

Chapter 1

The Development of Family Therapy

Family therapy emerged, in the years following the Second World War, as a novel means of helping people with psychiatric, emotional and relationship problems. Previously, such people's problems had generally been understood as being theirs, rather than existing in their families or wider social environments. While their family environments often appeared problematic – whether they were considered cause or effect of the subjects' difficulties – the 'solution' favoured was often to remove the patient/client from their family and local environment to a different setting. This was sometimes a psychiatric hospital or institution far removed from the subject's home and family.

The treatment of the individual sufferer, whether living at home or not, continued to be focused on the individual rather than the family group. Before the Second World War, and up to the 1950s, even the 1960s, psychoanalysis reigned supreme. The work of Sigmund Freud and of such contemporaries of his as Carl Jung and Alfred Adler was highly regarded and influenced strongly the therapeutic approach of many practitioners.

The pioneers of family therapy, on the other hand, rejected this approach. Instead, they advocated tackling the family and other environmental problems in the setting where they operated. In its day, this was a somewhat revolutionary idea.

Family therapy's early years

Family therapy was but one of the several new therapeutic approaches that emerged during the 1950s. These included a variety of new drugs, especially a range of antipsychotics and antidepressants. Chlorpromazine was the first antipsychotic to become available. It was soon followed by many others, mostly related chemically and pharmacologically to it. It is no exaggeration to say that chlorpromazine and similar compounds revolutionized the treatment of schizophrenia, a condition which the early family therapists had struggled to understand and treat effectively.

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At about the same time antidepressant drugs made their appearance. The first of these was a 'tricyclic' compound named imipramine. It was soon followed by other similar drugs. Then behaviour therapy, and its close relative, cognitive behavioural therapy, joined the throng of new treatments. As new treatments came on the scene, the shackles of psychoanalysis and other psychodynamic approaches were gradually loosened.

Despite the developing competition, the family therapy pioneers continued their studies of the *families* of individuals with schizophrenia and other mental disorders. One of the first of these was Christian Midelfort whose book *The family in psychotherapy* was published in 1957. This was followed, in 1958, by *The psychodynamics of family life*, by Nathan Ackerman, one of the foremost of the family therapy pioneers. Ackerman pointed out that while psychiatrists had 'acquired adeptness in the retroactive study of mental illness, in the minute examination of family histories . . . they (had) not yet cultivated an equivalent skill in the study of family process in the here and now' (Ackerman, 1958, p. 89). He went on to say that, by acquiring skills in working with whole family groups, we would come to add 'a new dimension to our insights into mental illness as an ongoing process that changes with time and the conditions of group adaptation'. Prophetic words indeed!

Family therapy sprung up in a variety of centres that were not initially closely connected. Each tended to be inspired and led by an, often charismatic, creative therapist. Ackerman was one of the first of these. His second book, *Treating the troubled family*, was published in 1966 and was one of the first books focusing on the treatment of 'the family as an organic whole'.

Another pioneer was John Elderkin Bell, but he did not publish descriptions of his work until the early 1960s (Bell, 1961, 1962), and his book *Family therapy* did not appear until 1975 (Bell, 1975).

During the 1950s, several groups embarked on the study of subjects suffering from schizophrenia, and their families. In 1952, Gregory Bateson obtained a grant to study communication and its different levels. He was joined in 1953 by Jay Haley and John Weakland, and by a psychiatrist, William Fry. In 1954 the group initiated a 'Project for the Study of Schizophrenia'. Don Jackson joined this group as a consultant and as the supervisor of psychotherapy with patients with schizophrenia. This group's work had a profound influence on the thinking of many family therapists. Bateson and his colleagues introduced the concept of 'double bind', discussed in a later section.

The Mental Research Institute (MRI) was founded by Don Jackson, in Palo Alto, California, in 1959. Although Jackson acted as consultant to the Bateson group, the MRI was a separate entity. It had an important role in the development of family therapy, and continued after Bateson's group disbanded in 1962.

Theodore Lidz (Lidz & Lidz, 1949) began studying the families of patients with schizophrenia at Johns Hopkins Hospital, Baltimore, in 1941, later moving to Yale University. He introduced the concepts of *schism*, the division

of the family into two antagonistic and competing groups; and *skew*, where there is one partner in the marriage who dominates the family to a striking degree, as a result of serious personality disorder in at least one of the partners.

Lyman Wynne started studying the families of schizophrenic patients while on the staff of the National Institute of Mental Health, which he joined in 1952. In 1972, he became a professor in the Department of Psychiatry at the University of Rochester, New York, and continued his studies there until his retirement. He introduced the concepts of *pseudo-mutuality* and *pseudo-hostility*.

A person in a pseudo-mutual relationship (Wynne, Ryckoff, Day, & Hirsch, 1958) tries to maintain the idea or feeling that he or she is meeting the needs of the other person, in other words, that there is a mutually complimentary relationship. Those involved in pseudo-mutual relationships are concerned with fitting together at the expense of their respective identities. Genuine mutuality, by contrast, thrives upon divergence, the partners in the relationship taking pleasure in each other's growth. In pseudo-mutuality, there is dedication only to the facade of reciprocal fulfilment, not to its actuality.

Pseudo-hostility exists when a hostile relationship is a substitute for a true, intimate relationship, which is absent. Wynne and his colleagues concluded that the families of 'potential schizophrenics' are characterized by pseudo-mutuality and consequently have rigid, unchanging role structures to which they cling, as they feel they are essential.

Wynne et al. (1958) also introduced the concept of the 'rubber fence', a psychological boundary by which family members are confined within the family system. If necessary the 'fence' can move to ensure that the members remain part of a self-sufficient social system.

Other early family therapy pioneers included Carl Whitaker and Ivan Boszormenyi-Nagy, both of whom were psychoanalytically trained but became family therapists. Boszormenyi-Nagy and his colleague, James Framo, edited the book *Intensive family therapy* (1965). Boszormenyi-Nagy founded the Eastern Pennsylvania Psychiatric Institute in Philadelphia in 1957.

Boszormenyi-Nagy, with colleagues James Framo, David Rubinstein, Geraldine Spark and Gerald Zuk, developed an approach to family therapy that paid particular attention to its multigenerational aspects. They introduced the term 'invisible loyalties', the title of a book of which Boszormenyi-Nagy was co-author (Boszormenyi-Nagy & Spark, 1973). This group believed that therapy should not be limited to the nuclear family, or to current transactions, but should also consider multigenerational linkages.

Two other pioneers were Murray Bowen and the British psychiatrist Ronald Laing. Bowen (1960) saw schizophrenia as a process requiring three generations to develop. Laing also studied the families of patients with schizophrenia. His findings concerning the first 11 patients and families were reported by Laing and Esterson (1964). He was interested in the process of

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mystification (see Laing, 1965), which he linked with the ‘six ways to drive the other person crazy’ proposed by Searles (1959).

It will be clear from the above brief summary that much of the work of the early pioneers of family therapy was devoted to the study of the processes occurring in their patients, particularly those suffering from schizophrenia. But in the matter of *therapy*, that is of relieving their patients of their symptoms or remedying the underlying causes of the symptoms, little progress was made. It was perhaps unfortunate, viewed with the benefit of hindsight, that so much attention was given to schizophrenia at the expense of other psychiatric disorders.

The 1960s

Bateson’s group disbanded in 1962, but most of the pioneers mentioned above continued their work with families during the 1960s. Despite having had psychoanalytic training, Jackson increasingly concentrated on the study and treatment of interpersonal processes. His work was reported in a series of papers, some written with John Weakland (Jackson & Weakland, 1959, 1961; Jackson, 1961, 1965). Jackson was also co-author of *Pragmatics of human communication* (Watzlawick, Beavin, & Jackson, 1967), which set out much of what had been discovered at the MRI concerning human communication, especially in families. Jackson died in 1968.

Jay Haley, originally a member of Bateson’s group, was also much influenced by the work of Milton Erickson, which he later described in *Uncommon therapy: The psychiatric techniques of Milton H. Erickson* (Haley, 1973). *Strategies of psychotherapy* (Haley, 1963) set out Haley’s early position, and a series of publications have since traced his development as one of the most creative of the fathers of family therapy (Haley, 1967, 1976, 1980, 1984).

Haley took a directive approach in treating families. He also saw many family problems as due to confused or dysfunctional hierarchies within the family. So he worked actively to get families to do something different that would help them change their dysfunctional ways of interacting.

During the 1960s, Murray Bowen expanded his work by tackling families with children who had problems other than schizophrenia. He also described what he called the *undifferentiated ego mass*, observing that in many troubled families members often lacked separate identities (Bowen, 1961).

In the mid-1960s, Bowen experienced an emotional crisis, which he came to understand as related to the process of *triangulation* in his family of origin. Triangulation occurs when a third member is drawn into the transactions between two people. Instead of communicating directly with each other the couple communicate through the triangulated third person, who may be a child. Bowen came to believe that this situation existed in his family of origin. He, therefore, returned to his family in Pennsylvania and managed to ‘detriangulate’, as he described in a paper he published anonymously (Anonymous, 1972). This is included in *Family therapy in clinical practice*.

Ackerman continued his work throughout the 1960s, and in 1961, he and Jackson co-founded *Family Process*, the first journal devoted to family therapy. He made many other contributions to the family therapy literature (Ackerman, 1961, 1966, 1970a, 1970b, 1970c). He died in 1971.

Virginia Satir joined Jackson shortly after he founded the MRI. Her book *Conjoint family therapy* (Satir, 1967) influenced many therapists. She was particularly interested in the communication of feelings in families and in the personalities and development of the individuals in the family.

Salvador Minuchin, a native of Argentina and a psychoanalytically trained psychiatrist, came to New York to work with young delinquents at the Wiltwyck School for Boys in New York City. Realizing the limitations of the current methods used to treat these boys and their families, he and his colleagues developed their own treatment methods, reported in *Families of the slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). This embodied the 'structural' approach, more fully described in *Families and family therapy* (Minuchin, 1974). It is discussed further in Chapter 5.

Minuchin also advocated the use of the one-way observation screen. Prior to its introduction, family therapists rarely watched each other working. Therapists in training were able only to report to their supervisors what they believed had happened during their therapy sessions. Family therapists opened up the process, both by being able to observe what was happening through one-way observation screens and, later, by the use of closed-circuit television and audiovisual recordings.

Although most of the early family therapists worked in the United States there were developments elsewhere. A 'family psychiatric unit' was established at the Tavistock Clinic, London, in the late 1940s. Under the direction of Dicks (1963, 1967), the staff of this unit worked mainly with marital couples who were having problems in their relationships. Another British therapist was Robin Skynner, who made two noteworthy contributions to the family therapy literature before the 1970s (Skynner, 1969a, 1969b). In Germany, family therapy had made enough progress that Horst Richter could, by 1970, publish his book *Patient familie*. This was later translated into English and published as *The family as patient* (Richter, 1974). In Montreal, Canada, Nathan Epstein led the 'family research group' at the Department of Psychiatry of the Jewish General Hospital. His team developed one of the earlier systems for describing family functioning, the 'Family Categories Schema' (Epstein, Rakoff, & Sigal, 1968).

The 1970s

Many feel that family therapy came of age in the 1970s. It was increasingly accepted in major psychiatric centres, and family therapists began to address themselves to a wider range of disorders. Many new centres for the study and development of family therapy were established and many new books appeared.

In 1971, the American Association for Marriage and Family Therapy (AAMFT) developed the first set of standards for the approval of family

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therapy training programmes. This resulted, in 1975, in formalized accreditation standards. In 1978, these were recognized by the United States Department of Health, Education, and Welfare. This was an important step in the professionalization of family therapy in the United States and Canada.

Papp (1977) edited *Family therapy: Full length case studies*, which presented the work of 12 prominent family therapists, including herself. Each contributed an account of the treatment of a family. The book provides a snapshot of family therapy in the 1970s and illustrates the diversity of approaches used by therapists at that time. Hoffman's (1981) *Foundations of family therapy: A conceptual framework for systems change* surveyed the state of family therapy as the 1970s came to an end.

The Philadelphia Child Guidance Clinic, under Salvador Minuchin's leadership, became one of the world's leading family therapy centres. The child guidance clinic was closely associated with the Children's Hospital of Philadelphia, facilitating the joint study of children with psychosomatic disorders and their families. This led to the book *Psychosomatic families: Anorexia nervosa in context* (Minuchin, Rosman, & Baker, 1978).

Jay Haley spent several years at the Philadelphia Child Guidance Clinic before going to Washington, DC, where, with his wife, Cloe Madanes, he founded the Family Institute of Washington, DC. Also established in Washington, DC, by Murray Bowen, was the Georgetown Family Center.

During the 1970s Murray Bowen continued to refine his theory, renaming the 'undifferentiated family ego mass' the 'nuclear family emotional system'. He ceased treating the families of schizophrenics, applying his methods instead to a wider range of problems. Wynne, on the other hand, continued his studies of schizophrenia and their families and built up a team of researchers at the University of Rochester (Wynne, Cromwell, & Matthysse, 1978). They also addressed the issue of the relative 'invulnerability' of some children by studying the presence of healthy communication patterns and other aspects of healthy family functioning that may coexist with disturbed family relationships.

In Canada, Nathan Epstein and his colleagues made the Department of Psychiatry at McMaster University, Hamilton, Ontario, an important centre for the practice and teaching of family therapy. With colleagues he developed, from the Family Categories Schema, the McMaster Model of Family Functioning (Epstein, Bishop, & Levin, 1978) and, later, the McMaster Model of Family Therapy (Epstein & Bishop, 1981).

The 1970s also saw important developments in Europe, especially Italy and Great Britain. In Milan, Italy, Mara Selvini Palazzoli played a major role in setting up the Institute for Family Study. This was founded in 1967 but had its main impact in the 1970s. She was one of the four psychoanalytically trained psychiatrists who became the 'Milan Group'. The others were Gianfranco Cecchin, Giuliana Prata and Luigi Boscolo. They were much influenced by the work of the Palo Alto therapists, especially Bateson, and by Watzlawick and his colleagues. They found that families often came for help, yet seemed determined to defeat the attempts of their therapists to

help them change. They proposed the term 'families in schizophrenic transaction' for such families and described them, and their treatment, in the book *Paradox and Counterparadox* (Palazzoli, Boscolo, Cecchin, & Prata, 1978; the book was originally published in Italian in 1975).

Among the contributions to family therapy made by the Milan group were their techniques of 'circular interviewing' and 'triadic questioning', whereby the therapist asks a third family member about what goes on between two others; their concept of developing hypotheses about the functioning of a family in advance of the interview and then devising questions to test the hypotheses; developing a better understanding of how the 'symptom' is connected to the 'system'; and their way of structuring each therapy session. The latter comprised a five-part 'ritual' consisting of a pre-session discussion, the interview, the inter-session discussion, the intervention and the post-session discussion.

In Rome, Maurizio Andolfi started working with families early in the 1970s and in 1974 founded the Italian Society for Family Therapy. By 1979, he was able to publish an excellent systems-based book, *Family therapy: An interactional approach* (Andolfi, 1979).

In Britain, Skynner, in 1976, published *One flesh: Separate persons* (published in the United States as *Systems of family and marital psychotherapy*). This provided a view of family therapy as seen by a British psychiatrist trained in the Kleinian School of Therapy. Important work was also being done at the Family Institute in Cardiff, Wales. The first director of this institute, Walrond-Skinner (1976), published *Family therapy: The treatment of natural systems*, a book addressed primarily to social workers. Brian Cade and Emilia Dowling were among other members of the staff of this institute who were responsible for placing it in the forefront of family work in Britain. Walrond-Skinner (1979) also edited the book *Family and marital psychotherapy*, with contributions from 11 British family therapists, giving a wide-ranging view of the British family therapy scene at that time.

Milton Erickson must be mentioned here. Erickson was not a family therapist. He was an unconventional but creative psychiatrist who made much use of hypnosis in his practice of psychotherapy. He studied hypnotic phenomena throughout his long career and published extensively on hypnotherapy. He greatly influenced Haley who wrote *Uncommon therapy: The psychiatric techniques of Milton H. Erickson* (Haley, 1973), a fascinating description of how Erickson worked.

Erickson's importance in the development of family therapy is due to his interest in the interpersonal processes in which his patients were engaged and his use of strategic and solution-focused methods of treatment. Traditional psychodynamic psychotherapy explores and aims to resolve the repressed conflicts of individuals. The objective of the family therapist is rather to get the family members to *do* something different, to interact with each other in a different way; this was how Erickson approached many of the clinical problems with which he was confronted. Moreover, he found, as family therapists have too, that telling people what to do does not always

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work. Instead indirect, or 'strategic', methods, including paradoxical ones, may be needed.

Conversations with Milton H. Erickson, MD, Volumes II and III (Haley, 1985a, 1985b), consist of transcriptions of conversations between Erickson and, in most cases, Jay Haley and John Weakland. These took place in the 1950s and early 1960s and make it clear that Erickson had by that time developed many innovative, strategic ways of helping families change. Erickson's influence on the mainstream of family therapy has mainly been indirect, however. He himself wrote little on the subject and his innovative ideas were spread mainly by those who studied with him, notably Haley and Jackson.

The 1970s also saw an explosive development of the family therapy literature. Books not so far mentioned include *Family therapy: Theory & practice* (Guerin, 1976), *The family life cycle* (Carter & McGoldrick, 1980) and the first two editions of this book (Barker, 1981, 1986). Many new journals joined *Family Process*.

The 1980s

The 1980s saw something of a *rapprochement* between the various schools of family therapy. Many of the pioneers were charismatic characters with strongly held views. So in family therapy's early days, it was hard to discern a body of knowledge which all, or even most, family therapists would accept. Increasingly, however, a middle ground was defined, if not precisely, as therapists of previously distinct schools began to accept and use the concepts and techniques of others.

New concepts and techniques also continued to emerge. These included the 'narrative' approach and the technique of 'externalizing' problems of the creative Australian therapist, Michael White (White & Epston, 1990); various cognitive approaches to treating family problems (Epstein, Schlesinger, & Dryden, 1988); and the 'systematic family therapy' of Luciano L'Abate (1986). In *Milan systemic family therapy* (Boscolo, Cecchin, Hoffman, & Penn, 1987), two of the original members of the Milan group, with Lynn Hoffman and Peggy Penn, set out a method of therapy developed from that presented in *Paradox and counterparadox* (Palazzoli et al., 1978). Minuchin's contribution in the 1980s was *Family Kaleidoscope* (Minuchin, 1984). Beautifully written, it presented this great family therapist's views of the contemporary family and how families may be helped. Another development was brief, 'solution-focused' therapy. *Patterns of brief family therapy* (de Shazer, 1982) was influential in this. It describes the work of the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin, and is presented as a 'practical integration of Milton Erickson's clinical procedures and Gregory Bateson's theory of change':

The work at BFTC owed a lot to the MRI approach as well. This book describes a quite stylized approach to therapy, employing a therapy team,

one member being the 'conductor', the person who goes into the room with the family, the others being the observers behind the one-way screen. The team, observers and conductor devise interventions, which are often tasks for the family to perform that may enable the family see their problems in a different light. In other words, the problems are 'reframed'.

In de Shazer's next book, *Keys to solution in brief therapy* (de Shazer, 1985) the distinctive solution-focused approach began to emerge. de Shazer and his colleagues devised an approach in which the characteristics of the problem were noted and 'skeleton keys' were devised as solutions for each type of problem. Soon after, the BFTC staff published an article entitled *Brief therapy: Focused solution development* (de Shazer et al., 1986). This article was not only a homage to the MRI approach (Weakland, Fisch, Watzlawick, & Bodin, 1974), but also represented a clear break from it.

The BFTC group advanced the idea, quite radical at the time, that a therapist does not need to know much about a problem in order to build solutions. One only needs to know *what the client wants*, that is, what hypothetical solutions would look like – elicited by the 'miracle question', or other similar questions. This was more fully described in de Shazer's (1988) next book, *Clues: Investigating solutions in brief therapy*.

During the 1980s, books appeared focusing on various particular aspects of family therapy such as 'transgenerational patterns' (Kramer, 1985); 'doing therapy briefly' (Fisch, Weakland, & Segal, 1982); the use of rituals (Imber-Black, Roberts, & Whiting, 1988); 'families in perpetual crisis' (Kagan & Schlosberg, 1989); and the use of family systems principles in family medicine (Glenn, 1984; Henao & Grose, 1985) and in nursing (Wright & Leahey, 1984, 2005); the families of adolescents (Mirkin & Koman, 1985); and the alcoholic family (Steinglass, Bennett, Wolin, & Reiss, 1987).

In *Expanding the limits of family therapy* (Nichols, 1987) Nichols says, on page x, 'If people were billiard balls, their interaction could be understood solely on the basis of systemic forces. The difference is that human beings interact on the basis of conscious and unconscious expectations of each other'. In advocating for the inclusion of consideration of family members' personal experience in the family therapist's thinking, Nichols takes further the ideas of Kirschner and Kirschner (1986).

1990s and the new millennium

Family therapy now has an established place among the psychotherapies. The initial enthusiasm of some has given way to a more balanced view of its place in the therapeutic scheme of things.

Steinglass (1996), writing as the journal *Family Process* entered its 35th year of publication, mentioned family therapy's 'ups and downs'. He used its approach to major mental disorders as an example. He pointed out that during the 1960s and 1970s family therapists were 'hot on the trail'

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of family factors that might cause or contribute to schizophrenia, but they largely abandoned this as evidence of genetic factors emerged. Yet during the 1990s, they were back working with patients with schizophrenia and their families, psychoeducational family therapy now being viewed as important.

Some of the assumptions made, implicitly if not overtly, during the 1960s have been questioned. For example, free and open communication within families was assumed to characterize healthy functioning. But an in-depth examination of the question of secrets in families (Imber-Black, 1993) showed that this is not a simple issue. Some secrets are 'functional' and the borderline between pathological secrecy and appropriate privacy is not always clear.

In the book *Therapy as social construction* (McNamee & Gergen, 1992), a series of writers questioned many of the traditional views of the process of therapy. The editors wrote of how they saw that there had been 'a generalized falling-out within the academic world with the traditional conception of scientific knowledge' (p. 4). The concept of the scientist, or the therapist, being the 'expert' who will solve people's problems has come to be questioned. Many now believe that solutions of many of our problems must come from within.

But family therapy theories come and go. Thus, the concept of the 'functionality' of symptoms and the behaviour of family members was popular in the early days of family therapy, but later fell into disrepute. But now it is being suggested that it may have a place and needs to be revisited (Roffman, 2005). New approaches to therapy have continued to be developed. The use of the 'reflecting team' (see Hoffman, 2002, pp. 149–168) is but one example.

During the 1990s, interest increased in the application of cognitive behavioural methods in family therapy. In *Understanding and helping families: A cognitive-behavioral approach*, Schwebel and Fine (1994) described and discussed the 'cognitive-behavioural family model' (CBF). The basis of this approach is the assumption that the 'experiences, thoughts, emotions and behaviours (of individuals) are heavily shaped by the manner in which they cognitively structure their world' (p. 30). Therapy aims 'to help participants become aware of and correct' their unhealthy cognitions.

In Chapter 3 (pp. 36–55) of their book, Schwebel and Fine describe the *family schema*. In CBF, this term describes 'all the cognitions that individuals hold about their own family life and about family life in general' (p. 50). These cognitions are 'the guidance system that directs the individual's family related behaviour' (p. 55) and may need to be a focus of attention. Since that was written, the application of cognitive behavioural techniques in family therapy has received increasing attention (Dattilio, 2005; Dattilio & Epstein, 2005).

Another development has been increased attention to spiritual issues. These have come to be seen by many as an important consideration when working with families (Hodge, 2005).

Family therapy is also being applied to an ever-widening range of family types and ethnic groups. For example, the September 2005 issue of *Contemporary Family Therapy* was devoted to *Treating Indian Families: In India and Around the World*.

Nurturing queer youth: Family therapy transformed (Fish & Harvey, 2005) addressed the issue of working with 'sexual minority youth'. The authors prefer this term or, more simply, *queer youth*, to terms such as *gay*, *lesbian*, *bisexual* and *transgendered*, because they consider the former term to be more inclusive. They point out that young people are 'coming out', to themselves, to their families and to their wider environment at ever younger ages. Fish and Harvey discuss the challenge of working with such young people and their families.

The second edition of *Family therapy in changing times*, by Gorell Barnes (2004) took a broad look at the diversity of family forms created by such things as:

- New cohabitation and marriage patterns
- The choice by some of lone parenthood
- Divorce and re-partnering
- Gay and lesbian parenting
- Migration
- Cultural diversity

The book discusses methods of working with families affected by such circumstances.

The family forms that Barnes considers are but a few of the many that exist around the world. Religious practices and cultural traditions vary enormously. For example, in the Muslim faith the sexes worship separately, whereas Christian couples can, and usually do, worship together (Hünler & Gençö, 2005). In some countries, polygamy is accepted and indeed, as this is written, King Mswati II of Swaziland has, probably, 14 wives and 23 children, though 3 is the usual maximum number of wives.

The 1990s saw the emergence of the 'post-modern' approach to therapy. This was well described in Harlene Anderson's (1997) book *Conversation, language, and possibilities*. The 'post-modernists' reject the concept of the therapist as the expert with the skills and knowledge to promote change in the family so that it becomes more 'functional'. Instead, therapy becomes a collaborative endeavour involving family and therapists as equals. Anderson (1997, p. 32) writes:

In the modern perspective therapy constitutes a dominant cultural-truth-informed, *therapist-led endeavour* and yields *therapist-determined possibilities*. These truths determine and actualize a priori, across-the-board diagnoses, goals and treatment strategies. (Anderson's italics)

Anderson (1997, Chapters 5 and 6) goes on to provide one of the clearer descriptions of the post-modern approach to therapy. No longer is the therapist 'an objective, neutral, and technical expert who is knowledgeable about

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pathology and normalcy and who can read the inner mind of a person like a text' (p. 93). By contrast, in the collaborative approach the focus 'is on a relational system and process in which client and therapist become conversational partners in the telling, inquiring, interpreting, and shaping of the narratives' (p. 95). Anderson continues:

A client brings expertise in the area of content: a client is the expert on his or her life experiences and what has brought that client into the therapy relationship. When clients are narrators of their stories, they are able to experience and recognize their own voices, power and authority. A therapist brings expertise in the area of process: a therapist is the expert in engaging and participating with a client in a dialogical process of first-person storytelling. It is as if the roles of therapist and client were reversed: *The client becomes the teacher*. A therapist takes more of an 'I am here to learn more about you from you' stance. (p. 95)

Out of such collaboration, solutions to the client's problems are expected, by the post-modern therapist, to emerge.

Lynn Hoffman is a talented writer who has been intimately involved in the family therapy scene since 1963, when she was engaged to edit Virginia Satir's *Conjoint family therapy*. In *Family therapy: An intimate history* (Hoffman, 2002) Hoffman recounts, as puts it on page xi, her 'journey from an instrumental, causal approach to family therapy to a collaborative, communal one'. The book, however, offers more than this, providing an insightful, if somewhat selective, account of the development of family from 1963 to about the year 2000.

Innovative approaches to helping those involved in troubled relationships continue to be proposed. Sue Johnson has described *emotionally focused therapy* (EFT) (Johnson, 2008). She understands many 'conflictual' relationships in terms of attachment theory. Jones (2009) provides a helpful outline of EFT.

Johnson emphasizes the role of emotional bonding in human relationships, which she considers as important in adult relationships as in those that develop between children and their parents. Jones (2009) quotes Marion Bogo: 'In EFT, you take behaviour that on the outside looks provocative, negative, and outrageous, and you reframe it in terms of a person's best efforts to get their needs for attachment met'. Johnson calls this 'the howl for connection'.

Johnson provides a fuller discussion of EFT in the book *Hold me tight* (2008), with many illustrations of this therapeutic approach.

Family therapy continues to come up with charismatic and creative therapists who offer us new ways of helping people in troubled relationships. One of these is John Gottman (Sue Johnson may be another). Gottman claims to have developed a 'revolutionary' method of helping couples. Its essence is the reinforcement of the positive aspects of a relationship. Gottman has also identified four emotional reactions which, he says, are destructive and,

therefore, may lead to divorce. These are criticism, defensiveness, stonewalling and contempt, the latter being the most important.

On the other hand, Gottman has set out seven principles in his book, *The seven principles for making marriage work* (Gottman & Silver, 2000). Gottman and his wife Dr. Julie Gottman founded the non-profit *The Relationship Research Institute* and the for-profit *Gottman Institute*, which is concerned with training therapists.

Gottman's seven principles are probably not as revolutionary as he claims. They seem, to some extent at least, to be logical extensions of previous work by other therapists and researchers. This does not invalidate them of course.

Common factors theory (Duncan, Miller, Wampold, & Hubble, 2009) has been applied to psychotherapy generally as well as to family therapy. It postulates that as there are many forms of psychotherapy that have been shown to be of benefit these are likely to have factors in common. There is vigorous debate about whether an emphasis on the *common* factors in effective therapy (*client characteristics and extra-therapeutic factors*, the *therapeutic relationship*, the therapist's *model or technique or hope and expectancy*) should be emphasized over the *specific* factors found in particular therapeutic approaches (Sexton & Ridley, 2004; Sprenkle & Blow, 2004). Discovering how to operationalize these factors, it is suggested, could lead to more effective treatment for the disorders concerned. However, the fact that two or more modes of treatment are equally effective does not necessarily mean that they have factors in common. Although there has been significant model development in this area (Davis & Piercy, 2007a; 2007b), and there is some promising research evidence (Anker, Duncan, & Sparks, 2009), more is required.

The field of family therapy is a lively one, with help being provided to many who suffer from a variety of emotional, relationship and other difficulties. At the same time, its practitioners continue to develop new treatment methods and to evaluate those in current use.

Summary

Family therapy has developed since the Second World War as a new way of dealing with the human problems that were previously addressed by individual or group psychotherapy methods. It was based on a new conceptualization of how these problems come to exist. Formerly, they were thought to be mainly the result of intrapsychic processes, or the 'psychopathology' of individuals, which was believed often to have its roots in early childhood experiences.

The family approach, by contrast, is based on the belief that these problems are related to the current interactions taking place between the individuals in the family and, sometimes, between these individuals and other social

systems. It also takes into account multigenerational and extended family factors.

Initially, family therapists worked mainly with patients suffering from schizophrenia and their families, but they have come to apply their methods to the full gamut of psychiatric disorders. In its early days, family therapy was divided quite sharply into schools of thought and practice. Over time, however, a common body of knowledge has emerged and this continues to expand. Family therapy methods are nowadays being applied to an ever-increasing number of cultural and ethnic groups and family forms.

Recent years have seen the development of 'post-modern' approaches, in which therapy is seen more as a collaborative endeavour between clients and therapist. This is in contrast with the 'modern' approach, in which the therapist plays the role of 'expert' who has the training, skills and insights to intervene so as to resolve clients' problems. Many other innovative approaches are also being proposed and tested in clinical practice and research programmes.

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