The Practice of FAMILY THERAPY

Key Elements Across Models

FIFTH EDITION

Suzanne Midori Hanna

The Practice of Family Therapy

Now in its fifth edition, *The Practice of Family Therapy* comes at a time when traditional approaches to psychotherapy have given way to multidimensional strategies that best serve the needs of diverse groups who are grappling with the many challenges unique to family therapy practice. With expanded coverage of different models, along with new developments in evidence-based and postmodern practices, this integrative textbook bridges the gap between science and systemic/relational approaches, as it guides the reader through each stage of family therapy.

Part I lays the groundwork by introducing the first-, second-, and third-generation models of family therapy, teaching the reader to integrate different elements from these models into a systemic structure of practice. Part II explores the practical application of these models, including scripts for specific interventions and rich case examples that highlight how to effectively work with diverse client populations. Students will learn how to make connections between individual symptoms and cutting-edge family practices to respond successfully to cases of substance abuse, trauma, grief, depression, suicide risk, violence, LGBTQ families, and severely mentally ill clients and their families. Also included are study guides for each model and a glossary to review main concepts.

Aligned with the Association of Marital and Family Therapy Regulatory Boards' (AMFTRB) knowledge and content statements, this textbook will be key reading for graduate students who are preparing for the national licensing exam in marriage and family therapy.

Suzanne Midori Hanna, PhD, LMFT, is a licensed marriage and family therapist with over 30 years' experience as a clinician, educator, and researcher. She is a clinical fellow and approved supervisor of the American Association for Marriage and Family Therapy (AAMFT) as well as an instructor in three graduate programs. She has also been a program developer, founding COAMFTE program director, and professor in Wisconsin, Kentucky, and California. Dr. Hanna is co-editor of *The Aging Family*, with Terry Hargrave, and author of *The Transparent Brain in Couple and Family Therapy*.

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The Practice of Family Therapy

Key Elements Across Models

Fifth Edition

Suzanne Midori Hanna

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To Masako, Joyce, Nori, Lisa, Todd, Mark, Clinton, Teruko, Junko, and Hiroki: In the midst of our generational detours, you helped me find my way back home. For your inspiration and love, domo arigato!

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Contents

List of Figures, Tables, and Boxes xv
List of Cases xvii
Preface xviii
Acknowledgments xxi
List of Abbreviations xxii

PART I How to Think Systemically 1

1 Family Therapy: The Interpersonal View 3
Prologue 4
What Is Family Therapy? 5
The Interpersonal View: Family Process, Cybernetics, and Social Ecology 6
How Did It Begin? From Freud to Minuchin 9
Why Are There So Many Models? 13
Overview of First-Generation Family Therapy 14
Structural Family Therapy 15
Organization 15
Power 16
Interactional Sequences 16
Hypotheses 16
Strategic Family Therapy 16
Systemic Meaning of Symptoms 17
Hierarchy 17
Hypotheses 17
Mental Research Institute (MRI) Model 18
Communication and Behavior 18
Anxiety 19
Hypotheses 19
Behavioral Family Therapy 19
Sequences and Reinforcements 20
Coercion Theory 20
Hypotheses 20
Psychodynamic Family Therapy 20
Past Is in the Present 21
Subjective Experience 21
Object Relations 22
Attachment 22
Hypotheses 23

Bowenian Family Therapy 23
Natural Systems 24
Eight Interlocking Concepts 24
Hypotheses 25
Contextual Family Therapy 25
Relational Ethics 26
Ledger System 26
Hypotheses 27
Experiential Family Therapy 27
The Satir Method 28
Carl Whitaker 28
Human Growth and Development 29
Hypotheses 29
So, Where Do I Start? Toward Integration 30
Organization 31
Problem-Solving 31
Emotional Climate 31
First Steps 31
Summary 32

2 The Postmodern Era and Integration 36
Constructivism and Social Construction 38
Impact of Diversity 39
Major Mental Illness and the Recovery Movement 40
Second Generation: 1970–2000 41
Solution-Focused Family Therapy 41
Narrative Family Therapy 44
Applications 49
Emotionally Focused Couple Therapy 50
Cognitive-Behavioral Couple Therapy 51
Multidimensional Family Therapy 54
Multisystemic Therapy 55
Multifamily Groups for Schizophrenia 57
MFGs and Sandy Hook 60
Applications 62
Third-Generation Emphasis on Special Populations: 2000–Present 65
Oppositional Defiant Children and Adolescents 65
Depressed and Suicidal Youth 67
Military Personnel 68
Trauma Survivors 69
Importance of Screening 70
Trauma-Sensitive Family Therapy 71
Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Families 73
Summary 75

3 Integration of Theory: Common Themes 79
Gender 82
Gender Politics and Family Therapy 83
Empowerment for Men 83

Empowerment for Women 84
Gender Balance 86
How to Focus on Gender 86
Race and Culture 88
Black Families 89
Just Therapy: The Therapy of Social Justice 90
Belonging 91
Sacredness 91
Justice 91
Simplicity 91
Liberation 92
Mrs. Obutu: An Immigrant's Dilemma 92
How to Focus on Race and Culture 93
Intergenerational Relationships 95
Development in Adulthood 95
Symptoms in Context 96
How to Focus on Intergenerational Relationships 98
Transitions and Development 100
Normative Changes 101
Adolescence 102
Midlife 102
Later Life 102
Divorce or Remarriage 105
Nonnormative Changes 106
Military Service 106
Out-of-Home Placements 107
How to Focus on Transitions and Development 107
Family Structure 108
Parent Engagement 109
How to Focus on Family Structure 110
Individual Experience 113
Attachment 115
Fairness and Entitlement 115
Belonging and Identity 116
Personal Authority and Interdependence 116
Self-Esteem and Self-Acceptance 116
How to Focus on Individual Experience 117
Cup of Coffee Intervention 117
Tracking Personal Growth 117
Awareness Wheel 118
Reframing Anger 121
Summary 121

4 Integration of Practice: Common Factors 123
Client Attributes and Extratherapeutic Factors, 40% 125
Honor the Client's Worldview 125
Reframe Resistance 126
Stages of Change 127
Motivational Interviewing 129

Guiding Style 130
Ambivalence 130
Exploring Values 130
Change Talk 131
Affirmation 131
Summarizing 131
The Therapeutic Relationship: Joining, 30% 131
Develop an Alliance 134
Highlight Family Strengths 135
Acknowledge Effort, Caring, and Intent 136
Gift Giving 136
Instilling Hope, 15% 137
Use Positive Language 137
Discover Successes 138
Emphasize Small Steps of Change 138
Explore Possibilities 139
Therapist Attributes and Approaches, 15% 140
Feedback Informed Therapy (FIT) 141
The Self of the Therapist: Attributes of Good Clinicians 142
Centered and Self-Reflective 143
Flexible 144
Therapeutic Strategy 148
Yes, But . . . 148
One Down 149
Discussion of Harvey 152
Tips for Self-Development 152
Summary 153

PART II Systemic Thinking in Action 157

5 Starting Off on the Right Foot: Referral and Intake 159
Task 1: Assess the Referral Process 161
The Politics of Referrals: Who Defines the Problem? 162
Stigma 164
Self-Referrals 164
Couple Referrals 165
Family Referrals 166
Professional Referrals 166
Mandated Referrals 168
Task 2: Describe the Problem in Relational Terms 169
Intakes: From Problem to Process 169
What Is the Problem? 170
Who Should Be Included? 173
Who Has Tried to Help? 175
Hypotheses: Use the Common Themes 176
Joining 178
Referral and Intake 179
Client Motivation 180
Family and Others 180

Hypotheses: Common Themes 180
Initial Treatment Contract 180
Discussion 181
Questions That Beginning Clinicians Often Ask 181
1. How Should I Handle the Issue of Substance Use if I Suspect It Is a Part of the Problem? 181
The Importance of an Individualized Approach 182
The CAGE 183
Trauma Screening 183
2. How Should I Deal with a Suicide Threat? 184
Explore Individual Experience 184
Explore Relational Resources 184
Safety Planning 185
3. What Should I Do If I Discover Family Violence? 186
Assess Lethality 186
Deconstruct Rage 187
4. How Should I Handle Family Secrets? Privacy vs. Secrecy 188
Summary 190

6 From Problem Definition to Treatment Plan 192
Task 3: Organize Treatment 195
Clarify the Role of the Therapist 195
Describe the Therapeutic Process 197
Task 4: Assess Individual Functioning 199
Talk the DSM Talk 199
Walk the MFT Walk 200
Task 5: Assess Relational Functioning 201
Track Interactional Sequences: The “Microscope” of Family Therapy 202
What’s in a Couple Sequence? 203
Discussion 205
Expand the System 206
Relational Hypotheses: Use Common Themes 209
Discussion and Application 211
Sample Summary for Denise 212
Task 6: Develop Shared Goals 213
Assess Level of Crisis 213
Explore Hidden Agendas 214
Set Family Goals: Where Are They Going? 215
Prioritize 216
Make Goals Concrete and Specific 216
Discussion 218
Multisystemic Goals 219
Task 7: Plan Interventions: How Will You Help Them Get There? 219
Developmentally Appropriate Practice 220
What Would You Like to Have Happen? 221
Discussion 223
Problem History 224
Compare Family Therapy Models 226

Treatment Plans 229
The Language of Managed Care 229
Recovery Models and Person-Centered Care 229
Summary 232

7 Relational Assessments as Interventions: Exploring Client Experience 234
Assessments as Intervention 235
Interactional Patterns: Content and Process 236
Temporal Patterns: Past, Present, Future 237
Genograms 238
Types of Genograms 238
Constructing Genograms 239
Circular Questioning: In Relationship to What? 243
Tracking Interactional Sequences: Facts vs. Assumptions 245
Just the Facts 246
Assumptions and Interpretations 247
Tracking Longitudinal Sequences: Narratives About Changes Over Time 247
Advantages of Timelines 249
Deconstruction: People and Experiences 251
Developing a Rationale for the Timeline 251
Creating a Sense of Movement 252
Summarizing Details 252
First Session: Intake and Initial Interview 253
Defining the Problem 253
Tracking Interactional Sequences 253
Precipitating Events 254
Goals 254
Contract 255
Data-Gathering Phase (Genogram) 255
Second Session: Tracking Longitudinal Sequences 256
Timeline 256
Marking and Discussing Time Periods 256
Comparing Life Stages 257
Using, Identifying, and Emphasizing Family Strengths 257
Third Session: A Return to the Presenting Problem 257
Cultural Issues and Family Values 257
Family Interaction and Structure 257
Transforming Assessment to Intervention Through Reframing 257
Hypotheses 259
Gender, Race, Culture 259
Intergenerational 259
Transitions 260
Family Structure 260
Individual Experience 260
Interventions 260
Discussion 261
The Process of Change 264
Summary 264

8 Biopsychosocial Interventions in the Real World **266**
Managing In-Session Process 267
Focusing 268
Increasing Intensity 269
Marking Boundaries 270
Unbalancing 271
Making the Covert Overt 272
Reconstructing Belief Systems 273
Identifying Current Belief Systems 273
Reframing the Meaning of Symptoms 274
Stressing Complementarity 275
Using Metaphors 276
Experimenting with New Behaviors 279
Generating Alternative Solutions 279
Resolving Conflict 280
Coaching Communication 281
Modeling 281
Instruction 282
Practice 283
Feedback 283
Assigning Tasks 284
Developing Rituals 285
Introducing Paradox 287
Discovering Hidden Emotions 288
Validating Attachment Patterns 289
Introducing Attachment Needs 289
Promoting Acceptance of Attachment Needs 289
Inviting Responsiveness to Attachment Needs 290
Enacting Attachment Dialogs 290
Balancing the Nervous System 291
Stress Physiology 292
Survival First 293
Trauma Therapy: Restoring the Basics 294
Social Engagement 294
Orienting 294
Anchoring Safety in the Body 295
Grounding and Resourcing 296
Restoring Defensive Movements 297
Summary 298

9 Advanced Strategies **300**
Interventions for Children 301
Behavior Management 302
Parent Training 302
Emotional First Aid for Children 305
Games for Symptoms 305
Art Interventions 307
Understanding Expressive Communication 308
Developmentally Appropriate Practice 310

Accessing Relationships Through the Creative Process 310
Activities for Traumatic Injuries 312
Trauma Healing 314
Military Trauma 314
Childhood Abuse 317
Resources for Trauma Healing 319
Unresolved Grief and Loss 321
Operational Mourning 321
Reclaiming Relationships 322
Memorials 323
Health-Care Interventions 324
Guidelines for Chronic Illnesses 325
End-of-Life Care 326
Network Therapy: Who Is the Client? 328
The Teacher 329
The Probation Officer 331
The Multidisciplinary Team 332
Summary 333
Epilogue 335

Appendices **339**

Appendix A: Sandy Hook 341
A.1 Timeline: Peter, Nancy, Ryan, Adam 341
A.2 Sandy Hook Emails 343
A.3 Sandy Hook Government Report Excerpts 345
Appendix B: Online Resources 350
Appendix C: Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) 352
Appendix D: Adverse Childhood Experience (ACE) Questionnaire 354
Appendix E: Ethics At-Risk Test for Marriage and Family Therapists (MFTs) 356
Appendix F: Questions to Assess Violence 358
Appendix G: A Family Suicide Watch 360
Appendix H: Sample Treatment Plans 362
Appendix I: Teacher Consultation 369
I.1 Teacher Consultation: Functional Analysis 369
I.2 Behavior Management Plan 370
Appendix J: Emotional First Aid for Children 372
Appendix K: Daddy and Granddaddy: A Teen's Resolution of Family Suicides 374
Appendix L: Films of Interest to Students of Family Therapy 382
Appendix M: Structural Family Therapy Mapping 387

Glossary 388
References 397
Subject Index 410

Figures, Tables, and Boxes

Figures

1.1	The Nelsons' Genogram	14
2.1	Jerry's Genogram	47
3.1	Amish Family Genogram	112
3.2	Awareness Wheel	119
5.1	Ellie's Genogram	179
6.1	Genogram of Denise's Extended-Family Network	210
7.1	Genogram Depicting Issues of Race, Culture, Loss	240
7.2	Timeline of Randy and Betty	250
7.3	Genogram of the Wilsons	253
7.4	Timeline of the Wilsons	254
7.5	Ellie's History	262

Tables

1.1	Historical Contributions of Early Therapists	12
1.2	First-Generation Models of Family Therapy	34
2.1	Sample Solution-Focused Sequence	43
2.2	Sample Narrative Sequence	45
2.3	Narrative Focus Upon Strengths	46
2.4	EFT Treatment Process	52
2.5	Basic Tasks in MDFT	55
2.6	MST Principles	56
2.7	Second-Generation Family Therapy	76
3.1	Circular Questions	110

5.1 From Problem to Process 170
6.1 Model Comparisons 227
6.2 Matching Direct and Indirect Interventions to Problem Severity 228
7.1 Circular Questions and Guidelines for Genograms 242
8.1 Four Stages of Enactments 291
9.1 Chapman Art Therapy Treatment Intervention (CATTI) 313
9.2 Common Attitudes Taken by Parents and Teachers 329

Boxes

3.1 Questions for the Assessment of Racial and Cultural Factors 94
3.2 Questions for Developmental Interviews 102
3.3 Questions for Divorced and Remarried Families 105
3.4 Common Themes Worksheet 122
4.1 Stages of Change 128
4.2 MST Adherence Scale 140
6.1 From Referral to Treatment Plan 194
6.2 Negotiating the Process of Therapy 197
6.3 Tracking Sequences 202
6.4 Common Themes Worksheet – Denise 212
6.5 Treatment Plan Format 230
6.6 Managed Care Interventions 230
7.1 Common Themes Worksheet – Wilsons 258
8.1 The Metaphor Game 277
9.1 Steps to Individual Behavior Management 302
9.2 Monster-Taming Summary 306
9.3 Desired Outcomes in Art Therapy 309
9.4 Instructions for Kinetic Family Drawing 311
9.5 Agenda – Team Meeting 332

Cases

Case 1.1 Lee	4
Case 1.2 The Nelsons	15
Case 2.1 Jerry, a Gay Man	47
Case 2.2 Missed Opportunities at Sandy Hook	61
Case 3.1 Ghosts in Donna's Depression	97
Case 3.2 Helen's Healing from Allen's Murder-Suicide	99
Case 3.3 An Amish Family Regroups	111
Case 4.1 A Therapist's Experiment	145
Case 4.2 Harvey	151
Case 5.1 Frank, a Man in Transition	177
Case 5.2 Ellie and the System	178
Case 6.1 Dick and Jane Dissect Conflict	204
Case 6.2 Denise and Her HIV	209
Case 6.3 Mrs. Burns and Her Goals	217
Case 6.4 Empty Nest Dilemmas	222
Case 7.1 Lewis and Sheila at a Crossroads	248
Case 7.2 Randy and Betty	249
Case 7.3 The Wilsons	252
Case 7.4 A Return to Ellie and the System	262
Case 9.1 Sara and Stealing	304
Case 9.2 Ray and the Lunchroom	311
Case 9.3 Dan and Pearl	315
Case 9.4 Sherena Taking Back Control	318
Case 9.5 Lee's Memorial Service	324
Case 9.6 A Return to Harvey	327
Case 9.7 Gary, the Star Gazer	331

Preface

The world of family therapists has changed dramatically in the past ten years. If you had told me then that my students today, in their first semester of practicum, would have clients who needed help with gender reassignment, or perhaps, their clients were hearing voices as they entered the therapy room, I would wonder, "How is this possible at such an early point in their career?" If you had told me then that they would work with those recovering from the murder-suicide of a loved one, or with four sexually reactive foster siblings who were doing everything they could to stay together, I would have welcomed the chance to share similar experiences from my caseload. The truth is, my students are seeing very complex cases, and so am I.

Every week, I think about how I can help them provide cutting-edge service to those who have the greatest needs. I approached this book thinking about my excellent students who do some amazing work with amazing clients, even before they are licensed! So, welcome to the "real world" of family therapy practice. Those who have a passion for systemic practice find some inspiring ways to make a difference. With that as the main goal of this fifth edition, I hope you'll come with me behind the one-way mirror of home-based therapy, couple therapy for trauma survivors, and family therapy with families who have an undocumented member. Some are war-torn as they return from Iraq. Others will make you laugh. All want better relationships, and they bring their hopes and dreams with them when they walk in the door. Even mandated clients inspire us.

So, this edition continues to teach the basics and to visit each model of family therapy like it was an old friend, reminiscing about the past and catching up on the latest developments. In addition, you are invited to have a bird's-eye view of how our clinical work can take key elements of our theory and practice and weave them into a tapestry of hope and creativity for each family. There are 23 case studies and over 20 dialogs to help you feel like you're behind a one-way mirror.

When first-generation family therapists stepped in front of that one-way mirror, they had all the hope and creativity in the world. So, in Chapters 1 and 2, we'll follow their footsteps from first- to second- and third-generation family therapists. Then, in Chapters 3 and 4, we'll see how key elements from these models turn into common themes and common factors that help beginning practitioners find their way amid the smorgasbord of ideas that exists. These four chapters help practitioners to think systemically and to use an interpersonal lens to make sense of each case.

Then, Chapters 5 to 9 provide numerous applications of systemic thinking in the real world. As readers walk through family therapy practice from referrals, intakes, treatment planning, and

intervention, they will meet many of the clients I have just described. In addition, they will see how systemic/relational practice ultimately brings out the humanity of clients and therapists alike.

What's New?

There is an expanded coverage of our models with an eye toward some of their latest applications. For example, narrative family therapy has always focused on oppression, and many people want to know more about "just therapy," the therapy of social justice from New Zealand. In addition, structural, strategic family therapists have some novel ways of approaching oppositional defiant disorder. There are expanded sections on how to approach substance abuse, suicide risk, violence, family secrets, and LGBTQ families. All practitioners can benefit from a roadmap that prepares them for life-threatening risks. In addition, our military deserve practitioners who can think systemically, including how the nervous system fits into the family without stigmatizing the service member, and there are somatic exercises in three chapters that are good for all members of the family.

There is a special section on work with seriously mentally ill clients and their families. Applying a systemic/relational perspective to the tragic school shooting at Sandy Hook illustrates how family therapists can play a larger role in the prevention of violence in our communities. There are relevant risk assessments that compensate for the inability of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) to adequately screen those who are at risk. Chapter 6 spends more time on Bertram's (2001) suggestion that we must "talk the DSM talk," and "walk the MFT walk." Paired with motivational interviewing skills and a desire to look for the context behind the diagnosis, family therapists will find some ways to bridge these cultures.

Chapter 9 highlights new material on narrative approaches to unresolved grief, art therapy approaches to trauma, and a section on children's issues and behavior problems. My students seem to need the practical skills that come from this chapter when specific models fall short. In addition, there are expanded case examples that help to organize couple therapy by taking a case step by step through tracking sequences and changing behaviors.

Last but not least, it's time to help our students orient to the national licensing exam. The Association of Marital and Family Therapy Regulatory Boards (AMFTRB) has knowledge and content statements that help our beginning practitioners study for the exam. These items begin each chapter as a way of helping readers connect the dots between their study and practice while in school, and the world of licensing that takes a wide view of the field. For this purpose, there are updated tables that summarize the distinguishing features of all models, even one that pairs our models with the language of managed care to help with treatment plans.

What Stays the Same?

I make the assumption that beginning students often want suggestions as to what to say or where to start, so each chapter contains many sample questions a therapist can ask, dialogs between the therapist and client, and corresponding commentaries. The result is a mosaic of basic skills that form the core of many current mainstream approaches with families. As

students proceed through each chapter, they are given rationales for how the strengths from these varied approaches can be most useful during different stages in therapy, for different cases, and in different settings.

The approach in this book views problems as embedded in multiple relationships that evolve through many transitions. The importance of interpersonal and intrapersonal dynamics is illustrated in presenting problems, and strategies for tracking historical and day-to-day sequences of interaction with genograms and timelines are woven throughout the chapters. The theory of change in this work is strength-based and client-centered, drawing from those approaches that maximize the therapeutic alliance and realistically address the nature and history of a problem by using the resources that every family brings into the room.

Acknowledgments

I am so grateful to my editors and their staff at Routledge for talented guidance during the production of this edition: Elizabeth Graber provided the initial encouragement that validated my vision for this edition. George Zimmar (now retired), Clare Ashworth, and Nina Guttapalle have given me invaluable guidance during each stage of the process. I'm particularly grateful for their insights and planning that kept me on track and in touch with how to produce a high-quality product. Our production editor Jashnie Jabson and the copyeditor from Bookbright Media have been excellent sleuths in attending to all the final details so that our readers have an excellent experience. Many, many, thanks to a wonderful team!

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Abbreviations

AAMFT	American Association for Marriage and Family Therapy
AATA	American Art Therapy Association
ABFT	Attachment-Based Family Therapy
ACE	adverse childhood experience
ACOA	adult children of alcoholics
ACT	assertive community treatment
AMFTRB	Association of Marital and Family Therapy Regulatory Boards
APA	American Psychiatric Association
APRN	Advanced Practice Registered Nurse
ARISE	a relational intervention sequence for engagement
ATR-BC	a registered art therapist who is board certified
BPD	borderline personality disorder
CACREP	Council for Accreditation of Counseling and Related Programs
CAGE	cut down, annoyed you, guilty, eye opener
CATTI	Chapman Art Therapy Treatment Intervention
CBCT	cognitive-behavioral couple therapy
CBT	cognitive-behavioral therapy
CO	concerned others
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
CPS	Child Protective Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUDIT-E	Drug Use Disorders Identification Test – Extended
DUI	driving under the influence (traffic violation)
EE	expressed emotion
EFT	emotionally focused couple therapy
ESSFT	evolving structural strategic family therapy
ETC	expressive therapies continuum
FACT	family-assisted assertive community treatment
FAP	Family Acceptance Project™
FBI	Federal Bureau of Investigation
FIT	feedback informed therapy
GARF	Global Assessment of Relationship Functioning
ICD	International Statistical Classification of Diseases and Related Health Problems
KFD	kinetic family drawing (a common art intervention)
LGBTQ	lesbian, gay, bisexual, transgender, and questioning (community)
LMFT	licensed marriage and family therapist
MDFT	multidimensional family therapy

MFG	multifamily groups (for schizophrenia)
MFT	marriage and family therapy
MI	motivational interviewing
MRI	Mental Research Institute
MST	multisystemic therapy
NIMH	National Institute of Mental Health
ODD	oppositional defiant disorder
ODD-JI	oppositional defiant disorder–justice injury
PCL-C	Post-Traumatic Stress Disorder Checklist – Civilian
PCL-M&C	Post-Traumatic Stress Disorder Checklists – Military and Civilian
PHQ-9	patient health questionnaire
PTSD	post-traumatic stress disorder
TBI	traumatic brain injury
TFT	transitional family therapy
YCSC	Yale Child Study Center

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PART I

How to Think Systemically

As a revolution of thinking and practice in mental health treatment, family therapy is known for its historic emphasis on family relationships, systems theory, and social context. At the time, mental health treatment was emerging as a societal phenomenon in post-war America with newfound services cloaked in psychoanalytic thought and medical practice. One person at a time, psychological problems were laid bare on the couch. Meanwhile, there were those embedded in this landscape who thought about how families provided a context for understanding these problems. Families might be part of the problem and part of the solution. One family at a time, people sat up on the couch! When those pioneers finally burst onto a national stage and found each other, marital and family therapy was here to stay.

Part I is a three-generational family reunion beginning with first-generation contributions from 1940 to 1970, reviewing the transitions made in the second generation from 1970 to 2000 and celebrating new developments in the third generation from 2000 up to the present. This reunion appears in Chapters 1 and 2. They tell the story and introduce the ideas that make this family an enduring tribe of professionals who believe in the capacity of family and intimate relationships to improve the human condition.

This tribe has its identity and customs. In a family reunion, everyone may come with their dyed hair and tattoos of individuality. But, as Chapter 3 will show, once we embrace those differences, everyone comes together around common themes that reveal our systemic thinking and our values. After all, family is family. Learning to think systemically is the work of generations, handing down thoughts of communication and intimacy, human growth and development, equity, justice, and belonging. We even have dirty words, and all are instructed to avoid them. Terms like resistance, manipulation, and pathology give way to uniqueness, creativity, and wound healing.

Then, when the going gets rough, we all pitch in. This reunion will have a barn-raising. We put our traditions to work. Chapter 4 illustrates those common practices that happen, regardless of the setting, client, or type of problem. No problem is too big for this tribe, and all understand that what binds us together is our ability to deliver strength-based, relationship-centered services to a wide range of people who need flexibility, validation, and hope in a deficit-prone mental health system. We all speak the language of potential and develop healing relationships with our clients that empower them to think more highly of themselves.

In the end, we have our language, rituals, and traditions. On the street, we recognize our brothers and sisters when they talk of joining, empowering, and celebrating our clients' talents. We wink at each other when the discussion is about how family members can be recruited as part of our team. We party together when one more family launches their children after overcoming trauma, war, and poverty. Welcome to this tribe of systemic thinkers! Because relationships are a matter of life and death, we hope you will also find this revolution contagious.

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CHAPTER 1

Family Therapy: The Interpersonal View

Chapter Outline

Prologue 4
What Is Family Therapy? 5
The Interpersonal View: Family Process, Cybernetics, and Social Ecology 6
How Did It Begin? From Freud to Minuchin 9
Why Are There So Many Models? 13
Overview of First-Generation Family Therapy 14
Structural Family Therapy 15
Organization 15
Power 16
Interactional Sequences 16
Hypotheses 16
Strategic Family Therapy 16
Systemic Meaning of Symptoms 17
Hierarchy 17
Hypotheses 17
Mental Research Institute (MRI) Model 18
Communication and Behavior 18
Anxiety 19
Hypotheses 19
Behavioral Family Therapy 19
Sequences and Reinforcements 20
Coercion Theory 20
Hypotheses 20
Psychodynamic Family Therapy 20
Past Is in the Present 21
Subjective Experience 21
Object Relations 22
Attachment 22
Hypotheses 23
Bowenian Family Therapy 23
Natural Systems 24
Eight Interlocking Concepts 24
Hypotheses 25
Contextual Family Therapy 25
Relational Ethics 26
Ledger System 26
Hypotheses 27

Experiential Family Therapy 27
The Satir Method 28
Carl Whitaker 28
Human Growth and Development 29
Hypotheses 29
So, Where Do I Start? Toward Integration 30
Organization 31
Problem-Solving 31
Emotional Climate 31
First Steps 31
Summary 32

AMFTRB Knowledge

01. Foundations of marital, couple, and family therapy
02. Models of marital, couple, and family therapy
03. Development and evolution of the field of marital and family therapy
06. General Systems Theory
11. Impact of couple dynamics on the system
13. Family homeostasis as it relates to problem formation and maintenance

AMFTRB Content

02.02 Assess client's verbal and nonverbal communication to develop hypotheses about relationship patterns.
02.03 Identify boundaries, roles, rules, alliances, coalitions, and hierarchies by observing interactional patterns within the system.
02.04 Assess the dynamics/processes/interactional patterns to determine client system functionality.
02.09 Identify client's attempts to resolve the presenting issue(s).
03.10 Determine sequence of treatment and identify which member(s) of the client system will be involved in specific tasks and stages.

PROLOGUE

Case 1.1: Lee

I first meet Lee on a hot August afternoon, when he walks into a community agency, breathless, wide-eyed, dripping with sweat. Holding a brown paper bag, he is a tall man in a tank top with tattoos that show through the freckles on his muscular arms.

LEE: The man at the Dollar store said I should come over here for some help.
SECRETARY: Would you like an appointment, sir?
LEE: (Impatient and angry) No! I'm here to get some help!

The secretary summons myself (SMH), an Asian middle-aged female, and a colleague (BG), a white male with a ponytail and Levi jeans from an adjoining conference room. We usher him in.

SMH: (Motions into the doorway) Hi. Why don't you come in here? It's hot out there, isn't it? We can talk in here . . .

Agitated, he enters and stands at the head of a table while we sit.

SMH: Can we help you?
LEE: (Sarcastically) No. You can't help me. You can entertain me, but you can't help me!
SMH: OK. So . . . we can go with that (glances at my colleague).
BG: Yeah. Are you thinking a little tap dance? I can do that for you (taps his foot).
SMH: We're used to entertaining people. Sometimes, that's the place to start. Sounds like you've got a lot on your mind.
LEE: (Grumbling) Yeah, you guys don't know shit about what's on my mind!
SMH: You're right. We don't. A lot of times, therapists just shoot in the dark, don't they?
LEE: (Scoffs) You got that right! M____F____s act so smart . . .
SMH: So true. We don't know your shit. What kind of shit you got goin' on?
LEE: My baby died! Her mama killed her! They throw'd me in jail when I was up there before. She got to pay for what she did!
SMH: (Sincerely, shaking her head) I'm so sorry . . . so sorry . . . Damn! That sounds like a tough spot!
LEE: You got that right! (He reaches in his sack, pulls out a hamburger, and sits down.)

What Is Family Therapy?

Was this initial encounter with Lee family therapy? Perhaps all is in the eye of the beholder. The therapists were family therapists. We would draw upon our family therapy training in interaction analysis as we worked with Lee. We would also draw upon our humanity and life experience. As this book tells the entire story of Lee and his encounters with family therapists and decades of other mental health professionals, a picture emerges that shows the unique, unconventional traditions of family therapy practice and why these are a good fit for him. Currently, family therapy is a mainstream, empowering approach to the problems of mental health for individual, couple and family functioning. However, at the beginning, the pioneers appeared to be rogue professionals or outsiders who were challenging sacred traditions. How did they do this?

First, there was a decision to "think outside the box." What began as thoughtful observations outside tradition became a rebellion against psychoanalysis, an individual view of problems, and medicalized language. In many ways, Lee was also rebelling against conventional mental health services as he had known them.

Next, family therapy pioneers focused on the politics of language and communication. With Lee, therapists attended to the political and relational aspects of his language and theirs. A dance began as we adopted and explored his language. We resonated with his nonverbal distress and validated the unspoken messages he sent ("Professionals don't understand me. Why should I have respect for them?"). We embraced and explored the meaning behind "entertain me." We also sympathized with his tragedy and validated his distrust of an institutionalized society.

Lee poses unique challenges because he is homeless and has suffered multiple traumas. Many clinicians overlook the traumas of people in poverty (Mani, Mullainathan, Shafir, & Zhao, 2013; Merling, 2013; Mullainathan & Shafir, 2013). How does family therapy address

these issues? Most survivors of trauma have needs for safety that appear to others as extreme measures of control. Nonverbally, Lee was speaking volumes ("Professionals are hopeless. How can I trust you? Show me what you've got. I'm in crisis!"). By exploring the meanings of "entertain me," a nonverbal message was sent to Lee. "We can work with you on your terms. We see you have gotten a bad rap." These messages came through a calm, inquisitive, and sympathetic demeanor.

Those careful, minute-by-minute responses are rooted in the history of family therapy practice (Ruesch & Bateson, 1951). Important communication is often implied and more powerful than words. The verbal level (report) is the content of a message. The nonverbal level (command) is the implied expectation for that relationship. Lee was telling them what happened to him (report) and how he wanted to be treated (command). As a first step in the therapist–client relationship, each party exchanged information and expectations. As this family therapy dance continued, the relationship expanded to include additional aspects of an interpersonal approach.

The Interpersonal View: Family Process, Cybernetics, and Social Ecology

In family therapy, context is everything. What is the context of a certain behavior or problem? Initially, pioneers turned to family process as the context and used the field of **cybernetics** as a lens for exploration. These ideas were about communication and control in human systems. All behavior is communication (Watzlawick, Beavin, & Jackson, 1967). This interpersonal view explores these questions:

1. What ***interaction patterns*** surround the problem?
2. Are there ***repeating cycles*** of communication?
3. How do people ***talk*** about it?
4. How do we ***treat each other*** when the problem is occurring (behavior)?
5. Are there ***politics*** in a family that involve different ***opinions*** about the problem (meaning)?
6. How do these opinions ***affect*** those who are needing help (outcome)?
7. ***How long*** have people held these opinions? When did they begin (development)?

At first, Lee communicated his distress nonverbally with voice tone and labored breathing. Reading those signals was an important step. When the receptionist responded with a routine, business-like question, Lee showed more distress. The communication didn't fit his developmental level. The receptionist may have read his nonverbal messages, but she did not respond to them. It would have been helpful if this had been the sequence:

SECRETARY: Hi, how are you today? It's hot out there, isn't it? What brings you here?
LEE: The man at the Dollar Store said I should come over here for some help.
SECRETARY: Did he say what type of help he thought you should have?
LEE: No. I was tellin' him about my problems and he said to come over here and talk with somebody right away.
SECRETARY: OK. It looks like you're having a tough time – let me see who is free right now.

These details may seem small, but for family therapists, success begins with attention to small bits of communication and the action that follows. What type of help did he need? One client

sent her therapist a postcard that read, "If you could only hear what I cannot say." Family therapists decipher and look for ways to respond to unspoken messages until clients feel settled enough for verbal communication. One pioneer might say to clients, "Don't trust me, yet" (Watzlawick, Weakland, & Fisch, 1974). Trust is a process that happens over time. Rather than expecting clients to trust them at the outset of therapy, clinicians can acknowledge the lack of safety inherent in a new relationship. This is especially important for trauma survivors. The content of the statement is relational (trust), and the implied expectation for the relationship respects the uncertainty of it (not "yet"). Such realistic messages provide safety for survivors.

As therapist–client interaction begins to fit, there are signs of relaxation. Lee sits down and eats. His emotional crises provide a good opportunity for therapists to express their sympathy and humanity. This is not the time to conduct business. Problem-solving should come after a bond is established. Lee feels hopeless, but he sees some people who seem to care. He watches them closely. So far, they can handle his "shit" without anxiety. They provide him with emotional first aid. They do not act like other practitioners. Cybernetics explores **feedback loops** or cycles of interaction that form a pattern. So far, these loops seem satisfactory to Lee. They do not result in shame, criticism, or distance.

LEE: (eating his burger) I called the district attorney, and they said they can't press charges. Son of a bitch's been bought off by her mama. Oh yes! I know it! She's got her connections to the system, and she's gonna get her little girl off. It ain't right. They tested her breath. Don't tell me she wasn't drunk when she rolled over on my baby. She had all kinds of DUI's (shakes his head) . . . shit . . .

BG: That sucks, man. Is this someone you're with now?

LEE: Hell no! I had to get outta there before the cops locked me up again. I shoulda never gotten with her. She came on to me, and I believed her. I shoulda listened to my friends. They told me she was no good.

SMH: Was this here?

LEE: Nah, nah. Over in ________.

BG: That's a long way from here. How'd you get over there?

LEE: My friend from jail said I should come visit. I couldn't stand my mother's house and Granny's got Alzheimer's. I went over there and stayed a few years, then things went bad, you know? I had to do somethin' . . .

SMH: You said your Granny has Alzheimer's?

LEE: Yeah. It sucks, ya know? She's OK sometimes . . . but she got poop all over, and she won't let go of her cats and dogs. Man, it's bad in there. She won't let us do nothin' . . .

SMH: Do you live with her?

LEE: I'm not s'pose to be with her. They say I ain't allowed 'cause of my felony, but she lets me be there.

SMH: I've worked with people who have Alzheimer's. It's tough on family members. I bet it's tough on you. You got any help? There's people who can help, you know?

LEE: I don't know . . . nothin' much gets through to her . . .

SMH: Here's my card, in case you want to check your options . . . I wish I could help her in some way . . .

LEE: (abruptly stands up) I got to go. I can't handle all this stuff. I need some beer. Man, nothin's gonna help . . . My baby's gone. Shit!

SMH: Oh, uh . . . what about talking a little more about your baby?

LEE: (shaking his head) Nah, nah. I'm outta here. I just need to find me some beer . . .

SMH: OK. Let us know if you want to talk again. We'll be here.

Three days later, Lee leaves a voicemail: "Can you help my Granny?"

What may have seemed like a side issue became an entry point for helping Lee with his grief and injustices. This encounter raises many questions. Why ask about Granny instead of staying with Lee's grief? How did he end up in jail? Is he telling the truth? Why not make a follow-up appointment?

Granny seemed to be a relational resource. One way to help Lee with his grief is to explore the people who may be resources in his healing and offer them support. These relationships are at the center of family therapy practice. Answers to the other questions would emerge in other sessions but were not relevant to developing an alliance. The focus on his language and relationships was of primary importance to understand his world view.

In the meantime, his opening message still hangs in the air. "You can't help me. You can entertain me, but you can't help me." This is a message about his hopelessness for the relationship, but he provides many nonverbal clues to his real longings and motivations. At this stage in the process, therapists work on trust-earning and engagement. We follow his lead. As the dance continues, verbal messages focus on Lee's relationships, such as his ex-girlfriend and Granny.

As the conversation continues, his angry demeanor and heartfelt narrative raise other questions. Can we help him? Is he mentally ill? Is he dangerous? Do we have the skills to provide appropriate treatment? Some of these questions are based on stereotype and bias. Managing the **self of the therapist** is an important part of practice (see Chapter 4). By taking a personal inventory and laying aside these biases, practitioners can form important alliances with people outside their immediate culture. As this happens and we take Lee at face value, answers to these questions emerge. His humanity shines brightly as he describes his relationship with Granny. Taking an interest in this side of his life proves to be beneficial.

Regarding Lee's cultural context, pioneers in family therapy do not report on work with homeless, mentally ill men. Now, practitioners see a larger context outside the family. **Social ecology** refers to the quality and health of the human environment as a web of relationships inside and around the family (Bronfenbrenner, 1979). This framework examines the health of the family and community on behalf of each child. It examines the resources that parents and spouses need for their well-being. What are Lee's resources? How can we use them?

Ecosystemic family therapy approaches address social justice issues, community resources, and extended-family dynamics alongside the intimate cybernetic dynamics that create secure attachments (Liddle & Schwartz, 2002). Lee will benefit from this broad focus, because he has an extensive social network and he has been the target of cultural and gender discrimination (low income, rural, white male). However, the first step involves engagement skills in cybernetics, communication analysis, and systems thinking about his relationships. Chapter 2 continues with additional information about his therapy.

An ecosystemic map helps therapists to individualize treatment and grasp the severity of Lee's situation. It contains a three-generational family diagram, a list of his friends, and a timeline depicting his life story (Chapter 7). These visual maps help his prefrontal cortex to stay focused on the immediate process in sessions. Born into a devoutly religious family, he was once a "good church boy" who taught himself how to read the "big words that rich people use." They told him he was smart. For a while, he got good grades in school. Now, at age 39, he had tumbled down a road that involved moving from the country to the city, his parents' divorce, mother's mental illness, victimization from neighborhood bullies, prostitution, drug dealing, domestic violence, incarceration, and brain injury. During the 18 months of his treatment, the voices of family therapy approaches in this book emerge as consultants. They join the voices of family

members who participate in the work with Lee. This flexibility keeps the process on his terms and not bound by a narrow model. Not all of Lee's goals are achieved, but he never misses a session. And, as he meets some milestones and makes some transitions, it is clear there is much more to this man than meets the eye.

Thus, cybernetics, family process, and social ecology give family therapy approaches a range of motion that brings forth an understanding of all clients on their terms. How does this behavior make sense? The answer is embedded in an interactional, developmental, and ecosystemic context. These three elements comprise a framework called "systemic thinking." This is a shorthand phrase for **general systems theory**, the umbrella that brings these ideas out of psychoanalytic traditions and into an interpersonal world view (von Bertalanffy, 1949). It takes a bird's-eye view of all important relationships and suggests that connections between "parts," such as biology, family members, neighbors, therapists, police, etc., provide a map of relationships relevant to any given symptom or problem. In working with Lee, it is important to keep the big picture in mind, because his pain comes from many directions. His behavior and language make perfect sense, once we understand his life story as a system of relationships. When the view expands beyond the individual to a system, solutions and resources also expand. Although systemic thinking is not new, a brief history of how family therapy emerged will illustrate the radical shift in mental health and social services that emerged from a rebellion of visionaries who wanted to lessen the suffering of others.

How Did It Begin? From Freud to Minuchin

There are some interesting parallels between the development of psychoanalysis by Sigmund Freud and that of family therapy. In his day, Freud rebelled against mainstream medical practice, too. Ironically, once psychoanalysis became part of medical practice, family therapists rebelled against mainstream psychoanalytic practice. Progress, it seems, often comes from rebellion. To place these developments in context, when Freud was born in 1856, there were no automobiles or telephones. For the treatment of "hysteria," doctors performed hysterectomies. He made just one visit to America in 1909 and abandoned the hope of psychoanalysis as a cure by the time of his death in 1939 at age 83. Instead, Freud preferred psychoanalytic theory as an explanation of human behavior and personality (McCall, 1954). However, the American public fell in love with his mode of treatment, much to the early chagrin of the psychological establishment, who were behaviorists (Benjamin, 2009). Something resonated beyond the expertise of these scientific experts. For his time and place, Freud's suggestion that the inner world of a person related to medical and emotional symptoms was revolutionary.

There were also those who expanded on Freud's fundamental belief in the importance of childhood experiences. As he was breaking away from the traditions of European medicine, his inner circle was breaking away from him. They began to study family relationships from many developmental perspectives. With Alfred Adler in 1911, the point of departure was a focus on how **social environment** influenced personality (Adler, 1938). For Adler, a basic human motivation was the **desire to belong** and **make a contribution**. Around the world, he would go on to inspire generations of child-care workers, educators, and therapists. His theory was outside Freud's "box," and the practice of seeing parents in a session soon followed.

In 1933, Sándor Ferenczi, a Hungarian psychiatrist, departed. He has often been an unsung hero in the history of psychoanalysis. First, he substantiated with family members that many patients were not fantasizing but were victims of **childhood molestation** (Ferenczi, 1949). As a leading psychoanalyst at the University of Hungary, he would mentor Melanie Klein, a developer of **object relations theory** and who would mentor John Bowlby, whose sweeping work in