From a radical new experiment in the 1960s, family therapy grew into an established force, complete with its own literature, organizations, and legions of practitioners. Unlike other fields organized around a single conceptual model (psychoanalysis, behavior therapy), family therapy was always a diverse enterprise, with competing schools and a multitude of theories. What they shared was a belief that problems run in families. Beyond that, however, each school was a well-defined and distinct enterprise, with its own leaders, texts, and ways of doing therapy.

Today, all of that has changed. The field is no longer neatly divided into separate schools, and its practitioners no longer share a universal adherence to systems theory. As family therapists have always been fond of metaphors, we might say that the field has grown up. No longer cliquish or cocksure, the family therapy movement has been shaken and transformed by a series of challenges—to the idea that any one approach has all the answers, about the nature of men and women, about the American family—indeed, about the possibility of knowing anything with certainty. In this chapter, we'll examine those challenges and see what family therapy looks like in the twenty-first century.

Erosion of Boundaries

The boundaries between schools of family therapy gradually blurred in the 1990s to the point where now fewer and fewer therapists would characterize themselves as purely Bowenian or structural, or what have you. One reason for this decline in sectarianism was that, as they gained experience, practitioners found no reason not to borrow from each other’s arsenal of techniques. Suppose, for example, that a card-carrying structural therapist were to read White and Epston’s little gem of a book, Narrative Means to Therapeutic Ends, and start spending more and more time exploring the stories clients tell about their lives. Would this therapist still be
a structuralist? A narrative therapist? Or perhaps a little of both?

Suppose that our hypothetical therapist were to hear Jim Keim at a conference describing his strategic approach to families with oppositional children and started using it in her own practice. What would we call this therapist now? Structural-narrative-strategic? Eclectic? Or maybe just “a family therapist”?

Another reason for the erosion of orthodoxy was the growing recognition of the need for individualized techniques to deal with specific problems and populations. In the past family therapists cherished their models. If a particular family didn’t quite fit the paradigm, maybe they just weren’t “an appropriate treatment case.” Today, one-size-fits-all therapies are no longer seen as viable.

Now therapists approach families less as experts confident of fixing them than as partners hoping to shore up their resources. These resources are constrained not only by a family’s structure but also by political and economic forces beyond their control. Some of the change in status of the classic schools was due to the death or retirement of the pioneers and the absence of dominating figures to replace them. Our current era of questioning and uncertainty is also related to a growing recognition that doctrinaire models aren’t always relevant to the specific needs of their clients. Family therapy is one of many social sciences that has been turned upside down by the postmodern revolution.

**Postmodernism**

Advances in science at the beginning of the twentieth century gave us a sense that the truth of things could be uncovered through objective observation and measurement. The universe was a mechanism whose laws of operation awaited discovery. Once these universal laws were known, we could control our environment. This modernist perspective influenced the way family therapy’s pioneers approached their clients—as cybernetic systems to be decoded and reprogrammed. The therapist was the expert. Structural and strategic blueprints were used to search out flaws that needed repair, regardless of whether families saw things that way themselves.

**Postmodernism** was a reaction to this kind of hubris. Not only are we losing faith in the validity of scientific, political, and religious truths, we’re also coming to doubt whether absolute truth can ever be known. As Walter Truett Anderson (1990) writes in *Reality Isn’t What It Used to Be*, “Most of the conflicts that tore the now-ending modern era were between different belief systems, each of which professed to have the truth: this faith against that one, capitalism against communism, science against religion. On all sides the assumption was that somebody possessed the real item, a truth fixed and beyond mere human conjecture” (p. 2). In family therapy it was structural truth versus psychodynamics; Bowen versus Satir.

Einstein’s relativity undermined our faith in certainties. Marx challenged the right of one class to dominate another. In the 1960s we lost trust in the establishment and gained a sense that there were other realities besides those of ordinary consciousness. The feminist movement challenged assumptions about gender that had been considered laws of nature. As the world shrank and we were increasingly exposed to people of different cultures, we had to reexamine our assumptions about their “peculiar” beliefs.

This mounting skepticism became a major force in the 1980s and shook the pillars of every human endeavor. In literature, education, religion, political science, and psychology, accepted practices were deconstructed—that is, shown to be social conventions developed by people with their own agendas. Social philosopher Michel Foucault interpreted the accepted principles in many fields as stories perpetuated
to protect power structures and silence alternative voices. The first and perhaps most influential of those voices to be raised in family therapy was the feminist critique.

**The Feminist Critique**

Feminism prompted family therapy's rudest awakening. In an eye-opening critique heralded by an article of Rachel Hare-Mustin's in 1978, feminist family therapists not only exposed the gender bias inherent in existing models, they also advocated a style of therapy that called into question systems theory itself. Cybernetics encouraged us to view a family system as a flawed machine. Judith Myers Avis (1988) described this family machine as one that

\[\ldots\text{ functions according to special systemic rules and is divorced from its historical, social, economic, and political contexts. By viewing the family out of context, family therapists locate family dysfunction entirely within interpersonal relationships in the family, ignore broader patterns of dysfunction occurring across families, and fail to notice the relationship between social context and family dysfunction. (p. 17)}\]

The Batesonian version of cybernetics had claimed that personal control in systems was impossible because all elements are continually influencing one another in repetitious feedback loops. If all parts of a system are equally involved in its problems, no one is to blame.

To feminists, however, the notion of equal responsibility for problems looked suspiciously like a sophisticated “version of blaming the victim and rationalizing the status quo” (Goldner, 1985, p. 33). This criticism was particularly germane in crimes against women, such as battering, incest, and rape, for which psychological theories have long been used to imply that women provoked their own abuse (James & MacKinnon, 1990).

The family constellation most commonly cited as contributing to problems was the peripheral father, overinvolved mother, and symptomatic child. For years, psychoanalysts had blamed mothers for their children’s symptoms. Family therapy’s contribution was to show how the father’s lack of involvement contributed to the mother’s overinvolvement, and so therapists tried to pry the mother loose by inserting the father in her place. This wasn’t the boon for women that it might have seemed because, in too many cases, mothers were viewed no less negatively. Mothers were still “enmeshed,” but now a new solution appeared—bringing in good old dad to the rescue.

What feminists contended that therapists failed to see was that “the archetypal ‘family case’ of the overinvolved mother and peripheral father is best understood not as a clinical problem, but as the product of an historical process two hundred years in the making” (Goldner, 1985, p. 31). Mothers were overinvolved and insecure not because of some personal flaw but because they were in emotionally isolated, economically dependent, overresponsible positions in families, positions that were crazy-making.

Gender-sensitive therapists sought to help families reorganize so that no one, male or female, remained stuck in such positions. Thus, instead of undermining a mother’s self-esteem by replacing her with a peripheral father (who was likely to have been critical of her parenting all along), a feminist family therapist might help the family reexamine the roles that kept mothers down and fathers out. Fathers might be encouraged to become more involved with parenting—not because mothers are incompetent, but because it’s a father’s responsibility (Goodrich, Rampage, Ellman, & Halstead, 1988; Walters, Carter, Papp, & Silverstein, 1988).

Feminists weren’t just asking therapists to be more sensitive to gender issues. Rather, they asserted that issues of gender or, more
specifically, patriarchy, permeated therapists’ work, even though we had been conditioned not to notice them. They therefore believed that gender inequality should be a primary concern for family therapists (Goldner, 1988; Luepnitz, 1988).

Only when we become more gender sensitive will we stop blaming mothers and looking to them to do all of the changing. Only then will we be able to fully counter the unconscious bias toward seeing women as ultimately responsible for childrearing and housekeeping; as needing to support their husbands’ careers by neglecting their own; as needing to be married or at least to have a man in their lives (Anderson, 1995). Only then can we stop relying on traditional male traits, such as rationality, independence, and competitiveness, as their standards of health and stop denigrating or ignoring traits traditionally encouraged in women, like emotionality, nurturance, and relationship focus.

As one might anticipate, the feminist critique wasn’t initially welcomed by the family therapy establishment. The early to mid-1980s was a period of polarization, as feminists tried to exceed the establishment’s “threshold of deafness.” By the 1990s that threshold had been exceeded. The major feminist points are no longer debated and the field is evolving toward a more collaborative and socially enlightened form of therapy.

Lest we get too complacent about family therapy’s acceptance of feminism, it’s important to remember that women still face political, economic, and social problems on a daily basis. Women still earn less than men for their labor. Women are still assigned most domestic work. Women are still often blamed for family problems. Men’s violence against women is still tolerated by many families, peers, and cultural forces. Moreover, although some men resist, the masculine ideal still influences most men, who strive to be “manly” and reject less macho men as geeks, wimps, or wusses. Although many men do not experience themselves as powerful within their own families, men still benefit from arrangements that give them power in society. As Rachel Hare-Mustin says, “Although it is true that men can cry now, too, they still have less to cry about.”

Social Constructionism and the Narrative Revolution

Constructivism was the lever that pried family therapy away from its belief in objectivity—the assumption that what one sees in families is what is in families. Human experience is fundamentally ambiguous. Fragments of experience are understood only through a process that organizes it, selects what’s salient, and assigns meaning and significance.

Instead of focusing on patterns of family interaction, constructivism shifted the emphasis to exploring and reevaluating the perspectives that people with problems have about them. Meaning itself became the primary target.

In the 1980s and 1990s Harlene Anderson and Harry Goolishian translated constructivism into an approach that democratized the therapist–client relationship. Along with Lynn Hoffman and others, these collaborative therapists were united in their opposition to the cybernetic model and its mechanistic implications. Their version of postmodernism focused more on caring than curing, and they sought to move the therapist out of the position of expert into a more egalitarian partnership with clients.

Perhaps the most striking example of this democratization of therapy was introduced by the Norwegian psychiatrist Tom Andersen, who leveled the playing field by hiding nothing from his clients. He and his team openly discuss their reactions to what a family says. This reflecting team (Andersen, 1991) has become a widely used aspect of the collaborative model’s therapy by consensus. Observers come out from behind the one-way mirror to discuss their impressions with the therapist and family. This process creates an open environment in which the family feels part of a team and the team feels more empathy for the family.

What these collaborative therapists shared was the conviction that too often clients aren’t heard because therapists are doing therapy to them rather than with them. To redress this authoritarian attitude, Harlene Anderson (1993) recommended that therapists adopt a position of “not knowing,” which leads to genuine conversations with clients in which “both the therapist’s and the client’s expertise are engaged to dissolve the problem” (p. 325).

This new perspective was in the tradition of an approach to knowledge that emerged from biblical studies called hermeneutics, a term derived from the Greek word for interpretation. Before it surfaced in family therapy, hermeneutics had already shaken up psychoanalysis. In the 1980s Donald Spence, Roy Schafer, and Paul Ricoeur were challenging the Freudian notion that there was one correct and comprehensive interpretation of a patient’s symptoms, dreams, and fantasies. The analytic method isn’t, they argued, archaeological or reconstructive; it’s constructive and synthetic, organizing whatever is there into patterns it imposes (Mitchell, 1993).

From a hermeneutic perspective, what a therapist knows is not simply discovered through a process of free association and analysis—or enactment and circular questioning—it’s organized, constructed, and fitted together by the therapist alone, or collaboratively with the patient or family. Although there’s nothing inherently democratic about hermeneutic exegesis, its challenge to essentialism went hand in hand with the challenge to authoritarianism. In family therapy, the hermeneutic tradition seemed a perfect partner to efforts to make treatment more collaborative.

It’s hard to give up certainty. A lot is asked of a listener who, in order to be genuinely open to the speaker’s story, must put aside his or her own beliefs and, at least temporarily, enter the

2. Collaborative therapists distinguish these conversations from the nondirective, empathic Rogerian style because they don’t just reflect but also offer ideas and opinions, though always tentatively.
other's world. In so doing, the listener may find those beliefs challenged and changed. This is more than some therapists are willing to risk.

Constructivism focused on how individuals create their own realities, but family therapy has always emphasized the power of interaction. As a result, another postmodern psychology called social constructionism now influences many family therapists. Social psychologist Kenneth Gergen (1985), its main proponent, emphasized the power of social interaction in generating meaning for people.

Gergen challenged the notion that we are autonomous individuals holding independent beliefs and argued instead that our beliefs are fluid and fluctuate with changes in our social context. Gergen (1991b) asks, "Are not all the fragments of identity the residues of relationships, and aren’t we undergoing continuous transformation as we move from one relationship to another?" (p. 28).

This view has several implications. The first is that no one has a corner on the truth: all truths are social constructions. This idea invites therapists to help clients understand the origins of their beliefs, even those they had assumed were laws of nature. The second implication is that therapy is a linguistic exercise; if therapists can lead clients to new constructions about their problems, the problems may open up. Third, therapy should be collaborative. Since neither therapist nor client brings truth to the table, new realities emerge through conversations in which both sides share opinions and respect each other's perspective.

Social constructionism was welcomed with open arms by those who were trying to shift the focus of therapy from action to cognition, and it became the basis for an approach that took family therapy by storm in the 1990s, narrative therapy (Chapter 13). The narrative metaphor focuses on how experience generates expectations, and how expectations shape experience through the creation of organizing stories. Narrative therapists follow Gergen in considering the "self" a socially constructed phenomenon.

The question for the narrative therapist isn't one of truth but one of determining which points of view are useful and lead to preferred outcomes. Problems aren't in persons (as psychoanalysis had it) or in relationships (as systems theory had it); rather, problems are embedded in points of view about individuals and their situations. Narrative therapy helps people reexamine these points of view.

Family Therapy's Answer to Managed Care: Solution-Focused Therapy

Solution-focused therapy was the other new model to rise to prominence in the 1990s. Steve de Shazer and his colleagues (Chapter 12) took the ideas of constructivism in a different, more pragmatic, direction. The goal of this approach is to get clients to shift from "problem talk"—trying to understand their problems—to "solution talk"—focusing on what's working—as quickly as possible. The idea is that focusing on solutions, in and of itself, often eliminates problems.

The popularity of a solution-focused model exploded during a period in which agency budgets were slashed and managed care dictated the number of sessions for which practitioners could be reimbursed. This produced a tremendous demand for a brief, easy-to-apply approach, to which solution-focused therapy seemed the perfect answer.

Family Violence

In the early 1990s family therapy took a hard look at the dark side of family life. For the first time, books and articles on wife battering and
sexual abuse began appearing in the mainstream family therapy literature (e.g., Trepper & Barrett, 1989; Goldner, Penn, Sheinberg, & Walker, 1990; Sheinberg, 1992). The field was shaken out of its collective denial regarding the extent of male-to-female abuse in families. Judith Myers Avis (1992) delivered a barrage of shocking statistics regarding the number of women who have experienced sexual abuse before the age of eighteen (37 percent), the percent of abusers who are male (95 percent), the number of women abused each year by the men they live with (one in six), the percent of male college students who had coerced sex from an unwilling partner (25 percent), and those who said they would commit rape if guaranteed immunity from punishment (20 percent). After reiterating the indictment of theories that call for therapist neutrality and that treat the abused as partially responsible for their abuse, she concluded that

As long as we train therapists in systemic theories without balancing that training with an understanding of the non-neutrality of power dynamics, we will continue producing family therapists who collude in the maintenance of male power and are dangerous to the women and children with whom they work. (p. 231)

Michele Bograd (1992) summarized one of the central predicaments for family therapy in this decade:

In working with family violence, how do we balance a relativistic world view with values about human safety and the rights of men and women to self-determination and protection? When is the clinical utility of neutrality limited or counterproductive? When is conviction essential to the change process? (pp. 248, 249)

The systemic view, now under attack, was that family violence was the outcome of cycles of mutual provocation, an escalation, albeit unacceptable, of the emotionally destructive behavior that characterizes many marriages. Advocates for women rejected this point of view. From their perspective, violent men don’t lose control, they take control—and will stop only when they are held accountable.

While the claim made by some women’s advocates that couples therapy has no place in the treatment of violent marriages was controversial, their warnings provided a wake-up call. Domestic violence—let’s call it what it is, wife battering and child beating—is a major public health problem, right up there with alcoholism and depression.

**Multiculturalism**

Family therapy has always billed itself as a treatment of people in context. In the postwar America of family therapy’s birth, this principle was translated into a pragmatic look at the influence of a family’s relationships on its members. Now as we’ve become a more diverse country enriched by a flow of immigrants from Asia, Central and South America, Africa, and Eastern Europe, family therapy as a profession has shown its willingness to embrace this influx of diversity. Not only are we learning to respect that families from other cultures have their own valid ways of doing things but our journals and professional organizations are making an effort to become more diverse and inclusive.

Monica McGoldrick and her colleagues (McGoldrick, Pearce, & Giordano, 1982) dealt the first blow to our ethnocentrism with a book describing the characteristic values and structure of a host of different ethnic groups. Following this and a spate of related works (e.g., Falicov, 1983, 1998; Boyd-Franklin, 1989; Saba, Kar rer, & Hardy, 1989; Mirkin, 1990; Ingoldsby & Smith, 1995; Okun, 1996; McGoldrick, 1998), we are now more sensitive to the need to know something about the ethnic background of our client families, so we don’t assume they’re sick just because they’re different.
Multiculturalism has become a prevailing theme in family therapy, as reflected in conference agendas, journal articles, and graduate school curriculums. The attention to these issues represents a welcome sensitizing to the influence of ethnicity.

Multiculturalism is certainly an advance over ethnocentrism. Yet in highlighting differences, there is a danger of overemphasizing identity politics. Segregation, even in the name of ethnic pride, isolates people and breeds prejudice. Perhaps pluralism is a better term than multiculturalism because it implies more balance between ethnic identity and connection to the larger group.

As we suggested in Chapter 4, ethnic sensitivity does not require becoming an expert—or thinking you’re an expert—on every culture you might conceivably work with. If you don’t know how a rural Mexican family feels about their children leaving home or what Korean parents think about their teenage daughter dating American boys, you can always ask.

Race

In the early days of family therapy, African American families received some attention (e.g., Minuchin et al., 1967), but for many years it seemed that the field, like the rest of the country, tried to ignore people of color and the racism they live with every day. Finally, however, African American family therapists such as Nancy Boyd-Franklin (1993) and Ken Hardy (1993) brought these issues out of the shadows and forced them into the field’s consciousness.

White therapists still, of course, have the option to walk away from these issues. People of color don’t have that luxury (Hardy, 1993):

To avoid being seen by whites as troublemakers, we suppress the part of ourselves that feels hurt and outraged by the racism around us, instead developing an “institutional self”—an accommodating facade of calm professionalism calculated to be nonthreatening to whites. . . . Familiar only with our institutional selves, white people don’t appreciate the sense of immediate connection and unspoken loyalty that binds black people together. . . . We are united by being raised with the same messages most black families pass on to their children: “You were born into one of the most despised groups in the world. You can’t trust white people. You are somebody. Be proud, and never for one minute think that white people are better than you.” (pp. 52–53)

Laura Markowitz (1993) quotes a black woman’s therapy experience:

I remember being in therapy years ago with a nice white woman who kept focusing me on why I was such an angry person and on my parents as inadequate individuals. . . . We never
looked at my father as a poor black man, my mother as a poor black woman and the context in which they survived and raised us. . . . Years later, I saw a therapist of color and the first thing out of her mouth was, “Let’s look at what was going on for your parents.” It was a joyous moment to be able to see my dad not as a terrible person who hated us but as a survivor living under amazingly difficult conditions. I could embrace him, and I could understand my anger instead of blaming myself for feeling that way. (p. 29)

It’s hard for whites to realize how many doors were open to them based on their skin color, and to understand how burdened by racism nonwhites are. African American families not only have to overcome barriers to opportunity and achievement but also the frustration and despair that such obstacles create.

The task of therapists working with nonwhite families is to understand their reluctance to engage in treatment (particularly if the therapist is white) in the context of their environment and their history of negative interaction with white people, including many of the social service agents they encounter. In addition, the therapist must recognize the family’s strengths and draw from their networks, or help them create networks of support if the family is isolated.

Finally, therapists must look inside and face their own attitudes about race, class, and poverty. Toward this end, several authors recommend curricula that go beyond lectures to personal encounters—that is, confronting our own demons of racism (Pinderhughes, 1989; Boyd-Franklin, 1989; Green, 1998).

Poverty and Social Class

Money and social class are not subjects that most helping professionals like to discuss. The shame of economic disadvantage is related to the pervasive individualist ethic that people are responsible for their own success or lack of it. If you’re poor, it must be your own fault.

Despite decreasing fees due to managed care, most therapists are able to maintain a reasonably comfortable lifestyle. They often have little appreciation of the obstacles their poor clients face and the psychological impact of

Nonwhite clients may feel that white therapists can’t fully understand their experiences.
those conditions. When poor clients don’t show up for appointments or don’t comply with directives, some therapists are quick to see them as apathetic or irresponsible. In many cases, this is also the way poor people come to see themselves—and that negative self-image can become the biggest obstacle of all.

How can we counter this tendency to think that poor people just can’t cut it? First, therapists need to educate themselves to the social and political realities of being poor in the United States. Recently, investigative journalist Barbara Ehrenreich (1999) spent a year trying to live like a former welfare recipient coming into the workforce. Living in a trailer park and working as a waitress left her with virtually nothing after expenses.

How former welfare recipients and single mothers will (and do) survive in the low-wage workforce, I cannot imagine. Maybe they will figure out how to condense their lives—including child-raising, laundry, romance and meals—into the couple of hours between full-time jobs. Maybe they will take up residence in their vehicles [as she found several fellow workers had done], if they have one. All I know is that I couldn’t hold two jobs and I couldn’t make enough money to live on with one. And I had advantages unthinkable to many of the long-term poor—health, stamina, a working car, and no children to care for or support. . . . The thinking behind welfare reform was that even the humblest jobs are morally uplifting and psychologically buoying. In reality these are likely to be fraught with insult and stress. (p. 52)

The fact is, this isn’t the land of equal opportunity. The economy has built-in disparities that make it extremely difficult for anyone to climb out of poverty and that keep nearly one in four children living in privation (Walsh, 1998).

These days, it isn’t just families of poverty who live with financial insecurity. As mortgages, car payments, and college tuitions mount up, and corporations frequently lay off employees suddenly and ruthlessly, family life at all but the wealthiest levels is increasingly dominated by economic anxiety. Median family income has declined in the past two decades to the point where young families can’t hope to do as well as their parents, even with the two incomes needed to support a very modest standard of living (Rubin, 1994).

Therapists can’t pay their clients’ rent, but they can help them appreciate that the burdens they live with are not all of their own making. Even when they don’t bring it up, a sensitive therapist should be aware of the role financial pressures play in the lives of their client families. Asking about how they manage to get by not only puts this issue on the table, it can also lead to a greater appreciation of the effort and ingenuity that it takes to make ends meet these days.

Gay and Lesbian Rights

Family therapy’s consciousness was raised about gay and lesbian rights in the same way it was for race. After a long period of neglect and denial, family therapy in the late 1980s began to face the discrimination that a sizable percentage of the population lives with (Krestan, 1988; Roth & Murphy, 1986; Carl, 1990; Laird, 1993; Sanders, 1993). The release in 1996 of a major clinical handbook (Laird & Green, 1996) and the magazine In the Family (edited by Laura Markowitz) meant that gay and lesbian issues were finally out of family therapy’s closet.

Despite gains in tolerance in some segments of our society, however, gays and lesbians continue to face humiliation, discrimination, and even violence because of their sexuality. After a childhood of shame and confusion, many gays and lesbians are rejected by their families once they come out. Due to the lack of social support, the bonds in gay and lesbian relationships can be strained by the pressures of isolation, generating stress and jealousy.
Parents often feel guilty, in part because early psychoanalytic studies blamed them for their children’s sexual orientation. Parental reactions range from denial, self-reproach, and fear for their child’s future, to hostility, violence, and disowning (LaSala, 1997). Therapists should remember that, while gay or lesbian children may have struggled for years to come to grips with their identity, their parents may need time to catch up after the initial shock.

When working with gay, lesbian, bisexual, or transgendered clients, we recommend that therapists get as much information as they can about the unique identity formation and relationship issues that these groups face. Therapists who aren’t well informed about gay and lesbian experience should seek supervision from someone who is, or refer these clients to a clinician with more experience. It simply isn’t true that individuals and families, regardless of their cultural context, all struggle with the same issues.

We hope the day will arrive soon when gay and lesbian families, bisexual and transgendered persons, African Americans, and other marginalized groups are studied by family therapists to learn not only about the problems they face but also about how they survive and thrive against such great odds. For example, gays and lesbians often create “families of choice” out of their friendship networks (Johnson & Keren, 1998). As Joan Laird (1993) suggested, these families have much to teach us “about gender relationships, about parenting, about adaptation to tensions in this society, and especially about strength and resilience” (p. 284). The question is whether we are ready to learn.

**Spirituality**

Throughout the twentieth century, psychotherapists, wanting to avoid any association with what science considers irrational, tried to keep religion out of the consulting room. We’ve also tried to stay out of the moralizing business, striving to remain neutral so that clients could make up their own minds about their lives.

At the turn of the twenty-first century, however, as increasing numbers of people found modern life isolating and empty, spirituality and religion emerged as antidotes to a widespread feeling of alienation—both in the popular press (making covers of both *Time* and *Newsweek*) and in the family therapy literature (Brothers, 1992; Burton, 1992; Prest & Keller, 1993; Doherty, 1996; Walsh, 1999).

Some of a family’s most powerful organizing beliefs have to do with how they find meaning in their lives and their ideas about a higher power. Yet most therapists never ask about such matters. Is it possible to explore a family’s spiritual beliefs without proselytizing or scoffing? More and more therapists believe that it’s not only possible, it’s crucial. They believe that people’s answers to those larger questions are intimately related to their emotional and physical health.

**Tailoring Treatment to Populations and Problems**

In recent years, family therapists have come down from the ivory towers of their training institutes to grapple with the messy problems of the real world. They find it increasingly necessary to fit their approaches to the needs of their clients, rather than the other way around. The maturing of family therapy is reflected in its literature. Once most of the writing was about the classic models and how they applied to families in general (e.g., Haley, 1976; Minuchin & Fishman, 1981). Beginning in the 1980s, books no longer tied to any one school began to focus on how to do family therapy with a host of specific types of problems and family constellations.
Books are now available on working with families of people who abuse drugs (Stanton, Todd, & Associates, 1982; Barth, Pietrzak, & Ramier, 1993), alcohol (Steinglass, Bennett, Wolin, & Reiss, 1987; Treadway, 1989; Elkin, 1990), food (Root, Fallon, & Friedrich, 1986; Schwartz, 1995), and each other (Trepper & Barrett, 1989; Friedrich, 1990; Madanes, 1990).

There are books about treating single-parent families (Morawetz & Walker, 1984), stepparent families (Visher & Visher, 1979, 1988), divorcing families (Sprengle, 1985; Wallerstein & Kelley, 1980; Ahrons & Rogers, 1989; Emery, 1994), blended families (Hansen, 1982; Sager et al., 1983), and families in transition among these states (Pittman, 1987; Falicov, 1988).

There are also books on treating families with young children (Combrinck-Graham, 1989; Wachtel, 1994; Gil, 1994; Freeman, Epstein, & Lobovits, 1997; Selekman, 1997; Smith & Nylund, 1997; Bailey, 1999; Nichols, 2004), with troubled adolescents (Price, 1996; Micucci, 1998; Sells, 1998) and young adults (Haley, 1980); and with problems among siblings (Kahn & Lewis, 1988). There are even books on normal families (Walsh, 1982, 1993) and "successful families" (Beavers & Hampson, 1990).

There are books for working with schizophrenic families (Anderson, Reiss, & Hogarty, 1986), families with bipolar disorder (Miklowitz & Goldstein, 1997), and families with AIDS (Walker, 1991; Boyd-Franklin, Steiner, & Boolland, 1995); families who have suffered trauma (Figley, 1985), chronic illness or disability (Rolland, 1994; McDaniel, Hepworth, & Doherty, 1992); families who are grieving a death (Walsh & McGoldrick, 1991), have a child with a disability (Selgman & Darling, 1996), or have an adopted child (Reitz & Watson, 1992); poor families (Minuchin, Colapinto, & Minuchin, 1998); and families of different ethnicities (Boyd-Franklin, 1989; Okun, 1996; McGoldrick, Giordano, & Pearce, 1996; Lee, 1997; Falicov, 1998). There are also several books in the works about treating gay and lesbian families (e.g., Laird & Green, 1996; Greenan & Tunnell, 2003).

In addition to these specialized books, the field has broadened its scope and extended systems thinking beyond the family to include the impact of larger systems like other helping agents or social agencies and schools (Schwartzman, 1985; Imber-Black, 1988; Elizur & Minuchin, 1989), the importance of family rituals and their use in therapy (Imber-Black, Roberts, & Whiting, 1988), and the sociopolitical context in which families exist (Mirkin, 1990; McGoldrick, 1998).

There are practical guides to family therapy not connected to any one school (Taibbi, 1996; Patterson, Williams, Grazl-Grounds, & Chamow, 1998), and edited books that include contributions from all of the schools but that are focused on specific problems or cases (Dattilio, 1998; Donovan, 1999). Thus, as opposed to the earlier days of family therapy when followers of a particular model read little outside of what came from that school, the trend toward specialization by content rather than by model has made the field more pluralistic in this postmodern age.

Among the most frequently encountered family constellations with unique challenges are single-parent families, African American families, and gay and lesbian families. The following recommendations are offered merely as introductions to some of the issues encountered in treating these groups.

**Single-Parent Families**

The most common structural problem in single-parent families is the same as it is in most two-parent families: an overburdened mother, enmeshed with her children and disengaged from adult relationships. From this perspective, the goal of therapy is to strengthen the mother’s hierarchical position in relation to her children and help her become more fulfilled in her own life as a woman. However, it’s important to keep in mind that single parents are
often overwhelmed and rarely have the resources to manage much of a social life on top of working all day and then coming home at night to take care of the kids, cook dinner, wash dishes, and do six loads of laundry.

Before going any further, we should acknowledge that single-parent families come in many varieties (U.S. Census Bureau, 2001). The children may be living with a teenage mother and her parents, a divorced college professor, or a father whose wife died of cancer. Such families may be rich or poor, and they may be isolated or part of a large family network. In the discussion that follows, we will concentrate on the most common variant encountered in clinical situations: a financially burdened mother with children who is going it alone.

In working with single-parent families, therapists should keep in mind that supporting the parent’s care of her children and helping her find more satisfaction in her own life are reciprocal achievements. The therapist should enter the system by addressing the presenting complaint, but whether that problem is, say, a mother’s depression or a child’s poor school performance, in most cases it’s important to work toward both helping the parent take more effective charge of her children and increasing her outside sources of support.

Effective treatment for a single parent begins with an actively supportive therapeutic relationship. An empathic therapeutic relationship helps shore up the single-parent’s confidence to make positive changes and, later, serves as a bridge to help her connect with ongoing supportive relationships in her environment. To begin with, it’s well to recognize that single parents are often angry and disappointed over the loss of a relationship, financial hardship, and trying to cope with the demands of work and children. These demands leave many single parents stressed and often depressed.

Poverty may be the most overwhelming burden on single parents and their children (Duncan & Brooks-Gunn, 1997). Therapists should not underestimate the impact of poverty on a mother’s depression, self-esteem, independence, and the decisions she makes about putting up with soul-draining jobs and abusive relationships. Many single-parent families live on the edge of crisis, managing most of the time but always aware that any unexpected emergency can push them over the edge. A supportive therapist recognizes the burdens of financial hardship, makes accommodations to the parent’s work schedule, and in some cases helps the single parent consider options, like going back to school, that might help her to become more financially stable.

Often one of the most readily available sources of support for the single parent is her own family. Here, the therapeutic task is twofold: facilitating supportive connections and reducing conflicts. Sometimes, by the way, it’s easier to develop dormant sources of support than to resolve contentious existing ones. The sister who lives twenty miles away may be more willing to look after her nieces and nephews from time to time than a depressed single mother thinks. A single parent’s family can provide financial support, a place to stay, and help with the children. However, since most parents have trouble getting over treating their grown children as children—especially when they ask for help—a therapist may have to meet with the grandparents, develop an alliance, and then help them and their adult children negotiate effective working relationships.

Many families of young mothers find it particularly difficult to support the ongoing involvement of the baby’s father (Johnson, 2001). They resent him and may even consider him an enemy. If their understandable feelings are treated with respect, they can often be helped to support the father’s involvement.

Facilitating the continued involvement of teen fathers deserves special attention because it’s so important and so challenging (Lehr & MacMillan, 2001). Since it’s relatively easy for
them to be ignored and to abandon contact with their child, it’s important to reach out to them, to establish rapport, and to encourage them in becoming responsible parents. A therapist can assist in this process by helping the mother and her family see that continuing contact with the father is in the best interests of the child.

When intergenerational conflicts are minimized these contacts can provide a rich source of support. Grandparents can have stronger connections with their grandchildren; single parents can have respite, knowing their children are being cared for by family members who love them; and children can have a variety of adult contacts as well as sibling-like relationships with cousins.

Pointing out these potential sources of assistance for single parents should not be taken to suggest that a family therapist’s only, or even primary, function should be supportive counseling. Most families, single parent or otherwise, seek clinical services because they are stuck in conflict—psychological, interpersonal, or both. In working with single parents, the therapist’s most important job is to identify and help resolve the impediments holding clients back from taking advantage of their own personal and interpersonal resources.

Sometimes the most significant conflict for single-mother households isn’t visible: it’s the potential involvement of the children’s father, who is not infrequently described as “out of the picture.” He may be out of the picture, but in most cases he shouldn’t be. (Family therapists should never leave fathers out of the equation.) Some of these men are caring fathers who would like to be involved in the lives of their children. Even invisible or unavailable fathers may well desire more contact, and be willing to take on more responsibility for the sake of their children. The therapist should consider contacting the noncustodial father to assess his potential contribution to his children’s emotional and financial support.

Here, too, triangles can complicate the picture. In an effort to be sympathetic to their mates (and sometimes from unconscious jealousy), new partners often fan the flames of conflict with the noncustodial parent, which only reinforces the cutoff.

---Case Study---

Elana Santos contacted the clinic because her ten-year-old son, Tony, was depressed. “He’s having trouble getting over my divorce,” she said, “and I think he misses his father.” After two sessions, the therapist determined that Tony was not depressed and, although he did miss his father, it was his mother who hadn’t gotten over the divorce. Tony had stopped hanging out with his friends after school; however, it was worrying about his mother, who’d become bitter and withdrawn, rather than depression, that was keeping him in the house.

The therapist’s formulation was that Mrs. Santos was enmeshed with her son and both were disengaged from contacts outside the family. The therapist told Mrs. Santos that her son was sad because he worried about her. She didn’t seem to be getting on with her life and Tony was sacrificing himself to become her protector. “Do you need your son to be your protector?” the therapist asked.

“No,” Mrs. Santos insisted.

“Then I think you need to fire him. Can you convince Tony that he doesn’t need to take care of you, that he can spend time with friends and that you’ll be alright?”

Mrs. Santos did “fire” her son from the job of being her guardian angel. The therapist then talked about getting Tony more involved in after-school activities where he could meet friends. “Who knows,” the therapist said, “maybe if Tony starts making friends, you’ll have some time to do the same thing.”

The only person Mrs. Santos could think of to help look after Tony so that she could have some time for herself was the boy’s father, and he was “completely unavailable.” Rather than accept this statement at face value, the therapist expressed surprise “that a father would care nothing about his son.” When Mrs. Santos insisted that her

---

3. Those cases where abusive fathers would have a destructive influence on their children’s welfare are usually obvious.
ex-husband wouldn’t be willing to spend any time with Tony, the therapist asked permission to call him herself.

When the therapist told Mr. Santos that she was worried about his son and thought the boy needed his father’s involvement in his life, Mr. Santos seemed responsive. But then the therapist heard someone talking in the background, and Mr. Santos started to back off.

What had begun as a problem firmly embedded in one person’s head (“It’s my son, he’s depressed”) turned out to involve not just the interaction between the boy and his mother, but also a triangular complication in which the father’s girlfriend objected to his involvement because she didn’t want “that bitch of an ex-wife of his taking advantage of him.” What followed were a series of meetings—with the father and his girlfriend, the father and mother, the father and son, and finally all four of them together—in which the therapist concentrated on helping them clear the air by voicing feelings of resentment that stood in the way of their working cooperatively together.

The father’s girlfriend had made the same mistake that a lot of us make when someone we love complains about how someone else is treating them. In response to his complaints about his ex-wife’s angry phone calls, she had urged him to have nothing to do with her. In response to these feelings and to Mrs. Santo’s own anger and resentment, the therapist helped them to understand an important distinction between two subsystems in a divorce. The first (the couple) was dead and should be buried; the second (the parents) still needed to find a way to cooperate in the best interests of their child. “Burying” the divorced couple’s relationship in this case was facilitated by Mrs. Santo’s having an opportunity to ventilate her bitterness and anger at having been abandoned by the man she loved, though most of these discussions took place in individual sessions with the therapist.

When noncustodial fathers do start spending time with their children, they may need help behaving as parents rather than friends. Mr. Santos, for example, was so anxious to develop a good relationship with Tony that once he started seeing more of his son he had trouble saying no to the boy’s demands. With encouragement, however, he began to assume a more adult role, and the two of them continued to get along well.

Reducing a single parent’s disengagement from adult relationships facilitates her beginning to strengthen the generational boundary between herself and her children. This involves delegating age-appropriate responsibilities to older children, enforcing discipline, and helping the children get involved in activities of their own. The primary structural goal for the single parent is to assume power as the primary executive in the family system. This task may be particularly difficult for a parent who is demoralized by loss or depression. Therefore some structural goals may make sense but may not be practical. Setting up charts and token economies to rein in out-of-control children, for example, may require an unrealistic amount of monitoring and overtax an already overburdened single parent. When feeling overwhelmed, single parents often lose the ability to set effective limits. Some parents may also permit more misbehavior than they think they should to make up for the loss their children have suffered from divorce or lack of father involvement. Chores should be delegated not abdicated—mother is still in charge—and a boy is not “the man of the house” (which implies that a son has taken his father’s place).

Live-in partners—who shouldn’t be overlooked any more than noncustodial parents—provide additional sources of support, and conflict. Many compete with the children for the mother’s time and attention. Some undermine the mother’s authority and rule setting, while others try to enforce their own, often stricter rules, setting up a triangle in which the mother is forced to side either with her boyfriend or her children. Live-in partners’ attempts to enforce discipline are frequently rebuffed, especially by adolescents. Their job isn’t that of a parent, but that of a supporter and a backup for the mother as the primary authority over her children.
Children may benefit from increased social contacts to help balance the intensity of the single-parent-and-child connection. Resources to consider include teachers, coaches, Big Brothers and Big Sisters, activity group leaders, community groups (“Parents Without Partners” “Mother’s Day Out”), religious congregations, craft classes, and workplace contacts.

Families take many forms; the single-parent family is one of them. Families don’t get broken or destroyed, but they do change shapes. Unfortunately, the transition from being together to being apart is a road without maps. No wonder there is so much pain and confusion.

We pointed out earlier that single-parent families are burdened with complex challenges. But these are only the dark side of what can be a set of satisfying relationships. Families are rich with possibility; single-parent families can be difficult, but with a little help they can not only survive but flourish.

**African American Families**

Among the most frequently described features of the black experience in the United States are extended kinship networks, religion and spirituality, absent fathers, the three-generational system, poverty, and, of course, racism.

Therapists working with African American families should be prepared to expand the definition of family to include an **extended kinship system**. The kinship network remains one of the keys to coping with the pressures of oppression (Billingsley, 1992; Staples, 1994). A clinician should be aware that there may be a number of aunts, uncles, “big mamas,” boyfriends, older brothers and sisters, cousins, deacons, preachers, and others who operate in and out of the African American home (White, 1972, p. 45). However, many families who come to the attention of mental health workers have become isolated from their traditional support network. Part of a therapist’s task is to search for persons in the family or kin network who represent islands of strength and enlist their support in helping the family. Asking “Who can you depend on when you need help?” is one way to locate such individuals.

A structural assessment should consider not only those people who are involved with the family but also those who might be called on for support. In the African American community, these potential connections include an extensive kinship network, made up of both family and friends (Billingley, 1968; McAdoo, 2002). This network might include not only all those mentioned above but also grandparents and great-grandparents, as well as godparents, babysitters, neighbors, friends, church members, ministers, and so on.

These extended connections, real and potential, mean that family boundaries and lines of authority can become quite blurred, as the following example illustrates.

---

**Case Study**

When Juanita Williams entered a residential drug treatment program, she was lucky to have her neighbor and friend, Deena, willing to take in her three children. Six months later Juanita was ready to leave rehab and return home. By that time, the Williams children had grown accustomed to living with “Aunt Deena” and her two teenagers.

When the children’s case worker arranged a meeting with Juanita and her children and “Aunt Deena,” Deena praised Juanita for completing the rehab program and preparing to resume the responsibility for her children. “You know I love them, almost like they was my own,” she said to Juanita, who nodded. “But now it’s time for them to move back with their rightful mother.” However, it appeared to the social worker that Deena had effectively taken over the family and Juanita had lost her position of authority. Deena did most of the talking while Juanita sat quietly, looking down. Martin (14), Jesse (12), and Coretta (11) said nothing.

The social worker concluded that Deena and the Williams children were enmeshed while Juanita was disengaged; and the worker saw her job as helping Juanita and her children reconnect while Deena stepped back into a
supportive but less controlling role. Toward this end she said that Juanita was lucky to have such a good friend to act as foster mother to her children, but now it was time for her to reclaim her role as head of the family. She then set up an enactment in which she asked Juanita to talk with her children about her plans for the immediate future.

When Juanita began by telling the children how much she had missed them, Deena spoke up to say that the children had missed her, too. Deena's intentions were good, but her interruption was a sign of her overly central role. The therapist complimented Deena for being helpful but said that it was time to show her support by letting Juanita speak for herself. Juanita resumed talking to her children, saying, "I know that I can't promise anything, but every day I will try my hardest to be the right kind of mother to you and not to give in to my disease. And," she went on with tears in her eyes, "I know that with God's help we can be the family that we never were."

Martin looked down, Jesse and Coretta had tears in their eyes. Then Martin turned to the therapist and said, "Can I speak?" "Of course, Martin, you can say whatever you want to your mother."

"I love you, Mommy," he said. "And I hope to God that you don't go back to the drugs. But I will never—never—live in a house where I have to watch my mother going into the streets again. When I don't know whether we're going to have any supper that night because you're out getting high. You will never put me through that again."

"Martin—" Once again Deena started to interrupt, and once again the social worker blocked her.

Martin went on talking for fifteen minutes about the pain and rage of growing up with a mother who was a drug addict. He held nothing back. When Martin finished, there was a long, heavy silence. Then Juanita spoke up. "I know what I put you through, Martin. What I put all my children through. And I know that I can never, ever make up for that. But, as God is my witness, I will do everything in my power never, ever again to let you down or make you ashamed of me. All I want is another chance." It was a gut-wrenching exchange. Martin had spoken straight from the heart, and he and his mother had gotten through to each other—with no interference from well-meaning friends, or helpful professionals, anxious to put a good face on things.

The prominence of religion and spirituality in African American family life (Hines & Boyd-Franklin, 1982), like the extended kinship network, provides both a real and potential resource. Many African American families have gained strength from church membership and connection to their church community (Billingsley, 1994; Walsh, 1999). Therapists who work with black families can profit from developing a relationship with ministers in the African American community who have a great deal of influence and can often help mobilize support for an isolated single mother, an adolescent who is abusing drugs, or a mentally ill adult who is cut off from family support following the death of the main caregiver (Boyd-Franklin, 2003).

One reason father-absent households are so common among African Americans is that there are far fewer men than women in the black community. Among the reasons for the absence of black men are infant mortality rates double that of whites, an epidemic of substance abuse, death related to hazardous jobs, delays in seeking health care, military service, homicide, and of course the astonishingly high percentage of young black men in prison (U.S. Bureau of the Census, 2003). Not only are there fewer black men but their participation in family life is often undermined by limited job opportunities and a tendency on the part of mental health professionals to overlook men in the extended family system, including the father’s kinship network and the mother’s male friends, who may be involved in the children’s lives.

It’s important to involve fathers and other adult males in family treatment, although this may be difficult when the men hold several jobs or can’t take time off from work to participate in therapy sessions. Too many therapists resign themselves to the nonparticipation of fathers in family therapy. A therapist who is regarded as unavailable may agree to attend if contacted directly by the therapist. Even if the father has trouble getting away from work, he may agree
to come to one or two sessions, if he’s convinced that he’s really needed. Therapists can also use phone calls and letters to keep fathers involved in their family’s treatment. Respecting a father’s family role decreases the likelihood of his sabotaging treatment (Hines & Boyd-Franklin, 1996), and even limited participation may lead to a structural shift in the family.

Partly as a consequence of absent fathers, many families in the African American community are three-generational systems, made up of a mother, her children, and a grandmother. Sometimes grandmothers are asked to take over the job of raising a second set of children. At other times, single mothers or fathers and their children may move back in with the grandparents. In some cases, teenage mothers will turn their children over to their own mothers but later want to take back the responsibility of raising their children. While none of these family structures is inherently dysfunctional, they all create complications.

Grandmothers who take over may have trouble letting go. They see their young adult children behaving irresponsibly, and they treat them accordingly. Unfortunately, this perpetuates the classic control-and-rebel cycle that so many young people get caught up in with their parents. Therapists can’t always remain neutral in this kind of impasse. It may be useful to support the young mother or father in the role of parent, while respecting the grandmother’s contribution and availability for advice and support (Minuchin, Nichols, & Lee, In press).

Within the past twenty years there has been an increase in the number of middle-class black families to where they now make up 25 percent of the African American community (Hill, 1999). However, the majority of African American clients encountered in clinical situations are likely to be dealing with stigmas of race and class together. Although some black families have benefited from job and educational opportunities, most urban African American communities remain mired in multigenerational poverty (Boyd-Franklin, 2003).

Even the healthiest families have trouble functioning effectively under the crushing weight of financial hardship. When survival issues—like food, housing, and utilities—are involved, these take precedence over family conflicts. Therapists can usefully act as a resource to encourage family members to take effective steps and to work with available community and social agents in dealing with housing, job training, employment, and child care (Rojano, 2004).

The combination of discrimination and oppression, augmented by racism and poverty, has produced a “fierce anger” in many African Americans (Cose, 1993). Service providers must realize that some of this anger may be directed against them. It’s important not to get defensive. Moreover, the legacy of intrusion by social and child protective services, police, legal, and criminal justice systems into poor African American communities has resulted in an understandable suspicion toward agencies and their representatives (Boyd-Franklin, 1989; Grier & Cobbs, 1968). Therapists who ignore the background context for this suspiciousness may take it personally and presume that these families don’t want their services or can’t be treated. Nancy Boyd-Franklin (1989) recommends that mental health providers expect a certain amount of distrust and join with their black clients to build trust at the very outset of treatment. Communicating respect is key to successfully engaging families.

In working with African American families, it’s useful to expand the context of therapy to include the kinship network, the community, and whatever social agencies may be involved in the life of the family (Aponte, 1994; Boyd-Franklin, 1989). The therapeutic task includes not only identifying sources of support for overburdened parents and families but also helping to negotiate effective working arrangements—
to avoid structural problems, inconsistencies, and triangles.

In working with poor, inner-city African American families, therapists must take into account that they may be enmeshed with a variety of organizations such as schools, hospitals, police courts, juvenile justice systems, welfare, child protective services, and mental health services (Henggeler & Borduin, 1990). Empowering families in this context can be accomplished by (1) setting up meetings with various agencies involved with the family, (2) writing letters in support of the family, and (3) setting up conferences with the supervisors of resistant workers (Boyd-Franklin, 2003). The point is to empower families by encouraging them to take charge of these issues themselves. Therapists can help but should not take over.

**Therapy with Gay and Lesbian Families**

Gay and lesbian partners struggle with the same sorrows of confusion and longing as any intimate partners. Every couple must find a way to balance time together with independent interests, choose whether and when to have children, and decide whose family to spend the holidays with. But same-sex couples also face unique challenges, including coping with homophobia in the larger society and their families; resolving relational ambiguities in the areas of commitment, boundaries, and gender-linked behavior; differences about being “out” professionally or socially; and developing networks of social support (Green & Mitchell, 2002). In order to work effectively with gay and lesbian clients, it’s important neither to ignore nor exaggerate the unique nature of same-sex pairings.

While it may be reassuring for heterosexual therapists to dissociate themselves from the overt homophobia in our culture, it’s a little more difficult to deal with internalized homophobia—in themselves and in their clients. Therapists who aren’t comfortable with love and sex between two men or two women may have trouble talking frankly with gay couples or, and this may be more common, may behave with patronizing deference. A therapist who is overly anxious to convey his or her progressive attitude may find it difficult to push for change or to ask the kinds of tough questions that may be necessary with couples who aren’t getting along.

---

**Case Study**

Stephen and David sought therapy during a crisis induced by Stephen’s wanting to open up their relationship to other partners and David refusing to even discuss this possibility. Their therapist, who was anxious to distance himself from the stereotype that gay men are promiscuous and unable to maintain a stable relationship, got caught up in trying to solve the problem of Stephen’s inability to commit, rather than exploring the broader problem of the couple’s difficulty communicating and making decisions. Had the couple been a man and a wife disagreeing over whether to buy a house or rent an apartment, it is unlikely that the therapist would have so quickly taken sides and reduced therapy to an exercise in problem solving.

Homophobia may also manifest itself in subtle and not so subtle ways in lesbian and gay people themselves (Brown, 1994; Meyer & Dean, 1998). When you grow up in a society in which homosexuality is considered deviant, it’s impossible not to absorb at least some of this attitude. And for those who begin to discover their own homosexual feelings, they may find it hard to avoid a certain amount of self-loathing. Well-meaning heterosexual therapists who consciously affirm gays and lesbians may be especially blind to this dynamic.

In working with same-sex couples, it’s important to probe for subtle manifestations of
deeply held negative images of homosexuality and of same-sex relationships. One stereotype that can be particularly destructive is the cultural expectation that same-sex pairings are inherently unstable. Many people, gay as well as straight, believe that enduring love relationships between same-sex partners (especially gay men) are impossible to achieve. As with many biases, it’s probably more useful for therapists to examine and recognize their own attitudes and assumptions than to pretend to themselves to be without bias. Consciously recognizing your assumptions makes it easier to hold them in check; pretending that you don’t have assumptions allows them to act on you unsuspectingly.

The belief that same-sex couples are inherently unstable undermines many gay male couples themselves, especially considering that for men separation is often a knee-jerk response to conflict (Greenan & Tunnell, 2003). Given the frequency with which men threaten to end their relationships when they experience difficulty, it’s wise to anticipate such threats and be prepared to confront them. Instead of getting drawn in to the content of the threat, the therapist can interpret it as a defense against feeling helpless. “Obviously you’re upset, but if we can find a more constructive way to help you feel that your needs are being taken seriously, maybe you won’t have to use tactics that potentially destroy the relationship when you have a disagreement.”

Working with gay and lesbian couples requires sensitivity to the internalization of traditional gender norms, as well as the overt prejudice they continue to face in their current social environments. Heterosexual partners have typically been socialized for complementary roles. Women and men may no longer expect to be “Leave-It-to-Beaver” parents, June and Ward Cleaver, but, like it or not, women are still taught to be more nurturant and relationship oriented and to have a less distanced sense of self (Jordan et al., 1991), while men are brought up to be in control, to be territorial, to tolerate distance, and to thrive on competition. So what happens when same-sex partners get together expecting to play a certain role and expecting the other person to play a complementary role? Who picks up the towels from the bathroom floor? Who initiates sexual activity?

Many gay and lesbian couples struggle as much as heterosexual couples over the issue of whether and when to have children. But, unlike their heterosexual counterparts, gays and lesbians have to resolve the issue of who (if either) will be the biological parent.

**Case Study**

Rachel and Jan have been together for ten years and were considering having a child. Both agreed that they would like to have a biological child rather than adopting. However, both women very much wanted to be the recipient of the sperm donor.

Seeing that Rachel and Jan were at an impasse, the therapist suggested that they consider adopting. Worn out and frustrated by their inability to decide which of them would give up the wish to carry their baby, the women jumped at this suggestion. However, their relief turned to anger when they discovered that the state they lived in (which starts with the letter V) did not allow gay and lesbian couples to adopt children. Their experience made them lose confidence in their therapist and they dropped out of treatment.

In contrast to the stereotype presented in such popular films as *La Cage aux Folles*, only a small minority of gay and lesbian couples divide into butch and femme roles (Green & Mitchell, 2002). The ideal for most gay and lesbian couples is sharing the instrumental and emotional tasks usually associated with male and female roles (Carrington, 1999). Compatibility without fixed complementarity allows for a great deal of flexibility. On the other hand,
with no standard roles or familiar expectations, the division of labor in same-sex couples must be more conscious and deliberate than for heterosexual couples.

One of the issues in therapy with same-sex couples is likely to be the need to negotiate clear agreements about commitments and boundaries and roles. Among the questions a therapist might usefully ask are:

“What are the rules in your relationship about monogamy?”

“What are your agreements about finances, pooling of resources, and joint ownership of property?”

“Who does what tasks in the household, and how is this decided?”

These questions are offered as examples of how to pursue issues once they are broached by clients. It’s important, however, to strike a balance between helping couples address such important issues and dictating that they should, especially when they may not be ready to.

Many of the usual expectations that heterosexuals bring to marriage don’t necessarily apply to same-sex couples unless they are discussed and explicitly agreed to (Green & Mitchell, 2002). Among these expectations are monogamy, pooled finances, caring for each other through serious illness, moving together for each other’s career advancement, caring for each other’s families in old age, mutual inheritance, health care power of attorney in the event of incapacitation, to name just a few. Because there are no familiar models for being a same-sex couple, partners may have discrepancies in their visions about how these issues will be handled. We suggest that therapists be aware of these issues and prepared to help clients discuss them but not introduce these or any issues that clients don’t yet seem ready to deal with.

Heterosexual therapists may underestimate the complexities involved in “coming out” to family and friends (LaSala, 1997). Here it may be well to remember that therapy isn’t pushing people to go where they’re afraid to go, but is about helping them recognize and resolve the fears that hold them back.

Because many same-sex couples are understandably anxious in an unsafe world, their antennae will be tuned for any suggestion of homophobia. For this reason the joining phase of therapy may need to be longer because the therapist will have to work to gain their trust (Greenan & Tunnell, 2003). Starting off by asking “What brings you in as a couple?” is one way to convey respect for them as a family unit.

Another difficulty that heterosexual therapists may overlook in same-sex relationships is the prevalence of extreme jealousy on the part of one of the partners (Green & Mitchell, 2002). This jealousy is based on the belief that others are a threat because of lack of respect for the couple’s commitment to each other. After all, how can the relationship be “real” if the partners aren’t married?

--- Case Study ---

Jim enjoys the club scene as a way to socialize with his friends in the gay community. His partner, Kyle, prefers to avoid bars and clubs. According to Kyle, his objections aren’t so much to Jim’s having a good time, but that he believes other men in the clubs have little respect for the fact that Jim is part of a couple. “They don’t care about us if they think they can get good sex out of hitting on you.” Kyle was also concerned about the prevalence of designer drugs—like ecstasy, cocaine, crystal meth, and special K—that were part of the club atmosphere. Jim insisted that he wasn’t interested in other men and didn’t do drugs. He just wanted to hang out with his friends.

Although some therapists might see Jim’s insistence on going to bars as a failure to accept that he was no longer single, the therapist in this case was aware that, in fact, not going to bars and clubs can result in a significant disconnect from much of the gay community. And so, rather than accept the Hobson’s choice the couple presented—either Jim gave in and stayed home or Kyle gave in and
Jim continued to go clubbing—the therapist wondered out loud if there were alternative ways for the couple to socialize within the gay community.

Therapists who fail to value gay and lesbian couples’ commitment may, when they have serious problems, see them as insurmountable and support termination more quickly than they would for a married heterosexual couple. The opposite may also occur if a therapist, intent on overcoming the stereotype that same-sex relationships aren’t permanent, acts as though longevity were the prime good rather than relationship satisfaction.

Angry squabbling can be a problem in any relationship, but it is particularly common in gay male couples who seek therapy (Greenan & Tunnell, 2003). It isn’t just a failure to follow Roberts Rules of Order that makes people resort to anger as a defense mechanism. The goal of treatment for many couples is to create an atmosphere in which the partners feel safe to explore any shame that they may have around their needs for affection and intimacy in their relationship (Bowlby, 1988). This level of work is essential in the treatment of gay men, who are often uncomfortable expressing their need for tenderness and understanding with another man (McWhirter & Mattison, 1984). This reticence may be exaggerated by a fear that tenderness is “effeminate.” Most men—gay or straight—who equate their need for closeness with effeminacy want to avoid what Richard Isay (1989) calls “the sissy boy syndrome.” Real men don’t cry. One of the insidious things about prejudice is how the minority group often internalizes the stereotypes attributed to them by the majority culture or imitates an exaggerated version of the majority image (Allport, 1958).

Maybe the best advice for therapists working with gay and lesbian couples is to ask themselves: “What messages am I communicating to this couple about the meaning, value, and worth of same-sex relationships.” It isn’t just negative messages that therapists should be alert to but also the danger of glamorizing same-sex relationships. Denigration and idealization have an equal potential for harm.

**Home-Based Services**

Home-based services are a descendent of the “friendly visitor movement,” in which social workers, inspired by Mary Richmond, called on families in their own homes. In the past social workers, more often than not, found themselves removing vulnerable children from harm’s way. Unfortunately, this misguided altruism often undermined the family unit. Beginning in the 1970s, and influenced by the principles of deinstitutionalization and community care, there has been more of an effort to keep fragile families together and to prevent placement of children (McGowen & Meezan, 1983).

Like traditional versions of family therapy, home-based services target the family as the primary recipient of mental health care (Friesen & Koroloff, 1990). Unlike conventional models, however, the home-based approach focuses more on expanding the network of a family’s resources than on repairing family dysfunction (Henggeler & Borduin, 1990). While home-based services recognize and address problems in the family system, the primary emphasis is on building relationships between the family and various community resources.

Home-based therapists approach families with a collaborative mind-set and positive expectations. This “strength-based” approach, which assumes that families contain the resources to deal with their own problems, can also be applied to the expectation that competence is inherent in other agencies as well, such as other organizations involved with the family.
Consequently, agencies and other influences are viewed not as adversaries but as potential partners in the treatment process.

Home-based services generally include four elements: family support services, therapeutic intervention, case management, and crisis intervention (Lindblad-Goldberg, Dore, & Stern, 1998). Family support services include respite care as well as concrete assistance with food, clothing, and shelter. Therapeutic intervention may include individual, family, or couples treatment. The overriding therapeutic goal is strengthening and stabilizing the family unit. Families are empowered by helping them utilize their own strengths and resources for solving problems rather than relying on out-of-home placement of the children. Case management involves developing links to community resources, including such things as medical care, welfare, education, job training, and legal services. Crisis intervention means making available twenty-four-hour emergency services, either with the home-based agency staff or by contracting with an outside mental health emergency service.

Visiting a family at home gives a therapist the opportunity to show interest in the things that define their identity—such as children, pets, religious artifacts, mementos, awards, and so on. Looking through photo albums can be a valuable method in joining with a family and learning about their history and their hopes and dreams. Once a positive relationship has been established—but not before—the therapist can ask the family directly to reduce such distractions as smoking, loud television playing, or barking dogs. (Barking cats are less likely to be a problem.)

Roles and boundaries that are implicit in an office setting may need to be spelled out. Clarifying roles while in the home begins with defining what the process of treatment entails, the ground rules for sessions, and what the therapist’s and family members’ roles will be. The following comments illustrate the process of clarifying roles.

—Case Study—

"Before we start, I want to say that I have no intention of coming here and telling you how to run your lives. My job is to help you figure out how you want to deal with your children. I can’t solve your problems. Only you can do that.

In our meetings, it’s important for you to say whatever you think and feel. We need to be honest. Tell me what you expect of me, and I’ll tell you what I expect of you. I won’t act like I have all the answers, because I don’t.

Will Grandmother be coming tonight? If not, that’s okay, but I would like her to attend future sessions, because I’m sure she has valuable ideas to contribute.

Tonight, I’d like to get to know each of you a little bit. After that, I’d like to hear what concerns each of you have about your family life and what you’d like to change."4

While many family therapists speak glibly about their “eco-systemic” orientation, home-based workers really must coordinate their efforts with a variety of other service systems. To do so, it is imperative to understand the concerns of other agencies involved with the family and to develop collaborative relationships with them. Rather than being critical of school personnel or juvenile justice workers who don’t seem to support both the family and the child, home-based workers must learn to appreciate that these other agencies are equally concerned about the needs of their clients, even though their approaches may differ. A family served by multiple agencies that don’t see eye to eye is no different from a child caught in a triangle between parents who can’t function together as a team.

Operating with a systemic perspective begins with working collaboratively with other agencies. It also means keeping the entire family constellation in mind even when meeting with subsystems. Thus, for example, a therapist who meets individually with a disgruntled adolescent should remember that there are two sides to every story and that often the best way to support children is to support their parents’ constructive efforts rather than to side uncritically with the children.

While in-home therapy offers a unique opportunity to influence families directly in their natural environment, seeing people in their living rooms also increases the pressures of induction into a family’s problematic patterns. Working with a cotherapist may help minimize the tendency to be drawn unwittingly into the family’s unproductive way of seeing things. Home-based therapists who don’t work with cotherapists must make special efforts to maintain professional boundaries and to avoid being inducted into playing missing roles in the family. For example, if a child needs comforting, it is far better to support the parents in providing it than to take over that function.

The first priority in home-based work should be to demonstrate that the therapist is consistent and genuine. Having a connection with someone who can be counted on may be more important to families with a history of unmet dependency needs than having a worker who is powerful, smart, or controlling.

One of the most damaging things that can happen in any form of psychotherapy is clients recreating with their therapists the same unsatisfying kinds of relationships they have with most people. Perhaps the most important thing a therapist can do is to avoid being drawn into the usual pattern. The most dangerous pattern for home-based workers to repeat is moving in too close and then pushing clients to go where they are afraid to go. Rather than start pushing for change right away, it’s often more effective to begin by recognizing the obstacles to change.

Beleaguered families fear abandonment; insecure therapists fear not being helpful. The worker who feels a pull to do everything for a client may subsequently feel overwhelmed by the family’s needs and back away by setting rigid limits and withholding support. The “rescuer” then becomes another “abandoner.” This process reactivates the client’s anxiety and inevitably pushes the client away. The lessons for the family are clear: Nothing will ever change—and don’t trust anyone.

**Medical Family Therapy and Psychoeducation**

Over the past fifteen years a new conception of family therapy has emerged. Rather than solving problems, the goal of this approach is to help families cope with disabilities. This represents a shift from the idea that families cause problems to the idea that problems, like natural disasters, sometimes befall families. **Psychoeducational family therapy** emerged from working with schizophrenic patients and their families, whereas **medical family therapy** developed from helping families struggle with chronic illnesses such as cancer, diabetes, and heart disease.

**Psychoeducation and Schizophrenia**

The search for a cure for schizophrenia launched the field of family therapy in the 1950s. Ironically, when we now know that schizophrenia involves a biological vulnerability of unknown origin, family therapy, or at least the psychoeducational model, is once again considered part of the most effective treatment for this baffling disorder.

The psychoeducational model was born of dissatisfaction with both traditional family
therapy and psychiatric approaches to schizophrenia. As Carol Anderson, Douglas Reiss, and Gerald Hogarty (1986) lamented,

We have blamed each other, the patients themselves, their parents and grandparents, public authorities, and society for the cause and for the too often terrible course of these disorders. When hope and money become exhausted, we frequently tear schizophrenic patients from their families, consigning them to the existential terror of human warehouses, single room occupancy hotels, and more recently to the streets and alleys of American cities. (p. vii)

In their attempts to get at the function of the schizophrenic’s symptoms, family therapists urged family members to express bottled-up feelings and thus created sessions of highly charged emotion, which often did little more than stir up tension. After noticing the frequent decline in functioning of patients and increased anxiety in their families after such sessions, Anderson and her colleagues (1986) “began to wonder if most ‘real’ family therapy was in fact antitherapeutic” (p. 2).

Meanwhile, studies began to show that the patients who fared best after hospitalization were those who returned to the least stressful households. A British group, including George Brown, John Wing, Julian Leff, and Christine Vaughn, focused on what they called “expressed emotion” (EE) in the families of schizophrenics—particularly criticism, hostility, and emotional overinvolvement—and found that patients returning to high EE households had higher rates of relapse (Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976; Vaughn et al., 1984).

Research on expressed emotion suggests that schizophrenia is a thought disorder that renders individuals particularly sensitive to the expression of criticism and hostility. The theory is that intense emotional input makes it difficult for patients to cope with the welter of chaotic thoughts that plague them. When recovering patients return to stressful family settings, where EE is high, intrusive overconcern and critical comments lead to increased emotional arousal, and it is this affective overload that triggers relapse. On the other hand (as Bowenian theory would suggest), patients returning to households with low EE and whose family members are not overly anxious are allowed more psychological space in which to recover (Leff & Vaughn, 1985).

Expressed emotion is now the most well-documented factor in the relapse of schizophrenia (Milkowitz, 1995):

The family, then, is seen as a risk or protective factor that may augment or diminish the likelihood that underlying genetic and/or biological vulnerabilities in a family member will be expressed as symptoms of mental disorder. (p. 194)

Moreover, the benefits of reducing EE in helping families cope with schizophrenia has been repeatedly demonstrated (Atkinson & Coia, 1995). Lowering EE has also been shown to contribute to reduced relapse rates for major depression and bipolar disorder (Muesser & Glynn, 1995).

With this in mind, three different groups in the late 1970s and early 1980s began experimenting with ways to reduce stress in the most common environments for schizophrenic patients—their parents’ homes. Michael Goldstein led a group at UCLA (Goldstein et al., 1978) who designed a brief, structured model focused on anticipating the stresses a family was likely to face and reducing conflict around the patient. Following the Goldstein study, groups headed by Ian Falloon at the University of Southern California (whose model is primarily behavioral) and Carol Anderson at the Western Psychiatric Institute in Pittsburgh experimented with psychoeducational models.

Psychoeducators try not only to help families change their ideas about and interactions with
patients but also to reverse the damage done by insensitive professionals. Instead of providing the information, support, and sense of control that these families need when in crisis, many mental health professionals ignore family members except to gather information—information about what went wrong. The implications of this line of questioning only add to the guilt and shame family members already feel. No wonder many families either give up or get into antagonistic battles with these authoritarian professionals.

Psychoeducators seek to establish a collaborative partnership in which family members feel supported and empowered to deal with the patient. To achieve this kind of partnership, Anderson and her colleagues (1986) find that they must reeducate professionals to give up ideas that the family is somehow responsible for schizophrenia, reinforce family strengths, and share information with the family about schizophrenia. It is this information-sharing that constitutes the educational element of psychoeducation. Information about the nature and course of schizophrenia helps family members develop a sense of mastery—a way to understand and anticipate the often chaotic and apparently uncontrollable process.

One of psychoeducation’s key interventions is to lower expectations, to reduce pressure on the patient to perform normally. For example, the goals for the first year following an acute episode are primarily the avoidance of a relapse and the gradual taking on of some responsibilities in the home. Family members are to view the patient as someone who’s had a serious illness and needs to recuperate. Patients may need a great deal of sleep, solitude, and limited activity for some time following an episode; they may also seem restless and have trouble concentrating. By predicting these developments, psychoeducators try to prevent conflict between the patient and the family.

Anderson’s psychoeducational approach looks very much like structural family therapy, except that the family’s structural flaws are construed as the result of rather than cause of the presenting problem. Much of the therapy follows familiar themes: reinforcing generational boundaries, opening up the family to the outside world and developing support networks, urging parents to reinvest in their marriage, and getting family members to not speak or do for the patient.

Anderson and her colleagues begin with a day-long survival skills workshop in which they teach family members about the prevalence and course of schizophrenia, its biological etiology, current modes of pharmacologic and psychosocial treatment, common medications, and prognosis. The patient’s needs and the family needs are discussed and family coping skills are introduced. Research findings on expressed emotion are presented and guidelines are offered for keeping EE in check. Families are encouraged not to pressure recovering patients or to urge them to hurry back to normal functioning. Families are also advised to respect boundaries and to allow the recovering family member to withdraw whenever necessary.

Bill McFarlane’s multifamily approach typically includes five or six families and begins with lecture-and-discussion workshops. Following these workshops the patients and their families meet regularly for at least a year. The multifamily format is thought to offer increased social support. The goal for the patient is for symptoms to be reduced rather than cured. Families are encouraged to provide a quiet, stable milieu in which the recovering patient doesn’t feel criticized or blamed, and not to expect too much of him or her during recuperation. The goal for the family is to learn coping techniques for the difficult and long-term task of living with a schizophrenic person and preventing or delaying his or her relapse and rehospitalization.

Table 11.1 presents a set of typical psychoeducational guidelines for managing rehabilitation following a schizophrenic episode.
Is the psychoeducational model effective? Yes. For example, in the study by Anderson and colleagues (1986), among treatment takers ($n=90$), 19% of those receiving family therapy alone experienced a psychotic relapse in the year following hospital discharge. Of those receiving the individual behavioral therapy, 20% relapsed, but no patient in the treatment cell that received both family therapy and social skills training experienced a relapse. These relapse rates constitute significant effects for both treatments when contrasted to a 41% relapse rate for those receiving only chemotherapy and support. (p. 24)

Other studies have shown equally impressive results (Falloon et al., 1982; Leff et al., 1982). There seems to be little question that psychoeducation can delay relapse and readmission to a hospital better than other approaches to schizophrenia.

### Medical Family Therapy

If one considers schizophrenia a chronic disease, then psychoeducational family therapy can be seen as a specialized form of medical family therapy. Medical family therapists work with families struggling with illness or disability in much the same way as described previously for families of schizophrenics.

Chronic illness often has a devastating impact. It can take over a family’s life, ravaging health, hope, and peace of mind. As Peter Steinglass says, it can be like a robber “who has appeared on the doorstep, barged inside the home and demanded everything the family has” (quoted in McDaniel et al., 1992, p. 21).

The demands of the illness interact with the qualities of the family, such as the family’s lifecycle stage and the role the stricken family member plays; the family’s leadership resources and degree of isolation; and their beliefs about illness and who should help, derived from their
ethnicity and history with illness. With an awareness of these factors, therapists can help families prepare to deal with an illness or, if the illness has been with them for years, gain perspective on their resulting polarizations and enmeshments.

In medical family therapy, the system isn’t just the sick person’s family; it’s the family and the physicians and nurses involved in the sick person’s care. The goal, therefore, is to foster communication and support not only within the family but also between the family and the medical personnel. Illness leaves people feeling helpless and confused. Medical family therapy is designed to combat such feelings by fostering communication and a sense of agency.

Medical family therapists work in collaboration with pediatricians, family practitioners, rehabilitation specialists, and nurses. They advocate that near the time of diagnosis, families should receive a routine consultation to explore their resources relative to the demands of the illness or disability. They cite the growing body of research suggesting a strong relationship between family dynamics and the clinical course of medical conditions (Campbell, 1986) and more recent research showing that family therapy has a positive effect on physical health and health care usage (Law & Crane, 2000).

In the early 1990s the field came of age, with three books setting the pace (McDaniel et al., 1992; Ramsey, 1989; Rolland, 1994). It has now mushroomed into a whole new paradigm called collaborative family health care, with a large annual conference that began in 1996 and now offers fourteen plenaries and more than fifty workshops. There, well-known medical family therapists, such as John Rolland, Bill Doherty, Lorraine Wright, Susan McDaniel, and Thomas Campbell, present their work alongside experts in medicine, nursing, social work, and hospital administration. The hope and promise of this movement are to provide new careers for family therapists but also to become a new model for cost-effective and humane health care nationally.

In conclusion, psychoeducational and medical family therapy share many elements with the other models in this chapter, which together represent a significant trend: a move away from an antagonistic relationship with families toward a collaborative partnership. Therapists are now encouraged to look for a family’s strengths rather than deficits and find ways to lift families out of the guilt and blame that often accompany their problems.

**Relationship Enrichment Programs**

The psychoeducational method has also been applied to couples and families who wish to acquire skills for coping with everyday relationship problems. Some therapists are skeptical that self-help courses can substitute for the individual attention of a professionally trained therapist, yet these programs are enormously popular, not least because participants in marital enrichment programs feel little of the stigma that attaches to “being in therapy.” One of the best known of these practical, skills-training programs is the Relationship Enhancement system developed by Bernard Guerney, Jr. (1977) at Penn State. Relationship Enhancement usually involves ten sessions that may extend over several months. Facilitators teach participants to clarify their conflicts and then to recognize and express what they are feeling, accept each other’s feelings, negotiate and work through problems, and learn to achieve satisfaction by becoming emotional partners (Ginsberg, 2000). Both lectures and experiential training take place in each session, and homework assignments are given to practice and extend skills in participants’ everyday lives.
Relationship Enhancement programs provide couples with training in three sets of core skills (Ginsberg, 2000):

- The *Expressive* (Owning) Skill (gaining awareness of one’s own feelings, and taking responsibility for them without projecting them onto others, and asserting them)
- The *Empathic Responding* (Receptive) Skill (learning to listen and gain an understanding of the other person’s feelings and motives)
- The *Conversive* (Discussion-Negotiation/Engagement) Skill (learning to listen and give back a sense of understanding the meaning of what was heard; partners may switch positions between listener and speaker)

To help couples assess their preparation for marriage, David Olson and his colleagues developed the Premarital Personal and Relationship Inventory (PREPARE). This 165-item questionnaire (Olson, 1996) is designed to help couples understand and discuss their backgrounds, expectations, and areas where they might encounter difficulties. The partners’ attitudes and expectations are explored in eleven areas, including marriage expectations, communication, sexual relationship, personality differences, financial management, conflict resolution, child rearing, leisure, family and friends, marital roles, and spiritual beliefs. PREPARE has proven useful for identifying potential conflicts and promoting discussions that may head off problems in the future (Stahmann & Hiebert, 1997).

By far the most popular and widespread of the relationship enhancement programs is the *marriage encounter* weekend, first introduced in Barcelona by a Jesuit priest, Father Gabriel Calvo (Chartier, 1986). These weekend retreats, which provide support and enrichment for Catholic married couples, were imported into this country in the late 1960s and have since been widely adopted by a variety of church groups (Stahmann & Hiebert, 1997). Thousands of couples have taken advantage of these weekend enrichment programs to work on their communication, problem-solving skills, sexual intimacy, and spiritual issues. Some denominations even require couples to participate in such a program before they can be married in the church.

A more carefully researched relationship enrichment program is the Prevention and Relationship Enhancement Program (PREP), developed by Floyd, Markham, Kelly, Blumberg, and Stanley (1995) at the University of Denver. This social learning approach, developed in the 1980s, teaches communication and conflict-resolution skills, and explores attitudes and expectations about marriage. The primary goal is to help couples learn to face and resolve conflicts, and thus avoid incorporating unhealthy defensive patterns in their relationship.

PREP sessions come in two formats: weekly meetings over several weeks and marathon sessions held in a hotel over one weekend. Both versions include lectures and experiential exercises focusing on conflict management, communication, and forgiveness, as well as religious practices, recreation, and friendship. Couples learn such things as how and when to bring up conflictual subjects, how to identify hidden issues behind chronic arguments, a structured approach to problem solving, and making time for fun. Outcome results have been encouraging. Short-term gains in relationship satisfaction include improvement in communication, sexual satisfaction, and lower problem intensity. Long-term gains (at follow-up to four years) generally show sustained benefits, especially in communication (Silliman, Stanley, Coffin, Markman, & Jordan, 2002). In Table 11.2 we offer some guidelines for making relationships work.
TABLE 11.2 Critical Skills for Effective Functioning as a Couple

A. Structure
1. Accommodation
   Learn to accept and adjust to each other’s preferences and expectations, compromising on some issues, but not always giving in, so as not to build up resentment.

   *She learned to accept his wish to eat supper early, while he agreed to join her for weekly religious services. But she didn’t agree to put her career on a part-time basis; and he continued to take his yearly fishing trip with his brothers despite her hating to be left behind.*

2. Boundary Making
   Create a protective boundary around your relationship that reduces but doesn’t eliminate contact with outsiders.

   *He stopped going out three nights a week with his buddies; she started asking him if it was okay before agreeing to let her parents come for the weekend.*

   Demonstrating your commitment to your partner builds a secure base of attachment as well as confidence in the permanence of your relationship. Make sure your partner knows that you care, and that you are committed.

   *He stopped defending himself by saying “If you don’t like it, why don’t you find someone else,” because it only made her insecure and angry. She made a point of telling him who she had lunch with, because she knew his jealousy made him worry.*

B. Communication
1. Listen to and acknowledge your partner’s point of view.

   *She discovered that making a sincere effort to say things like “So you like that one better because . . .” before countering with her own opinion made him feel that she respected his point of view.*

   When it came to the most contentious issues, he discovered that asking first how she felt and then listening at length was essential. In some cases it was a good idea not even to express his side of the matter until a later time.

2. Short-circuit escalation in arguments by learning to back off before negative spirals get nasty. Call a time-out and agree to talk at a specific time later.

   *“I’m getting upset; let’s stop and talk about this tonight after supper, okay?”*

3. Avoid invalidation and put-downs.

   *“You’re so irresponsible” may be obvious but is no more invalidating than “I think you’re overreacting.” Don’t criticize your partner’s personality or deny what he or she is feeling.*

C. Problem Solving
1. Make positive requests, such as “Would you be willing . . . ?” rather than criticisms, such as “You never . . . !”

2. If you ask for something, be prepared to give something in return.
It was easier to get him to do things with her and the children if she also made a point of suggesting times when he could do some of the things he liked to do by himself. He learned that occasionally volunteering to do the shopping or cook dinner made her feel more like doing things for him—and that volunteering worked better than trying to make deals.

3. Wait until you’re not angry before bringing up a problem to be solved. Raise concerns directly but gently.

She was furious that he took her father’s side against her in an argument. But she decided not to say anything until she calmed down. The following night after supper she began by saying “Honey, I want to talk about something I’m feeling but I’m afraid to because it might make you mad.” Emphasizing that it was her feelings and saying that she was concerned about how he might react helped put him in a receptive mood.

4. Think of the two of you as a team working against the problem.

Instead of battling over his “coldness” and her “dependency,” they started talking about how they could adjust for their “different comfort levels.” As a result they planned their next vacation so that they could play golf and tennis together, and she could visit friends while he took one day off for fishing.

5. Be sure you understand your partner’s concerns before trying to work on a solution.

He was upset that she wanted to make only a minimal down payment on their new house, because it would result in large mortgage payments. To him it made more sense to put down as much as they could in order to make the monthly payments as low as possible. But instead of continuing to argue he asked her what she was worried about. Her concern turned out to be that without a cushion of savings, they might be wiped out by some unforeseen emergency. Now at least he understood how she felt.

D. Consideration

1. Do pleasing things for your partner and the relationship.

Spontaneous gestures—like compliments, hugs, little presents, calling in the middle of the day to say “I love you”—reassure your partner that you care and help to maintain a positive feeling about the relationship.

E. Fun

1. Make the effort to spend enjoyable time together, and don’t use fun activities as a time to discuss difficult issues or conflicts.

He got in the habit of inviting her to join him for a movie, a walk in the park, or a visit to the museum and then supper out on Saturdays. She learned that bringing up problems on these trips tended to spoil the mood.

Managed Care

It seems ironic that with all the exciting developments in family therapy, the most powerful influence on the field today has nothing to do with clinical theory. Managed care companies increasingly control not only access to clients but also what kinds of therapy they receive, how long they can be treated, and how much therapists are paid.

In the first wave of managed care, therapists applied to be on panels to receive referrals. Once they received a referral, they had to ask permission from a case manager for more sessions and had to justify their treatment plans. Increasingly, managed care companies are finding this micromanagement too expensive, so the second wave involves incentives for therapists themselves to reduce costs. In this second wave, therapists agree to “capitated” contracts under which they provide mental health services for a specific group at a preset annual fee. While the capitated system may discourage therapists from offering some services, at least therapists will be wrestling with their own consciences rather than with faceless strangers.

Therapists have reacted in a variety of ways. Some see managed care as a positive, or at least inevitable, correction to a situation that was out of control. They suggest that before managed care, psychotherapy was unaccountable and exploitative, with no incentive to contain runaway costs. These therapists learn how to please managed care companies and have plenty of business, even though they make less per hour. Others are trying to survive by increasing their marketing to clients who can pay out-of-pocket and by finding other ways to use their skills, such as divorce mediation; consulting to businesses, schools, and courts; teaching and leading workshops; and working in human resource departments. Still others are actively fighting the managed care tidal wave by organizing in groups that offer alternatives to managed care, by feeding the media a constant stream of managed care horror stories, and by pursuing antitrust suits.5

The final verdict on managed care isn’t in yet. While there are huge profits to be made by those who want to restrict services, there is growing dissatisfaction with those restrictions. It’s unlikely that we will return to the unrestricted days that some long for, and perhaps that’s as it should be. It is likely, however, that as consumers realize they aren’t getting the help they need, new alternatives will emerge to fill the demand, and these new alternatives will be more palatable to clients and therapists alike.

5. One such group is the National Coalition of Mental Health Professionals and Consumers (telephone: 516-424-5232).

Summary

During the past two decades, the family therapy movement ran into a series of hard-hitting critiques—from feminists, postmodernists, social constructionists, multiculturalists, and those who work with the abused, gays and lesbians, the poor, and the chronically ill. Therapists were challenged to become more collaborative; sensitive to differences in ethnicity, race,
class, gender, and sexual orientation; and interested in beliefs and values rather than just actions and interactions. The family systems expert was dethroned by the compassionate conversationalist.

This new interest in collaboration is no accident—it reflects a maturing of the field. The pioneers first encountered the family as a powerful adversary—"homeostatic," "resistant"—in part because they approached it with a built-in prejudice. Bent on rescuing "family scapegoats," they saw mothers as enemies to be overcome and fathers as peripheral figures to be ignored. Systems do resist change; but one reason family therapists encountered so much resistance was that they were too eager to change people, and too slow to understand them.

Family therapists taught us to see past individual personalities to the patterns that make them a family—an organization of interconnected lives governed by strict but unspoken rules. But in the process they created a mechanistic entity—the family system—and then set about doing battle with it. Most of the challenges that have rocked and reshaped family therapy have been in reaction to this mechanism. But if the systemic revolution went too far in one direction, the same may be true of some of its critics.

The feminist critique was the first and perhaps most influential of the challenges to family therapy's traditions. In taking a stand against mother bashing, feminists challenged the essence of systems thinking by pointing out that concepts like complementarity and circular causality can imply that subjugated women were as much to blame as their oppressors.

Family therapy's bridge to the twenty-first century was social constructionism. Much as was the case when the pioneers shifted their focus from individuals to families, this recent shift from behavior to cognition, and from challenging to collaborating, is opening up a new world of possibilities. We'll see just how exciting some of those possibilities are in the next few chapters.

Since Paul Watzlawick first brought out the constructivist implications of the MRI model in *The Invented Reality* (1984), family therapists have become increasingly aware of the power of the stories people tell themselves. As we shall see in Chapter 13, Michael White and his colleagues in the narrative movement have translated this insight into a powerful new approach to treatment. Helping clients construct new and more useful stories of their experience is surely an advance on the manipulative attempts to control and outwit them. But to the extent that narrative therapists merely substitute cognition for action and interaction, they risk ignoring all that we've learned about how family dynamics shape the lives of family members—regardless of what stories they tell themselves.

The two great values of postmodern skepticism are diversity and democracy. Surely, respecting multiple perspectives is a good thing. Two very positive expressions of this value are the rise of integrative models and a renewed respect for diverse forms of family organization. But it's not so good if we reject all norms and treat every individual as absolutely unique. This means we have no need for knowledge and no room for guidelines. Family therapists have embraced democracy by advocating nonhierarchical approaches and opposing the imposition of influence. But, as Bateson pointed out, hierarchy is inherent in nature; certainly families in treatment, like other social systems, need some kind of executive decision-making team.

The headline story of family therapy's evolution—from first- to second-order cybernetics, from MRI to solution-focused therapy, from Milan systemic to Hoffman and Goolishian, and from constructivism to social constructionism and now narrative—is what's been in the forefront of intellectual discussion. All the while these front-page developments were taking
PART THREE  ●  Recent Developments in Family Therapy

place, family therapists practicing less trendy approaches (behavioral, psychoanalytic, structural, Bowenian, and experiential) have continued their work. So it can be a mistake to think that what’s new and gets attention is the only or even major thing going on in the field.

The collaborative movement has raised new questions about the therapist’s style of leadership. When Harlene Anderson and Harry Goolishian advocated a “collaborative approach,” what was being rejected was the medical model—an authoritarian role model in which the clinician plays the expert, to whom the patient looks for answers. But being an expert doesn’t mean being an ogre. Here the advance is challenging the medical model that, ironically, was perpetuated in such avant-garde models of family therapy as the strategic and Milan systemic approaches. No longer do we see the therapist as a technocrat of change. But that doesn’t mean therapists shouldn’t be experts—leaders in the process of change.

Finally, it should be said that, just as family therapy hasn’t stood still in recent years, neither has the family. Today’s family is evolving and stressed. We’ve gone from the complementary model of the family in the 1950s to a symmetrical version—though we haven’t come to terms with the new model yet. Perhaps it’s time to ask the question: As the American family struggles through this stressful time of transition, what concepts does family therapy offer to help us understand and deal with the protean family forms of the twenty-first century?

—Recommended Readings—


References


CHAPTER 11  ●  Family Therapy in the Twenty-First Century  317


