset, the effects are unlikely to be enduring.

In response to these findings, Andrew Christensen and Neil Jacobson[2] developed a couple therapy with a new emphasis on acceptance rather than change—Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1996; Christensen, Wheeler, & Jacobson, 2008). This treatment is akin to many of the "third wave" behavioral therapies developed during this period of the 1980s and 1990s (DBT, Linehan Armstrong, Suarez, & Allmon, 1991; ACT, Hayes, Strosahl, & Wilson, 1999). It acknowledges that many issues couples struggle with are essentially unresolvable (e.g., extroverted versus introverted personality styles). Instead of attempting to find solutions, therefore, it focuses on enhancing both partners' ability to empathize with one another and respond in a more accepting way, thus building intimacy "around" the problem.

Major Theoretical and Research-Based Constructs

Acceptance Versus Traditional Change

Where "traditional change" typically refers to focusing attention on changing the behavior of the "wrong-doer" in a conflict, "acceptance" focuses on modifying the other partner's response to this behavior. In behavioral terms, the goal of acceptance work is to change the stimulus value of one partner's behavior for the other. As this definition demonstrates, acceptance is in actuality another type of change, but one with a very different clinical impact. It is important to note that emphasizing acceptance does not mean

couples are expected to embrace the status quo in their relationship, as this would be unlikely to improve relationship satisfaction (and may in some cases be extremely unfair to one partner; Jacobson & Christensen, 1996).

Instead, acceptance means letting go of the struggle to change the other partner in order to turn toward more fully understanding and experiencing empathy for him or her. A couple's disagreement can result in argument, unhappy resignation, or a third option: mutually sharing their feelings of frustration and experiencing increased intimacy and closeness as a result (Jacobson & Christensen, 1996). In many cases, as this increased intimacy naturally leads to more caring behaviors, couples find they have a decreased need for traditional behavior change. At the same time, many couples also find that increased intimacy increases their motivation to change their own behaviors as their partners had desired—a welcome result (Jacobson & Christensen, 1996).

Contingency-Shaped Versus Rule-Governed Change

IBCT also differs from TBCT in its tendency to emphasize contingency-shaped over rule-governed change. Skinner (1970) first distinguished these types of behavior change as follows: rule-governed change occurs in response to specific imposed demands; for example, if a therapist asks an individual to practice a new communication behavior and she does so, she is changing in response to a rule. When the therapist is no longer present and the rule is consequently less salient, it is not clear that the individual will continue to maintain the new behavior (Jacobson & Christensen, 1996). Contingency-shaped change proceeds more naturally from the person's response to the environment; for example, if the therapist highlights part of the individual's comments so that she softens her communication, her partner may give a more receptive response that reinforces her behavior.

Molar Versus Molecular Problem Definition

TBCT tends to focus on individual instances of behavior between partners and intervenes in those that appear to be particularly problematic; therefore, it tends to take a molecular approach to problem definition. For example, a conversation between two partners in which one criticized the other might be viewed as problematic because both partners failed to use communication skills and made negative attributions about each other's comments, two very specific problem targets for intervention. By contrast, IBCT tends to define couples' problems in a broad, molar way. For example, the therapist might reframe this particular argument in terms of an ongoing pattern of interaction between the two partners: "this looks like that district attorney interviewing a hostile witness pattern again" (Jacobson & Christensen, 1996).

Research-Based Treatment Protocol

IBCT takes place in three stages: assessment, feedback, and treatment (Jacobson & Christensen, 1996). Over the course of one conjoint and two individual sessions (one with each partner), the therapist assesses the couple's present difficulties, relationship history (including any history of intimate partner violence), and level of commitment to the relationship (including the presence of any affairs). Then, the therapist meets with both partners to summarize the results of the assessment and provide them with a formulation of their presenting problem. This formulation emphasizes the natural personality differences between partners, any emotional sensitivities that they may have developed through past experiences, external stressors that may be exacerbating their problems, and maladaptive patterns of interaction the couple has engaged in as they cope with these differences and sensitivities in the context of their ongoing stressors (Jacobson & Christensen, 1996). As the therapist describes various aspects of the formulation, he or she invites the couple to revise as they see fit. If the couple adopts the formulation as descriptive of their problems, it can alter their understanding of the problem into one that is more interpersonal and less blaming. The therapist then describes treatment in IBCT as focusing on incidents and issues related to their formulation, with the therapist being active in helping them discuss these incidents and

issues in a constructive way. The therapist then asks the couple to consider whether they would like to proceed with a course of IBCT, and if so, may encourage them to read an IBCT self-help book for couples as they go through treatment (Christensen & Jacobson, 2000).

The treatment phase of IBCT is less formally structured. When the couple arrives for a session, each partner typically brings a brief questionnaire that he or she has completed, the "Weekly Questionnaire" (Christensen, 2010). In this questionnaire, they complete the short version of the Couple Satisfaction Index (the CSI-4; Funk & Rogge, 2007) to give the therapist a quick view of how their week went. Then, they answer questions to identify: a) the most important positive and negative or difficult events since the last session; b) any upcoming event that will be challenging for them; and c) any issue of concern. They then rank order these in terms of what they feel is most important to discuss in therapy. Typically, the therapist reviews the positive events and creates an agenda based on the incidents or issues that they couple has identified, preferably ones related to the formulation (Jacobson & Christensen, 1996). The therapist then engages the couple in a discussion of the identified incidents or issues, actively intervening to promote any of three interrelated aspects of acceptance: empathic joining, unified detachment, or tolerance building. Sequencing of these interventions (or the addition of the more change-oriented TBCT interventions) is based on the formulation, the current presentation of the couple in the room, and the therapist's clinical judgment.

Empathic joining is a process in which the therapist guides the couple to great emotional intimacy by having them describe their deepest feelings to one another and expressing empathy for the other's distress. To help partners join with one another when discussing a problem area, the therapist restates each person's position as a reasonable view with which the other partner could potentially sympathize and encourages both partners to disclosure some of the emotions that they may not have expressed before (Christensen et al., 2004). Once one partner has expressed soft emotions about the problem (e.g., fear of rejection), the therapist models empathy for that disclosure and may encourage the other partner to respond to the disclosure. The therapist will most likely need to take an active role in eliciting vulnerable feelings from each partner early in therapy and validating those emotions, but the experience of being responded to compassionately is expected to be naturally reinforcing of the behavior of self-disclosure.

Unified detachment is a couple's stance when they both "stand back" from their difficulties and jointly focus on understanding their typical sequence of behavior, describing each individual's role in the conflict in a non-blaming way. Unified detachment can be thought of as a joint mindfulness about difficulty or conflict, at the time of the conflict, in anticipation of a conflict, or after a conflict has occurred. In essence, the therapist's goal is for the couple to fully endorse the original formulation and apply this perspective to new situations in their relationship, allowing them to explain a conflict as an "it" that is separate from "us." Together, they might create a metaphor or label they can use to refer this kind of interaction, such as "I push, you pull." Discussing the issue in this way helps the couple empathize with one another and build intimacy through better understanding their difficulties. Therapists can promote unified detachment by asking for both partners' perspectives on an event, modeling the construction of a non-blaming analysis, and reinforcing the couple when they attempt it (Christensen et al., 2008).

IBCT therapists also use tolerance-building interventions when what is most destructive to the couple's relationship is not the original subject of their disagreement but how they react to one another when disagreeing (Christensen & Jacobson, 1996). The goal of tolerance building is to change one's own typical pattern of behavior following a partner's actions rather than directly asking the partner to change those actions. Although the second partner may continue performing behaviors the first partner finds unpleasant or non-optimal, the first partner learns to react with fewer negative emotions and fewer maladaptive coping strategies, thus slowing or halting the escalation of the conflict. If certain words or styles of arguing are particularly

distressing to the second partner, it may be useful to provide a series of exposures to those behaviors and thus reduce their emotional impact. For example, the therapist may ask the first partner to practice the distressing behavior outside of session. Simply knowing that at times the first partner's behavior is "fake" rather than real may also alter the emotional impact of the behavior for the second partner.

Once these acceptance-oriented techniques have increased a couple's collaborative mindset, the IBCT therapist can also introduce behavior exchange, communication training, and problem-solving training. However, the IBCT therapist tends to use these strategies in a more flexible and less-rule governed fashion than is typical in TBCT.

Methods of Model Evaluation

Two small clinical trials and one large multisite clinical trial support the efficacy of IBCT. Additional analyses of these data reveal important mechanisms of change and predictors of response to treatment in this model.

Research Evidence That Supports the Model

In an unpublished dissertation, Wimberly (1998) demonstrated that eight couples randomly assigned to a group format of IBCT were significantly more satisfied than nine waitlist couples at the end of therapy. In a small clinical trial of twenty-one couples, Jacobson, Christensen, Prince, Cordova, and Eldridge (2000) compared TBCT and IBCT; effect size data and clinical significance data favored IBCT.

The most extensive data in support of the efficacy of IBCT comes from a large, two-site randomized clinical trial (Christensen et al., 2004) of TBCT and IBCT that enrolled seriously and chronically distressed couples as participants. Some 134 married couples in Seattle, Washington and Los Angeles, California, participated in an average of twenty-three therapy sessions each over the course of approximately thirty-six weeks. Participants' mean ages were 41.6 years for wives and 43.5 years for husbands, mean length of marriage was ten years, and the sample was approximately 80% Caucasian. Couples were excluded if either partner had a current diagnosis of schizophrenia, bipolar disorder, substance use or dependence, borderline personality disorder, schizotypal personality disorder, or antisocial personality disorder. Couples in which the wife reported that the husband had engaged in dangerous levels of battering also could not enter the study. To ensure that this was a significantly distressed sample that would provide a rigorous test of the treatment method, couples had to meet criteria for marital dissatisfaction on three separate measures over the course of three time points. Almost 100 couples who wanted couple therapy were excluded as not distressed enough; a follow-up indicated that half of these couples subsequently sought couple therapy in the community.

All study therapists were experienced community practitioners who delivered both TBCT and IBCT and received intense supervision in both (Christensen et al., 2004). Adherence coding indicated that TBCT and IBCT were distinguishable, and as practiced, IBCT therapists engaged in about three times as many acceptance-oriented interventions as TBCT therapists, while TBCT therapists had three times as many change-oriented interventions. Also, to ensure that the TBCT provided in this study was state-of-the-art, an outside consultant who co-wrote the original TBCT manual (Gayla Margolin of Jacobson & Margolin, 1976) provided competence ratings for selected TBCT sessions. The average rating was 52.1, which falls between "good" and "excellent." Participants' responses to measures of therapeutic bond and consumer satisfaction with therapy were also high and equivalent across treatment groups. These findings suggest that this trial was a fair comparison of the two treatments.

Multilevel modeling of how couples' self-reported marital satisfaction (DAS; the primary outcome measure) changed from pre-treatment to post-treatment indicated that couples improved significantly in therapy, with a fairly large effect size of $d = 0.86$ (Christensen et al., 2004). Trajectories for the treatment groups differed, however; TBCT couples' satisfaction initially increased more quickly but then plateaued,

while IBCT couples' satisfaction increased more steadily. Fully 71% of IBCT couples saw their satisfaction increase reliably or even reach a normative "recovered" level by the end of treatment, while only 59% of TBCT couples were in this clinical significance category.

The two-year follow-up to this study suggested that change in satisfaction after the end of treatment did not occur linearly (Christensen, Atkins, Yi, Baucom, & George, 2006). Instead, couples' trajectories followed a "hockey stick" pattern of decline in the weeks immediately following termination and then a reversal in which satisfaction again began to increase (Christensen et al., 2006). In the model that best fits these trajectories, the initial decline was significantly more rapid and more prolonged for TBCT couples than IBCT couples. During the four six-month assessments through the first two years of follow-up, IBCT couples showed significantly greater satisfaction than TBCT couples (Christensen, Atkins, Baucom, & Yi, 2010). Some 69% of IBCT couples and 60% of TBCT couples were reliably improved or recovered at the two-year follow-up assessment, a considerable number given the initial distress of this population (Christensen, et al., 2006). At five-year follow-up, treatment groups differences in marital satisfaction were no longer significant (Christensen et al., 2010). Half of couples continued to show reliable improvement or recovery but a quarter were separated or divorced. The authors suggested that with this population of seriously and chronically distressed couples, additional "booster" sessions might be needed to maintain gains over the long term (Christensen et al., 2010).

This clinical trial included data concerning a large set of possible intrapersonal and interpersonal baseline predictors of pre-treatment to post-treatment change (Atkins et al., 2005): demographic variables, such as age and ethnicity; intrapersonal variables, such as personality and psychopathology; and interpersonal variables, such as communication style and commitment level. Reporting a greater desire for closeness, better communication, and fewer steps taken toward divorce predicted a higher initial level of marital satisfaction; but few variables predicted change in satisfaction over the course of treatment. However, these authors did find that couples who had been married longer demonstrated greater improvements during treatment. Sexually unhappy couples in TBCT improved quickly in the beginning of treatment but then actually decreased in satisfaction toward the end of treatment, while sexually unhappy IBCT couples' satisfaction increased more steadily throughout treatment. The finding that interpersonal factors are important predictors of initial status rather than rate of change suggests that IBCT is successful at helping all types of couples improve their satisfaction.

Baucom, Atkins, Simpson, and Christensen (2009) examined the same set of possible predictors through two-year follow-up; they also added several variables coded during interaction tasks, including emotional arousal (measured as fundamental frequency in voice recordings) and influence tactics defined in terms of amount of freedom to respond as hard (limited freedom) and soft or collaborative (lots of freedom). As in the earlier prediction study, couples who had been married longer showed greater improvement at two-year follow-up. Lower levels of pre-treatment emotional arousal and lower levels of hard influence tactics predicted greater treatment response at two-year follow-up in moderately distressed couples but not in severely distressed couples. Wives with higher emotional arousal at pre-treatment were more likely to show deteriorated satisfaction if they received TBCT than if they received IBCT. Greater use of collaborative ("soft") influence tactics was strongly associated with clinical improvement/recovery at the two-year follow-up for IBCT couples only (Baucom et al., 2009). Although high emotional arousal presents challenges for any therapist, IBCT's emphasis on emotion may have improved therapists' ability to help this kind of couple (Baucom et al., 2009). In combination, the results of these two studies suggest that although some characteristics like power processes and encoded arousal may indicate a preferred treatment, both treatments are able to meet the needs of most couples.

Two studies have examined mechanisms of change in IBCT. Cordova, Jacobson, and Christensen (1998) found that IBCT and TBCT couples did not differ on the amount of

detachment or soft emotion (such as fear or sadness) demonstrated in early therapy sessions, but IBCT couples displayed significantly more of each in the middle and late sessions. Across groups, increases in soft emotion and detachment, as well as decreases in problem behaviors, correlated with improvements in marital satisfaction. These results suggest that IBCT produces more significant changes than TBCT in couples' tendency to discuss problems in a non-blaming, empathy-inducing way, behaviors which are then associated with greater relationship satisfaction (Cordova et al., 1998). Doss, Thum, Sevier, Atkins, and Christensen (2005) found that TBCT led to greater changes in frequency of targeted behaviors (those rated as important to either partner) early in therapy, but IBCT led to greater changes in acceptance of targeted behavior both early and late in therapy. Moreover, change in behavioral frequency was strongly related to improvements in satisfaction early in therapy, while emotional acceptance was more strongly related to changes in satisfaction later in therapy. Self-reported communication patterns also improved over the course of treatment (Doss et al., 2005). Both TBCT and IBCT couples increased their incidence of mutually positive interactions and decreased their incidence of mutually negative and demand-withdraw interactions; each of these changes was associated with improvements in marital satisfaction for both husbands and wives. Together, these studies suggest that IBCT's focus on acceptance is a mechanism of change in marital satisfaction in this treatment, possibly explaining its comparatively greater effect on satisfaction through two-year follow-up (Doss et al., 2005).

Implementation of the Model in Community/Practice Settings

Since its development, IBCT has been disseminated through graduate training and a series of national and international workshops given by Christensen and by Jacobson as well as by their colleagues. The IBCT website, http://ibct.psych.ucla.edu/therapists.html, provides a list of therapists throughout the country who have been thoroughly trained and supervised in IBCT, including observation of couple therapy sessions over the course of six months or longer.

IBCT is one of the empirically supported treatments currently being "rolled out," or promoted, by the VA for its clinicians. For the last three years, the VA has sponsored five four-day trainings in IBCT, followed by six months of weekly group phone supervision for all training participants. During this time, trainees must see at least two IBCT cases, audio record at least twenty therapy sessions that are then observed by a supervisor, and ultimately meet criteria on a detailed rating scale of adherence and competence based on these recordings. Of the approximately thirty to fifty individuals who have participated in each training thus far, about 80% have met criteria at the end of six months; the most common barrier to success is not obtaining cases quickly enough. The VA is currently attempting to make IBCT training more accessible by making the workshop available on video, with trained staff available for ongoing consultation.

Another way in which IBCT is being implemented in community settings is through the development of OurRelationship.com, an online program for distressed couples based on IBCT principles (Doss, Benson, Georgia, & Christensen, 2013). Couples complete approximately six to eight hours of interactive activities, videos, questionnaires, and structured conversations in order to develop a new conceptualization of their relationship (just as a therapist might develop a formulation) and make plans for changing their own behavior. Developed through a grant[3] from the National Institute of Child Health and Development to Doss and Christensen, this site is currently under study, with early pilot data suggesting it is appealing to couples and produces some improvement in relationship satisfaction.

The dissemination of IBCT is also occurring through a new approach to training couple therapists: the idea of "common principles" in couple therapy (e.g., Christensen, 2009; Benson, McGinn, & Christensen, 2012; Davis, Lebow, & Sprenkle, 2012; Snyder & Balderrama-Durbin, 2012). According to this view, given the many empirically supported treatments that exist for relationship difficulties, it may be most sensible to train new therapists in the principles shared by

all these therapies. Gurman (2013) further suggests giving trainees an empirically supported "home theory," with an emphasis on adding other empirically supported interventions according to what is effective for a particular couple. We have argued that IBCT is particularly well-suited to be a home theory given its flexibility and functional contextualist orientation (Benson, Sevier, & Christensen, 2013). While data on training practices are needed, it seems likely that the dissemination of IBCT to new practitioners may occur with this emphasis on what it shares with other treatments.

It is in this variety of ways that the legacy of behavioral couple therapy continues into the 21st century. Although additional research is needed on the efficacy of new dissemination methods, particularly those using technology, the existing evidence on the ability of traditional and integrative behavioral therapies to improve couples' lives suggests these new applications could also be potentially transformative.

Notes

1. This treatment was originally referred to as Behavioral Marital Therapy but will be called Traditional Behavioral Couple Therapy to better distinguish it from Integrative Behavioral Couple Therapy (in accordance with Christensen et al. (2004)) and because the field has moved toward the more inclusive term "couple therapy" rather than the more limited term "marital therapy."
2. Christensen and Jacobson's names have been listed in alphabetical order to reflect their view that they were equal co-creators of IBCT, in accordance with their own practice for listing authorship.
3. Grant R01HD059802 to Brian D. Doss from the Eunice Kennedy Shriver National Institute of Child Health & Human Development.

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19.

COGNITIVE-BEHAVIORAL COUPLE THERAPY

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Cognitive-behavioral couple therapy (CBCT) has grown rapidly over the past four decades to become one of the evidence-based treatments for couples' general relationship distress as well as for the treatment of forms of individual psychopathology in the couple context. This chapter describes the development of CBCT and the aspects of the model that have established it as among the most widely used couple therapy approaches among practicing clinicians (Northey, 2002). The fact that the model addresses three major domains of couples' experiences in their intimate relationships—cognitions, emotional responses, and behavioral interactions—makes it easy for clinicians who use other theoretical models to integrate CBCT principles and interventions into their work. In turn, we will describe how CBCT has grown from an initial focus on partners' exchanges of pleasing and displeasing behaviors to a model that is much more integrative with other major models such as emotionally focused therapy and structural family therapy.

History and Background

Cognitive-behavioral couple therapy (CBCT) has roots in several sources that have led to its development over the past several decades into a flexible and multidimensional model with applicability to treating a wide variety of couples' presenting concerns. The major influences have been: a) behavioral marital therapy (BMT) principles and procedures based on social exchange and social learning theories, b) cognitive therapy models, c) basic research on social cognition, d) family systems theory, e) research on the effects that emotions have on cognition and behavior, f) stress and coping theory, and g) integrative therapy models. The following is an overview of those foundational influences on CBCT.

Social Exchange and Social Learning Bases of Behavioral Marital Therapy

The behavioral core of CBCT initially was formulated by theorists and therapists who applied social exchange and social learning principles to understand relationship problems and to design interventions for distressed couples. A premise of social exchange theory (Thibaut & Kelley, 1959) that an individual's level of satisfaction with a relationship is a function of the ratio of his or her positive experiences to negative experiences in the relationship led

to intervention strategies designed to maximize positive behavioral exchanges between partners and minimize negative exchanges (Jacobson & Margolin, 1979; Liberman, 1970; Stuart, 1969; Weiss, Hops, & Patterson, 1973). Social exchange theory also posited that members of a relationship tend to reciprocate positives and negatives, so couple therapists and researchers attended to dyadic patterns, examining behavioral *sequences* between partners, not only the frequencies with which each person enacted particular types of positive or negative acts.

Social learning principles (e.g., Bandura, 1977) describing how an individual's behavior is controlled by its antecedents and consequences led to the application of functional analysis to understand and modify problematic behavior in intimate relationships. Partners continuously provide *consequences* (reinforcement and punishment) for each other's actions, as well as *discriminative stimuli* or cues indicating the conditions under which an individual is likely to receive such consequences. Thus, the members of a couple shape each other's behavior, and both contribute to an existing pattern that they experience as satisfying or distressing. Based on the same learning principles that account for the development of partners' problematic behavior toward each other, behavioral marital therapists could coach a couple in developing a new and more satisfying pattern. The primary methods used to structure more positive behavioral exchanges included forms of behavioral contracts, training in constructive communication skills, and training in collaborative problem solving (Jacobson & Margolin, 1979; Liberman, 1970; Stuart, 1969; Weiss, Hops, & Patterson, 1973). Practitioners of BMT emphasized the scientific nature of their concepts and methods, even referring to it as a "technology" (Weiss et al., 1973).

Thus, beginning with its initial versions, practitioners of behavioral marital therapy (BMT) paid close attention to the *process* of couple interactions and developed systematic assessment procedures for identifying patterns that contributed to or detracted from partners' satisfaction. The development of behavioral coding systems such as the Marital Interaction Coding System (MICS; Weiss et al., 1973; Weiss & Summers, 1983), the Kategoriensystem für Partnerschaftliche Interaktion (KPI; Hahlweg et al., 1984), and the Couples Interaction Scoring System (CISS: Gottman, 1979; Notarius & Markman, 1981) allowed researchers and clinicians to obtain reliable observational samples of couples' interactions and track changes in behavior due to therapy. This empirical approach became a hallmark of therapy outcome studies that examined pre- to post-therapy changes in observed frequencies of partners' positive and negative behaviors, as well as their self-reports of subjective relationship satisfaction The emphasis on empiricism in BMT served it well in developing a strong tradition of systematic research on treatment effectiveness. As described later in this chapter, the behavioral and cognitive-behavioral approaches to the treatment of couple problems have one of the strongest records of empirical support of any theoretical model (Gurman, 2013).

However, the BMT focus on assessment and modification of couples' overt behavior patterns, and its foundation in social exchange principles, also contributed to a stereotype that the model is superficial and ignores "deeper" problems that couples bring to therapy. Writings such as Goldstein's (1971) description of training wives to reinforce specific actions that they wanted their husbands to increase provided support for the influences that partners have each on other but appeared to ignore other sources of marital distress. Even as Jacobson and Margolin (1979) and Stuart (1980) developed more sophisticated methods for implementing behavioral contracts and improving partners' communication and problem-solving skills, and as evidence accumulated from outcome studies that the skills-based improvements in partners' behavior were associated with improvements in partners' subjective relationship satisfaction (see Baucom & Epstein, 1990 for a review), the major focus on behavior and the relative inattention to partners' subjective thoughts and emotions seemed to be limitations of the model. Furthermore, the assumption

that all distressed couples had deficits in communication and problem-solving skills has long been questioned (Gurman, 2013), based partly on studies that showed that partners who exhibited negative communication with each other communicated positively with strangers, and partly on clinical reports of individuals intentionally abandoning good communication guidelines when angry toward a partner (Epstein & Baucom, 2002). Theoreticians began to look elsewhere to expand the BMT conceptual model and methods.

Margolin and Weiss (1978) and Jacobson and Margolin (1979) noted that partners' cognitions (in particular their attributions regarding the intentions underlying each other's actions) influence their responses to each other's behavior, and that those cognitions can be inaccurate. Thus, if an individual attempts to behave in a positive way toward a partner, the impact may be negative if the partner attributes the action to a selfish motive (e.g., trying to impress the couple's therapist). However, the publications describing BMT provided little detail about methods that therapists could use to assess and modify partners' potentially distorted cognitions. Gottman, Notarius, Gonso, and Markman (1976) also described subjectivity in couple communication by emphasizing common discrepancies between the message that one person intends to send and the message that the other person perceives. They noted that the gap between intent and impact can be caused by a "filter" on the sender's end (e.g., being in a bad mood adds negative non-verbal behavior to an intended neutral message) and by a "filter" on the receiver's end (e.g., "mind reading" in which the listener assumes he or she knows the speaker's underlying intentions or goals). Gottman et al. (1976) addressed intent-impact discrepancies by teaching couples to use good expressive and listening communication skills to minimize the effects of such filters. The speaker is responsible for describing his or her thoughts and emotions clearly and acknowledging their subjectivity. The listener reduces the likelihood of misperception by practicing empathic listening and reflection of the speaker's verbal and non-verbal messages, giving the speaker opportunities to clarify his or her intent. Thus, although misinterpretations may be due to the listener's mood state and cognitive distortions, the intervention primarily focuses on a behavioral solution of maximizing clear communication, not addressing the cognitive and affective factors.

At this stage in the development of BMT, research investigated types of communication behavior that are associated concurrently and longitudinally with relationship distress, and the findings were used to substitute constructive forms of communication for the negative verbal and non-verbal behavior. This trend has continued throughout the development of CBCT, as findings from behavioral observation studies using micro-level coding of partners' interactions have been used to design preventive and therapeutic interventions (Gottman, 1994, 1999; Hahlweg & Jacobson, 1984; Weiss & Heyman, 1997). Social exchange and social learning principles affecting positive and negative couple interactions and their effect on relationship satisfaction are still important influences.

Cognitive Therapy Applied to Couples

Although cognitive therapy models originally were developed to address problems in individual functioning such as depression and anxiety (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979; Ellis, 1962; Meichenbaum, 1977), their core concept that individuals respond to their subjective construal of life events rather than objective events was relevant to understanding and intervening with problems within relationships. Ellis' focus on *irrational beliefs* and Beck and colleagues' attention to individuals' relatively stable *schemas* or knowledge structures were consistent with behaviorists' acknowledgment that partners' perceptions of each other's actions can be filtered or shaped by the perceiver's pre-existing characteristics. Ellis (1977) proposed that individuals experience marital distress when they judge the quality of their relationships according to irrational beliefs about characteristics that a good relationship should possess. Based on this concept, Ellis and his colleagues applied rational-emotive therapy to the treatment of couple problems (Ellis, Sichel, Yeager, DiMattia, & DiGiuseppe, 1989), with a focus on challenging

and modifying partners' beliefs rather than their behavioral interactions.

Epstein (1982), Beck (1988), Dattilio and Padesky (1990), and Rathus and Sanderson (1999) applied Beck et al.'s (1979) cognitive therapy model to the assessment and treatment of couple relationship problems. In addition to examining the influences of individuals' long-standing beliefs or schemas, Beck's model led couple therapists to assess and intervene with partners' moment-to-moment *automatic thoughts* about each other and their relationship. For example, an individual might make an arbitrary inference that a partner failed to phone about being late arriving home because the partner was inconsiderate, triggering the individual's hurt and anger. Traditional Socratic questioning used in cognitive therapy could be used to coach the individual in considering alternative causes of the partner's behavior and in collecting more information from the partner. Cognitive therapy with couples began to focus on patterns in which distortions in each person's cognitions about his or her partner, or unrealistic standards for the partner's behavior, result in negative emotions and behavior toward the partner, creating a reciprocal negative interaction pattern. Epstein (1982) also applied Meichenbaum's (1977) stress inoculation principles in proposing ways in which couple therapists can assist partners in the use of constructive self-statements to regulate strong emotional responses to each other and guide their behavioral interactions.

In general, the initial applications of cognitive therapies to couple problems emphasized assessment and modification of cognitions that elicited or maintained conflict and distress. The importance of good communication between partners was acknowledged, but most of the interventions targeted partners' cognitions. At that point, the strong body of empirical evidence for the effectiveness of cognitive therapies for treating individual psychopathology was considered sufficient for targeting partners' cognitions in couple therapy, and there was little research on the degree to which cognitive interventions improved relationship functioning. Baucom's therapy outcome studies (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990) indicated that interventions designed to modify couples' negative attributions about each other and their unrealistic relationship beliefs had comparable positive effects to those resulting from BMT interventions (communication training, problem-solving training, and contracting). Huber and Milstein (1985) conducted the only couple therapy study restricted to cognitive interventions and found positive effects on relationship satisfaction. Nevertheless, the emphasis turned to integrating foci on assessing and modifying *both* cognitions and behavior in CBCT (Baucom & Epstein, 1990; Epstein & Baucom, 1989), with little attention to evaluating the degree to which the cognitive interventions themselves contributed to improvement in couples' relationships.

Dattilio (e.g., 1994, 2005, 2006, 2010) added to the depth of CBCT by expanding assessment and interventions with couples' (as well as families') *relationship schemas*—shared relatively stable assumptions and standards about the qualities of intimate relationships. Dattilio described intergenerational patterns in which beliefs are passed from one generation to the next, and beliefs that are shared among family members can be especially resistant to change. This focus on intergenerational history runs counter to the stereotype of CBCT as virtually present-focused. The systematic collection of information about qualities of relationships in the partners' families of origin can be facilitated by constructing a genogram—an assessment procedure commonly associated with intergenerational family therapy (McGoldrick, Gerson, & Shellenberger, 1999) but quite useful in a CBCT approach.

Social Cognition Research

In addition to drawing on cognitive therapy concepts and methods, CBCT theorists and practitioners applied findings from basic research on social cognition, regarding individuals' information processing that can bias appraisals of another person. Research that indicated how a person's schemas contribute to selective perceptions of ongoing events in interpersonal relationships and can bias one's memories of past events in a relationship (e.g., Fiske & Taylor, 1991) provided indirect support for cognitive interventions with

couples. Increasingly, researchers also developed methods for measuring couples' relationship cognitions, such as unrealistic relationship beliefs (Epstein & Eidelson, 1981; Eidelson & Epstein, 1982) and attributions (Bradbury & Fincham, 1990; Pretzer, Epstein, & Fleming, 1991) and conducted studies demonstrating their associations with relationship distress.

The developments in applying knowledge about cognitions that can influence couple functioning were guided in part by a typology of five forms of relationship cognitions identified by Baucom, Epstein, and their colleagues (Baucom & Epstein, 1990; Baucom, Epstein, Sayers, & Sher, 1989; Epstein & Baucom, 1989). *Assumptions* are an individual's generally long-standing beliefs about typical characteristics of individuals and relationships (e.g., individuals who love each other can mind read each other's thoughts and emotions), *standards* are beliefs about the characteristics that individuals and relationships "should" have (e.g., a partner who loves you should want to spend as much time with you as possible), *attributions* are inferences about determinants of observed events (e.g., the reason why my partner didn't call to say she would be late was because I am not important to her), *expectancies* are inferences involving a prediction about future events (e.g., if I tell my partner that his actions hurt my feelings, he will just get defensive and won't apologize), and *selective perceptions* involve noticing particular aspects of a situation while overlooking others (e.g., an individual notices instances in which a partner failed to provide emotional support and overlooks other instances in which the partner was supportive). There is empirical support for the association between each of these types of cognition and relationship quality; for example, see reviews by Baucom and Epstein (1990), Epstein and Baucom (1993, 2002), and Weiss and Heyman (1997). Thus, basic research on social cognition has provided support for the design of interventions to modify types of cognition that are risk factors for emotional distress and negative behavioral interactions between intimate partners. Furthermore, decreases in partners' negative attributions over the course of couple therapy has been found to be associated with improvements in relationship satisfaction and couple behavioral interactions (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011).

Family Systems Theory

The functional analysis concept in social learning theory tracks antecedents (stimuli) and consequences (e.g., reinforcement, punishment) of an individual's action in a rather linear manner. Similarly, cognitive therapy models have tended to emphasize linear effects that individuals' cognitions have on their emotions and behavior. Those models can create an impression that the roots of CBCT result in it focusing on linear causal processes and failing to conceptualize circular recursive processes emphasized in family systems theory. However, Bandura's (1977) social learning theory actually emphasizes reciprocal determinism, involving circular processes in which individuals are both influenced by and influence their environments. BMT writers such as Jacobson and Margolin (1979) described in detail the negative *circular processes* that commonly occur in distressed couples, and research has indicated that distressed couples are less likely than happy couples to stop escalation of reciprocal negative behavior exchanges (Hahlweg & Jacobson, 1984). Similarly, cognitive therapy models take into account processes through which emotions shape cognitions, and in a couple relationship each person's behaviors influence the other's cognitions and emotions (Baucom & Epstein, 1990; Epstein & Baucom, 2002). Although the authors of early writings on BMT and cognitive therapies paid minimal attention to systems theory, as well as to each other (Gurman, 2013), systemic concepts increasingly have been integrated into CBCT. Gurman's (1978) warning that conducting individual therapy for relationship problems ignores circular dyadic processes and has been shown to be less effective than conjoint treatment has been well heeded in the field.

Research and Clinical Models Regarding Effects of Emotions on Cognition and Behavior

Early versions of BMT and CBCT placed partners' emotional responses in a secondary role,

as consequences of their behaviors toward each other and their cognitive interpretations of each other's actions. However, Weiss (1980) drew researchers' and clinicians' attention to *sentiment override*, in which an individual's existing global feelings about a partner influence his or her experience of the partner's current behavior more than the objective characteristics of the partner's behavior do. Research (e.g., Hawkins, Carrère, & Gottman, 2002) has supported the existence of sentiment override, and CBCT clinicians increasingly have paid attention to assessing partners' mood states and more long-standing evaluations and feelings about each other as "filters" that bias communication, as described by Gottman et al. (1976).

Furthermore, the broader field of cognitive-behavioral therapy has seen the development of procedures for intervening with individuals' emotional dysregulation problems. Although these procedures have been applied most commonly in dialectical behavior therapy (DBT) for borderline personality disorder (Linehan, 1993), they also are highly relevant for developing emotion regulation in couples in which one or both members experience and express intense emotions when in conflict (Fruzzetti & Iverson, 2006). The therapeutic interventions focus on: a) individuals' difficulties with vulnerability to experiencing negative emotions (high reactivity and slow return to baseline arousal), and b) their deficiencies in emotion regulation skills. Emotion regulation deficits commonly include low awareness of distressing situations that could be avoided, lack of awareness that one's arousal is increasing, reliance on "powerful" emotions such as anger to avoid vulnerable emotions such as hurt that are experienced as intolerable, ineffective ability to shift one's attention away from distressingly arousing stimuli, lack of awareness that one's emotions are triggered by particular stimuli, inaccurate labeling and differentiation of various emotions, anger eliciting cognitions such as unrealistic standards ("My partner *should* be supportive of all my ideas") and negative attributions about others' motives, inaccurate expression of emotions to others, and general deficits in relationship-building skills (Fruzzetti & Iverson, 2006). A combination of traditional DBT skill training for reducing emotional dysregulation and relationship skill training to reduce couple and family distress is delivered in conjoint sessions. As CBCT has developed further over the past two decades, increased attention has been paid to integrating interventions for increasing emotional awareness and regulating one's strong emotions (Baucom, Epstein, LaTaillade & Kirby, 2008; Epstein & Baucom, 2002; Kirby & Baucom, 2007a, b).

In contrast to difficulties that some individuals have in regulating the experience and expression of emotions in their intimate relationships, others have deficits in degrees to which they are aware of emotional experiences or are inhibited in sharing their feelings with their partners. Although earlier forms of CBCT (Baucom & Epstein, 1990; Epstein & Baucom, 1989) addressed these deficits primarily by coaching couples in the use of expressive and empathic listening skills, Epstein and Baucom's (2002) enhanced CBCT model focuses on a broader range of barriers to emotional experience and the resulting limited intimacy. For example, some individuals grew up in families in which emotions were rarely expressed overtly, and may have been punished for revealing feelings. Others developed an assumption that the arousal associated with emotions is "messy" and likely to interfere with constructive rational thinking. Yet others had previously experienced traumas and as part of post-traumatic stress disorder (PTSD) quickly become alarmed at the first cues of emotional arousal. Therefore, a comprehensive approach to assessment and intervention in CBCT now includes attention to degrees and quality of emotional experience. CBCT practitioners have been influenced by principles and methods of emotionally focused couple therapy (EFT; Greenberg & Goldman, 2008; Greenberg & Johnson, 1988; Johnson, 1996) that focus on identifying emotions that shape partners' behaviors toward each other. Epstein and Baucom (2002) describe a variety of experiential approaches for increasing individuals' awareness of their emotional responses and using communication guidelines to coach partners in expressing their emotions to each other and responding empathically. Monson and Fredman's (2012) cognitive-behavioral conjoint

therapy for PTSD is an example of a CBCT approach that uses couple interventions to treat a partner's PTSD symptoms, including emotional reactivity, numbing, and avoidance.

Stress and Coping Theory

Traditionally, BMT and CBCT tended to focus on couple functioning in the here-and-now. Although it was assumed than partners learned much of their interpersonal behavior in past relationships (family of origin, prior couple relationships, media portrayals of close relationships), assessment and interventions for the most part were based on a "snapshot" of the couple's current functioning. However, theoretical models of couple and family coping with life stresses have presented opportunities to capture developmental processes and changes that influence a couple's relationship functioning. The characteristics of the partners (e.g., physical health) and the circumstances within which their relationship exists (e.g., extended family relationships, economic conditions) change over time. Consequently, Epstein and Baucom (2002) applied a developmental framework in their enhanced CBCT model that addresses the inevitability of change over time and the fact that any couple will face a variety of stresses or demands over the course of their relationship and must cope effectively.

The events that place pressure on a couple to adjust or cope can include what are generally considered to be positive life events (e.g., the birth of as child, moving to a new city for a job promotion), as well as negative events (e.g., a serious illness in one partner, the loss of a job). The demands may be based on characteristics of the individual members of the couple (e.g., a partner's chronic depression), the couple as a dyad (e.g., a difference in the two individuals' needs and desire for emotional intimacy), or the couple's physical or interpersonal environment (e.g., stress from the partners' jobs) (Epstein & Baucom, 2002). Some demands on a couple tend to be long term and stable (e.g., a partner's lifelong physical disability), whereas others develop at a particular time, either relatively normatively (e.g., retirement) or unexpectedly (e.g., heart disease).

Epstein and Baucom applied the ABCX family stress and coping model (McCubbin & McCubbin, 1989) for conceptualizing the disruptive effects of life demands (the "A") on a couple's functioning (the "X"), with the couple's resources ("B") and perceptions of the demands and resources (the "C") as potential moderators of the negative effects of demands. In this model, a couple is more likely to weather the variety of demands that they face over the years when they have and use adequate resources for coping with demands and also perceive the demands as manageable rather than catastrophic and uncontrollable. According to McCubbin and McCubbin (1989), whereas resources can buffer negative effects of stressors, *vulnerabilities* (depression in a partner, poor communication between partners) can exacerbate the negative effects. Karney and Bradbury's (1995) vulnerability-stress-adaptation model is another framework that has been used to conceptualize factors affecting couples' adjustment to the challenges that they face together by taking into account couple characteristics that influence success in meeting life's challenges. For example, Karney and Bradbury cite empirical evidence that a partner's neuroticism acts as a vulnerability for poor couple responses to stressors.

Bodenmann (2005) has expanded the conceptualization of couple coping further to encompass dyadic patterns in which members of a couple provide support for each other's coping with individual stressors, and also engage in joint efforts to cope with shared stressors. In dyadic coping, the whole is truly greater than the sum of the parts. Thus, the general CBCT model has been expanded to take into account a variety of normative and non-normative challenges that a couple may face, and the capacities that the partners have to cope with them individually and as a dyad.

Integrative Therapy Models

Integration of psychotherapy models to create more comprehensive conceptualizations and interventions for multiple determinants of people's problems has become a major trend in the mental health field, as reflected in international professional organizations such as the Society for

the Exploration of Psychotherapy Integration, journals (e.g., the *Journal of Psychotherapy Integration*), and books (e.g., Norcross & Goldfried, 1992; Stricker, 2010). The integration movement has extended into the couple therapy field, with models such as those developed by Snyder and colleagues (Snyder & Mitchell, 2008) and Gurman (2008). Although the merging of traditional behavioral couple therapy with cognitive therapy and family systems concepts in itself represented a major integration of theoretical models, CBCT theorists have expanded the model further to take both intrapsychic and systemic factors into account more comprehensively. The two major integrative models have been Jacobson and Christensen's Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1996; Dimidjian, Martell, & Christensen, 2002) and Epstein and Baucom's Enhanced Cognitive-Behavioral Couple Therapy (ECBCT; Baucom, Epstein, & LaTaillade, 2002; Epstein & Baucom, 2002).

Integrative Behavioral Couple Therapy. Jacobson and Christensen (1996; Dimidjian et al., 2002) developed IBCT based on their concern that traditional behavioral marital/couple therapy (TBCT) focused almost exclusively on improving relationships by changing a couple's current interaction patterns that were distressing to the partners. They stressed that the TCBT model did not take into account limitations in how much change in existing patterns is possible, or in some cases even desirable. On the one hand, some characteristics of each partner may be associated with trait-like or temperament factors, such that intentional efforts to change ingrained responses may produce some change but not as much as the person's partner may desire. On the other hand, an individual may have the right to take a stand against a partner's request that he or she change in particular ways (e.g., "When you married me you knew that my career was important to me, but now you want me to make it a low priority."). Therefore, Jacobson and Christensen developed a therapy model that balanced traditional behavior change methods used in TBCT (e.g., communication skills and problem-solving training) with interventions intended to increase partners' *acceptance* of each other's existing characteristics. The acceptance interventions have been drawn from models such as strategic, client-centered and emotion-focused therapies, but they are integrated with a traditional behavioral model that emphasizes how two partners' behaviors are influenced by the context that each person provides for the other's actions. For example, if interventions increase each person's empathy for the other and acceptance of the other's negative behavior, reducing reciprocal negative responses, the context of the relationship can become more positive.

Enhanced Cognitive-Behavioral Couple Therapy. Enhanced Cognitive-Behavioral Couple Therapy (ECBCT; Baucom, Epstein, & LaTaillade, 2002; Epstein & Baucom, 2002) integrates the foci on relations among traditional cognitive, affective, and behavioral components of CBCT with aspects of a number of other couple therapy models. As described previously, the model is consistent with a family systems conceptualization of circular processes occurring between members of a couple, and it also addresses the couple's ability to cope with life stressors or demands, including developmental changes. In addition, the emotional responses that shape partners' behaviors toward each other that are emphasized in emotionally focused therapy (EFT) are important affective components of ECBCT (Baucom, Epstein, & LaTaillade, 2002; Epstein & Baucom, 2002). Whereas Johnson's (1996) version of EFT focuses on primary (underlying) emotions such as anxiety and loneliness associated with forms of insecure attachment as well as secondary (surface level) emotional responses such as anger, Greenberg's EFT (Greenberg & Goldman, 2008) encompasses a broader range primary emotions, including anger associated with power dynamics between partners. In ECBCT, therapists use EFT approaches to empathic listening and reflection, which mesh well with the CBT "downward arrow" method of inquiring about underlying emotions and associated thoughts, to help both members of a couple understand their own and each other's emotions involved in the couple's interactional cycle. As in EFT, the therapist heightens awareness and expression of emotions

that are influencing couple interactions but have been overlooked, but in ECBCT the therapist also assists partners in reducing emotion dysregulation when it is occurring and in developing communication and problem-solving behavioral skills to address attachment, power, and other issues.

ECBCT also integrates aspects of structural therapy involving interaction patterns that define boundaries and hierarchy in the couple's relationship, in relation to each other and significant others (e.g., children, in-laws) in their life together. In addition to behavioral interactions involving the distribution of power and the degree of connectedness versus autonomy between partners, ECBCT examines partners' cognitions such as their personal standards about appropriate boundaries and power/control (Epstein & Baucom, 2002).

Thus, CBCT has become a much more comprehensive approach to understanding and treating distressed couples.

Major Theoretical and Research-Based Constructs

The CBCT model encompasses behavioral interactions, cognitions, and emotional responses that contribute to the quality of couple relationships, including the partners' abilities to have their basic human needs met within the relationship and successfully cope with demands experienced as individuals and as a dyad. Many of the constructs regarding effects of behavior, cognitions, and emotions on relationship quality have been supported by empirical evidence. A detailed review of the empirical support for each construct is beyond the scope of this chapter, but citations to representative literature are provided in the following sections.

Constructs Regarding Behavior

Effects of positive and negative behaviors enacted. Each individual's positive instrumental and affectional actions toward the other tend to be associated with the recipient's overall higher satisfaction with the relationship. In contrast, negative actions tend to be associated with lower satisfaction (Baucom & Epstein, 1990; Weiss & Heyman, 1997). There also is some evidence (e.g., Gottman, 1999) that negative actions have a stronger effect than positive actions on the recipient's relationship satisfaction. However, some longitudinal studies (e.g., Karney & Bradbury, 1997) have found that wives' greater negative communication prior to marriage predicted less decline in their relationship satisfaction over time, perhaps because they were addressing issues of concern to them and facilitating their resolution. Thus, therapists must assess the functions that positive and negative behaviors serve in couple's interactions rather than simply focusing on attempting to increase positives and decrease negatives.

Effects of social support behavior on partner psychological well-being. Social support behavior from a partner is a significant buffer against negative mental health effects of life stressors (Cutrona, 1996). Epstein and Baucom (2002) describe "guided behavior change" strategies (as opposed to skill-building approaches) used in CBCT to enhance partners' provision of social support to each other. Because there are individual differences in types of behavior that individuals experience as supportive, therapists need to explore subjective preferences when attempting to enhance mutual support in a couple.

Effects of negative behavior on partner psychopathology. There is considerable evidence that negative couple interactions are a risk factor for individuals' development and maintenance of depression, anxiety disorders, and other forms of psychopathology (Whisman, 2013). CBCT interventions that reduce relationship discord have been shown to improve both relationship satisfaction and depression.

Effects of positive and negative problem-solving behavior. When a couple discusses problems in their relationship, constructive problem-solving messages (e.g., suggesting collaboration, agreeing) are associated with greater relationship satisfaction and stability. In contrast, negative problem-solving messages (e.g., criticism, defensiveness, expressions of contempt for the partner, stonewalling, demanding, withdrawing) are

associated with lower satisfaction and greater risk of relationship dissolution (Christensen, Eldridge, Catta-Preta, Lim, & Santagata, 2006; Gottman, 1994). Whether members of distressed couples actually have deficits in problem-solving skills or choose to behave negatively due to negative intentions or feelings toward their partners, therapists' coaching them in constructive problem solving has long been a core CBCT behavioral intervention in protocols that have been found to improve relationship satisfaction (Baucom & Epstein, 1990; Christensen et al., 2004; Epstein & Baucom, 2002).

Constructive communication of emotions and empathic listening. The more that members of a couple express their thoughts and emotions to each other in constructive ways (e.g., acknowledging the subjectivity of one's feelings, conveying empathy for the listener's position) and the more that the listener engages in non-judgmental reflective listening, the greater the partners' satisfaction with their relationship is. Training in such communication guidelines is a core component of traditional and enhanced CBCT (Baucom & Epstein, 1990; Epstein & Baucom, 2002; Jacobson & Christensen, 1996).

Constructs Regarding Cognition

Negative or unrealistic relationship cognitions and relationship distress. As noted previously, Baucom, Epstein, and their associates (e.g., Baucom & Epstein, 1990; Baucom et al., 1989) identified five types of cognitions that can influence the quality of couples' relationships: *assumptions*, *standards*, *attributions*, *expectancies*, and *selective perception*. The CBT model posits that cognitions that are *negative*, such as attributing a partner's actions to negative intentions, will elicit negative emotional responses (e.g., anger, sadness) and overall unhappiness regarding the partner and relationship. In addition, it is assumed that *unrealistic or extreme* cognitions, such as holding a standard that one's partner should be able to mind read one's preferences will be associated with emotional distress when reality fails to match them. Research findings have supported these theoretical constructs (Epstein & Baucom, 2002; Marshall, Jones, & Feinberg, 2011; Sanford, 2010).

Negative or unrealistic relationship cognitions and negative couple behavioral interactions. Similar to the theoretical model's propositions regarding problematic effects of negative and unrealistic cognitions on partners' affective responses, the model posits that those forms of cognition are associated with (and lead to) individuals' negative behavior toward their partners, such as less constructive problem-solving behavior, more verbal aggression, etc. Cross-sectional and longitudinal studies have supported those hypothesized negative effects of cognition on couples' behavioral interactions (Clements & Holtzworth-Munroe, 2008; Epstein & Baucom, 2002; Marshall et al., 2011; Sanford, 2010).

Constructs Regarding Emotion

Association between failure to experience or express emotions and relationship distress. The CBT model includes an assumption that in order to resolve issues in a relationship the partners need to be aware of their emotions and convey them to each other. Epstein and Baucom (2002) note that some partners have deficits in awareness of cues of their emotional states and need therapeutic assistance in self-monitoring. It is assumed that individuals can unwittingly behave negatively toward a partner based on unacknowledged negative emotional states (the "sentiment override" process described by Weiss, 1980). Furthermore, as described earlier, individuals who are aware of their emotions but have deficits in skills for describing the emotions to others are assisted in doing so through communication skill training.

Association between emotion dysregulation and relationship distress. In the CBT model, unregulated experiences of emotion can interfere with positive behavior toward a partner and fuel destructive actions. There is research evidence that emotions such as depression increase individuals' negative attributions about their partners as well as their negative behavior toward the partners (Marshall et al., 2011; Tashiro &

Frazier, 2007). In addition, Bloch, Haase, and Levenson (2014) found that wives', but not husbands', greater ability to regulate their emotional responses predicts later marital satisfaction. Bloch et al. suggested that the gender difference is consistent with prior findings that women are more likely than men to be "emotion experts" in couple relationships, monitoring their emotions and making conscious decisions about the ways they express them. Partners with emotion dysregulation problems are taught skills for increasing control over intense emotional responses (Fruzzetti & Iverson, 2006; Kirby & Baucom, 2007a).

Constructs Regarding Processes Involved in Change

Reciprocal, circular, mutual patterns of influence in couple interaction. As noted earlier, the CBT model draws on family systems concepts in identifying patterns in which members of a couple influence each other mutually (Epstein & Baucom, 2002; Dattilio, 2010). Reciprocity in exchanges of positive and especially negative actions occurs commonly, so interventions commonly are designed to alter dyadic patterns. Change is assumed to occur more easily when both members of a couple acknowledge their roles in a negative pattern and take responsibility for making some changes. However, systems concepts do not hold a victim of abusive behavior responsible for the perpetrator's damaging actions.

Effects of psychoeducation on insight into effects of behaviors, cognitions, and emotions and on motivation for change. Based in a social learning framework, the CBT model focuses on teaching members of a couple new and more constructive ways of interacting. Psychoeducational interventions contribute to new learning by introducing new *concepts* (instituting cognitive change) and *instructions* to guide new responses. For example, psychoeducation regarding negative effects of particular destructive forms of communication and positive effects of constructive communication skills can increase clients' motivation to change their behavior and also guide them in how to do it.

Structured skills training and guided behavior change to institute new patterns. Although insight into existing patterns and potential new patterns may be a prerequisite for modifying a couple's dyadic interactions, the CBT model emphasizes the need for coaching and active practice of new behavioral, cognitive, and emotional responses (Epstein & Baucom, 2002). Therapists coach couples in rehearsing communication skills, cognitive restructuring skills for modifying negative and unrealistic relationship cognitions, and enhancing or regulating the experience and expression of emotions. In addition to teaching specific skills, CBT therapists guide couples in increasing particular types of behavior patterns (e.g., forms of mutual social support) to meet partners' basic needs better (Epstein & Baucom, 2002).

Research Evidence That Supports the Model

There has been more research on the effectiveness of behavioral and cognitive-behavioral forms of couple therapy than on any other theoretical approach, with the exception of substantial research on emotion-focused therapy (EFT) (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dunn & Schwebel, 1995; Gurman, 2013; Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003, 2005). There have been approximately two dozen well-controlled treatment outcome studies on CBCT conducted, beginning in the 1970s. Most of the studies indicating its effectiveness compared CBCT protocols with a no-treatment "waiting list" control condition and/or a placebo or "nonspecific" treatment (e.g., having couples discuss relationship issues but not intervening directly to change behaviors, cognitions or emotions). The reviews of the outcome studies indicated that across studies there has been consistent evidence of CBCT interventions improving self-reported relationship satisfaction and couple behavioral interactions. The positive findings have been replicated across several continents, and with both experienced therapists and student therapists. The effects of the CBCT interventions tended to last through one-year follow-up assessments, although in the earlier studies approximately

one-third of the couples who had improved relapsed over the next few years. Approximately one-third to one-half of the treated individuals scored in the non-distressed range on marital adjustment questionnaires. However, the controlled studies included in the published reviews involved an average of only eleven therapy sessions, which may not be an adequate amount of treatment for many distressed couples, and the sample sizes often were small.

A more recent investigation of CBCT demonstrated more promising long-term effects. In Christensen, Atkins, Yi, Baucom, and George's (2006) outcome study that used a larger sample and treatment that lasted approximately eight months, about 60% of the couples who received traditional behavioral couple therapy (behavior exchange contracts, communication skills training, and problem-solving skills training) improved in relationship satisfaction relative to pretreatment levels according to clinical significance criteria. Change was not linear, as couples declined for approximately six months after the end of treatment, but then they improved. About 70% of the couples who showed improvement immediately at the end of therapy maintained those gains at the two-year follow-up assessment, and an additional 21% of couples who had not improved initially showed improvement at the two-year follow-up. At a five-year follow-up, the traditional behavioral couple therapy demonstrated enduring effects for improvement in relationship satisfaction, with a large effect size of 0.92 from pre-treatment to five years after treatment (Christensen, Atkins, Baucom, & Yi, 2010).

Some studies have compared the effectiveness of the behavioral intervention components in CBCT and found them to be equally effective, but the small samples in those studies may have limited their ability to detect differences (Baucom et al., 1998; Hahlweg & Markman, 1988; Shadish et al., 1993). Most studies have evaluated the standard "package" of treatment components, so little is known about the relative contributions of the individual components to the positive outcomes.

The vast majority of the CBCT protocols that have been tested have included primarily behavioral interventions (behavioral contracting, communication training, problem-solving training), without components targeting partners' cognitions or their emotional responses that are important aspects of Enhanced Cognitive-Behavioral Couple Therapy (ECBCT; Baucom et al., 2008; Epstein & Baucom, 2002). A few studies did examine outcomes for cognitive restructuring interventions. Huber and Milstein (1985) compared an intervention focused on reducing partners' unrealistic relationship beliefs (assumptions and standards) with a waitlist control condition, and they found that the cognitive intervention produced more realistic beliefs and higher relationship satisfaction than the control condition. Halford, Sanders, and Behrens (1993) compared twelve to fifteen 1.5-hour sessions of traditional behavioral marital therapy with an integrative intervention that included cognitive restructuring (identifying partners' maladaptive relationship beliefs and attributions, using cognitive therapy Socratic questioning to challenge them, and self-instructional training), exploration of partners' emotional responses, and treatment generalization, in addition to the behavioral interventions. The amount of each type of intervention in the integrative treatment varied according each couple's needs. Both the traditional behavioral marital therapy and the integrative treatment condition decreased negative behavior and cognitions, but those changes were not significantly correlated with increased relationship satisfaction. Because the amount of cognitive restructuring was not specified, and it was combined with other interventions, it is not possible to determine the degree to which it contributed to improvement in the couples' relationships.

Studies by Baucom and Lester (1986) and Baucom, Sayers, and Sher (1990) have been cited as demonstrating the degree to which cognitive restructuring can contribute to effectiveness of couple therapy. In both studies, the investigators examined whether adding cognitive restructuring modules to standard behavioral components of contracting, communication training, and problem-solving training increases positive outcomes. The cognitive restructuring involved educating partners about negative attributions and unrealistic relationship beliefs and guiding them

in identifying which of those cognitions they experience in their own relationship. The only intervention addressing emotions was emotional expressiveness training, teaching partners communication skills for expressing emotions to each other and being good empathic listeners (primarily a behavioral intervention). Each study compared different combinations of behavioral and cognitive interventions to determine whether a combination treatment would be more effective than solely behavioral treatment. In order to keep the number of sessions constant across the treatments, the researchers replaced some sessions of behavioral interventions with sessions of cognitive restructuring. For example, Baucom et al. (1990) provided couples in all treatments twelve weekly sessions. The *behavioral marital therapy alone* condition was twelve sessions of communication training, problem-solving training, and quid pro quo contracts, whereas *cognitive restructuring plus behavioral marital therapy* included six sessions of cognitive restructuring (three on attributions, two on unrealistic relationship standards, and one session integrating the cognitive restructuring concepts) followed by six sessions of behavioral interventions. The *cognitive restructuring plus behavioral marital therapy plus emotional expressiveness training* condition included three sessions of each of the three components.

The studies by Baucom and colleagues indicated that cognitive interventions tended to produce more cognitive change and behavioral interventions produced more behavioral change, but all conditions increased relationship satisfaction more than a waitlist control condition. Because the treatments were equally effective, some writers concluded that the findings indicated that cognitive restructuring did not enhance effects of behavioral interventions (Baucom et al., 1998; Halford et al., 1993). However, substituting cognitive restructuring sessions for behavioral intervention sessions produced *equal overall effectiveness*, so the cognitive interventions did have demonstrable impact. In addition, the very small number of sessions of each type of intervention in the combination treatment conditions may have weakened the effectiveness of each component. To date there still has been inadequate research on an integrated or enhanced CBCT that provides sufficient intervention for the cognitive, behavioral, and affective aspects of each couple's problems. Whisman and Snyder (1997) noted that tests of cognitive interventions also have failed to address the variety of cognitions (selective attention, expectancies, attributions, assumptions, and standards) that Baucom et al. (1989) identified as influencing relationship quality. Furthermore, the few studies that examined effects of cognitive interventions were limited to samples of predominantly white, middle-class couples, so the effectiveness with other racial and socioeconomic groups is unknown. Thus, in spite of the popularity of CBCT among practitioners (Northey, 2002), in studies that have examined interventions to reduce *overall relationship distress*, empirical support mostly has been found for behavioral interventions, and the encouraging findings for cognitive interventions need to be extended through further outcome research.

Empirical Support for CBCT with Problems in Individual Functioning

Addition support for CBCT interventions, including those that include components targeting cognitions and emotional responses, has been found in studies on couple therapy for problems in partners' individual functioning, or in specific relational problems. Reviews by Whisman and Baucom (2012) and Baucom, Whisman, and Paprocki (2012) have indicated that relationship discord and individual psychopathology are associated both concurrently and longitudinally in a bi-directional manner, ongoing relationship discord predicts poorer responses to individual-based treatments for psychopathology, individual treatments for psychopathology generally do not lead to improvement in couple relationships, and couple-based interventions have positive effects on psychopathology while often also improving couples' relationship satisfaction. The following is a brief overview research that involved applications of CBCT.

Regarding individual psychopathology, studies by Beach and O'Leary (1992) and Jacobson, Fruzzetti, Dobson, Whisman, and Hops (1993) tested the effects of behavioral

couple therapy interventions for depression that were designed to decrease negative couple interactions and enhance mutual emotional support (Beach, Dreifuss, Franklin, Kamen & Gabriel, 2008; Whisman & Beach, 2012). The findings indicated that couple therapy improved both the depression symptoms and the relationship distress of women who presented with both problems, and whose marital distress appeared to contribute to their depression. Similarly, CBCT has been used as an adjunctive intervention with standard individual or group CBT treatments for anxiety disorders (Baucom, Stanton, & Epstein, 2003). Chambless' (2012) couple intervention for anxiety disorders includes psychoeducation (essentially cognitive intervention) about the individual's anxiety disorder and how anxiety symptoms can affect and be affected by couple interactions. It also includes communication skill training, problem-solving training, strategies for coping with anxiety symptoms, and reduction of the couple's patterns of accommodating their daily interactions to the individual's symptoms. Chambless (2012) reports details of two case studies, one involving a partner with obsessive-compulsive disorder (OCD) and the other with generalized anxiety disorder (GAD), in which the couple-based treatment resulted in improvement in the anxiety symptoms. Abramowitz et al. (2013) developed a couple-based CBT intervention to enhance standard individual exposure and response prevention for OCD, which includes psychoeducation about OCD and effective treatment, partner-assisted exposure therapy, couple interventions to change maladaptive couple patterns such as a partner's symptom accommodation through assisting the individual with checking behavior, and general couple therapy to address relationship issues unrelated to OCD. Abramowitz et al. (2013) conducted a pilot study to test the approach with eighteen couples who had a member with moderate to severe OCD symptoms (sixteen of whom completed the protocol), and they assessed both individual symptoms and couple functioning at pre-therapy, immediately post-therapy, and at six- and twelve-month follow-up points. They found a large decrease in OCD symptoms (to the mild symptom range) at post-therapy, which was maintained at the follow-up points, as well as a significant decrease in depression symptoms at post-therapy, which held up at follow-ups on the self-report measure but not on clinician ratings. The effect size for the decrease in OCD symptoms was larger than those found in studies on individual CBT interventions. Furthermore, couples' relationship satisfaction increased significantly at the post-therapy assessment but returned to baseline after a year, as did self-reported constructive couple communication. Demand-withdraw couple communication decreased significantly during therapy and remained stable.

Monson and Fredman's (2012) cognitive-behavioral conjoint therapy for post-traumatic stress disorder also includes psychoeducation regarding mutual influences between an individual's PTSD symptoms and the couple's interactions, guidance in building positives in the relationship, techniques for improving emotion regulation, practice in using communication skills to reduce the individual's emotional numbing and avoidance, use of problem-solving skills to resolve conflicts, and practice of cognitive restructuring to reduce partners' beliefs that maintain PTSD symptoms and relationship problems. Monson, Schnurr, Stevens, and Guthrie (2004) initially found empirical support for the approach in a pilot study of seven male Vietnam War veterans with PTSD and their wives. The improvements in PTSD symptoms based on ratings by clinicians and veterans' partners showed large, statistically significant effects sizes (1.60 and 1.18, respectively), and the veterans themselves reported improvements in PTSD symptoms with a moderate effect size (0.64), as well as significant large effect sizes for improved symptoms of depression (1.55) and anxiety (1.01). There also was a trend ($p = .07$) with an effect size of 0.92 for wives to report increased relationship satisfaction, but there was no appreciable improvement in veterans' relationship satisfaction ($d = 0.05$). In a second uncontrolled pilot study involving couples in which a member had a PTSD diagnosis, Monson et al. (2011) found that five of the patients in the six couples that completed the treatment no longer met PTSD diagnostic criteria, and the effect sizes for decreases in PTSD symptoms based on ratings by

the patients, partners, and clinicians ranged from 1.32 to 1.69. However, there were inconsistent effects on patients' and partners' levels of relationship satisfaction.

Bulik, Baucom, Kirby, and Pisetsky (2011) applied CBCT with couples in which a partner experienced anorexia nervosa (AN). Their UCAN (Uniting Couples in the Treatment of Anorexia Nervosa) protocol combines psychoeducation (regarding AN symptoms, associated features such as depression and anxiety, etiological factors such as genetics and sociocultural factors, and characteristics of the recovery process), interventions focused on the eating disorder (e.g., guiding the asymptomatic partner in providing emotional support to the individual with AN to reinforce his or her appropriate eating and other healthy behaviors) with traditional CBCT problem-solving and communication skill training procedures. The UCAN treatment focuses on guiding the couple in developing strategies that reduce eating disorder behaviors and support the patient's goals for recovery (e.g., normalized eating, weight gain, managing anxiety). Bulik et al. (2011) compared changes occurring from UCAN to those from a highly regarded randomized controlled trial for adult AN by McIntosh et al. (2005) that included individual treatment for the patient with CBT, interpersonal psychotherapy, or social support/case management. The AN patients in the UCAN treatment on average gained two to four times as much weight as those in the McIntosh et al. treatment groups, all statistically significant differences. Furthermore, whereas there was an average dropout rate of 37% across the three treatment conditions in the McIntosh et al. (2005) study, only 5% of patients dropped out in the CBCT-focused UCAN intervention.

Another CBCT application addressing individual psychopathology is Birchler, Fals-Stewart, and O'Farrell's (2008) empirically supported program that integrates behavioral couple therapy (with components for increasing exchanges of pleasing and caring behavior, increasing shared rewarding activities, improving communication and problem-solving skills, avoiding threats of separation, focusing on the present, and avoiding physical aggression) with interventions focused on a partner's substance use (e.g., attendance at self-help meetings, use of medication to inhibit drinking, couple behavioral contracts to promote the individual's abstinence). Powers, Vedel, and Emmelkamp's (2008) meta-analysis of twelve randomized controlled outcome studies in four couples in which one member had a substance use disorder revealed that behavioral couple therapy of the Birchler et al. (2008) type was more effective than individual therapy in reducing substance use ($d = .36$) and reducing relationship discord ($d = .57$).

CBCT also has been applied to assisting couples dealing with severe physical illness. For example, Baucom et al.'s (2009) relationship enhancement program was designed for women who are being treated for breast cancer and their male partners. Couples are taught expressive and listening communication skills that they apply to cancer-related topics (e.g., fear of mortality), as well as problem-solving skills for making medical treatment decisions. They also are provided psychoeducation regarding psychological and physical effects of cancer treatments on partners' sexual functioning. Other cognitive interventions focus on helping partners find meaning and growth individually and as a couple from their experiences with cancer.

Empirical Support for CBCT with Specific Relationship Problems

In addition to its general use in treatment of partners' dissatisfaction with their couple relationships, and as a component of treatments for problems in individual partners' functioning, CBCT has been used to treat specific dyadic problems. For example, CBCT has been found to be a safe and effective approach to treating couples who exhibit psychological and mild to moderate physical partner aggression (but is not used as a treatment for cases of battering) (Heyman & Neidig, 1997; LaTaillade, Epstein, & Werlinich, 2006). The components of the CBCT protocol include psychoeducation about partner aggression and its negative consequences, instruction and practice with strategies for anger management (e.g., self-soothing practices, non-aggressive

self-talk, and use of "time-outs" to de-escalate aggressive interactions), and skills training for constructive communication, problem solving, and modifying aggression-eliciting cognitions. The Couples Abuse Prevention Program protocol by Epstein and colleagues (Epstein, Werlinich, & LaTaillade, 2006; Hrapczynski et al., 2011) that has been delivered in a racially and socioeconomically diverse community clinic sample improved couples' relationship satisfaction, negative attributions about one's partner, trust, self-reports of aggression, and observed negative communication behavior. Decreases in negative attributions were associated with decreases in aggression. The study did not identify the relative contributions of the treatment components to those outcomes, so further research is needed to identify the degree to which modification of cognitions leads to reduction in aggression and improvement in relationship quality.

Baucom et al.'s (2009) largely CBT-based program for couples experiencing infidelity addresses another major relational issue. The interventions help both partners cope with traumatic aspects of the impact of the major stressor on the relationship, gain insight into factors that led to the affair, make decisions about the future of the relationship, and develop strategies for reducing risk factors for further relationship problems if they choose to stay together.

Although as yet there have been no randomized clinical trials evaluating the effects of using such a CBCT-based treatment with couples experiencing affairs, Baucom, Gordon, Snyder, Atkins and Christensen (2006) tested the degrees to which such interventions produced positive changes in affair couples in two separate samples. One sample was from a pilot study conducted by Gordon, Baucom, and Snyder (2004), consisting of a series of nine replicated case studies (with no control group) using their program with couples who had experienced affairs during the past year but that had since ended. The second sample consisted of a total of nineteen affair couples from both treatment conditions in Christensen et al.'s (2004) larger sample of 134 couples who participated in a randomized clinical trial comparing traditional behavioral couple therapy and integrative behavioral couple therapy. Atkins, Eldridge, Baucom, and Christensen (2005) examined pre- to post-therapy changes for those nineteen couples to determine whether behaviorally focused interventions were helpful to the partners who had the affairs and to the betrayed partners.

Because both samples were too small for inferential statistical analyses, Baucom et al. (2006) examined the effect size regarding change from pre-treatment to post-treatment in terms of pooled standard deviation units. On self-reported global marital distress, the effect sizes for the injured partners were substantial at 0.70 and 0.79 for the Gordon et al. (2004) and Atkins et al. (2005) samples, respectively, whereas the corresponding effect sizes for the participating (unfaithful) partners were 0.08 and 1.02. Baucom et al. (2006) suggest that the lack of improvement among participating partners in the Gordon et al. sample may be due to the fact that those couples were recruited on the basis of the injured partners' distress regarding the affair, whereas couples were selected for the Atkins et al. sample based on overall marital distress of both partners rather than one partner's infidelity. Improvement in individual psychopathology symptoms was notably higher for the injured partners in Gordon et al.'s sample, consistent with prior evidence that being betrayed commonly elicits trauma symptoms (which Baucom and associates' infidelity treatment are designed to reduce).

In sum, there is a substantial body of empirical support for the effectiveness of the behavioral components of CBCT, positive findings regarding the impact of cognitive interventions but a need for further research on their effects, and limited information about effects of interventions designed to increase partners' awareness and regulation of their emotions within their couple interactions. In addition, there is substantial evidence that CBCT protocols are helpful to couples experiencing problems with individual psychopathology, coping with physical health issues, and struggling with relational issues of partner aggression and infidelity. The flexibility of CBCT in addressing both intra-psychic factors (partners' emotional responses and both long-standing and momentary cognitions) and behavioral interaction patterns makes it a highly

relevant approach to treating a variety of couple-presenting problems.

Research-Based Treatment Protocol

CBCT treatment protocols have been shaped by the structure typically imposed in the many controlled outcome studies (e.g., treatment tends to be time-limited rather than open-ended; sessions have structure that begins with a review of the couple's experiences since the previous session, review of homework they had undertaken, introduction and/or practice of particular skills for self-monitoring and modification of behavioral, cognitive, and emotional response patterns, and planning of homework for the next week). Sessions typically are weekly at first and are tapered as the couple makes progress. Nevertheless, when we have conducted training workshops, participants often have expressed stereotypes that CBCT is very highly structured and "mechanical," which we work to dispel by demonstrating its great flexibility in clinical practice. The length of treatment can vary widely from several sessions to several months or more, depending on the severity and complexity of the presenting problems. The CBCT clinician is always aware of the interplay among behavior, cognition, and emotion, and therefore addresses all three domains routinely, but the amount of attention paid to each domain depends on each couple's patterns and needs. The amount of structure imposed on sessions depends on the degree to which the couple is engaging in repetitive destructive forms of behavioral, cognitive, and emotional responses. The therapist creates structure by interrupting negative couple interactions, providing psychoeducation regarding the goals and methods of CBCT, and coaching partners in initiating and maintaining new positive patterns. Partners who are more collaborative and self-reflective require less directive intervention.

The major texts on behavioral and cognitive-behavioral therapy with couples (Baucom & Epstein, 1990; Dattilio, 2010; Epstein & Baucom, 2002; Jacobson & Christensen, 1996; Jacobson & Margolin, 1979; Rathus & Sanderson, 1999; Stuart, 1980) provide details of the concepts and procedures of interventions targeting couples' behavioral, cognitive, and affective responses. Because the model has strong roots in behavioral marital therapy that emphasized social learning and social exchange concepts, the treatment manuals typically begin with chapters describing positive and negative forms of couple behavioral interactions and methods to assess them clinically through interviews, questionnaires, and behavioral observation. Next, the manuals include chapters describing procedures for behavioral interventions focused on behavior exchanges, communication skills, and problem-solving skills, commonly with a separate chapter devoted to each type of intervention. Epstein and Baucom (2002) propose that it is important to emphasize behavior change initially in order to instill some hope in distressed couples who have developed a sense of hopelessness about their relationships based on a history of aversive interactions. Epstein and Baucom distinguish between "primary distress" that is caused by differences in partners' needs, preferences, personal behavioral styles, goals, etc. and "secondary distress" resulting from negative interactions that a couple has developed to deal with their differences and conflicts. For example, a couple may experience primary distress from differences in their needs or desires for emotional intimacy, and they may have developed a demand-withdraw pattern (the individual who desires greater intimacy pursues the partner who desires less and withdraws) that causes them secondary distress. Epstein and Baucom (2002) suggest that it is difficult to work on a couple's underlying source of primary distress (e.g., differences in partner's basic needs for intimacy) as long as the couple is engaged in distressing behavioral responses to their conflicting needs.

Consequently, therapists need to intervene initially with the couple's behavioral pattern that is associated with secondary distress. Behavioral interventions to block destructive interactions and build positive exchanges (e.g., communication skills training, problem-solving training, informal contracts for partners to exchange caring and supportive acts) are intended to create more positive experiences for both partners. In contrast to skills-based interventions such as communication and problem-solving training,

"guided behavior change" interventions focus on encouraging partners to engage in classes of behavior toward each other that fulfill a deficit in a particular area of their relationship, such as intimacy (Baucom & Epstein, 1990; Epstein & Baucom, 2002). However, these initial behavioral interventions are not designed exclusively to reduce secondary distress, because increases in constructive expression of thoughts and emotions, empathic reflective listening, collaborative problem-solving, and mutual provision of caring acts such as forms of social support also tend to address partners' basic needs that have been sources of primary distress.

The treatment manuals typically have chapters devoted to description of forms of cognition that influence the quality of couple relationships and methods for assessing these cognitions through interviews, questionnaires, and observation of couple discussions. The manuals then include descriptions of interventions designed to increase partners' awareness of their automatic thoughts that commonly involve selective perceptions of their couple interactions, attributions about causes of their relationship problems, and expectancies about probabilities regarding each other's likely responses, as well as more long-standing schemas involving assumptions and standards. Subsequent interventions focus on techniques, derived from cognitive therapy protocols but adapted to address relationship patterns, and to increase partners' abilities to evaluate how appropriate or realistic their cognitions are and substitute more constructive thinking. For example, couples are coached in considering alternative attributions for a partner's upsetting behavior, explore alternative expectancies regarding a partner's future actions and test them with behavioral experiments, and construct modified (more realistic) relationship standards that are still consistent with the partners' basic life values (Dattilio, 2010; Epstein & Baucom, 2002; Rathus & Sanderson, 1999).

Although the initial focus tends to be on behavioral interventions to demonstrate to a couple that they have the potential to interact in more satisfying ways, cognitive interventions often are used early in the process when it is evident that partners' cognitions are interfering with the reduction of negative behavior and the enhancement of positive behavior (Baucom & Epstein, 1990; Epstein & Baucom, 2002). For example, individuals who hold unrealistic standards that a partner should be able to mind read their thoughts and emotions may put limited effort into practicing expressiveness skills, so the therapist must work to modify that belief. Similarly, an individual who attributes a partner's negative actions to malicious intent or a lack of love may have little motivation to take the initiative to behave positively toward the partner, and interventions for modifying the negative attributions may be necessary.

The interventions focused on affective components of couple relationships have evolved over time in the treatment manuals. As we described earlier, most behavioral and cognitive-behavioral texts limited their coverage to interventions focused on educating partners about the variety of positive and negative emotions one might experience, in practicing expressiveness skills, and in using active reflection of the other person's expressed thoughts and emotions. Epstein and Baucom's enhanced (ECBCT) approach (Baucom et al., 2008; Epstein & Baucom, 2002) expanded the attention to emotions substantially, integrating aspects of emotionally focused therapy (EFT) and dialectical behavior therapy (DBT) into the CBCT model to increase partners' attunement to their own and each other's emotional responses, as well as to improve their ability to regulate strong negative emotions. These components are covered in separate chapters in the Epstein and Baucom (2002) text and throughout Fruzzetti and Iverson's (2006) book. Epstein and Baucom (2002) use interventions for emotions early in therapy when the assessment of a couple reveals that one or both partners has limited awareness of their emotional states or has difficulty regulating emotions. Awareness of emotions is a prerequisite for effective use of behavioral communication interventions, as is the individual's ability to regulate negative emotional responses, as intense anger, anxiety, etc. interfere with constructive communication.

Thus, although the three response realms of behavior, cognition, and affect typically are separated in CBCT treatment manuals for clarity of

presentation (e.g., a chapter is devoted to procedures for teaching couples communication skills for expressing and listening), in clinical practice a therapist commonly integrates the interventions in order to take into account the complex relations among behavior, cognition, and affect in intimate relationships. Throughout the process, the therapist engages in psychoeducation with the couple; on the one hand, explaining the intrapersonal mutual influences among *each person's* behaviors, cognitions and emotions, and on the other hand, guiding the couple in tracking the interpersonal dyadic influences in which the partners continually respond to each other.

Methods of Model Evaluation

Because empirical evaluation of treatment outcome has been a hallmark of CBCT from its earliest days, researchers have developed a common set of measures that are used in controlled outcome studies and can be applied to varying degrees by practicing clinicians. The most common evaluation methods involve self-report questionnaires and systematic observation of couples' behavioral interactions administered to couples both pre- and post-therapy. The following are representative measures, with comments about how they may be used in clinical practice as well as research.

Self-Report Measures

Couple therapy outcome studies most often include a self-report questionnaire assessing *overall relationship satisfaction*. Among the commonly used measures are the thirty-two-item Dyadic Adjustment Scale (DAS; Spanier, 1976), the 150-item Marital Satisfaction Inventory–Revised (MSI-R; Snyder, 1997), and the six-item Quality of Marriage Index (QMI; Norton, 1983). It is beyond the scope of this chapter to review the psychometric properties and the pros and cons of each measure, so we note only a few key issues for each measure, and the reader is encouraged to consult literature on each of them and determine which would serve his or her purposes. Spanier designed the DAS to assess four aspects of relationship adjustment (dyadic consensus, dyadic cohesion, dyadic satisfaction, and affective expression), but factor analyses of the DAS have failed to confirm those dimensions, and both researchers and clinicians often use the total score as an overall index of each partner's experience of their relationship's quality, with scores lower than ninety-eight representing the distressed range. Because the DAS confounds subjective satisfaction with behavioral factors that are associated with satisfaction (e.g., arguing), some users only score the satisfaction subscale. The MSI-R includes two validity subscales (inconsistency and conventionalization), a global distress scale, and ten subscales assessing satisfaction in various areas of the relationship (e.g., affective communication, problem-solving communication, aggression, time together, disagreement about finances, sexual satisfaction, role orientation). Norms for the subscales help the clinician determine areas of strength and concern for each couple. The QMI's six items assess a global evaluation of one's marriage (e.g., "We have a good marriage"), so the scale provides a quick assessment of subjective satisfaction relative to the DAS and MSI-R, but less differentiated measurement of various components of experienced relationship quality that can be assessed by the DAS and especially by the MSI-R. Users also should consider the terms used to describe the couple, because the QMI refers to "marriage" whereas the DAS and MSI-R use language appropriate for same-sex and opposite-sex married and unmarried couples.

A variety of self-report measures that assess aspects of *behavioral interactions* between partners can be helpful in evaluating effects of CBCT. The Communication Patterns Questionnaire (CPQ) developed by Christensen and his colleagues (Christensen, 1988; Christensen et al., 2006) differs from other communication measures by describing a number of *dyadic* patterns (female demand/male withdraw, male demand/female withdraw, mutual avoidance, mutual constructive communication) that commonly are targeted with CBCT behavioral interventions. Physical and psychological forms of partner aggression can be assessed with the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and the

Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999). The MMEA has subscales assessing four forms of negative behavior that commonly occur in distressed couples and are foci of CBCT interventions: domination/intimidation (e.g., "threw, smashed, hit or kicked something"), denigration (e.g., "called you a loser, failure or similar term"), hostile withdrawal (e.g., "refused to have any discussion of a problem"), and restrictive engulfment (e.g., "tried to stop you from seeing friends or family members"). The respondent rates the frequency of each behavior twice, for acts committed by oneself and for acts committed by one's partner during a specific period.

Because the above scales predominantly measure negative behavior, it is important to include an instrument that assesses a range of positive behaviors that CBCT is designed to increase. One such instrument is the Positive Partner Behavior scale (PPB; Broderick & O'Leary, 1986). This questionnaire is a subset of the items included in Broderick and O'Leary's *Daily Checklist of Marital Activities*, asking the respondent to indicate which of fifty-four positive acts (a variety of instrumental behaviors and actions expressing caring) that his or her partner exhibited during the past week. The respondent also is asked to rate how pleasant each behavior that occurred was for him or her.

There is a limited number of measures available to assess changes in partners *relationship-oriented cognitions* over the course of CBCT. The following are examples of measures that can be helpful in evaluating effects of CBCT.

Pretzer, Epstein, and Fleming's (1991) Marital Attitude Survey (MAS) includes subscales assessing the degrees to which an individual attributes problems in the couple's relationship to the partner's personality, the partner's behavior, the partner's lack of love, the partner's malicious intent, his or her own personality, and his or her own behavior. Two additional subscales assess expectancies that the couple has the *ability* to resolve their problems and that they will be successful in resolving them. Attributions such as those measured by the MAS are frequently addressed in CBCT.

Baucom, Epstein, Rankin, and Burnett (1996) developed the Inventory of Specific Relationship Standards (ISRS) to measure individuals' personal standards regarding the degrees to which partners should have clear boundaries between them (e.g., the amount of time they should spend together and the amount of personal information they should share with each other), how much time and effort partners should invest in the relationship to accomplish instrumental tasks and make each other happy, and how control/power should be divided between partners (egalitarian decision-making versus one partner or the other dominating decisions). The ISRS asks respondents how much they endorse statements regarding these dimensions of standards across twelve areas of a relationship (e.g., household tasks, parenting). Because relationship standards are a common focus of CBCT, the ISRS is a relevant outcome measure.

As an example of a measure of *emotion* that is relevant in evaluations of CBCT, the State-Trait Anger Expression Inventory (STAEI; Spielberger, 1988) includes three subscales assessing how the respondent controls or expresses anger. The subscales are *anger out* (venting anger verbally or physically, without controlling its expression), *anger in* (feeling strong anger internally but trying to suppress its outward expression), and *anger control* (using anger management strategies to reduce the intensity of one's anger).

Because CBCT is used as a primary or adjunctive treatment for a variety of forms of *individual psychopathology*, self-report measures of relevant symptoms often are included in evaluations of treatment outcome. For example, depending on the client population being treated (e.g., couples that include members with depression, anxiety disorders, or PTSD), measures such as the Beck Depression Inventory-II (BDI-II; Beck, Steer & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), and the Trauma Symptom Inventory (TSI; Briere, 1995) can be used.

Behavioral Observation Measures

Because self-report questionnaires are subject to response biases and because the roots of CBCT are in an empirical approach to functional analysis of problematic behavior, evaluations of CBCT

typically include coding or rating of samples of couples' behavioral interactions. Most often a couple is coded while the partners are engaged in a structured discussion assigned by the assessor; for example, the assessor asks the partners to discuss and try to resolve a topic that the couple identified as an ongoing source of conflict in their relationship. For the purposes of controlled outcome studies conducted in research settings, a number of validated coding systems are available to assess forms of positive and negative behavior during problem-solving discussions; for example, the Marital Interaction Coding System (MICS; Heyman, Weiss, & Eddy, 1995; Weiss & Summers, 1983) and the Kategoriensystem für Partnerschaftliche Interaktion (KPI; Hahlweg et al., 1984). These coding systems involve observing video recordings of a couple's discussion and placing each speaking turn by each partner into specific categories of positive and negative behavior. In addition to coding systems designed to measure the quality of problem-solving behavior, other coding systems focus on a more specialized type of couple behavior that CBCT therapists commonly work toward increasing in distressed couples. For example Dehle's (2007) Partner Support Ratings Scale (PSRS) is used to code types of social support acts provided by each member of a couple to the other. Another specialized coding system was developed by Sullivan and Baucom (2005) to assess verbal expressions that reflect "relationship-schematic processing," the tendency to think about events in one's relationship in terms of mutual dyadic processes (e.g., "We both get caught up in trying to win arguments") rather than holding a partner or oneself solely responsible. One of the goals of cognitive interventions in CBCT is to shift partners from thinking in linear, blaming terms toward thinking in circular causal terms, so this coding system can be helpful in evaluating cognitive change over the course of therapy.

Although the behavioral observation coding systems have been useful in measuring the degree to which CBCT decreases negative behaviors and increases positive behaviors, they are complex, require extensive training, and are too time-consuming for application by individual clinicians. As a possible compromise, global rating systems such as Weiss and Tolman's (1990) Marital Interaction Coding System – Global (MICS-G) involve watching two-minute segments of a couple's discussion and rating the extent to which each partner engaged in each of three positive types of behavior (problem solving, validation, and facilitation) and three negative types of behavior (conflict, invalidation, withdrawal). Because the ratings are based on sets of verbal and non-verbal behaviors of the partners, the MICS-G still may be too complex for evaluating CBCT in clinical practice, but therapists who are interested in using behavior observation as a means of assessment can become sufficiently familiar with the MICS-G rating dimensions to use them as a guide in judging change in the quality of a couple's communication over the course of therapy.

All of the above measures are among those commonly used to evaluate the effects of CBCT; for example, the DAS, CTS2, MMEA, CPQ, STAEI, and MICS-G were among the measures used in the evaluation of the Couples Abuse Prevention Program (Hrapczynski et al., 2012; LaTaillade et al., 2006). Although such a large set of measures would be unwieldy for assessments in individual clinicians' practices, those who wish to obtain some objective data regarding CBCT effects can choose among them judiciously.

Implementation of the Model in Community/Practice Settings

We have described CBCT as a model with a strong empirical base and a relatively high level of structure both in the organization of activities within sessions and in the procedures used to assess and modify behavior patterns, cognitions, and emotional responses. Although that degree of structure might suggest that transporting the model from the research lab to clinical settings in the community would be onerous, we believe that in fact the situation is quite the opposite. Northey's (2002) survey of clinical members of AAMFT indicated that CBCT was the most widely practiced theoretical model, whether clinicians used it solely or as a component of an integrative approach. The fact that CBCT substantially addresses the three major domains of

human experience in relationships—behavior, cognition, and affect—makes its concepts and methods highly relevant to practitioners from diverse theoretical orientations (Dattilio, 1998). For example, a therapist whose primary model is structural family therapy can intervene to reduce disengagement between members of a couple by using CBCT procedures for communication training and intimacy-focused guided behavior change. Similarly, the parental subsystem can be strengthened through problem-solving training, as well as by modifying their shared belief that setting rules that upset their children will result in the loss of their children's love. Furthermore, the flexibility of CBCT has led to its application with a wide range of client-presenting problems (e.g., decreased intimacy, infidelity, partner aggression, substance abuse, individual psychopathology, physical health problems), as described in this chapter.

Thus, CBCT, in whole or in part, can easily be implemented in community practice settings, as clinicians can follow the clear guidelines for conducting assessments and interventions that are detailed in this chapter and in greater depth within the texts that we have cited. As clinical practice in community settings increasingly has become constrained by limitations in clients' insurance coverage, with requirements for short-term treatments using evidence-based procedures, CBCT offers clinicians practical and effective interventions. Treatment plans can be constructed with specific measurable goals, and the CBCT philosophy of collaborating with clients to set meaningful and realistic goals can contribute to positive therapeutic alliances.

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20.

TREATING ADOLESCENTS WITH EATING DISORDERS

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History and Background of Family Therapy for Eating Disorders[1]

Anorexia nervosa (AN) was first clinically described in the late 1600s (Morton, 1694) and appeared as a distinct psychiatric syndrome at the end of the 19th century (Gull, 1874; Lasegue, 1883). While AN, like most severe psychiatric disorders, was initially treated mostly in hospital settings, many of the early authors where interested in the family context of the disorder, albeit primarily because they believed that families either caused the disorder or impeded treatment. These authors generally recommended isolating the patient from the family as a key therapeutic intervention (Gull, 1874; Laseque 1883), a practice that continues to be recommended by some to this day (Jeammet & Chabert, 1998; Godart et al., 2004). The negative view of the family, being generally seen as intrusive, overprotective, and overcontrolling, was reinforced by psychodynamic conceptualizations postulating a disturbance of the mother–child relationship leading to high levels of compliance, failure to develop autonomy, and a pervasive sense of ineffectiveness (Bruch, 1973; Thomä, 1977; Waller, Kaufman, & Deutch, 1940).

The emergence of family therapy offered a new way of thinking about families and by the 1970s a growing number of the pioneers in the field had started applying this new conceptualizations to eating disorders (ED) (Minuchin et al., 1975; Selvini-Palazzoli, 1974; Wynne, 1980). The work of Minuchin and colleagues (Minuchin, Rosman, & Baker, 1978) were particularly influential in two ways. First, their clinical descriptions and conceptualization of the family context of AN, or what they described as the "psychosomatic family," provided a highly persuasive explanatory model of AN and an associated model of change that could be used to guide clinical interventions. Second, their positive empirical data from a case series of fifty-two mainly adolescents treated by structural family therapy (Minuchin et al., 1978), while having limitations, was far stronger than anything else published till that date. Although the conceptual model of the psychosomatic family has not been supported by empirical studies (Eisler, 1995; Holtom-Viesel & Allan, 2014), their case series gave credence to the theory which has continued to be referenced long after empirical evidence brought it into question (Eisler, 2005).

In the early 1980s, a clinical research team at the Maudsley Hospital/Institute of Psychiatry in London began their work evaluating family therapy for ED in a more systematic way. Their clinical approach (Dare, 1983; Dare & Eisler, 1995, 1997; Eisler, 1993) integrated many of the ideas from the early structural (Minuchin et al., 1975, 1978) and strategic models (Haley, 1973; Selvini Palazzoli, 1974), and the newly emerging narrative approaches (White, 1987; White & Epston, 1990), and was gradually refined in the context of a series of randomized trials (Dare et al., 1995; Eisler, Wallis, & Dodge, 2015).

The developing ideas within the family therapy field were paralleled by important changes regarding the understanding of the etiology of ED (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Keel & Forney, 2013; Konstantellou, Campbell, & Eisler, 2012), the broadening of the evidence base for the effectiveness of family therapy for AN (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Downs & Blow, 2013; NICE, 2004), and the importance of the context in which the treatment is delivered (House et al., 2012). The growing number of research centers evaluating family therapy for ED has been an important factor influencing ongoing conceptual developments not only through the publication of new findings, but also by developing new variants of FT-AN such as multi family therapy (Dare & Eisler, 2000; Gabel, Pinhas, Eisler, Katzman, & Heinmaa, 2014) and parent focused FT-AN (Hughes et al., 2014), or evaluating different lengths (Lock, Le Grange, Forsberg, & Hewell, 2006) and intensities of treatment (Marzola et al., 2015; Wallis et al., 2013). A key factor has also been the development of treatment manuals as part of the research studies (e.g., Eisler et al., 2012; Lock, Le Grange, Agras, & Dare, 2001; Lock & Le Grange 2013; Robin & Le Grange, 2010), which have helped to crystalize the theoretical concepts, and have themselves had a significant impact on practice (Couturier et al., 2014; Wallace & von Ransom, 2012).

The Theoretical and Conceptual Base of FT-AN

The history of family therapy is often described in terms of the discontinuities and innovations (Flaskas, 2010) represented by different models of family therapy, ignoring the overlaps and continuities of ideas and therapeutic techniques. This is equally true of the way family therapy for ED has evolved from a focus on explanatory models (Minuchin et al., 1978; Selvini Palazzoli, 1974) and techniques aimed at addressing putative dysfunctional family functioning through the shift in the mid-1990s to a focus on mobilizing the family as a resource (Dare & Eisler, 1995, 1997; Lock et al., 2001). In spite of this shift, there are important continuities that integrate many of the earlier ideas and intervention techniques, but require a change in conceptualization of how change comes about and, in recent years, have also tried to develop a more differentiated approach, taking into account differences in symptom presentation, family organization, and the growing understanding of the neurobiological factors that might predispose individuals to develop an ED (Eisler, 2005; Le Grange & Lock, 2007 Eisler et al., 2015; Kaye et al., 2015).

We have described elsewhere (Eisler et al., 2010) the importance and reasons for the shift away from the earlier pathologizing approaches and why this required a different way of understanding observations of family dynamics. We have also suggested that illness family models (Le Grange & Eisler, 2009; Rolland, 1994; Steinglass, 1998) offer a useful perspective for understanding the processes through which families become organized around serious and enduring problems.

Whatever the nature of the dynamics in individual families prior to the onset of the problem, living with an ED has a major impact (Cottee-Lane, Pistrang, & Bryant-Waugh, 2004; Withers et al., 2014), resulting in changes in patterns of family organization and functioning (Eisler, 2005; Whitney & Eisler, 2005). The family begins to accommodate to the demands of the ED, family routines begin to change, and decision-making becomes ever harder as failed attempted solutions lead to a sense of resignation. Family roles begin to change, often resulting in potential resources becoming redundant, overlooked, or unavailable with an escalating sense of uncertainty and paralysis. While family responses will vary depending on the stage

of the illness, the nature of family organization and interactional style, and the particular life-cycle stage they are at when the illness occurs, we have suggested (Eisler, 2005; Eisler, Lock, & Le Grange, 2010) that the following are some of the common ways in which families become reorganized around an ED:

1. The ED gradually takes on a central role in family life, dominating all aspects of family interaction and family relationships.
2. There is a narrowing of time focus to the here-and-now, where the ever-present concerns about the ED and the high levels of anxiety this generates, make it difficult for the family to focus on anything other than the present.
3. Daily life patterns become increasingly inflexible and narrow, predictable, and the roles that each person has becomes more fixed.
4. Pre-illness patterns of family functioning and relationships become amplified. This is likely to be the case both for a range of pre-existing family dynamics that were not problematic (for instance, differences in closeness and distance of relationships which become more pronounced), as well as potentially difficult family dynamics such as hostile or conflictual relationships or insecure patterns of attachment.
5. The family's ability to meet the family life-cycle needs of all its members become significantly diminished. This applies to the developmental needs of the ill child as well as the needs of siblings, parents and the family as a whole.
6. The parents as well as the young person have a sense of helplessness and loss of control.

It is easy to see how the observation of the above patterns can give rise to the assumption that they are a manifestation of an inherent family dysfunction that perhaps had a causal role in the ED, rather than the family's adjustment to the problem. The current evidence indicates that family factors play a limited role in the development of ED, although they may play a role in maintaining the illness (Holton-Viesel & Allan, 2014). Understanding the family dynamics described above is important clinically, therefore, not because it offers an explanatory model of ED as suggested by Minuchin (Minuchin et al., 1978), but rather for the following reasons:

1. *The reorganization of the family has a disabling effect, weakening the families' usual resources and resilience.* Central to much of family therapy today is the notion that the family is first and foremost a resource rather than the origin of the problem. However, simply stating that the family is not the cause of the ED, while important, will be frequently discounted by the family whose own sense of failure and guilt are often stronger than positive pronouncements by therapists. An understanding of the mechanisms that have led to the way the family is now is therefore likely to be a more effective way of reversing some of these effects and also provides a coherent framework that the family and the therapist can work with. For example, exploring the way the family used to be and how this has been distorted by the ED may open up conversations about the advantages and disadvantages of closeness and distance, how these patterns have varied over time and context, and how the family might use both "Mum's greater closeness and understanding of her daughter" as well as "Dad's less involved position." Offering a tentative description of how families generally respond to the advent of an ED often provides the family with a coherent but less blaming understanding of how they function and what they might need to change.
2. *The changes in family functioning interact with the neurobiologically determined temperamental predispositions of individuals who develop an ED.* Considerable progress has been made in recent years in gaining an understanding of the neurobiological factors that predispose individuals to develop an ED (Kaye, Fudge, & Paulus, 2009; Kaye, Wierenga, Bailer, Simmons, & Bischoff-Grethe, 2013). These include temperamental differences (e.g., increased rates of anxiety or perfectionism; Halmi et al., 2012; Kaye

et al., 2004), differences in cognitive styles such as set shifting (the ability to move back and forth between multiple tasks) or weak central coherence (extreme attention to detail) (Lang, Lopez, Stahl, Tchanturia, & Treasure, 2014; Roberts, Tchanturia, Stahl, Southgate, & Treasure, 2007), differences in affect regulation (Brockmeyer et al., 2012) or different appetitive responses to food (Kaye & Bailer, 2011). These factors are complex and do not apply to every individual with an ED, and in many instances vary between adolescents and adults. Many of these factors are exacerbated by starvation and it is therefore not always clear what role the different factors might be playing in the genesis and/or the maintenance of the illness. Nevertheless, the evidence is persuasive that these factors play an important role and are likely to link to the evidence of a significant genetic component particularly in AN (Thornton, Mazzeo, & Bulik, 2011).

The challenge from a family systems point of view is to understand how these factors interact with the family environment and how this interaction is best addressed in treatment. One example is the role that intolerance of uncertainty plays in AN and its treatment. There is evidence that individuals who develop AN have a significantly low intolerance of uncertainty (Frank et al., 2012; Konstantellou, Campbell, Eisler, Simic, & Treasure, 2011), which is likely to invoke changes in the family environment which lead to greater predictability that the young person finds reassuring. Starvation also tends to lower anxiety levels (Brockmeyer et al., 2012) further reinforcing the behavior and leading to highly positive values being attributed to the illness (Schmidt & Treasure, 2006). Attempts by parents to feed their child are met with strong resistance not just because of the fear of weight gain, but also because they challenge the young person's need to be in control and manage uncertainty. The narrowing of the families' perception of time to the here-and-now can also be understood as a response to the intolerance of uncertainty.

A key aspect of FT-AN is to support parents to effectively take on the task of feeding their child. In order for this to be possible a change is required in the meaning of this act, on the part of both the young person and the parents. The adolescent's initial response to their parents' attempts to take responsibility of managing their eating raises their anxiety and fear of uncertainty because they experience it as giving up control. In order for the parents to succeed, the meaning of the parental behavior has to change from being in control to being a caring parent. The adolescent continues to be fearful of gaining weight but the predictability of the parents' behavior around mealtimes is also reassuring (and often demanded by the adolescent to be adhered to at this stage with extreme detail and rigidity). While early on in treatment the greater predictability of the home environment reduces anxiety in the young person and reinforces the new parental behaviors, as treatment progresses, therapeutic efforts need to target increasing tolerance of uncertainty, or as Mason (1993) puts it, the acceptance of "safe uncertainty."

3. *The way in which the family responds to the problem will be determined by pre-existing family dynamics and these may moderate response to treatment.* Relatively little empirical data exist to indicate what might be family variables that moderate response to FT-AN. Several studies suggest that increased levels of parental criticism are associated with disengagement from treatment and poorer outcome (Szmukler, Eisler, Russell, & Dare, 1985; Eisler et al., 2000), and that warmth and positive family functioning may predict good outcome (Le Grange, Hoste, Lock, & Bryson, 2011, Holton-Viesel & Allan, 2014). At a theoretical level, and given our account above, attachment relationships both between parent and child and parents' own attachment patterns are also likely to play a mediating role in these relationships (Tasca, Ritchie, & Balfour, 2011) through its impact on the child's experience of parenting and the parents' perceptions of themselves as a competent parent. When there is limited progress in treatment, the early narrow problem-oriented focus on helping to restore nutrition

(Lock & Le Grange, 2013; Eisler et al., 2012) needs to be broadened to include an exploration of potential blocks to progress which may include addressing ruptures in attachment patterns (Dallos, 2004) or addressing strong negative, emotionally highly laden interaction patterns (Johnson, Maddeaux, & Blouin, 1998; Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014).

A General Treatment Framework for FT-AN

Models of therapy typically have at least an implicit model of change that differentiates it from other models. FT-AN is an integrative treatment that draws on ideas from different models (Dare & Eisler, 1997). Here we set out a general integrative framework for understanding change under four conceptual headings: 1) relationship framework, 2) maintenance framework and constraints to change, 3) framework with a focus on changes in beliefs and meaning, and 4) influencing framework. These headings are not mutually exclusive and most interventions will include elements of all four. Describing interventions under these headings is, however, more useful than focusing on distinct models of therapy which provide a more limited concept of change and do not reflect day-to-day practice particularly well.

Relationship Framework

Thinking about relationships is clearly a key aspect of all psychotherapies including family therapy. This includes the relationship of the therapist with the family as well relationships within the family or with significant others. Early on in treatment the development of the therapeutic alliance and a shared sense of purpose of treatment (Friedlander, Escudero, Heatherington, & Diamond, 2011) will be a central focus. In FT-AN the development of a balanced alliance may appear difficult to achieve as the adolescent will typically espouse a lack of interest or need for therapy. Engaging the adolescent as well as parents is, however, important and therapists need to be aware of and respond to, often subtle, cues from the young person to achieve this.

FT-AN is generally very task focused early on in treatment and relationship issues are typically not a major focus of conversation at that stage. Therapists attend to them often indirectly; for example, stressing the importance of fathers' involvement in the therapy or when reframing the parental task of managing the young person's food intake as caring rather than controlling behavior. In the minority of families where the instrumental task of helping the young person eat is not progressing, relationship issues may need to be more prominently focused from the start. These are often families where there are unresolved attachment issues (either between young person and parents or parents' own attachment patterns), which may give rise to negativity, self or other blame (Besharat, Eisler, & Dare, 2001) and ruptures in therapeutic alliance. In such families, addressing the unresolved attachment issues will often help move the treatment on (Dallos, 2004).

This framework also provides a context to consider the exploration and management of emotions and feelings in the family. How overtly and at what stage in treatment these need to be addressed will vary from family to family. In many families this may be confined to explorations of how different family members manage and show their feelings while in others they will be a way of addressing road blocks in treatment (Lafrance Robinson et al., 2014).

Finally this framework is one that includes the therapist's self-awareness and use of self as part of the treatment process. The nature of the problems that FT-AN has to address has a strong impact on the therapeutic relationship and demands a high level of self-reflection on the part of the therapist. The intensity of the engagement and resulting therapeutic relationship is a driver of both therapeutic change and recovery yet it also has the capacity to become a hindrance if the therapist cannot continually reflect on this relationship and on the process of the therapy.

Maintenance Framework and Constraints to Change

The notion of maintenance does not make any assumptions about the origin of difficulties but postulates that families become organized around

problems in a way that may contribute to their maintenance either by directly reinforcing problems or by disrupting adaptive or change processes. When working with families, a significant component of any therapist's activity will be to observe family interactions, connections between individuals, and the way in which the difficulties that the family brings appear connected with the family system. Two important points need to be emphasized.

First, observed patterns of interaction that appear to have acquired a maintaining role should not be confused with causal or etiological accounts and therapists need to be clear that they are not looking for an explanation of causes and focus more on the way that the family has changed over the time the problem has developed.

Second, while describing patterns, the main focus is on behaviors (who does what, how others respond, etc.). Observed patterns of behavior cannot be understood without also exploring the meanings that people attach to them and the context from which they developed. Here reference to pattern includes particular stories told and how these stories shape interactions and responses. The process of change in this framework can happen at all these levels.

Frameworks Focusing on Changes in Beliefs and Meanings

In one sense, all therapies are concerned with meanings and creating an alternative understanding of problems, although therapies vary in the extent to which this is an explicit part of therapy. The importance of meanings and narratives connects with the idea that all difficulties are embedded and shaped by their social context and partly also help to shape this context. The interpersonal nature of problems requires that we take an interest in language, beliefs, cognitions, and narratives because these are central to understanding the process of social interaction. The way in which a therapist explores the narratives and meanings that families bring to therapy invites change by setting the scene for different meanings to emerge.

From the perspective of this framework change may occur through several processes. Focused attention on small aspects of neglected narratives may give the family members a greater salience for the individual or the family. A negative, constraining narrative may be replaced by a more positively supported alternative highlighted in therapeutic conversations about hopes for the future, alternative strengths and abilities, and personal values. The availability of alternative accounts may allow individuals in the family to take a more self-reflexive stance and/or to distance themselves from the emotional impact of others' behaviors. The therapist's respectful interest in the alternative stories that different family members bring will often be an important validating experience, which may encourage a greater willingness on the part of family members to step back from the immediacy of their own emotionally driven interchanges.

Influencing Frameworks

The interventions considered under this heading are primarily characterized by their purposive nature, the therapists' understanding of why and when they chose specific interventions, and how this might lead to change. The emphasis is on the therapist's intentions and does not assume that the therapist can know with any certainty what the outcome of such an intervention is going to be. Much of the minutiae of the therapy process, such as the choice and sequencing of interventions, the specific type of questions used, how and when therapists use their expert knowledge, or alternatively when they emphasize the limits of their expertise and invite families to look for their own solutions, can be understood as part of this framework.

A key aspect of this framework is that it overtly acknowledges the potential of the power of the therapist (positive as well as potentially negative) and requires therapists to be aware of and reflect carefully on their own motivation, their position in the system, on the impact they are having and the effect of their interventions on their relationship with the family. Therapists are often uncomfortable in accepting the role of expert, preferring to adopt a more collaborative stance. This stems partly from a recognition that the therapist is not an outside observer of the

family system using his/her "meta position" to observe and intervene in the family dynamic to bring about change (Hoffman, 1985) and partly because of issues of power and control. Being in the position of expert can skew therapeutic relationships and reinforce a sense of dependency on professionals. It can ally the therapist more obviously with parents, making it more difficult to engage the young person. While it is important to be aware of these pitfalls, one should not assume that they can be avoided just by adopting a more neutral position, as these pitfalls are as much a product of the nature of the problem as they are of the position adopted by the therapist.

An awareness of these issues and a willingness to address them openly with the family is more effective than attempting to avoid them occurring. Feedback from families about experience of treatment shows consistently that such expertise is valued and when used wisely can promote desired change (Lose et al., 2014). Being aware of how and when to use therapeutic authority is key as is acknowledging the limitations of our knowledge (Mason 2005).

Research Evidence That Supports the Approach

Systematic research in the treatment of ED is significantly behind most other mental disorders (Bulik et al., 2007). More progress has been made in evaluating treatments for adults with bulimia nervosa (BN) and binge eating disorder (BED) (Mitchell, Agras, & Wonderlich, 2007; Wilson, 2010), while no treatments for adults with AN have demonstrated systematic benefits (Bulik et al., 2007). In contrast, relatively good progress has been made in demonstrating that family therapy for adolescents with AN is effective (Lock, 2010).

The first randomized controlled trial (RCT) of family therapy for ED (Russell, Szmukler, Dare, & Eisler, 1987) was designed to examine the usefulness of family therapy in preventing weight loss after weight restoration in hospital in four different groups of patients with ED: adolescents with AN for a short duration (≤ three years), adolescents with a long duration of AN (> three years), those with an adult onset of AN, and patients with BN. Following discharge from hospital, the eighty participants were randomized to either family therapy or supportive individual therapy for one year. End of treatment results favored family therapy for the adolescents with a short duration of AN, with those with an adult onset of AN responding somewhat better to individual therapy, and those in the remaining two groups showing no significant differences in outcome between treatments.

Because of the promising findings of the initial RCT, the next study aimed to gain a better understanding of the key components that might lead to change during family therapy. It was hypothesized (cf. Dare et al., 1995) that there were three key components underpinning the therapy: 1) close attention the therapist paid to the construction of the family as an evolving interactional system; 2) engagement of the family around the life-threatening quality of anorexia which was used overtly to help the parents, temporarily, to take charge of the child's eating; and 3) in later stages the exploration of issues of individual development and themes of growing up and leaving home. The first component was the one that was most clearly dependent on the therapist's ability to explore and intervene in the family system as a whole. The second could, at least in principle, be addressed by working with the parental dyad alone. The third, similarly, could be addressed through individual work with the adolescent. To test the hypothesized central role of the first component, a comparison to the usual conjoint family therapy (CFT) was devised, a "separated" family therapy (SFT) in which the same therapist saw the parents and separately the adolescent.

The initial pilot study by Le Grange and colleagues randomized eighteen adolescents to either CFT or SFT. The study found no differences in outcome, although families where parents were more critical (measured on Expressed Emotion scales) or more dissatisfied with their family (on the FACES questionnaire) had poorer response to treatment (Le Grange, Eisler, Dare, & Hodes, 1992a). A larger RCT (n = 40) also found no overall differences in outcome between treatments, although EE had a moderating role, which will be discussed in the next section (Eisler et al., 2000).

Research in family therapy moved forward in the United States when Robin and colleagues compared family therapy similar to that used in the Russell et al. (1987) study, but adding a cognitive component (described by them as Behavioral Family Systems Therapy) (Robin & Foster, 1989; Robin & Le Grange, 2010) to a more robust individual therapy called Ego-Oriented Individual Therapy (EOIT) (Robin, Siegal, Koepke, Moye, & Tice, 1994) that aimed to improve psychosexual development, self-efficacy, and promote autonomy (Robin et al., 1994, 1999). They hypothesized that family therapy would be more effective in promoting weight restoration, but individual therapy would have greater effects on measures of psychological health and ED thoughts. This study included thirty-seven adolescent females with short duration AN. The results confirmed that family therapy was more effective in weight restoration than EOIT, however, there were no differences in measures of psychological health or eating-related cognitions.

The generalizability of the findings of all the above studies was limited by small numbers (n =10–20/treatment group).

The first larger RCT (n = 86) was conducted at Stanford University (Lock, Agras, Bryson, & Kraemer, 2005) and examined the question of how much family therapy for adolescent AN was needed to be effective comparing a treatment consisting of twenty sessions over one year a with a briefer therapy of ten sessions over six months. There were no differences between groups at end of treatment although participants who came from non-intact families or who reported high levels of obsessive compulsive features did better if they received the longer treatment.

A much larger study (n = 121) comparing FT-AN and an individual therapy was recently conducted at Stanford University and the University of Chicago (Lock et al., 2010). This study intended to extend the findings of Robin et al. (1999) by comparing FT-AN to a therapy similar to EOIT called Adolescent Focused Therapy (AFT) (Fitzpatrick, Moye, Hostee, Le Grange, & Lock, 2010) both treatments consisting of twenty-four sessions over one year. At the end of treatment (EOT), participants in FT-AN showed significantly greater improvement in weight gain and in eating related cognitions, though there was not a significant difference on the primary measure of recovery[2] at the EOT (FT-AN recovery rate = 41%; AFT recovery rate = 21%). At twelve-month follow-up, the recovery rate in FT-AN was significantly greater than AFT (49% vs. 19%). It was also noteworthy that those in FT-AN were weight restored significantly faster and required fewer medical hospitalizations during treatment than those in AFT. This study demonstrated in an adequately powered RCT that FT-AN was superior to AFT. Taken together the studies conducted provide compelling evidence of the effectiveness and the superiority of FT-AN to comparison treatments examined to date for adolescent AN.

Two studies provide evidence that a generic family therapy (FT) confers benefit, but that FT-AN may have some additional advantages. The first (Godart et al., 2012) compared the addition of FT focusing on intra-familial dynamics rather than ED behaviors as part of aftercare to hospital treatment with follow-up as usual. At eighteen-months follow-up, the FT group had significantly better outcomes than the TAU group. Agras et al. (2014) have provided a direct comparison of FT-AN with a general (manualized) systemic FT in a sample of 164 adolescents with AN. Although overall the treatments were equally effective, the FT-AN group achieved faster weight gain early in treatment, required fewer hospitalizations, and was more cost effective. This suggests that FT-AN provides additional advantages over and above a non-ED focused family therapy.

Several studies have reported on the maintenance of the benefits of FT-AN (Eisler et al., 1997; Eisler, Simic, Russell, & Dare, 2007; Lock et al., 2006; Le Grange et al., 2014). They show generally that those who respond to FT-AN continue to improve and have low relapse rates of less than 10% (compared to relapse rates from inpatient treatment of 25–75%; Lay, Jennen-Steinmetz, Reinhard, & Schmidt, 2002; Strober, Freeman, & Morrell, 1997).

Although family therapy for adolescent BN (FT-BN) has been utilized clinically for over fifteen years (Dodge, Hodes, Eisler, & Dare, 1995), the approach has only recently been evaluated in

RCTs. Le Grange, Crosby, Rathouz, and Leventhal (2007) (n = 80; mean age 16.1 years) compared FT-BN to supportive psychotherapy (Walsh et al., 1997) and found that both at the EOT and at one-year follow-up FT-BN was more effective. A UK study compared FT-BN to guided self-help CBT (Treasure & Schmidt, 1997). This study included somewhat older adolescents with BN (n = 85; mean age 17.6 years) and found that both groups improved with no difference in clinical outcome between the groups, though in the CBT group there was a more rapid reduction in bingeing at six months and the treatment was more cost-effective (Schmidt et al., 2007).

Treatment Manuals for Eating Disorders-Focused Family Therapy

Family Therapy for Adolescent Anorexia Nervosa (FT-AN)

The role of treatment manuals in the development of evidence-based practice is complex and not without controversy. For some, the use of manuals is relatively straightforward, the key issue being how to ensure that that well-defined treatments found to be effective in RCTs are disseminated as accurately as possible into routine practice (Shafran et al., 2009); the main challenge being that the latter is hard to achieve (Kosmerly, Waller, & Robinson, 2014; Wallace and von Ransom, 2012). Others have argued that manuals are too prescriptive and do not take into account the specific needs of individual and their families (Beutler, 2002; Sexton & van Dam, 2010; Strupp & Anderson, 1997) or that they ignore the role of common factors in psychotherapy (Messer & Wampold, 2002).

Treatment manuals have had a key role in the development of family therapy for ED. The early trials conducted in London did not use manuals and maintained consistency of treatment through close supervision of a small number of therapists. The first (unpublished) treatment manual was used in the Robin et al. (1994, 1999) study and all subsequent studies have relied on manuals. From a research point of view this is primarily to ensure the possibility of replication of the treatment approach in diverse settings, facilitation of therapist training and supervision, and promotion of therapeutic fidelity (McHugh & Barlow, 2010; Weisman et al., 2002).

The first published FT-AN manual (Lock et al., 2001; Lock & Le Grange, 2013) set out to operationalize the treatment approach from the early Maudsley studies (Dare, Eisler, Russell, & Szmukler, 1990; Dare & Eisler, 1995, 1997). Its publication has had a major impact on the field over and above the impact of the research studies that have used the manual. The manual is widely cited and has generated research about its use and implementation in practice (Couturier et al., 2013, 2014; Kimber et al., 2014) and has also sparked a debate about the potential pitfalls of uncritical application of the treatment with complex cases by clinicians with limited expertise (Strober, 2014; Lock & Le Grange, 2014).

The third is the Maudsley Service Model manual (Eisler et al., 2012) which includes treatment manuals for FT-AN and multifamily therapy (MFT) AN and BN manuals and various group treatments used as part of an Intensive Day Programme. The three FT-AN manuals illustrate the diversity of manuals in general and highlight the importance of avoiding the straitjacket of debates about the utility or uselessness of manuals when carried out in general terms without consideration of the actual use of manuals in practice (Forbat, Black, & Dulger, 2014).

The similarities and differences between the three FT-AN manuals are of interest as they highlight key areas of consensus but also show some of the variability of treatment approach that are worthy of future investigation and theoretical developments. All three share the following:

- *Clear focus on working with the family to help their child recover, coupled with a strong message that the family is not seen as the cause of the problem*. From the very first contact with the family, the therapist displays a lack of interest in the causes of the problem, emphasizing that the primary task is to overcome the daughter's illness. The reason for meeting the family is not because they are seen as the source of the problem but because they are needed to help their daughter recover. The therapist should be alert to indications of feelings of guilt and self-blame and address

these early on, emphasizing the lack of any evidence that families cause anorexia.

- *Expecting parents to take a lead in managing their child's eating in the early stages of treatment whilst emphasizing the temporary nature of this role.* Although the overall approach in all three manuals is similar, there are differences in technique and subtle nuances in conceptualization. Robin and Siegel use structured behavior modification techniques and a formal behavioral contract to manage the adolescent's eating, and provide parents with clear dietetic advice. The expectation is that the initial stage when parents are helped to gradually establish a regular meal routine may take six to eight sessions. Lock and Le Grange recommend intensifying the sense of crisis and emphasize the urgency of parents taking charge, and a family meal is used as a routine intervention at session two. They generally avoid giving explicit dietetic advice to parents, aiming to reinforce parents' own sense of mastery by exploring with them what they have tried and what might need modifying. Eisler and Simic also recommend a family meal early on in treatment, but also describe other possibilities of using food as part of treatment (e.g., a mini-meal challenge used with very ill young people as part of an assessment if out-patient treatment is possible). Similarly to Robin and Siegel, they also provide dietetic advice and written meal plans if parents feel that it would be helpful. Unlike Robin and Siegel, who use a dietician throughout but alongside the treatment, they would not generally recommend separate consultations with a dietician but incorporate such advice into the therapy sessions either by the therapist or on occasions inviting the dietician to join in the family therapy session.
- *Externalizing the ED.* All three manuals provide specific strategies to achieve this. Robin and Siegel and Lock and Le Grange use physical illness analogies that have to be managed by parents; Lock and Le Grange also use visual representation of how an illness obscures the healthy child. Eisler and Simic describe a range of narrative externalizing conversation techniques that implies anorexia is a separate entity and also places an emphasis on using psychoeducation about the effects of starvation as a way of externalizing the illness.
- *In later stages of treatment, a shifting of focus on adolescent and family developmental life cycle issues*. Robin and Siegel routinely use cognitive restructuring techniques, including behavioral experiments to address eating disorder cognitions in the later stages of treatment which neither of the other two manuals describe. A range of other behavioral techniques, such as skills and problem solving and communication training are also used. The work is done jointly with parents and adolescents, though siblings generally only attend a single session early on in treatment. Lock and Le Grange and Eisler and Simic encourage siblings to attend some sessions but recognize that the needs of siblings vary and will agree with the family when including siblings in sessions might be most appropriate. Eisler and Simic (similarly to Robin and Siegel) meet individually with the adolescent as part of the assessment and also include individual sessions in the later stages if the adolescent expresses a wish to have some space to think about her own issues.

All three manuals describe the treatment as happening in phases although the description of the phases (and their number) varies. Thus Robin and Siegel describe three phases (Assessment; Weight gain; Weight maintenance), Lock and Le Grange also three (Weight restoration; Transitioning control of eating to the adolescent; Adolescent issues), and Eisler and Simic describe four phases (Engagement and development of the therapeutic alliance; Helping families manage the eating disorder; Exploring issues of individual and family development; Ending treatment and discussion of future plans and discharge). In reality the phases are fairly similar and address the different issues in a comparable sequence, with the differences being more one of emphasis. This highlights, on the one hand, the degree of arbitrariness when describing treatment phases; they

should not be taken in any way as absolutes and should not, outside of a research context, be seen as prescribing how long different stages of treatment last. On the other hand, they also illustrate the importance of transition points in treatment such as handing back to the adolescent, moving the focus of treatment away from eating and weight or addressing ending issues.

Conceptually all three manuals are very similar, but are also sufficiently different to raise important questions about the detailed aspects of how the treatments are delivered. To what extent the differences are simply a reflection of the different context and different time when the manuals were written and how much they represent differences that might have an impact on treatment is not known.

Family Therapy for Bulimia Nervosa (FT-BN)

While there is considerable overlap in the style of working between FT-AN and FT-BN, there are also significant differences (cf. Le Grange & Lock, 2007). These differences are determined by a number of factors: developmental stage, the level of distress caused by the ED symptoms to the adolescent, comorbidities, and impact on the families where there is BN. FT-BN recognizes that most adolescents with BN are developmentally more "on track" than their counterparts with AN and that the experience of bulimic symptoms are more overtly experienced as distressing and shame inducing, whereas the adolescent with AN, at least initially, are likely to value and have a distinct sense of pride in their ability to lose dramatic amounts of weight (Schmidt & Treasure, 2006).

Comorbidities are high in both AN and BN but their pattern tends to be somewhat different and generally greater and more heterogeneous in BN (Fischer & Le Grange, 2007; Le Grange, Doeb, Van Orman, & Jellar, 2004). A key difference is that in AN, other than acute suicidality, comorbid problems seldom trump the severity of self-starvation. In contrast, many behaviors that are quite prevalent among patients with BN, such as mood disorder, impulsivity, self-harming behaviors, substance use, oppositional defiant behavior, all interfere with the therapist's efforts to keep a relentless focus on the ED behavior.

In families with adolescent AN, criticism and/or overt hostility of parents toward their child is generally low (Le Grange et al., 1992a, 2011). There are probably many reasons to explain this phenomenon, but it is likely that the dramatic medical crises the AN patient finds herself in, and obvious emaciation, tend to elicit parental sympathy as opposed to criticism. In contrast, bulimic symptoms such as binge eating and purging, in light of the patient's otherwise "healthy looking" status, may appear more willful and unpleasant and therefore more likely to elicit criticism and/or hostility. The sense of shame, secrecy, and more negative relationship with parents means that adolescents with BN are more often reluctant to involve their families in treatment (Perkins et al., 2005). Engaging the family and developing a good therapeutic alliance with the whole family with a shared sense of therapeutic purpose can take time and requires therapists to be alert to possible ruptures in the alliance throughout the treatment.

From the start the treatment is visibly more *collaborative*, encouraging the adolescent to work with her/his parents and explore the best way that s/he can get support from them to abstain from bingeing and purging and instead restore healthy eating. This makes the adolescent an active participant in treatment, providing that she is willing to supply helpful suggestions as to how his/her parents could go about curtailing bingeing and purging. The therapist encourages the adolescent with BN to express his/her point of view and experience in order to arrive at a joint solution to the ED symptoms. The specific focus of the treatment, that is, the extent to which other problems need to be addressed alongside of the ED symptoms, also need to be negotiated with the adolescent taking an active part in agreeing the goals of treatment.

Multifamily Therapy (MFT) for ED

A major drive for developing MFT arose out of a wish to develop a more intensive version of FT-AN, particularly for those who might otherwise require inpatient treatment (Dare & Eisler,

2000; Scholz & Asen, 2001). The interested reader is referred to detailed descriptions of MFT-AN elsewhere (cf. Eisler et al., 2012; Fairbairn, Simic, & Eisler, 2011; Simic & Eisler, 2015).

MFT-AN draws conceptually on the same principles as FT-AN, aiming to help families to rediscover their own resources but additionally provides a context where several families can work together to share their experiences, which reduces their sense of isolation and stigma in an environment that creates a sense of solidarity, stimulates new perspectives and reflectivity, and allows families to learn from each other to provide mutual support and feedback, to develop and strengthen competencies, and to raise hope that they can work toward their child's recovery (Asen & Scholz 2010).

At the Maudsley Hospital in London, MFT-AN typically starts with a four-day block running from 10 am to 4 pm. This is then followed by six to seven one-day follow-up meetings; the first being within one to two weeks, while the remainder are conducted at longer intervals. It is quite typical for families to attend single FT-AN sessions between these MFT meetings as needed.

Moderators and Mediators of Treatment

Few of the limited RCTs for adolescent AN, and fewer still for BN, have explored the effects of moderators and mediators on outcome. Earlier in this chapter we discussed the eight published RCTs examining family therapy for adolescent AN and two for BN; however, only half of these studies examined the effects of moderators and mediators on outcome, that is, three AN studies (Eisler et al., 2000; Le Grange et al., 2012; Lock et al., 2005), and one BN study (Le Grange et al., 2007). RCTs are mostly invested in the evaluation of the relative efficacy of treatments, however, clinical practice stand to be meaningfully informed when we examine the predictors/moderators and mediators of outcome (Kraemer, Wilson, Fairburn, & Agras, 2002). Identifying moderators and mediators serve to inform clinical practice in two ways, that is, it tells us which treatment is best for which patient (moderators), and it tells us ways to enhance the effectiveness of treatments (mediators).

Given the limited research, it is not surprising that no mediators and only a few moderators of treatment outcome have been identified so far. Expressed Emotion (EE) has been shown to moderate outcome in several studies with parental criticism being associated with poorer outcome, particularly in conjoint FT-AN as opposed to separated FT-AN (Eisler et al., 2000; Le Grange, Eisler, Dare, & Russell, 1992b), while parental warmth was associated with good treatment outcome in FT-AN (Le Grange et al., 2011). Interestingly those adolescents seen in conjoint FT-AN made greater improvements on individual psychological measures such as depression and obsessionality in comparison with the "separated" FT-AN. A further potential family moderator was identified in the Lock et al. (2005) dose study, with those from non-intact families (single parent, divorced) faring significantly better with the longer course of therapy in terms of ED cognitions.

At an individual level, the most consistent moderator has been eating-related obsessionality (YBC-ED). In the Lock et al. (2005) study, those with higher scores fared better in terms of weight gain if seen in the longer treatment. In the Lock et al. (2010) study, high YBC-ED scores predicted better response in FT-AN compared to AFT (Le Grange et al., 2012), while in the comparison of FT-AN with a generic systemic therapy (Agras et al., 2014) high YBC-ED favored the latter. These somewhat disparate findings are not easy to interpret but one possibility is that high levels of obsessionality pose additional challenges to the parents and treatments offering greater opportunities to address relational issues alongside of the more behaviorally focused interventions may have had some advantages.

Two other potential individual moderators were identified. First, patients with high levels of ED cognitions did better in FT-AN compared with AFT. Although much more tentative, AN type also emerged as a moderator at follow-up with patients with binge-eating/purging type responding less well than restricting type when receiving AFT rather than FT-AN.

Only one study has explored moderators and mediators in FT-BN (Le Grange, Crosby, & Lock, 2008) and found that those with less severe ED specific psychopathology were more likely to be partially remitted at follow-up if seen in FT-BN than in individual supportive psychotherapy.

Taken together, these findings from the limited AN and BN literature are still tentative in nature. Our knowledge of family therapy for adolescent ED remains underdeveloped and few indicators are available to help the clinician match their patient with treatment modality. Also, our understanding of *how* family therapy works for this patient population remains largely anecdotal.

Implementation of the Model in Community/Practice Settings

The treatment of ED requires a complex set of skills and knowledge and effective evidence-based practice, therefore, cannot be reduced to the question of implementation of an effective family therapy approach. Research on the treatment of ED has been conducted nearly exclusively in the context of highly expert multidisciplinary specialist services with expertise in a number of areas provided by staff with shared, overlapping skills and knowledge. These include family therapy but also individual therapy skills, knowledge of individual and family developmental and life-cycle needs, knowledge of ED, nutrition and the effects of starvation, knowledge of medical risks associated with ED and their management, as well as the management of comorbid problems such as depression or OCD.

As discussed earlier, within such specialist contexts FT-AN has been shown to be an efficacious evidence-based treatment and the majority of adolescents with an ED can be treated on a purely outpatient basis. When considering how the research results translate to routine, practice two questions arise.

1. Is FT-AN Effective Outside of the Context of a Controlled Research Treatment Trial?

Several small case series have shown that FT-AN with a relatively brief training using a treatment manual and regular supervision can be successfully implemented in outpatient specialist ED services for both adolescents (Couturier, Isserlan, & Lock, 2010; Le Grange, Binford, & Loeb, 2005; Loeb et al., 2007; Tukiewicz, Pinzon, Lock, & Fleitlich-Bilyk, 2010) and younger children (Lock et al., 2006) with outcomes comparable to those reported in treatment trials. A recent prospective case series of 286 cases seen at the specialist Child and Adolescent ED Service (CAEDS) at the Maudsley Hospital in London provides another perspective of how FT-AN is utilized in practice. CAEDS provides a comprehensive service, which integrates outpatient treatment and an intensive day program (ITP) with access to pediatric or psychiatric admissions where these are indicated. CAEDS serves a catchment area of 1.8 million in South East London and sees the majority of all ED cases in this area up to the age of eighteen years. Nearly 80% are seen on a purely outpatient basis, the rest receive a combination of outpatient and day care (14%) or outpatient and inpatient care (9%). FT-AN (singly or in combination with MFT-AN) is the main outpatient treatment although some patients will also receive some individual therapy. Adolescents with BN receive FT-BN, MFT-BN, individual CBT or a combination of these. ITP actively involves families and includes a significant MFT-AN component. The study found that at the end of an average of one year of treatment 82% required no further treatment for an ED (68% discharged back to primary care and 14% referred to local services for treatment of comorbid problems such as depression or anxiety) (Eisler et al., 2014).

Several other services have recently reported on use of FT-AN and MFT-AN as part of a day program (Girz, Robinson, Foroughe, Jasper, & Boachie, 2013) or follow-up to inpatient treatment. Two Australian settings (Westmead Hospital in Sydney and the Royal Children's Hospital in Melbourne) found that following training and implementation of FT-AN as a follow-up to inpatient treatment, rates of readmission to the unit reduced significantly in the years subsequent to its introduction (Hughes et al., 2014; Rhodes & Madden 2005; Wallis, Rhodes, Kohn, & Madden, 2007).

2. What Role Does the Specialist Treatment Context Play in Delivering Effective Evidence-Based Practice for Adolescent ED?

Gowers et al. (2007) addressed this question in an RCT comparing specialist outpatient treatment with treatment in generic Child and Adolescent

Services Mental health Services (CAMHS) and inpatient psychiatric treatment, finding no differences in treatment outcome between the three arms. The study had two key limitations. First, there was poor adherence to the allocated treatment arm (dropping to 50% for inpatient treatment), and second, the specialist treatment was a relatively brief, primarily individual, treatment. The non-specialist CAMHS "treatment as usual" frequently included a family-based treatment.

House et al. (2012) report a naturalistic study, which compared areas of London that provide direct access to specialist ED outpatient services with other areas where initial referrals are made to generic CAMHS. The study assessed three outcomes: rates of case identification, the need for inpatient treatment, and continuity of care. In specialist areas the rates of case identification was two to three times higher than in non-specialist area; those who were initially assessed and treated in a generic CAMHS service had more than twice the number of admissions to hospital compared to those assessed and treated in a specialist service. Finally, of those seen from the start in a specialist context, received all their care from the same service in more than 80% of cases. This is in contrast with those initially assessed in CAMHS where half were immediately referred on; and of those actually offered treatment, a further 60% were at some point transferred to another service.

The specialist services in the London Care Pathways study varied in a number of ways, but all had FT-AN as their core treatment approach. The study had a number of limitations, in particular an uneven distribution of those consenting to be included in the study between the specialist and non-specialist arms. Nevertheless, the striking differences between the different care pathways provide a compelling argument for taking into account the service context of treatment delivery when evaluating treatments for ED.

Conclusions

Eating disorders-focused family therapy is an integrative treatment that has evolved over a number of years. There is now compelling evidence for its effectiveness in the treatment of adolescent anorexia nervosa and emerging evidence of efficacy for adolescent bulimia nervosa. Nevertheless, the knowns are still far outweighed by the unknowns. We are only at the beginnings of understanding how the treatment works, which aspects of the treatment are of key importance, and what modifications are needed for those who currently do not respond. This is particularly true for the treatment of adolescent BN where a great deal more research is needed, building on existing findings both from within and outside the family therapy field. To this end, a large RCT at the University of Chicago and Stanford University, comparing FT-BN with individual CBT is being completed. Similarly, the Maudsley group have been piloting a MFT-BN which draws conceptually on FT-BN, but also includes significant elements of Dialectical Behavior Therapy (Stewart, Voulgari, Eisler, Hunt, & Simic, 2015).

Debates about the implementation of evidence-based treatments all too often focus too narrowly on the need for implementing these with the highest degree of adherence to evaluated treatment manuals despite the fact that psychotherapy research on adherence in general suggests that the relationship between adherence and outcome is complex, most probably curvilinear, and moderated by factors such as therapist experience, strength of the therapeutic alliance, and complexity of presentation (Castonguay, Constantino, & Holtforth, 2006; McHugh, Murray, & Barlow; 2009; Webb, DeRubeis, & Barber, 2010). As many have pointed out (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Kazdin 2008), evidence-based practice is not simply a matter of implementing treatments shown to be efficacious in RCTs particularly when our knowledge of how the treatment works and responds or does not respond to particular aspects of treatment is limited. The tension between the aspiration to implement effective treatments as well as possible while maintaining the necessary clinical flexibility to meet the specific needs and wishes of individual clients and families creates a degree of uncertainty for both clinicians and researchers. We should, however, welcome this uncertainty as it allows treatments to continue to develop and draw on new evidence and new conceptual understandings.

Notes

1. Note on terminology: in the eating disorders literature a number of terms have been used to describe family therapy with an eating disorders focus—for example, Maudsley Family Therapy, Maudsley Model Therapy and in recent years most commonly Family Based Treatment or FBT. In our view what makes the treatment distinct is not that it is a different model of treatment (in the sense that, e.g., structural therapy is) but rather the nature of the problem that it is addressing (Eisler, 2013). For a family therapy readership, the term "FBT" has the additional disadvantage that it has been used to mean something different—for example, in addictions a treatment that is aimed not just at the family but also at wider systems. For clarity and consistency we use the term "family therapy for anorexia nervosa" (FT-AN) or "family therapy for bulimia nervosa" (FT-BN) throughout.
2. Recovery was defined as >95% of expected median body weight for age and gender using CDC norms (Kuczmarski et al., 2000) and an Eating Disorder Examination (Cooper & Fairbairn, 1987) global score within 1 SD of community norms (Alison, 1995).

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PART IV

RESEARCH FOUNDATIONS

21.

CURRENT STATUS OF RESEARCH ON COUPLES

Rebecca L. Brock, Emily Kroska, and Erika Lawrence

> The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed.
>
> *Carl Jung*

Intimate relationships can be a source of considerable joy and comfort, and intimate partners play a primary role in fulfilling interpersonal needs such as safety, security, and companionship; therefore, it is not surprising that almost everyone enters into a committed relationship at least once during their lifetime. Nonetheless, intimate relationships are complex, and multiple factors converge to influence their quality. Functioning will inevitably be impaired at times, and couples may not be capable of repairing fractures in their relationships on their own. Indeed, relationship difficulties are one of the most common reasons cited for seeking mental health care, and family therapists report couple problems as the primary presenting concern in over two-thirds of their cases (Gurman, 2010). Although there is overwhelming evidence that couple therapy is effective (Gurman, 2011), a notable proportion of couples who recover eventually relapse (Christensen, Atkins, Baucom, & Yi, 2010; Jacobson & Addis, 1993). Therefore, scientific progress is needed to better understand what contributes to the deterioration of intimate relationships in order to inform the development of novel interventions and refine existing clinical practices. Fortunately, the past decade has yielded innovative research that has the potential to inform couple interventions not only for the prevention and treatment of relationship dysfunction, but also for the promotion of individual health and well-being.

This chapter is divided into two sections. Part 1 summarizes research on intrapersonal, interpersonal, and contextual risk factors for relationship dysfunction, and presents implications of this research for couple interventions. Part 2 provides a review of research clarifying the role of intimate relationships in the mental and physical health of individual partners, and includes a discussion of how this research can be applied to inform both couple and individual-based interventions for individual psychopathology and chronic illness. The research presented in this chapter is not intended to be exhaustive; rather, we highlight what we believe is novel and innovative research emerging within the past decade. Indeed, there are exciting developments such as the application of genetics and epigenetics for understanding relationships (e.g., Beach & Whisman, 2013), and examinations of novel interventions for treating infidelity (e.g., Atkins, Marin, Lo, Klann, & Hahlweg, 2010), that were beyond the scope of this review.

Part 1: Intrapersonal, Interpersonal, and Contextual Risk Factors for Relationship Dysfunction

Three types of risk factors are generally recognized as contributing to relationship functioning: a) intrapersonal factors brought to relationships by each partner; b) contextual factors arising outside of the relationship (e.g., stress) that spill over into the relationship; and c) relationship processes and interactions. In this section we provide a review of research on each risk factor with a particular focus on novel research emerging within the past decade. We conclude with a discussion of implications of these novel empirical advances for couple interventions.

Intrapersonal Vulnerabilities for Relationship Dysfunction

Multiple disciplines provide frameworks for understanding the role of intrapersonal vulnerabilities in relationship dysfunction. Individual difference perspectives emphasize the impact of personality traits throughout the lifespan, which are considered to be heritable and relatively stable (Clark, 2005). In particular, the personality trait *neuroticism* (i.e., individual differences in the extent to which a person perceives and experiences the world as threatening, problematic, and distressing) is a notable predictor of dyadic adjustment, accounting for close to 10% of the variability in marital satisfaction (Karney & Bradbury, 1995). Cognitive models have also been employed, with a particular emphasis on the role of *attributions* about dyadic events. Research provides compelling evidence that maladaptive attributions place couples at risk for declines in relationship satisfaction (see Bradbury & Fincham, 1990, for a review and critique of the literature). Developmental perspectives highlight the role of *family of origin* factors in adult intimate relationships (Sabatelli & Bartle-Haring, 2003; Story, Karney, Lawrence, & Bradbury, 2004), especially with regard to risk for relational aggression (Cui & Durtschi, 2010).

One of the most widely examined intrapersonal risk factors for relationship dysfunction—*attachment*—also fits within a developmental framework. Individuals with insecure attachment representations are more likely to remain in unhappy marriages (Davila & Bradbury, 2001), to engage in maladaptive dyadic behaviors such as poor communication (Feeney, 1994), and to enact negative behaviors during conflict interactions (Creasey, 2002; Shi, 2003; Simpson, Rholes, & Phillips, 1996). People who are insecurely attached are also less responsive caretakers in relationships (e.g., Carnelley, Pietromonaco, & Jaffe, 1996) and are more likely to provide unhelpful support (e.g., Brock & Lawrence, 2014a). In contrast, individuals who are more securely attached tend to experience more satisfaction with their intimate relationships in adulthood (e.g., Collins & Read, 1990; Feeney, 1994). Attachment style influences other intrapersonal risk factors as well, including attributions about dyadic behaviors (Gallo & Smith, 2001). (See Mikulincer & Shaver, 2007 for a thorough review of the literature on attachment and close relationships.)

Novel Developments in the Identification of Enduring Vulnerabilities for Relationship Dysfunction

Research over the past decade has led to novel developments in our understanding of intrapersonal risk factors for relationship dysfunction. These developments include: a) clarification of the scope and nature of how personality traits influence relationship functioning; b) application of novel methodologies to capture the complexities of attachment representations in the context of intimate relationships; and c) investigations into previously overlooked intrapersonal risk factors.

Personality

During recent years, research has demonstrated that numerous aspects of personality influence relationship adjustment. Indeed, certain personality traits appear to *promote* relationship functioning, such as openness, agreeableness (Daspe, Sabourin, Péloquin, Lussier, & Wright, 2013), and dispositional optimism (Assad, Donnellan, & Conger, 2007). Examinations of personality disorder features suggest that histrionic and

paranoid personality traits put individuals at particular risk for discord and divorce (Disney, Weinstein, & Oltmanns, 2012). Strides have also been made with regard to understanding the complexity of the association between personality and relationship functioning. For example, dispositional optimism appears to contribute to global satisfaction through its impact on more cooperative problem solving (Assad et al., 2007). This particular finding highlights the relative importance of specific dyadic processes and behaviors as mechanisms through which intrapersonal risk factors ultimately impact relationship outcomes. Recent research also suggests that it is overly simplistic to assume a linear relation between personality and dyadic adjustment. In a recent study by Daspe et al. (2013), a curvilinear association was identified such that both high levels of neuroticism and *very low levels* of neuroticism led to increased risk for maladjustment. The ways that partners perceive and understand personality traits are also significant. Indeed, emerging research suggests that how one views his or her partner (i.e., partner ratings of personality) has a greater impact on relationship adjustment than one's self-reported personality (e.g., Altmann, Sierau, & Roth; 2013; Brock, Dindo, Clark, & Simms, 2014). Further, the extent to which partners are in agreement about one another's attributes (i.e., self-verification) is associated with less relationship discord (Letzring & Noftle, 2010). Finally, partners who are more similar are at greater risk for decline in relationship satisfaction over time relative to partners with distinct traits and temperaments (Shiota & Levenson, 2007).

Attachment

Attachment has been examined rather extensively; however, novel methodologies have revealed the complexities of attachment representations within the context of intimate relationships. For example, incorporation of biobehavioral methodologies has produced results suggesting that attachment-related anxiety is not only associated with relationship maladjustment assessed via self-report methods, but also greater electrodermal reactivity during dyadic interactions (Holland, Fraley, & Roisman, 2012). Efforts have also been made to clarify the unique contributions of *specific* attachment bonds versus *global* attachment styles. Barry, Lakey, and Orehek (2007) demonstrated that specific bonds developed with romantic partners have a stronger relation to aspects of relationship functioning (e.g., perceived social support) than general attachment dispositions. Researchers are also directly examining the role of attachment in couple interventions. Conradi, De Jonge, Neeleman, Simons, and Sytema (2011) found that individuals high in insecure attachment tend to benefit less from couple therapy, suggesting that modifications to treatment planning may be necessary when one or both partners is insecurely attached.

Mindfulness

Emerging research has linked relationship functioning to key processes targeted in third-wave behavioral interventions such as *Dialectical Behavior Therapy (DBT)* and *Acceptance and Commitment Therapy (ACT)*. Specifically, *mindfulness* appears to have important implications for the quality of intimate relationships. Mindfulness has been defined as "paying attention in a particular way: on purpose, in the present moment, nonjudgmentally" (Kabat-Zinn, 1990, p. 4). A recent study demonstrated that mindfulness is associated with greater relationship adjustment and facilitates numerous adaptive processes in relationships, including more effective coping with relationship stress, protection from negative perceptions of the relationship resulting from conflict, and more effective communication (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007). The link between mindfulness and relationship functioning is not surprising given that more mindful attention during dyadic interactions may promote better emotion regulation, greater awareness of positive feelings toward one another, and more skillful interactions (Fruzzetti & Iverson, 2004).

Further research examining mindfulness, along with other key processes targeted in individual-based interventions (e.g., thought defusion, self-soothing behaviors, values clarification), has the potential to isolate individual-based

interventions that may be effective components to integrate into couple therapy. For example, a randomized clinical trial was recently conducted in which ACT processes were incorporated into a Batterers Education Program (court-mandated programs for individuals convicted of domestic violence offenses). When this novel intervention was compared to the standard program used across the country (a combination of feminist and cognitive-behavioral approaches), rates of physical, psychological, and sexual aggression were significantly lower at the end of treatment (twenty-four weeks) among men who received the ACT-based treatment compared to treatment-as-usual (Lawrence et al., 2014a). Additionally, recidivism rates (violent re-offenses) were significantly lower among men who received the ACT-based treatment one year later (Lawrence et al., 2014b). This intervention is just one example of the ways in which third-wave behavior techniques in general, and mindfulness in particular, can be used to target a range of challenging and treatment-resistant couple problems and dysfunctions.

Interpersonal Processes

The majority of research on interpersonal processes in intimate relationships has been focused on conflict management (Bradbury, Rogge, & Lawrence, 2001). This research has involved investigations of various negative behaviors that arise in the context of conflict and problem-solving interactions including expressions of anger and contempt, criticism, maladaptive problem-solving behaviors, psychological and physical aggression, and poor conflict resolution strategies; ample evidence demonstrates the deleterious effects of these negative behaviors on relationship satisfaction (see Karney & Bradbury, 1995 for a review). In particular, intimate partner violence (IPV) has been widely examined, with results documenting the serious consequences of IPV for the longevity and quality of intimate relationships (e.g., Lawrence & Bradbury, 2007; Yoon & Lawrence, 2013). Within the past two decades, notable shifts have occurred such that researchers have enhanced the scope of dyadic processes under investigation to best explain the nature and correlates of relationship dysfunction. A shift from an emphasis on more distressing relationship processes (e.g., conflict behaviors) to a consideration of positive dyadic behaviors has been observed (Fincham & Beach, 2010). In particular, examinations of the role of *partner support* processes in intimate relationships have become more common. Additional relationship processes such as emotional intimacy and quality of the sexual relationship are also receiving attention. Results of this research provide compelling evidence that relationships involve varying and complex processes that influence each other and contribute to relationship outcomes.

We now turn to a review of novel developments in research on interpersonal processes including: a) the flourishing area of research on partner support processes; and b) emerging research on relationship processes that have traditionally received less attention such as emotional intimacy and disengagement, quality of the sexual relationship, gratitude, relational control, and forgiveness.

Partner Support Processes

Although research on conflict and problem-solving interactions is important, conflict behaviors only account for a proportion of the variance in relationship satisfaction (Bradbury, Fincham, & Beach, 2000). Fortunately, considerable attention has been paid to partner support during the past two decades. This shift to accounting for more positive interpersonal processes has proved beneficial. In particular, *partner support*—typically conceptualized as supportive responses by one's partner (e.g., listening, providing guidance) in the context of distress—not only accounts for a notable amount of the variance in couple outcomes above and beyond that of conflict, but also predicts relationship satisfaction and dissolution up to ten years later (Sullivan, Pasch, Johnson, & Bradbury, 2010). Given the relative importance of partner support, it is not surprising that there has been a notable increase in research clarifying how partner support ultimately leads to more satisfying and stable relationships. Demonstrating the considerable growth in this area of research, several reviews of the literature on support in intimate relationships have recently been published

(Cutrona, 2012; Rafaeli & Gleason, 2009; Sullivan & Davila, 2010).

Much of the novel research that has emerged can be embedded within a multifaceted transactional model of support (Brock & Lawrence, 2010a). Partner support is a higher-order construct composed of multiple lower-order facets, such that it is insufficient to simply examine the amount of support provided in relationships to understand the ultimate impact of support on relationship functioning. Support transactions unfold in a dynamic and dyadic fashion such that both partners are interacting in an intricate exchange that may include solicitation of support (either direct or indirect), support provision, and perceptions of support offered including the perceived adequacy of that support. We now turn to a review of recent research focused on some of the specific components of support transactions.

Observations of Support Behaviors

Parallel to the focus on behavioral observations in conflict research, much of the early work on partner support was focused on the *observable* components of support exchanges such as support provision. This research demonstrated that providing support is a skill, and that certain supportive behaviors are associated with more positive marital outcomes. The extent to which support providers respond with acceptance, validation, and understanding about their partners' experiences is of particular importance (Fruzzetti & Worrall, 2010). Indeed, the foundational behaviors of psychotherapy—validation, active listening, expressions of understanding and empathy, normalization—are just as vital in the context of intimate relationships. Research also indicates that support provided in a spontaneous fashion may be most helpful (Rini & Dunkel-Schetter, 2010).

Perceptions of Received Support

Examinations of the observable components of support transactions have been vital for understanding the nature of support in relationships; however, a growing area of research recognizes that just because support is provided does not mean it is helpful. Support is a subjective experience, and behaviors coded as supportive by an outside observer may not be experienced as supportive by the recipient. Accordingly, attention has been paid to perceptions of support once it has been provided and, more specifically, to appraisals of support behaviors with regard to their adequacy and effectiveness. Indeed, the *adequacy* of support that is received (i.e., the extent to which there is a match between desired and received levels of support) may be essential for explaining the impact of support transactions on the health of relationships (Brock and Lawrence; 2010b). Support that is received must meet the unique needs of support recipients in order to facilitate coping efforts, and this appears to have implications for intimate relationship satisfaction. For example, more adequate support is directly linked to greater marital satisfaction for men above and beyond the frequency of support behaviors (Lawrence et al., 2008a), and interacts with stress to promote relationship satisfaction for women during the early years of marriage (Brock & Lawrence, 2008). Rini and Dunkel-Schetter (2010) have investigated a construct similar to support adequacy—*support effectiveness*—which considers the quantity and quality of support attempts, and have demonstrated the importance of support effectiveness in facilitating efforts to adapt to stress (Rini et al., 2011; Rini, Schetter, Hobel, Glynn, & Sandman, 2006; Stapleton et al., 2012).

Awareness on the part of the support provider as to whether the recipient *is ready* to receive support is also vital (Sullivan, Pasch, Bejanyan, & Hanson, 2010). If a support recipient is not ready to make changes (e.g., in the context of physical health problems), support may not be welcomed. The risk of providing unwanted support (support overprovision) has been examined relative to the effects of receiving too little support (support underprovision); overprovision of support places couples at greater risk for decline in relationship satisfaction over the first five years of marriage (Brock & Lawrence, 2009). Receiving unwanted support is expected to impede individual efforts to cope with stress because attention cannot be directed toward more helpful coping strategies, just as receiving

too little support may leave individuals without vital coping resources. However, overprovision of support may be especially detrimental to relationships given the potential for support recipients to experience support as unwanted. Support recipients may also feel as though their autonomy has been undermined or that their partners view them as incapable. They may feel frustrated that their partners are "getting it wrong" and may feel uncomfortable redirecting their partners to solicit more helpful support.

Support in Response to Positive Events

A novel approach to conceptualizing partner support recognizes that support may be provided in the context of positive life events, not just stressful life circumstances. Collins and Feeney (2010) applied attachment theory to a broader and more inclusive understanding of support processes in intimate relationships. They proposed that partners not only provide a safe haven within which support can be provided during times of stress, but also a "secure base" from which partners can venture out to explore the world. When individuals are actively engaged in goal-directed behavior, they rely on secure-base support from their partners to reach their goals. Depending on how their partners respond, there may be different implications for the relationship. In a recent study, Feeney and Thrush (2010) identified three key characteristics of secure-base support, including availability (partner's attentiveness and responsiveness), non-interference (lack of interference in exploration), and encouragement (motivation to pursue goals and take on challenges), and demonstrated that these factors have strong associations with exploration behaviors and experiences.

Gable and colleagues (Gable & Algoe, 2010; Gable & Reis, 2010) proposed that *capitalization* (i.e., supportive responses to personal positive events) is as important for the health of intimate relationships as support in response to distressing circumstances. They identified a range of potential responses that might occur when a positive event has been shared with one's partner, and delineated the potential outcomes of these various responses. In a recent longitudinal investigation, Logan and Cobb (2012) demonstrated that perceptions of support in the context of distressing versus positive events have unique implications for relationship satisfaction over time, suggesting that capitalization plays a prominent role early in relationships whereas support in response to distress may be more important as relationships develop and challenges are faced.

Recognition of Additional Relationship Processes

Although considerable attention has been paid to conflict interactions and, to an increasing degree, support transactions, numerous other processes have implications for relationship functioning. One such process is *emotional intimacy*, which shares certain characteristics with partner support (e.g., responsiveness, validation) but is a distinct construct. Emotional intimacy refers to the overall sense of closeness, warmth, affection and interdependence in the relationship, degree of trust, and demonstrations of love and affection between partners. One of the novel developments in the area of intimacy research has been the integration of daily diary methods to conduct micro-analytic investigations of the dyadic and dynamic behavioral exchanges contributing to intimacy. Much of this research has been embedded in an interpersonal process model of intimacy (Reis & Shaver, 1988), which suggests that a key element of intimacy development is empathy and respect in response to disclosures in the relationship. A recent daily diary study demonstrated that to the extent that partners are perceived as more responsive to one another, couples experience more intimacy (Debrot, Cook, Perrez, & Horn, 2012). Additionally, emotional intimacy has been found to impact other domains of relationship functioning. For example, low levels of trust increase the risk for more negative behaviors (e.g., criticism, blame) and less positive behaviors (e.g., expressions of positive affect, trying to resolve the conflict) during conflict and problem-solving interactions (Campbell, Simpson, Boldry, & Rubin, 2010).

Related to emotional intimacy, disengagement in intimate relationships—one of the most challenging issues to address in couples

therapy—has also received increasing attention. *Romantic disengagement* refers to emotional indifference and distancing in relationships. Novel efforts to operationalize and measure disengagement have been undertaken (e.g., Barry, Lawrence, & Langer, 2008), and results of this research suggest that romantic disengagement represents a unique construct that is distinct from negative affect (e.g., anger, contempt) and from (a lack of) positive affect (e.g., humor, affection). Further, romantic disengagement appears to represent a key mechanism through which couples who begin their relationships relatively satisfied and committed progress to a stage of discord and dissolution. In an effort to identify factors that influence the process of romantic disengagement, Barry and Lawrence (2013) examined individual and situational factors as potential predictors of disengagement. They found that, across both conflictual and supportive couple interactions, wives' negative affect during interactions predicted husbands' post-interaction disengagement when husbands were higher in avoidant attachment. Longitudinally, the link between husbands' perceptions of their conflict as destructive and husbands' conflict avoidance was stronger for husbands who were higher in attachment avoidance (Barry & Lawrence, 2013). Thus, the longitudinal process of romantic disengagement appears to be influenced by both individual (avoidant attachment, perceptions of conflict as destructive) and situational (conflict interactions, support transactions) factors.

In addition to emotional intimacy, physical intimacy has also been examined more extensively within the past decade. Historically, research efforts have focused on sexual dysfunction on the one hand (e.g., anorgasmia, erectile dysfunction, premature ejaculation) and on frequency and global satisfaction of sexual intercourse on the other. In contrast, the overall *quality of sexual intimacy* in relationships has received far less attention. Nonetheless, there is evidence that changes in sexual satisfaction contribute to changes in relationship satisfaction (Sprecher, 2002). A multifaceted investigation of sensuality and quality of the sexual relationship (i.e., frequency of sexual and sensual behaviors, who initiates sexual activity, satisfaction with the sexual relationship, negative emotions experienced during sex, sexual difficulties) revealed that the quality of the sexual relationship at the onset of marriage predicts initial levels and rates of change in relationship satisfaction over the first four years of marriage, even after controlling for other aspects of relationship quality (Lawrence et al., 2008b). Further, for husbands, the quality of the sexual relationship emerged as the most salient predictor of relationship satisfaction (compared to other areas of relationship functioning). In another study, diminished sexual satisfaction had a negative effect on the degree of emotional closeness and intimacy in one's relationship which, in turn, predicted relationship satisfaction (Sanchez, Phelan, Moss-Racusin, & Good, 2012).

Other relatively novel and previously overlooked dyadic processes continue to emerge as predictors of relationship outcomes. For example, expressions of *gratitude* appear to have important implications for the health of a relationship; both providing and receiving gratitude predicts greater relationship satisfaction and closeness (Algoe, Gable, & Maisel, 2010). *Relational control* (i.e., lack of respect for autonomy, imbalance in decision-making, poor negotiation of power across areas such as money management and parenting) also has consequences for couples. Greater relational control at the onset of marriage is associated with greater decline in relationship satisfaction, and relational control is a unique predictor of change in satisfaction (controlling for other key relationship processes) for men (Lawrence et al., 2008b). Recently, *forgiveness* in intimate relationships has been identified as "one of the most important factors in maintaining healthy romantic relationships" (Braithwaite, Selby, & Fincham, 2011, p. 551). Multiple studies have demonstrated that forgiveness predicts relationship satisfaction (Fincham, Hall, & Beach, 2006), and emerging research identifies mechanisms through which forgiveness contributes to satisfaction including increased relational effort (i.e., how much a person works at the relationship by regulating behavior) and decreased negative conflict (Braithwaite et al., 2011).

The Broader Context Surrounding Relationships

Numerous theories have been proposed to account for the impact of stress on dyadic functioning, including the *stress spillover* perspective (Bolger, DeLongis, Kessler, & Wethington, 1989), *ABC-X theory* (Hill, 1958), the *vulnerability–stress–adaptation model* (Bradbury, Cohan, & Karney, 1998; Karney & Bradbury, 1995), and a *stress–divorce model* (Bodenmann, 1995). A common thesis among these theories is that distressing and taxing elements of the environment experienced by each partner in the relationship have the potential to negatively impact relationship processes and outcomes. For example, proponents of the stress–divorce model propose that daily stress can lead to relationship deterioration through less time being spent together, decreased self-disclosure, poor dyadic coping, less communication, and low relationship satisfaction.

Despite early recognition that the context surrounding a relationship has implications for dyadic functioning, it has only been during the past two decades that a notable increase has occurred in research establishing the impact of stress on relationship processes and outcomes. Numerous studies demonstrate that high levels of stress (both major stressful events and chronic daily stressors) are associated with various aspects of relationship dysfunction including poor communication, disengagement and withdrawal, sexual problems, decreased self-disclosure, fewer positive and more negative behaviors, and greater relationship instability. (See Randall and Bodenmann, 2009 for a detailed review of the literature.) Stress also contributes to more negative attributions about partner behaviors (Neff & Karney, 2004) and less accepting views of one's partner (Crouter & Bumpus, 2001).

Novel Developments in Stress Research in Couples

One of the novel developments within this area of research is a recognition that stressors often result in the subjective experience of stress by *both* partners—what is referred to as "dyadic stress" (Randall & Bodenmann, 2009). This way of conceptualizing stress within the social context takes into account that a) both partners may be directly impacted by stress, b) only one partner may be directly impacted but the other partner will be indirectly influenced, or c) stress may arise within the relationship as opposed to externally. Indeed, some researchers argue that stress is *always* a dyadic phenomenon and that the ways that couples work together to adapt to stressors (i.e., *dyadic coping*) is of vital importance. Conceptualizing stress in this manner is novel in and of itself given that stress has been traditionally viewed as a relatively individual phenomenon.

Acknowledgment of the dyadic nature of stress has led to investigations of cross-spouse effects of stress in couples. Ledermann, Bodenmann, Rudaz, and Bradbury (2010) examined dyadic associations between relationship stress (e.g., tension that arises in the relationship in response to upsetting partner behaviors) and individual stress (e.g., tension that originates outside of the relationship such as social and economic strains) in a sample of 345 couples and found that perceptions of relationship distress not only influenced one's own experience of external stress, but also the partner's external stress (although to a lesser extent). In a sample of newlywed couples, Brock and Lawrence (2008) demonstrated that husbands' chronic stress (originating outside of the relationship) has implications for both their own and their wives' marital satisfaction.

Longitudinal Designs

Longitudinal research designs have been applied more frequently during the past decade to clarify temporal relations between stress and relationship outcomes. Average role strain over the early years of marriage is associated with decline in marital satisfaction for both husbands and wives (Karney, Story, & Bradbury, 2005). Further, the extent to which stress escalates over time is associated with deterioration in relationship satisfaction during the first four years of marriage for men (Brock & Lawrence, 2008). Brock and Lawrence (2008) found that increasing stress during the early years of marriage was

actually associated with greater marital satisfaction for women suggesting that, under certain conditions (when husbands are responsive to their needs), stress might create an opportunity for relationship growth. Chronic role strain during the transition into marriage also impacts specific relationship processes, predicting greater rates of support overprovision during the first five years of marriage (Brock & Lawrence, 2014a).

Adaptation to Stress

Progress is also being made with regard to clarifying why some couples experience deterioration in their relationships in response to stress whereas others thrive. A stress-coping cascade model (Bodenmann, 2005) indicates that it is customary for partners to first engage in individual coping efforts before joining together to address stress as a couple. The latter is what is referred to as "dyadic coping" which includes supportive behaviors, but also considers the presence of negative dyadic behaviors (e.g., hostility, disengagement, ambivalence) that may impede coping efforts. Conceptualizations of dyadic coping also take into account distinct ways that couples might work together to adapt to stressors including one partner taking initiative to address the issue at hand, joint efforts (e.g., mutual problem solving), and delegated coping efforts (when one person is asked directly to take action). Numerous studies have emerged from this perspective demonstrating the long-term impact of dyadic coping on relationship outcomes. For example, Bodenmann, Pihet, and Kayser (2006) found that more positive and less negative dyadic coping behaviors predict greater relationship quality over two years. Further, dyadic coping predicts relationship quality above and beyond that of individual coping efforts (Papp & Witt, 2010). A novel intervention approach has been developed based on this body of research and is demonstrating promise in preventing relationship distress. The Couples Coping Enhancement Training (CCET), which is focused on promoting individual and dyadic coping skills, contributes to improved marital quality up to one year following treatment (Bodenmann, Charvoz, Cina, & Widmer, 2001; Bodenmann & Shantinath, 2004).

Clinical Implications of Research on Intrapersonal, Interpersonal, and Contextual Risk Factors for Relationship Dysfunction

Intimate relationships involve varying and complex processes, and research emerging over the past two decades demonstrates that more than just conflict contributes to relationship discord and dissolution. Consequently, implementation of assessment tools that capture functioning across multiple domains of the relationship appears advantageous in the context of couple therapy. Indeed, a couple may present with a particular concern (e.g., high levels of conflict) that may overshadow dysfunction in other areas of the relationship that are also contributing to discord and dissatisfaction. The *Relationship Quality Inventory (*RQI; Lawrence et al., 2011; Lawrence, Brock, Barry, Langer, & Bunde, 2009) is a semi-structured interview designed to conduct functional analyses of relationships across multiple processes including conflict and problem solving, partner support, emotional intimacy, balance of power and control, and quality of the sexual relationship. A series of open-ended questions followed by closed-ended questions allow clinicians to obtain novel contextual information including concrete behavioral indicators to facilitate objective ratings of functioning across domains. Implementation of a semi-structured interview provides an opportunity to a) initiate a discussion between partners about the nature of behaviors enacted in their relationship, b) explore distinct perspectives of each partner, and c) facilitate communication between partners about the impact of each other's behaviors. Finally, quality of the sexual relationship and balance of power and control dynamics appear to be especially important to men; therefore, routinely inquiring about functioning in these domains may help to facilitate greater engagement in the therapy process by male partners.

With regard to intrapersonal vulnerabilities each partner brings to a relationship, multiple factors contribute to dysfunction and have

the potential to interfere with the therapy process. Accordingly, incorporation of measures that assess these risk factors at the onset of therapy, and referrals to individual-based treatments as an adjunct to couples therapy, may be warranted. Indeed, given the range of personality traits influencing relationship functioning, a comprehensive assessment of personality may be beneficial in the context of couples therapy. For example, the *Schedule for Nonadaptive and Adaptive Personality-2* (SNAP-2; Clark, Simms, Wu, & Casillas, 2014) assesses a range of personality traits and also provides ratings of personality disorder criteria. Alternative-form versions of the SNAP—the SNAP-Self-Rating Form and SNAP-Other-Rating Form (Harlan & Clark, 1999)—assess the same fifteen traits (the three "temperament" traits and the twelve "personality" traits), but also account for both self and partner-ratings and are much shorter for more efficient administration. Nonetheless, the short forms do not provide personality disorder scores and, as expected with short forms, are somewhat less reliable than the full version. Results of such an assessment might facilitate a discussion that will help partners understand their unique characteristics and reach agreement about their attributes (self-verification), and would also provide an opportunity to highlight how differences may actually prove to be an asset in the relationship. Special attention might also be paid to attachment styles at the onset of therapy so that adjustments to the treatment plan might be made if one or both partners are insecurely attached. Given that these couples may be at particular risk for relapse after treatment termination, the course of treatment might be adjusted to provide more intensive treatment with booster sessions periodically after treatment termination. Incorporation of individual-based treatment components into couple therapy, such as mindfulness-based interventions, may also prove beneficial.

Finally, screening for intrapersonal risk factors and carefully assessing a range of relationship processes is important; however, consideration of the larger context surrounding couples is also warranted. Stress arising external to the relationship—even stress that may be considerably more salient to one partner than the other (e.g., job-related stress)—should be routinely assessed with particular attention to how stress may be spilling over into the relationship, impacting functioning. Integrating components of *The Couples Coping Enhancement Training* (CCET; Bodenmann et al., 2001; Bodenmann & Shantinath, 2004) when couples report heightened levels of stress might promote both individual and dyadic coping skills to help couples adapt to ongoing strains on the relationship.

Part 2: The Role of Intimate Relationships in Physical and Mental Health

Functioning in intimate relationships has implications not only for long-term satisfaction and stability of relationships, but also for the physical and mental health of each individual partner. Efforts to incorporate components of couple interventions in the prevention and treatment of physical and mental illness have demonstrated utility. In this section, we review the state of knowledge with regard to the impact of intimate relationship dysfunction on psychological and physical health, and highlight novel developments in each area. We conclude with a discussion of clinical implications of basic research for interventions aimed at preventing and treating individual psychopathology and promoting adaptation to chronic illness.

Relationship Dysfunction and Psychological Health

It is widely recognized that marital discord has consequences for individual psychopathology (see Whisman & Baucom, 2012; Whisman, 2012, for recent reviews). Large-scale epidemiological studies demonstrate the notable risk for mood, anxiety, and substance-use disorders associated with relationship discord (Whisman, Sheldon, & Goering, 2000; Whisman, Uebelacker, & Weinstock, 2004; Whisman, 1999, 2007).

In particular, countless book chapters, review articles, and empirical studies highlight the robust association between marital discord and *depression* in both community and

clinical samples (e.g., Weinstock & Whisman, 2006). Prospective two-wave designs suggest that marital distress temporally precedes major depressive episodes and symptoms (Beach, Katz, Kim, & Brody, 2003; Whisman & Bruce, 1999; Whisman & Uebelacker, 2009). Significant cross-spouse associations (Beach et al., 2003; Whisman et al., 2004) suggest that when one partner is dissatisfied with his or her relationship, *both* partners are at increased risk for depression. Highly comorbid with depression, anxiety disorders are also associated with relationship discord (McLeod, 1994; Whisman et al., 2000; Whisman, 1999, 2007), and marital discord predicts the onset of subsequent anxiety disorders (Overbeek et al., 2006).

In addition to examinations of general distress in the relationship, researchers have examined specific relationship processes and their associations with depressive disorders and symptoms. Conflict and problem-solving has been one of the most widely examined relational processes with ample evidence suggesting that greater conflict is associated with depressive disorders and symptoms (O'Leary & Cano, 2001). In particular, intimate partner violence poses considerable risk for psychopathology in victims of intimate partner violence (IPV) (see Lawrence, Orengo-Aguayo, Langer, & Brock, 2012, for a recent review of the literature). There is also evidence that inadequate partner support (e.g., Dehle, Larsen, & Landers, 2001), low levels of emotional intimacy (e.g., Waring, Patton, Neron, & Linker, 1986), and uneven distributions of power in the relationship (e.g., Hautzinger, Linden, & Hoffman, 1982), are associated with depression.

Results from population-based samples suggest that relationship discord is also associated with *substance abuse*, and that this effect remains significant when controlling for comorbid depressive and anxiety disorders (Whisman et al., 2000). Individuals who are dissatisfied with their intimate relationships are 3.7 times more likely to have a diagnosis of an alcohol use disorder one year later than those who are satisfied, and this effect remains significant when accounting for demographic variables and history of alcohol use (Whisman, Uebelacker, & Bruce, 2006). Divorce is also prospectively associated with incidence of later alcohol abuse (Overbeek et al., 2006). With regard to specific aspects of relationships putting individuals at risk for substance abuse, IPV has been extensively examined. In a national epidemiological survey, results indicated that being a victim of IPV is associated with increased risk for drug abuse and dependence, and alcohol dependence (Okuda et al., 2011).

Given the considerable empirical evidence demonstrating a link between relationship discord and individual psychopathology, it is not surprising that couples interventions can be an effective treatment option. Most notably, behavioral couples therapy (BCT) is an empirical supported treatment for depression (Barbato & D'Avanzo, 2008; Nathan & Gorman, 2007), and a recent meta-analysis of twenty-three studies makes a compelling case for the efficacy of BCT for treating substance abuse (Ruff, McComb, Coker, & Sprenkle, 2010). Finally, relationship maladjustment interferes with the effectiveness of individual-based treatments, further demonstrating its role in individual psychopathology (see Whisman & Baucom, 2012, and Whisman, 2012, for reviews).

Novel Developments in Research on Relationships and Individual Psychopathology

A notable and consistent link has been observed between relationship dysfunction and individual psychopathology (e.g., depression, anxiety, and substance use disorders); however, during the past decade, research has emerged that includes: a) utilization of multi-wave research designs to conduct more sophisticated examinations of covariation between relationship discord and depression; b) examinations of moderators of the link between discord and depression to clarify who is most vulnerable to these effects; c) clarification of how relationships ultimately contribute to individual psychopathology by examining specific relationship processes; d) examinations of broad dimensions of psychopathology to clarify the scope of the impact

of relationship discord on mental health; and e) investigations of other indicators of mental health previously overlooked (e.g., life satisfaction). We now turn to a review of each of these advancements.

Implementing Multi-Wave Research Designs

Early research on relationship discord and depression relied heavily on cross-sectional research designs, limiting knowledge about the potential impact of discord on subsequent depression. Two-wave longitudinal designs were implemented, suggesting temporal precedence of relationship discord as a predictor of depression up to eighteen months later (Banawan, O'Mahen, Beach, & Jackson, 2002). More recently, multi-wave designs consisting of three or more repeated measures have emerged in order to model within-subject change, examine covariation between changes in relationship discord and psychopathology over time, and clarify reciprocal links between discord and symptoms. Research, including measures of both depression and marital distress across multiple occasions, demonstrates that decreases in relationship adjustment are associated with increases in depression (Davila, Karney, Hall, & Bradbury, 2003; Kouros, Papp, & Cummings, 2008; Whitton, Stanley, Markman, & Baucom, 2008). Further to the extent that relationship satisfaction is less stable over time, partners experience greater depression (Whitton & Whisman, 2010).

Time-lagged associations have also been investigated; however, results provide inconsistent support for a reciprocal link between relationship discord and depression. A recent study by Poyner-Del Vento and Cobb (2011) suggests that changes in marital satisfaction contribute to *subsequent* changes in depressive symptoms; however, the reciprocal association (depression → relationship discord) was not established and may only reach significance under high levels of stress, as evidenced by moderation analyses. In another study focused on time-lagged effects from one week to the next (over twelve weeks), relationship functioning did not contribute to subsequent depressive symptoms, nor did depression predict relationship functioning during the following week (Whitton et al., 2008).

Identifying Moderators

Efforts have been made to identify who is particularly vulnerable to the detrimental effects of relationship discord on mental health. Characteristics of the relationship, intrapersonal factors, and context all appear to contribute to the relative risk for depression associated with relationship discord. The impact of relationship distress on depression is greater for married couples than those who are cohabiting and have not married (Uebelacker & Whisman, 2006), and for couples who are more committed (Whitton & Kuryluk, 2012). Intrapersonal factors including insecure attachment (Scott & Cordova, 2002), blame-oriented attributions (Gordon, Friedman, Miller, & Gaertner, 2005), neuroticism (Atkins, Dimidjian, Bedics, & Christensen, 2009; Davila et al., 2003), co-rumination (e.g., "venting" as opposed to constructive problem-solving; Whitton & Kuryluk, 2013), and older age (Whisman, 2007) bolster the effect of relationship discord on depression. Context is also important, with a stronger association between relationship discord and depression observed for women living in poverty (Liu, Diego, & Chen, 2006). Further, as previously noted, covariation between marital dissatisfaction and depression is amplified to the extent that couples experience greater stress (Poyner-Del Vento & Cobb, 2011).

There has also been considerable debate and uncertainty about the role of gender in the link between marital discord and depression. Nonetheless, converging evidence suggests that women may not be more vulnerable to the effects of relationship discord (relative to men) as was once speculated (Whisman, 2012). A recent study by Whitton and Kuryluk (2013) suggests that perhaps the effect of relationship dysfunction on individual psychopathology does not vary as a function of gender, but instead as a function of *gender role identification*. Indeed, results from this study indicate that women are especially susceptible to the depressive effects of relationship

discord to the extent that they identify as more feminine.

Enhancing Specificity

Another area of growth has been in clarifying how relationships ultimately contribute to individual psychopathology by focusing on specific relationship processes (e.g., partner support). A marital discord model of depression (Beach, Sandeen, & O'Leary, 1990) suggests that when functioning is poor in a relationship (e.g., high levels of conflict) individuals are expected to experience elevated stress, and stress is a well-established risk factor for the onset or recurrence of individual psychopathology. Further, decreased positive interpersonal functioning (e.g., inadequate partner support) is expected to reduce one's ability to cope with and adapt to challenges, minimizing the potential protective function that relationships might serve. This framework highlights the importance of considering unique relational processes and clarifying their roles in individual psychopathology.

As previously discussed (see "Part 1: Risk Factors for Relationship Dysfunction") there has been a notable increase in attention to support processes in intimate relationships during the past two decades, and this has included examinations of how partner support impacts mental health. Consistent with a marital discord model, we might expect that support's primary function is to protect individuals from the detrimental effects of stress. However, a growing body of research suggests that the role of support in mental health may be more complicated than originally hypothesized. Indeed, research aimed at examining partner support as a moderator of the link between stress and depression has produced inconsistent results (Whisman, 2012). These discrepancies may arise from the complexity of support transactions which are dyadic, dynamic, and multifaceted. Indeed, there is evidence that if support does serve a stress-buffering function, it is *perceptions* of support, not observed support behaviors, that are essential (Beach, Fincham, & Katz, 1998). Further, supportive exchanges can consist of different types of behaviors ranging from advice giving to physical comfort, and support is provided in the context of different types of stress (e.g., acute traumatic events versus minor daily hassles). Different types of support may serve different functions in the context of different types of stress.

Partner support processes are complex, but emerging research sheds some light on the function of support in individual psychopathology. Indeed, research suggests that partner support may demonstrate both main effects and stress-buffering effects contingent on which facets of a transaction are investigated. In a recent study, *more frequent* support perceived by women during pregnancy mitigated the effects of prenatal maternal stress on subsequent depressive symptoms up to thirty months postpartum, whereas *adequacy* of support did not interact with stress but did demonstrate a significant direct effect on depression (Brock et al., 2014). Physiological measures of stress provide further evidence that partner support interacts with the stress process but suggest that the type of support matters. Partner support is associated with higher plasma oxytocin which plays a cardioprotective role in sympathetic activity and blood pressure (Grewen, Girdler, Amico, & Light, 2005). However, only physical contact with one's partner prior to experimentally induced stress contributes to less stress responsiveness (lower cortisol and less heart rate response), not verbal social support (Ditzen et al., 2007). Visibility of support may also determine the ultimate impact that partner support has on individual functioning. Indeed, research suggests that invisible support (i.e., support that is provided but *not* noticed by the recipient) may result in the best mental health outcomes (Bolger & Amarel, 2007; Bolger, Zuckerman, & Kessler, 2000; Shrout, Herman, & Bolger, 2006). It appears advantageous when partners can reap the benefits of support without the potential costs associated with noticing when they have been supported (e.g., reduced self-esteem or self-efficacy, perceived indebtedness).

Closer examinations of the specific aspects of relationship processes most influential to individual psychopathology are also emerging. This research has particular clinical relevance for identifying treatment targets and priorities (i.e., specific dyadic behaviors). For example, extensive

research demonstrates the direct effect of conflict and aggression on depression (Lawrence et al., 2012; O'Leary & Cano, 2001). However, recent efforts to delineate the nature of the link between conflict and individual dysfunction suggest that psychological aggression is actually more detrimental to mental health than physical aggression, contributing to greater escalation in depressive symptoms over time (Lawrence, Yoon, Langer, & Ro, 2009).

Capturing Broad Dimensions of Psychopathology

Rates of comorbidity are extremely high among mood and anxiety disorders, and a compelling body of research indicates that depression and anxiety actually represent manifestations of a higher-order class of disorders—referred to as the "internalizing" or "emotional" disorders (South & Krueger, 2008; Watson, 2005). Accordingly, researchers have started investigating the impact of relationship discord on broad dimensions of psychopathology as opposed to focusing on specific diagnoses. This has important implications for clarifying the scope of the impact of relationship dysfunction on mental health. Brock and Lawrence (2011) demonstrated that relationship dysfunction at the onset of marriage puts individuals at risk for higher levels of internalizing symptoms over the first seven years of marriage. Further, results of twin studies suggest that relationship dysfunction does indeed represent a broad liability for the spectrum of internalizing disorders as opposed to risk for a specific disorder (South, Krueger, & Iacono, 2011; South & Krueger, 2008). Emerging research (Burt & Donnellan, 2010; Humbad, Donnellan, Iacono, & Burt, 2010; South et al., 2011) also demonstrates the link between relationship dysfunction and the broad externalizing spectrum (i.e., substance-use disorders, conduct disorder, adult antisocial behavior).

Examinations of broad dimensions of psychopathology also have implications for the integration of couple research into existing frameworks of individual psychopathology. Marital distress is conceptualized as a form of stress that activates underlying genetic risk for internalizing psychopathology (South & Krueger, 2008). That is, adults with an innate risk for internalizing psychopathology are at even greater risk to the extent that they are in dysfunctional marriages. Researchers have also proposed that increased risk for internalizing disorders resulting from relationship dysfunction may be due to personality traits leading to both internalizing symptoms *and* relationship distress (e.g., South et al., 2011). Brock and Lawrence (2014b) provide some evidence in support of this supposition: individuals high in the personality trait neuroticism experienced greater marital dysfunction (i.e., less adequate partner support, lower levels of intimacy, poor conflict management, and less respect for autonomy of individual partners) and higher levels of internalizing symptoms. Nonetheless, relationship processes demonstrated incremental predictive utility beyond that of neuroticism, suggesting that intimate relationship quality plays a unique role in internalizing disorders. Further, for wives, the effects of non-marital stress on internalizing symptoms was no longer significant when accounting for dysfunction in the relationship, suggesting that relationship distress may represent a primary environmental pathway through which neuroticism contributes to individual psychopathology for women.

Additional Indicators of Mental Health

The majority of research on the role of intimate relationships in mental health has been focused on depression or substance abuse, and to some degree anxiety; however, researchers are expanding their focus to include other indicators of mental health and well-being. For example, relationship discord is associated with multiple indicators of functional impairment (e.g., social and work impairment; Whisman & Uebelacker, 2006). Better functioning in one's relationship appears to increase the likelihood that individual partners will utilize mental health care services (Schonbrun & Whisman, 2010). Finally, changes in relationship adjustment are positively associated with future life satisfaction, suggesting that promoting relationship functioning not only has the potential to prevent and treat psychological distress but also

promote overall quality of life (Stanley, Ragan, Rhoades, & Markman, 2012).

Relationship Dysfunction and Physical Health

There is considerable empirical evidence suggesting that relationship discord is a robust risk factor for a range of psychological disorders. Similarly, a compelling body of literature demonstrates the impact of intimate relationships on physical health (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Early research highlights the protective effects of marriage: married individuals are generally healthier than non-married individuals (Burman & Margolin, 1992). Further, coping with a chronic illness is less emotionally and physically burdensome when an individual is married (Morgan, 1980; Cutrona & Russell, 1990; Thomson & Pitts, 1992). For patients with cancer, being married is associated with a greater likelihood of survival (Goodwin, Hunt, Key, & Samet, 1987). Nonetheless, it is overly simplistic to conclude that marital status unequivocally promotes physical health. Indeed, an unhealthy relationship functions as a risk factor for a range of physical health issues. In particular, *dissatisfaction* with one's intimate relationship negatively affects physical health, having direct implications for physiological functioning including blood pressure (Brown, Smith, & Benjamin, 1998), heart rate and skin conductance (Stampler, Wall, Cassisi, & Davis, 1997).

Novel Developments in Research on Relationships and Physical Health

Within the past decade, research on the impact of intimate relationships on physical health has flourished. Similar to research on relationships and individual psychopathology, there has been an increase in research aimed at clarifying how relationships ultimately impact health. Much of this research has been based upon one of two established models that, similar to a marital discord model of depression, suggest that certain aspects of relationships function as interpersonal stressors whereas others serve a protective function in the context of stress. Specifically, the main effect model posits that certain aspects of a relationship have direct effects on physical health (Burman & Margolin 1992). In contrast, the stress-buffering model postulates that positive interpersonal processes (e.g., social support) function as buffers in stressful situations (Cohen & Wills, 1985).

Numerous relationship processes appear to have main effects on physical health. High levels of hostility in intimate relationships are associated with greater calcification in the arteries surrounding the heart (Smith et al., 2007), and increased activity in the endocrine system (Malarkey, Kiecolt-Glaser, Pearl, & Glaser, 1994). Women who inhibit their emotions during conflict interactions are at four times the risk for mortality compared to women who express themselves (Eaker, Sullivan, Kelly-Hayes, D'Agostino, & Benjamin, 2007). Further, individuals experiencing a myocardial infarction, who also report high rates of disclosure in their relationships, are significantly less likely to experience pain or hospitalizations after the initial incident (Eaker et al., 2007).

Relationship processes also serve important protective functions in the context of stress. A great deal of research has been devoted to examining the individual stress response (Lazarus & Folkman, 1984), and results demonstrate the adverse consequences of stress for physiological functioning (see review by Lupien, McEwen, Gunnar, & Heim, 2009). Under stressful conditions, individuals in intimate relationships are most likely to turn to their romantic partners for support to facilitate coping efforts (Bodenmann, 1995). As previously discussed (see "Part 1: Risk Factors for Relationship Dysfunction"), Bodenmann and colleagues recognize a process that unfolds between intimate partners when one or both partners is directly exposed to stress (i.e., dyadic coping). To the extent that dyadic coping is successful, not only will the relationship be protected from the deleterious effects of stress, but also the health of each individual partner will be preserved. Research focused on a critical element of dyadic coping—*partner support*—suggests that relationships do indeed serve critical stress-buffering functions. For example, Ditzen and colleagues (2007) found reduced cortisol and

heart rate reactivity in response to a stressful task in couples who were placed in a physical contact intervention (i.e., couples were instructed to provide non-sexual massages). Similarly, Robles, Shaffer, Malarkey, and Kiecolt-Glaser (2006) found that the positive behaviors of a husband predicted endocrine responses in the wife during an experimentally induced conflict interaction; after accounting for marital satisfaction, the amount of negative conflict predicted flatter slopes in cortisol and adrenocorticotropic hormone (ACTH) in wives.

Chronic Illness

Intimate relationships can function to protect the physical health of individual partners in the context of stress, and one particular type of stress directly related to physical health—*chronic illness*—has been widely examined. When the diagnosis of a chronic illness occurs, a couple is faced with numerous challenges including making choices regarding treatment, adjusting responsibilities to account for new limitations experienced by the ill partner, and coping with the reality of a potentially lifelong and sometimes life-threatening condition (Berg & Upchurch, 2007). Roberts, Black, and Todd (2002) found that in the case of cancer, couples are not only faced with coping with the diagnosis and treatment, but also must live with uncertainty about possible recurrence of cancer after remission. Berg and Upchurch (2007) proposed a *developmental-contextual model* that conceptualizes how couples cope with chronic illness. The model posits that the diagnosis of a chronic illness affects both partners, not just the person who is diagnosed with an illness. The model includes multiple elements contributing to how well a couple adjusts, including how the illness is perceived (e.g., individual or shared experience), navigation of shared stressors arising from the presence of the chronic illness (e.g., financial burdens of treatment or adjustments in household care duties), involvement and collaboration of each partner in managing the illness (e.g., how the couple negotiates the role of caretaker, how the couple copes with the emotional burden; Revenson, 1994), and control processes (e.g., the extent to which the couple perceives loss of control over managing the illness and experiences uncertainty about the prognosis; Kuijer et al., 2000). (See Berg and Upchurch, 2007 for a comprehensive review of this research.) In general, the extent to which couples cope collaboratively with a chronic illness (e.g., diabetes, autoimmune disorders, heart disease, or cancer) is associated with better physical outcomes for the partner diagnosed with the illness (e.g., Badr, 2004; Berg, et al., 2008).

Researchers have examined specific dyadic behaviors in the context of chronic illness, and the extent to which couples engage in more positive and less negative interactions appears to have important implications for the health of the chronically ill partner. For example, in a sample of women with rheumatoid arthritis, positive dyadic interactions were predictive of better health (e.g., less T cell activation, lower clinical ratings of disease severity) whereas negative interactions were associated with disease flares (Zautra et al., 1998). The prolonged course of chronic illness and corresponding fluctuations in dyadic coping have also been studied longitudinally, and results suggest that communication about prognosis and management of the chronic illness is critical for preventing partner burnout (Fang, Manne, & Pape, 2001; Helgeson, Snyder, & Seltman, 2004). Cohesion (i.e., emotional bonding among family members) also protects against the stress of a cancer diagnosis within the family unit (Baider, Koch, Esacson, & De-Nour, 1998). The extent to which couples use the pronoun *we* when discussing an illness also appears to have a positive impact on physical health over time (Rohrbagh, Mehl, Shoham, Reilly, & Ewy, 2008).

Global relationship satisfaction also appears to be significant in the context of physical illness. Women experiencing chronic pain from osteoarthritis or fibromyalgia report adaptive changes in physical functioning and greater positive affect to the extent that they are in more satisfying relationships (Zautra, Johnson, & Davis, 2005). Women who report satisfying marriages also have fewer markers of active inflammation following periods of stress (Zautra et al., 1998). Recent research with males with acute coronary syndrome also demonstrates the role

of relationship satisfaction in promoting adjustment to a new diagnosis (Dekel et al., 2013).

In sum, broadly promoting adaptive relationship functioning and global relationship satisfaction appears critical for couples coping with chronic illness. As the medical field continues to advance, the life expectancy of most individuals living with a chronic illness increases, requiring prolonged periods of coping that might deplete resources over time and put considerable strain on intimate relationships. Future research aimed at understanding how to help couples navigate the numerous challenges that arise when one partner is living with a chronic illness has important implications for understanding stress processes in couples and the effects of intimate relationships on physical health.

Clinical Implications of Research on the Role of Intimate Relationships in Mental and Physical Health

Relationship dysfunction is a general risk factor for a broad range of mental health problems including dimensions of both internalizing and externalizing disorders, in addition to other indicators of individual well-being such as level of functional impairment and life satisfaction. Further, relationship functioning has important implications for physical health and well-being. Taken together, this body of research suggests that it is insufficient to treat individuals in isolation of their intimate relationships, and that interpersonal treatment components may be an essential adjunct to individual-based clinical interventions.

Whisman and Baucom (2012) proposed a framework for understanding how individual problems can be best addressed through targeting dyadic functioning, recognizing that a partner can be an important part of the treatment process even if a couple is not experiencing notable relational distress. They propose different types of interventions with varying degrees of partner involvement. *Partner-assisted interventions* involve the partner adopting a supportive role to help the partner who is undergoing treatment to make the changes necessary to promote improvement. The target of the treatment is the individual dysfunction, not relationship distress. *Disorder-specific interventions* involve targeting dysfunctional relationship processes, but only to the extent that they are directly related to the disorder for which one partner is seeking treatment. Finally, *couples therapy* may be implemented as an adjunct to individual treatment when there are multiple areas of dysfunction in the relationship and/or when relationship dysfunction is severe. Any combination of these types of interventions might be indicated for a particular client. (See Whisman & Baucom, 2012, for a detailed discussion of these interventions and guidelines for selecting appropriate interventions.)

Emerging research has also clarified who might benefit from relationship-focused interventions by examining moderators of the link between relationship discord and individual psychopathology. Aspects of the intimate relationship (e.g., low levels of commitment), intrapersonal variables (e.g., insecure attachment, neuroticism, gender role identification), and contextual factors (e.g., higher levels of stress) all appear to bolster the effect of relationship discord on individual psychopathology. Further, research aimed at identifying specific dyadic behaviors putting individuals at risk for mental health problems emphasizes the importance of considering multiple relationship processes in both couple and individual-based interventions. Focusing exclusively on processes traditionally viewed as distressing, such as conflict, is insufficient.

Research on the role of intimate relationships in physical health suggests that routinely assessing intimate relationship functioning, and targeting dysfunctional relationship processes, may be a critical element of treatment for individuals diagnosed with chronic illness. In particular, there is compelling evidence that emotional disclosure and effective communication have important implications for adapting to the stress of a chronic illness as a couple. Encouraging open discussion about concerns and fears in the face of a chronic illness, and encouraging supportive responses, may promote dyadic coping for navigating this potentially lifelong stressor. Couple assessments and interventions have been developed for application in the context of chronic

illness. For example, Arden-Close and colleagues developed the Couples' Illness Communication Scale (CICS; Arden-Close, Moss-Morris, Dennison, Bayne, & Gidron, 2010) to measure communication about chronic illness. This assessment tool may be useful for determining how well a couple is communicating about an illness, and facilitating a more productive discussion when communication is impaired.

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22.

INTEGRATING RESEARCH AND PRACTICE THROUGH INTERVENTION SCIENCE

New Developments in Family Therapy Research

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Introduction

Family therapy is a distinct clinical process with a systemic focus that calls for complex research and statistical tools to capture the multidimensional and relational nature of therapeutic change. Despite the challenges of studying family therapy, research has produced substantial evidence about the clinical utility of family-based programs (Sexton, Robbins, Hollimon, Mease, Mayorga, 2003; Sexton, Datchi, Evans, Lafollette, Wright, 2013; Sprenkle, 2012). Family therapy science has evolved from a focus on the efficacy and effectiveness of the broad modality of family therapy to the study of specific interventions and treatment models and the mechanisms that produce positive outcomes in "real-life" clinical settings. Similarly, clinical practices (techniques, interventions, and treatment programs), which are the object of intervention research, have progressed from "schools" of therapy to specific, systematic, and well-articulated evidence-based clinical models that add to the core common factors of any good family therapy. Even our current research methodologies have advanced to a level where it is possible to describe the unique interplay between clinical presenting problems, therapeutic factors, demographic variables, and model-specific change mechanisms (Sexton, 2007; Sprenkle, Davis, & Lebow, 2011). Liddle, Bray, Levant, and Santisteban (2002) call this evolution the emergence of "family intervention science": a knowledge base of clinical expertise and a growing body of outcome and process studies that meet the highest standards of research methodology.

Current family therapy intervention research focuses on the efficacy and effectiveness of well-identified treatment techniques and intervention programs, the underlying processes of change, and the factors that moderate the effects of treatment, in order to refine clinical protocols and improve practice. More recently the scope of intervention science has expanded to include knowledge gained from translational studies about the implementation of treatment models in clinical settings and the better ways to match organizational and service delivery needs while replicating interventions and models with fidelity and producing consistently good outcomes.

Just as in education, medicine, and psychiatry, evidence-based practices have become the gold standard in psychology, and treatment guidelines are one of the most recent attempts to bring science into practice (Hollon et al., 2014). These guidelines make research on family therapy intervention a central part of clinical practice. However, at the same time

as evidence-based guidelines become more prevalent, there is a healthy and growing skepticism regarding research and its relevance to clinical practice. Many practitioners remain cautious about the applicability of research findings to complex and unique client situations, and they have been slow in adopting research-based programs that they often perceive as cookie-cutter interventions. Likewise, many academic programs remain committed to traditional broad theories of family therapy rather than interventions supported by current research. Research reviews, like this one and others, are often intended to bring together the diverse and expansive scientific knowledge and to identify the most useful family therapy clinical practices. Unfortunately, research reviews have uneven methods that make difficult the comparison of findings and the direct application of themes and recommendations.

About the Chapter

This chapter reviews systematic research and meta-analytic reports published since 2003. Our goal is to describe the current state of knowledge about the effectiveness of family-based interventions that target a wide range of clinical problems, and to address three critical questions: What family-based treatment programs work for a wide variety of clinical problems? What is their level of specificity and what is the strength of the evidence? And what are the common mechanisms of change? Our focus is on efficacy and effectiveness rather than process studies (see Friedlander, Heatherington, and Escudero in Chapter 23 this volume) and on interventions, outcomes, and the demonstrated mechanisms that have been linked to those outcomes. Rather than organizing information by interventions and treatment models, we decided to present the research findings from a clinical point of view. This means we first identified the clinical problems—the symptoms or syndromes that are likely presented to the family therapy clinician. Then we organized the information according to the category of individual and relational disorders that family-focused interventions and programs are intended to resolve. This chapter includes a discussion of the family processes that accompany specific psychopathology and how systemic therapies attend to problematic family interactions. This method of providing information is consistent with that of recent guideline development templates (NICE, 2009; Hollon et al., 2014). Last, this chapter examines current issues in the dissemination of evidence-based family therapy programs and identifies existing or yet-to-come strategies that may promote research utilization in everyday practice.

There are a number of issues to acknowledge at the outset. Any review of the research on family therapy evokes the tension between the practice and science perspectives. This tension is part of the art vs. science or research vs. clinical experience debate. For example, there is still uncertainty about the "validity" of psychological research particularly in regard to its application to therapy. The emerging consensus is that best practice requires both specific interventions and core common therapeutic factors such as the therapeutic relationship (APA, 2006; Sexton et al., 2011). In fact, there are a number of evidence-based treatments in family therapy with a systematic clinical program and specific clinical interventions that can be described, taught to practitioners, and reproduced with a high probability of successful client outcomes. Yet, even the outcomes of the most successful evidence-based treatment depend on a combination of factors: the nature of the clinical interventions that constitute the treatment, the therapist's implementation of these interventions, and the relational and service delivery context in which the treatment is implemented. Consequently, our belief is that the best couple and family treatments are those that are both scientifically sound and clinically relevant.

Finally, in this review we focus exclusively on family-based treatments and the clinical problems for which they are successful. Family-based treatments are broader than traditional family therapy interventions and include parenting programs. We chose this broader and more inclusive category to enhance clinical utility and recognize that in community-based practice there are many different treatment modalities available.

Interventions, Models, and Levels of Evidence in Family Therapy Research

Finding clinically useful information from a large number of studies, systematic reviews, and meta-analyses can be daunting. To establish both the reliability and the validity of purported evidence-based treatments, it is necessary to evaluate the research in a way that goes beyond the standards of sound methodology, and to look at the accumulated evidence as well as the context and the clients for whom the findings of those research studies apply. To be clinically relevant, and thus more likely to be successfully translated into practice, the cumulative research evidence should come from diverse studies about clients, change mechanisms, and varied relational outcomes.

Figure 22.1 illustrates the theoretical framework—the interaction between level of evidence and treatment specificity—we used to organize the following review. On one side of the diagram are the various levels of treatment specificity. *Replicable and identifiable clinical interventions* are the mindful, intentional actions of therapists, engaged in a clinical context, with the express purpose of improving the client's functioning across domains (Sexton et al., 2013). Interventions vary according to their type (e.g., therapeutic, curricular), their focus (e.g., skills building), their specificity (manual vs. theory vs. general practice), the populations they serve (children, adolescents, families, couples) and the clinical problems they are designed to address. *Treatment models* are comprehensive clinical intervention programs that target clinically meaningful syndromes with a coherent conceptual framework that underlies model-specific clinical interventions. These model-specific interventions are described in sufficient detail to explain the specific actions and therapist qualities necessary to carry them out. The most reliable clinical intervention programs also have research to support *within-model change*

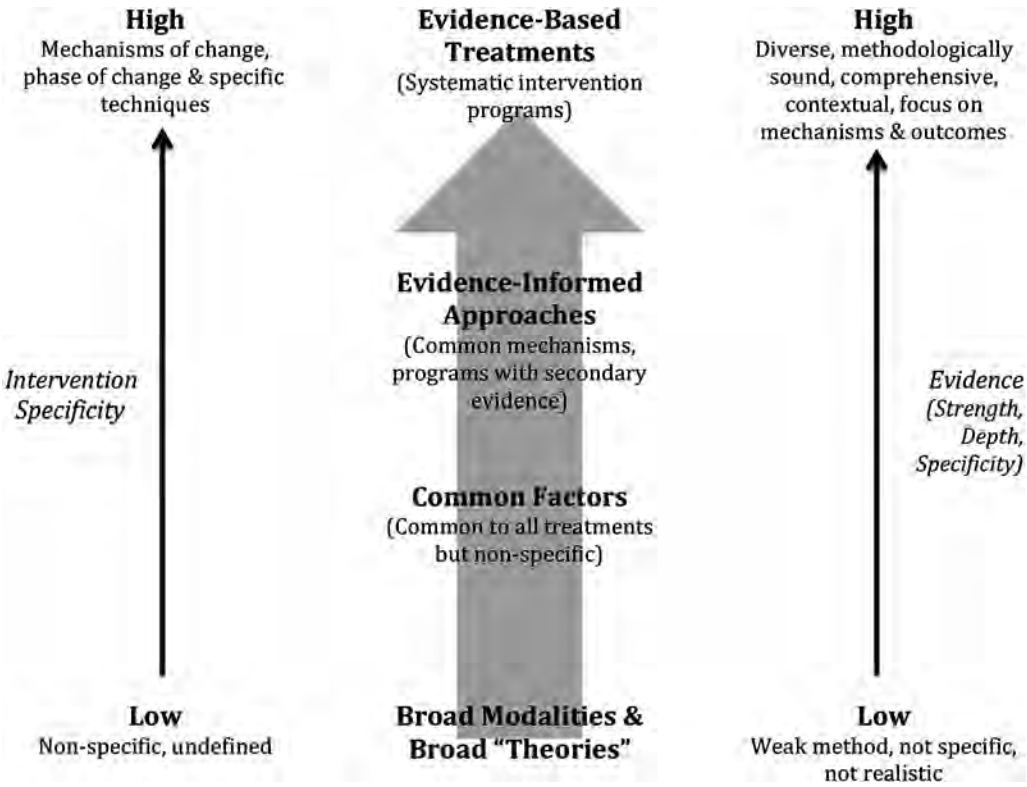

Figure 22.1 Specificity of evidence and intervention

mechanisms. Clinical intervention programs are frequently composed of a variety of specific clinical change mechanisms.

On the other side of the figure are the various levels of scientific evidence for the clinical intervention programs. Evidence needs to be *consistent, strong, and reliable*. Typically, the strength of the evidence is evaluated based on the methodological rigor of the studies. Alas, determining what works is more complex and depends on the accumulation of evidence across different studies, clients, and contexts. The evidence should result from *high-quality yet diverse research methodologies*. High-quality studies of family therapy should include clear specifications regarding the elements of the treatment model or intervention (e.g., manual) and the measures of treatment fidelity (e.g., therapist adherence or competence) with a diversity of clients and clinical problems.

Effectiveness of Family-Based Interventions

It is now well accepted that family therapy as a whole produces superior outcomes to no treatment for a variety of problems, and that it is at least as effective as alternative therapies, including individual counseling and group therapy (Sexton et al., 2013; Shadish & Baldwin, 2003; Baldwin, Christian, Berkeljon, Shadish, & Bean, 2012). Many reviews have produced strong evidence in support of the efficacy of couple and family interventions (Beck, 1975; Gurman, 1971, 1973, 1975; Gurman & Kniskern 1981, 1991; Sexton et al., 2013). Previous meta-analyses have shown that family therapy generally is effective for treating many kinds of clinical disorders, including alcoholism, schizophrenia, drug abuse, and conduct problems (Shadish & Baldwin, 2003). Earlier reviews have also identified specific treatment programs that have strong, reliable research suggesting potential positive outcomes for clients. For example, Sexton and colleagues (2003) identified five family-based intervention programs that had significant research evidence: Functional Family Therapy (Alexander et al., 2000; Sexton, 2010), Multisystemic Therapy (Henggeler, Cunningham, Schoenwald, Borduin, & Rowland, 2009), and Brief Structural Strategic Therapy (Szapocznik & Hervis, 2004) for youth behavior and drug abuse problems; Family Psychoeducation for schizophrenia; and Behavioral Family Systems Therapy for eating disorders. Sexton and colleagues (2003) concluded that family therapy interventions had effects substantial enough to suggest they be primary treatment options for child and youth behavior problems, substance misuse, eating disorders, and the management of schizophrenia (Sexton et al., 2003).

More recently, Sexton and colleagues (2013) did a systematic review of the family therapy research over the last decade, and found a significant breadth in the research that reflects current clinical needs and interests. They looked at 205 family studies and found that most of them (81.5%) were about systematic intervention programs while 18.5% were about single interventions not directly linked to a comprehensive treatment program. They also found that 66% of the studies were about family-focused interventions or family therapy and 34% were about parenting. These studies evaluated the process and/or outcomes of family therapy (39%), psychoeducational interventions (30%), and group-based family work (24.9%). In most studies, the family-focused interventions and programs involved the family (40.3%), the parents (30.6%), or a combination of the parents, the youth, and the family at different time points over the course of treatment (18.9%). Adolescents were the primary target of the intervention or program (40%).

The 205 studies reviewed by Sexton and colleagues (2013) examined the effects of treatment on twenty-six distinct clinical problems, among which four emerged as the primary focus of the research: youth behavior problems (40%), general mental health (3.4%), parenting (4.4%), family relationships (3.9%), and schizophrenic symptoms (3.4%). In their analysis, Sexton and colleagues (2013) found that 46% of the research (including studies of parenting programs) produced significant findings that support the effectiveness of family-focused interventions, 43.4% had mixed results, and 10.2% found that family-focused interventions did as well as the alternative treatment in the study. No studies

reported iatrogenic outcomes. It is clear that family-focused interventions and programs are effective but that their success depends on moderating factors, informants' perspective, and the measures used to capture client outcomes.

In the following sections we discuss the results of our research review and organize the information by categories of clinical problems that are the main focus of family therapy research. First we examine the evidence that has accumulated regarding the positive outcomes of specific family-focused treatments relative to alternative therapies as well as advances in the adaptation of empirically supported systemic interventions for mood disorders, anxiety, eating disorders, and chronic illness. We look at the research on common change mechanisms in a subsequent section.

Psychiatric Disorders

Relationship research has begun to identify the characteristics of the family environment that contribute to individuals' increased vulnerability to mental illness (Beach, Wamboldt, Kaslow, Heyman, & Reiss, 2006). In particular, expressed emotion (EE), the degree to which family members show hostility and criticism and are emotionally preoccupied with the mentally ill, is a well-known factor in the recurrence of depressive, manic, and psychotic episodes (Hooley, Miklowitz, & Beach, 2006). EE is an environmental stressor that interacts with individual genetic vulnerability and increases the likelihood of relapse. It describes the reciprocal process of negativity in family interactions: psychiatric symptoms force changes in family relationships that may result in interpersonal difficulties; in turn, relational conflict influences the course of mental disorders.

Family-based programs target the relational processes that play a significant role in the development and maintenance of psychopathology. They include family psychoeducation and family therapy interventions that are either the treatment of choice in the case of youth delinquency and substance abuse, or an essential adjunct to pharmacology in the case of schizophrenia and bipolar disorder. The sections that follow report what is known about mental illness, relational processes, and the outcomes of family therapy as related to specific mental disorders in childhood, adolescence, and adulthood.

Schizophrenia

Family expressed emotion (EE) and communication deviance (or lack of clarity and structure in communication) are well-established risk factors for the onset of schizophrenia (McFarlane, 2006). As such, they are the focus of psychoeducational interventions that aim to increase family members' understanding of the disorder and their ability to manage the positive and negative symptoms of psychosis (Lucksted, McFarlane, Downing, Dixon, Adams, 2012). Family psychoeducation (FPE) recognizes the reciprocal influence of individuals and their family, and targets how family members respond to patients' progress and support medication adherence and recovery (McFarlane, Dixon, Lukens, & Lucksted, 2003). Family EE, in particular, is both a reaction and an environmental stressor that increases the probability of relapse. Prior reviews indicated that FPE was successful in postponing the recurrence of psychotic episodes and in reducing relapse rates by more than 50% compared to routine care (Sexton et al., 2003; McFarlane et al., 2003). Recent reports confirm the effectiveness of psychoeducational interventions as an adjunct to pharmacology in diverse cultural contexts, and define FPE as an evidence-based practice in the treatment of adult schizophrenia (Bird et al., 2010; Carr, 2009a; Lucksted et al., 2012; McFarlane et al., 2003; Patterson & Leeuwenkamp, 2008). FPE comprises a variety of programs that share critical elements yet differ in intensity, duration, and formats—single family, multiple families, and relatives only with or without the patient (McFarlane et al., 2003). In general, these evidence-based programs emphasize family resilience, last at least six months, and address families' need for education, crisis intervention, skills training, and emotional support. Newer research has shown that the benefits of FPE included improved family well-being and patient's social functioning, reductions in negative symptoms, and cost savings (Lucksted

et al., 2012). However, there still are questions about the long-term maintenance of these effects beyond termination, and findings suggest that FPE delays but does not prevent rehospitalization (Patterson & Leeuwenkamp, 2008).

Bipolar Disorder

Bipolar disorder (BD) is a severe emotional disorder characterized by manic and depressive symptoms, and its primary treatment is pharmacotherapy for mood stabilization (Carr, 2009a). The effects of medication, however, are significantly enhanced when patients and their relatives participate in family-based psychoeducation programs designed to reduce the negative family interactions that develop around the disorder. Qualitative reviews have identified three effective psychosocial interventions for adults, adolescents, and children with bipolar disorders. *Family Focused Therapy* for bipolar disorder (FFT-BD) is an effective treatment program for adults and their close relatives. Delivered by a therapist in approximately twenty sessions, the treatment aims to increase knowledge about the disorder, enhance communication and problem solving, and decrease high expressed emotions in family interactions. There is strong empirical evidence that FFT-BD reduces the recurrence of depressive and manic symptoms and the need for rehospitalization. Miklowitz and Scott (2009) reviewed the findings of three randomized controlled trials where FFT-BD was compared to individual therapy, brief psychoeducation, or crisis management plus pharmacotherapy in the treatment of adults and adolescents with bipolar disorder. The outcomes of FFT-BD were superior to the effects of the alternative treatment in three domains: medication adherence, severity of symptoms, and relapse. For adolescents, the results were mixed: participation in FFT-BD led to improvements in youth depressed state, but did not bring about change in youth manic symptoms.

There are two promising programs for the treatment of children with bipolar disorder. The *RAINBOW Program* is a family-focused cognitive-behavioral intervention adapted from the Family Focused Therapy model for children age 8 through to 12. The results of randomized controlled trials suggest that this program has positive effects on children's global functioning, aggression, and symptoms of bipolar disorder and ADHD. *Multi-Family Psychoeducation Group* (MFPG) is an alternative to individual family treatment for children with unipolar and bipolar depression (Miklowitz & Scott, 2009; Young & Fristad, 2007). Parents and children receive treatment in separate but concurrent groups where they gain support from other members, increase their knowledge of the disease, and develop effective symptom-management and problem-solving skills. In addition, parents learn to advocate for the mental health needs of their children. A pilot study of MFPG produced promising results about the effectiveness of this intervention compared with waitlist and pharmacotherapy alone (Miklowitz & Scott, 2009; Young & Fristad, 2007). In particular, the findings suggest that MFPG had positive effects on family interactions, and delayed rehospitalization.

Depression

Family conflict and rejection, low family support, ineffective communication, poor expression of affect, abuse, and insecure attachment bonds are relational processes associated with depression (Beach & Whisman, 2012; Bernal, Cumba-Avilés, & Sáez-Santiago, 2006). For example, depressed adults are more likely to use ineffective parenting strategies and to experience parent–child conflict. In turn, these relational difficulties increase parents and adolescents' disposition toward depressive episodes. There is empirical support for the success of family therapy and parenting programs in the treatment of youth and parental depression (Beach & Whisman, 2012; Paz Pruitt, 2007). In particular, research findings suggest that *Attachment-Based Family Therapy* (ABFT) and *Systems Integrative Family Therapy* (SIFT) are effective approaches (Diamond & Josephson, 2005; Paz Pruitt, 2007; Trowell et al., 2007). ABFT aims to decrease adolescent depressive symptoms and suicidal ideation through the resolution of family conflict and the promotion of securely attached relationships between youths and their parents. In two randomized controlled

trials, depressed youths who participated in ABFT fared better at termination and follow up than peers who received minimal contact or referrals to other mental health providers (Diamond et al., 2010; Kaslow, Robbins Broth, Oyeshiku Smith, & Collins, 2012; Paz Pruitt, 2007). Similarly, the results of a RCT conducted in Europe indicated that SIFT was effective in reducing childhood depression, but was not superior to psychodynamic individual therapy. A total of 81% of the participants in SIFT no longer met the criteria for clinical depression six months after the end of treatment (Trowell et al., 2007).

Parenting programs for unipolar depression are interventions that aim to reduce parenting stress, improve the family's ability to manage depressive symptoms and support remission through parent training. Behavioral parent training, in particular *Triple P-Positive Parenting Program*, has been associated with reduced levels of maternal depression at termination and follow up (Beach & Whisman, 2012). In addition, parent training has been successfully combined with cognitive-behavioral and interpersonal interventions for depression. Together these treatments have produced improvements in parental mood states and child behaviors.

Anxiety

Family-based treatment for anxiety combines family therapy with cognitive-behavioral interventions (CBT), and targets the characteristics of the family environment that support adults and children's anxiogenic beliefs and avoidant behaviors. Specifically, the goal is to disrupt the interactional patterns that reinforce the disorder and to assist family members in using exposure, reward, relaxation, and response prevention techniques to extinguish the patients' fears (Carr, 2009a; Diamond & Josephson, 2005). This combined approach (Family Cognitive-Behavioral Therapy, FCBT) has produced greater rates of remission than individual CBT alone for children and adolescents diagnosed with Social Anxiety Disorder, Generalized Anxiety Disorder and Obsessive Compulsive Disorder, when parents were also anxious (Diamond & Josephson, 2005; Kaslow et al., 2012). FCBT was as effective as individual CBT when parents did not have anxiety; however, new research findings suggest that differences in outcomes depend on measurement, with parents in FCBT, but not children, reporting greater improvements than parents in individual CBT (Kaslow et al., 2012). Remission rates for FCBT ranged from 75% to 96%, and gains were maintained at one-year follow-up. Empirical evidence also suggests that group-based FCBT is as effective as traditional FCBT in the treatment of childhood and adolescent anxiety, and that the positive effects of FCBT generalize to comorbid symptoms, both internalizing and externalizing.

Eating Disorders

In the past decade, family-based interventions have emerged as treatments of choice for younger adolescents with Anorexia Nervosa (AN). AN is associated with severe psychological impairment and medical complications, including cognitive distortions, refusal to eat, bradychardia, osteoporosis, and death (Lock, 2011; Lock & Fitzpatrick, 2007). Typically, AN develops during adolescence at about age 15, and is best addressed in the context of family interactions, in particular, parents' efforts to help their child regain and maintain a healthy weight. Early systemic interventions (i.e., Structural Family Therapy) targeted the dysfunctional family processes, namely, enmeshment and over-protectiveness, which were seen as the cause of disordered eating. Recent developments in family therapy have challenged the view that the family is the cause of the problem, and emphasized the importance of involving parents in the therapeutic process. The *Maudsley Method*, in particular, is a family-based model designed to help parents build effective and developmentally appropriate strategies for promoting and monitoring their child's eating behaviors. Treatment is delivered in three phases wherein responsibility for weight management gradually shifts toward the youth in and out of the home setting. It also includes a focus on developmental processes and family changes associated with adolescence (Lock & Fitzpatrick, 2007; Smith & Cook-Cottone, 2011). Qualitative reviews of family therapy studies suggest there is inconsistent support for the efficacy of the Maudsley Method, also called

Family-Based Treatment (FBT; Diamond & Josephson, 2005; Kaslow et al., 2012; Lock, 2011). Small sample sizes and variations in treatment protocol are limitations that make it difficult to draw firm conclusions about the superiority of FBT for AN (Smith & Cook-Cottone, 2011). However, the evidence indicates that FBT is linked to greater weight gain and menstrual functioning and lower relapse and hospitalization rates compared with individual therapy. A recent randomized controlled trial showed that FBT had higher remission rates than individual therapy at one-year follow-up but not termination (Lock et al., 2010). In addition, treatment delivery methods have been found to moderate the success of FBT: families with higher levels of maternal criticism achieved better outcomes in separate parent–child sessions compared with conjoint family sessions (Kaslow et al., 2012). Family therapy research has begun to explore the clinical utility of FBT for bulimia nervosa; to date, the results have been mixed (Lock, 2011).

Childhood Disorders

Empirical evidence has accumulated to confirm that behavioral parent training has positive effects on childhood behavior problems associated with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD; Diamond & Josephson, 2005; Kaslow et al., 2012; Roberts, Mazzucchelli, Taylor, & Reid, 2003; Sexton et al., 2013). Contemporary research has established the success of three family-focused programs: *Parent-Child Interaction Therapy* (PCIT), *Triple-P*, and *Incredible Years* (IY) are evidence-based manualized interventions for pre-adolescent children. Their primary focus is the development of effective parenting and contingency management strategies that will disrupt the problematic family interactions associated with ADHD and ODD. Sexton and colleagues (2013) examined the quality of recent investigations and noted the evidence was strong for the superiority of parent training interventions, in particular PCIT, to alternative treatments. Overall 60% of individuals who participated in these programs reported improvements in their child's behaviors, compared with 40% in the control group (Sexton et al., 2013). New studies have found that the positive effects of PCIT, IY, and Triple-P were maintained at two- to three-years follow-up (Kaslow et al., 2012). Given the well-established effectiveness of these models, research has now focused on their cultural adaptation and international dissemination. Kaslow and colleagues (2012) identified one recent randomized controlled trial of IY. This study highlighted the moderating influence of client factors on the program outcome. Specifically, IY produced reductions in oppositional behaviors for children with greater baseline problems.

Studies of parent training for autism spectrum disorders (ASD) constitute a new development in family therapy research (Kaslow et al., 2012). Family-based interventions for ASD involve parent education and coaching: parents are the primary medium through which treatment influences the behaviors of children with ASD; they learn to use communication and social training tools that are adapted to the needs of their children, and apply these techniques to their family interactions at home. There is some preliminary evidence that parenting programs enhance the social competencies of toddlers with autism (Kaslow et al., 2012). However, more research is needed to establish their clinical utility for childhood developmental disorders. Qualitative reviews also suggest that parent training is beneficial for families of children with sleeping, feeding, and attachment problems (Carr, 2009b).

Chronic Illness

Cancer, diabetes, neurological, and cardiovascular diseases are chronic medical problems that impact both individual and family functioning (Linville, Hertlein, & Prouty Lyness, 2007; Shields, Finley, Chawla, & Meadors, 2012). Patients and relatives must learn to cope with the challenges of chronic illness, including physical and emotional suffering, and manage the burden of caregiving. *Medical Family Therapy* (MedFT) is an emerging subspecialty of family therapy that offers a biopsychosocial systems approach to medical care and emphasizes interdisciplinary collaboration between family therapists

and physicians (Linville et al., 2007). MedFT is intended to address the medical and psychological needs of both patients and families, to enhance family emotional support in the management of the chronic illness, and to examine the impact of the disease on family relationships as well as the influence of family dynamics on physical health (Carr, 2009a; Linville et al., 2007). Qualitative reviews of MedFT studies indicate that family-based interventions for medical problems have the potential to improve health behaviors, decrease caregiving burden, depression and anxiety, and reduce health care utilization (Carr, 2009a; Hodgson, McCammon, & Anderson, 2011; Linville et al., 2007). For example, research has shown that cancer patients who participated in brief manualized family-based interventions were less likely to report hopelessness and negative thoughts about the illness compared with individuals receiving usual care (Hodgson et al., 2011; Tyndall, Hodgson, Lamson, White, & Knight, 2012). However, the findings also indicate that the positive effects of MedFT are inconsistent across investigations and across categories of physical illness (Shields et al., 2012; Tyndall et al., 2012). Tyndall and colleagues (2012) point out that further developments in the study of MedFT effectiveness will require a clear and agreed upon description of the boundaries and competencies that define the subspecialty. In addition, it will be essential to further specify MedFT intervention programs, their mechanisms of change, and the parameters of their implementation, in order to gather solid evidence about their clinical utility relative to alternative treatments. This may involve the adaptation and integration of specific evidence-based family programs into healthcare practice, such as *Multisystemic Therapy* (MST) and *Behavioral Family Systems Therapy* (BFST) for child and adolescent diabetes. Shield and colleagues (2012) report that adapted versions of MST and BFST have produced positive health outcomes. Specifically, improvements in family relationships and parent monitoring led to increased treatment adherence and glycemic control for families that participated in family therapy; and the effects of BFST were maintained up to eighteen months post-termination. While in the beginning stages of its conceptual and empirical development, MedFT has shown the value of integrating family therapy into medical care, it is also proof that family therapy is a dynamic field with many potential applications.

Substance Misuse

Drug and alcohol misuse are chronic problems that produce stress in family relationships and impact individual and relational functioning, including physical and psychological health, financial hardship, parenting difficulties, and children's social and emotional development (Copello, Templeton, & Velleman, 2006; Rowe, 2012; Templeton, Velleman, & Russell, 2010). At the same time, problematic family processes such as conflict and disengagement influence the onset and course of drug and alcohol problems and the outcomes of substance abuse treatment. The reciprocal influence between family factors and drug and alcohol misuse makes it necessary to intervene at both the individual and the relational level, in order to: a) enhance the coping ability of family members and reduce the negative consequences of alcohol and drug abuse on concerned relatives; b) eliminate the family factors that constitute barriers to treatment; c) use family support to engage and retain the drug and/or alcohol user in therapy; and d) change the characteristics of the family environment that contribute to relapse (O'Farrell & Clements, 2012; Rowe, 2012).

Family therapy approaches have long been considered one of the viable treatment interventions for adolescent and adult drug abuse. Drug abuse is difficult to single out as a sole clinical problem because it often occurs as a complex profile of externalizing behavior disorders (e.g., drug use, delinquency, risky sexual behaviors) and related family and individual psychological problems. Particularly in the areas of adolescent drug problems, many of the programs with proven efficacy for conduct disorders are also useful for the specific issues of adolescent drug use and abuse.

Youth Substance Use Problems

Both meta-analytic and individual clinical studies indicate that family intervention programs can

be successful with youth substance use problems. Smit, Verdurmen, Monshouwer, and Smit (2008) describe a number of family interventions that are effective in reducing alcohol misuse among adolescents. The research findings suggest family interventions are effective in reducing adolescent alcohol consumption up to forty-eight months post-treatment. Waldron and Turner's (2008) meta-analysis focused on family interventions and outcome moderators. Potential moderators for adolescent substance abuse treatment include sex, co-occurring conditions (e.g., delinquency, comorbid disorders), adolescent motivation for change, parenting and family factors, baseline impairment in coping skills deficits, traumatic life events, and exposure to environmental risk factors. Waldron and Turner (2008) found that two family-based approaches, MDFT and FFT, as well as group CBT, are well established for adolescent substance abuse treatment and that other family models, including MST, BSFT, and BFT, are probably efficacious, pending replications by independent research teams. CBT approaches appear promising, but additional research is needed. Despite the collective evidence, however, no clear pattern emerged for the superiority of one treatment model over another.

Adult Substance Use Problems

The empirical literature identifies three types of successful family-based interventions for adult substance use problems: 1) programs designed to improve family coping skills and to support the family members of alcohol and drug users—Al-Anon and coping skills therapy; 2) interventions that aim to promote substance users' readiness for change and participation in therapy—*Community Reinforcement and Family Training* (CRAFT), *Engaging Moms Program* (EMP), and *Brief Family Treatment* (BFT); and 3) family therapy with a focus on family transactional patterns and relational and environmental contingencies that maintain problematic drug and alcohol use—*Behavioral Family Counseling* (BFC), *Social Behavior and Network Therapy* (SBNT), and *Motivational Stepped Care* (MSC). New developments in the field of family therapy for adult substance misuse include programs that integrate drug abuse and parenting interventions to improve child functioning and prevent substance misuse in adolescence and adulthood (Rowe, 2012): *Families facing the Future* (FFF) and *Parenting Skills with Behavioral Couple Therapy* (PSBCT).

Outcome studies have shown that family-based interventions for adult substance use problems are as successful as alternative forms of treatment and superior to case management or individual therapy alone (O'Farrell & Clements, 2012; Rowe, 2012; Templeton et al., 2010). Compared to Al-Anon facilitation, coping skills therapy for women with alcoholic partners produced greater reductions in interpersonal violence and depressive and anxious symptoms (O'Farrell & Clements, 2012). There are still limited data about the outcomes of coping skills programs and more research is needed to establish the effectiveness of these promising interventions with diverse populations (Templeton et al., 2010). *Community Reinforcement and Family Training* (CRAFT) is an outgrowth of the Community Reinforcement Approach to substance misuse that targets both the social and the familial environment of substance users to increase treatment engagement. One new study, published in 2009 and cited in O'Farrell and Clements (2012), provides evidence that CRAFT can be successfully transported to community-based settings. Program engagement rates range from 55 to 65%, and are superior to twelve-step approaches (Rowe, 2012). Regarding the emotional and social well-being of family members, CRAFT is equivalent to Al-Anon. The *Engaging Moms Program* (EMP) was specifically developed for drug-abusing black mothers and tested with black and Hispanic women enrolled in drug court (Rowe, 2012). Empirical findings suggest that EMP participants are more likely to enroll in treatment, to graduate from drug court, and to be reunified with their children than mothers who receive case management services. Other positive outcomes include decreased drug use and improved mental health, family relationship, and parenting. *Brief Family Treatment* (BFT) is a one-session intervention implemented with drug users and key family members during detoxification. There is some evidence that BFT

is successful in enlisting the support of key family members and increasing drug users' participation in aftercare (Rowe, 2012). Likewise, research has shown that *Behavioral Family Counseling* (BFC), an adaptation of BCT with alcoholics for relatives other than partners and spouses, has positive effects on treatment engagement, abstinence, and relationship quality (Rowe, 2012). *Social Behavior and Network Therapy* (SBNT) is another family-based approach that has produced promising results, equivalent to *Motivational Enhancement Therapy* (MDT), on substance use, mental health, and quality of life (O'Farrell & Clements, 2012). In addition, recent findings suggest that SBNT is superior to MET as relates to physical health and family functioning (Copello et al., 2006). Last, family therapy research has begun to investigate the effects of family-based interventions for adult substance abuse that integrate parent training. It has found support for the superiority of *Parent Skills with Behavioral Couple Therapy* (PSBCT) compared to BCT and individual therapy, as relates to children's mental health, reduced involvement of child protective services, and improved parenting (Rowe, 2012). *Families Facing the Future* (FFF) is another promising program for drug-abusing parents on methadone maintenance that increases the resilience of boys over time.

Youth Behavior Problems and Youth Violence

Externalizing problems of youth, including violence, are significant in their scope and impact. Because of the serious social consequences of this category of clinical problems, a significant degree of research attention and support has been directed to understand effective interventions for youth violence. The meta-analytic and individual studies support the effectiveness of family therapy for youth behavior problems. Three meta-analyses focused on specific intervention programs. For example, in a meta-analysis of two different specific intervention models, McCart, Priester, Davies, and Azen (2006) looked at the outcomes of seventy-one studies of *Behavior Parenting Therapy* (BPT) compared to *Cognitive-Behavior Therapy* (CBT) for antisocial youth. Results indicated both programs had a strongly positive effect size (0.40), yet there were differences in the two treatments: BPT had a stronger effect for preschool and school-aged youth (0.47) while CBT had a stronger effect for adolescents (0.45). Farrington and Welsh (2003) studied the impact of different general and specific treatment programs for preventing future delinquency and antisocial child behaviors.

Baldwin and colleagues (2012) conducted a meta-analysis of the four major family-based approaches for delinquency (FFT, MDFT, BSFT, and MST) to determine if these evidence-based programs have better outcomes than treatment as usual (TAU). The results of this meta-analysis suggest that participants with delinquency or substance-abuse problems receiving BSFT, FFT, MDFT, or MST fared better than participants receiving either TAU or an alternative therapy. Although these differences were statistically significant, they were relatively small ($d = 0.21$ for family therapy vs. TAU and $d = 0.26$ for family therapy versus alternative therapy).

Summary

In the past ten years, research has provided additional evidence that family-based interventions are an essential component of treatment for a variety of psychiatric and behavioral problems. The strength of the findings, however, is variable: studies of family therapy and youth delinquency have yielded the most compelling evidence regarding the clinical utility of *Functional Family Therapy*, *Multisystemic Therapy*, and *Multidimensional Foster Care* for at-risk, substance-abusing youth. Likewise, research on parent training and childhood behavior disorders has demonstrated the success of *Parent Child Interaction Training, Incredible Years*, and *Triple-P*. There is also substantial support for *Family Focused Therapy* for adult bipolar disorder, *Family Psychoeducation* for schizophrenia, and *Attachment Based Family Therapy* and *Systems Integrative Family Therapy* for adolescent depression. More research is needed to determine the value of family-based interventions for chronic illness and adolescent eating disorders. Yet, recent findings underscore the benefits of addressing the relational processes

that play a key role in the course of these mental and physical problems.

Family therapy research has expanded knowledge about the outcomes of specific family therapy programs with specific client problems. This knowledge is directed at clinicians, mental health administrators, and policy makers to enhance their confidence in the interventions they select, fund, and implement in response to major social issues. Yet, outcome research is often of limited value when it does not take into account the client and contextual factors that make psychotherapy a complex task. Recent qualitative reviews suggest that scientists have begun to address the matter and to explore the moderating influence of variables such as problem severity, parental criticism, and treatment duration and format. More research is needed to understand the role of organizational, client, and therapist characteristics and to determine which therapeutic processes make family-based programs effective with a variety of populations in order to guide clinical practice in real-world settings.

What Are the Active Ingredients of Effective Family Therapy Programs?

Process and process-outcome research describes how family therapy works over the course of time and highlights the treatment conditions practitioners must create in order to help diverse clients. It provides valuable information about the active ingredients of therapeutic change, the client factors that influence the impact of treatment, and the therapist activities that are associated with positive outcomes. Despite its clinical utility, process and process-outcome studies constitute a small domain of family therapy science (Heatherington, Friedlander, & Greenberg, 2005; Sexton et al., 2003, 2013). Most recently, Sexton and colleagues (2013) observed that investigations of change processes represented only 15% of the family therapy research published in the past ten years. In addition, existing process studies tend to emphasize therapist activities rather than client factors that may influence the impact of treatment (Heatherington et al., 2005). This narrow focus together with the paucity of studies that examine change mechanisms limit the improvement and dissemination of evidence-based programs, and thus hamper the development of the field of family therapy.

Change processes are factors that cut across effective psychotherapy models (i.e., common factors) as well as mechanisms that are specific to individual treatment programs. Common factors unique to family therapy include a relational understanding of client problems, a systemic approach that engages key players in the clients' life, the creation of a balanced alliance within the therapeutic system, and the disruption of interactional patterns that contribute to clients' distress (Sprenkle, Davis, & Lebow, 2009). The theoretical models of effective psychotherapies specify how and when these mechanisms get activated and describe how they interact with one another; they provide frameworks necessary for the operation of common factors (Sexton et al., 2003; Sprenkle et al., 2009). Sexton and colleagues (2003) reviewed the findings of process-outcome studies and noted that research emphasized three core mechanisms: the therapeutic alliance, the management of conflict in family relationships, and the substitution of problematic patterns with healthy relational processes. The evidence showed that higher levels of family negativity in session were associated with higher rates of premature termination, that specific therapist interventions (e.g., reframing) were linked to reduced family conflict, and that the effects of the alliance on program retention varied with the mode of service delivery. In particular, balanced alliances were predictive of lower dropout rates in conjoint family therapy, while the strength of individual alliances was more important in mixed conjoint and individual treatment. Process studies had also established a link between improvements in parenting and decreased adolescent drug use and behavior problems. However, knowledge of therapeutic change was limited to the early phase of treatment, and the link between intermediate and distal outcomes had not been specified. The next sections summarize information accrued in the past ten years, and highlight unanswered questions as well as new scientific advances regarding common change mechanisms of effective family-based programs.

Therapeutic Alliance

The couple and family therapy (CFT) alliance is a multilevel and systemic construct that describes the interactions of individual and group processes and their influence on the development of the therapeutic relationship in family therapy. Specifically, it refers to the emotional bond and the agreement on goals and tasks that happen within the family, between the therapist and the family (the group-level alliance), and between the therapist and each individual family member over the course of treatment (the individual-level alliance; Friedlander, Escudero, Heatherington, & Diamond, 2011). Friedlander and colleagues (2011) identified another important aspect of the CFT alliance: the family's feeling of safety or the degree to which individuals in the family are comfortable sharing and discussing disagreements in session. The individual and family dimensions of the CFT alliance are interdependent. As family members observe and interpret their individual and collective experiences of psychotherapy, they influence one another and the formation of the CFT alliance.

Studies of the CFT alliance show that individual and family-level alliances have a differential impact on client retention and outcomes at different stages of treatment. Friedlander and colleagues (2011) found that the relation between alliance and outcomes in family therapy was small to moderate, yet this association was moderated by family and treatment factors, in particular, family role and type of treatment. For example, parental alliances may be more important than adolescents' alliances in predicting treatment completion for teenage anorexia, while a balanced alliance may increase retention in family therapy programs for youth externalizing problems (Friedlander et al., 2011). Process-outcome research has begun to identify the factors that moderate the relation between the CFT alliance and treatment outcomes: time, the strength of individual and family-level alliances, the severity of client presenting problems, and individual characteristics such as ethnicity and level of emotional reactivity are variables that carry some weight as the therapist engages in alliance-building activities. In particular, there is evidence that culture moderates the effects of the alliance on client retention in *Functional Family Therapy* with substance abusing adolescents: unbalanced or split alliances in the first session have been associated with greater dropout rates for Hispanic, but not Anglo families (Flicker, Waldon, Waldron, Brody, & Ozechowski, 2008); and ethnic matching between therapists and clients has been linked to greater reductions in substance use for Hispanic, but not Anglo youths (Flicker, Waldron, Turner, Brody, & Hops, 2008). These findings suggest therapists working with Hispanic families should pay close attention to the group-level alliance, and foster family cohesion and a shared sense of purpose early in treatment. They also show the importance of attending to cultural issues with minority families.

The FT alliance has lasting effects on adolescent drug use and has been linked to improved youth outcomes in follow-up studies of *Multidimensional Family Therapy* (MDFT; Hogue & Liddle, 2009). These outcomes were moderated by the interaction of individual-level alliances between the youth, the parents, and the therapist: youth alliance was associated with decreases in substance use and externalizing symptoms, only when parent alliances were high early in treatment.

Creating a Family Focus

Hogue, Liddle, Dauber, and Samuolis (2004) examined the relation between family focus and post-treament outcomes in both individual and family therapy and found that focus on family themes in therapy was associated with a reduction in adolescent substance use and externalizing and internalizing symptom distress. This finding suggests that creating a family focus is an important ingredient of change regardless of the treatment modality. This has implication for families that are hard to engage in treatment and for interventions with substance abusing youths.

Altering Family Interactions

Specific interventions of MDFT have been associated with healthier family processes and

reductions in adolescent behavior problems (Hogue & Liddle, 2009; Sprenkle, 2012). They include working through negative affect and encouraging parent–youth dialogue about significant issues. These findings are consistent with knowledge about the family risk factors that contribute to adolescent externalizing symptoms and substance use. In particular, building parenting skills is a key mechanism of change that cuts across effective family therapy programs for at-risk youth (Sprenkle, 2012).

Therapist Adherence

Adherence, the degree of consistency between therapists' in-session behaviors and the clinical model is a therapist factor that determines the direction of change in family therapy. To date, adherence research has focused on well-established treatment programs for youth drug use and delinquency: *Functional Family Therapy* (FFT), *Multisystemic Therapy* (MST), *Multidimensional Family Therapy* (MDFT), and *Brief Strategic Family Therapy* (BSFT). These programs have in common a well-articulated theory of the clinical process and a clear description of the procedures therapists should follow to attain specific intermediate and long-term goals, which are necessary conditions for the measurement of model fidelity. Adherence studies of FFT, MST, MDFT, and BSFT have shown that higher rates of therapist adherence predicted reductions in adolescent drug use, externalizing symptoms and delinquency (Chapman & Schoenwald, 2011; Hogue et al., 2008; Robbins et al., 2011; Sexton & Turner, 2010). By contrast, lower rates of adherence had iatrogenic effects on youth behaviors. Of particular interest is Robbins and colleagues' (2011) investigation of therapist adherence levels for discrete activities of BSFT over the course of treatment: reframing, joining, restructuring and tracking. When therapists used these techniques as prescribed by the model, they were more likely to engage and retain clients in therapy. In addition, the less their use of joining declined and the more their use of restructuring increased across sessions, the greater the reduction in youth drug use and the more improvement in family functioning. Hogue and colleagues (2008) also found that the relation between therapist adherence and treatment outcomes in MDFT was linear for some, not all, client problems. Specifically, intermediate levels of adherence produced the most improvement in youth internalizing symptoms (Hogue et al., 2008). Last, a recent study of MST has found a positive relation between ethnic matching and caregivers' ratings of the therapist model adherence, between therapist adherence and youth externalizing and internalizing problems at one-year follow-up, and between therapist adherence and recidivism four years post-treatment (Chapman & Schoenwald, 2011). The findings add support to the theory that model adherence is a key moderator of change and a necessary condition of program effectiveness. In addition, they raise questions about the influence of culture as relates to parents vs. youth's experience of therapy, and suggest there may be an indirect link between ethnic matching and youth outcomes in MST. Research on cultural processes is greatly needed: the role of human diversity is an under-researched area of family therapy, and for the most part, study participants are non-Hispanic, white individuals in heterosexual relationships, which makes it difficult to generalize findings to ethnic, racial and sexual minorities in the United States (Sexton et al., 2013; Sprenkle, 2012).

Family therapy research has also begun to investigate the relation between client factors, model fidelity, and outcomes in family psychoeducation for schizophrenia. In particular, Carlson and Weisman de Mamani (2009) found that family difficulty at baseline predicted therapist adherence and competence ratings for both the general and the model-specific interventions of Culturally Informed Therapy for Schizophrenia. The severity of the patient's psychotic symptoms was associated with therapist adherence and competence for general interventions only, and higher adherence and competence were linked to lower dropout and greater family satisfaction.

Summary

Process-outcome studies highlight the complexity and interconnectedness of family therapy processes. They also say something about the specific

therapist behaviors that facilitate client improvement, and indicate what factors to activate at what time in the course of treatment. In particular, recent findings suggest that the effects of the CFT alliance are a function of psychopathology, with the parent–therapist alliance being more important than the family alliance in the treatment of adolescent anorexia but not in the treatment of youth substance abuse. Likewise, specific changes in therapist behaviors across sessions are most critical to outcomes, such as the maintenance of joining and increased restructuring in the course of *Brief Strategic Family Therapy*. For the most part, however, process research has been limited to a few mechanisms of change (i.e., therapeutic alliance and therapist adherence) and a few evidence-based interventions for youth delinquency and substance use. There is much left to understand as relates to the specific activities and factors that make family therapy successful. This knowledge is essential for training, supervision, and the dissemination of effective family-based programs, because it supports the development and refinement of clinical protocols, and because it provides useful guidance for clinical practice. Last but not least, process-outcome studies must continue to examine the effects of specific family therapies on different populations, determine the role of cultural factors in the implementation of family-based interventions, and identify which adaptations are necessary to enhance the cultural sensitivity of evidence-based practices.

Translating Research into Practice: Challenges and Opportunities

The ultimate utility of family therapy intervention research depends on its ability to inform mental health practice, public policy making, and training. To do so, research must provide evidence that family-based treatments are effective in natural settings under real-world conditions. Recent reports suggest that researchers have met this challenge. In the past ten years, the majority of family therapy studies (71%) have occurred in the context of outpatient clinics; however, most of these studies (86%) focused on family-based practices for youth behavior problems and substance abuse (Hogue & Liddle, 2009; Sexton et al., 2013; Sprenkle, 2012). This finding reflects the poor adoption of evidence-based practices in mental health care, and shows that only a few evidence-based family therapy programs have been transported and evaluated in the community (McHugh & Barlow, 2012a).

Sexton and colleagues (2003) concluded that family therapy research was rigorous and the findings were strong regarding the overall success of family-based treatments and the effectiveness of specific intervention programs for specific problems. They stressed the practical value of this information for educators, administrators, policy makers and clinicians; they also called for the expansion of process-outcome research, and noted with optimism that investigations were underway looking at the dissemination of evidence-based practices in real-world settings. Studies of change mechanisms are particularly important because they help answer questions that are meaningful to clinical practice: How does family therapy work under what conditions? What happens in and outside of sessions within and between family members? What therapist activities produce which outcomes when in the course of treatment? The paucity of process-outcome studies is both disappointing and surprising given the clinical relevance of the phenomena they investigate, although this trend is likely due to the complexity of process-outcome research which requires well-articulated theories of systemic change and sophisticated techniques of analysis (Heatherington et al., 2005; Sexton et al., 2003, 2013).

The next sections highlight new developments in the field of family therapy that may facilitate and advance the study of systemic change processes. In particular, it describes strategies that have the potential to reduce the gap between research and practice, to foster the creation of practice research networks, and to improve the dissemination of evidence-based programs to community-based settings. It is followed by a discussion of the barriers to dissemination.

Measurement Feedback Systems and the Making of Local Scientist-Practitioners

Measurement feedback systems (MFS) are both clinical and scientific tools that make it possible

to track intrapersonal and interpersonal change in and between therapy sessions. The Systemic Therapy Inventory of Change (STIC; Pinsof, Goldsmith, & Latta, 2012) and the Contextualized Feedback Systems (CFS; Bickman, Kelley, Douglas, & Athay, 2012), in particular, are internet-based applications designed to measure clients' experience of the CFT alliance and individual and family functioning. On the one hand, they constitute a rich source of data that researchers may use to investigate the relation between therapist activities and client outcomes. On the other, they provide a mechanism for giving clinicians critical information about client progress in family therapy. This information may then guide the selection of session goals and interventions. It may also have practical value for supervision and training, because it allows for the identification of patterns in therapists' clinical activities with diverse clients; for example, a clinician's difficulty maintaining a balanced alliance in the middle phase of treatment. In other words, measurement feedback systems engage practitioners in the scientific process of verifying theory-based hypotheses about the client through the collection and analysis of case-specific data, and thus create an avenue for integrating research into everyday clinical practice.

Measurement feedback systems can be used to honor clients' perspective in treatment and thus enhance the collaborative aspect of psychotherapy (Pinsof et al., 2012; Sprenkle, 2012). When implemented across programs and practice settings, they increase measurement homogeneity and make it possible to compare the outcomes of different family-based interventions. They also show the relevance of the scientific process to clinical practice, offer a training tool for the transportation of evidence-based programs to community-based clinics, and thus have the potential to foster partnerships between practitioners and researchers.

Treatment Dissemination and the Development of Practice Research Networks

The implementation of effective family-focused treatments in real-world clinical settings has met significant barriers (McHugh & Barlow, 2012a; Northey & Hodgson, 2008; Sanders & Turner, 2005): clinicians' perception that treatment manuals limit their ability to use professional judgment; concerns about the effects of standardized interventions on the therapeutic relationship; and inadequate funding and administrative support for training. Dissemination and implementation (DI) research has just begun to identify the factors that limit the effective transportation of evidence-based programs from the laboratory to the community and that contribute to the research-practice gap. Important findings have emerged from the study of treatment dissemination, specifically, the need for training strategies other than publications and presentations and the need for greater collaboration between administrators, clinicians, and researchers.

Although DI research is still in the beginning stages of development and many questions remain unanswered regarding the outcomes of specific training procedures and their effective timing and dosage with diverse therapists in a variety of settings, studies have shown that the use of passive didactic methods alone (e.g., books, workshops) does not have the desired effects on therapist behaviors in session. By contrast, training that includes supervision with a focus on therapist adherence has been associated with higher ratings of therapist competence and greater improvements in client functioning (McHugh & Barlow, 2012b). The duration and intensity of training are also important factors in the adoption and proper implementation of evidence-based practices in mental health care. In particular, longer and sustained training has been linked to better clinical outcomes (McHugh & Barlow, 2012b; Schoenwald, McHugh, & Barlow, 2012).

Collaboration is yet another critical ingredient of successful dissemination (Carr, 2010; McHugh & Barlow, 2012c; Sanders & Turner, 2005). It must occur at three levels during the adoption, implementation, and maintenance phases of the transportation process: between researchers and administrators, between researchers and practitioners, and between administrators and practitioners. In other words, for dissemination efforts to succeed, clinicians and

administrators must be active participants in the selection of new interventions and in the ongoing refinement of evidence-based practices and their adaptation to the specific needs of mental health agencies. Practice-research networks (PRNs) may provide a structure for the creation of fully collaborative relationships between researchers and practitioners, motivate therapists to pay attention to and even take ownership of new scientific findings, and as a result, improve the dissemination of effective family therapy programs in the community. Finally, the dissemination of evidence-based practices not only depends on the commitment and engagement of mental health organizations, but also are a function of broader contextual factors such as community support which determines continuous funding and utilization of services by the justice, child welfare, school and health care systems (Henggeler & Sheidow, 2012).

Conclusion

The goal of this chapter was to answer critical questions about the effectiveness of family therapy, based on the review of qualitative and meta-analytic reports published from 2003 to 2013. The research findings suggested that family-based interventions were effective approaches in the treatment of various psychiatric disorders. However, the majority of the studies focused on a few empirically validated programs with well-articulated clinical protocols. These studies have begun to examine the link between specific change mechanisms, relational processes, and individual and systemic outcomes. More research is needed to identify the active ingredients of effective family programs and to distinguish the model-specific and common factors of therapeutic change. Likewise, the role of client variables such as psychiatric comorbidity and cultural diversity remains widely unknown, yet is an important condition of clinical practice. To increase the clinical relevance of family therapy science, researchers must shift their focus away from the outcomes of well-established programs to the mechanisms of change that underlie evidence-based treatments. They must also identify the contextual factors that facilitate the implementation of effective practices in community-based settings, evaluate existing dissemination procedures, and develop collaborative partnerships with clinicians, administrators, and community stakeholders. Finally, dissemination and implementation research may pay increased attention to the role of graduate training in the transportation of evidence-based practices and suggest strategies for increasing students' exposure to empirically validated treatments in ways that prepare them for the changing landscape of family therapy.

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23.

RESEARCH-BASED CHANGE MECHANISMS

Advances in Process Research

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As every experienced therapist knows, what takes place in the consulting room with a couple or family is far less predictable than it is with an individual client. It is not unusual for family members to have different motives for seeking assistance and different views on the nature of the problem and how it should be addressed in therapy. Indeed, one person may well have coerced other family members into treatment. Secrets are commonplace, and the underlying hostility in a family member's comment may be clear to the family but missed altogether by the therapist. For all these reasons, what begins as an ordinary conversation can suddenly erupt into name calling, screaming—even threats of violence.

Moreover, it is often difficult to identify what constitutes successful treatment in couple and family therapy (CFT). When there is an "identified patient" who has been diagnosed with major depression, schizophrenia, or substance abuse, for example, success involves reducing or managing this individual's symptoms. Yet it is arguably more common for professional help to be sought for relational problems that, while highly distressing for the people involved, do not involve symptoms at all. For some couples, success means avoiding divorce, whereas for other couples, success means divorcing without hostility. Because defining successful CFT is not straightforward, identifying processes that lead to success is even less straightforward.

All of the complexities in the consulting room are reflected in the research on effective processes in CFT. Even as recently as 2005, Pinsof and Wynne pointed out that despite strong outcome evidence, precious little is known about effective change processes in CFT, particularly as practiced in community settings. In fact, there are far fewer studies of CFT processes than of processes in individual psychotherapy, not because of a lack of interest in CFT but because of its complex, systemic nature.

In our view, process investigations have been hampered by four defining aspects of CFT that are unique to conjoint treatment. First, assessing the process of change in CFT involves measuring how multiple family members think about, feel, and behave toward the therapist as well as toward one another. Because a strong therapeutic relationship with one family member can negatively affect the therapist's relationship with another family member, should we assess the therapist–family relationship using an average of the clients' scores, a sum of their scores, discrepancy in their scores, or some other index? Second, because it is commonplace for different subsystems to attend sessions at different times, interpreting in-session changes over time can be misleading. Third, because what is said in a session is likely

to affect everyone who is present, even when the therapist is only addressing one individual, it is difficult to know who is (or who should be) influenced. Even if we could predict how an intervention will affect three or more people simultaneously, dyadic-level analyses are inadequate for capturing this effect. Fourth, measuring symptom change is not meaningful if no one is symptomatic. Even if symptom reduction is the ultimate goal for a particular couple or family, we also need to measure change in the systemic forces that maintain the symptom. Unfortunately, there are few instruments that take into account the recursive processes that are theoretically necessary to sustain lasting relational changes.

In other words, due to the complexity of CFT, we cannot necessarily generalize from what "works" in individual psychotherapy to what might work in a conjoint treatment format. Yet, despite the challenge of studying conjoint therapy, identifying effective change processes is essential for practice, particularly now that we have solid meta-analytic evidence (e.g., Shadish, Ragsdale, Glaser, & Montgomery, 1995) that a) CFT is a successful treatment modality and b) there are few substantive differences in efficacy based solely on theoretical approach.

In this chapter, we review the scope, methods, and practical implications of the most recent process research in CFT. To put this review in context, we begin by summarizing the scope and recommendations of two previous reviews of the process literature. Next, we summarize the scope of topics and methods covered by the empirical studies published between the years 2000 and 2012, when this review was written. Finally, we discuss the clinical implications of this body of research and suggest critical needs for future scholarship in the field.

Recommendations from Previous Reviews of the Literature

In the first published review of CFT process research, Friedlander, Wildman, Heatherington, and Skowron (1994) located only thrity-six process studies, dating from 1963, on in-session behaviors and/or self-reported perceptions of the therapeutic process. The majority of these studies focused on overt behavior—individual speech acts, i.e., single statements or speaking turns taken out of context, such as client defensiveness or type of therapist response (e.g., interpretation, confrontation). A number of studies were analyses of demonstration interviews conducted in the 1960s and 1970s by leading theorists, such as Salvador Minuchin, Don Jackson, Murray Bowen, and Carl Whitaker. The intent of these descriptive studies was simply to identify what generally occurs in CFT, what is common across theoretical approaches and what is distinctive, how demographic characteristics—particularly gender—affect CFT processes, and how speech acts change over time. Few investigations considered these process variables in relation to treatment outcomes. Only a handful of studies identified specific change processes, such as important moments, effective episodes, or "best" sessions, and only five investigations focused on the therapeutic relationship. In terms of topics for future study, the reviewers suggested that investigators consider: a) what clients "do, think, or feel in effective family therapy" (Friedlander et al., 1994, p. 410); b) how change occurs in the less studied but increasingly popular CFT approaches, such as constructivist therapy; c) how clients from diverse cultural backgrounds experience CFT; and d) how therapists' interventions affect family members simultaneously.

In a 2000 review of the literature, Friedlander and Tuason noted that fewer than twenty process studies of CFT had been conducted since the 1994 review was published. Nonetheless, the newer research was more clinically rich. Notably, investigators had taken a turn away from merely describing what occurs in CFT sessions toward identifying processes shown to produce meaningful change. Moreover, there was a greater focus on clients' cognitive constructions and emotional experiences in CFT, and there were several studies that modeled how positive change can take place within a session. Importantly, the more recent studies focused on therapeutic events that are critical in conjoint CFT, such as resolving conflict, reducing blame, facilitating engagement, and reframing child-focused problems as interpersonal.

In terms of methodological recommendations, Friedlander et al. (1994) encouraged future

researchers to test theory-based hypotheses, to develop measures and use analyses that are systemic in nature, to study entire cases micro-analytically, and to avoid the study of client and therapist behavior isolated from the surrounding clinical context. In the second review, Friedlander and Tuason (2000) noted that more qualitative research was being conducted. Additionally, there were more discovery-oriented and mixed methods studies, as well as more theory-driven studies. The authors recommended small-scale, clinically rich studies that would focus on process indices that lead to measureable change.

Scope of the literature in the Years 2000 to 2012: Topic Areas

Theory-Specific Process Research

One notable change in the field between 2012 and 2015 has been an increased focus on modeling the process of change in evidence-based treatments. Consequently, there was some research focusing on treatment adherence and fidelity (e.g., Hogue & Liddle, 2009; Huey, Henggeler, Brandino, & Pickrel, 2000); in other words, the degree to which accurate and faithful delivery of a specific therapy model predicts family outcomes (Shoham, 2011). In Huey et al., for example, therapist adherence to the multisystemic therapy (MST) protocol predicted improvements in family relationships, which in turn predicted decreases in juvenile delinquent behavior. Interestingly, at least one treatment manual was developed from a process analysis of a specific approach to therapy. That is, using multiple methods, mainly qualitative, Pote, Stratton, Cottrell, and Boston (2003) developed and subsequently tested a protocol for systemic family therapy that incorporated elements from postmodern and narrative theories.

In line with earlier recommendations to study CFT change processes with diverse families, we located four theory-based studies in which clients' sociocultural characteristics (e.g., race, ethnicity, income status) were considered as predictors. Three were process studies of MST (Foster, Cunningham, Warner, Moyer McCoy, & Henggeler, 2009; Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012; Huey et al., 2000), and one was a process investigation of functional family therapy (FFT; Flicker, Turner, Waldron, Brody, & Ozechowski, 2008).

Therapists' qualities and techniques were studied within seven explicitly defined treatment approaches. First, in a qualitative study of psychoeducational family therapy (James, Cushway, & Fadden, 2006), the therapist's "humanity" (behaving naturally and being comfortable with transparency and with personal limitations) emerged as a core characteristic that therapists believed could facilitate engaging families in treatment (p. 355). Second, within multidimensional family therapy (MDFT), techniques directed to the family versus to the adolescent were studied as predictors of outcome at six and twelvemonths (Hogue, Dauber, Samoulis, & Liddle, 2006). Third, in MST therapists' educational, problem-solving, and supportive techniques were studied in relation to caregivers' engagement and positive responses to treatment (Foster et al., 2009). In home-based MST, the therapists' comfort with the treatment model predicted their perceived alliance with the family (Glebova et al., 2012). Fourth, in emotion-focused therapy (EFT), therapist facilitation of blamer softening was studied (Andersson, Butler, & Seedall, 2006; Bradley & Furrow, 2004; Furrow, Edwards, Choi, & Bradley, 2012), as was facilitation of attachment resolution (Makinen & Johnson, 2006). Fifth, narrative/constructivist therapy was examined in relation to collaboration with clients (Sutherland & Strong, 2011) and responses to client blaming (Friedlander, Heatherington, & Marrs, 2000). Sixth, a key technique in structural family therapy, enactment, was studied (Nichols & Fellenberg, 2000), as was empathy, a personal quality of therapists not generally considered central to the structural approach (Hammond & Nichols, 2008). Seventh, relational reframing (Moran, Diamond, & Diamond, 2005) and other attachment-oriented techniques (Moran & Diamond, 2008) were studied in attachment-based family therapy.

Common Factors Process Research

A large proportion of the 2000–2012 CFT process literature focused on aspects of treatment that are not theory specific but are, rather, common

to multiple approaches to working with couples and families. Much of this research had to do with the therapeutic alliance and its relation to retention and successful outcome. Other topic areas include clients' and therapists' perceptions of CFT, in-session behavior, and the effects of client feedback on outcome.

Therapeutic Alliance

In a meta-analysis of twenty-four alliance/outcome studies with 1,416 clients, Friedlander, Escudero, Heatherington, and Diamond (2011) found an effect size comparable to that reported by Horvath, Del Re, Flückiger, and Symonds (2011) for individual psychotherapy. Moreover, the link between alliance and outcome did not differ between the seventeen family and the seven couple studies. Although most investigations were conducted on treatments-as-usual, a few demonstrated the importance of alliance in specific treatment models; for example, FFT (Flicker et al., 2008; Robbins, Turner, Alexander, & Perez, 2003), MDFT (Shelef, Diamond, Diamond, & Liddle, 2005), and psychoeducation for mental illness (Smerud & Rosenfarb, 2008).

Although many researchers used alliance measures that were originally developed for studying individual psychotherapy, in the past few years more investigators used measures that reflect conjoint treatment: the Working Alliance Inventory-Couples (WAI-Co; Symonds & Horvath, 2004), the revised Integrative Psychotherapy Alliance Scales (Pinsof, Zinbarg, & Knobloch-Fedders, 2008), and the System for Observing Family Therapy Alliances (SOFTA-o; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, Heatherington, & Cabero, 2006).

The SOFTA-o was specifically developed to study conjoint treatment. In the conceptual model of the alliance that underlies the SOFTA-o, two of the four dimensions are common to individual psychotherapy as well as CFT (*Engagement in the Therapeutic Process* and *Emotional Connection to the Therapist*), and two dimensions are unique to conjoint therapy (*Safety within the Therapeutic System* and *Shared Sense of Purpose within the Family*, i.e., within-family alliance). Studies using the SOFTA's observational and self-report measures showed a relationship between alliance and clients' and therapists' session evaluations (Friedlander, Bernardi, & Lee, 2010; Friedlander, Kivlighan, & Shaffer, 2012), problem severity (Escudero, Friedlander, Varela, & Abascal, 2008) and progress in treatment (Escudero et al., 2008; Friedlander et al., 2012; Muñiz de la Peña, Friedlander, & Escudero, 2009). Intensive analyses of alliance-related behaviors were conducted within a single case (Escudero, Boogmans, Loots, & Friedlander, 2012; Friedlander, Lee, Shaffer, & Cabrera, 2014) and across a small sample of cases (Beck, Friedlander, & Escudero, 2006; Friedlander et al., 2010; Friedlander, Lambert, Escudero, & Cragun, 2008a; Lambert, Skinner, & Friedlander, 2012).

Of particular interest to alliance researchers have been four questions: What factors predict strong working alliances in CFT? How do alliances in CFT change over time? How do therapists contribute to strong and weak alliances with couples and families? What are the characteristics and consequences of problematic alliances? With respect to the first question, alliance predictors include individual characteristics, such as client gender (Anderson & Johnson, 2010; Anker, Owen, Duncan, & Sparks, 2010; Bartle-Haring et al., 2012; Glebova et al., 2011; Knobloch-Fedders, Pinsof, & Mann, 2007; Symonds & Horvath, 2004; Thomas, Werner-Wilson, & Murphy, 2005), family role (i.e., parent or adolescent; Friedlander et al., 2012), levels of stress (Knerr & Bartle-Haring, 2010), relationship satisfaction (Knerr et al., 2011), and differentiation of self (Knerr & Bartle-Haring, 2010; Lambert & Friedlander, 2008).

With respect to the second question, several studies have considered changes over time in CFT alliances. Four group studies compared alliance strength, either observed or self-reported, at two (Escudero et al., 2008; Glebova et al., 2011; Knobloch-Fedders et al., 2007; Symonds & Horvath, 2004) or three (Friedlander et al., 2006) discrete points in time, and four studies tracked alliances over time within cases (Anker et al., 2010; Bartle-Haring et al., 2012; Friedlander et al., 2008a; Friedlander, Lee, Shaffer, & Cabrera, 2014).

With respect to understanding how therapists contribute to strong or weak alliances

in CFT, there have been a handful of studies. Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) found that stronger alliances with black adolescents seen in MDFT occurred when the therapists used developmentally appropriate and culturally sensitive interventions; for example, ones that explicitly focused on "anger/rage, alienation, respect, and journey from boyhood to manhood," but not when the therapists focused on racial identity or socialization (p. 321). In another study, the WAI-Co was used to code therapist behavior (Thomas et al., 2005), and five studies used the SOFTA to assess therapists' alliance-related behaviors within sessions (Escudero et al., 2012; Friedlander et al., 2014; Lambert et al., 2012) or within cases over time (Friedlander et al., 2008a; Muñiz de la Peña, Friedlander, Escudero, & Heatherington, 2012). One study found that stable and deteriorating alliances were reflected in the relational control dynamics observed between therapists and their adolescent clients (Muñiz de la Peña et al., 2012).

Finally, with respect to problematic alliances, the bulk of the literature concerns "split" or "unbalanced" alliances, where different family members report discrepant views of the alliance. Researchers have shown that split alliances are commonplace and vary from mild to severe (Muñiz de la Peña et al., 2009), that splits can be observed (Beck et al., 2006; Muñiz de la Peña et al., 2009), and that they are often, but not invariably, associated with dropout (Bartle-Haring, Glebova, Gangamma, Grafsky, & Delaney, 2012; Beck et al., 2006; Flicker et al., 2008; Friedlander et al., 2008a; Knobloch-Fedders et al., 2007; Muñiz de la Peña et al., 2009; Robbins et al., 2003, 2006).

Another kind of problematic alliance can occur within the family system itself, when there is poor collaboration among family members because they disagree on the problem, the goal, or the value of conjoint therapy. Researchers have shown that there are various reasons for problematic collaboration (Lambert et al., 2012), that poor within-couple alliances predict individual distress (Anderson & Johnson, 2010), and that effective therapists increase safety and emotional connection to repair these problematic alliances (Escudero et al., 2012; Friedlander et al., 2014).

Perceptions of CFT

In addition to the specific literature on perceptions of the working alliance, either as a predictor of outcome or as related to in-session behavior, there were several other studies of clients' perceptions of CFT. Tambling and Johnson (2010), for example, found that clients' initial expectations about their therapists' behavior and personality were confirmed over the course of several couple therapy sessions. Other researchers selectively studied clients' perceptions of "pivotal moments" (Helmeke & Sprenkle, 2000, p. 469) or compared helpful to unhelpful aspects (Bowman & Fine, 2000) of couple therapy. One qualitative study contrasted the perceptions of therapists with those of former clients who saw their experiences in CFT as either "extremely satisfying" or "extremely dissatisfying" (Lazloffy, 2000, p. 391). Yet another qualitative study was based on interviews with families that had dropped out after one or two sessions of narrative therapy (Lever & Gmeiner, 2000). (For a synthesis of research on clients' experiences in CFT, see Chenail et al., 2012.)

A particularly interesting triangulation of perceived common factors was conducted by Davis and Piercy (2007a, 2007b). Model developers of EFT (Susan Johnson), cognitive-behavioral therapy (Frank Dattilio), and internal family systems therapy (Richard Schwartz) were interviewed, as were their former students and successful clients. Results showed common dimensions of change across sources and respondents, including conceptualizations, alliance, client and therapist characteristics, interventions, the nature of the change process, outcomes, expectations, and motivation.

In-session Behavior

Aside from the previously referenced studies of theory-specific behaviors and behaviors related to the therapeutic alliance, we located three studies in which other kinds of behaviors were studied in treatments as usual. Jankowski and Ivey (2001) used observations of CFT sessions, followed by interviews with the therapists, to understand the process of conceptualizing,

defining, and conversing about family problems. Morgan and Wampler (2003) coded behaviors from videotaped sessions to assess how therapists enhance clients' creativity, which the authors defined as optimism and playfulness. Other authors found that: a) during enactments with couples, the therapist using a "proxy voice" for the client (Seedall & Butler, 2006); and b) interventions that were structuring and directive yet supportive (Woolley, Wampler, & Davis, 2012) were most effective.

Client Feedback

Compared with burgeoning evidence in the individual therapy literature for the effectiveness of providing therapists with client feedback, only a few CFT studies evaluated this process. Anker, Duncan, and Sparks (2009) and Reese, Toland, Slone, and Norsworthy (2010) conducted randomized experimental studies of couple therapy in which client feedback was contrasted with a no feedback control condition. In both studies, couples in the feedback condition filled out a progress questionnaire every session, which was provided to their therapists. Results showed impressive gains for couples in the feedback condition as compared with controls. In a six-month follow up to their 2009 study, Anker et al. (2011) obtained written feedback from a subsample of couples, which showed greater satisfaction with treatment on the part of those in the feedback condition. In a case study of CFT, Pinsof, Goldsmith, and Latta (2012) used a technologically sophisticated feedback delivery system to show how client feedback was used to shape a therapist's interventions.

Methodologies: Current State of the Art

Instrumentation

Many process investigators have relied on measures originally developed to study individual psychotherapy, both as predictors and as outcome indicators. However, some self-report measures are now being used to assess theoretical constructs in CFT, such as differentiation of self (Knerr et al., 2011; Lambert & Friedlander, 2008), family cohesion and conflict (Hogue et al., 2006), and within-family alliance (Friedlander et al., 2006; Lambert et al., 2012 Pinsof et al., 2008; Symonds & Horvath, 2004).

In terms of observational rating systems, two alliance measures reflect the conjoint aspect of CFT, the WAI-Co (Symonds & Horvath, 2004) and the SOFTA-o (Friedlander et al., 2006). Other coding systems have been used to study important systemic processes in CFT. These systems measure enactment (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2012; Nichols & Fellenberg, 2000; Woolley, Wampler, & Davis, 2012), blamer softening (Bradley & Furrow, 2004), reframing (Moran & Diamond, 2008; Moran et al., 2005; Robbins, Alexander, & Charles, 2000), and family relational control communication (Muñiz de la Peña et al., 2012).

Designs and Analyses

Group Designs

Alliance research generally involves some assessment of self-reported alliances early in treatment as predictors of change post-treatment. Some researchers, however, considered the alliance in relation to retention (e.g., Bartle-Haring, Glebova, Gangamma, Grafsy, & Delaney, 2012; Robbins et al., 2003, 2006), which is arguably more difficult to achieve in CFT than in individual therapy, and in relation to mid-treatment evaluations of therapeutic progress (Escudero et al., 2008; Friedlander et al., 2012; Glebova et al., 2011).

More complex group designs began to appear in the CFT process literature. These include moderated (Foster et al., 2009) and mediated (Friedlander et al., 2008) models, as well as multi-level models that tested individual therapist effects (e.g., Anker, Sparks, Duncan, Owen, & Stapnes, 2011; Friedlander et al., 2012). One dyad-level model is particularly promising for CFT research, the actor–partner interdependence model, which researchers have used to test mutual influence processes between partners (Anker et al., 2010) and between parent and adolescent (Friedlander et al., 2012). Mutual influence has also been studied using sequential

analysis (Friedlander et al., 2008a; Moran & Diamond, 2008; Muñiz de la Peña et al., 2012).

Small Sample Studies

Single and multiple case studies began to appear more frequently in the CFT literature. Although a few case studies were published prior to 2000, none was evidence-based, as currently defined by Carlson, Ross, and Stark (2012). These more rigorous case designs require multiple process and outcome measures, as well as verbatim case material and an assessment of clinically significant change over time. Three evidence-based case studies appeared in the literature (Escudero et al., 2012; Friedlander et al., 2014; Gill, Hyde, Shaw, Dishion, & Wilson, 2008).

Some less extensive case studies reported data on every session (e.g., Friedlander et al., 2008a), on a single, representative session (Sutherland & Strong, 2011), or on a few early sessions (Beck et al., 2006; Moran et al., 2005). In some mixed-methods studies, a small sample of sessions was selected for analysis based on alliance scores (Higham, Friedlander, Escudero, & Diamond, 2012; Lambert et al., 2012; Muñiz de la Peña et al., 2012), on session evaluation scores (Friedlander et al., 2010), or on quantitative outcome indicators (Friedlander et al., 2008a).

Task analyses of theoretically important change events, which assess mid-range theories of systemic change, as recommended by Hogue and Liddle (2009) and Heatherington, Friedlander, and Greenberg (2005), also appeared more frequently in the literature. Most task analyses were mixed-methods studies (Bradley & Furrow, 2004; Furrow et al., 2012; Makinen & Johnson, 2006; Nichols & Fellenberg, 2003). Others were either solely quantitative (Woolley et al., 2012) or qualitative (Higham et al., 2012).

Finally, as recommended by Woolley, Butler, and Wampler (2000), important qualitative research began to be conducted on CFT processes, including grounded theory methods and conversation analyses. Among the qualitative studies were those that analyzed data within cases (e.g., Lazloffy, 2000), within sessions (Friedlander et al., 2000; Lambert et al., 2012; Sutherland & Strong, 2011), or within moments identified as particularly good or poor through client self-report (Helmeke & Sprenkle, 2000; Strickland-Clark, Campbell, & Dallos, 2000).

Implications for Practice

In contrast to most randomized controlled trials that simply demonstrate the efficacy of a whole treatment package, process research can have a direct impact on clinical practice due to its potential to identify the most effective, in-session change mechanisms. In general, process researchers are concerned with general questions like, "How does family therapy work?" and "What makes 'good therapy' good?" An ambitious yet reasonable expectation for developing a comprehensive, evidence-based practice model involves constructing empirically informed guides to practice that are based on solid research findings. Doing so requires identifying interventions that are less formulaic (to preserve therapist creativity and flexibility) and more congruent with systemic thinking than tends to be found in some traditional individual psychotherapy manuals (Escudero, 2012). Many of these manuals are based on conceptualizing the treatment as the independent variable, the therapist as a static feature of the model, and the therapeutic relationship as a potential confounding variable. In our view, developing a nuanced, contextual understanding of CFT, supported by high-quality process research, requires isolating crucial process mechanisms that explain success or failure in everyday practice.

The literature reviewed in this chapter indicates that research productivity between 2000 and 2012 represents a positive change toward greater diversity in models as well as methods for studying the process of change in CFT. The clinical implication of the movement toward integrating qualitative research with traditional group designs is important (Sexton, Kinser, & Hanes, 2008), inasmuch as the intensive analyses of cases are clinically rich, do not consider unique features of a case as "experimental errors," and offer relevant information for practice.

Taken together, the relatively recent process research reviewed in this chapter does

not lead us to conclude that there are specific directives as to what a family therapist "must" do with any particular type of problem or client. Rather, this body of literature suggests two general but practical recommendations to facilitate the process of change across diverse intervention models and therapy contexts: 1) attend to results from common factors research, and 2) consider the therapeutic alliance as a barometer of change.

These two general recommendations are discussed below in more detail. We refer readers to the theory-specific chapters (6 to 20) within this *Handbook* for a discussion of the clinical implications of empirically supported change mechanisms within each model.

Attending to Common Factors

The process research appearing in the literature during the past decade clearly supports the importance of identifying factors that are common across different models of CFT. The implications of this evidence affect not only the practice of specific approaches, but also the training of future therapists and the evaluation of CFT effectiveness in general practice settings. These common processes include clients' positive perceptions of the process in general as well as their perceptions of "pivotal moments," the value of in-session enactment, the importance of therapist empathy and optimism, the instillation of hope, a strong alliance, as well as other, more specifically systemic processes, such as the disruption of dysfunctional relational patterns and the value of expanding the treatment system (Sprenkle, Davis, & Lebow, 2009).

Consideration of all these common mechanisms of change suggests that each family therapist could construct a "map" of important and desirable features that need to be integrated into his or her practice. Clients' feedback to the therapist seems to be a highly effective place to begin that map. For example, a therapist could use various client self-reports about change processes (e.g., perceptions of progress, perceptions of the most helpful aspect of the previous session, value and smoothness of the session, strength of the therapeutic relationship) at select intermediate points of the treatment in order to check on the progress and quality of the therapy.

Using the Alliance as a Barometer of Change

Arguably, the most stable and robust findings in the recent process literature have to do with developing and maintaining strong therapeutic alliances. The alliance appears to be an essential feature of good therapy and, independent of any specific approach, its strength predicts success and explains failure in CFT (Friedlander et al., 2011), just as it does in individual psychotherapy (Horvath et al., 2011).

The implications of this powerful finding are obvious, and in fact some studies provide specific ways to maximize the alliance that family therapists could easily integrate in their practice. For example, instruments to evaluate the alliance by researchers can also be used by therapists to identify positive or negative alliance-related behaviors as they occur in session. Research tools, like the SOFTA-o (Friedlander et al., 2006), were developed not only for research but also to enhance training and practice, because inferring clients' thoughts and feelings about the alliance from their observable behavior is what therapists do naturally.

Of particular concern to family therapists is the problem of engaging reluctant or resistant adolescents. A few recent studies suggest specific strategies to do so that are particularly pragmatic; these strategies include structuring the conversation, fostering adolescent autonomy, building the adolescent's systemic awareness, rolling with resistance, understanding the adolescent's subjective experience, and encouraging parents to directly encourage the adolescent to take part in the session (Higham et al., 2012).

Despite specific and straightforward ideas like these, the research also indicates that alliances fluctuate over time in treatment. The alliance is not a static characteristic of therapy but rather a highly dynamic process, particularly when different family constellations are present in a session. Adolescents who feel safe in sessions with their primary parent, for example, may close up entirely when a step-parent joins

the therapeutic system. The primary implication for practice is that therapists should assess the alliance (using self-reports or observational rating systems) throughout the process because its strength is a useful barometer of the potential for treatment retention and meaningful progress.

A unique and particularly important characteristic of the alliance in CFT is the within-family alliance, which can become problematic when there is conflict or poor collaboration among family members. Although there is scant research about how family therapists create a strong within-family alliance, the clinical implications of the few studies on this topic are fairly explicit: build safety with the entire therapeutic system, and reframe or redefine the problem in order to reduce blame. These interventions seem to be indispensable. In fact, an early task described in many family therapy models involves helping family members re-construe the problems that motivated them to seek help in a way that is less blaming and less linear, because a systemic new problem definition makes it more likely that all members will become engaged in the therapeutic process. At a more microanalytic level, the recent process research provides some useful information for family therapists about specific, empirically tested techniques to promote a strong within-family alliance (e.g., eliciting family dialogue, using enactments and circular questioning, facilitating compromise, encouraging clients to ask each other for their perspective and to respect each other's point of view, or drawing attention to family members' shared values and experiences).

Another area of CFT alliance research is the body of evidence on the frequency and consequences of a "split" or "unbalanced" alliance. A number of studies suggest that split alliances occur in a majority of cases, particularly early in treatment, and with almost all therapists. The risk of not repairing a seriously split alliance seems to be high. Interestingly enough, though, splits in which the alliance is stronger with an adolescent than the parent(s) occur just as often as the reverse. Thus therapists should not assume that by virtue of age, maturity, and authority, parents necessarily feel a greater connection to the therapist than do their teenagers.

Although up until 2012 there were only a few studies on repairing alliance ruptures in CFT, most of which were single case or small sample studies, results suggest that effective repair interventions are similar to those that an individual therapist might rely on—namely, being empathic, normalizing feelings, meta-communicating, and explaining the rationale for introducing new goals or tasks. There are, nevertheless, some potentially powerful repair interventions that are unique to conjoint treatment, such as seeing various members of the family alone to enhance safety, or focusing the discussion on the family's shared positive experiences.

Critical Needs for Future Process Research

This review revealed some progress, notably in measure development and theory-based specification and testing of change mechanisms. There was, for example, considerable progress in articulating methodological and statistical strategies to account for non-independence in family data (nested and multilevel models, sequential and actor-partner analyses) and in disseminating these analytic strategies to researchers (cf. Wittenborn, Dolbin-MacNab, & Keiley, 2013). However, many of the critical needs for change process study cited in the two earlier literature reviews (Friedlander et al., 1994; Friedlander & Tuason, 2000) remain unmet. Indeed, relative to the study of individual therapy processes, research on change mechanisms in CFT remains at a fairly early stage of development.

These circumstances, coupled with the sheer number and complexity of change processes that take place in CFT, suggest that we may learn the most from intensive, small-scale, mixed methods studies that stay close to the data and close to systemic theories of change. Studies whose conclusions are grounded in verbatim transcripts, client-reported progress over time, and behaviors examined in context are likely to help us identify the most salient change mechanisms that are at the heart of conjoint treatment. The change mechanisms identified by these evidence-based case studies can subsequently be tested in multiple $N = 1$ studies to assess their validity and

generalizability to diverse couples and families. Although theory should be used to guide the search for change processes, theory should not fully constrain this search. As is the case in individual therapy, there are common change processes that are not theory specific—particularly relationship factors and the mechanisms that make these factors important.

Among relationship factors, the therapeutic alliance is likely the best starting point, given solid evidence of its contribution to successful outcomes in CFT. We need more work on specifying the mechanisms by which the alliance and outcomes are related, focusing not solely overall treatment outcome but also on proximal outcomes like retention in treatment, engagement in the session, completion of homework assignments, and so forth. Specific questions include the following: In what way does an improved, or a recently repaired, alliance move the therapy along? How does alliance repair change clients' expectancies, emotional states, or willingness to cooperate? Does alliance repair facilitate more intimate or risky disclosures or less blame and defensiveness? How does an improved alliance between one family member and the therapist affect the behavior of other family members, and how does the emergence of new behavior affect the within-family alliance? It would be especially useful to study these questions transtheoretically, using culturally diverse cases and theoretically diverse approaches to treatment.

Of course, not all change mechanisms are non-specific. Our review highlights recent progress in the specification and testing of theory-specific mechanisms, such as blamer softening in EFT, enactment in structural therapy, and relational reframing in ABFT, although these studies are limited to the most studied treatment approaches. There is a critical need to develop a wider range of theories so that mid-level changes can be specified and tested.

This recommendation is closely tied to fidelity, which looms large in any study of couple or family therapy. Fidelity is of most concern in outcome trials, because valid interpretations of results require confidence that the treatment being tested is delivered in line with the theory's core strategies and techniques. But fidelity is also critically important in change process research (Shoham, 2011), which requires specification of how therapeutic interventions (e.g., relational reframing) affect which intrapersonal (e.g., cognition) and interactional processes (e.g., blaming) and how these changes in turn bring about individual and family outcomes. Testing theory-based predictions about how and when changes unfold—which, after all, is the essence of all psychotherapy process research—requires that the interventions be faithful to the treatment model. If not, conclusions about the outcomes that follow from the interventions are suspect.

Unfortunately, research on fidelity in CFT is sparse and limited to the most well-studied treatment models. Moreover, there is evidence suggesting that, even in the few studies that have been done, fidelity is elusive when empirically supported treatments are conducted in community settings (Shoham, 2011).

Testing fidelity requires sound measures. Such measures have been developed for a few well-supported, manualized treatments, including MST (Schoenwald, Henggeler, Brondino, & Rowland, 2000) and EFT (Denton, Johnson, & Brant, 2009), but there remains a critical need for instruments to test fidelity in other widely used CFT approaches. Such measures could be used to assess the quality with which theory-specific interventions (e.g., enactment, solution-focused questioning) are delivered in order to begin to disentangle the effects of theory-specific and common factors. Of particular relevance are common factors that are systemic and unique to CFT, such as repairing split alliances or reducing intergenerational triangulation within the family.

With regard to measurement, there also is a need for systemically sensitive indices of treatment progress, especially the "micro-outcomes" that mediate change throughout therapy, within individuals as well as within the couple or family unit. For assessing individual, couple and family-level progress, the intersession version of the Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2009) can provide session-by-session indices of client functioning and the strength of the alliance. Although in contrast to individual therapy, conjoint therapy tends to focus less on symptoms, in many cases symptom reduction

(e.g., decreased drug use, reduced depression) is a major treatment goal. In these cases, standardized self- and other-report rating scales can be used to track symptom change and link it to systemic, interpersonal processes, such as improved parent–child communication or reduced detouring of marital conflict.

For treatment outcomes that are not symptom-focused, goal-attainment scaling is particularly well suited for articulating and then tracking meaningful interpersonal changes over time. One example is the goal of expressing unmet intimacy needs to a partner without tears or blame. Another example is the goal of improving consistency in parenting. Indeed, studying common interpersonal goals like these could lead to the development of progress measures that reflect core elements of CFT. In evidence-based case studies, these new progress measures could be supplemented with goal attainment scales that are specific to a given family.

When interpersonal change begins to take place in CFT—when couples argue less, or when parents start taking charge more effectively—good therapists notice the change and point it out as a matter of course. This naturally occurring feedback can have a powerful effect. The few client feedback studies in CFT suggest positive effects when clients report on their progress systematically. The assumption is that therapists use systematized feedback to alter their behavior in the sessions in order to inform the therapeutic tasks and thereby improve outcomes. Clearly, feedback can also be used to study what goes on in sessions to shape family members' progress, which is of course the essence of change process research. Moreover, with CFT's rich clinical history of providing live feedback to families about their interpersonal processes (literally or metaphorically bringing the family "behind the mirror"), our field is well poised to study the effect of client feedback on systemic change processes.

Feedback to therapists has also been used to provide information about client deterioration or demoralization that is associated with treatment failure and dropout, so that corrective interventions can be used. Studying the effects of this information, specifically how it sets in motion processes that reverse deterioration, is another avenue for future research. The clinical literature on managing difficult and deteriorating family therapy cases (e.g., Heatherington, Friedlander, & Escudero, 2012) could be consulted for specific recommendations for identifying, articulating, and then studying these reparative processes.

As the science of change process research matures, it can and should involve more and better collaboration between practitioners and researchers, not solely or even primarily for the purpose of dissemination of results, but also for building clinicians' perspectives into the ongoing articulation and testing of hypotheses about change mechanisms in CFT. This kind of practice located exchange, in which therapists are systematically consulted about their use of evidence-based practices in their communities, will allow us to address a particularly glaring gap in our research programs—how to deliver culturally sensitive therapy to diverse couples and families.

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PART V

EMERGING DOMAINS

24.

MEDICAL FAMILY THERAPY

Nancy Ruddy and Susan H. McDaniel

Illness creates loss, necessitates role changes, and siphons financial and emotional resources. Experiencing illness is a major stressor in and of itself. Therefore, it is not difficult to imagine how illness sets the stage for psychological and interpersonal difficulties.

Most physicians now recognize the importance of the interplay between biological, psychological, and social factors in illness. The "biopsychosocial model" (Engel, 1977) has become increasingly integrated into modern medicine. However, many medical providers feel overwhelmed by the tasks of monitoring and treating their patients at all levels. Frequently, medical providers find they need assistance in helping patients who have serious mental health or relational difficulties, whose medical and psychosocial issues are intertwined, or who are struggling to cope with their own or a family member's illness.

The field of Medical Family Therapy has developed in order to meet the needs of these patients (McDaniel, Doherty & Hepworth, 2014). While Medical Family Therapy utilizes many theories and techniques from other types of family therapy, it is a metaframework that draws attention to the biopsychosocial nature of human experience. Medical family therapists must be familiar with illness and its effects on individuals and families, they must understand the medical system and how to work collaboratively with medical providers, and they must be familiar with techniques that assist families in coping with the unique stress illness places on them. This chapter will review these areas, beginning with the various settings in which medical family therapy is likely to be practiced. We will then discuss the approaches and techniques used in medical family therapy, and the literature regarding the utility of these approaches and techniques.

Context and Medical Family Therapy

Many mental health professionals are surprised when they learn that the majority of patients with mental health issues are not treated in a mental health setting. Primary care medicine has been called the "de facto mental health system" (Regier, Goldberg, & Taube, 1978) because such a large proportion of significant mental health issues are treated in this setting. Other statistics support the contention that primary care providers are central to mental healthcare delivered in the United States. Ormel and others (1994) found that approximately 25–30% of patients in primary care present with depression, anxiety, substance abuse, and somatoform disorders. Primary care clinicians prescribe 70% of the psychotropic medications (Miranda, Hohnmann, Attkisson, 1994) prescribed each year. Some 78% of patients

with a diagnosable mental health condition will seek care from a primary care physician, as opposed to 28% who will seek care from a specialty provider (Miranda et al., 1994).

Although many primary care visits have a psychosocial component, patients often present in this context with somatic, rather than psychological, issues. Thus, the provider must deftly balance the need for an appropriate biomedical work up to rule out serious, treatable biomedical illness, and the need to go beyond the "somatic ticket in the door" to understand underlying psychological issues. Medical family therapists who work in primary care settings can serve a unique role in helping medical providers find this middle ground. (Marlowe, Hodgson, Lamson, White, & Irons, 2012; Robinson & Reiter, 2006). First, they can educate their medical colleagues regarding the importance of conducting an interview that intersperses and integrates both the biomedical and the psychosocial issues from the beginning of the diagnostic process (Doherty & Baird, 1983; McDaniel, Campbell, & Seaburn, 1990 Phillips, Miller, Patterson, & Teevan, 2011). Second, they can serve as a resource for medical providers, both by providing information regarding psychosocial issues and by providing clinical services to patients whose needs exceed the medical provider's capabilities (Hunter, Goodie, Oordt, & Dobmeyer, 2009). This sense of shared care and appropriate back up helps the medical provider delve into psychosocial issues without the fear that they will not know how to manage what they discover.

Tertiary care settings also serve patients with psychotherapeutic needs. In specialty care, there has been an increasing recognition of the need to treat patients holistically, rather than each organ system individually. With this enlarged systems view has come a greater recognition of the impact of illness on individuals and their families (Robinson, Fortinsky, Kleppinger, Shugrue, & Porter, 2009). Tertiary care settings, particularly clinics that focus on chronic and terminal illnesses, have expanded their services to include individual and family support groups and psychoeducation. Data suggests these services help patients cope better and may improve health outcomes (Glasdam, Tim, Vittrup, 2010, Harding, List, Epiphaniou, & Jones, 2012; Kazak et al., 1999; Langelier & Gallagher, 1989).

Chronic illness presents unique challenges and opportunities for medical family therapists. Patients with chronic disorders such as diabetes, coronary artery disease, high blood pressure and cystic fibrosis present with rates of depression and anxiety significantly higher than the general population (Frasure-Smith, Lesperance, & Jalajic, 1993; Mann, 1999; Rozanski, Blumenthal, & Kaplan, 1999). Thus, families often have to cope not only with the impact of the illness, but also with the psychological sequalae. The challenges of adapting to a family member's chronic illness alone can be daunting and has been associated with depression in caregivers (Beeson, 2003; Tsai & Jirovec, 2005). Chronic illness is like an uninvited guest who will not leave—it disrupts normal routines, creates uncertainty, and increases tension.

There are a number of adaptations the family must make to cope with chronic illness (see Box 24.1). First, family roles often need to change, as the ill person cannot fulfill old roles, and caregivers may find much of their time devoted to caring for the ill person. These necessary changes range from reassigning childcare arrangements and domestic tasks, to reworking who oversees the emotional health of the family.

Box 24.1 Continua of Family Adaptations Necessary to Cope with Chronic Illness

- Family role changes to care for the illness—flexible vs. rigid
- Caregiver burden—shared vs. individual
- Financial hardship due to loss of employment and healthcare costs—light vs. heavy
- Family members' accommodation to treatment regimens—willing vs. resentful
- Communication about the illness—open vs. secretive

Second, caregivers often feel stressed and overburdened, while experiencing guilt about these feelings in the context of their own relative health. Caregivers may have difficulty asking others for assistance. In addition, some families have very limited resources available to assist the caregiver.

Third, chronically ill people often see a decrease in their earning power, even a complete inability to work at the same time that medical bills can be very taxing. The financial ramifications can be devastating, particularly if the ill person has been the primary wage earner, or is at the height of their earning potential.

Fourth, everyone in the family must make accommodations for treatment regimens. These accommodations may be relatively simple dietary changes, or may be much more complicated. For example, the family may need to integrate time-consuming treatment regimens into their every day routines. The varying levels of willingness and ability to make such changes amongst family members can create enormous tension (McDaniel & Cole-Kelly, 2003). Well family members may feel resentment as they make difficult changes to assist the ill member of the family. Some family members may willingly embrace necessary changes while others struggle. It is not uncommon for family members to interpret the attitudes toward success with such changes as an indication of loyalty to the ill family member and/or to the family itself.

Fifth, families often struggle to maintain communication about the illness while protecting each other from painful realities. Family members often have different ideas about how much and what type of information should be shared, and with whom. This can be complicated if the illness has a shroud of shame or secrecy (e.g., HIV, chronic mental illnesses) (Landau-Stanton, Clements, & Associates, 1992), or if the prognosis is particularly poor or unclear.

Finally, the family must cope with and grieve multiple losses. These might include the loss of the "old normal lifestyle", loss of function, loss of intimacy, and perhaps the anticipated death of a loved one.

Characteristics of the illness itself also affect the ways the family is challenged, and their options for coping. In his book *Families, Illness and Disability*, John Rolland (1994) describes a psychosocial typology of illness, identifying the elements of different illnesses that stress families in different ways (see Box 24.2).

Rolland notes that different illness courses challenge the family in different ways. Illnesses can have a gradual or sudden onset, and can have a progressive (always getting worse), constant (staying at about the same level), or relapsing (alternating periods of function and dysfunction) course. The course of the illness affects the family in terms of how much uncertainty they must cope with day in and day out, how much time they have to make necessary changes and learn to cope with the affects of the illness, and how much hope they have for the future of the ill person. In addition, families often struggle with how to communicate about the illness course. For example, families coping with a relapsing illness may find that the definition of "relapse" or "health crisis" changes over time as they cycle through health and illness time and time again.

Box 24.2 Elements of Chronic Illness That Stress Families Differentially

- Onset—gradual or sudden
- Course—progressive, constant, or relapsing
- Outcome—non-fatal, shortened lifespan, imminently fatal, or sudden death
- Diability—mild to severe
- Predictability of the course—very predictable to very uncertain
- Genetic component—none, multifactorial, to single gene dominant disorder with high penetrance

Source: constructed from a psychosocial typology of illness presented by John Rolland (1994).

A second illness characteristic that Rolland noted was the anticipated outcome. Outcomes of a chronic illness can be non-fatal, a shortened lifespan, imminently fatal, or sudden death. When the anticipated outcome is non-fatal, the family does not have to engage in anticipatory grieving, but must determine how to cope with the illness over the long haul. The other anticipated outcomes involve various levels of anticipatory grieving, and coping with the uncertain lifespan of their loved one.

Finally, the illness can result in varying levels of incapacitation. Clearly, when the ill family member is largely incapacitated physically or mentally, the illness places greater stress on caregivers and necessitates more role shifts and resource reallocation. In addition, greater incapacitation often places greater financial and social pressures on the family. Financially, the family loses income from the ill person and others who stop working, or have to pay for professional assistance. Socially, greater incapacitation generally results in greater social isolation.

Rolland also notes that all illnesses have a degree of uncertainty/predictability that affects the challenges the family faces as well. Other variables, such as visibility of symptoms, incidence and severity of health crises, and the extent to which the illness has a genetic component, also create different trials for families.

Obviously, the family's own characteristics affect adaptation to illness, as well. The stress of an illness can serve to pull a somewhat disengaged family together, or to heighten tensions in an already struggling family. Pre-existing patterns of communication and roles often become more rigid when the family is stressed by illness. The pre-illness role of the ill family member impacts how stressed the family is by the potential loss of function, and how able they are to replace the functions that person is no longer able to perform.

All families have some patterns of behavior and scripts about illness management before they are stressed by a major illness (Seaburn, Lorenz, & Kaplan, 1992). These patterns can facilitate or complicate healthy adaptation. Destructive scripts include a negative history with the particular illness, a pessimistic view of one's ability to impact particular health outcomes, or a negative history with healthcare professionals.

Finally, illness creates different challenges for families who are in different stages of development. Caring for both children and an ill adult may overwhelm a family with young children. Illness that strikes young people is inconsistent with the normal life cycle, and carries a particularly sad burden. Illness that strikes just as children are planning to leave home greatly complicates the leaving home process. Families that have recently suffered a loss may find it overwhelming to cope with the losses associated with chronic illness. Even illness that is within the normal life cycle can be extremely difficult as adults are "sandwiched" between the needs of their elderly failing parents, and the needs of their spouse and children (McDaniel, Hepworth, & Doherty, 1997).

Special Needs in Medical Family Therapy

The primary theoretical underpinning of medical family therapy is systems theory and the biopsychosocial model (Engel, 1977). The biopsychosocial model emphasizes the interelatedness of biological, psychological, interelational and community factors on health and disease. It applies systems theory to human functioning by recognizing how all of these levels simultaneously affect one another, and how healthcare intervention affects many levels of human experience.

The concept of collaboration is also essential to medical family therapy. Medical family therapists must be willing to bridge the largely separate worlds of mental healthcare and medical care. They must be willing to be "a stranger in a strange land" and learn about medical culture to constructively work in a different set of mores and traditions. Medical family therapists must familiarize themselves with the illnesses of patients, to predict how the characteristics of the illness might differentially stress the family. Medical family therapists must also find a productive means of communicating with medical

providers, and increasing awareness of parallel process between the family, family therapist, and medical team. Creating an environment of collaboration and shared care facilitates each of these goals (Ruddy, Borresen, & Gunn, 2008). Family therapists' joining and systems consultation skills assist in creating such an atmosphere. Often, it takes time and the sharing of difficult cases to create an environment of mutual respect and trust.

Before embarking on medical family therapy work, therapists need to examine some of their own biases and beliefs about illness, the medical system, and the interplay of the mental health and medical systems. Almost everyone has experience with illness and loss in their own family, which can facilitate or complicate working with families experiencing illness. Familiarity with one's own "illness scripts" is essential (McDaniel et al., 1997; Ruddy, 1997). It is very helpful to feel comfortable working with families at multiple levels (individual, couples, and family work), as families often need multiple types of intervention. Ascribing to the belief that all levels of functioning are important, from the interplay of cells to the impact of larger systems on administration of healthcare, helps family therapists avoid an overly rigid view that only their contribution to the intrapsychic and relational functioning of the person and family is important. Family therapists beginning to work in a medical setting should be aware of their own feelings about the medical system as a whole and their role in it. Clearly, negative feelings about the medical culture, or a sense of being treated as a second-class citizen will make it difficult for a family therapist to be productive in this setting.

Medical family therapists also benefit from a collaborative approach with the families themselves. Families facing illness have lost so much control and sense of power that they need their therapist to support them and treat them as equals rather than judge them or behave in a hierarchical "one-up" manner. Therapists who are able to discern and join with the family's chosen "family health expert" have an ally in facilitating growth and change in the family (Landau, 1981).

Special Approaches That Work

Psychoeducation

Family therapists who are familiar with the impact of illness on families can help by educating families about what they can expect, in terms of both the illness itself and how families tend to react to such a situation. This helps the family plan for the future, and normalizes a range of reactions. Information gives the family a sense of agency, as family members learn there are things they can do to help themselves cope and enhance their quality of life (McDaniel et al., 2014). Psychoeducation can be provided through support groups, bibliotherapy, including medical providers in sessions to answer family questions, and multifamily educational groups (Gonzalez & Steinglass, 2002). The rise of social media and online communities has helped many families find information and support (Coiera, 2013). In addition, the family can learn from their own experiences as they discuss the unique challenges they have experienced in the context of illness.

Two examples of psychoeducational groups come from our work at the University of Rochester. The first we termed a "Wellness Group." This psychoeducational group was part of the treatment in a study of collaborative care (medical family therapists and family physicians) for distressed high utilizers of primary care services (Campbell & McDaniel, 1997). This is an underserved population, in that these patients define their problems as "medical," though they have multiple psychological/interpersonal problems in addition to their medical problems. To reach these patients, we developed a six-week multifamily group run by a medical family therapist that included a medical question-and-answer period with a physician, relaxation techniques with a nurse practitioner, and a psychoeducational support group with topics such as communicating with your physician; dealing with stress and understanding how it impacts your health; dealing with chronic problems; and the role of the family in coping with chronic illness.

A second psychoeducational group was for women who tested positive or uncertain to the BrCa 1 or 2 breast cancer mutation genes. The impetus for this group came from a geneticist who had enrolled these women in a study of genetic testing for breast cancer. A year after the study was over, the research team noticed that about half of the women who tested positive or uncertain for the mutation remained distressed. The geneticist asked that we develop some service for these women. We constructed a family-sensitive psychoeducational group for patients who label themselves as having a physical, rather than psychological, problem (McDaniel & Speice, 2001; Speice, McDaniel, Rowley, & Loader, 2002). We used the same format as with the primary care high utilizing patients. A medical family therapist facilitated the six-week group that began with a medical question-and-answer period with the geneticist and genetics counselor. This was followed by a psychoeducational support group with topics developed by the women themselves, including family reactions to testing; disclosure—who in the family is also at risk, who to tell and when; confidentiality with insurers and the workplace; their own emotional reactions and coping strategies; body image; and relationships with physicians and other health professionals.

Promoting Adaptation to the Illness

As mentioned earlier, families have to make many adaptations to manage illness (see Box 24.3). First, family members' roles and the accompanying patterns of behavior, from daily routines to emotional/interactional patterns, must shift. Such shifts may involve negotiating the redistribution of various concrete daily tasks (e.g., who will pick up the children) or may involve more subtle changes in roles, such as the management of the emotional life of the family, or the management of communication in the family (e.g., "switchboard" role). Medical family therapists can help the family redistribute daily tasks by facilitating conversation and planning of tasks and by normalizing that even every day things become more difficult for families facing illness. The more subtle role shifts can be facilitated by making them overt, and facilitating discussion of both what shifts need to be made, and how these shifts affect the family. It is important to highlight the ways the ill person can still contribute to the family in meaningful ways. In addition, the focus on roles can include how the ill person has or has not adopted an "illness role" and how this impacts the rest of the family. Sometimes, the ill person will not accept new limitations, resulting in a great deal of frustration to other family members. Other times, the ill person all too willingly takes on a role of reduced responsibility and then does not function or take responsibilities that are appropriate to his or her actual ability upon recovery or during periods of symptom remission. A very rigid "illness role" can be just as problematic as a rigid "well role (McDaniel, Doherty, & Hepworth, 2014)."

Box 24.3 Techniques to Promote Family Adaptation to Illness

- Heighten awareness of shifting family roles—pragmatic and emotional
- Facilitate major family lifestyle changes—smoking cessation, dietary changes, etc.
- Increase communication within and outside the family regarding the illness
- Help family to accept what they cannot control, focus energies on what they can
- Find meaning in the illness
- Facilitate them grieving inevitable losses—of function, of dreams, of life
- Increase productive collaboration among patients, families, and the healthcare team
- Trace prior family experience with the illness through constructing a genogram
- Set individual and family goals related to illness and to non-illness developmental events

Gender, and the role gender plays in a particular family, also affect the family's ability to adapt (McDaniel & Cole-Kelly, 2003). Rigid traditional gender roles may be problematic in different ways, depending upon who is sick. If the woman becomes ill, the man may feel ill equipped to take on a caregiver role. If the man becomes ill, the woman may take on a rigid caregiver role, and may have difficulty asking for or accepting assistance. In addition, the traditional female coping mode of "emoting" and the traditional male coping model of "action" may clash, particularly when the illness interferes with communication or taking action. Non-traditional gender roles also can be problematic, in that the medical system tends to assume more traditional roles, and may not recognize how an illness differentially challenges a father who is a househusband or a mother who is the primary bread winner. Finally, gender roles can affect how the ill individual copes with the limits placed on them by the illness. Men often have been socialized to "be strong" and "suck it up," making it difficult for them to ask for or accept assistance, or even to acknowledge the illness and its effects. Women's socialization may be more consistent with accepting a passive sick role, making it more difficult for them to take an active role in their medical treatment, or in adjusting to renewed health upon cure or improved management. Medical family therapists can heighten awareness of these issues, possibly enlarging the family's repertoire of role options.

Second, the family may need to make major lifestyle changes. Medical family therapists can give family members a sense of agency by assisting them to help their ill loved one make changes. Without assistance, lifestyle changes such as dietary changes or smoking cessation can become a battleground between family members, and between the family and medical providers. Family discussions of the pros and cons of making changes, as well as the barriers to change, can help family members understand and accept change that is less than optimal. In addition, these discussions can motivate the patient or other family member to make changes, as they become aware of the impact of not changing on other family members, and possibly on the course of the illness itself. Normalizing the difficulty of such changes, and helping the family discuss means of making such changes improves overall coping (Doherty, 1988; Harkaway, 1983).

Third, the medical family therapist must help the family to communicate about the stresses of the illness, and to find support both within and outside the family. This sense of "communion" (McDaniel et al., 2014) can reduce conflict and increase emotional closeness. Facilitating open discussion of how the illness is affecting each individual within the family creates opportunities for family members to better understand each other's experiences, and to support family members who are struggling. This process can maximize the amount of support available amongst family members and highlight how much they need to work together to cope. In addition, reaching out to people outside the family who have experienced similar challenges reduces the isolation that tends to accompany illness, normalizes experiences, and helps families identify means of coping that have worked for others.

Fourth, the medical family therapist can help families recognize what they can and cannot control about the situation. Feeling unable to control aspects of an illness can generalize into an incapacitating sense of helplessness. It is important for family members to identify and understand elements of the illness they cannot control, and begin to accept these issues as reality. Family members with realistic beliefs about what they can control typically cope much better than family members with unrealistic or inaccurate beliefs (McDaniel et al. 2014).

Fifth, finding meaning in the illness can give the family a sense of peace and acceptance (Park 2010, Rolland, 1994; McDaniel et al., 2014). Medical family therapists can help families move beyond "Why us?" and find meaning in the illness. In therapy sessions, the family can be encouraged to reflect on how the illness has changed their lives for the better. This discussion often helps families recognize a purpose for the illness. For example, families often note that the

illness has created greater closeness and made them appreciate each other more. The illness can be a crisis that leads to growth for the family, and put old grievances in perspective.

Sixth, the medical family therapist can help the family grieve. Losses associated with illness range from the anticipated loss of life associated with terminal illness to the simple loss of the sense that we can predict life from day to day (Rolland, 1994; McDaniel & Cole-Kelly, 2003). Discussing death can be particularly difficult, because family members often want to protect themselves and one another from mortality. However, these discussions may help family members make critical decisions at the end of life, and cope better after the death of their loved one (Seaburn, McDaniel, Kim, & Bassen, 2005).

Seventh, the medical family therapist can help families develop collaborative, productive relationships with their medical providers. This can be achieved by helping the family recognize any biases they may have toward the medical community, coaching the family on how to get their needs met and questions answered, and helping the family recognize any parallel process between themselves and their interactions with the medical community. Often families find that their modes of interaction that are functional between themselves are not functional with the medical system. In other cases, the family's struggles are reenacted with the medical team. In addition, the therapist should work collaboratively with the medical team to improve communication and collaboration between the family and medical team. This may be accomplished by having joint meetings with the family and medical team, or by consulting with the medical providers to better understand both sides of the issues (Ruddy, Borresen, & Gunn, 2008).

There are many techniques that are widely used in multiple models of family therapy that find an alternate or complementary use in the context of a medical illness. Many of the above goals can be achieved by giving the family the opportunity to share their illness experience through narratives. Some families are able to simply allow each person to tell the story of the illness from their own perspective, while other families benefit more from the structure of creating an illness timeline together. Genograms are a fantastic tool for eliciting the family's history with illness, experiences with the medical community, management of loss and grief, and pre-illness functioning and structure (McGoldrick, Gerson, & Shellenberger, 1999; Daly et al., 1999). In addition, mapping the family in this way can help make old and new roles more overt. Structured goal setting gives each family member an opportunity to share his or her hopes and fears for the future, and to gauge how realistic the family is about the future.

Managing Problematic Patterns Related to Illness

As noted earlier, the stress of illness often results in the development of maladaptive patterns. Caregiver burnout and depression is a common problem (Schultz, O'Brien, Bookwala & Fleissner, 1995; Tsai & Jirovic, 2005). In many families, caregivers do not feel supported, either because they do not ask for help directly, or other family members are unable or unwilling to help. This type of perceived lack of support can reflect the exacerbation of old issues. Communication difficulties, old resentments, over/under functioning patterns, and other problems can become entrenched or intensified just when adaptability and support are most needed.

Unfortunately, just as the family most needs support, they may be less able to access it. It can be difficult to find time and energy for a social life when the ill person often does not feel well enough to socialize, and the caregiver feels overwhelmed with responsibilities. In addition, friends and family may withdraw because they do not know how to support the couple, or are overwhelmed by their own emotional reactions to the illness. Even within the family, the illness can increase emotional distance, by creating "an elephant in the living room." For example, family members may avoid discussion of the illness to protect other family members, as well as themselves. Finally, couples may experience greater emotional distance if the illness disrupts sexual intimacy.

Other problematic patterns can result from differing coping mechanisms among family members. One family member may withdraw in an attempt to shield self and others from his or her own pain, while others may seek comfort and support from other family members. Differences in coping styles may negatively influence individual and family functioning. Differing levels of denial often cause conflict. Some denial is almost necessary to allow the family to continue functioning, while too much denial (e.g., denial that interferes with appropriate treatment) can be problematic. Family members often disagree on what constitutes a "crisis," when medical personnel should be involved, when family members should be notified of a health event, or how much information should be shared with various people. Some family members may feel that others are making too much of a small issue, while others feel that very real issues are not being dealt with. This tension is particularly challenging for families who are facing illness with an unclear prognosis or treatment plan.

Similar problematic problems can occur when family members are at differing levels of acceptance and understanding of the illness. Differing levels of acceptance can result in mismatched expectations, coping behaviors, and readiness to make decisions and take action. This discrepancy can create conflict, particularly when family members need to make treatment or end-of-life decisions collectively. Such discrepancies can be exacerbated by illness characteristics. For example, an illness that remits and returns may force the family to endure the acceptance process many times over. An illness that does not coincide with the course and prognosis predicted by healthcare providers also may confound the family.

Simply heightening awareness of and communication about problematic patterns is often enough to help families make the needed changes. Sometimes families need a mediator to help them negotiate the new care-giving tasks to ensure no one person is overburdened. In these situations, it can be helpful to create a schedule outlining each person's care-giving responsibilities and ensuring the primary caregiver gets breaks. Clearly, there are times when family members simply are unable or unwilling to help. In these instances, it is useful to help the family procure outside help. Families often need encouragement to continue a social life, and to revive old traditions and routines. Some families find it helpful to create an "illness free" zone in their home, where no one is allowed to discuss the illness and life is to be as close to the "old normal" as possible. At the same time, it is important that the family does not sentimentalize the "old normal" such that any "new normal" will always be worse. Families need to incorporate as much of the positive from the "old normal" while accepting the "new normal" as a reality. In this vein, families often need to determine how their larger social network can be part of the "new normal." Identifying the barriers to continuing a social life, and creating solutions to these problems is essential. Sometimes, it is just a matter of recognizing the importance of maintaining connection with the family's social support, and making this a priority. Sometimes this is complicated when the family had little social interaction before the illness, and has few resources to turn to.

Family therapists working with families facing illness also need to get a history beyond the onset of the illness. Often, difficult patterns predate the illness, or reflect issues unrelated to or simply exacerbated by the illness. Illness can be reframed as an opportunity to discuss and bring closure to old hurts, to improve communication, and to improve family functioning in general. This is one common way that families find a sense of meaning and purpose in the illness.

In summary, family therapists can provide psychoeducation about illness and its effects on families, help families adapt to the challenges that illness brings, and recognize and change problematic patterns that arise in the context of illness. Illness can be the crisis that creates an opportunity for healing and growth, thus giving the family a sense that the illness brought them closer together, rather than drove them apart.

Evaluation/Research Efficacy Research in Medical Family Therapy

Medical family therapy is a young field. Although clinicians have been practicing in

medical settings for some time, it is only in the last thirty years that medical family therapy has emerged as a separate area, with a structure for communication and collaboration among medically centered therapists (Hodgson, Lamson, Mendelhal, & Crane, 2014). Also, because the field has grown largely out of clinical need, it is only recently that researchers have started to use systematic methods to evaluate its efficacy. Also, because the field has grown largely out of clinical need, it is only recently that researchers have started to use systematic methods to evaluate its efficacy (Tyndall, Hodgson, Lamson, White, & Knight, 2012).

Most of the research on psychotherapeutic intervention in medical settings has focused on group and individual interventions. Few of these studies have included family members in interventions, or have measured the impact of the interventions on family functioning or even the functional level of family members.

An early review conducted by Tyndall et al (2014) again illustrated the need for more research on the impact of family interventions in health conditions, noting there still were no randomized control trials comparing medical family therapy to other mental health interventions. Sellers (2000) did conduct a qualitative and quantitative assessment of the impact of medical family therapy with patients receiving cancer care in an outpatient setting. Both patients and medical providers noted that having such services on site was reassuring and relieved emotional stress associated with the diagnosis and treatment. A quantitative survey of patients and families indicated they associated the medical family therapy services with a perceived 90% reduction in emotional suffering.

Other research has sought to discern the critical elements of successful medical family therapy. Hodgson and colleagues (2011) investigated the impact of medical family therapy in an adult oncology setting. Their results revealed three primary aspects of the service that patients found helpful; addressing anxiety in an systemic manner, providing services wherever the patient needed them, and addressing the effect of the cancer diagnosis and treatment on the couple relationship. These results mirrored those of Harrington, Kimball and Bean(2009) in a pediatric oncology setting. Participants cited a sense of relief secondary to the medical family therapists' presence in the medical setting to help them cope with the emotional and relational effects of pediatric cancer.

Some research has examined the correlation of family variables with health outcomes for patients with chronic illness. Helgeson (1994) reviewed the research on the goals of agency and communion, and the association of these constructs with illness coping. She found that unmitigated agency, or unmitigated communion, is associated with increased symptomatology and decreased coping. In other words, balancing an individual sense of efficacy and a relational sense of connection facilitates good physical and mental health outcomes in the context of chronic and serious illness. Medical family therapy works to increase and achieve a balance of agency and communion for the patient and the family.

Future Developments and Direction in Medical Family Therapy

From the scant data discussed above, it is obvious that the most pressing need in medical family therapy at this time is outcome research. Does medical family therapy help families cope better? Do patients who undergo medical family therapy have better health outcomes secondary to reduced stress and better family support and functioning? Does medical family therapy save healthcare dollars? Do physicians note improvements in their interactions with families who have undergone medical family therapy? Do families who undergo medical family therapy have an easier time making healthcare decisions, particularly the difficult decisions families encounter at the end of life? These are but a few of the many important questions yet to be answered.

In addition to "simple" outcome research, medical family therapy must adapt to developments in medical care. Genetic testing is likely to become more central in medicine, with the potential to create myriad family issues (Riley,

Culver Skrzynia et al, 2012). Families must struggle with decisions about who should undergo genetic testing, and how the results for one person affect others in the family. Some couples must decide if they will undergo genetic testing before starting a family, and how they will proceed if the results of the genetic testing indicate potential problems for future children. Medical technology has already blurred the boundary between life and death, complicating already almost impossible decisions families must make at the end of life. Medical family therapists must stand ready to help families confront these new challenges in a productive manner with innovative approaches.

Healthcare delivery systems have been in flux for decades, with no end in sight. The recent focus on Primary Care Medical Homes may set the stage for integrated mental health services to become normative (Baird, Blount, Brungardt et al, 2014). This likelihood, and changes in demographics guarantee that there will be work for medical family therapists for a long time to come. As our population ages, families will encounter more and more difficult decisions and situations that could well come under the purview of medical family therapists.

This seems even more likely, given that "baby boomers" are more open to mental health intervention than their parents' generation. In addition, beyond the sheer numbers of people who will face their elder years at the same time, the "baby boomer" generation has been noted to change the concepts and expectations connected to various life stages. They may not be as accepting of mental and physical decline, and may thus look for a variety of ways to minimize the impact of illness and age-related ailments on everyday functioning (Robison, Shugrue, Fortinsky, & Gruman, 2014). Medical family therapists can assist in this regard.

Finally, changes in disease patterns have created opportunities for medical family therapists. Health threats have shifted from sudden illnesses such as influenza to chronic illnesses often arising from lifestyle variables such as diet, smoking, exercise, and stress. Research indicates that family behavioral patterns significantly impact health outcomes for people with chronic illnesses (Rosland, Heisler, & Piette, 2012). Medical family therapists have a unique skill set to address problematic patterns, and to help families cope with and manage chronic illnesses optimally. These skills underlie the important role medical family therapists are likely to play in the provision of health care in the future.

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25.

SEPARATING, DIVORCED, AND REMARRIED FAMILIES

Robert E. Emery and Diana Dinescu

All family therapists must be familiar with separation, divorce and remarriage, because these are common and often wrenching experiences for families today. Given the frequency of divorce, the emotional turmoil for parents and children and the increased need for psychological intervention, many family therapists may choose to specialize in divorce-related work including family therapy, co-parenting counseling, mediation and/or parenting coordination.

Overview: Some Demographics

Nearly half of first marriages end in divorce in the United States today (Copen, Daniels, Vespa, & Mosher, 2012), and 60% of divorces involve children (Sorentino, 1990). Divorce typically is followed by remarriage, as 78% of men and 69% of women remarry at some point following divorce (Schoen & Standish, 2001). Of all divorces, half occur with the first seven years of marriage (Bramlett & Mosher, 2002). The median length of time between first divorce and remarriage is 3.3 years for men and 3.1 years for women (Kreider & Fields, 2002). Because couples are more likely to divorce early in their marriage, divorces typically involve young children, often including infants and toddlers (Tornello et al., invited resubmission). About one-third of all children will experience the remarriage of one or both of their parents (Copen et al., 2012)

Cohabitation and non-marital childbearing are two additional common and important aspects of family life today. Over half of young people in the United States live together before marriage (Goodwin, Mosher, & Chandra, 2010). And as is already common in some countries (e.g., Sweden, New Zealand), a growing number of American couples are living together as an alternative to, rather than a step toward, marriage (Cherlin, 2009). Cohabitation is also common following divorce, either as a prelude or an alternative to remarriage (Bramlett & Mosher, 2002). In 2008, 41% of childbirths in the United States occurred outside of marriage (Martin et al., 2010), of which an estimated half are to parents who cohabit (Sigle-Rushton & McLanahan, 2002). The large number of children born outside of marriage to parents who do not live together is unique to the United States. In countries like Sweden, almost all children born outside of marriage have parents who are cohabiting (Kiernan, 2001).

We use the terms "separation," "divorce," and "remarriage" throughout this chapter; however, the emotional issues, systems concepts, and most child-related legal issues also apply to people in serious, cohabiting relationships. Thus, "separation" or "divorce" also means "break-up following committed cohabitation," and "remarriage" also means "committed cohabitation following divorce." Although we intend for our discussion to apply to committed cohabitations, which are even more likely to dissolve than marriages (Cherlin, 2009), this chapter does not directly address the issues found among couples who have never lived together or otherwise had a lasting, serious, romantic relationship. People who have children as a result of casual sexual relationships may not experience the painful emotions that accompany divorce, yet the new parents' task of raising children is complicated by the absence of a co-parenting relationship, or really any meaningful relationship. This chapter does not focus on these families, nor do we discuss families disrupted by death. Bereaved families face very different challenges, emotionally and to the family system, than are found in divorce.

Overview: Renegotiating Family Relationships

Divorce is common and socially acceptable today, thus the break-up of a marriage without children may be no more (or less) complicated than the ending of a romantic relationship (with exceptions such as divorce in the face of strong religious beliefs or a long-term marriage). Spouses without children can follow the advice embodied in the common impulse and expression, "I never want to see you again!" In contrast, former partners who are also parents soon face a huge and perhaps unexpected reality. As at least one of them is trying to end their relationship, parents learn: they cannot. Parents are tied together throughout life by their children. They may encounter each other regularly during exchanges of the children or when both parents are present at their children's school or extracurricular activities. Even when one parent is physically absent, he or she is psychologically present. That psychological presence may be indexed by the other parent's feelings of competition or loss, subtle or not-so-subtle denigration of the missing parent, or simply the things children learn they are *not* supposed to discuss about one parent in front of the other. Even after many years pass and children grow older, events like graduations, weddings and the birth of grandchildren make it clear that former partners remain parents together.

Renegotiating Relationships

Because relationships do not end with divorce, families need to *renegotiate* their family relationships (Emery, 2011). Even if they may be desperate to keep everything the same for their children, parents soon learn that these relationships must be redefined as a result of changing boundaries of time, contact, and/or complications in showing love or exercising authority. The renegotiation of parent–child relationships is most obvious for parents who have a relatively small amount of time with their children following divorce. This contact is sometimes called "visitation," a term many find pejorative. Divorced parents and many state laws increasingly refer to "parenting time" or a "parenting plan," a more palatable alternative. Yet, even parents who have sole legal (decision-making) and physical (actual care) custody, or those who share joint legal and physical custody, still must redefine their relationships with their children according to the new demands of parenting alone or across households.

For many divorcing parents, the biggest challenge is renegotiating their relationship with each other, not with their children. The challenge is not merely one of dealing with each other during exchanges, soccer matches, or other times that involve direct contact. The task for divorced parents is a far broader one that includes containing hurt and angry feelings, emotions that can and frequently do lead to conflict around and about the children—or to the denigration and undermining of their children's other parent. Ideally, former spouses who remain parents also will establish an effective co-parenting relationship, where they can support mutual goals in childrearing and directly or indirectly share pride in and love for their children. Effective co-parenting and contained

conflict are among the best predictors of children's successful social and emotional adjustment to their parents' divorce (Emery, 1999).

Remarriage involves a whole new set of negotiations. A parent gets to pick his or her new partner, but remarriage is an "arranged marriage" for the children. Remarriage also involves arranged marriages for the new spouse who is "marrying" the children, the ex, and perhaps the ex's new partner and his or her children too. While family therapists are unlikely to treat all of these people together, they may work with different subsystems separately and surely need to be aware of the influence of relationships that can extend far beyond a single household.

A Plea to Individual Therapists

This chapter is written for family therapists, but we urge individual therapists also to take a systems perspective when working with divorced clients. It may appear therapeutic, for example, to encourage a divorced parent to vent their anger toward their former partner. Yet, the resulting conflict may be detrimental to the children and the needed cooperation in the co-parenting relationship. As an alternative, individual therapists might encourage divorced clients to express their anger in therapy, while learning to contain their feelings in relating to their former partner. We believe such an approach ultimately will be more effective for the individual as well as the family, as will helping the individual client to explore the many feelings that may be hiding behind their anger (e.g., pain, fear, longing, grief and guilt) (Emery, 2011). Finally, we urge individual therapists *not* to diagnose their client's former partners, particularly with a personality disorder (a diagnosis *in absentia* that is frequently relayed to us). Such diagnoses not only undermine motivation for promoting change in the family system, but diagnosing the former partner also undercuts the basic tenet of individual therapy: maintaining an inner focus of change.

A New Family System: Redefining Boundaries of Love and Power

A basic and essential problem in divorce is that the family's boundaries have crumbled and may be in dispute. No one knows where they stand, and different family members are likely to want different rules, different relationships. Typically, the central conflict is intense debate about distance, or closeness, in the relationship between the former partners.

Because most divorces are one-sided (Braver, Shapiro, & Goodman, 2006), former partners often are in dispute about their boundary of love, specifically, whether their relationship is *really* over and, if so, what their new relationship will become. Elsewhere, we have argued that love and power are the two basic dimensions of family relationships (Emery, 1992), thus family members can have "power struggles," "love struggles," or mixed conflicts where one member is focused on love and the other on power. The leaver wants the marriage to end, but because of concerns about the children, genuine caring for the former spouse, or perhaps as a tactic to hasten legal negotiations, the leaver may still hope to "be friends." The problem, of course, is that the left partner is unlikely to want to be friends—or to quickly wrap up a legal settlement. In fact, he or she may contest an agreement about the children or money as an indirect, and usually ineffective, way of contesting the end of the marriage. ("I'll make leaving so bad that you'll have to stay.") The left partner may feel like she or he has only one emotional choice: to be lovers or enemies.

As a result of the ill-defined love boundary, conflicts may erupt about all sorts of issues. Conflict may be direct and focus on topics like getting together to talk about the children, attempting to reconcile, or dating others. Often, however, the conflict is indirect. The children are likely to be a frequent focus, since they link the partners together. For example, one parent may insist that "the children" need the parents to be friendly, while the other claims that "the children" are not ready to see their parents dating. Such expressions may indeed be partially about the children, but they frequently include each parent's projections. Putting feelings onto the children is far safer emotionally than saying, "I won't feel so guilty if we can be friends" or "I can't tolerate the idea of you dating when I'm still in love with you."

Partners in the Business of Parenting

The "solution" to this central love struggle is twofold. (We put solution in quotes, because there is no easy or fast cure in therapy or for either of the parents.) On a systems level, we encourage divorcing parents to not to try to be lovers, friends, or enemies, but to be business partners instead. Divorced parents have a job to do, not a relationship to resolve. That job, of course, is to continue to raise their children, as best they can, despite their (likely) divorce. Toward that end, we encourage parents to view themselves as partners in the business of parenting their children, and we urge them to use the metaphor as a guide in relating to each other. Business partners are polite but distant socially. Their relationship is defined clearly and formally (e.g., schedules are followed, no late night telephone calls). They keep emotions out of their relationship, even when they are upset.

Moving from being lovers to becoming business partners is a huge change, obviously, and we recognize that divorcing parents are not robots. So, even as we urge them to work toward a businesslike relationship with each other, we also urge them to address their emotions—just not with their ex. For the partner who is left, this is likely to mean working through their grief and other hard but honest emotions that may underlie their anger. The partner who is leaving may face less clear emotional tasks, but he or she typically needs to slow down, accept that their former partner is in a different place emotionally, and perhaps deal with their own grief or unrealistic fantasies of a new life (including the future of an affair if they are involved in one).

Divorced Parents' Power Struggles

Unlike the boundary of love, which may disrupt legal proceedings, but is not considered in a "no fault" divorce, the law explicitly addresses several power issues between divorcing spouses. Legal decisions redefine financial power by dividing marital property, perhaps awarding spousal support (alimony), and specifying an amount and mechanism for paying child support. The law also redefines some boundaries of parental authority, at least generally, by determining legal custody (decision making) and physical custody (a parenting plan).

There is no bright line between joint and sole physical custody; a parenting plan where children spend at least 25–35% of their time with each parent commonly is viewed by experts as constituting joint physical custody (e.g., Bauserman, 2002; Buchanan & Jahromi, 2008). Interestingly, child support laws in different states define widely varying thresholds for joint physical custody, as child support is modified accordingly. In 2006, the lowest threshold for modifying child support due to joint physical custody was fifty-two overnights per year in Indiana; the highest threshold was 164 nights in North Dakota (Brown & Brito, 2007). The exact numbers are arbitrary, of course, but this variability underscores two points. First, the division of parenting time is, at least in part, and economic decision. Second, there are many definitions of joint physical custody, not just 50/50. In fact, we worry when we hear a parent insisting on sharing precisely equal time with the children, as this often signals a focus on oneself and not the children.

Parents with joint legal custody share responsibility for making major decisions in their children's lives. Laws generally limit shared decision making to education (choice of schools), elective medical care (e.g., whether a child needs psychotherapy), and religious upbringing, plus a few less common circumstances (e.g., passport applications). A parent with sole custody can make these decisions alone. Except in very unusual circumstances, a parent who does not have legal custody still has a right to access to his or her children's school and medical records, as well as to spend time with the children and exercise parental authority during these times.

The law thus provides broad guidance, but divorcing couples still must negotiate their own rules for parenting and co-parenting. Examples might include appropriate bedtimes, dress, extracurricular activities, and study or eating habits, as well as how to actually make major decisions (if parents share legal custody, as most now do). This renegotiation of parenting roles often is confusing and strained, as parents try to assume roles formally preformed by the other parent (e.g., as disciplinarian or caretaker), unilaterally

make decisions that affect not only the children but also the other parent (e.g., extracurricular activities that affect both parents' schedules), or enact disputes in their relationship through their connection via the children.

As with other conflicts, a family therapist or mediator can help parents to negotiate and to develop very clear, somewhat rigid boundaries of parental authority. Key parenting decisions may be negotiated with professional help, perhaps repeatedly as children's schedules change with each season. Through education and experience, divorced parents learn that shared custody is not a license to micromanage, but their communication and cooperation about minor issues still can be enormously important (e.g., continuing medical care across households, presenting a united front for discipline). One technique for balancing these completing goals is to help parents develop a structured method for communicating about the children. For example, they might schedule a brief, weekly telephone call at a set time when the children are in bed. Texts or emails also can be useful for addressing minor, practical issues, but can be cumbersome and encourage inappropriate venting and misinterpretation about more difficult issues. Inflammatory, written communications can provoke conflict, and they may also end up as evidence in a court hearing.

Boundaries of Love in Parent–Child Relationships

Divorce can cause children to feel less secure in their parents' love. Some insecurity stems from realistic concerns such as spending less time with one or both of their parents. In addition, the attention and affection children receive may be diminished as a result of the parents' emotional and practical concerns. Other doubts may stem from children's fears and fantasies. For example, many preschoolers and school-age children fear that their divorced parents will abandon them (Kurdek & Berg, 1987).

Because of such fears, realistic or not, parents are wise to reassure children of their unconditional love—and hopefully of the other parents' love too. A particularly important time for discussing this bedrock of affection is when divorcing parents sit their children down for "the talk," the painful discussion about their plan to separate. Offering such mutual reassurance at this time can be as difficult for hurt and angry parents to say as it is essential for their children to hear. Yet, many parents succeed in putting their children first from the outset. We recommend keeping the discussion short, focused on practical implications for the children, and underscoring the parent's shared and indivisible love for their children. Elsewhere, we elaborate on these principles, and even offer sample scripts (Emery, 2006). Ultimately, of course, reassurance about parental love stems from actions not words, which is perhaps the most important reason for talking with the children together.

Following a martial separation, non-residential parents often complain about the difficulty of trying to "love children on a schedule." Structured and perhaps infrequent access to one's children certainly is a huge change and emotional challenge, and such complaints are understandable from the parent's point of view. But children benefit from predictability in the schedule, especially soon after a divorce (Healy, Malley, & Stewart, 1990). And despite strongly held opinions and personal desires about joint physical custody, from the perspective of children's emotional well-being there is no single, ideal amount of time for non-residential parents to spend with their children. The quality of their relationship with their non-residential parent predicts children's psychological adjustment; the quantity of contact does not (Amato & Gilbreth, 1999).

Residential parents, in contrast, can struggle with showing their children consistent love due to preoccupation with their own emotions, financial worries, or the burdens of parenting alone. Residential parents also may need to work more, use more childcare, and try to carve out time for new social activities like dating. These circumstances can lead to a short supply of love and attention, plus another related danger. Some parents become overinvolved with or dependent upon their children following a marital separation. This can lead to a reversal of roles, so that the child becomes the caretaker for the parent's emotional needs. (Asking children for increased *practical* assistance with chores or carrying for

siblings is much less of an emotional burden for children, even though they may resent the added responsibilities.) The actions of an emotionally "parentified" child may *look* resilient, and dependent parents sometimes laud such a child's strength. But attempting to care for a distraught parent is a developmentally inappropriate burden, one that can teach children that they are responsible for others' (un)happiness. This unrealistic belief can increase the risk for future depression and relationship problems (Emery, 2006; Peris & Emery, 2005; Peris, Goeke-Morey, Cummings, & Emery, 2008).

Boundaries of Power in Parent–Child Relationships

As long as they respond to the children's needs, and do not reverse roles, parents are not likely to make mistakes in loving their children. On the other hand, discipline often becomes a big problem for parents in divorce (Hetherington & Kelly, 2002). Guilt and uncertainty—perhaps one parent relied on the other for discipline—can lead parents to define unclear or inconsistent boundaries of parental authority with their children. Divorced parents do not have a handy partner to consult about discipline, or to help enforce rules. In fact, one or both parents may actively undermine each other's discipline efforts in an effort to "win" the children to their side by being the "nice" parent.

Residential parents spend more time with their children, and often encounter more difficulties with discipline. They can mistakenly attribute children's misbehavior to the divorce, for example, and rules that had been standard become a source of internal debate and perhaps an indulgence. Parents can forget that testing the limits is completely normal for children, even children who say, "But Dad (or Mom) lets me do it!" Thus, the most useful focus of discipline (and family therapy about discipline) often involves increasing parents' confidence, not questioning children's motivations. As with redefining other boundaries, clarity and consistency are the keys to effective discipline. Bedtime can be 8:30, 9:00, or 9:30, as long as it is consistent and consistently enforced.

Non-residential parents also may discipline less often and less effectively; some discipline their children very little or not at all. These "Disneyland dads" (or moms) turn their limited time with their children into a trip to fantasyland. Everything is always fun, too much is never enough, and nothing is ever wrong. While non-residential parents understandably want to make the most of their limited contact with their children, fantasyland visits are *not* normal. A normal, healthy parent–child relationship includes both "down time" and discipline, and non-residential parents may especially need to hear this reminder.

Children are not the only ones who benefit from a more normal relationship with the non-residential parent. Many residential parents feel like they do all of the work, while the non-residential parent has all of the fun. Non-residential parents who discipline appropriately, however, not only share the load with their co-parent but they also achieve their goal of being more of a presence in their children's lives.

Overview: Key Emotional Tasks

While family interventions focus on systems dynamics and change, divorce and remarriage involve enormous individual emotional challenges. Family therapists must recognize the similar, different, and ever-changing emotions that various family members are likely to experience. Some of these feelings may be addressed briefly in family therapy, perhaps through education and referral for individual therapy. We briefly touch on central issues below. We have elaborated on these themes in detail elsewhere (Emery, 2006, 2011).

Divorced Parents

As noted, difficult divorces are rarely equally desired by both parties, and much divorce conflict centers on the differing emotional and relationship agendas of the leaver and the left. Anger typically is at the forefront of their disputes, and in the eyes of family therapists and mediators, dealing with that anger often is the most vexing and unpleasant task. As we have

discussed (Emery, 2011) and elaborate on briefly later, anger often is an "emotional cover-up" for deeper, more honest and more painful emotions. Thus, we begin our discussion of divorcing emotions as we begin therapy, by looking beyond and beneath anger.

Grief

Divorce involves multiple losses: the loss of a lover, a partner; the loss of one's role as a husband or wife; lost time and experiences with your children; lost connections with extended family, friends, and social roles; perhaps the loss of your home, cherished possessions, savings, and financial plans. Divorce involves the loss of hopes and dreams, of trust and security.

Grief is a normal, healthy response to loss, yet grief often goes unrecognized or unacknowledged in a divorce. Divorcing partners often fail to identify their own grief, or their children's. Even mental health professionals can overlook the grief that is central to many emotional and interpersonal conflicts in divorce.

A central problem with grief in divorce is that nothing is final. The possibility of reconciliation means that hope can live on during a separation, after the legal divorce, even when one partner is about to remarry—or beyond then. If a loss is uncertain, when does grief start? If hope is not dead, does one have to kill it? Such questions mean that, in contrast to bereavement following death, grief in divorce is likely to be delayed, interrupted, repeated, and prolonged.

People grieve in different ways, even within the same family. The partner who leaves is likely to see a separation as final. He or she may have begun grieving months or even years earlier, while contemplating and deciding to separate. The left partner, in contrast, may deny the loss, cling to hopes of reconciliation, and refuse to grieve, because grief means the relationship is over. The leaver and the left grieve in different ways, and this can lead to misunderstanding, conflict, and insensitivity to the children. Each parent may project their own feelings onto their children, but children's grief is likely to differ from either parent's. In fact, if both parents stay involved in their life, children may have less to grieve than their parents do.

Dominant theories suggest that grief proceeds in series of predictable stages (Bowlby, 1979; Kubler-Ross, 1969)—including an angry stage. Such descriptions convey a sense of organization and control, and imply that grief is time-limited. Grief in divorce is not so tidy, however. Our theory of cyclical grief in divorce emphasizes frequent, wrenching swings between feelings of love, anger, and sadness (Emery, 1994, 2011). Grief in divorce is an "emotional rollercoaster," although at any one point in time one emotion dominates to the exclusion of other feelings.

Therapists can encourage divorcing clients to recognize their grief and to experience their "missing" emotions. Often, this means encouraging feelings of sadness or longing that lie behind anger, an emotion that is much safer to express. (A longing spouse may unwittingly want to "get a reaction" from his or her ex by infuriating them. This tactic for testing if the partner is still "hooked" is far less risky than saying, "I miss you. Do you miss me?") Because of the emotional risks and the differences between the leaver and the left, therapists should raise issues related to grief when meeting alone with each partner. Goals may include increasing awareness, getting beyond anger, or making referrals for individual therapy.

Pain, Longing, Fear, and Guilt

Like grief, other emotions often lie beneath anger in divorce. Perhaps the most important is intense emotional pain. Like the rage people feel (and express) toward inanimate objects after stubbing a toe, much of the fury former partners vent at one another is fueled by the stabbing pain of rejection. In fact, neuroscience evidence shows that the same brain regions are involved in processing physical and emotional pain (MacDonald & Leary, 2005; Panksepp, 2005), thus the adaptive covering of pain with anger, as well as the primitive desire to hurt back (to kick the furniture a second time), is rooted in the deep evolved structures of the emotional brain. As with grief, the short- and long-term goal of therapy is to help clients recognize and begin to heal the pain

behind the anger. Also as with grief, partners are unlikely to discuss their hurt feelings in family therapy. Rather, the emotional insight can help them control anger, make needed interactions more productive, and identify an issue that might be addressed in individual therapy.

Very similar emotional dynamics and evolutionary origins explain how longing, fear, and guilt can lie beneath anger in divorce (Emery, 2011). Like the outbursts of a toddler who cannot find his way back to an attachment behavior, some angry expressions in divorce are best viewed as a form of "reunion behavior." Family systems theorists have noted that high-conflict couples are enmeshed, not disengaged (Minuchin, 1974); the opposite of love is indifference, not hate. At other times, anger can be part of a fight or flight response, whether one feels under attack or is frightened by the many uncertainties of living a new life alone. Finally, some argue that guilt too has evolutionary origins (Haidt, 2001). In any case, shifting all responsibility for the failure of a marriage onto a former partner surely is an effort to alleviate guilt, even though embracing responsibility for one's own actions, including one's failings, is ultimately the most healthy course of action.

Children's Feelings

Of course, children can feel similarly as a result of divorce, although they are likely to express their concerns in age-appropriate ways (e.g., self-blame in preschoolers, studied indifference or rebellion among adolescents). As noted, parents must guard against projecting their own emotions on to children, and if relationships with both parents are maintained, divorce may entail fewer losses for children than for their parents.

While divorce may involve less loss for children, remarriage is likely to offer fewer solutions than for the parent who is remarrying. Parents need to recognize that, while they got to pick their new partner, the relationship is an "arranged marriage" for children. This analogy implies that children should not be expected to feel immediate warmth toward a stepparent. Positive feelings may evolve over time, especially if the stepparent earns a child's caring and respect (and if their other biological parent does not attempt to undermine this relationship).

New Partner's Emotional Challenges

Similarly, new step-parents cannot expect—or be expected—to feel immediate connections toward stepchildren. "Go slow" is the best advice all around, particularly regarding a stepparent's role in discipline. As with the normal development of parent–child relationships, attachment comes first. The initial (and perhaps the only) goal for step-parents is to become an "adult friend" to their stepchildren, particularly teenagers.

Step-parents also face a host of other potential emotional challenges. Especially if they do not have children themselves, they may feel neglected by their new partner, much of whose time and energy is directed toward their children. Step-parents also may feel threatened by or competitive with a former spouse, or perhaps jealous of any interaction between the former partners. Fueling conflict may ease some of these insecurities, while creating a new set of problems. However, step-parents can embrace their new roles, accept inevitable challenges, and perhaps reduce conflict by supporting both biological parents and even facilitating negotiations between them. Even in this latter circumstance, the norm and expectation today is that, except in situations of (near) abandonment, biological parents remain their children's parents. They are "mom" and "dad" with all attendant connotations. Parental authority should not be delegated to a new spouse by one parent, nor should a stepparent attempt to usurp this role from either biological parent.

Remarried couples with children do not have as much time alone as couples without children to build their relationship and to create a strong marital bond. Their focus, instead of being solely on each other, is at best shared with the child, or at worst completely absorbed by the child. This lack of initial privacy and bonding opportunities can have a negative effect on relationship quality and satisfaction (Michaels, 2011). If, in addition, one of the partners has never been a parent before, the tension can be even stronger as one spouse is learning parenting skills while at the

same time negotiating his relationship with a stepchild (Michaels, 2011).

In some cases, the biological parent has been alone with the child for a prolonged period of time, and the two have formed certain routines and interaction patterns. The subsequent appearance of a new family member who will share the parental role may be met with resistance by the child, who may fear that the relationship with his parent is growing apart. The child will miss the time spent exclusively with the parent and may reject the step-parent, who is seen as the cause of this sudden loss of the time and special relationship that the child shared with his biological parent. The biological parent will need to bridge the gap between the stepparent and the child, since the child may be unwilling to submit to disciplining or to be open in creating a positive relationship with the stepparent. At the same time, the biological parent may have to educate the spouse about previous rules of the household, and negotiate new rules and shared parental responsibilities.

The issue of loyalty is very important in stepfamilies. The biological parent finds himself or herself having to divide time and emotional availability between the child and the stepparent, which can create internal tension. The parent could often end up feeling guilty about spending time with the child to the detriment of the new partner, or vice versa. In families where both partners have children from previous marriages, biological parents will naturally feel more attached to their own children (Sweeney, 2010), which can also create feelings of guilt and internal conflict.

Children, too, are prone to experiencing major loyalty conflicts, as they may feel that not getting along with the stepparent will disappoint their residential parent, while forming a bond with them means betraying the non-residential parent (McGoldrick & Carter, 2011). Especially if the biological parents do not get along, the child is often the one who most acutely experiences the contention. For instance, if the parents fight or badmouth each other in front of the child, that can introduce a lot of tension into the child's relationships and could lead to significant internal conflict (Everett, Livingston, & Bowen, 2004). As noted earlier, this makes it very important for the biological parents to work toward creating or maintaining a good relationship with the each other at least throughout the child's young life.

As in a first marriage, or ever more so, the financial aspect of a remarriage is also very important (McGoldrick & Carter, 2011). Issues such as who makes more money and who has more children from a previous marriage can create problems for the new family. The divorced parent may have to pay child support, or may have already made financial decisions about the child's schooling (i.e., private college fund) in which the new spouse did not partake. While they may not be present in every case, these concerns should be assessed by the therapist along with every other issue specific to remarried couples. After a thorough assessment, a family therapist will decide how to address the family's concerns and work with them to strengthen the family unit.

Current Thinking about Family Intervention in Divorce and Remarriage

There are a number of potential and active interventions with divorced and remarried families, including legal interventions that can be quite intrusive in terms of making parenting decisions and restricting parenting time (Emery & Emery, 2008). Unfortunately, almost all of these sundry efforts share one commonality: a limited or nonexistent research base. In the following sections, we offer an introduction to several interventions, particularly efforts to create more "family friendly" resolution of legal disputes. We then outline some key principles for family therapy in divorce and remarriage.

Legal Issues: Alternative Dispute Resolution

The break-up of a marriage (or an unmarried relationship that produced children) raises a number of legal as well as psychological issues. These include legal and physical custody, as discussed earlier, and also the key financial issue of child support, spousal support (alimony), and property division. We offer only a few observations

about these potentially complex issues here. First, parental disputes about the children often are intertwined with financial matters (e.g., who pays child support and how much; who stays in the family home). Second, the emotional dynamics discussed earlier are typically intertwined in legal disputes (e.g., the left parent may contest legal issues as a way of contesting the end of the marriage). Third, many legal and psychological commentators fear that the adversary legal system can exacerbate rather than solve parental conflicts to the detriment of children (Emery & Wyer, 1987). Because of this last concern—and because courts are overwhelmed with divorce-related disputes, a great deal of effort in recent decades has gone into creating methods of alternative dispute resolution (ADR) (Emery, Sbarra, & Grover, 2005). We briefly outline the main developments below in order from least to most intrusive interventions.

Couple Therapy and Divorce Education

Traditionally, couple therapists refer clients to lawyers when conjoint therapy ends in a decision to separate. For reasons we have discussed in detail elsewhere, we view this as a mistake and a disservice to divorcing families (Emery & Sbarra, 2002). While couple therapists differ about whether staying together is the overriding goal of therapy, for couples with children, the decision to separate sets off a crisis through which parents desperately need guidance in renegotiating family relationships. Separating spouses undoubtedly need legal advice, but they also need emotional and relationship guidance through this difficult transition. A couple therapist may well be in the best position to help families to begin their renegotiation, and should carefully consider transforming rather than ending the therapy relationship (Emery & Sbarra, 2002).

At a minimum, couple therapists can educate separating parents about how divorce is likely to affect their children—highlighting the problems caused by parental conflict and the benefits of cooperation in supporting children's relationship with both of their parents. Education also can describe alternative methods of dispute resolution (discussed below). In fact, *divorce education* is one of those alternatives. Many states and/or local jurisdictions require divorcing parents to attend a series of educational sessions (Blaisure & Geasler, 1996), sometimes completed online (Bowers, Mitchell, Hardesty, & Hughes, 2011). Evidence on the benefits of divorce education is limited with perhaps the best outcome being increased awareness of children's needs and increased readiness for ADR (Sigal, Sandler, Wolchik, & Braver, 2011).

Divorce Mediation

The most firmly established form of ADR, both in terms of practice and research, is *divorce mediation*, where divorcing partners meet together with an impartial third party who helps them to discuss and hopefully resolve disputes about their children and perhaps financial matters too (Emery, 1994, 2011). Mediation almost always is strictly confidential (i.e., matters discussed in mediation cannot be used in legal proceedings), and the mediator has no decision-making power. Rather, mediators facilitate communication and perhaps offer advice toward the end of helping parents resolve disputes. Empirical evidence clearly shows that mediation resolves 50–75% of disputes, greatly reduces court hearings, creates higher levels of party satisfaction compared to litigation, and perhaps reduces expenses (Emery, Otto, & O'Donohue, 2005). A twelve-year longitudinal follow-up of a randomized trial of mediation and litigation found that mediation also reduced parental conflict over the long run, while increasing children's contact with *both* parents, improving parenting quality, and allowing parents to make more informal changes in their parenting plans over time (Emery, Laumann-Billings, Waldron, Sbarra, & Dillon, 2001). In many states, mediators need not have a professional degree, although many experts believe that mental health professionals or attorneys make the most effective mediators.

Collaborative Law

Collaborative law is an innovation in the practice of divorce lawyers which, like mediation, touts the benefits of more cooperative dispute

resolution in divorce for children, parents, and perhaps finances too. The key is that collaborative lawyers and their clients sign an agreement indicating that the lawyers will no longer represent their clients if they fail to reach an out of court settlement (Tesler & Thompson, 2007). This creates an incentive for the parties and the lawyers to settle rather than try cases. Collaborative lawyers also sometimes embrace other practices, such as negotiating openly and in good faith rather than using adversarial legal tactics, and perhaps involving other "collaborative professionals" like financial experts or "divorce coaches," mental health professionals who coach individuals, couples, or families through the emotional process (Tesler & Thompson, 2007). While widely discussed and apparently used with increasing frequency, the effectiveness of collaborative law has not been compared with mediation or traditional legal practice in any systematic empirical research.

Custody Evaluations

A *custody evaluation*, an assessment of an individual family's legally relevant aspects of children's and parents' well-being in divorce, traditionally has been used as a part of adversary legal proceedings. However, some commentators view custody evaluations as a form of de facto arbitration because judges routinely follow the recommendations of neutral evaluators (Emery et al., 2005). Recent innovations in the practice of custody evaluations have made this implicit goal explicit. For example, "early neutral evaluations" are performed before formal legal proceedings and are inadmissible at trial, but have the goal of encouraging parents to settle their parenting disputes (Santeramo, 2004). Some initial evidence suggests that they do just that (Pearson, 2006). While traditional custody evaluations are still the norm, many experts are coming to view custody evaluations as a potential dispute resolution technique.

Parenting Coordination

One of the newest and fastest growing areas of divorce ADR is *parental coordination* where a mental health or legal expert first tries to mediate parenting disputes, but if mediation fails, the mediator becomes an arbitrator (i.e., he or she assumes decision-making powers, like a judge, but more limited). Parenting coordination is used primarily with high conflict, repeat litigation cases in an effort to keep divorced parents from abusing the legal system, each other, and their children (Coates, Deutsch, Starnes, Sullivan, & Sydlik, 2004). The authority of parenting coordinators may be limited to more minor decisions (e.g., deciding how parents will share a holiday when they are in a last-minute dispute), and parents can appeal decisions made by parenting coordinators to a court. To date, parenting coordination has been enthusiastically embraced and is a growing practice, but this form of ADR has not been studied in randomized trials (Sullivan, 2013).

Family Therapy Research and Principles

A wide range of educational, psychoeducational, and psychotherapeutic interventions have been developed specifically for divorcing families. One might expect to find a large body of research on alternative treatments given the importance of divorce as a risk factor for both children and adults, the high frequency of family dissolution, the effects on and efforts of the legal system, economic consequences, and professed public and political concerns. On the contrary, *no randomized trials have been conducted on alternative therapies for divorced families or individuals*, including family therapy, our present focus. Other than the randomized trials of mediation mentioned earlier, random or quasi-random trials have been conducted on only two preventative interventions: 1) groups for divorced mothers (and perhaps their children) and 2) school-based groups for children from divorced families. We briefly consider these topics before outlining some principles for family therapy in divorce.

Parenting Groups

The most thoroughly studied family intervention in divorce is New Beginnings, a psychoeducational program designed to prevent the development

of psychological problems among children from divorced families. The eleven-session, structured group program for custodial mothers underscores the importance of mother–child relationship quality, effective discipline, interparental conflict, and father's access to children's well-being. An eleven-session group for children focuses on cognitive, coping, and family relationship skills. In two randomized trials and a six-year longitudinal follow-up, the intervention was found to improve mother–child relationship quality, which, in turn, mediated improvements in a variety of indices of child adjustment (McClain et al., 2010). A conceptually similar program run and evaluated by a different research team also found that a parent training program for custodial parents led to reduced child externalizing behavior among divorced families (DeGarmo & Forgatch, 2005). As an alternative, a program targeting non-custodial fathers and designed to improve both father–child and co-parenting relationships has shown promising evidence for reducing child behavior problems and preventing the deterioration of co-parenting quality (Cookston, Braver, Griffin, de Luse, & Miles (2006).

School-Based Children's Groups

While not directly relevant to family therapy, school-based groups for children from divorced families merit at least brief mention as one of the few, empirically evaluated areas of intervention in divorce. The best-known and most thoroughly evaluated group is the Children of Divorce Intervention Program (CODIP), a school-based preventative group designed to foster support and share coping skills among group members. CODIP programs have been adapted for children of various ages and have been demonstrated to reduce children's behavior problems and improve healthy coping in several controlled studies (Pedro-Carroll, 2005). Importantly, conceptually similar groups have also been shown to produce documented benefits by an independent research team (Stolberg & Mahler, 1994).

Themes for Family Therapy

Even though there is no direct treatment research on family therapy for divorced and remarried families, the issues outlined earlier in the chapter are based largely in empirical findings and thus form the foundations for an evidence-based approach. In this section, we highlight a few key themes for family therapy that are consistent with that discussion.

Perhaps the most basic theme is that, when children are identified as having emotional problems or being part of a wider family concern, family therapists should contact and hopefully involve both biological parents. It is distressing, and surprising, how often parents and especially therapists can "overlook" the importance of the other parent. If the parents share legal custody, then a therapist is required to get both parents' consent for treatment, since elective medical care is decided together as a part of joint legal custody. Even if one parent has sole custody, a family therapist is wise to contact the other parent, if he or she has significant contact with the children, as that relationship is likely to be important psychologically, as well as for supporting, or undermining, therapy. A family therapist may want to work with both parents together or see them separately, depending on their level of conflict, the goals of treatment, and the children's comfort.

A second theme is that, as in family life, biological parents come first when it comes to involvement in therapy and decision making about children. In order to reinforce the central role of the biological parents, we have, at times, refused to include step-parents, grandparents, and even lawyers in initial family therapy sessions, despite their wish to attend. The reason for doing so is not to diminish the importance of these parenting figures, but to underscore the biological parents' authority and responsibility, which includes not only a primary parenting role but also overseeing the roles played by new spouses, their own parents, and, yes, even lawyers. In cases where another adult is playing a substantial role in children's lives, we have included them later in treatment, once the role and responsibilities are made clear. In still other cases, remarriage issues are the focus of treatment, as we discuss below.

A third theme of therapy with divorced families is keeping children out of the middle. Achieving this may involve a variety of specific scenarios. Parents might be seen separately with

children, so the children are not exposed to parental conflict. Separately or together, parents may be directed or maneuvered to avoid pulls for children's loyalty, which creates dilemmas about loving one parent more or less. At other times, parents might be encouraged to present a united front, backing up discipline in each other's home. And, unless they express clear, reasonable, and strong preferences on their own, we generally refrain from giving children too much of a "voice" about matters like the parenting plan schedule. Asking children about decisions that appropriately belong to parents often ends up giving children the responsibility of choosing between their parents, not acknowledging children's "rights" (Emery, 2002; Guggenheim, 2005).

Consistent with the prevention efforts of parent training groups, a fourth theme is working on parenting—and co-parenting. Family therapy may focus on one or both parents' individual relationships with the children, including themes related to providing consistent love/attention and/or discipline/rules. Co-parenting work may address loyalty dilemmas, but often focuses on establishing more consistent rules and routines across households. Establishing effective means of communication outside of family therapy also is a key goal of co-parenting work.

A fifth theme of family therapy is to address the parents' issues, even if the identified focus is the children. When working with divorced parents together, establishing a more businesslike co-parenting relationship is a common goal. A more individual focus might involve alleviating a parent's guilt, so he or she can discipline more effectively, or identifying a parent's grief or depression and how it is interfering with childrearing. Whether working with divorced parents together or separately, another very common goal is addressing parentification, so that children are not taking care of one or both parents' needs. Renewed co-sleeping with a 6, 8, or 10 year old "because the child wants it" is a concrete issue linked with parentification that we have had to address with any number of families.

A sixth and final (although not exhaustive) theme is to address legal issues, or at least not to shy away from them. Many legal matters in divorce involve emotional and child-rearing issues. A family therapist can offer education and guidance about parenting, co-parenting, and constructing a parenting plan after divorce whether or not the therapist is serving as a mediator. Family therapists should not simply say, "You better talk to a lawyer," about matters of such importance to divorced family life.

Stepfamily Therapy Research and Principles

Given the high likelihood of remarriage following divorce, and the potential hardships that remarriage causes for partners and children (discussed above), it is surprising that research is so scarce with regards to therapy interventions for remarried couples. In fact, randomized controlled trials of such interventions are impossible to find. Nevertheless, studies have suggested a number of factors that clients see as helpful in therapy, as well as therapy-specific issues they might struggle with. Initial family characteristics, as well as therapist traits, are some of the important contributors to the success of stepfamily therapy and outcomes (Pasley, Rhoden, Visher, & Visher, 1996; Visher, Visher, & Pasley, 1997; Greeff & Du Toit, 2009).

Initial Family Characteristics

In a study on aspects of family resilience that are associated with the adaptation to life in a new family, parents and children responded to questionnaires which identified a number of important factors: internal family relationships and support among family members; good communication with their families; a stable marriage relationship; family hardiness, characterized by adapting to hardship through working together; spirituality and religious beliefs and activities; social support, represented by the presence of good social networks; family time and routines; positive individual personality traits; and relationships with previous marriage partners (Greeff & Du Toit, 2009). These factors were identified as the most important for the accommodation to a new family environment.

Therapist Traits

Therapist characteristics that study participants tended to endorse as very helpful in stepfamily/

remarriage therapy were validating the client's feelings, having expertise, and normalizing the stepfamily situation for the clients (Visher et al, 1997). Therapists who were knowledgable about stepfamily issues and respectful of the uniqueness of stepfamily life were seen by clients as beneficial. However, those lacking such knowledge were perceived by stepfamily members as unhelpful (Pasley et al., 1996). In a study conducted on both men and women who had sought stepfamily therapy, the most unhelpful factor in therapy was found to be therapists' ignorance about stepfamily issues and dynamics (Visher et al., 1997). This led to problems such as "The therapist believed I loved my stepchild. When I said I didn't, she couldn't quite get it. It made me feel less understood," or "Our therapist came from a position of stepfamilies as the underdog, less than, worse off. This starts us with a negative and implies an extraordinary amount of work just to reach 'normal'." (Visher et al., 1997) These findings suggest the need for training therapists who want to work with stepfamilies, as inadequate knowledge may lead therapists to work from a biological family model, which is inappropriate with stepfamilies.

Themes for Therapy with Stepfamilies

Based on the findings described above, we suggest that therapists work with stepfamilies to improve communication between family members, build and maintain their social networks outside of the family, create routines (such as meal or bedtime) for the children, organize family activities, and include the ex-spouse in therapy in order to work on their parenting relationship outside of marriage. Additionally, or maybe most importantly, therapists should have a clear understanding of the issues and dynamics of stepfamily living (Seibt, 1996). With this knowledge, they will be better able to deal with the turmoil that these families encounter, and to help them acquire tools they can use independently. Fixing an acute problem is often why people seek therapy, but we believe that working on the positive aspects and building skills to pre-empt future problems also helps create a long-term solution to support remarried couples in building a strong and healthy family.

Future Directions

Families are no longer exclusively composed of two married, opposite-sex parents and their biological children. "Family" is a singular word with plural meanings. Parents raise children without being legally married. Biological parents get divorces and raise children in collaboration with their new spouses, in a three- or four-parent arrangement. Same-sex couples marry, or do not (or cannot), and raise children from former relationships, have a biological child of one partner together (with a donor), or adopt children. Family therapists need to know about all these possibilities, and, of course, adapt to the unique family who is in the room with them.

Research also needs to catch up with changing family realities. While demographic and descriptive studies are fairly common, if still needed, there is a shocking absence of randomized trials of alternative therapies for adults and children from never married, separated, or divorced families. This is *not* due to a shortage of innovation. As we have outlined, the opposite is true. There is a huge array of creative and promising approaches to deal with these families, ranging from new approaches to family therapy to new legal interventions. What we need are systematic studies of these interventions.

If we had only one wish for the future, we would make research on alternative psychological and legal interventions in never married, separated, and divorced families a major funding priority for public institutes or private foundations. Given the sweeping demographic upheavals in family life, the impact of family change on individuals, and the consequences for social institutions ranging from courts to welfare agencies, we fervently hope that our wish will come true.

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26.

EMPIRICALLY INFORMED COUPLE AND FAMILY THERAPY

Past, Present, and Future

William Pinsof, Terje Tilden, and Jacob Goldsmith

The Empirical Tsunami in Couple and Family Therapy

Along with, and slightly behind, the general field of psychotherapy, couple and family therapy has experienced an empirical tsunami over the last twenty-five years. The bulk of this wave has taken the form of establishing empirically supported treatments (ESTs). As this volume and the recent literature attest, there is now a substantial number of empirically supported couple and family therapies. These therapies have been manualized, therapists have been trained in the manualized treatments, and the prescribed treatments have been tested and shown to be more effective than no treatment or treatment as usual in clinical trials. Most of the clinical trials have been focused on specific disorders in specific populations (particularly substance abusing, conduct disordered adolescents; depressed and relationally distressed partners in couple therapy; and affectively and thought-disordered adults in couples and families).

This aspect of the empirical transformation has legitimized couple and family therapy under the gold standard of empirical research—randomized clinical trials. However, despite its impact and import, the wave of empirically supported treatments has been problematic. The central component of the problem has been the gap between these empirically supported treatments that are typically developed and tested in university or medical facilities, and "real-life therapy" or what has been called "community-based intervention." One of the problems with ESTs is that therapists, particularly experienced therapists, do not generally like to follow manuals as they engage in what they consider to be an individualized, idiosyncratic, and improvisational art. Furthermore, when ESTs leave the laboratory and the hands of their developers, they do not consistently get equivalent results. They do not translate well to real life. Lastly, ESTs are usually better than no-treatment or a diffuse treatment-as-usual, but in head-to-head trials, no particular EST gets consistently better results than any other EST. The general results consistently reveal that with ESTs, about two-thirds of the clients improve by termination, but a substantial number (in some cases up to half) of those that improved, deteriorate post-therapy (Shadish & Baldwin, 2005; Snyder & Halford, 2012).

Empirically Informed Psychotherapy

This chapter is about a complement (potentially boosting outcomes) and alternative to ESTs called empirically informed treatment (EIP). To date, it has been a growing, but small part of the empirical tsunami in the general field of psychotherapy and even less so in the field of couple and family therapy. The hallmark of EIP is that it involves collecting scientific data from clients over the course of therapy and feeding these data back to therapists in real time to inform them about the status and/or progress of their clients. These data may or may not be shared with clients, but the goal of this feedback is to influence clinical decision making and the course of treatment (Sexton & Fisher, in press). Bickman and his colleagues coined the term Measurement Feedback Systems (MFSs) (Bickman, 2008; Bickman, Kelly & Athay, 2012) for linked procedures to measure client systems during therapy and feed these data back to therapists (and other clinical stakeholders) in real time. EIP has been called various things—patient focused research (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert, Hansen, & Finch, 2001), progress research (Pinsof & Wynne, 2000) and feedback research. However, what has become clear over time is that work within the domain of EIP is more than just research. EIP integrates research into practice. It is action research that collects and uses scientific data to influence (and ideally improve) client and therapist behavior in therapy. As will be discussed, the gold standard question with EIP is whether or not the use of MFSs improves outcomes. As such, MFSs are both research tools to track and provide feedback change data as well as, we hope, powerful interventions to enhance the therapeutic process with or without ESTs. As some of us have opined (Bickman et al., 2012; Pinsof, Goldsmith, & Latta, 2012; Sexton, Patterson, & Datchi, 2012), EIP holds great promise for bridging the historically unbreachable scientist–practitioner gap.

In this chapter, we will briefly review the history of EIP within individual therapy. We will then focus on MFSs that have been used to study couple and/or family therapy. To foreshadow, we will differentiate MFSs that have been developed within the context of individual therapy that have been applied to couple and family therapy, as well as the few MFSs that have been developed for and within the theoretical and methodological context of couple and/or family therapy. We will also begin articulating a framework or set of criteria for understanding and evaluating MFSs that can hopefully inform and facilitate the development of EIP in couple and family therapy.

Client Self-Report Methodology

Before launching our review, it is interesting to note that all of the MFSs within the broad field of EIP (including individual, couple, and family therapies) share a common methodological emphasis—they measure client systems and the process of change from a client (or in certain rare cases, the therapist) self-report perspective. None of the extant measures use observational methodologies. We believe that the rationale for this decision is twofold. The first is cost (time, personnel, and money). Given that repeated and frequent measurement is the *sine qua non* of EIP, the frequent and repeated use of observational measurement (the use of direct observation by coders or videotaping, the application of valid and reliable coding systems to the observed behavior by trained coders, etc.) is more cumbersome, intrusive, and expensive than self-report measurement (the client fills out a questionnaire online, presses the "Send" button and therapists get instant analyzed data).

The second rationale is that the client is the customer in psychotherapy and ultimately it is their experience that reflects their level of distress and their satisfaction with the progress and results of their therapy. We believe (as do the other developers of MFSs) that the best way to measure client experience (as opposed to behavior) is to ask the client. All of the questionnaires and procedures in the extant MFSs ask the client to rate aspects of their life and/or experience of therapy.

A Brief History of EIP in Individual Therapy

EIP began in the last decade of the 20th century in the context of individual therapy with Howard's (Howard, Brill, Lueger, O'Mahoney, & Grissom, 1993) COMPASS MFS and Lambert's (Lambert et al., 1996) OQ-45 MFS. Unfortunately, after delineating some very provocative and powerful dose-response findings—what changed when (Lueger et al., 2001)—Howard's research was cut short by his untimely passing. However, Lambert's pathbreaking research with the OQ-45, a forty-five item questionnaire, over the last twenty-five years has clearly established that providing therapists with feedback on their client's progress improves psychotherapeutic outcomes (Shimokawa, Lambert, & Smart, 2011), particularly for clients who are found to be "off track" by the third or fourth session. Two aspects of this research particularly impress. The first is that providing therapists with feedback on their client's progress improves outcomes above and beyond the historically unassailable two-thirds. Second, it works (improves outcomes) with virtually any therapy and population/disorder—it is not tied to any particular therapeutic orientation (e.g., cognitive-behavior therapy, psychodynamic therapy, emotionally focused therapy).

Building on Lambert's work, Miller and Duncan took on the task of developing a simpler and briefer MFS called the Partners for Change Outcome Measurement System (PCOMS) (Miller & Duncan, 2004). It contains two measures which use a visual analogue rating procedure: the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). Clients rate their functioning (ORS) and alliance with the therapist (SRS) by putting a mark (with a pencil) on a bipolar (from negative to positive) 10 centimeter line. The ORS has three client functioning dimensions (individual, interpersonal, and social) and the SRS has three alliance dimensions (relationship, goals/topics, and approach/method). The fourth and last dimension of each measure globally assesses daily functioning (ORS) and the quality of the session (SRS).

Emerging around the same time, an English research group headed by Michael Barkham (Barkham et al., 1998; Evans et al., 2002), developed the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure), a thirty-four-item client self-report instrument that addresses subjective well-being, symptoms, functioning and risk. The CORE-OM has been well validated and widely used within the British Health System.

EIP in Couple and Family Therapy

Although the development of EIP in family therapy has lagged behind its development in individual therapy, there is one historical exception to this conclusion—the work of Gerald Patterson and his colleagues at the Oregon Social Learning Center. In the late 1960s, Patterson et al. (Patterson, 1976; Patterson, Cobb, & Ray, 1972; Patterson, Ray, Shaw, & Cobb, 1969) developed a behaviorally oriented intervention for families with conduct disordered children. Coming out of a behavioral, or more specifically social learning orientation, Patterson et al. collected data to plan and evaluate their interventions. In fact, they were probably and unconsciously the first empirically informed therapists. Their program involved collecting coded observational data during dinner in their clients' homes for two weeks before intervention began. Their coding system focused on examining the ways in which family members did or did not respond to the identified patient. Specifically, they focused on conditional probabilities—the probability that the parents would attend to the identified patient when he misbehaved and the alternative probability that the parents would attend to him when he behaved prosocially. They shared these data with the parents and the goal of therapy was to decrease the former and increase the latter probability. Once therapy began, Patterson's coders would visit and code the family during dinner periodically. In subsequent therapy sessions, these data would be shared with the parents. To some extent, Patterson et al.'s pathbreaking and innovative program came out of the simple behavioral tradition of collecting data (and sometimes sharing it with clients) during therapy, which has characterized the work of many behaviorists since its inception in the late 1950s and early 1960s.

Unfortunately, this tradition did not build or extend beyond the behavioral domain until the 1990s.

The modern development of EIP in couple and family therapy is at least a decade behind its emergence in individual therapy. It is still very early and just getting off the ground. There have been what might be thought of as five exemplars (or paradigms) for EIP in couple and family therapy. The first takes MFSs that have been designed to collect and feedback change data in individual therapy and uses them to study couple (and/or potentially family) therapy. The second develops and uses individually based MFSs to collect and feedback change data in the treatment of adolescents and their caregivers. The third paradigm develops and uses family focused MFSs for family therapy. The fourth paradigm develops and/or transports MFSs into ESTs (Empirically Supported Treatments) to enhance their effectiveness and assess the fidelity of the interventions to the model. Lastly, the fifth involves the development and use of multisystemic MFSs to assess, measure, and provide feedback change data in individual, couple, and family therapy. Each paradigm is discussed and exemplified below.

The Transfer Paradigm

As mentioned above, the first paradigm involves the application of an MFS developed originally within individual therapy to collect and provide feedback change data in couple and/or family therapy.

Miller and Duncan: Partners for Change Measurement System

The primary system within this paradigm is Miller and Duncan's PCOMS (described above) that has been utilized in two couple therapy clinical trials comparing treatment-as-usual with the PCOMS to treatment-as-usual (Anker, Duncan, & Sparks, 2009; Reese, Toland, Sloan, & Norsworthy, 2010). In both studies, treatment-as-usual with the PCOMs had better results.

The Adolescent/Child and Caregiver Paradigm

The second paradigm involves MFSs that have been developed to be used in the treatment of adolescents. This type of treatment is not technically family therapy in that it does not derive from a "systemic" perspective nor does it explicitly focus upon or engage the whole family (siblings, both parents, etc.). However, many of the most empirically supported family therapies address families with conduct disordered and "addicted" adolescents and the MFSs within this category not only target the experience of the adolescent, but also target the caregiver(s) of the adolescent whether or not they are directly and consistently involved in the therapy.

Bickman: Contextualized Feedback Systems

The most extensive example of this measurement and feedback paradigm is the work of Bickman and his colleagues, who developed Contextualized Feedback Systems (CFS) as a web-based MFS "specifically designed to be easy to operate and provide new information to those who treat individuals with behavioral health problems" (Bickman et al., 2012, p. 277). The measurement component of the CFS is a set of measures called the Peabody Treatment Progress Battery (PTPB) (Reimer et al., 2012), a multidimensional set of eleven instruments (scales) measuring distinct aspects of the therapeutic process and outcomes in the treatment of youth aged 11–18. It has shown "strong psychometric properties in large samples of youth, and their respective caregivers and clinicians" (Bickman et al., 2012, p. 278). Bickman, Kelley, Breda, Vides de Andrade, and Riemer (2011) conducted a very large randomized (by site) clinical trial of their CFS within a home-based mental health treatment for youths and found that youths treated at sites where clinicians received weekly feedback improved faster than youth treated at sites without weekly feedback. Of particular interest was their dose-response finding, which showed that clinicians who viewed feedback more often had faster and better outcomes.

Weisz: TOP Problems

Over the last decade, Weisz et al. (2011) have also developed a unique MFS called the TOP Problems (TP) measure. The TP measure aims to integrate a variant of goal attainment scaling (Kieresuk & Sherman, 1968) with repeated measurement of change. To date, the TP measure has been administered and utilized with distressed youth (ages 7–13) and their caregivers in what has appeared to be primarily individually based youth treatment.

The TP measure is administered separately to each youth and one caregiver before and during therapy at regular (approximately weekly) intervals over the phone by trained assessors. In the first phone interview, the assessor asks the client (youth or caregiver) to list what he/she considers to be the problems they are most concerned about. The interviewer then asks the youth or caregiver whether there are other problems that should go on the list. The interviewer next asks the respondent to rate the severity of each problem on the list from 0 ("not at all") to 10 ("very, very much"). At this stage the respondent is presented with their full list and asked to identify the biggest problem right now. The interviewer then asks him/her to identify the next biggest and repeats this procedure a third time, thus delineating the top three problems for each youth and caregiver. For each weekly follow-up phone interview, the assessor asked the client or caregiver to rate the severity of each of the three problems identified initially.

The focus of their major reported study (Weisz et al., 2011) was to evaluate the methodological characteristics of the TP measurement system. The authors reporting that study did not specify whether or how the therapists were given "feedback" from the assessors about their clients' problems. However, given the authors' historical review and plans for the TP measure, surely the TP data are fed back at least to therapists at certain points in the therapy.

Their major study examined the treatment of 178 youth (cases) at nine outpatient treatment centers in two metropolitan centers in the United States. In addition to the TP measure, clients and caregivers (primarily mothers) were administered a battery of initial measures with which the TP problems could be compared. Youth and caregivers were also administered one of these measures (the Brief Problems Checklist; Chorpita et al., 2010) during each of the weekly TP assessment sessions during the therapy. The results strongly supported the test–retest reliability, the convergent and discriminant validity, and the criterion validity over time of the TP measure. The authors conclude that the TP measure is a reliable and valid procedure for idiographically assessing youth and their caregivers as well as tracking change over the course of therapy.

Family-Focused MFS

The third emerging paradigm for MFSs in couple and family therapy addresses measurement (and potentially feedback) systems that derive from a systemic perspective and that focus on whole families and/or couples. The only MFS singularly devoted to the repeated measurement of family and/or couple systems in conjoint therapy is the SCORE System.

Stratton et al.: SCORE

Building on the work of Barkham et al. (1998), in England, on the Clinical Outcomes in Routine Evaluation (CORE), an individually focused MFS for individual treatment, Stratton, Bland, James, and Lask (2010) developed the forty-item SCORE, targeting family functioning in couple and family therapy. They subsequently, reduced the forty-item version to fifteen items to facilitate the brevity and ease of administration. The forty- and fifteen-item SCOREs focus on three dimensions of family life: strengths and adaptability; overwhelmed by difficulties; and disrupted communication. Clients in couple and/or family therapy fill out the questionnaire in regard to their family. Recently, Jewell, Carr, Stratton, Lask, and Eisler (2013) reported the development of the Child SCORE for children aged 7–10 that was developed and tested on a normal sample of pupils in a London primary school. The SCORE and Child SCORE were developed as "outcome measures", as opposed to feedback measures. In fact, their use as feedback measures has been

presented as one possible utilization pathway. Clients are requested to fill it out (in a paper and pencil format) prior to therapy, at mid-therapy, and again at termination. Research on the SCOREs has been primarily methodological, establishing their validity and reliability.

MFSs within ESTs

The fourth category represents an advance within MFS research in family therapy that goes beyond what has been attempted within MFS research in individual therapy to date. This approach involves the development and use of tailored MFS systems within ESTs to simultaneously increase their effectiveness and assess the fidelity with which they are implemented by practitioners. This research approach develops MFSs that are specifically designed to be used within a particular EST as opposed to other types of therapy. This "specificity" of the MFS derives from the researchers desire to not only enhance the effectiveness of their model, but also to assess and ensure the implementation of specific and particular aspects of their model. The pioneers in this area have been the research groups within family therapy focusing on the treatment of drug-abusing and conduct-disordered adolescents (Sexton & Alexander, 2005; Liddle, Rodriguez, Dakof, Kanski, & Marvel, 2005; Schoenwald & Henggeler, 2005). For illustrative purposes, we focus within this paradigm on the work of one of these groups, Sexton et al., who have developed an elaborate system called the FFT Clinical Feedback System (Sexton, 2010).

The FFT Clinical Feedback System (FFT-CFS)

The FFT-CFS was developed within the context of Functional Family Therapy research and practice to provide real-time data to clinical stakeholders on model fidelity (were therapists doing what they were supposed to do), client outcomes, and service delivery. It is the product of a collaboration between Tom Sexton and Len Bickman to adapt Bickman's CFS (described above) to the FFT model and research program. The FFT-CFS provides feedback to therapists within three primary domains: the symptom level of youth functioning; the impact of the session in regard to the accomplishment of phase specific goals that are hypothesized to be the change mechanisms within the FFT model; and phase and overall progress. Feedback is divided into three domains: client, session, and therapist information. Client information addresses treatment history, demographic information and current clinical treatment status. Session information addresses critical events, session type (who, what, where, and when); client progress and session success are rated according to the therapist. Therapist information includes treatment planning, clients and clinical measures, service delivery profile and treatment model adherence level.

The FFT-CFS, obviously, is not only a progress feedback measure, but also provides an extraordinary amount of information that can inform assessment, treatment planning, evaluation of progress, goal attainment, therapist adherence (fidelity), and outcome evaluation. It represents an elegant example of how what was developed as a general system for evaluating progress within any treatment program focusing on adolescents and their caregivers (Bickmans' CFS) can be adapted and elaborated to fit the specific theoretical, methodological and clinical requirements of a specific empirically supported treatment model like Functional Family Therapy. Additionally, the FFT-CFS goes beyond most if not all MFSs in that it begins to function almost like an electronic medical record system for FFT.

Multi-Systemic Integrative MFSs

This fifth category of MFSs in couple and family therapy includes systems that derive from a multi-systemic and integrative perspective and that can be applied to virtually any individual, couple, or family therapy. They explicitly and simultaneously address multiple systems or systemic levels (individual, couple, family, etc.) to create an integrative picture of a client system. To some extent the CORE/SCORE investigators have the potential to create this kind of integrative and multi-systemic MFS by linking Barkham

et al.'s CORE System to address individual adult functioning with Stratton et al.'s SCORE measure (and eventually a feedback system) to tap family-level functioning. However, to date, the only measure in this category is Pinsof et al.'s (2009, 2012, 2015b) Systemic Therapy Inventory of Change–STIC.

The STIC MFS

The STIC, developed from an integrative and multisystemic perspective, provides a comprehensive picture of the intimate systems in a person's life. This perspective, Integrative Problem Centered Metaframeworks (Breunlin, Pinsof, Russell, & Lebow, 2011; Pinsof, Breunlin, Russell, & Lebow, 2011; Russell et al., this volume), asserts that all therapies intervene into a "client system" that consists of all of the people who are or may be involved in maintaining and/or resolving the presenting problem. The STIC system has three major components that delineate a client system.

The STIC Initial, an online client self-report questionnaire, contains: life history and demographic questions; questions about the client's readiness for therapy; and six "system" scales that target different subsystems within the client's system. The first scale, Individual Problems and Strengths (IPS), assesses individual adult or adolescent's current symptoms, well-being and life functioning. The second, Family of Origin (FOO), addresses adult's recollection of psychosocial aspects of his/her family when they were growing up. Relationship with Partner (RWP) assesses clinically relevant aspects of "partnered" clients' relationship with their significant other (spouse, partner, etc.). Family Household (FH) focuses on a parent or adolescent's current family experience. The last two scales are filled out by parents for each child between ages 5 and 18. Child Problems and Strengths (CPS) targets the parent's perception of the child's psychosocial and academic functioning. Relationship with Child (RWC) taps parent's perception of their relationship with the child. The six system scales contain thirty-nine factors that tap specific aspects of their respective domains. Each adult or adolescent in a case fills out the STIC Initial before the first session. Clients fill out all demographically appropriate scales regardless of the therapy they are in (individual, couple, or family). A partnered parent needs about forty-five minutes to complete the Initial. Clients fill it out at home or at the therapist's office on a tablet or computer. The Initial takes progressively less time for single parents, non-parent partners, single non-parent adults, and adolescents.

Each client fills out the second component, the STIC Intersession, in the twenty-four hours before each session after the first. It contains briefer versions of the six system scales as well as three alliance scales that derive from the Integrative Psychotherapy Alliance model (Pinsof & Catherall, 1986; Pinsof, 1994; Pinsof, Zinbarg, & Knobloch-Fedders, 2008), which adds four interpersonal dimensions to Bordin's (1979) Tasks, Goals and Bonds alliance model. The three measures, the Individual, Couple, and Family Therapy Alliances Scales, measure this expanded alliance concept respectively in individual, couple, and family therapy. The client fills out the alliance scale for the type of therapy he/she is in. For a married parent, the Intersession takes seven to eight minutes to fill out at home or the office.

The third STIC System component is the online data collection and feedback system. Before the first session, after being registered by the therapist, each client gets an email inviting them to complete the STIC Initial. First, the client picks their preferred language (currently English, Spanish or Norwegian). After the consent form and demographic and readiness questions, the system presents the demographically appropriate scales. Upon completing their scales, clients hit "Send" and therapists get an email that says in essence "You've got STIC mail." If the client endorsed a risk item (suicide, homicide, abuse), the email says "You've got high priority email." The therapist clicks on the email and gets the Feedback Report. It gives the therapist a client system "snapshot in 90 seconds"—the time a therapist would have before a session to review client data. It contains endorsed risk items; psychotropic medication changes since the last session; STIC system scale factors that have changed significantly since the

last session; significant alliance scale changes (ruptures, etc.) since the last session; the current status of the six most clinical STIC Initial factors (the Big 6) since the beginning of therapy as well as bar graphs for the factors in each system scale. The therapist can click on a factor indicator to see its change graph since the beginning of therapy or on a bar graph to see actual items and answers.

Research on the STIC

To create the STIC, Pinsof and his colleagues asked experienced clinicians (all with over twenty-five years of experience) in individual, couple, and family therapy to generate typical statements that clients make in therapy about themselves, their relationship with their partner, their families, and their children. These statements (about 80–100 per scale) were then given to outpatients at The Family Institute at Northwestern University. These data were analyzed and reanalyzed with a Confirmatory Factor Analytic procedure that ultimately yielded the STIC Initial Scale Factors (Pinsof et al., 2009). Subsequently that factor structure was reconfirmed and normed for both the STIC Initial and Intersession on another outpatient sample from The Family Institute and a random representative sample of the United States from the National Opinion Research Center at the University of Chicago (Pinsof et al., 2015a). Norming permits any client's factor score to be delineated in standard deviation units into the normal or clinical range from the cut-off. The further into the clinical range a client's factor score, the more clinical or problematic that factor. All of the factors on the six scales in which a case or client scores in the clinical range constitute that client or case's clinical profile.

Currently randomized clinical trials are being conducted in Chicago and Norway. All of them compare treatment-as-usual to treatment-as-usual with the STIC. Clients are assigned to a STIC-trained therapist and then randomly assigned to one condition or the other with that therapist. Clients are assessed with a battery of standardized measures (including the STIC) before therapy and at termination.

The STIC as a Clinical Tool in Practice

Therapists are taught to use the STIC as a collaborative tool with clients (Pinsof et al., 2012; Pinsof, Breunlin, Chambers, Solomon, & Russell, 2015a) based on a set of guidelines. The first guideline is that therapists should review STIC data (the Feedback Report) before each session and at least comment on it briefly to the clients. The second is that in the second or third session the therapist shows clients their Initial STIC data and asks them to help clarify the relationship between the factors (and scales) in the clinical range—their Clinical Profile. This conversation results in the co-delineation of a problem narrative that integrates the client's reports and their STIC data. From this "assessment" conversation, the therapist and clients co-delineate an empirically informed treatment plan specifying which problems (factors in the clinical range) will be addressed in what order. By the end of the third session, the therapist and clients have co-created a preliminary understanding of their problems as well as an initial plan for their therapy.

The third guideline is that about every four sessions (after the Initial review), the therapist shares (shows) the Feedback Report with the clients. The report is used to facilitate an empirically informed progress review—a conversation about what has improved and what has not improved or deteriorated. Sometimes, lack of progress or deterioration on a factor may be appropriate, as with intense grief or a client awakening to the painful reality of his/her situation. When the therapist and clients deem lack of progress or deterioration "not appropriate," they explore constraints that might be preventing progress and alter the problem narrative and therapeutic plan accordingly.

The Power of Conjoint Feedback

A unique feature of the STIC feedback system is that in couple and family cases, each client's graphed data (bar and change graphs) can be and generally are displayed together on the same graph. For example, each partner in couple therapy gets to see their own as well as their partner's scores on the Individual Problems and Strengths (IPS), Family of Origin (FOO), and Relationship

with Partner scales (RWP). The wife can see her husband's low Commitment Score (RWP) and he can see her high Negative Affect (anxiety and depression) and low Self-Acceptance scores (IPS). This feature challenges denial and increases a partner's empathic, if not sympathetic understanding of the "other." The other's data (and one's own) cannot be avoided. It infuses the conversation with "real" or "objective" data. This also occurs with parents and children.

The Art of Empirically Informed Multi-Systemic Therapy

The STIC is a relatively complex and sophisticated instrument for integrating data into every phase of treatment with families, couples, and individuals. It provides a continuous and comprehensive picture of the "client system," regardless of the therapeutic modality. Co-creating a problem narrative and treatment plan, using actual STIC data as part of the therapeutic discourse, dealing with conjoint feedback, and co-revising the problem narrative and treatment plan are not simple tasks. As well as good technology, these tasks require clinical judgment, therapeutic sensitivity, and courage to help clients face their own and each other's truth (STIC data). Pinsof and colleagues are just addressing how best to train therapists to successfully engage in these tasks.

Issues and Challenges in Empirically Informed Couple and Family Therapy

The preceding section, reviewing the major MFSs that have been used to study couple and family therapy, suggests several general conclusions. First, the field is barely out of its infancy. MFSs are in the process of being created, tested, and refined. Second, the variation in MFSs is immense, ranging from collecting data from clients over the phone about their top problems, to sitting with clients and asking them to make a pencil mark indicating their progress, all the way to sitting with clients in front of a computer or tablet displaying their most recent conjoint STIC data and asking them to help interpret what they mean. In order to facilitate comparison of the MFSs and more importantly, to illuminate the issues that this emerging field and clinical tradition must address as it moves forward, we have delineated eight topics as criteria or challenges for EIP in couple and family therapy.

Theoretical Derivation and Interpersonal Focus: Individual, Systemic, and Multi-Systemic/ Integrative

The five categories of MFSs delineated above clearly distinguish MFSs that have been derived from and for the study of change or progress in individual versus family or couple therapy. Both the OQ-45 and the PCOMS systems were originally derived to measure progress in individual therapy and predominantly the latter (and to some extent increasingly the former) have been or are being used to measure progress in family and couple therapy. Both focus on the individual client and his/her experience of his social relations in general, as well as the client's general sense of his/her alliance with the therapist. Neither address the couple, family, or other members of the client system.

In contrast, although not explicitly derived from a systemic or family systems perspective, the CFS and TP MFSs are implicitly systemic in that they not only focus on the adolescent client, but also on the experience and perspective of a caregiver. The FFT-CFS even expands that to include the therapist. All of these systems as well as the OQ-45 and the PCOMS, however, ignore the impact of the couple (husband/wife), co-parental (mother/father), and family systems on the adolescent and vice versa. The SCORE, in contrast, derives very explicitly from a systemic focus and addresses the client's experience of their family system. However, unless it is paired with another system like the CORE, it does not address the individual, couple, or co-parental system.

Pinsof and Lebow (2005) have articulated criteria for a scientific paradigm for family psychology that stresses the theoretical, methodological, and clinical importance of a multi-systemic perspective at the core of the

paradigm. If our science is to keep pace with our practice, which is increasingly integrative (Lebow, 2013), couple and family therapy research needs to focus simultaneously on the multiple key systems in most people's intimate lives. Our literature is replete with research on the impact of parental depression and marital conflict on child and adolescent behavior. Our culture recognizes this multi-systemicity with comments like "If momma ain't happy, ain't no one happy," or "You are only as happy as your unhappiest child." Of the extant MFSs, only the STIC has been constructed and aims to measure this multi-systemicity.

Purpose and Focus: Progress Versus Assessment and Planning

The field of empirically informed therapy exists on a continuum. One end of the continuum contains those MFSs that focus primarily, if not singularly, on the evaluation of progress. The PCOMS and OQ-45 fall on this end of the continuum. They were designed to provide therapists and clients with feedback about whether the clients were making progress toward a good outcome. Lambert et al. (Shimokawa et al., 2010) have even developed an algorithm that provides therapists, at the third or fourth session, with information as to whether they are on track or off track in regard to the trajectory of their change curve. If the client is off track, the OQ System provides a variety of alternative suggested interventions. The OQ does not specify how the client is off track (what they are off track about), but rather that their overall change trajectory is not like other cases that tend to have good outcomes.

The other end of the continuum contains MFSs that not only track progress, but also provide some kind of initial assessment that delineates the specific nature of the client's problems that then informs treatment planning and subsequently organizes the ongoing feedback (progress evaluation) more or less around those problems. This assessment also provides a basis for the articulation of a therapeutic plan that ideally derives from the assessment. The STIC and FFT-CFS epitomize this type of MFS. The STIC Initial generates a clinical profile (the subscales in the clinical range) to help the therapist and client focus, subsequently identifying the six most clinical subscales for ongoing tracking. It also provides therapists with the flexibility to add additional clinically relevant subscales to the Big 6, about which progress information will be fed back automatically with each Feedback Report. The FFT-CFS provides therapists with treatment history and client status information that can then be integrated into the phase goals of the model for planning purposes.

The TP system falls in the middle of this continuum in that the client and caregiver are each asked at the beginning of therapy to specify a problem list and then select the top three problems they want to address in the therapy. Their progress is subsequently tracked in regard to those three major problems. Although the problems formulated by the adolescent and the caregiver are idiosyncratic, Weisz et al. (2011) have found high correlations between the type of problems they identify and standardized measures.

A key challenge, particularly to the rating of progress, is the extent to which progress means "improvement" on a particular factor. Pinsof and colleagues have documented cases (2012, 2015a) in which STIC deterioration (or lack of statistical improvement) is actually more reflective of progress in couple therapy than improvement on a specific factor. Specifically, if a wife in a couple is three standard deviations into the clinical range on Commitment (which means she does not think their relationship will last and is not willing to do a lot to save it) and her husband is in the normal range, either he is oblivious (perhaps because his wife has not communicated her waning commitment) or in denial. Over the course of therapy, if her Commitment does not change (because she has decided to divorce) and his commitment score moves deeply into clinical range (approximating hers), his change reflects his acceptance of where she is and what she wants. Similarly, with an individual client who repeatedly gets into trouble at work and loses jobs, his lack of anxiety (being in the normal range on IPS Negative Affect) may be maladaptive. A more clinical score would reflect his waking up and

accurately assessing his occupationally perilous situation.

Dimensional (Factorial) Multiplicity and Molecularity

The MFSs in couple and family therapy vary widely in the level of molecularity and multiplicity they bring to measurement and feedback. By multiplicity we refer to the number of different factors, dimensions, or subscales that are measured by an MFS. By molecularity (as opposed to globality), we refer to the level of specificity of the factors or dimensions—the extent to which they address specific aspects of systemic functioning. To a large extent, multiplicity and molecularity are correlated—you cannot get to a very specific level of molecularlity without multiple factors or subscales within an MFS. Clearly the OQ-45, which contains three dimensions, but primarily measures and reports progress in regard to one "on track/off track" index, and the PCOMS, which measures three global aspects of client functioning (individual, interpersonal, and social) with a single progress mark for each, represent the most global and least molecular of the extant MFSs. In contrast, the STIC, with thirty-nine subscales across six system scales has the greatest multiplicity and molecularity. The FFT-CFS is right up there with the STIC in regard to molecularity.

There are at least three critical aspects in regard to this issue. The first is the verisimilitude of the MFS to the reality of most psychotherapies, particularly couple and family therapies. Is progress and outcome in psychotherapy best conceptualized as a unidimensional or multidimensional phenomenon? Most people experience their life as multi-dimensional. "I don't feel depressed [STIC IPS-Negative Affect], but it is hard for me to express myself [STIC IPS-Self-Expression] and hard for me to know what I am feeling [STIC IPS-Self-Misunderstanding]." Similarly, most people experience their partnership (coupleness) as multi-dimensional. "I trust my partner [STIC RWP-Trust], but I don't feel like he is my best friend or that we have fun together very often [STIC RWP-Positivity]." Most client systems present multiple problems and co-morbidity is more typical in community populations than having a single mental disorder.

Multi-dimensionality (versus unidimensionality) within a system (individual, couple or family) makes the measurement of progress and outcome more complex. How do we evaluate a couple that has improved (and even gone from the clinical into the normal range) in certain areas (STIC RWP-Positivity and STIC RWP-Commitment), but are still very unsatisfied sexually (STIC RWP-Sexual Satisfaction). The answer that Pinsof et al. are working on is the development of a multi-dimensional formula that specifies outcome or progress criteria that look at the proportion of subscales that were in the clinical range initially that have "recovered" (gone into the normal range) and/or "improved" (changed significantly) in a case.

The second critical aspect of the dimensionality issue is how most therapists experience the process of therapy. It is our belief that, as with clients, most therapists experience therapy multidimensionally. For instance, with a couple, the therapist may work initially to build trust (STIC RWP-Trust) and diminish anger (STIC RWP-Anger/Inequity) before addressing their lack of a good sexual relationship (Sexual Satisfaction). Few, if any, couple therapists work primarily on Relationship Satisfaction (the most common outcome measure in couple therapy research), but rather on the specific components that make up satisfaction for that couple. This raises the issue of the relative value of global versus specific feedback for therapists. To know that the case is off track (OQ-45) or not progressing (PCOMS) does not tell the therapist what is going well and what is going poorly. To be able to see what is getting better and what is not and to be able to address those factors that are not getting better is more helpful to both the therapist and the client.

The third critical aspect in regard to multidimensionality is how many dimensions should we have in each systemic domain? Pinsof and colleagues have addressed this issue with the STIC by "letting the clients decide." By developing the STIC from the ground up, they ended up with a set of dimensions or factors for each system that fit how clients organize their experience

of that domain, not how therapists or researchers would like to organize it. For instance, in their three sample (two clinical and one normal) confirmatory factor analysis, they could not find any good scientific evidence to separate Anxiety and Depression (they correlated over .90), thereby ending up with an IPS factor of Negative Affect that was confirmed in all three samples. Similarly, as much as they wanted to, they could not find scientific evidence in their samples to separate couple intimacy, love, and friendship, ending up with a RWP factor of Partner Positivity that was also confirmed in the three different samples. The set of factors that Pinsof and colleagues ended up with for each system scale closely approximates how people experience that domain. In that sense, the STIC scales can be thought of as generic, relatively atheoretical and how clients (and people) cleave their experience.

Comprehensiveness

MFSs also differ in their comprehensiveness. We are using comprehensivenss to refer to whether the MFS can function as a comprehensive stand-alone system for assessing systems and tracking outcomes, or whether it is intended to be used with other measures or MFSs. With the exception of the STIC and the FFT-CFS, none of the other MFSs was designed or has been utilized as a comprehensive system. For instance, all of the extant systems other than the STIC do not provide a comprehensive picture of a family or client system and its relevant subsystems. None of the other measures focus specifically on the couple system as a relevant family subsystem. Additionally, the STIC includes an extensive demographic section that, beyond the normal questions (age, education, income, etc.), provides important information about the racial, ethnic and gender identity as well as the sexual orientation of each client. In other words, the STIC has the potential to be used by family agencies and organizations working with couples and families as a comprehensive, stand-alone battery of measures that can support empirically informed and multi-systemic assessment, treatment planning, and progress and outcome evaluation in individual, couple and family therapy.

Technological Sophistication

As the special section of the *Journal of Couple and Family Psychology: Research and Practice* on technology and family therapy attests (Sexton, 2012), information technology holds great promise for bridging the scientist–practitioner gap. The articles by Bickman et al. (2012), Pinsof et al., (2012) and the introduction by Sexton (2012) make clear that the marriage of MFSs with information technology opens new horizons in the empiricization of couple and family therapy. For the first time in the history of family psychology and family therapy, information technology reduces the gap between a client submitting data and a therapist receiving the analyzed data to milliseconds. Of the MFSs reviewed in this chapter, Bickman et al.'s (2012) CFS, Sexton and Bickman's FFT-CFS and Pinsof et al.'s (2009, 2012) STIC are the most technologically sophisticated.

Although information technology provides the ideal platform for empirically informed therapy in that it provides "hot," real-time data that can be used to impact therapist behavior in the next session, there are still barriers to its utilization. The primary barrier is the aversion that many therapists have to using data as part of their practice. Many therapists have chosen to be therapists because they did not want to make research and statistics a central feature of their work life. Convincing them that data can be "friendly" and "helpful" as opposed to "cold," "distancing," "unrelated to real life and suffering," or "incomprehensible and intimidating" takes time and repeated exposure. Certain therapists are not comfortable accessing a computer between sessions to examine feedback data. For virtually all therapists, once they get the data, the question becomes what to do with it—how to use it.

Sophisticated information technology support and guidance can help therapists use quantitative feedback with clients. For instance, Pinsof and his colleagues have been working assiduously to provide therapists with "everything they need to know in 90 seconds" in the Feedback Report. Of course, providing therapists with "everything they need to know" in any amount of time is an impossible task, but the goal is to extract the

most important information from the client's data and give it to therapists in a format that is as easy to understand and use as possible. Although expensive, the productive interaction of software developers and therapists who want to conduct empirically informed couple and family therapy can be very fruitful. Although we know it is not this simple, we still subscribe to the belief that if we can provide therapists, our true customers in this endeavor, with great, useful, and easy to understand feedback, they will like it and use it.

Training/Supervision in the Use of Measurement and Feedback Systems

As should be obvious from the preceding, a key issue in the creation of an empirically informed couple and family therapy is how to train therapists to do it. Only at the most progressive Couple and Family Therapy Training Programs and Clinics do therapists learn anything about MFSs. Also and obviously, the MFSs that have been reviewed require different amounts of training to become proficient. Of all the systems that have been reviewed, the STIC System probably requires the most training, particularly in regard to its use as a collaborative, clinical tool. Although a therapist can become minimally proficient in the use of the STIC with approximately three hours of training, it probably takes well over a year of concerted practice to get comfortable using STIC data with clients to facilitate empirically informed assessment, treatment planning, and progress evaluation. How to talk about and present data to clients throughout the course of therapy is a complex and nuanced process that involves clinical judgment, experience, courage and a willingness to do things that you have never done before.

The training of students and therapists to use MFSs represents one of the major challenges facing empirically informed couple and family therapy. We are barely at the beginning of thinking about that process and how it can best be accomplished. Manuals, online training modules, and videos of experienced therapists using data as part of real treatment need to be developed and the whole domain of empirically supported supervision (bringing data into supervision) remains to be fleshed out.

Brevity, Cost, and Simplicity

Many developers of MFSs have stressed the importance of brevity, simplicity, and low if any cost to utilization. Particularly, Miller and Duncan viewed their PCOMS system as a briefer, simpler and more user-friendly variant of the OQ-45. Clearly, the PCOMS system and Weisz's TP problems MFS are the simplest, least expensive, and briefest measurement and feedback systems we have reviewed. The STIC and FFT-CFS are the most expensive, complex, and extensive MFS we have reviewed.

A core feature of the brief and simple argument is that feedback is an add-on element to treatment-as-usual. At the center of this chapter is the idea that empirically informed therapy is a new type of therapy that integrates data into every facet of treatment. A therapist or mental health agency would not hesitate to spend thousands of dollars and years getting trained in an empirically supported, manualized treatment; why should we expect less of an investment in a practitioner or agency becoming empirically informed?

In a similar vein, if MFSs are viewed as add-ons to therapy, then having them take up as little time as possible is desirable. In essence, the message to therapists and clients is "let's get this feedback process" out of the way as quickly as possible so we can get on with the therapy. What we are arguing is that "this feedback process" is part and parcel of the therapy, not an add-on. Using data to explore what is going on with a client system in therapy is an emotional, artful, and complex endeavor that hopefully can ground the therapeutic discourse in more than the opinions and ideas of the therapist and the clients. It does not and should not need to be confined to the first several minutes of the session, but can be woven into the discourse at key points throughout the session. Lastly, we would hypothesize that asking clients to regularly and consistently reflect on their level of functioning and progress in multiple domains of their life facilitates the development of "an observing ego" and helps clients become more sensitive to and aware of themselves and others from a psychosocial perspective.

Model Fit and Specificity

As this review illustrates, MFSs can be general (potentially applicable to multiple therapies

or models) or model specific. A number of the MFSs reviewed above are modality specific in that they were designed to fit individual (OQ, SRS, CORE) or family therapy (SCORE). The STIC is designed to be a general system from a modality perspective that can fit individual, couple and family therapy. Undoubtedly, the most modality and model-specific MFS that we have reviewed and that exists within family therapy is the FFT-CFS, which was specifically developed to fit FFT.

The issue with specificity is that if the model gets too specific it cannot be used to compare change processes in different types of therapy within and/or across modalities. Ideally, our field needs to move toward the utilization of both general and specific MFSs within a particular study that can facilitate some degree of comparison with other work and still capture unique aspects of a particular model. We believe that of the general models, the multi-dimensionality and molecularity of the STIC brings it closest to a general model that can capture particular aspects of specific models within and across modalities. In contrast, the richness and complexity of the FFT-CFS, and the fact that it uses some measurement components (the CFS) that are more general, hold promise for the development down the line of model-specific MFSs that can also facilitate comparison with other specific therapy models.

Research on and with MFSs

There are at least five research foci or questions in regard to MFSs. The first focus concerns the question "Does their addition to therapy-as-usual make that empirically informed therapy better that therapy-as-usual?" There are a number of studies that say that the answer to this question is "yes" for the OQ-45 (in individual therapy) and the PCOMS (in couple therapy), although the effect sizes are small to moderate. A second set of questions, which remains to be explored, concerns the different MFSs. Are some more effective and/or more efficient (work faster) than others? It may well be that the complex MFSs (e.g., the STIC and Bickman's CFS) compared to simple MFSs (e.g., the OQ-45, PCOMS or TP) do not make treatment-as-usual more effective or efficient. A third set of questions concerns the differential effectiveness of the different components of the MFSs. For instance, with the STIC, what is the impact of having clients fill out the Intersession before every session, independent of whether therapists look at the feedback and then subsequently share it with the clients.

A fourth focus addresses the question "Are there therapist and/or organization differences in empirically informed therapy, such that it increases the effectiveness of certain therapists and/or therapists in certain organizations but not others?" Related questions then become "What are and what accounts for these therapist or organizational differences?" We believe that the primary "customer" for MFSs is the therapist. A whole set of questions concerns how best to get therapists to use MFSs in their work and to keep doing it after the pressure (from their organization), project, or study is over. Stated simply, how do we "addict" therapists to the use of data in treatment. This leads into questions about teaching and training therapists how to use MFSs.

The fifth focus concerns the "fertility" of the MFS data for answering different kinds of research questions about therapy and the change process. Clearly the more global and unidimensional the MFS, the less it can be used to test other empirical questions about therapy and how systems change. For instance, the multi-systemic and multi-dimensional nature of the STIC permits the investigation of how the change process works in individual, couple, and family therapy. Questions about how other systems, like the couple, the family, and the children, moderate and/or mediate change in individual therapy with parents and children, or how individual processes (adult and child) impact change in couple or family therapy, can only be addressed with multi-systemic MFSs. Similarly, questions about how different kinds of change within a system (individual or couple) impact the change process can only be addressed with multi-dimensional MFSs that focus on specific aspects of the systems they address. For instance, with couples, does growth in STIC Positivity (love and friendship) precede or follow changes in Commitment and Trust? How do all three relate to changes in Sexual Satisfaction?

Evaluation Versus Making Therapy Better

A crucial issue in the development and use of MFSs is the macro or institutional purposes to which they can be put. Specifically, a key issue concerns that extent to which MFSs could and are used by third party payers or organizational administrators to evaluate the progress of any particular case or the effectiveness of any particular therapist or group of therapists. As mentioned above, most of the tests of MFSs have been clinical trials comparing treatment-as-usual to treatment-as usual with the MFS in question (OQ-45, PCOMS, and STIC). In other words, the "test" has been to see whether using the MFS improves therapy. These MFSs have been primarily developed to help therapists do better work and reinforce the idea that the primary customer or consumer of these systems is the therapist.

The problem is when the "customer" becomes someone other than the therapist, like an institutional administrator/supervisor, an employer or an insurance company whose primary goal is to reduce the costs of paying for mental health services. If the therapist feels or believes that he or she is being evaluated by a third party with the data from an MFS, the data are no longer trustworthy or, in research terms, valid. If an insurance company were to use MFS data to decide whether a particular treatment was warranted and, if warranted, deserved to continue beyond a certain point, it would be in the client's interest to make themselves look as "sick" or clinical as possible, regardless of the reality of their situation. If the client believes that the possibility or continuation of his or her treatment depends on a particular MFS score, the data are no longer trustworthy or valid for research or clinical decision making.

The bottom line is that as a clinical and research field, we must ensure the integrity of the data from the MFSs that are used in research and practice. By "integrity" we mean the trust of clients and therapists that their data will only be used to help them do a better job of working together to address the clients' problems. If that is lost, MFS data become political and strategic information subject to the professional and personal goals of therapists and clients in securing and continuing their livelihood and healthcare. At that point, the scientific and clinical integrity of MFS data are fundamentally compromised.

Conclusion

Empirically informed couple and family therapy is a complex initiative that is in its infancy. It is actually a new form of therapy (and supervision) that is just beginning to make its mark. The multiplicity of MFSs is critical at this early stage of development, and their refinement and evaluation will yield valuable insights into the change process and how to improve couple and family therapy. The importance of research on empirically informed therapy cannot be overstated. It will not only shed light on how people change in therapy, but hopefully make all treatments better and more efficient, offering the individuals, couples, and families who seek our help more confidence and hope in the alleviation of their problems and suffering. It also holds promise to help our field move beyond specific treatment models toward a more generic client or patient-focused language of change.

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27.

ADVANCING TRAINING AND SUPERVISION OF FAMILY THERAPY

Douglas C. Breunlin

This is a chapter about the status of training and supervision of family therapists. My decision to use the word "advancing" rather than "advances" in the chapter's title is intentional. The word "advancing" suggests an active process of attempting to move forward with the possibility of various levels of success, whereas advances points toward outcomes that are superior to what had come before. In one of the seminal reviews of the literature on training and supervision in family therapy, Liddle (1991) remarked about this review: "It seeks to identify where we have been and where we are headed, and perhaps most important, where we need to go" (p. 639). As I will show, this ambitious goal has not been realized. Rather, the history of training and supervision of family therapists can be characterized as a struggle to move forward. In some ways, progress has been made, but in others, the state of the art is little changed from what it was twenty-five years ago and in some ways the present state of the art is inferior to the past. I think there is much to learn from this struggle because insights into it offer possible pathways for significant advances called for by Liddle (1991). While it is customary in the literature to cite articles no more than a decade old, for reasons that will become clear, I will cite earlier work in order to shed light on the nature of this process of advancing. To examine this process of advancing, I will focus on three interrelated snapshots of training. The first addresses efforts to define training and supervision by cataloguing components of this endeavor. The second is the research that explicates both best practices of these components as well as whether and how they produce significantly positive outcomes both for the trainee and for the trainees' clinical outcomes. The third is important changes in how psychotherapy is practiced that have entered the field of family therapy and necessitate that they be addressed in training and supervision. Finally, I will make some modest proposals for how training can continue to advance. But first, it is important to distinguish between training and supervision. Training encompasses all of the practices essential to develop family therapists. Supervision is but one practice of training in which a supervisor and supervisee meet and use a variety of processes to enhance the development of the supervisee and to improve his or her clinical practice. Using an apprenticeship model, one can train a family therapist using only supervision; however, such apprenticeships are more characteristic of agencies or private practice wherein the supervisee seeks to learn family therapy. Supervision is also used to train family therapists in degree granting or postgraduate programs and to monitor and enhance the skills of a trained family therapist

working in agencies and/or private practices. In the literature, the terms "training" and "supervision" are often used interchangeably and/or together. So far the literature has been mostly concerned with supervision. The majority of family therapy training now takes place in degree-granting programs whose training arsenal includes academic course work, supervision, clinical practice, mentoring and sometimes research and/or a thesis or dissertation. In this chapter, I will use the terms "training" and "trainee" within the context of a training program and reserve the terms "supervision" and "supervisee" to refer to the specific practice of supervision. Compared to supervision, far less attention has been given to training, particularly the respective contributions to outcome of each of its practices. We still do not know which training practices are best suited to a particular aspect of therapist development, or how the practices work together to synergistically produce a family therapist. This is unfortunate because training is expensive and cost could be contained if some practices were shown to be redundant and/or less efficient than others.

Defining the Components of Training Family Therapists

Four highly influential papers in the training literature, each designed to capture the scope of the training enterprise, have emerged over the last thirty-five years at roughly fifteen-year intervals. Together these reviews cover over 400 articles on training and supervision. It is beyond the scope of this chapter to address this vast literature; however, the reviews are so thorough and well done that they constitute an excellent snapshot of family therapy training. This makes it possible to use them to examine how training is advancing.

The first review by Liddle and Halpin (1978) set the standard for defining the domain of training family therapists. Liddle (1991) later updated his original review. White and Russell (1995) used a modified Delphi method to define the essential elements of supervisory systems, and most recently Morgan and Sprenkle (2007) adopted a common factors approach to define the supervisory system.

Three more specific studies focused on the practices of AAMFT Approved Supervisors, each using the same questionnaire to allow direct comparison of results. The first study was done by Everett (1980) with subsequent studies by Nichols, Nichols, and Hardy, (1990), and most recently by Lee, Nichols, Nichols, and Odom (2004).

A major finding of the Liddle and Halpin review (1978) was that training styles are largely derivative of the model being taught. Liddle (1988) later called this the principle of isomorphism that is "the overlay of overlays—a framework under which all other elements of the training process can be subsumed" (pp. 154–155). The principle of isomorphism dictates that the goals, process and outcomes of training parallel the goals, process and outcomes of the therapy being taught. Two distinct training styles emerged in the Liddle and Halpin review (1978). One style focused primarily on trainee personal growth and was associated with training in experiential and psychodynamic models. The other was more skill based and directive and was associated with structural, strategic, and behavioral models. Haley (1976, 1988) has also written cogently about these distinct practices. As will be shown, it has been difficult for training to advance beyond the principle of isomorphism.

White and Russell (1995) conducted a Delphi study to classify family therapy supervision. Participants were AAMFT Approved Supervisors who had responded to a set of progressively modified questionnaires designed to capture the scope of supervision. Over 800 variables were identified that exhaustively catalogued the scope of supervision. The variables were classified into five clusters almost identical to those proposed by Liddle and Halpin (1978): supervisor variables, supervisee variables, supervisor-supervisee variables, supervisory interaction variables and contextual variables. White and Russell wondered if these variables could be cobbled into an overarching model of supervision applicable to supervision of all therapy models but fell short of an endorsement of this overarching model noting, "any unifying framework would be too broad and ethereal to have any pragmatic utility" (p. 43). They reiterated that the principle of isomorphism proposed by Liddle might still be the best map for understanding the relationship

between supervision and therapy. In twenty years, the field had not advanced beyond the principle of isomorphism. Furthermore, because the study made no rank ordering that might establish priorities among the variables, there was no way to make the lists more manageable by paring them down. The important advances of this study, therefore, capture the scope of supervision but also potentially overwhelm readers who are challenged to digest its scope.

Most recently, Morgan and Sprenkle (2007) analyzed the content of supervision articles in an effort to define the common factors associated with supervision. They then distilled 283 supervisory activities and grouped them along three continua. The first continuum was labeled "emphasis" and ranged between a focus on clinical competence and professional competence. This is essentially the same distinction made by Liddle and Halpin (1978) that was called personal growth vs. skill development. The second set of behaviors was labeled "specificity" and ranged from "Idiosyncratic/Specific" to Nomothetic/General. An example would be the focus on the specific dynamics of a particular blended family case vs. the focus on how blended families develop over time. The third was "Relationship" and ranged from collaborative to directive. Morgan and Sprenkle also added four roles that supervisors assume. The "Coach" focuses on the clinical competence of the supervisee as specifically related to his or her clinical work. The "Teacher" also focuses on clinical competence, but at the more general level of how families function. The "Mentor" focuses on the personal development of the supervisee. Finally, the "Administrator" focuses on ethical, legal, and standards that guide the profession. The administrator also attends to record keeping and risk management issues.

Morgan and Sprenkle (2007) then creatively presented the common factors that emerged using a "four-cornered plane where the Emphasis dimension (Clinical vs. Professional Competence) constituted the Y axis of the plane and the Specificity dimension (specific vs. general) constituted the X axis. The four roles could then be superimposed on the plane with the "Mentor" role at the idiosyncratic/particular-professional competence quadrant of the plane, the "Coach" role at the idiosyncratic/particular-clinical competence quadrant of the plane, the "Teacher" role at the nomothetic/general-clinical competence quadrant of the plane and finally the "Administrator" role at the nomothetic/general-professional competence quadrant of the plane.

Morgan and Sprenkle identify the "Administrator" role often ignored in the training literature. This is the time-consuming and essential activity that prepares trainees to open and use a client record and to follow the protocols of a clinical setting. Administration is actually the first priority in supervision because it manages risk. The other three roles are distributed among the remaining time in supervision.

The "Teacher" role is also important to consider. When this role is utilized in supervision, time is spent addressing the characteristics common to a particular kind of case. This same material could be covered in course work. This raises a question of emphasis with the possible answer that supervisors should pay close attention to what trainees are learning in class and use supervision only to augment this learning. In fact, Avis and Sprenkle's (1990) review of the training research reported findings that conceptual skills may be better taught in a classroom setting.

The focus of the "Coach" is essentially skill development while the focus of the "Mentor" is essentially personal growth. These are the same distinctions identified by Liddle and Halpin (1978). By identifying the "Coach" and "Mentor" as common factors of supervision, however, Morgan and Sprenkle (1990) force supervisors to transcend the principle of isomorphism and to question when and how both roles should be utilized in supervision. Unfortunately, Morgan and Sprenkle do not provide guidelines for how supervisors incorporate both roles.

Why has it proven so difficult to advance family therapy training to a point where the differential focuses on trainee skill development and personal growth have been more clearly established? If we focus on the pragmatics rather than the theory of supervision, one obvious answer emerges: every supervisor is first a therapist practicing a preferred model of therapy. It only stands to reason that supervisors are most inclined and comfortable passing on the knowledge of the

therapy they know and trust best. The principle of isomorphism, therefore, is a pragmatic necessity. To embrace the common factors of supervision, therefore, supervisors must commit to transcending their own clinical preference.

Advancing the Research Mission of Training Family Therapists

Research in training and supervision has had two foci. The first focus has been on efforts to measure two kinds of training effectiveness: first, how effective the training is at changing the trainee, and second, how effective it is in affecting the clinical outcomes of the trainee. The second focus has been on defining best practice for the components of training. While both foci are essential, the *sine qua non* of training is its ability to increase the clinical effectiveness of the trainee.

Does Training Improve the Trainee?

The first step for the nascent field of training was to demonstrate that training actually changes the trainee. Avis and Sprenkle (1990) reviewed sixteen studies conducted in the 1970s and 1980s. Liddle (1991) and Street (1997) also offer excellent reviews of this same body of work. Most of these studies examined skill acquisition by adopting the well-established training objectives template of perceptual, conceptual, and executive skills reported in several early training articles (Cleghorn and Levine, 1973; Tomm and Wright, 1979; Falicov, Constantine, & Breunlin, 1981). The review of these studies led Avis and Sprenkle (1990) to conclude: "We now have several instruments with some degree of validity and reliability which appear able to distinguish between beginning and advanced therapists, to measure the acquisition of conceptual an/or intervention skills, and to offer feedback to therapists on their in-therapy behaviors" (p. 260). These authors conclude by offering recommendations for how the field of training should advance and how research can inform these advances. They end the article by stating: "Evaluating the outcome of family therapy training is a fledgling research endeavor of tremendous importance to the field. As family therapy matures, it is increasingly urgent that its training procedures be based upon a sound empirical foundation of demonstrated effectiveness in producing therapists who offer better services to families" (p. 263).

The fact that I am citing training literature that would normally be discarded as obsolete should be taken as alarming and it is. The promise of these early studies and the foundation they laid was never carried forward by subsequent research. There are several important reasons that this type of training research did not advance. First, while all of the critiques of this body of work were congratulatory for its groundbreaking nature, the critiques also found that all of the studies had methodological weaknesses that could only be eliminated with more rigorous studies. The reviews called for new studies that would address these shortcomings. Unfortunately, this call for better studies forced researchers of training to face the enormous complexity of the training system and the huge methodological challenges that must be met to address this complexity. Second, the scope of research of this nature requires a greater number of subjects and longer time frames. Such research is expensive and requires federal money that has never been available to conduct it (Sprenkle personal communication, 2013).

It is important to note, however, that degree-granting MFT programs have continued to grapple with this issue of trainee change. In the early 2000s, AAMFT supported the development of a set of core competencies (AAMFT, 2004). These competencies articulate "the basic floor of knowledge that practicing family therapists should be expected to know, discern and do in their clinical work when they begin practicing therapy independent of supervision" (Lee and Nelson, 2014, p. 94). In addition, in 2005, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) changed its standards to an outcome-based format (Nelson & Smock, 2005) that requires accredited programs to specify and track their chosen outcome measures. The rigor with which this process occurs is more like program evaluation than methodologically sound research. Programs, therefore, are able to report positive training outcomes but are not able to attribute those outcomes to specific training

practices. Moreover, the resource-intensive nature of outcome-based education can strain program resources and thus constrain undertaking methodologically sound research (Nelson personal communication, 2014). Regarding the undertaking of research to demonstrate that training actually changes trainees; we must conclude that few if any advances have occurred in the past two decades.

Does Training Lead to Better Clinical Outcomes?

The benefits of training to change trainees are important; however, such benefits are at best an indirect link to client outcome. Ultimately, research on training must establish a significant correlation between training and a trainee's positive clinical outcome. This second kind of outcome research on training is even more challenging because it must incorporate both the training and the clinical systems.

There are no studies in the literature on family therapy training that address this most important issue and scant evidence in the literature on training of individual therapy. Watkins (2011) reviewed thirty years of research that investigated whether psychotherapy supervision affects patient outcome. Of the eighteen studies he reviewed, he concluded that only one addressed the question, met the standard of appropriate research design, and involved typical supervision. In this study (Bambling, King, Roué, Schweitzer, & Lambert, 2006), patients diagnosed with major depression received Brief Problem Solving Therapy from therapists who were divided into three supervision conditions (alliance skills focus, alliance process focus, and no supervision). Patients in the supervised conditions rated the working alliance higher, their symptoms lower, their satisfaction with treatment higher, and were more likely to stay in treatment.

While this study's findings are encouraging, it is a far more difficult to replicate them with a relational system. Only one article tackling this thorny issue has been published in the family therapy literature (Sparks , Kisler, Adams, & Blumen, 2011). These authors piloted the use of a client feedback instrument (Duncan, Miller, & Sparks, 2004). They argued that client feedback helps supervisees to stay accountable to their clients and to become effective family therapists. They presented data from a single case to illustrate how such client feedback can be helpful in supervision. The creators of empirically supported treatments (Henggeler, Alexander, Liddle, and others) would argue that a correlation between training and clinical outcome has been established because adherence to treatment manuals has been shown to produce better outcomes, and better adherence is the product of training and supervision. There remains the challenge, however, to demonstrate which specific training methods effect better trainee clinical outcomes. We must face the fact that we have a long way to go to advance the field of training and supervision to the point where we can reliably demonstrate that training improves trainees' clinical outcomes.

Research on the Components of Training

In the past fifteen years, the research focus has shifted to establishing the best practices of the most important components of training. This research has become a cottage industry, located mainly in degree-granting programs in marriage and family therapy that primarily utilize qualitative methods with small sample sizes. As such, there are threats to the validity of these studies and at best they offer hypotheses for future studies. A more complete summary of this research is reported elsewhere (Breunlin, Lebow, & Buckley, 2014). Studies have been published on supervisor qualities, supervisee qualities, the supervisor–supervisee relationship, how to promote multicultural competence, the role of the "self of the therapist," and live supervision. To offer a sampling of these studies, I will present the research on two supervision foci: the self of the therapist and live supervision.

Self of the Therapist Research

We only have the suggestive findings of five qualitative studies with small sample sizes that shed light on the self of the therapist supervision. Lutz and Irizarry (2009) reported the experiences

of six supervisees of the *Person-of-the-Therapist Training* (POTT) program at Drexel University. Supervisees in the POTT program were challenged to identify and differentiate themselves and their life experience from that of their clients. Outcome was measured through weekly journal entries. At the end of POTT program, trainees stated they felt more aware and more comfortable with themselves as therapists. It should be noted, however, that three participants quit the POTT for various reasons. McCandless and Eatough (2012) explored supervisees' abilities to identify self of the therapist issues as a key learning outcome. Transcripts of semi-structured interviews with three experienced supervisors were analyzed. The results revealed the importance of the supervisory relationship as the context for helping supervisees feel comfortable processing the emotional and experiential components of learning to be a clinician. Page, Stritzke, & McLean (2008) found that supervisees reported that the more they learn about themselves, the more accountable they were. Page et al. went on to suggest that the practice of supervisees learning about themselves was an important element to focus on in supervision. In a small qualitative study, Haber and Hawley (2004) found that working on transgenerational themes helped supervisees to formulate a more flexible use of self in the therapy room. They concluded that examining family of origin issues allowed supervisees to experience the idea that changing themselves could change the therapeutic system.

These studies reported positive responses of trainees to the focus of person of the therapist issues in training, but none established that this focus created more competent therapists. Nor was it demonstrated that addressing the person of the therapist actually led to better clinical outcomes. To advance the mission of training, these studies, at best, serve as background on which to build bolder studies that do tackle the question of trainee personal growth and clinical change.

Live Supervision

This important format of supervision was once viewed as the *sine qua non* of systemic supervision. The two surveys of AAMFT supervisors (Everett, 1980; Lee et al., 2004), however, reveal a decrease over time in its use. From 1986 to 2001, the percentage of supervisors reporting the use of live supervision decreased from 68% to 50% and the percentage of supervisors who named live supervision as the primary supervisory method decreased from 26% to 15% (Lee, et. al., 2004). This decrease can be explained by shifts in the focus of the therapy model being taught from interaction to meaning and emotion that render live supervision less useful and by time constraints of supervision. Still, more research has focused on live supervision than any other form of systemic supervision. Most studies have found that live supervision can be a particularly helpful tool when it is practiced and carried out thoughtfully. The findings of two suggestive studies are summarized below. Although the preponderance of this research affirms the value of live supervision, at least one study found no difference in client reports of helpfulness between live supervision and regular supervision (Bartle-Haring, Silverthorne, Meyer, & Toviessi, 2009).

Wark (1995) reported a qualitative study where five supervisor–supervisee pairs were observed during six live supervision sessions and then interviewed with a semi-structured interview format. Qualitative analysis of the interviews revealed six qualities of a positive live supervision experience: supervisors teach/direct; supervisors support and collaborate; supervisees are perceived as a colleague working together with the supervisor; supervisees feel connected to the supervisor; supervisors were not overly involved and used conscious restraint during live supervision; and supervisees know that their supervisors thought that they were capable.

Wright (1986) analyzed 150 phone-ins made during live supervision. The analysis focused on the content of the supervisors' statements, implementation of the supervisors' input and the professional level of the supervisees (beginning or advanced). Based on the findings, Wright offered several guidelines for creating a positive live supervision experience: 1) give supervisees opportunities to experience phone-ins through role-plays prior to actual work with families; 2) use restraint with phone-ins, limiting the number of call-ins to no more than five; 3) wait ten minutes to make the

first call; 4) state instructions in a clear, concise manner geared to the level of the supervisee; and 5) allow group input only later in the live interview session.

The Impact of the Evolution of Family Therapy on Training

Family therapy was never a monolithic enterprise that sprung from one source. Rather, under the umbrella of systemic thinking, family therapy evolved through the contribution of many proponents. Views of family therapy range from seeing only the whole family to the view that any combination of people can be in the room so long as the therapist maintains a systemic focus. Elsewhere Breunlin and Jacobsen (2014) argue that over time the whole family has been less and less the focus of family therapists. Doherty (1991), for example, found that family therapists utilize family therapy only 13% of the time and that 50% of a family therapist's clinical practice is individual therapy. Training family therapists today must accommodate these realities; consequently, it can no longer be modality specific. Rather family therapy training must train therapists who can conduct family, couple, and individual therapy. As psychotherapy (including family therapy) has developed, trends (advances if you like) are emerging that must also be incorporated into the domain of training. In the limited scope of this chapter, I will address four interrelated clinical advances that require a corresponding advance in training.

Training Implications of the Multileveled Perspective

Multileveled theory has been part of the family therapy scene from the beginning, having been a core principle of von Bertalanffy's (1968) conception of systems. He dubbed it the biopsychosocial system. In the early days of family therapy, however, von Bertalanffy's ideas served more as a rationale for thinking systemically than as a template for practice. Over time the practice implications of multileveled thinking have crept into family therapy, expanding and enriching the practice but also making training more complex as it incorporates levels other than the family. For example, family therapists once viewed the use of medication as biomedical reductionism antithetical to their holistic beliefs. When psychiatry shifted its focus almost exclusively to psychopharmacology, a plethora of new medicines to treat mental disorders entered the market. Strong pressure from consumers and insurance companies to use these medications coupled with their effectiveness has forced practitioners of all disciplines to factor them into treatment plans. Many classic models of family therapy placed mental process in the proverbial "black box" and ignored it in favor of interaction (Watzlawick, Beavin, & Jackson, 1967). This left many training programs without clear guidelines for understanding and treating individuals in systems. For example, an early proposal for a curriculum to train family therapists called for trainees to be "exposed" to one model of individual functioning, but not to be trained in the therapies associated with it (Winkle, Piercy, & Hovestadt, 1981). Since 50% of most family therapists practices is work with individuals, it is imperative that trainees be taught how to work with individuals, albeit from a systemic perspective. Schwartz's Internal Family Systems therapy (Schwartz, 1995) and Object Relations Therapy (Slipp, 1984) are examples of systemically informed individual models that are easily integrated into multileveled thinking. In the last two decades, couples' therapy (Gurman & Fraenkel, 2002) has emerged as a form of practice distinct from family therapy. Empirically informed couples therapy models such as emotion-focused therapy (Johnson, 2008; Greenberg, 2004) and integrative behavior couples therapy (Christenson, Jocobsen, & Babcock, 1995) are two examples. Family therapy training has been slow to accommodate this change. For example, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has no specific requirement for how many hours of couple therapy a trainee must accrue; hence, it is possible that a student could graduate from an accredited Marriage and Family Therapy program having never seen a couple. Training must now provide adequate exposure to couples' therapy. Finally, family therapy has continued to value the contributions to theory and practice of community psychology, larger systems thinking, social justice, sociology, anthropology and economics.

Findings from these disciplines have documented that distress at the social level often plays a role in the presenting problem.

In summary, family therapists can no longer focus exclusively on the level of the family. Training must prepare trainees to practice individual, couple and family therapy as well as to know when to refer for medication evaluations and/or neuropsychological testing.

Training Implications of The Integrative Perspective

Traditionally models of therapy have been offered in a pure form accompanied with an implied invitation to use each exclusively. The proliferation of models and the failure of any model to achieve empirical ascendancy, however, render model exclusivity dubious. Besides, most family therapists will ultimately practice individual, couple, and family therapy, automatically necessitating their use of several models. Training programs have limited options for how to deal with this issue. A program can specialize in one model, offer a limited number of models, offer a survey of the field and let the trainees decide, teach an eclectic approach, or develop a perspective that integrates the models.

While integration brings theoretical and practical challenges, there are also distinct advantages to integration (Breunlin, Schwartz, & MacKune Karrer, 1992, 1997; Pinsof, 1995; Lebow, 1984, 1997, 2013; Breunlin, Pinsof, Russell, & Lebow, 2011; Pinsof, Breunlin, Russell, & Lebow, 2011). An integrative perspective serves as a map of the territory. This map renders the complexity of training more manageable and serves the trainees well when they encounter a myriad of practice options after graduation. Integrative perspectives minimize the blind spots inevitably present in pure model practice. Finally, integrative perspectives afford therapists larger access to a range of tasks that best fit client needs and, therefore, improve the alliance.

The Contribution of Common Factors to Training

Common factors are therapeutic ingredients shown to exist across all therapies. These common factors were first established for individual psychotherapy through meta-analysis of research studies. Lambert's widely cited meta-analysis, for example, found that extra therapeutic factors accounted for 40% of change, and that the largest therapeutic contribution to change, around 30%, came from relationship factors captured by the construct of the alliance. Only 15% of the change was attributable to treatment interventions (Lambert, 1992).

Common factors have now been established as equally crucial in couple and family therapy (Sprenkle & Blow, 2004; Sprenkle, Davis, & Lebow, 2009). As in individual therapy, the therapeutic alliance has been the most powerful predictor of change. Given these findings, it seems axiomatic that training programs devote considerable attention to the formation and maintenance of the therapeutic alliance.

The alliance is not a unitary construct, but rather the product of a complex interaction of three related parts: tasks, goals and bonds (Bordin, 1979; Pinsof and Catherall, 1986). Tasks are the things to be done in the treatment, goals are the aspirations for the treatment and bonds are the affective connection between family members and therapist. Compared to individual therapy, the alliance in family therapy is more complex. The alliance includes the alliance the therapist has with each family member, the alliance of the family system with the therapist, and the alliance the family members have with each other. Needless to say, it takes a sophisticated therapist to maintain and trouble shoot this blend of alliances, and this skill should be an important part of training a family therapist.

Research on the alliance has shown that it is difficult to separate the parts of the alliance because they are highly intercorrelated (Pinsof, Zinbarg, & Knobloch-Fedders, 2008); nevertheless, the parts are still useful because they identify the activities essential to create and maintain an alliance. The alliance enables disparate training goals to be unified; consequently, it can serve as a centerpiece for training. Trainers teach trainees how to set goals and use tasks; therefore, training has a directive component (the coach). Trainers must also teach trainees how to form bonds; therefore, training has a collaborative component (the mentor) to develop the person of the

therapist. The long-standing difference between personal growth training for experiential and psychodynamic models and directive training associated with structural, strategic, and behavioral models dissolves in the common ground of the alliance.

The Contribution of Research to Training

Psychotherapy has always been touted as part art and part science. The connecting of therapist and client(s) in the intimate arrangement of therapy is a form of art; however, over the past twenty-five years, research in psychotherapy and in family therapy has produced findings robust enough to shift the balance toward science (Pinsof & Wynne, 2000). In 21st century training programs, graduate-level trainees should be taught to be research informed clinicians and doctoral-level trainees should be taught to be scientist practitioners (Karam & Sprenkle, 2010). An important distinction can be made here between training to know the evidence and training to use the evidence.

Knowing the evidence can be achieved by having a course on how to consume research and by assuring that the curriculum adequately presents the research literature pertinent to the topics of each course (Patterson, Miller, Carnes, & Wilson, 2004). Using the evidence in a training program is more challenging. Three options are available. First, the program could emphasize common factors and construct the program to impart as much knowledge and skill as possible about the common factors. Such a program would be evidence based because the common factors were derived empirically. Second, the program could teach empirically supported treatments (ESTs). Third, the program could incorporate a progress research into the training.

To build training fully around a radical common factors approach is unfeasible because accreditation in all fields requires the teaching of the models of therapy. Sprenkle et al. (2009) proposed a moderate common factors approach that balances exposure to common factors, but in the context of a thoughtful use of models. This approach allows common factors to be incorporated as a component of training.

The second approach builds training around an (EST). In degree-granting programs, this approach poses challenges. First, training programs are generally mandated to produce well-rounded therapists capable of treating a range of problems and populations. Since most ESTs target a specific problem or population, they can be too narrow for training programs. Second, many ESTs are franchised. The training must be purchased at considerable cost and delivered by the EST's designated trainers. Still, it is important to expose trainees to the existence and importance of ESTs. At a minimum, this can be done through course work.

ESTs are practiced in the context of the research studies involving them and in many agency settings. Most EST packages include the model as well as training and ongoing supervision in them. As such, an EST package constitutes a form of postgraduate training in family therapy.

Another aspect distinguishing supervision in ESTs from other forms of supervision is the use of a treatment manual and the notion of adherence to it. A treatment manual provides guidelines for conducting treatment. Supervisors can compare treatment (and often do) to the manual. Advocates for ESTs argue that treatment effectiveness correlates with manual adherence. Research has demonstrated that increasing adherence does improve outcome (Henggeler, Schoenwald, Liao, Letourneau & Edwards, 2002; Ogden, Forgatch, Askeland, Patterson, & Bullock, 2005; Perepletchikova, Treat, & Kazdin, 2007). It remains less clear, however, whether this effect has to do with adherence per se or with the general quality of the therapy delivered, which typically correlates with adherence. Little research has compared satisfaction and utility of supervision focused on adherence with more traditional supervision.

The third option is to emphasize progress research wherein trainees track the progress of their therapy using a progress research instrument completed by clients (Pinsof & Wynne, 2000). These instruments can be used with any model of therapy. Progress instruments not only teach trainees to use evidence, but also that very evidence ultimately can enable programs to determine how training improves the trainees'

clinical outcomes (Bambling et al., 2006; Sparks, Kisler, Adams, & Blumen, 2011). This is a tremendous advance in training because, to date, there is but scant data showing that any training method directly impacts on clinical outcome. Attention to progress data in training, however, comes with a cost. Supervisors must find a way to incorporate it into an already packed supervision agenda. To date no article suggests how to do this well (McComb, Mirecki, Chambers and Breunlin, under review).

A Modest Proposal for Advancing

Liddle (1991) ended his review of the family therapy training and supervision literature with a powerful statement: "Without exaggeration, the success of the family-therapy field depends on the next generation of supervisors. Our field can progress no further than do those who define it and teach it to others. These trainers represent what we have been and where we are going. It is they who carry the torch" (p. 688). I might paraphrase and say that it is they who advance the field. In the ensuing two decades, specific trainers and supervisors, no doubt, have lived up to this challenge; however, an argument can be made that the literature that supports them has not. I have identified several ways that training has not been advancing and in some ways has stalled. I am of the opinion that training needs to be jumpstarted if it is ever to live up to Liddle's challenge. I will offer a few suggestions for how this jumpstarting might take place.

Historically, training and supervision have not been high-status areas of expertise. This needs to change so that the most talented in our field are drawn to study, research, and write about training. This is essential for professionals to make careers out of the study of training. Sadly, some of the most promising thinkers in the arena of training eventually sought more prestigious endeavors. Howard Liddle, himself, once a leader in the field of supervision (Liddle and Halpin, 1978; Liddle, Breunlin & Schwartz, 1988; Liddle, 1991), redirected his career and developed Multi dimensional Family Therapy (Liddle, 2010).

I have noted above that funding challenges have impeded training research. This is ironic given Liddle's quote. If outcome is what matters, shouldn't the field advance to the point where it can demonstrate how a therapist capable of getting good outcomes has to be trained? Moreover, shouldn't all of the stakeholders in the field of supervision be committed to demonstrating this link between training and outcome? Two strategies can be pursued. One is to develop credible arguments that persuade the funding agencies to fund training studies. The second is for training programs to form consortiums to pool their resources to enable larger scale training research to occur.

Far too little emphasis has been given to studying the respective impact of course work and supervision. I suspect that there are redundancies between the two that could be eliminated to free training resources to be used in other ways. More research needs to focus both on the impact of coursework on trainee competence and on the relative impact of coursework and supervision. Programs need to constantly refine their curricula. I would suggest that a family therapy curriculum today should include at least two courses on the self in the system that prepare trainees to work systemically with individuals, and at least two courses on couples therapy. Since family therapy is increasingly taught as specialties in other degree-granting programs, it is imperative that the curricula of these programs also provide adequate course work in family therapy.

Finally, I urge trainers and supervisors to engage in a version of single-case research by attending more closely to their own practice of supervision. One way to do this is to use Morgan and Sprenkle's (2007) common factors framework. Using a simple pie chart, supervisors can estimate how they distribute their supervision among the four roles (coach, mentor, teacher, and administrator). Over time, this tracking of supervisory emphasis should reveal the supervisor's preferences. If the distribution of roles is unbalanced, the supervisor can ask why this is and also consider how to achieve a better balance of roles so as to produce better-rounded trainees.

Conclusion

If the past twenty-five years have demonstrated anything, it is that the landscape of family therapy

has constantly shifted, and that there is no reason to believe that it will not continue to do so. This simple fact raises two important points about training family therapists. First, of the myriad aspects of family therapy that trainees must absorb, the most important is that they become what Bateson (1972) called "deutero learners," that is, they must learn to learn. In this sense, they must complete their training knowing how to stay current with the field and eager to do so. Second, trainers cannot ever reach a point where they are content to stay put with the skill level they have achieved. Supervisors must also embrace deutero learning and demonstrate this to their trainees. They do this by staying abreast with the development in family therapy and with the way the fields of training and supervision are advancing.

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28.

INTEGRATIVE PROBLEM CENTERED METAFRAMEWORKS (IPCM) THERAPY

William P. Russell, William Pinsof, Douglas C. Breunlin and Jay Lebow

The field of couple and family therapy and, more generally, the field of psychotherapy contain an overwhelming plethora of information about human functioning, problem solving, therapeutic principles, clinical models, evidenced-based treatments, common factors, and established clinical competencies. Therapists face the daunting challenge of determining how to effectively utilize these ideas, models, and techniques. They do so in the face of client systems presenting with a variety of co-occurring problems maintained by factors ranging from a simple lack of information to complex and challenging networks of constraints. Therapists struggle with how best to utilize the available treatments, interventions, and knowledge, as well as how to organize and sequence therapy. Therapists who practice within a particular model struggle with what to do when the strategies and techniques of that model fail to produce the desired change. More eclectic therapists struggle to find a coherent way to organize their work—a set of principles to help them decide what to do and when to do it.

This confusing and overwhelming experience of individual clinicians presents a developmental challenge for the field of couple and family therapy. The field needs a meta-level model for integrating this mélange of knowledge about human systems, their problems, and the therapeutic models and techniques that have emerged to address them. This chapter presents Integrative Problem Centered Metaframeworks (IPCM) Therapy (Breunlin, Pinsof, Russell, & Lebow, 2011; Pinsof, Breunlin, Russell, & Lebow, 2011), a therapeutic perspective that addresses this need. Derived from the earlier work of Breunlin, Schwartz, and MacKune-Karrer (1997), Pinsof (1995), and Lebow (1997), IPCM integrates theory and research from family, couple, individual, and biobehavioral therapies; supports direct and cost-effective practice while accommodating clinical complexity; and provides therapists with real-time data to support empirically informed decision making throughout the course of treatment.

IPCM is an integrative, multisystemic, and empirically informed psychotherapeutic perspective. It is a comprehensive perspective in that it can be applied to a wide range of client concerns (symptoms, syndromes, disorders, and problems) in family, couple, and individual therapies. This chapter presents key elements of IPCM by discussing how the perspective addresses six questions that might be asked by any therapist seeking to integrate strategies and techniques from various models. The chapter then presents a case example illustrating IPCM within family and couple therapy contexts and briefly discusses the integration of art and science in psychotherapeutic practice.

What Is the Core Theoretical Foundation of IPCM?

IPCM rests on four theoretical pillars. The *epistemological pillar* asserts that there is an objective reality, but human knowledge of that reality is ineluctably partial and evolving. Over time and with engagement, our knowledge about a human system becomes more accurate but is never complete or definitive. The *ontological pillar*, General Systems Theory (von Bertalanffy, 1968), views human systems as nested levels of subsystems including person, relationship, family, community, and society. Systems principles, such as wholeness, self-regulation, and feedback apply to each level and to the interaction between levels. The third pillar, *differential causality*, views the interaction between systems as a web of mutual influence, with different systems contributing differentially to the variance in any process or outcome. For example, depression and marital distress frequently co-occur and mutually influence each other (Synder & Whisman, 2004); however, depression may account for more of the variance in marital distress in one couple than in another. The last pillar, *Constraint Theory* (Breunlin, 1999) derives from Bateson's (1972) concept of "negative explanation" and views therapy as the identification and removal of constraints that prevent problem solving. Instead of wondering "Why is this family struggling?" (positive explanation), we ask "What prevents them from changing?" Our theory and practice focus on identifying adaptive solutions (alternative adaptive sequences) and removing or mitigating "solution constraints"—the factors that constrain implementation of adaptive solutions.

In addition to its pillars, IPCM is defined by a set of therapy guidelines that inform clinical decision-making at important junctures in therapy. While the pillars provide the theoretical presuppositions of IPCM, the guidelines provide the practical basis for how to plan a systemic, integrative therapy. The derivation and justification for the guidelines are beyond the scope of this chapter, but can be found in the discussion of the premises and principles of Integrative Problem Centered Therapy (Pinsof, 1995) and IPCM (Breunlin et al., 2011; Pinsof et al, 2011). The guidelines, presented throughout the chapter, are labeled and italicized. The guidelines and a blueprint for therapy (described below), allow IPCM therapists to transcend the particular logic of a specific model while preserving the ability to utilize aspects of that model that may be useful with a given case.

What Is the Essence of IPCM Therapy?

Although IPCM accommodates and addresses the complexity of human systems, its essence is relatively simple. At its core IPCM is about collaborating with client systems to solve the problems they bring to therapy. IPCM therapists lead clients in a collaborative, improvised conversation that has multiple recursive tasks: 1) *define* the presenting *problem*; 2) locate the problem in a *problem sequence* (PS); 3) *identify* an *alternative adaptive sequence* (AAS) that is likely to resolve the problem; 4) *implement* the *AAS*; 5) *evaluate* the *outcome* of the AAS (successful or unsuccessful); 6) if successful, go to step 9; if unsuccessful, *identify constraints* to the AAS; 7) attempt to *lift constraints*; 8) *implement* the *AAS (or revised AAS)*; 9) *maintain* the *AAS*; 10) *terminate or repeat the steps* in regard to additional constraints and/or new problems. Figure 28.1 depicts this circular and recursive process.

Several IPCM therapy guidelines inform this "essential" process. The *problem centered guideline asserts that clients' presenting problems are the organizing foci of therapy and all interventions must be*

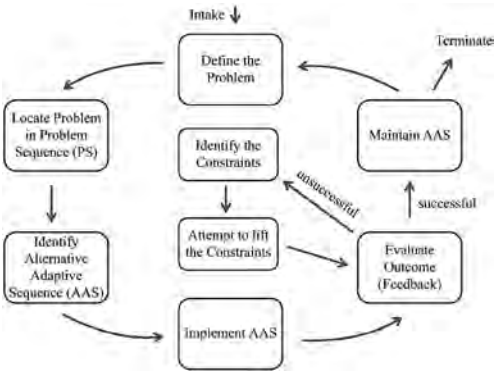

Figure 28.1 Essence of IPCM

linked to them in some way. People seek psychotherapy when they have been unable solve their psychological and/or interpersonal problems. The basis of the therapeutic alliance in voluntary psychotherapy is the problem-centered contract. Clients feel heard and acknowledged when they experience the therapist's interest in and understanding of their problems. The therapeutic alliance is strengthened when the therapist focuses on the clients' concerns and their goals for the therapy and clearly describes the relationship between therapy tasks and client goals. As therapy progresses, other problems may emerge. Such problems or issues may become the foci of therapy under one of two conditions. First, the client system designates an issue as a presenting problem ("Is this something you want to work on in therapy?"); or, alternatively, the therapist and client system determine that the newly identified problem constrains the client system from solving its presenting problem ("Is this something that keeps you from doing what we have agreed that you need to do?") and warrants being addressed as a solution constraint. Examples of the this second condition include explaining to a mother how her depression (non-presenting problem) interferes with her limit setting with her 6-year-old son who exhibits oppositional/defiant behavior (the presenting problem); or, helping a husband see how his drinking (non-presenting problem) reduces his inhibitions so that he is at greater risk of becoming physically abusive (presenting problem) in arguments with his wife.

IPCM views problems as being embedded in sequences (patterns) of interaction. *The sequence replacement guideline states that the primary task of the IPCM therapist is facilitating the replacement of the key problem sequences with alternative adaptive sequences that eliminate or reduce the problem*. The process of identifying these alternative adaptive sequences is collaborative and strength-based. IPCM therapists believe that clients, unless otherwise constrained, have the ability to identify and execute alternative adaptive sequences (solutions). The specifics of the solutions emerge out of a collaborative exploration of prior and current attempted solutions, common-sense approaches, client resources, therapist expertise, and cultural fit.

Establishing a *consensus* about an alternative adaptive sequence ("So, do we agree that this might be a good way to deal with this problem?") requires the therapist to be empathic, curious, and persuasive. The alternative adaptive sequence may involve implementation of a new course of action, better expression or management of emotion, or a shift in meaning or beliefs. This can be a relatively straightforward process. At other times, the problem is embedded in a network of sequences that must be addressed in an agreed-upon order.

IPCM's problem focus should not be confused with deficit-based thinking. IPCM is passionately committed to recognizing and supporting client strengths along with respecting the concerns (problems) clients bring to therapy. *The IPCM strength guideline asserts that until proven otherwise, the client system can utilize its strengths and resources to lift constraints and implement adaptive solutions to its problems with minimal and direct input from the therapist system.* So, clients are directly encouraged to enact new patterns of action, meaning, and emotion.

When clients are unable to implement the alternative adaptive sequence, the therapist leads a collaborative effort to identify and ameliorate or remove the constraints to change. Two fundamental questions facilitate understanding of constraints within any context: "What factors constrain the system?" and "Where in the multilevel system are they located?" The "where" question draws on the concept of inclusive organization from General Systems Theory: constraints can exist at any or all levels of the psychosocial system including the levels of person, relationships (dyadic and triadic), family, community, social/public, and civilization. The "what" question is addressed by considering eight Hypothesizing Metaframeworks, each of which delineates a domain of human functioning and a set of factors that can constrain problem solving. Although a detailed description of the Hypothesizing Metaframeworks is beyond the scope of this chapter, they are listed and briefly described below.

- Sequences: A framework for describing and analyzing sequential patterns of interaction (including action, meaning and emotion).
- Organization: A set of concepts that describes how the components of a system fit together

and function as a whole (boundaries, leadership patterns, balance among subsystems, harmony among members).
- Development: Concepts and information concerning developmental stages and competencies of families, relationships and individuals; fit of developmental demands among members and across levels.
- Mind: Three increasingly complex levels of analysis of cognitions, emotions, and intentionality: sequences of mind, organization of mind and development of self.
- Culture: A framework for examining the impact of membership in contexts of ethnicity, race, religion, class, geographic region, economic status, education, sexual orientation and age; cultural fit across levels of the system.
- Gender: Constraints derived from gender-based power imbalances, rigid gender roles and stereotyping; fit of gendered expectations and preferences across levels of the system.
- Biology: Medical and neurobiological constraints (e.g., physiology of emotional arousal, physical illness, disability, serotonin imbalance).
- Spirituality: Difficulty accessing spiritual resources such as faith, hope, prayer, transcendence, letting go and acceptance; constraints related to religious beliefs or the fit of religious beliefs and/or spiritual practices across levels of the system.

The "where" and "what" dimensions of constraints generate the "Web of Constraints" shown in Figure 28.2. The concentric circles represent levels of the biopsychosocial system and the axes represent the eight hypothesizing metaframeworks. The goal of IPCM is a modification of the Web sufficient to permit the client system to consistently and reliably implement an adaptive and successful solution to the presenting problem.

The Therapy System

The constraint-removing and problem-solving essence of IPCM applies to work done with any and all levels of the "system." The IPCM therapist sees him/herself as part of a system (the Therapist System) as well as intervening into a system (the Client System). The Client System contains all the people involved in the maintenance and/or resolution of the presenting problem. The Direct Client System consists of all of the people attending therapy at a given time; the Indirect Client System consists of all the members not currently attending therapy. The Direct/Indirect distinction (boundary) facilitates a multisystemic perspective that preserves a broader sense of who is in the Client System, regardless of who is attending therapy at the time. Over the course of therapy, the boundary between the Direct and Indirect Client System can be modified as different members move into or out of the sessions. The therapist leads a collaborative, ongoing conversation that determines who needs to attend what sessions in order to work most effectively on the constraints that need to be addressed. With the Client System concept, IPCM includes and re-defines individual therapy as a multisystemic intervention in which the Direct Client System includes one member of the Client System.

The Therapist System consists of everyone involved in the provision of therapy to the Client System. The therapist is typically the sole member of the Direct Therapist System. There are two categories of indirect providers. The first includes the therapist's supervisor, supervision team members and/or consultants. The second category includes any other therapists who provide therapy to members of the client system. Unaddressed or intractable conflicts within the supervisory/clinical team or lack of alignment between the therapist and "outside" therapists can impact the therapy as much as constraints within the client system. Together the Client and Therapist Systems constitute the *Therapy System*. IPCM Psychotherapy (individual, couple, and family) is the collaboration of Client and Therapist Systems to enact adaptive sequences and solve presenting problem(s).

How Does IPCM Integrate Strategies and Techniques from Various Treatment Models?

The process of identifying and lifting constraints is facilitated by a metaclinical logic provided by

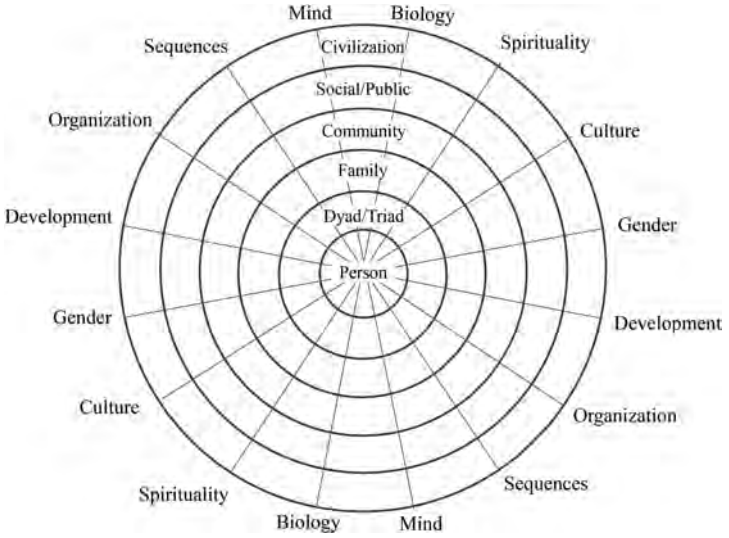

Figure 28.2 Web of constraints. From Breunlin et al., 2011. Reproduced with permission of John Wiley & Sons, Inc. (copyright 2011)

the IPCM blueprint for therapy. That logic asserts that all psychotherapies and psychotherapists implicitly or explicitly follow a fundamental blueprint or sequence of basic activities that constitute a clinical/scientific method. The Blueprint for Therapy (Breunlin et al., 1992, 1997, 2011), shown in Figure 28.3, has four key components—*Hypothesizing*, *Planning*, *Conversing*, and *Feedback*—that are enacted within sessions, between sessions, and over the entire course of therapy.

In *Hypothesizing* the therapist and clients recurrently explore the evolving definition of the problem, possible alternative adaptive sequences (solutions) and factors that appear to constrain the clients from implementing the solutions (constraints). The collaborative process of hypothesizing progressively informs the delineation of the "web of constraints"—the current hypothesized

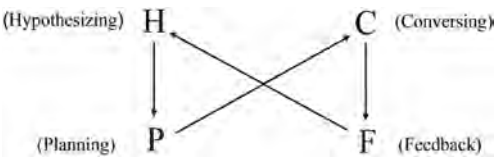

Figure 28.3 Blueprint for therapy. Adapted from Breunlin et al., 1992, in Pinsof et al., 2011. Reproduced with permission of John Wiley & Sons, Inc. (copyright 2011)

set of constraints. *Planning* entails co-developing strategies to implement alternative adaptive sequences and, as necessary to implement these sequences, lift the constraints identified in the web. *Conversing* refers to the collaborative conversation led by the therapist through which the plan is executed. Lastly, *Feedback* involves tracking outcome and "reading" the clients' reactions to interventions as well as using this feedback to revise the hypotheses, the plan and/or the conversation. The blueprint describes the reiterative, clinical-experimental process by which hypotheses are generated, tested, and refined through conversation and experimentation, until the constraints are lifted sufficiently to permit resolution of the presenting problems.

Intervention contexts. Plans developed to implement adaptive solutions and address constraints target-specific intervention contexts and draw strategies and techniques from a variety of therapy models. IPCM specifies three intervention contexts that define the Direct Client System (those directly involved in therapy at any particular time). The *Family/Community Context* includes at least two clients from different generations of a client system; the *Couple or Dyadic Context* involves two clients from the same

generation; and the *Individual Context* includes one client. IPCM suggests a failure-driven progression for the utilization of these contexts. As hypotheses and plans evolve and as interventions fail to resolve the presenting problem, the therapist may propose changing the context to facilitate intervention. For example, a family therapy may come to include sibling-only and/or parent-only sessions. Alternatively, a couple therapist may identify issues or constraints that require individual sessions. When work with an individual is required, the therapist in concert with the clients determines whether (s)he will conduct the individual sessions or refer the client for individual therapy with another therapist.

Planning metaframeworks. The therapist selects strategies and techniques from Planning Metaframeworks to facilitate the implementation of the alternative adaptive sequence and address constraints that prevent its implementation. IPCM's six Planning Metaframeworks organize and integrate models of therapy into domains, each of which share a common focus and mechanisms of change. Although a detailed description of these Metaframeworks is beyond the scope of this chapter, they are listed and briefly described below.

- Action: Strategies and interventions primarily aimed at helping clients modify their patterns of action and interaction (behavioral focus).
- Meaning/Emotion: Strategies and interventions that develop adaptive cognitions or narratives, heighten adaptive emotions and/or regulate maladaptive emotions.
- Biobehavioral: Psychopharmacological and behavioral strategies (biofeedback, mindfulness, EMDR) targeted to modify underlying biological processes.
- Family of Origin: Strategies and techniques that modify adult clients' relationships with their families of origin and facilitate differentiation of self, individuation and mature interdependence.
- Internal Representation: Strategies that seek to modify internal (mental) objects or parts, the relationships among them and/or the relationship between particular objects/parts and other people (transference, projection, etc.).
- Self: Strategies aimed at the development of a stronger, more flexible self (the core of identity and the container of the object relations).

As frameworks of intervention frameworks, the Planning Metaframeworks transcend the specific models of therapy and move the field of psychotherapy toward a more generic and common factor perspective. Each Planning Metaframework is an open category that includes existing and future therapy models that share the same focus and mechanisms of change. While the Hypothesizing Metaframeworks organize theories of problem formation and solution constraint, the Planning Metaframeworks organize strategies for ameliorating or removing constraints and solving problems. The three Intervention Contexts and the six Planning Metaframeworks form the 3 x 6 matrix presented in Figure 28.4. Additionally, the figure demonstrates the relationship between hypothesizing and planning by pairing Hypothesizing Metaframeworks with the Planning Metaframeworks that are typically utilized to address them.

In addition to displaying all of the Intervention Contexts and Metaframeworks, the matrix embodies certain therapy guidelines that, in concert with the blueprint, govern the integration of strategies and techniques. These guidelines encourage the therapist to begin working in an interpersonal context with an initial focus on hypotheses that require here-and-now, action-oriented strategies as well as strategies that address current aspects of emotion and meaning. More complex strategies, especially those that address the internalized effects of past experience, are reserved for cases that do not respond to more basic problem solving approaches.

What Does an IPCM Therapist Do when Therapy Is Not Working?

The IPCM failure-driven guideline states that therapeutic shifts are required when the current interventions fail to modify the Web sufficiently to permit implementation of the adaptive solution to the presenting problem. IPCM is perpetually

Metaframeworks (MFs)		Contexts of Therapy		
Hypothesizing MFs	**Planning MFs**	**Family-Community**	**Couple**	**Individual**
Sequences, Organization, Development	**Action** e.g., Structural, Behavioral, Strategic, Functional			
Culture, Gender, Spirituality, Sequences of Mind	**Emotion/Meaning** e.g., Cognitive, CBT, Narrative, EFT, DBT, Psychoeducation			
Biology	**Biobehavioral** e.g., Relaxation, Mindfulness, CBT, Psychopharmacology			
Intergenerational Patterns: Sequences, Organization, Mind	**Family of Origin** e.g., Structural, Bowenian			
Organization of Mind	**Internal Representation** e.g., Object Relations, Attachment Theory, Internal Family Systems			
Development of Self	**Self** e.g., Self Psychology			

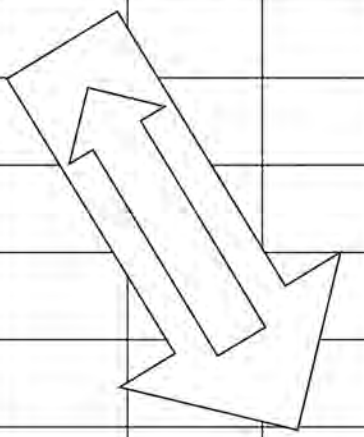

Figure 28.4 IPCM Planning Matrix. From Pinsof et al., 2011. Reproduced with permission of John Wiley & Sons, Inc. (copyright 2011)

concerned with whether a therapy is working (producing change) and what to do if it is not. IPCM gives therapists access to a plethora of strategies and interventions, so that there is almost always something else that can be done to help even the most constrained client systems. Feedback suggesting lack of progress is an invitation to revise the hypothesized web and/or intervention plan. Such revisions may involve fine tuning within a cell (position) on the matrix or, as is often the case, a more significant shift to a different cell of the matrix. The utilization of the planning matrix and the failure-driven guideline is informed by a set of additional guidelines.

Recognizing that human problems always involve an interpersonal component, IPCM encourages therapists to begin therapy by working directly with the most appropriate interpersonal system (family/community or couple/dyadic intervention contexts) and to move, only as needed, to individual work. *The "working rule" of IPCM's interpersonal guideline is that, if possible and appropriate, it is better to do an intervention, regardless of its nature (e.g., cognitive, psychodynamic, emotion-focused), within an interpersonal as opposed to an individual context*. This guideline allows the therapist to see the clients in action, create therapeutic alliances with as many of them as possible, and work directly to modify the sequences of interaction in which the problem is embedded. The applicability of this guideline to specific cases is subject to clinical appropriateness, strong client preference, and alliance maintenance considerations.

IPCM's cost-effectiveness guideline maintains that less expensive, more direct, and less complex interventions should be used before more expensive, indirect, and complex ones. In addition to facilitating cost-effective therapy, this guideline encourages therapists to approach new clients as if they have the ability to solve their problems with minimal intervention. Longer-term or more intensive approaches that derive from more complex theories of behavior are reserved for problems that do not respond to direct interventions based on less complex models of interaction and mind.

IPCM encourages therapists to begin working in the here-and-now and to move, as

necessary, to the past. This temporal guideline ensures that therapists work with constraints that derive from the internalization of past experiences only when necessary. For example, if a wife is reluctant to express her feelings of inadequacy for fear that her husband will humiliate her, we explore whether he can listen to her respectfully and if she can take the risk of sharing her feelings with him (with encouragement and support from the therapist) before addressing how prior attachment figures may have humiliated her.

The IPCM Principle of Application

The matrix in Figure 28.4 highlights how IPCM organizes Intervention, Contexts and Planning Metaframeworks. The large arrow in Figure 28.4 illustrates the IPCM principle of application (what to do when) and operationalizes many of the therapy guidelines discussed throughout this chapter. It recommends that therapy, in most cases: 1) begin in family or couple contexts (interpersonal guideline) with brief interventions (cost effectiveness guideline) and a focus on current constraints (temporal guideline); and 2) that it progresses, when initial interventions fail or are contra-indicated, toward individual and/or longer-term interventions (failure driven guideline). The smaller arrow within the larger one illustrates that as therapy moves down the matrix and as more historical and remote constraints are addressed, the therapist does not lose the link to the alternative adaptive solution and more direct means of lifting the constraints to its implementation. The smaller arrow minimizes the risk that therapist and clients will get lost in the exploration of remote constraints for their own sake, in which case the therapy loses its problem-centered focus. Therapy progressively addresses more remote constraints in smaller Direct Systems to the extent necessary to permit problem resolution.

The IPCM principle of application, as operationalized in the matrix, represents a set of general preferences regarding who to convene, which constraints to address first and how to proceed in therapy. The arrows depict a flexible process involving the progressive refinement of hypotheses and plans as opposed to a rigid or ideal progression. The principle of application is like a flashlight that can be brought to bear on particular aspects of the client system that need illumination and intervention at particular points in therapy. The light is moved with economy and sensitivity as the process of therapy unfolds. Other aspects of the client system may be partially illuminated at certain points, even though the light is not focused directly on them.

Operationalizing the Plan

The matrix broadly describes the intervention contexts and macro-strategies that should be used at particular points in therapy. It does not specify particular strategies and tactics (what techniques to use in a session), which are selected to address the specific hypotheses about constraints in the system and derive in part from the preferences and skills of the therapist. Initially, the plan involves addressing the presenting problem, the problem sequences, and the primary constraints as directly and cost effectively as possible by privileging hypotheses associated with strategies from the top three levels of the matrix—the here-and-now Planning Metaframeworks. If the client system resolves the problem, therapy terminates or moves on to address other presenting problems. When a variety of here-and-now interventions fail to solve the problem, hypotheses are revised and therapy moves down the matrix, drawing on the historical Planning Metaframeworks and working, as needed, in individual intervention contexts. Decision making about when and how to modify hypotheses and shift down the matrix depends on what happens as the therapist converses (intervenes) with the client system and reads the feedback. There are multiple sources of feedback, including information emerging from the referral and intake process, what the therapist sees and hears in session (client report, observation of behavior, and interaction), therapist emotional reactions, and data from measures that assess progress and outcome. Careful attention to the feedback facilitates the reformulation of hypotheses and the development of new plans (shifts).

Although the matrix and arrow (principle of application) suggest a progression from strategies involving action to those focusing on meaning and emotion, IPCM therapists focus on action, meaning, and emotion more or less in every session. Even the most straightforward action interventions are based in a mutual understanding of purpose (meaning) and supported by a level of attunement to clients' emotions. Frequently, changes in meaning or emotion often provide immediate consequences or opportunities in the realm of action. As constraints are identified, the nature of the constraint may dictate the preferred and proportionate focus on these elements of human functioning. For instance, if a couple continues to struggle with high levels of conflict despite the therapist's best efforts at teaching conflict resolution skills (action), the therapist may attempt to access the sadness and sense of loss that underlies the conflict (emotion). Alternatively, the therapist may suggest that the conflict is a means of avoiding the sadness and loss each partner experiences in the relationship (meaning).

How Does IPCM Incorporate Empirical Evidence into Therapy?

Although IPCM integrates strategies and techniques from evidenced-based models and, at times, may conduct a session or sessions within the guidelines of a particular evidenced-based model, it does not rely on the practice of such models for its empirical basis. Rather, with each case IPCM utilizes the reiterative clinical-experimental process of the blueprint in which hypotheses about the web of constraints are recursively generated, tested, and refined through intervention and feedback, until the constraints are lifted sufficiently to permit the clients to solve the problem. In this process, the therapist carefully considers the information that is fed back from the conduct of therapy, including progress data from repeated administration of empirically based self-report measures. The use of such measures operationalizes IPCM's *empirically informed guideline that states that practice must continually be informed with empirical/scientific data in order to be maximally effective and efficient.* For this purpose, the authors prefer the STIC—the Systemic Therapy Inventory of Change (Pinsof et al., 2009; Pinsof, Goldsmith, & Latta, 2012), a multisystemic, multidimensional measurement system that supports hypothesizing and tracks the progress of therapy. The utilization of the STIC, including the process of sharing data with the clients at key points in the therapy, empirically informs the practice of IPCM. It provides an empirical basis for a systemic, integrative therapy that focuses on the unique problems, problem sequences, strengths and constraints of each client system and preserves the therapist's flexibility to progressively modify the treatment plan in the face of new information.

The STIC is a client-report online progress research instrument that empirically assesses a client system and then measures change on the specific dimensions that constitute that system's clinical profile (the dimensions with scores in the Clinical Range). Clients, aged 12 or above, fill out the STIC before every session and their therapist gets an instant email with each client's data analyzed and graphed. Significantly, it tracks progress at the individual, couple, and family levels of the system as well as the status and vicissitudes of the therapeutic alliance over the entire course of therapy. STIC feedback is especially useful in deciding when to move down the matrix—when to shift Planning Metaframeworks. Lack of progress on key STIC dimensions is a primary indicator that the plan needs to be revised. Although a detailed discussion of this process exceeds the scope of this chapter, a general guideline is that when significant change has not occurred in key variables within a four to six week period, a modification of the hypotheses and plan is appropriate. This often involves a shift down the matrix.

The IPCM therapist uses STIC data with clients to help establish a consensual understanding of the web of constraints, to develop a consensual plan for therapy and to co-evaluate (what is and is not changing) the progress of therapy. This involves periodically showing clients their STIC data and inviting them to participate in its interpretation and utilization. In addition to bringing empirical data into each component of the blueprint, the STIC facilitates collaboration between the therapist and clients. It also ensures that every

client's "voice" and perspective is integrated into the treatment process.

What Is the Place of the Therapeutic Alliance in IPCM?

Developing and maintaining a therapeutic alliance, the most acknowledged common factor in psychotherapy (Sprenkle, Davis, & Lebow, 2009), is fundamental to the practice of IPCM. As the presenting problem is the focus of therapy, the alliance is the vehicle by which therapist and clients collaborate to solve the problem(s). IPCM uses the Integrative Psychotherapy Alliance model (Pinsof, 1995; Pinsof, Zinbarg, & Knobloch-Fedders, 2008), a multisystemic and multidimensional model of the therapeutic alliance that distinguishes two primary dimensions—Content and Interpersonal System. The Content dimension addresses Task, Goal, and Bond subdimensions of the alliance. The Interpersonal Dimension targets the interpersonal locus in which tasks, goals, and bonds unfold: Self (me and the therapist), Other (the therapist and the other people in my family), Group (the therapist and us as a family), and Within (me and the other people in my family). The therapist leads a conversation that addresses client concerns and carefully monitors the dimensions of the alliance as hypotheses and plans develop and evolve. Because the STIC includes a brief measure of the Integrative Psychotherapy Alliance, it tracks the alliance and provides feedback that is useful for identifying problematic alliances as well as alliance ruptures and repairs.

The IPCM alliance priority guideline states that growing, maintaining, and repairing the alliance takes priority over the principle of application (the arrow) unless doing so fundamentally compromises the efficacy and/or integrity of the therapy. The therapist, at various times in therapy, explores patterns, interprets constraints, and suggests specific changes in a manner that is typically consistent with IPCM's principle of application. In doing so s/he may use the power of persuasion to convince the clients of the benefit of a particular course of action; however, if the recommended sequencing of intervention strategies compromises the therapeutic alliance, the sequencing should be modified to protect or repair the alliance. For example, parents presenting with concerns about their adolescent son's acting out refuse to involve their younger daughter and son in the therapy. While the therapist would prefer to begin therapy with the whole family, she agrees to convene the parents and adolescent son with the hope that as the alliance strengthens, she can draw on the growing bond and make an effective case for some involvement of the younger children.

Case Example

Meghan called Karen, a 37-year-old Caucasian marriage and family therapist, with concerns about the somatic complaints of her 10-year-old son, Liam. Karen conducted a brief phone interview during which Meghan reported that Liam's pediatrician, the referring agent, ruled out any physical cause for the stomach pain that would sometimes keep Liam out of school. Meghan said that she was very worried about Liam and wanted to bring him in for therapy. Karen indicated that she would be happy to set up an appointment, but would like the whole family (Meghan, 31; Carlos, 33; Liam, 10; and Cassidy, 8) to attend. When Meghan questioned whether Cassidy needed to be involved, Karen suggested that Cassidy likely knew about the problem (which she did) and that she might have concerns about it or possibly be able to help in some way. Meghan agreed that this made sense and said she would talk this over with Carlos, stating further that she was not sure that he would be willing to participate in therapy. Meghan called back two days later to set the first appointment, indicating that all four of them would attend.

The first session began with introductions and a "getting to know you" conversation with the family. In response to Karen's general interest and specific questions, the family shared that they moved to the Chicago area (Meghan's home town) after Carlos completed military service two years ago. He had been in the army for eight years and, as Cassidy added, had done two tours of duty in Iraq. About a year ago Carlos began his new career as a police officer. Meghan took an administrative job with a small firm that

allowed some flexibility with her work hours. She planned to return to school and become an accountant. The family lived in a south suburb of Chicago where Meghan had grown up. The children attended public school and were involved in community activities. All family members were practicing Catholics. Carlos reported being a second generation Mexican-American from a military family. Meghan stated she was from a "South Side Irish" family with deep Chicago roots and a large network of relatives and friends.

When asked to talk about what brought them to therapy, Meghan described the concerns about Liam's stomach aches. Karen engaged all members in the discussion and noticed that Carlos deferred to Meghan who told the story of Liam's recent medical journey. Meghan commented that the stomach aches began several months after Carlos returned from Iraq (following his second and last deployment). In order to begin tracking the problem sequence(s), Karen directed the conversation to how the family responded to Liam's stomach aches, including what Liam did at the time. Liam, shy and polite, described his pain in vague terms. When asked what might make it better or worse, he said that a little milk sometimes made it feel better. Cassidy, more talkative, reported that she sometimes told Liam he would feel better soon. She said that she worried about what her father would say about Liam's pain. Carlos shared that he generally left this issue in his wife's hands, but would get frustrated when Liam missed school.

Karen and the family co-constructed the following problem sequence: Liam would complain of stomach ache in the morning; Meghan would typically spend some time with him (being supportive, asking if it was beginning to feel better, encouraging him to get ready for school); Liam would indicate whether it felt better and whether he would be able to attend school; Carlos would try to stay out of it but often felt frustrated with the conversations between Meghan and Liam that he observed or overheard. He would feel angry when Liam did not go to school and express that to Meghan, who would be defensive but try not to escalate the disagreement. Carlos would then withdraw. He would sometimes express his frustrations to Liam or in Liam's presence, but typically distanced himself when he felt frustrated. Cassidy often tried to engage Carlos when he withdrew. Karen said that she imagined this was frustrating and painful for all, but that they seemed to be a family with a lot of strength and loyalty. She asked if they would like to make changes in how they acted together around the stomach aches. All indicated that they would. Believing in the family's ability to participate in the resolution of the presenting problem, Karen asked them each to consider what they might do differently to deal with the problem and report on this during the next session. She also secured their permission to call the school for the purpose of case coordination. This initiative was a natural outgrowth of a multilevel systemic view—the patterns in school or between home and school might have included a problem sequence(s) or constraints to the implementation of certain adaptive sequences.

Karen contacted the principal of the school to share that the family had initiated therapy for Liam's pain and missed school time. The principal was concerned about the missed school days and was glad to hear they had entered therapy. She had no other concerns about Liam's performance or behavior. She could not recall any instance when Liam had asked to see the nurse or to go home due to pain. Karen and the principal left the door open for collaboration as appropriate. Based on family report and consultation with the principal, Karen did not identify a problem sequence involving the school. Meanwhile, prior to the second session, Karen began to wonder if the family might be constrained by such factors as imbalance in parent leadership (Organization Hypothesizing Metaframework), cultural differences in parental role expectations (Culture Hypothesizing Metaframework), lack of fit between civilian and military culture (Culture Hypothesizing Metaframework), gender-based skew or inequality (Gender Hypothesizing Metaframework), and/or Carlos' post-traumatic internal process (Mind and Biology Hypothesizing Metaframeworks). Consistent with IPCM's epistemological pillar, Karen was careful not to become overly attached to any of these ideas at this early stage in the process. She also reviewed the initial STIC data which suggested that Carlos had difficulty expressing

himself, occasionally experienced anxiety and intrusive images, and did not feel good about his relationship with the children. The data also suggested that Meghan had significant problems in her family of origin when she was growing up and that she was moderately depressed as well as somewhat distrustful of Carlos.

In the second session Karen followed up on the homework, asking the family members to discuss how they might handle the stomach aches differently. Carlos took the lead this time and suggested that he needed to be more involved with the problem and solution. Meghan agreed, but seemed a little reluctant. Karen asked them to discuss what they might do differently (searching for an alternative adaptive sequence). Carlos stated that he could handle the situation and would make sure that Liam got to school each day. Meghan said that she did not think that "strict military discipline" was the way to handle this. She then looked at Karen. Karen responded that perhaps the parents could agree on a firm, supportive way to coach Liam on this. The parents talked further and agreed on a plan for Carlos to work with Liam each morning on preparing for school. They agreed on a firm but reassuring approach. Karen created an in-session enactment between father and son to practice this. Meghan and Cassidy were asked to give feedback. Both of them approved.

The following session the family entered the room with some apparent tension. Karen was not surprised as this fitted with pre-session STIC data that showed a modest drop in partner positivity as reported by both Carlos and Meghan. In session they reported that the family had enacted the alternative adaptive sequence and for three days Liam went to school on time. On the fourth morning Meghan offered to coach Liam since Carlos had "a lot on his plate." She worked closely with Liam and drove him to school about two hours late. This pattern repeated the next day. Seeking to identify solution constraints, Karen began a curious, respectful exploration of what kept them from enacting the alternative adaptive sequence the last two days.

In the course of this discussion, Cassidy asked if her dad had a "bad dream." Carlos was silent. Meghan explained that he sometimes had nightmares and that on those mornings she thought it was better for her to handle the morning routines. Carlos agreed that that may be the case. A modification of the plan was discussed with Karen suggesting that each morning the parents would confer prior to coaching Liam. If it seemed prudent for Meghan to do the coaching, Carlos would first reach out to Liam and briefly encourage him to get ready for school, reassure him that he will be ok, and then let him know that his mom would be following through with getting him off to school. Karen suggested that the next session be a parent-only session. This temporary modification of the Direct Client System was suggested in order to explore, within the boundary of the couple subsystem, issues related to parenting roles and, specifically, Carlos' ability to coach his son in the morning given the impact of his nightmares. Karen also wondered if therapy would need to address post-traumatic symptomatology (as a constraint to the plan or as an additional presenting problem).

In the next session the parents reported that each morning Carlos had coached Liam to get off to school on time. On one morning they decided that Meghan would do the coaching, but when Carlos went to tell Liam about this, he stayed involved and followed through completely with the task. Carlos and Meghan reported feeling good about this which seemed to track with the STIC data showing improvement in partner positivity and therapeutic alliance. Karen congratulated them on their success and initiated a discussion of the factors that could interfere with the plan.

The therapy at this point moved from the Action Planning Metaframework to the Emotion/Meaning Planning Metaframework with the idea of identifying and modifying the emotions and beliefs that could constrain the alternative adaptive sequence. Carlos reported feeling unsure about his ability to help Liam. He shared that his father and, from his point of view, Mexican men in general didn't get very involved with the day to day care of the children. Furthermore, since his last deployment to Iraq, he had felt even more distant from the kids and unsure about his role as a father. He respected that the men in Meghan's family were generally more involved with their

children, but he often felt at a loss for how to relate. Meghan reported that she feared that Carlos would not be able to maintain his patience with Liam and that he would lose his temper. At times she felt she was "walking on eggshells." Meghan said that she thought Carlos had post-traumatic stress disorder from his service in the military. Carlos, with prompting from Meghan, admitted having nightmares, intrusive thoughts, situational irritability, and periodic withdrawal within the family, but stated that he felt he could manage these symptoms. Karen explored the influence of these symptoms on marital and family life. Concerned about Carlos' suffering and the impact of it on family functioning and problem solving, she suggested that they work on these issues in marital and family sessions and that he consider a referral to a local Vet Center, a Veterans Administration program that provides readjustment counseling services to qualifying veterans. The couple respectfully responded that they thought they were making progress with Liam and they wanted to keep the focus on that for now. Karen wondered if they were bypassing (or perhaps beginning to modify) the constraints and finding an effective solution to the problem that brought them to therapy. At least for the past week Carlos was finding his way as a more engaged father. Meghan was supporting this transition. Pre-session STIC data suggested that she was feeling more trusting of Carlos, he was feeling better about his relationship with the children, and their alliance with Karen was strengthening.

The family attended three more sessions to track the alternative adaptive sequence and the presenting problem of the stomach aches. They kept the adaptive sequence in place and Liam attended school each day on time. The pain occurred occasionally and then not at all for the last two weeks. An additional issue (and likely an additional constraint to problem solving) surfaced—the children shared that they had nightmares about their dad going back to Iraq. Karen suggested that it would be a good idea to talk about the dreams when they occur. The family agreed. Carlos reinforced that he would want to know when they had nightmares. He also reassured them that he would not be going back to Iraq. Additionally, he stated that although he may sometimes have a nightmare, he will be okay. "I am your dad and I will be there for you," he said. Meghan and Carlos felt good about the progress in therapy and were ready to terminate. Karen and the family reviewed their accomplishments and discussed possible challenges to their success. She emphasized that they were welcome to return for further sessions.

About eight months later, Meghan called to schedule an appointment for Carlos and her. In session they reported that the solution to their original presenting problem was still in place and that they continued to feel good about the development of the family. Then they reported that sometime in the new year Carlos' nightmares had intensified and they had become more distant as a couple. Following the discussion of these presenting problems, Karen suggested that they work on an alternative adaptive sequence of talking more directly and deeply to each other about their feelings and experiences. In session Meghan talked about her loneliness and fear. She contextualized this in her family of origin which included the history of her father's alcoholism and her adaptations of "walking on eggshells" and mobilizing herself to manage situations with hopes that problems could be avoided. She acknowledged Karen's interpretation that her experience in her family of origin may influence how she responded to Carlos. Carlos shared that he felt numb at times and preoccupied with memories of the war. They agreed to begin couples therapy and talk more at home.

When they returned for the next session, they had not talked much. Meghan was discouraged and Carlos felt bad about this. Karen asked them what kept them from talking more. Carlos then began to share how badly he felt about leaving the army. He shared that his father was a career soldier and since the trip to see his parents at Christmas he had been feeling "down" about this. Karen hypothesized that the marital relationship was constrained by Carlos' sense of shame and that the shame was contextualized by the culture of the military and his view of his father's expectations of him. As Karen explored this constraint, the therapy shifted down the matrix from the Action Planning Metaframework (plan for

Liam's stomach aches, plan for couple to talk) to the Meaning/Emotion Planning Metaframework (feeling of shame that constrained communication). Intervention at that point included accessing the primary emotion of shame and exploring the meaning of Carlos' service. The shift was "failure driven" in that the couple was unable to talk effectively while Carlos was secretly preoccupied by his sense of failure and feeling of shame. Karen continued to facilitate their communication in the next few sessions and they began to have more sustained and meaningful conversations in therapy and at home.

Although the couple was making progress, Carlos continued to feel uncomfortable about what his father likely thought of him. Karen and the couple agreed that the concern about Carlos' father seemed to have interfered significantly with Carlos' peace of mind. Karen decided that the most direct way of dealing with this issue would be to move further down the matrix and draw on the Family of Origin Planning Metaframework. She suggested that Carlos consider initiating a conversation with his father about his decision to leave the military. The couple declined the option of inviting Carlos' parents to Chicago to attend therapy session(s). Instead, they worked in session to prepare for the next time they visited the parents. During that visit, Carlos initiated a conversation with his father, reportedly "a man of few words," who confirmed that he was very disappointed when Carlos left the service. He explained that he had secured his place in the United States by virtue of his military service and had always thought that this would be the best road for Carlos as well. He indicated, however, that he could see that Carlos was finding his own direction and that, as a man, he would decide what was best for his family. Carlos shared more about what the army meant to him and why he decided not to be a career soldier. His father stated that he was proud of Carlos' service in the army and his work as a police officer. Carlos felt good about this conversation and reported feeling more comfortable with his father.

Carlos and Meghan continued in couple therapy for a few more months with a focus on improving communication and increasing connection. They addressed various constraints including Meghan's family of origin experience and the parts of herself affected by it (Internalized Representation Metaframework). She worked to moderate the part of her that tended to take over and put everything on her shoulders. Carlos shared a particularly traumatic war experience and felt that Meghan responded with sensitivity and respect. His nightmares occurred less frequently and he reported coping with them more effectively. He accepted the name of a therapist at the local Vet Center, but did not commit to seek services. Lastly, they continued to work on the management of their differences in parenting style and further development of their parental partnership. Liam and Cassidy continued to do well. STIC data supported the couple's report of significant improvement in family and individual functioning and successful resolution of the presenting problems. Therapy was terminated by mutual consent and Karen made it clear that they were welcome to return (again).

This case example illustrates in a limited way the capacity of the IPCM perspective to meet the need for a meta-level model that supports the integration of the many and varied sources of knowledge, information, perspective, and technique within the field of couple and family therapy. The therapy focused on the family's presenting problem, located it in a problem sequence, implemented an alternative adaptive sequence and identified constraints to change. While any and all of the Hypothesizing Metaframeworks could have been applied, Karen followed the hypotheses generated in the therapy, made plans to explore them, and developed conversations to implement the plans. She read the feedback (her own observations and STIC) in order to confirm or modify the hypotheses, plans, and conversations. There might have been more intensive intervention within various Planning Metaframeworks, but it was not necessary in order to bring about the desired changes. Thus, the principle of application (arrows on matrix) was implemented with flexibility, sensitivity, and economy.

Integrating Art and Science in IPCM

IPCM provides therapists with a comprehensive, integrative, multisystemic, and empirically informed perspective for the treatment of individuals, couples, and families. It makes explicit

the implicit hypothesizing that guides all psychotherapy. Therapists and clients become "co-experimenters" and "co-investigators"—developing and testing hypotheses with clinical experiments, evaluating the results (observational and empirical feedback) and revising the hypotheses until the clients solve their presenting problems. IPCM therapists engage clients as partners on a journey in which failed attempts to find solutions are welcome opportunities to learn, grow, and try something different.

IPCM is a perspective for both transcending and integrating existing and emerging models of individual, couple, and family therapy. It constructs therapy as an idiosyncratic and improvisational process that integrates art and science to provide clients with interventions that are designed for their particular problems, problem sequences, and constraints. The practice of IPCM requires knowledge and skills from multiple models as well as the important "meta-model" skills of hypothesizing, conversing, reading feedback, and maintaining alliances. A therapist can never fully master this perspective. In this sense, IPCM is not only a perspective for conducting therapy, but also a framework for referring clients to other therapists (identifying the help they need) as well as a schema for the learning and growth of psychotherapists over the course of their careers.

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